Article Type: Editorial**Article begins on page three of this document.**

Title	Screening for perinatal depression: is it enough?
--------------	---

Authors:

	Title	First name	Mid inits	Last name	Postnom (eg, PhD)	Position1	Address1	Position2	Address2	Tel	Email
1	Prof.	Philip	M	Boyce	MBBS, MD, FRANZCP	Professor of Psychiatry	1		2	8890 6687 / 0412 869 288	philip.boyce@sydney.edu.au
2	Prof.	Fiona		Judd	MBBS, DPM, FRANZCP, MD	Professorial Fellow	3	Perinatal Psychiatry	4	390357 122	fiona.judd@ths.tas.gov.au

Number of corresponding author:	1
Number of alternative corresponding author:	

Addresses:

	Institution	Postal address	City	State	Post Code	Nation
1	Westmead Hospital	Sydney Medical School, Westmead Clinical School, Faculty of Health and Medicine, University of Sydney	Sydney	NSW	2145	
2	Westmead Clinical School, University of Sydney	Westmead Hospital	Sydney	NSW	2145	
3	University of Melbourne	1 North, Main Block	Melbourne	VIC	3052	
4	Child and Adolescent Mental Health Services South	4 Liverpool Street	Hobart	TAS	7000	
5						

Postal address of first corresponding author (if different from the institutional address given above)	
--	--

Primary Keywords [Office use only]	Health services administration; Mental disorders
Secondary keywords [Office use only]	Public health; Depression, postpartum; Personality disorders
Notes:	

Article details (press ctrl – 9 to enter details):**Office use**

This is the author manuscript accepted for publication and has undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the [Version of Record](#). Please cite this article as [doi: 10.1002/mja2.12054](https://doi.org/10.1002/mja2.12054)

This article is protected by copyright. All rights reserved

Article type	Editorial
Blurb	Questions about current social circumstances and stressors, social and family support are also needed
Pullquote	

<i>Ms. Number</i>	mja18.00998. R1
<i>Medical editor</i>	Zoe Silverstone
<i>Medical editor email</i>	zsilverstone@mja.com.au
<i>Structural editor</i>	Paul Foley
<i>Structural editor email</i>	pfoley@mja.com.au
<i>Section/Category</i>	Editorial
<i>Strapheading</i>	Editorial
<i>Substrap</i>	

Elsevier – file data:

Filename for copyediting	boy_mja18.00998_ms.docx
Accompanying graphics	None
Stock images	boy_mja18.00998_im.tif boy_mja18.00998_im.jpg
Appendices	None

Office use – history:

Event	Date
Original submission received	23/09/2018

Event	Date
Accept	13/11/2018

Proof sent to author	
Proof returned by author	
Published (date format xx/xx/xx)	14/01/19
Issue	1
Vol	210
DOI	10.5694/mja18.00998
Journal	The Medical Journal of Australia
Original article DOI (for response)	

Screening for perinatal depression: is it enough?

Questions about current social circumstances and stressors, social and family support are also needed

Mental health problems in women during the perinatal period (from conception until the end of the first postnatal year) may cause significant morbidity and adversely affect the development of their children,¹ possibly mediated by stress-related epigenetic changes or impairment of the mother–infant relationship. Identifying and treating women with mental health problems during the perinatal period, a time when they are in regular contact with health care professionals, is accordingly important.

Screening with the Edinburgh Postnatal Depression Scale (EPDS) has been introduced as part of routine antenatal care. The EPDS was originally designed to identify postnatal depression,² but is now also used to identify depression and anxiety during pregnancy. Screening is recommended in many guidelines and jurisdictions, including in Australia;³ further, obstetricians are being encouraged to undertake screening with increased benefits under the Medicare Benefits Schedule (MBS).

Although screening is recommended in Australia, not all women are screened, as reported by San Martin Porter and colleagues⁴ in this issue of the Journal. They note that the screening rate has, however, increased over time. Of concern is the fact that many of the women who did not complete the screening questionnaire in their study were at particular risk of depression: Indigenous Australians, women born overseas, older women, and women who were either single or separated. The lower screening rates in the private sector identified by the authors reflect the situation before the MBS rebates for obstetricians were improved.

Screening during the perinatal period has, importantly, raised awareness about the importance of identifying maternal mental illness and the impact it can have on the infant. But it is not enough.

Screening is only a first step in providing mental health care for women. While screening rates may be useful indicators, whether appropriate pathways of care (with adequate staffing) are available to follow up women identified as being at risk, whether women accept follow-up, and whether screening improves outcomes are more crucial questions.⁵

Identifying women at higher risk of depression (those who score 13 or more on the EPDS) should trigger a comprehensive biopsychosocial psychiatric assessment.⁶ This is essential because the EPDS identifies women with significant symptoms which indicate that something is awry, and what underlies these symptoms requires deeper

evaluation.

Such an assessment should at least include a comprehensive review of the symptoms and, most importantly, their context.⁷ It is often these contextual problems (such as lack of social support, interpersonal difficulties, or personality dysfunction) that can lead to a woman subsequently having difficulties managing her infant rather than the depressive symptoms per se. This assessment must precede planning management; identifying the problem is not sufficient reason alone for prescribing antidepressants or a course of psychological treatment. Detailed evaluation is required, perhaps including, according to the circumstances, specialist psychiatric assessment.

Screening has some significant limitations. First, the EPDS identifies many women as being at risk because they are experiencing stress at the time they complete the questionnaire in a booking-in clinic.⁸ It is essential that the questionnaire is repeated two weeks later to check whether a woman's score remains high.⁹ Conducting a full evaluation because of a high score on a single assessment would unnecessarily burden limited resources.

Second, the EPDS will not identify women who have more severe mental disorders, such as schizophrenia or bipolar disorder. These women often have major difficulties after giving birth, including relapses of their mental illness, and doctors should specifically ask about these disorders. Further, the EPDS will not identify which women will subsequently experience a postpartum psychosis. Women who do are generally asymptomatic while pregnant and have no identifiable risk factors (but may have a family history of bipolar disorder or severe postpartum mental illness), but suddenly develop psychotic symptoms during the first 3 weeks after giving birth, a time when the disorder poses the most serious threat to their newborn child.

Third, depressive symptoms will often arise in women with severe personality disorders.¹⁰ These women will have the greatest difficulties in forming healthy attachments to their babies, leading to substantial problems with parenting. Focusing on depressive symptoms in women with serious personality disorders will not deal with the complex problems that underlie the woman's depression and her difficulties with the mother–infant relationship.

In addition to the EPDS, screening should therefore also include questions about current social circumstances and stressors, social and family support, and current or past treatment for mental illness (Box). Importantly, such enquiries should be made not only at the booking in visit when the EPDS is completed, but also at regular intervals throughout the perinatal period.

Competing interests: No relevant disclosures.

Provenance: Commissioned; externally peer reviewed.

Author details

Philip M Boyce^{1,2}

Fiona Judd^{3,4}

- 1 Westmead Hospital, Sydney, NSW.
- 2 Westmead Clinical School, University of Sydney, Sydney, NSW.
- 3 University of Melbourne, Melbourne, VIC.
- 4 Child and Adolescent Mental Health Services South, Hobart, TAS.

philip.boyce@sydney.edu.au

doi: 10.5694/mja18.00998

See Research, p. 000.

References

- 1 Howard LM, Molyneux E, Dennis CL, et al. Non-psychotic mental disorders in the perinatal period. *Lancet* 2014; 384: 1775-1788.
- 2 Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression: development of the 10-item Edinburgh Postnatal Depression Scale. *Br J Psychiat* 1987; 150: 782-786.
- 3 Austin M-P, Hight N, Group EW. Mental health care in the perinatal period: Australian clinical practice guideline. Melbourne: Centre of Perinatal Excellence, 2017. <http://cope.org.au/about/review-of-new-perinatal-mental-health-guidelines> (viewed Nov 2018).
- 4 San Martin Porter MA, Betts K, Kisely S, et al. Screening for perinatal depression and predictors of underscreening: findings of the Born in Queensland study. *Med J Aust* 2019; 210: 000-000.
- 5 Thombs BD, Arthurs E, Coronado-Montoya S et al. Depression screening and patient outcomes in pregnancy or postpartum: a systematic review. *J Psychosom Res* 2014; 76: 433-446.
- 6 Malhi GS, Outhred T, Hamilton A, et al. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders: major depression summary. *Med J Aust* 2018; 208: 175-180. <https://www.mja.com.au/journal/2018/208/4/royal-australian-and-new-zealand-college-psychiatrists-clinical-practice>
- 7 Boyce P, Lyndon B, Outhred T, et al. Priorities in the assessment and management of perinatal mood disorders. *Aust N Z J Psychiatry* 2017; 51: 1082-1084.
- 8 Matthey S. Are we overpathologising motherhood? *J Affect Disord* 2010; 120: 263-266.
- 9 Matthey S, Ross-Hamid C. Repeat testing on the Edinburgh Depression Scale and the HADS-A in pregnancy: Differentiating between transient and enduring distress. *J Affect Disord* 2012; 141: 213-221.
- 10 Apter G, Devouche E, Gratier M, et al. What lies behind postnatal depression: is it only a mood disorder? *J Pers Disord* 2012; 26: 357-367.

Box. Assessing pregnant women who score 13 or more on the Edinburgh Postnatal Depression Scale (EPDS)

The symptoms

- Have the symptoms endorsed on the EPDS been present for several weeks or more?
- Have these feelings interfered with daily activities?
- Has something happened recently that triggered these symptoms?

Psychiatric history

- Is the woman taking (or has recently ceased taking) medications for mental health problems?
- Is she currently receiving treatment from her GP, a psychologist, psychiatrist, or a mental health service? If so, for which disorders, and what treatments is she receiving?
- Has the woman had any mental health problems in the past, has she been treated for a mental disorder (including as an inpatient), and has she received any psychotropic medication?
- Did she have any mental health problems during earlier pregnancies or during the postpartum period? If so, which treatment did she receive?

Assessing quality of relationship

- Is her partner emotionally supportive (do they listen to her concerns) and do they provide practical support?
- Is she now or has she ever been in an abusive relationship?
- Has she been in difficult relationships in the past? If so, which difficulties were there?

Assessing social circumstances

- Does she have suitable and stable housing?
- Is she financially secure?
- How extensive and available is her social and family support?
- How extensive and how serious are any current stressors?

Further risk assessment

Assessing the risk of postpartum psychosis

- Is there a family history of bipolar disorder or severe postpartum mental illness?

Assessing significant personality dysfunction

- Does the woman have frequent or intense mood swings or difficulty in controlling her emotions? Does she have episodes of intense or difficult to control anger?
- Has she ever tried to hurt herself or attempted to kill herself?

Assessing problematic substance use

- How much alcohol did she drink before she was pregnant, and how much since becoming pregnant?
- Did she use cannabis or other illicit substances before she was pregnant or since becoming pregnant? If so, how much?

Minerva Access is the Institutional Repository of The University of Melbourne

Author/s:

Boyce, PM;Judd, F

Title:

Screening for perinatal depression: is it enough?

Date:

2019-01-14

Citation:

Boyce, P. M. & Judd, F. (2019). Screening for perinatal depression: is it enough?. MEDICAL JOURNAL OF AUSTRALIA, 210 (1), pp.19-20. <https://doi.org/10.5694/mja2.12054>.

Persistent Link:

<http://hdl.handle.net/11343/284961>