estimate of PPV is around 62% [26]; meaning that about 38% of women scoring ≥13 on the EPDS may be incorrectly diagnosed as having major depression if no further assessment is undertaken. This has led one author to highlight the potential risk for 'overpathologising' the presence of postnatal symptoms [27], with possible harm caused to the woman and in terms of cost to the system. . The other key concern is around availability of resources to support perinatal depression screening programs.

In the UK, universal depression screening using the EPDS (+/- the Whooley questions- see Appendix 1) is considered as potentially causing more harm than good [28] and not seen as cost-effective [29] on current available data. Interestingly, the US Prevention Task Force [30] recommends in favour of depression screening for the *general population* **given good evidence of clinical benefit when it is undertaken in an** *enhanced care* **setting [31]. Such an approach has not yet been assessed in the perinatal setting.**

P*sychosocial assessment***, which entails enquiring about the woman's** *overall* **psychosocial wellbeing (including past and current conditions as opposed to possible current depression), as part of maternity and postnatal care, clearly indicates to the woman that her clinician is interested in her overall wellbeing. There is a strong argument for considering such enquiry part of routine care - where physical and emotional care is integrated within the primary health care context. While some will disagree with the routine use of a depression screener (for the reasons outlined above) most clinicians would argue that psychosocial assessment has value in its own right (irrespective of availability of comprehensive psychosocial services) as a means of:**

a)

abusive care. We must thus be cognisant of the context in which psychosocial assessment is undertaken while minimising its potential to worsen the woman's predicament due to increased stigmatisation or even abuse [39].

Equally, identifying psychosocial risk factors (including those associated with poor antenatal attendance and nutrition) in resource-constrained countries has the potential to impact *both* the mental and physical health of women in pregnancy, thereby improving obstetric and offspring outcomes [40, 41]. In more economically advanced countries, much can now be undertaken by primary health care workers, both in regard to depression screening and broader psychosocial assessment.

Finally, we need to be mindful that depression screening instruments (mostly developed in Western settings) perform very differently in resource-constrained countries where there may be a very different understanding of concepts such as "depression". In such situations women may have fewer words to describe their emotional experiences and needs. As their lives are chronically difficult, questions that assess whether they are feeling worse than usual are invariably answered 'no'. The use of different cut-offs on screening tools will thus need to be evaluated in such settings [42]. Development of local methods for screening based on the needs of, and acceptability to, that specific culture, are recommended.

<u>In summary</u> while there is no simple answer to the question of *whether* '*there is a place for universal* psychosocial assessment (including depression screening) without adequate referral services', not undertaking such assessment because of the complexity of issues or a lack of mental health resources, overlooks the critical role of psychosocial wellbeing in maternal and infant outcomes.

There is now a growing, although not unanimous, view within the International Marcé Society in

1. **Austin, M.-P.,** *Antenatal screening and early intervention for 'perinatal' distress, depression and anxiety: where to from here?* **Archives of Women's Mental Health, 2004. : p. 1-6.**
2. **O'Hara, M., Swain, A.,** *Rates and risk of post-partum depression: a meta-analysis.* **International Review of Psychiatry, 1996. : p. 37-54.**
3. **Milgrom, J., et al.,** *Antenatal risk factors for postnatal depression: A large prospective study.* **Journal of Affective Disorders, 2008. (1-2): p. 147-157.**
4. **National Institute for Health and Clinical Excellence (NICE),** *Antenatal and postnatal mental health: The NICE guidelines on clinical management and service guidance CG45.* **National Collaborating Centre for Mental Health. The British Psychological Society & Royal College of Psychiatrists, 2007.**
5. **Scottish Intercollegiate Guidelines Network (SIGN),** *Management of perinatal mood disorders (SIGN Publication no. 127)***. March 2012, Edinburgh: Available from URL: http://www.sign.ac.uk.**

Over the last 10 years, three National level Clinical Practice Guidelines (CPGLs) have been developed. In addition, we have an extensive review of the use of the EPDS for depression screening perinatally from the US (AHRQ 2013 not summarised here). Each of these CPGLs is underpinned by a systematic literature review (SLR) and includes a number of graded evidence-based recommendations and good practice points. Each CPGL addresses two key domains:

1) **Model of psychosocial care. Each of the Guidelines recommend similar approaches to this:**
   Predominantly *integrated, primary care based psychosocial assessment care programs* **with the capacity for primary care clinicians to refer onto mental health services for secondary and tertiary level care;**
   Case planning and management *for complex cases, significant or severe psychosocial* **disorder;**
   A multidisciplinary team approach to allow for input from primary care and psychosocial clinicians and integration across disciplines;
   Programs supported by ongoing staff education and supervision from the mental health sector.

2) **Focus and method of assessment. There are significant differences between the Guidelines with respect to this as follows:**
   Australian (NHMRC endorsed 2011)
   Explicitly identify the infant and family as part of the assessment and management model (vs. the British and Scottish Guidelines);
   Recommend the use of the EPDS in both .99057(38(th)-6.00302(.99057(38(th)-6.000302(i)-9.98322(t)-3.99425(h)-3.990