Guideline on instrument-based screening for depression during pregnancy and the postpartum period – reviewer comments and CTFPHC responses

Reviewer 01 (Stakeholder): Dr. Donna Stewart, Canadian Psychiatric Association

Disclosure(s):
Unrelated section co-editor for the effects of maternal antidepressant medication exposure on the fetus/newborn for UpToDate
CIHR grant co-investigator on maternal choice of antidepressants
I have written publications on perinatal depression
Membership in International Association for Women's Mental Health

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** (No comments provided)	Thank you
3. Are the guidelines supported by the evidence?	**Yes** (No comments provided)	Thank you
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** Please emphasize that "usual care" is expected to routinely have discussions about overall wellbeing, depression, anxiety, mood history and family history of mental disorders. Established perinatal care in practice does not always include these questions and to my mind the only advantage of a screening questionnaire is to ensure this inquiry occurs.	We agree with the suggestion to emphasize what would be expected from providers who are providing usual care. We have noted in the 'Key Points' and 'Recommendation' sections that this recommendation assumes that usual care during pregnancy and the postpartum period includes inquiry and attention to mental health and wellbeing. We have also emphasized in the implementation section, "*the*

		task force definition of screening in this context means that the recommendation against screening emphasizes the importance of good clinical practice where clinicians should inquire and be alert to changes in physical and mental health symptoms of their patients. Given the health implications of depression during pregnancy and the post-partum period, it is essential that providers inquire about and be attentive to mental health and wellbeing. If providers are uncertain about how to engage in these discussions with patients, they may consider referring to questionnaires for discussion prompts (without engaging in formal screening by using the questionnaire score for determining subsequent actions)."
5. Do you have any comments or suggestions to improve the guideline?	Conclusions and key points need to include the expectation that inquiries about wellbeing, depression, anxiety, mood, past history and family history of mental disorder are part of expected established routine perinatal care. Key messages to the Public are unclear! The word "monitor" should be replaced by asking about wellbeing, mood, anxiety, past history and family history of emotional disorders. The word "speak to" should be replaced by "discuss with".	Thank you for this suggestion. We have emphasized in the 'Key Points' and 'Recommendation' sections that the recommendation assumes that usual care involves inquiry and attention to mental health. We have added your suggested edits to the 'Key Messages to the Public.' We have also made some other minor edits to this section to better emphasize what is expected of care providers.

Reviewer 02 (Peer reviewer): Dr. Michel Joffres

Disclosure(s): None

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** (No comments provided)	Thank you
3. Are the guidelines supported by the evidence?	**Yes** Actually, the guideline is supported by the lack of quality evidence, which leads to a very-low-certainty evidence assessment. You might want to reword this question to: 3. Are the guidelines supported by the evidence or the lack of evidence? Or something like that.	Thank you for pointing this out. We will consider alternate wording for our stakeholder questionnaires in the future.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**No** (No comments provided)	Thank you
5. Do you have any comments or suggestions to improve the guideline?	While the recommendation is about screening or not screening, I am wondering if there is a place to address the issue of having different approaches in each province and probably within provinces. This is a bigger question of standardization of clinical care, but the wide range of approaches in current use (Appendix) begs the question of the efficacy of these approaches when it comes to pregnant and postpartum women. And this is beyond the	Thank you for raising an important point. We have highlighted this variation in practice in the implementation section of the manuscript. We have also added a sentence to the introduction indicating that this variation in practice is part of the impetus for this guidance. Ultimately, Task Force guidelines are advisory in nature, and not compulsory, and thus it will be up to the various

	recommendation that you have, "Jurisdictions may reconsider the use of such screening in settings where screening is currently implemented. " I would suggest adding to this "systematic" in front of screening since there is a form of screening in clinical care, which is not systematic.	jurisdictions to make decisions about implementing the recommendation. We will also be developing knowledge translation tools to aid in this endeavour. We have also added additional detail to the introduction to clarify how we define screening for the purposes of this guideline, including the use of the term 'systematic' as suggested.

Reviewer 02 (Peer reviewer): Dr. Nicole Letourneau

Disclosure(s): None

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** --The objective is found if one examines the scope and recommendations statements; however, the guideline could benefit from a clear statement that uses the word "objective".	While we appreciate the clarity that a specific 'objective' statement might bring, to maintain consistency with the wording used in other task force guidelines, and the required sections of the guideline as per the journal, we have maintained the 'Scope' section as is.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** (No comments provided)	Thank you
3. Are the guidelines supported by the evidence?	**No** No, it is insufficient to base this recommendation against screening on one clinical trial in Hong Kong that showed no effect of screening on outcomes. Moreover, patient engagement methods are not described in terms of how sample identified and recruited, how data collected, how data analyzed,	A rigorous and transparent systematic review process was undertaken to inform this guideline (to be published with the guideline). We did not identify any evidence other than the single trial described in the guideline. As per international standards in guideline development, a recommendation in favor of a recommendation is made when there is evidence of a net benefit from the

	how sample size determined. It is difficult to assess this evidence as the methods are not clear.	intervention, compared to no intervention or usual are. In this case, there is no evidence demonstrating benefit for carrying out screening over usual care, and thus, we cannot recommend in favor. The alternative proposition would be to recommend that clinicians carry out a medical intervention that is not shown to benefit patients, which would not be appropriate. We have added additional detail to the methods section about how patients were engaged for the guideline. The methodology for developing the guideline is described in the methods section, which references the GRADE handbook that includes extensive details. More details related to the systematic review will be published along with the guideline. Challenges related to the methodology of the included study in the guideline are one of the contributing factors to the uncertainty of the evidence base.
	The stakeholder engagement was far too limited in restriction to just patients. Primary care and perinatal care providers ought to have been invited to take part in the engagement efforts.	We agree that restricting to just patients would be limiting. In addition to the peer review that you have provided, we have also sought critical review by a number of stakeholder organizations, including generalist organizations such as the College of Family Physicians of Canada, and specialist organizations such as the Canadian Psychiatric Society and the Society of Obstetricians and Gynecologists of Canada, among others. We received critical review from 12 stakeholder organizations. This represents one of our key stakeholder engagement activities that is standard for all Task Force guidelines. The guideline will undergo additional anonymous peer review coordinated by CMAJ before publication as well.

4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** --Patient engagement efforts revealed that mothers wanted to be asked about their symptoms, and were concerned this would not happen unless a screening was undertaken. The guideline then makes the assumption that mothers will have mental health assessment, regardless of screening. This assumption of an adequate perinatal mental health assessment is NOT UNDERPINNED BY PROVIDED EVIDENCE. That is, what evidence is there that perinatal clinical mental health care guidelines are in place (outside of screening), used and effective across the country? Can we be sure that all women are offered adequate perinatal mental health care by primary care providers? This evidence is required.	As noted in the guideline, asking women about their wellbeing, including mental wellbeing is a standard part of perinatal care in Canada. As noted in Appendix 1, almost all provinces and territories have guidance suggesting that patients be asked about their mental health during pregnancy and the postpartum period. Our systematic review of evidence did not identify any evidence that adding screening to this provides additional benefit. We agree that clinician non-adherence to guidance around inquiring about mental wellbeing is troublesome. However, this is a separate issue. We hope that by clearly indicating that clinicians should be inquiring into the pregnant and postpartum patients' moods we will help support standard of care. We will also be developing knowledge translation tools to accompany the guideline that will help in this endeavour.
	What of the perinatal home visitor who is not trained in mental health assessment (e.g. for child welfare assessment), visiting a marginalized mother who struggles to see a physician or nurse practitioner (if she has one). A screening tool, in widespread use, would be a familiar way to grasp the mother's situation and make appropriate referrals and to recognize the seriousness of the situation in order to deploy appropriate resources.	As noted in the guideline, discussions about wellbeing, including around mental health, are part of established perinatal clinical care. Screening is not 100% mechanistic and may also require clinical judgment. Providers who are not trained to make general inquiries into wellbeing and mental health with their patients may not be suited to provide screening either. We have however made a clearer distinction between screening and usual care throughout the guideline, which also indicates that questionnaires could be used as discussion prompts for those uncertain how to broach the subject, without engaging in formal screening by using a cut-off score to determine next steps.

	The recommendation recognizes that marginalized women report barriers to disclosure and that this recommendation may result in some women with depression not being identified, yet deems that an insufficient reason to screen, concluding that "if screening is not effective, implementation of an ineffective program would not improve inequities". Based on the evidence presented, i.e. one clinical trial in Hong Kong, I cannot be persuaded that screening is ineffective. One study should not guide policy.	If additional evidence had been identified, we would certainly have used it. Unfortunately, in this case, the evidence base for decision-making is one study. This study does not provide evidence that systematic screening provides a benefit over usual clinical care, while potentially identifying a large number of women as being potentially depressed, who are not in fact depressed upon further evaluation. Marginalized women would therefore be undergoing additional labelling and psychiatric evaluation, with no known benefit to them. We have, however, made changes to the language in the equity section of the manuscript to remove speculation as to the overall impact on equity (e.g., the sentence you have quoted).
5. Do you have any comments or suggestions to improve the guideline?	See above comment on Question 4.	See response above.
	The evidence is insufficient to make recommendations against screening. The rationale statement refers to a systematic review that only includes one RCT and other guidelines. Of the 6 other guidelines, 3 recommend screening and 2 others recommend screening after more basic assessment. Only 1 recommends against. How this literature contributes to a recommendation against screening is unclear.	The 'Rationale' section does not make reference to other guidelines as this would not be appropriate. The 'Other Guidelines' section is provided so that readers can compare how these recommendations align with, or differ from, recommendations from other groups. Recommendations from other groups are not a form of evidence as per GRADE so should not contribute to the current recommendations. Recommendations from other groups could differ for a wide variety of reasons unrelated to the evidence (e.g., country demographics, medical systems) and thus the recommendations on their face cannot be used to contribute towards developing new Canadian recommendations.

		As noted in Box 2, a conditional or strong recommendation in favour of screening would require evidence that benefits outweigh harms. In this case, we have no evidence that screening provides benefits over usual care. We have also added considerable additional detail to the rationale section to outline the potential unintended harms of screening. As such, the evidence that we currently have available supports a recommendation against.
	I also disagree with the statement in the rationale that the time to screen can take away from clinical care. Screening can be done with 3-10 questions, that in my experience takes less than 5 minutes. Mothers could even fill out the screen while waiting for an appointment or in advance of an appointment. This would incur zero time out of the primary care appointment, if there is no concern and an entre to relevant discussion if there is a concern. --I find it strange that the guideline does not consider the low-cost/low-effort, essentially pragmatic use of screening in the balance of decision making regarding the recommendation.	While the screen itself may not take any more time than brief discussions, the higher likelihood of a false positive test means that more time is likely to be spent in primary care explaining test results and on the ensuing referrals, unnecessarily. We have clarified in the Rationale section that screening is likely to result in an increase in false positives, unnecessary referrals and diagnostic evaluation, and overtreatment for some patients. We have added additional data and references to support this. Based on data regarding the accuracy of screening tools, for example, we would anticipate that about 10% of all patients screening would require additional assessment and referral, with about half being false positives. Spending even 1-2 minutes per clinical encounter reviewing the results of a formal screening instrument with no proven value could consume a significant amount of time during a 15-minute encounter. This means that resources could be unnecessarily diverted from those with identified mental health concerns, who face considerable challenges accessing care in Canada.
	While patient engagement efforts are laudable, interviews with other stakeholders who routinely work with perinatal women including primary care providers and others such as public health nurses	As noted above, we have sought critical review by a number of stakeholder organizations, including generalist organizations such as the College of Family Physicians of Canada, and specialist organizations such as the Canadian Psychiatric Society and the Society of Obstetricians and

	and home visitors, would add an important dose of pragmatism to this recommendation.	Gynecologists of Canada, among others. We received critical review from 12 stakeholder organizations. This represents one of our key stakeholder engagement activities that is standard for all Task Force guidelines. The guideline will undergo additional anonymous peer review before publication as well. We also note that the majority of Task Force members are primary care providers who provide this type of care.
	There is a typo in the systematic review document on page 5, search for the work "nono".	Thank you for flagging this.

Reviewer 04 (Stakeholder): Dr. Suzanne Tough, Maternal Infant Child & Youth Research Network

Disclosure(s): None

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** The objective is clear however I have concerns that providers will interpret this as 'screening doesn't work' where as I wonder if the key message is more nuanced in that 'clinical care strategies to identify women with ppd are effective although screening by questionnaire may confer no additional benefit when current clinical practice includes inquiry into mood and mental health. There is some evidence that women prefer to be asked rather then needing to disclose – and screening can make exchanging this information easier (see Kingston). An inclusion of more than RCT designs would improve the guideline quality because cost-effectiveness studies are longer term compared to RCTs, and there is an opportunity for rigorous long-term observation designs. Evidence	Thank you for your wording suggestion to communicate the nuances of this recommendation. We have added considerable additional detail about usual care and how it is to be distinguished from screening to introduction and the Rationale section. We have also clarified in the 'Key Points' and 'Recommendation' sections that this recommendation assumes that usual care during pregnancy and the postpartum period includes inquiry and attention to mental health and wellbeing. See below for more detailed responses regarding inclusion of cost-effectiveness or other study designs. It is unlikely that these study designs would improve our certainty in the evidence using the GRADE system.

	does suggest cost-effectiveness of screening through the analysis of administrative data- from Canada.	
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** Other evidence suggests that screening in the postpartum period using the EPDS questionnaire would confer benefits above usual clinic care alone based on screening at the 2-month well child visit which resulted in 34% of annual PPD cases diagnosed, compared to the not screening alternative (usual clinic care), where only 7% of annual PPD cases are diagnosed. See Premji https://doi.org/10.1016/j.jad.2020.11.051.	Note that detection rates from administrative data would be considered very low certainty evidence for decision-making, and as such, would not provide additional basis for our recommendations. The referenced model also does not reflect the decision-making being examined in this guideline. In this model, which examines the downstream outcomes of a patient accepting an offer to screen or not, individuals in the postpartum who are not screened would only be diagnosed with depression if they self-refer. Thus, it examines a different clinical scenario than this guideline (normal clinical care where clinicians will inquire into feelings of mood or other depression symptoms, versus universal screening with a questionnaire and cut-off score dictating clinical follow-up).
	Of note, the idea of identifying women at risk based on past history may be problematic- what is past history and would discussion of past history be any more time efficient than screening?	Past history means that the individual has received a formal diagnosis of depression in the past or has otherwise experienced depression. In operationalizing this guidance, determination of past history of depression diagnosis occurs prior to the determination of whether this guidance versus alternate guidance might apply to the individual, so in practice would not factor into whether a recommendation in favor or against screening is more time efficient.
3. Are the guidelines supported by the evidence?	**Yes** Although as noted, these guidelines are an outcome of lack of high quality evidence compared to information suggesting that screening is ineffective. Other evidence looking at cost effectiveness and	While we appreciate the suggestion, other sources of evidence such as detection rates and cost-effectiveness would not change the conclusions of the guideline. First, these sources of evidence are typically considered of very low certainty, and thus would not increase our confidence in

	rates of identification using different approaches may bring important nuances to the guidelines. Eg Premji https://doi.org/10.1016/j.jad.2020.11.051 and Premji S, McDonald S, Preventive Medicine Reports. June 2019, 14: 100888. DOI: 10.1016/j.pmedr.2019.100888.	the impact of screening. Second, the standard approach to developing evidence-based clinical practice guidelines is to focus on patient-important health outcomes. Detection rates, for example, do not indicate whether an intervention provides a benefit or a harm to patients without looking at downstream health outcomes. One study you have provided, for example, indicates that 51% of women with a positive EPDS screen had at least one subsequent doctor visit for PPD, but does not indicate whether that ultimately improved their health. The group that screens positive on the EPDS (for example) will include individuals who do not in fact have depression upon further testing (63% in the Premji study, which aligns with a recent meta-analysis on the accuracy of the EPDS), and thus will not benefit. Similarly, in the one RCT identified for this guideline, it was very uncertain whether there is an improvement in downstream health outcomes for women who are screened versus not screened. Detection of more cases, in the absence of downstream clinical outcomes, does not suggest a benefit (and may suggest harm). Similarly, if an intervention if not effective, it cannot be cost-effective, and one would not recommend in favor of something that may cost more than the alternative (i.e., usual care) if there is no benefit to patients. The Task Fore recommendations are based on patient-important outcomes, as listed in the methods section.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** The guidelines are clear that identification of ppd through usual clinical care and understanding of risk factor (prior history of mental health concerns) is likely to identify women at risk. One piece of information relevant to primary care is the comfort	Thank you for this suggestion. We have emphasized in the 'Key Points' and 'Recommendation' sections that the recommendation assumes that usual care involves inquiry and attention to mental health, and throughout the manuscript that a recommendation against instrument-

	providers have asking about mental health and the value of a 'tool' to ensure that no women is missed in follow up. So, for ease of interpretation I would structure some sentences to re-inforce that identification of women with ppd is very important and can be accomplished through routine clinical care.	based screening should not be interpreted as a recommendation against inquiring about mental health.
5. Do you have any comments or suggestions to improve the guideline?	It may be helpful to emphasize that all women should be asked about mood routinely and the use of a screening tool may assist some providers in ensuring no one is missed. This is similar to evidence on screening for alcohol use- it is important to ask about substance use and a tool can be a mechanism to ensure it is routinely asked. I think the guidelines should be clear that identification of women with ppd is important as it facilitates diagnosis and treatment.	We have emphasized in the 'Key Points' and 'Recommendation' sections that the recommendation assumes that usual care involves inquiry and attention to mental health. We have also made additional clarifications about what is involved in usual care and how that is distinguished from screening. We have noted that if providers are uncertain about how to engage in these usual care discussions with patients, they may consider referring to questionnaires for discussion prompts (without engaging in formal screening by using the questionnaire score for determining subsequent actions).
	There are some limitations to only relying on systematic reviews and RCTs, as for public health issues, diverse reputable sources are available and in the literature, a well-designed observational study can trump a RCT. Because there are limited RCTs in this area, there may be value in expanding the search to other types of study designs. (See: v056p00119.pdf (nih.gov))	The Task Force did not consider observational or other sources of evidence for the main question about the effectiveness of screening, as RCT evidence was available. Given that observational studies begin as low certainty evidence as per GRADE, it is unlikely that additional observational evidence would increase our certainty regarding the effects of screening.

Reviewer 05 (Stakeholder): Dr. Sarah Gower, Society of Rural Physicians of Canada

Disclosure(s):
Research grant from Canadian Federation of Medical Women
Research grant from PSI (Physicians Services Incorporated)

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** It is clear for sure. To be honest I'm surprised by how narrow the scope of this review is in terms of really only addressing, "hand them a quiz, yes or no" when mood disorders in pregnancy & postpartum are so important. But it's clear.	As noted in the introduction, screening is not simply having a patient fill out a quiz. We have added additional clarification in the introduction to clearly describe screening and distinguish it from usual care: "*In addition to usual clinical care, screening for depression would involve the systematic administration of a screening instrument (most commonly a questionnaire or small set of questions) with a pre-defined cut-off score to all pregnant or postpartum people in a particular setting such as a clinic. Individuals who meet or exceed the cut-off score would be considered "screen positive" and would be further evaluated to see if they meet diagnostic criteria for depression, whereas those below the cut-off score would be "screen negative" and would not be further evaluated"* The score on the screening questionnaire directly dictates the pursuant clinical action (e.g., referral to mental health professional). This is a key distinction between screening and simply having discussions or asking questions about mental health, and we hope the added detail to the manuscript makes this a clear as possible for readers. As noted in the implementation section, some jurisdictions may be using this type of screening to identify potentially depressed patients, while our systematic review suggests there is no clear evidence of benefit from this activity, thus it is an important clinical question to examine.

2. Are the patient groups to whom the guideline is meant to apply clearly described?	**No** I said "no" here because you only discuss women and pregnant women. I would strongly encourage you to use inclusive "pregnant people" wording as is now widely used in other organizations of similar stature – PCMCH in Ontario is great at this, for example.	Thank you for this helpful suggestion. We have revised to 'people' or 'individuals' throughout the guideline to be more inclusive.
3. Are the guidelines supported by the evidence?	**Yes** (No comments provided)	Thank you
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** As above, I think this guideline is too narrow. One useful place to start would be describing "usual care" which is assumed to be alternative to a formal screen. How can primary care discuss these topics with patients and ensure we aren't missing anyone?	Usual care is defined in the introduction of the guideline, and we have added additional detail to distinguish between usual care and screening. We have also emphasized in the 'Key Points' and 'Recommendation' sections that the recommendation assumes that usual care involves inquiry and attention to mental health. Knowledge translation tools will be developed to accompany this guideline to help support guideline implementation.
5. Do you have any comments or suggestions to improve the guideline?	As above.	See responses above.

Reviewer 06 (Stakeholder): Dr. John Higenbottam, Psychosocial Rehabilitation

Disclosure(s): None

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** (No comments provided)	Thank you
3. Are the guidelines supported by the evidence?	**Yes** (No comments provided)	Thank you
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**No** (No comments provided)	Thank you
5. Do you have any comments or suggestions to improve the guideline?	No	Thank you for your review

Reviewer 07 (Peer reviewer): Dr. Catherine Lebel

Disclosure(s): None

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** However, it would be good to see an acknowledgment that many women are under-served, and both more vulnerable to depression and more vulnerable to medical discrimination.	Thank you. This point has important relevance to the guideline's equity considerations. We have touched upon potential barriers to disclosing depressive symptoms faced by marginalized women in the 'Feasbility, acceptability, equity' section. This is also touched upon in the Evidence to Decision framework (appendix 1): "there could be an impact on equity if screening is implemented and resources are redirected away from treatment of patients with known mental health disorders who often do not receive adequate treatment and are re-allocated to universal screening."
3. Are the guidelines supported by the evidence?	**No** Absolutely not. Guidelines should be changed based on evidence presented, and not presented here. See attachment for more detailed comments. [see question 5]	The Task Force cannot recommend that resources be used by clinicians to implement an intervention that is not shown to provide a benefit to patients. See response to question 5 for additional detail.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** Relevant background and some evidence is missing. See attachment for major comments. [see question 5]	Thank you. See response to question 5.
	Minor: p.5 contains a "TO CITE" reference, which should be updated with the real reference.	This will be updated prior to publication. Thank you.
5. Do you have any comments or suggestions to improve the guideline?	Yes – these guidelines should be reconsidered in favour of screening, given substantial evidence of harm for untreated perinatal depression, some	Please see responses to individual concerns below.

	evidence in support of screening, and no evidence of harms of screening. See comments below.	
	Perinatal depression is a very serious public health issue and the harms associated with untreated depression, for mother and baby, are huge. With no evidence of harm associated with screening, I believe that recommendations of a task force should err on the side of providing more support to perinatal women in order to prevent these very real harms. Thus, there is a high bar to meet in terms of lack of evidence for screening benefits and/or clear evidence of screening harms. The evidence does not meet this bar. The recommendation against screening in this report is problematic for several reasons and is unsupported by the evidence. **The recommendation should be changed in favour of screening based on evidence presented within the report and other evidence not included.** I have outlined my concerns in more detail below, which boil down to a few key points: (1) without screening, depression is often missed (including in pregnant and postpartum women), (2) the report misses or downplays evidence in support of screening, while suggesting there are harms in the absence of evidence, (3) these guidelines go directly against the views of the patients consulted, and (4) the guidelines appear to contradict the same task force's guidelines for depression screening in adults.	
	Untreated perinatal mood disorders are a huge societal concern and should be treated as a very serious problem. The estimated cost associated with untreated perinatal mood and anxiety disorders in is huge: American research estimates these costs at	We agree wholeheartedly that perinatal mental health is incredibly important for parents, families, and society in general. Development of rigorous, evidence-based guidelines is a very resource intensive process, and as such is only done for topics that are of high priority.

	$14 billion, or $31,800 per mother-child pair in just the first 5 year postpartum. Given that many negative outcomes last well beyond age 5 years, the real costs are likely much greater. However, the rationale for these guidelines appears to downplay the seriousness of the situation. For example, they only report prevalence of major depression in pregnancy (1-6%). However, minor depression is also of significant concern, given that it impacts the woman and has long-term impacts on her baby. Minor and major depression together are estimated to affect 6.5-12.9% of women at any given point in pregnancy, with as many as 19.2% of women experience a depressive episode in pregnancy or postpartum. There is only a brief mention of the serious, long-term outcomes for mothers and children of untreated perinatal mood disorders, including maternal mental health problems, breastfeeding, children's behaviour, brain development, long-term risk of mental illness.	Our intention is not to minimise the potential impacts of perinatal depression. We have noted the impacts of this condition in the introduction of the guideline, to the extent possible given restrictions on word count. We have also included a number of these important health indicators as key outcomes for decision-making in the guideline (depression symptoms, quality of life, patient-child and other family interactions, suicidality, infant health and development; see Appendix 1).
	Research shows that without screening, ~75% of depressed women are not identified by health professionals (Milgrom et al., 2014, Best Practice & Research Clinical Obstetrics & Gynaecology, 28: 13-23; Spitzer et al., 2000, *American Journal of Obstetrics and Gynecology, 183*(3), 759-769). Furthermore, women are often reluctant to seek psychological help during pregnancy and postpartum (e.g., Hadfield et al., J Midwifery Women's Health; 2017 Nov;62(6):723-736.).	Ultimately these studies relate to the issue of detection rates for screening versus usual care. As noted above, having more positive screening tests is not a potentially misleading metric unless it is accompanied by improvements in downstream health outcomes. As noted in our review, there is no clear evidence that screening improved health outcomes. A higher rate of positive screens without downstream health improvements suggests either a gap in the clinical pathway from screening to diagnosis and treatment, or false positives/overdiagnosis. We agree that not seeking help for mental health issues is a concern, and thus we have added emphasis throughout the manuscript that providers should ensure to ask patients

		about these issues during visits, as they may not divulge them otherwise.
	Evidence supports a positive effect of depression screening to reduce depression symptoms in pregnant and postpartum women. This report cites one study that found a significant effect of screening for depression on 6-mont postpartum EPDS scores. While this evidence is cited as "very uncertain", it does point to a positive effect. Furthermore, there is additional evidence for benefits of screening perinatal women for depression. See this review by the US Preventive Services Task Force: https://jamanetwork.com/journals/jama/article-abstract/2484344. They identified 6 relevant studies and concluded that "screening pregnant and postpartum women for depression may reduce depressive symptoms". I agree that the evidence could/should be stronger, but it clearly favours screening.	We disagree that the available evidence favours screening. As per the systematic review that informed this guideline, the evidence of benefit for adding screening on top of usual care is very low. This means "the true effect is likely to be substantially different from the estimate of effect." In such cases we cannot draw conclusions about the direction of effect. Given that there is no clear evidence of benefit, while there is evidence that screening will increase false positives and thus additional resources required to further evaluate patients unnecessarily, the Task Force cannot recommend in favour of screening. We have added additional data to the rationale section about false positives and the potential harms of screening which we believe strengthen the argument. The USPSTF review included additional studies, as they included studies where both groups were screened, or screening was included as part of a multicomponent intervention. They also included studies that did not provide similar management and treatment resources to the intervention and control groups. For example, in Yawn et al. the intervention group received education and tools for postpartum depression screening, diagnosis and initiation of therapy, while the control group received a 30-minute presentation about postpartum depression. In the judgment of the Task Force, such studies would not provide evidence that would allow us to draw conclusions about the effect of screening compared to usual care, given the confounding from the various components of the interventions. Certainty about the effect of screening from these studies would be even lower than the RCT included in our review.

	There is no evidence of harms associated with screening. This recommendation states this clearly, yet still suggests there are harms by saying that screening "could reduce opportunities to discuss other aspects of health…". This unsupported speculation should not factor into evidence-based decisions.	We have added additional information to the rationale section about potential harms including additional data and references, which demonstrate that this is not just speculation. For example, a recent meta-analysis using individual participant data found that a half of participants screened positive using the EPDS would be false positives, requiring additional referral and assessment. This is a burden on the individual patients, but also on the healthcare system. It is well established in Canada that patients struggle to obtain sufficient mental healthcare, and wait lists are very long. Providing screening would add to this burden, with no evidence of additional benefits for the patients.
	Concerningly, the guidelines go directly against the views of the patients included in this research. The patients consulted said that they "Very Much" (mean rating of 9) want to be screened during pregnancy and the postpartum period, rated the benefits of screening as "critical", and "expressed concerns that without screening, they may not be capable of identifying symptoms of depression". However, the current recommendations appear to dismiss these wishes and concerns, and instead conclude that "the recommendation against routinely using questionnaire-based screening of all pregnant and postpartum women should be acceptable to most patients".	We disagree that the recommendations go against the views of patients. From the patient engagement study conducted for this guideline: "[W]hile participants rated their preference to be screened fairly highly in the survey, focus group discussions indicated that participants felt most strongly about having a discussion with a healthcare provider about their mental health and wellbeing, rather than a formal screening process. They felt a discussion about depression with a primary health care provider during the pregnancy and [postpartum] period is critical[.]" This recommendation takes into account the above patient preferences and emphasizes the importance of having discussions about mental health with patients.
	The Canadian Task Force on Preventive Health Care recommends "screening adults in the general population for depression in primary care settings that have integrated programs for feedback to patients and access to case management or mental	The most recent guideline on depression screening from the Task Force, from 2013, recommends **not** screening for depression routinely in adults, including perinatal or postpartum individuals. Please see: https://www.cmaj.ca/content/185/9/775.full

	health care" (https://www.cmaj.ca/content/172/1/33). Why is this recommendation not extended to pregnant and postpartum individuals? What makes pregnancy and postpartum exempt from these screening benefits?	

Reviewer 08 (Stakeholder): Dr. Lisa Gagnon, Canadian Psychiatric Association

Disclosure(s):
Expert testimony on behalf of GlaxoSmithKline in 2016

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**No** The objective of the guideline is not clear. The use of the word "questionnaires" could mean a variety of things, including standardized measures and basic information gathering forms that clinics have created. While "usual care" has been recommended by several provinces, the guideline does not provide much direction on anything other than questionnaires and, if that is the objective, that could be more clearly stated.	Thank you for your comment. Most depression screening interventions involve the use of a questionnaire, where the answers are converted to a score and patients are deemed as potentially depressed and referred for additional evaluation based on the score. We have made extensive edits to the introduction of the manuscript to better describe what we mean by screening and screening instruments, and to distinguish this from usual care.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** (No comments provided)	Thank you
3. Are the guidelines supported by the evidence?	**No** There are a number of assumptions in the guidelines that are implied, yet not stated.	The systematic review that informed this guideline searched for evidence on any screening tool regardless of validity metrics. No evidence was identified for any tool other than the EPDS.

	One is that all questionnaires are similar in their validity, reliability and false negative / positive rates which is not the case. EPDS is considered by many working with this population as one of the best validated, quick tools.	Without evidence of clinical benefit, the Task Force cannot recommend that resources be used by clinicians to implement an intervention that is not shown to provide a benefit to patients. We have also added additional information to the rationale section about the accuracy of the EPDS, which helps clarify the potential unintended harms of screening.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** It is my professional opinion that this guidelines minimizes the severity, prevalence and importance of perinatal mental health problems. This is a vast opportunity to improve clinical care AND prevent poorer outcomes for our next generation. a. The literature cited around the prevalence of depression in perinatal woman is dated and lower than current research. Also it would be helpful if we are citing Canadian data. For a meta-analysis (non-Canadian) on this see: Woody et al. (2017.) A systematic review and meta-regression of the prevalence and incidence of perinatal depression. Journal of Affective Disorders.	We agree wholeheartedly that perinatal mental health is incredibly important for parents, families, and society in general. Development of rigorous, evidence-based guidelines is a very resource intensive process, and as such is only done for topics that are of high priority. Our intention is not to minimise the potential impacts of perinatal depression. We have noted the impacts of this condition in the introduction of the guideline, to the extent possible given restrictions on word count. We have also included a number of these important health indicators as key outcomes for decision-making in the guideline (depression symptoms, quality of life, patient-child and other family interactions, suicidality, infant health and development; see Appendix 2).
	b. See just a few examples of ways this condition impacts obstetrical outcomes, the health of offspring's even as an adult, maternal mortality noted in #3.	Thank you for the suggested reference, which the Task Force evaluated. Due to concerns with the types of depression measures allowed in the analysis, we did not feel we could include it in the introduction. Unfortunately, we were also not able to identify reliable data on Canadian prevalence.
	c. Is the recommendation that if clinicians are doing routine screening with questionnaires, they should stop? Would there be some instruments be better choices than others?	As we have noted in the 'Considerations for implementation' section, "*Jurisdictions may reconsider the use of such screening in settings where screening is currently implemented.*"

	Is there any recommendation around "usual care?" It is my professional opinion that universal screening with a validated instrument should be recommended.	No studies were identified to indicate that providing screening over and above usual clinical care provides additional benefit. The Task Force cannot recommend in favor of a medical intervention that is not shown to provide benefit when it may also have important resource implications. We have added additional detail and emphasis throughout the manuscript to emphasize the importance of good clinical practice where clinicians should inquire and be alert to changes in physical and mental health symptoms of their patients.
5. Do you have any comments or suggestions to improve the guideline?	It is my professional opinion that this guideline *perpetuates the stigma* of mental health conditions, while noting stigma as a negative outcome of screening. If anyone were to search ways to combat stigma, it would be to talk about it, to bring light onto the subject and to ensure this is considered a serious medical condition with a national strategy. There are so many universal guidelines around pregnancy, neonatal care, and postpartum. To name a few: screening for gestational diabetes, hypertension, vitamin K administration, (many countries) on prevention of RhD Alloimmunization, second trimester ultrasound, obesity guidelines, breast is best etc. But out of all of those, one of the *most common complications* of pregnancy and postpartum is a mental health condition. It cannot always be easily seen and certainly goes missed. The risk is high for these mothers, children, and family and for us as a society.	Labelling and stigma are noted in the guideline as outcomes of interest for the review. Stigma is listed as a potential harm of screening due to concerns that screening could increase stigma, as it is more likely to identify someone as potentially depressed. However, ultimately the direction of effect determines whether it is a harm or benefit (e.g., if it was found that screening actually reduced stigma, we would report this as a benefit). However, we did not find any data on this outcome. We agree that talking about mental health can help combat stigma, and the current recommendation encourages clinicians to ask their patients about these issues, without the use of formal screening (this has been further clarified and emphasized throughout the manuscript). Screening is likely to identify a significant number of patients as potential depressed, who are not in fact depressed, and this is clarified in the 'Rationale' section: "…*screening could…lead to an increase in false positives, unnecessary referrals and diagnostic evaluation, and overtreatment for some patients.*"

	I would suggest a cost analysis of undetected perinatal depression of Canadian society. The impact on preterm birth, low birth weight, infant developmental outcomes, including ACEs, workplace productivity, family impact, etc., would make the cost of universal screening and subsequent treatment miniscule by comparison.	We have also included a number of these important health indicators as key outcomes for decision-making in the guideline (depression symptoms, quality of life, patient-child and other family interactions, suicidality, infant health and development; see Appendix 1). As such, these issues are already factored into the guideline, although we have no evidence that screening improves these outcomes. In order to recommend in favour of implementing a screening intervention, we would require evidence that it has a beneficial impact on these outcomes. We have also added additional data regarding the accuracy of screening tests, which demonstrates that screening results in increased false positives, as well as a substantial proportion of false negatives.

Reviewer 09 (Stakeholder): Dr. Justin A Mills, Agency for Healthcare Research and Quality (AHRQ)

Disclosure(s):
I serve as a medical officer supporting the USPSTF
I was the medical officer assigned to the [US] Task Force's most recent recommendation on preventive interventions for perinatal depression

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** For the most part this was clear- the recommendation applies to generally "asymptomatic" pregnant and post partum women (up to 1 yr postpartum) and include women who	Thank you

	could be considered high risk for post partum/ perinatal depression.	
3. Are the guidelines supported by the evidence?	**Yes** Based on the inclusion/exclusion criteria for the TF's evidence review, only 1 study was included. I agree that there is likely limited evidence on the effect of screening (if compared to a non-screened cohort).	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** One area that was confusing was the language around usual care. The recommendation seems to imply that, in addition to the paucity of evidence, screening pregnant persons for depression is no more effective than usual care (described as discussion with women about their history of mental illness, current symptoms and well-being). However the authors then describe the widespread practice of screening pregnant women using screening questionnaires. One could ask whether usual care for pregnant persons is truly is general depression inquiries or general depression inquiries and perinatal depression screening (with EPDS)? If this is to be a key message I think there needs to be more clarity on this point.	Thank you for this suggestion. We have added additional emphasis throughout the manuscript about what would be expected under usual care. We have also added a sentence to the introduction to clarify that while some jurisdictions may include screening as part of standard care, we use the terms 'screening' and 'usual care' as they are defined in the introduction.
5. Do you have any comments or suggestions to improve the guideline?	One area that was confusing was the language around usual care. The recommendation seems to imply that, in addition to the paucity of evidence, screening pregnant persons for depression is no more effective than usual care (described as discussion with women about their history of mental illness, current symptoms and well-being). However the authors then describe the widespread practice of screening pregnant women using screening questionnaires. One could ask whether usual care	Thank you for flagging this issue which could cause confusion. We have added additional emphasis throughout the manuscript about what would be expected under usual care. We have also more clearly explained in the introduction that although practice varies in Canada, we use the terms 'screening' and 'usual care' as they are defined in the

	for pregnant persons is truly is general depression inquiries or general depression inquiries and perinatal depression screening (with EPDS)? If this is to be a key message I think there needs to be more clarity on this point. It might be useful to provide more background on the rationale for the inclusion/exclusion criteria- specifically on the decision to limit the review to studies with only a no screen comparison.	introduction. This also matches with how these terms are operationalized in the evidence base.
	I agree that very little data exists showing the effects of screening alone compared with no screening. But in light of the different conclusions around screening pregnant person for PND (for example from the USPSTF) it might be worth adding language on the rationale for this choice.	We have added additional clarification and data around some of the potential harms of screening, including diversion of resources caused by false positives or overdiagnosis as a result of screening, in a constrained healthcare system. Given the significant challenges to accessing mental health services in Canada, the unnecessary redirection of resources from the treatment of patients with known mental health disorders could be an unintended harm of screening. This helps highlight one key difference in the decision-making of the Task Force versus other groups in other jurisdictions.

Reviewer 10 (Stakeholder): Mara Grunau, Centre for Suicide Prevention

Disclosure(s): None

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you
2. Are the patient groups to whom the guideline is	**Yes** (No comments provided)	Thank you

meant to apply clearly described?		
3. Are the guidelines supported by the evidence?	**Yes** (No comments provided)	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**No** (No comments provided)	Thank you
5. Do you have any comments or suggestions to improve the guideline?	No	Thank you for your review

Reviewer 11 (Stakeholder): Janice Christianson-Wood, Canadian Association of Social Workers

Disclosure(s):
President of the Canadian Association of Social Workers (2016-2020) and current board member
Board member, Manitoba College of Social Workers
Former executive of IFSW, board member 2016-2020
Current member of the Commonwealth Organization for Social Work

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**No** The information is that there is no support for screening but fails to support 'usual care' in successfully identifying and providing treatment or	Note that women specifically seeking services due to symptoms of depression would not fall within the scope of this guideline, as this would be considered testing, not screening. This recommendation relates to providing

	access to treatment for women who report symptoms.	screening to all-comers that aren't seeking care due to symptoms. This is clarified in the scope section. Nevertheless, we have added information to the results section that describes the detection rates for probable depression in the intervention and usual care groups of the identified RCT. Note that while there may appear to be a higher rate of detection with screening, there was no evidence that this led to better downstream health outcomes. Similarly, recent individual patient data meta-analysis on the accuracy of the EPDS indicates that more than half of the EPDS screens in this study would have been false positives. We have also added this data to the rationale section to strengthen and clarify the argument. http://depressionscreening100.com/epds/ https://www.bmj.com/content/371/bmj.m4022 This helps provide some data to support usual care. Note that we did not compare usual care versus no intervention.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** Yes BUT inadequate in failing to provide adequate information about the diversity within the groups. Pregnancy can be experienced differently culturally, economically and regionally just as depression has factors needing service beyond medication or advice.	The Task Force would have considered data on the effects of screening for depression during pregnancy and up to one year postpartum for all population groups. As noted in the guideline, only one study was identified, from Hong Kong. Thus, it was not possible to create different recommendations for the variety of pregnancy experiences in Canada (although the recommendation applies to all pregnant and postpartum individuals). We have added this as a knowledge gap.

		We have also touched upon potential equity considerations, particularly for marginalized women. We have also revised 'women' to 'individuals' or 'people' throughout to better reflect the diversity of people who experience pregnancy.
3. Are the guidelines supported by the evidence?	**No** I really didn't get a sense that the evidence supported either a uniform screening OR relying on PCP to have the knowledge, time and experience to assess the onset of depression. There was an over-reliance on commonality of skills among PCP	In both the screening and usual care scenarios, individuals identified as potentially depressed are referred for additional evaluation and treatment. Therefore, the assumption inherent to this recommendation is that usual care during pregnancy and the postpartum period involves inquiry and attention to mental health followed by good clinical judgment for those who may be depressed. This has been clarified in the recommendation section and emphasized throughout the manuscript. Given the importance of this health issue, the Task Force must make a recommendation between adding a formal screening process to usual care, or maintaining usual care (with some assumptions) as opposed to not making a recommendation in either direction. However, we think the additional data that we have added to the rationale section about the potential harms of screening makes the argument against screening much clearer.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** The assumption is the PCP will gain trust quickly—there are ways that this could fail; gender, PCP experience, difficulties in obtaining appointments, PCP experience with mental health screening and obtaining information on social/economic threats.	We agree that this is an issue, and one that applies whether clinicians carry out formal screening or usual care discussions about mental health. We will be developing knowledge translation tools to help patients and providers understand and implement the recommendation.
5. Do you have any comments or suggestions to improve the guideline?	It doesn't provide real guidance for physicians on next steps. PCP are generally very busy and may lack the time/skills to gain patients' trust. Information	Thank you for this suggestion. We agree that the issue of competing priorities facing healthcare providers that applies across the suite of potential health interventions that can be

	needed for diagnosis/support may be gathered at less cost to the practice by a registered mental health social worker who could provide ongoing support to the patient. Quick access to mental health service is not the rule in MB especially outside major centres and in the North. Practices with/sharing onsite mental health supports are a significant benefit to patients.	delivered in primary care. However, this is beyond the scope of the current guideline, which is focused at providing national-level recommendations on whether to screen for depression. Much of the details about how recommendations will be implemented and by whom will be determined at the provincial/territorial or municipal level. We have however noted in the Rationale section that the current challenges that Canadians face in accessing mental healthcare could be exacerbated by false positive screens, which could be an unintended harm of screening. We hope also that the knowledge translation tools developed to accompany this guideline will serve as easy-to-use supports for clinicians.

Reviewer 12 (Stakeholder): Dr. Amy McGee, Canadian Association of Midwives

Disclosure(s): None

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Somewhat** The number of transgender and non-binary clients continues to increase – it is important to create guidelines that include this population and guide care providers to use gender inclusive language themselves	Thank you for pointing out this important consideration. We have revised to 'people' or 'individuals' throughout the guideline to be more inclusive.
3. Are the guidelines supported by the evidence?	**Yes** But it isn't overwhelming – having said that, the evidence supporting an intervention such as routine	Thank you, we agree with this assessment.

	screening should be persuasive, not necessarily the reverse	
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**No** It is clear	Thank you
5. Do you have any comments or suggestions to improve the guideline?	I think it will be acceptable to care providers and clients, and easily implemented	Thank you for your review.

Reviewer 13 (Stakeholder): Dr. Alison Shea, Society of Obstetricians and Gynaecologists of Canada

Disclosure(s):
Received honorarium from Pfizer
Received grant funding from Pfizer

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** (No comments provided)	Thank you

3. Are the guidelines supported by the evidence?	**Yes** But the evidence is limited with only 1 RCT, so it is limited.	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**No** (No comments provided)	Thank you
5. Do you have any comments or suggestions to improve the guideline?	It may suggest that future studies should involve RCT so that we may have stronger evidence to support stronger guidelines.	Thank you. We have indicated in the 'Gaps in Knowledge' section that "*Trials that compare screening to usual clinical care, where participants identified as depressed in either arm receive the same level of care, are needed in order to isolate the effectiveness of screening as an intervention*."

Reviewer 14 (Stakeholder): Dr. Kathy Offet-Gartner, Canadian Counseling and Psychotherapy Association of Canada

Disclosure(s): None

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** (No comments provided)	Thank you
3. Are the guidelines supported by the evidence?	**Yes** (No comments provided)	Thank you.

4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**No** (No comments provided)	Thank you
5. Do you have any comments or suggestions to improve the guideline?	Availability for translation to different languages and an the ability to use simpler language (English words) to ensure those with lower vocabulary and comprehension (or ESL) can understand the question being asked of them. One cannot assume that the clinician will have a sufficient repertoire or ability to do so independently.	Thank you for this suggestion. The final guideline will be translated to French. We will also develop knowledge translation tools in both official languages to help providers and patients understand the recommendations. Our Knowledge Translation team will help us ensure that language used in these tools is appropriate for a wide audience with different levels of comprehension.

Reviewer 15 (Stakeholder): Dr. Heather McClenaghan, Society of Obstetricians and Gynecologists of Canada

Disclosure(s):
I am a member of the following:

- SOGC Family Practice Advisory Committee
- College of Family Physicians of Canada
- Society of Rural Physicians of Canada
- Doctors of BC/ CMA

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** (No comments provided)	Thank you

3. Are the guidelines supported by the evidence?	**No** The evidence cited supporting the guideline is limited to the postpartum period only and is low level evidence. Which explains why the recommendation is conditional.	Ideally we would have high quality evidence from RCTs for both pregnancy and the postpartum period, however, this type of evidence was not identified, despite our rigorous systematic review. We have included the lack of RCTs on screening as a knowledge gap in the guideline.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** Important to emphasize that routine screening using a questionnaire is not recommended, however DIAGNOSING depression using history and physical is still considered part of routine clinical care throughout prenatal and postpartum care.	Thank you for this suggestion. We have made a number of edits throughout the manuscript to further emphasize that the recommendation assumes that usual care involves inquiry and attention to mental health, and that we encourage clinicians to sure they are doing this with patients as part of usual care.
5. Do you have any comments or suggestions to improve the guideline?	Pregnancy and the postpartum period are fraught with new stressors. Providing an opening for discussion of mood, mental health and stress has been anecdotally helpful for many of my patients. I think it is important to underline that more research needs to be done into whether screening patients routinely (without standardized testing) shows clinical improvement. This will be difficult as physicians are trained to pick up on historical and physical cues for mood disorders even if not officially screening.	Thank you. We indicated in the 'Gaps in Knowledge' section that "*Trials that compare screening to usual clinical care, where those identified as depressed in either arm receive the same level of care, are needed in order to isolate the effectiveness of screening as an intervention*." We also agree that this is a very important and helpful discussion to have with patients. As noted above, we have added additional emphasis throughout the manuscript on the importance of asking patients about mental health and well-being as part of usual care, despite the recommendation against instrument-based screening.