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**on Preventive Health Care**
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## PPP Depression – Clinician Summary

This guideline on screening for depression during pregnancy and the postpartum period provides guidance to primary care health professionals (e.g., physicians, nurses, midwives or other providers) who could serve as first point of contact for care during pregnancy or the postpartum period.

### Population

This guideline is intended for individuals who are pregnant or who are within 1 year of having given birth. The recommendation extends to individuals who may be at an elevated risk of depression (e.g., trauma in early life, family history of depression). It does not extend to individuals with a personal history or current diagnosis of depression or another mental health disorder, those receiving assessment or treatment for mental health disorders, or those seeking services due to symptoms of depression.

### Recommendation

*The Canadian Task Force on Preventive Healthcare recommends against instrument-based depression screening using a questionnaire with cut-off score to distinguish “screen positive” and “screen negative” administered to all individuals during pregnancy and the postpartum period (up to 1 year after childbirth) (conditional recommendation, very low-certainty evidence).*

This recommendation assumes that, as part of usual care during pregnancy and the postpartum period, care providers will inquire about and be attentive to mental health and well-being.

### Putting into Practice

The term ‘screening’ in this recommendation refers to a routine process in which primary care providers administer an **instrument such as a questionnaire to every pregnant or postpartum individual not already reporting symptoms of depression and then use a cut-off score** to determine a follow-up action for those at or above the cut-off score.

Clinicians in primary care settings are advised:

- To inquire about and be alert to the mental health and well-being of pregnant or postpartum patients as part of usual care during visits.
- Not to systematically screen pregnant or postpartum individuals using screening instruments like the Patient Health Questionnaire (PHQ) or the Edinburgh Postnatal Depression Scale (EPDS) that provide a cut-off score to determine who may be depressed.
- Proceed with additional assessments of referrals using their clinical judgment based on responses to questions about well-being as well as other information about the patient.

Screening may be current practice in some jurisdictions. The Task Force suggests that jurisdictions may reconsider the use of such screening where it is already implemented.

**Burden of Illness**

Estimates of the prevalence of depression during pregnancy or the postpartum period vary. A 2005 systematic review estimated the point prevalence of major depression during pregnancy and postpartum from 1% to 6% at different time points (from the first trimester of pregnancy to one year postpartum). A 2008 national survey in the USA reported that the 12-month period prevalence of depression was 8% among pregnant individuals and 9% in postpartum individuals, compared to 8% among non-pregnant individuals.

Consequences of untreated depression during pregnancy and the postpartum period may impact the childbearing individual and their infant individually, as well as parent-infant interactions and relationships with partners.

**Potential consequences for the childbearing individual**

- Increased likelihood of future anxiety or depression
- Lower quality of life
- Increases in risky behaviours (e.g., tobacco smoking or alcohol consumption)
- Suicidal ideation

**Potential consequences for the infant**

- Delays in physical and mental development, including cognitive and language development
- An increase in overall infant health concerns

**Potential consequences on parent-infant interactions**

- Reduced breastfeeding
- Poor parent-infant bonding

**Basis of Recommendation**

**Evidence**

The available evidence on screening is very uncertain, due to the lack of high-quality studies on the benefits and harms of screening. Only one randomized trial of screening postpartum individuals was identified in our review of the literature, and the evidence it provided was of very low certainty. This means that the true effects of screening are likely substantially different from the study data. No studies were identified on screening during pregnancy.

Although no evidence was found on the harms of screening in our systematic review, evidence from other sources suggest the time and focus on screening could reduce opportunities to discuss other aspects of health during a perinatal primary care encounter as providers would be evaluating and potentially referring all patients who screen positive, in many cases unnecessarily. A study of the accuracy of the EPDS, for example, suggests that screening 100 patients with the EPDS, where the prevalence is 8% would result in 5 true positives, 3 false negatives, 5 false positives, and 87 true negatives.

**Rationale**

This conditional recommendation is based on the very low-certainty evidence on the effect of screening on benefit outcomes and limited evidence of harms. While it is very uncertain whether

screening provides a benefit over usual care, it could lead to an increase in false positives, false negatives, unnecessary referrals and diagnostic evaluation, and overdiagnosis for some patients.

- A false positive can occur when the patient meets a screening cut-off score and is sent for additional psychiatric evaluation, which finds they do not actually meet the diagnostic criteria for depression.
- Overdiagnosis could occur in patients with mild temporary symptoms, who might meet a screening cut-off score, leading to further evaluation and possible referral to specialty mental health services, but who would not benefit as the symptoms would subside on their own.

Given the significant challenges to accessing mental health services in Canada, the unnecessary redirection of resources from the treatment of patients with mental health disorders could be an unintended harm of screening. The Task Force is mindful of the resource constraints faced by our primary health care system and as such makes recommendations against interventions when the resource implication of a particular health intervention are certain to be important and benefits have not been demonstrated.

Depression during pregnancy and the postpartum period—Clinician FAQ:
**English:** https://canadiantaskforce.ca/tools-resources/chlamydia-and-gonorrhea-clinician-faq/
**French:** https://canadiantaskforce.ca/tools-resources/chlamydia-and-gonorrhea-clinician-faq/?lang=fr

Depression during pregnancy and the postpartum period—Patient FAQ:
**English:** https://canadiantaskforce.ca/tools-resources/chlamydia-and-gonorrhea-patient-faq/
**French:** https://canadiantaskforce.ca/tools-resources/chlamydia-and-gonorrhea-patient-faq/?lang=fr

Depression during pregnancy and the postpartum period—Infographic:
**English:** https://canadiantaskforce.ca/tools-resources/chlamydia-and-gonorrhea-infographic/
**French:** https://canadiantaskforce.ca/tools-resources/chlamydia-and-gonorrhea-infographic/?lang=fr