Marcé International Society Position Statement 2013

PSYCHOSOCIAL ASSESSMENT AND DEPRESSION SCREENING IN PERINATAL WOMEN

The case for undertaking universal psychosocial assessment (including depression screening) of women during the 'perinatal period' has attracted much interest, and vigorous debate [1]. The following position statement aims to articulate the arguments contributing to the debate and thus provide guidance to assist decision-making by **clinicians, policy makers and health services.**

Aims of the Position Statement

- To outline the *general principles and concepts involved* in psychosocial assessment and depression screening;
- To outline the *current debate regarding benefits and risks* in this area of practice including the clinical benefits and the *ethical, cultural and resource implications* of undertaking universal psychosocial assessment in the primary health care setting;
- To provide a document that will assist with *advocacy* for the development of perinatal mental health services in the primary care setting.

This document does *not* set out to make specific recommendations about psychosocial assessment and depression screening (as these will need to be devised locally depending on existing resources and models of care) nor does it attempt to summarise the vast evidence-base relevant to this debate.

Background

The perinatal period (*pregnancy and the first postnatal year*) is a time of great adjustment for all parents, made more challenging by the presence of existing psychosocial risk factors (or morbidity). Key risk factors for poor perinatal emotional adjustment include a history of past or antenatal anxiety or major depression, other mental health disorder or substance misuse, lack of supports, issues in partner relationship, a history of trauma (including adverse childhood events and domestic violence), isolation (physical, mental, cultural), stressful life events, poverty, and personality vulnerabilities e.g., low self-esteem or high trait anxiety [2-5].

The presence of psychosocial morbidity (especially high levels of anxiety and stress) in pregnancy can adversely impact on fetal development with associated suboptimal cognitive, emotional and behavioural outcomes in the offspring as identified in a number of large prospective cohort studies [6]. Postnatal depression may also impact on infant outcomes [7].

In many high income and developing countries, pregnancy and the postnatal period are opportunistic periods for health education due to the frequency of contact with health care providers. Expectant and new parents are often highly motivated to seek help in effecting change for the sake of their offspring and potential reduction in intergenerational family dysfunction. The perinatal period thus provides clinicians with a unique opportunity to address the *psychological, social and physical* health of their clients, and to consider *universal psychosocial assessment as part of mainstream maternity and postnatal care*. Early identification and treatment of psychosocial morbidity are especially important in relation to the functioning of the family unit and the critical parent-infant relationship with potential to positively impact on the health of the next generation. Equally important is the need to address adverse social circumstances (where possible) and history

of current or past violence and trauma [8, 9]. With the research focus to date focussing mainly on perinatal depression, interpersonal violence and past trauma have tended to be under-investigated as potential key risk and mediating factors.

Major depression – often accompanied by anxiety disorder and personality vulnerability – is the most common condition presenting in the postnatal period [10, 11], and may be associated with negative outcomes for mother, partner, infant and family. Such episodes can be new in onset or the recurrence of a pre-existing condition. In high income countries, the prevalence of major depression in the nine month pregnancy interval is 12.7%; and 7.1% in the first 3 months postpartum [12].

Large population studies demonstrate an increased risk of *new* onset psychiatric episodes, especially major depression and puerperal psychoses, arising in the first few months postpartum [13], while risk of *relapse of pre-existing mood disorder*, often following the cessation of medication, increases significantly both in pregnancy and in the postnatal period [14-16], especially bipolar disorder [17]. Maternal death associated with psychosocial morbidity (including substance misuse and interpersonal violence) has become one of the leading causes of maternal deaths in high income countries [18, 19]. There is a 70 fold increased risk of suicide in the first postnatal year after admission for a severe psychiatric episode compared to at other times in a woman's life [20].

The evidence base for depression screening in the perinatal period has been extensively examined in the process of developing the 2007 British [4], 2012 Scottish [5] and 2011 Australian [21] Clinical Practice Guidelines which are all underpinned by systematic literature reviews (SLR). These three Guidelines vary in their degree of recommendation for or against the use of the Edinburgh Postnatal Depression Scale (EPDS, [22]), with the Australian Guidelines recommending for its universal use within an integrated screening program; while the Scottish (SIGN) and British (NICE) CPGLs suggest its use only as an adjunct to clinical practice. An AHRQ 2013 systematic review of screening for postnatal depression [23] concludes that while current *depression screening* instruments are reasonably sensitive and specific in detecting postpartum depression, there is insufficient evidence to allow the benefits and harms of depression screening to be clearly balanced-or to ascertain whether the use of specific assessment tools/strategies would result in better outcomes.

While the Australian guidelines note the use of universal psychosocial assessment programs as a good practice point, in addition to the assessment of mother-infant dyads, neither of the SIGN or NICE Guidelines comment on the value of broader psychosocial assessment as defined in the current position statement. For more detail, the three sets of Clinical Practice Guidelines recommendations are summarised in Appendix 1 and Table 1. It is important to note that recommendations carry a variable weight dependent on the quality of the evidence at the time of guideline development, hence the variation in degree of recommendation by different guidelines for the use of, for example, the EPDS.

Key Definitions and Concepts in Perinatal Mental Health

Before proceeding to articulate the debate, we need to define the terminology and concepts that have arisen over the last two decades in the field of perinatal mental health.

1. *The perinatal period:* has been defined in different ways, but for the purposes of this document, it is defined as the period spanning *pregnancy and the first postnatal yea*r. The use of the term 'perinatal' in the psychosocial setting underscores the importance of considering maternal and infant emotional wellbeing at a time when maternal risk of onset/relapse of mood disorder is highest, when maternal social and emotional vulnerabilities are often heightened, and at a critical time in the development of infant attachment. It also highlights the value of early intervention (ideally beginning in pregnancy) and the importance of detecting psychosocial issues which may impact adversely on maternal, obstetric, infant & family outcomes.

2. *'Psychosocial morbidity':* for the purposes of this document, covers the spectrum of morbidity from diagnosable psychiatric disorders (e.g., major depression, psychosis, anxiety and bipolar

disorder) to psychosocial risk factors (as described in the background section), but may also include substance misuse; personality vulnerability/disorder and poor adjustment to parenting.

3. *Prevention:* preventive health care aims to reduce the burden of chronic conditions by early identification of people with risk factors or symptoms and applying appropriate interventions. It is the key premise underlying the benefits of universal psychosocial assessment & depression screening.

4. *Psychosocial assessment programs:* these encompass both the evaluation of current and longstanding psychological, social, and cultural risk factors impacting on the mental health of women across the perinatal period [1]. Such enquiry should cover the breadth of morbidity from the low prevalence serious mental health conditions (eg. schizophrenia, bipolar & personality disorders etc) through high prevalence conditions such as depression and anxiety disorders, to the presence of risk factors that will make adjustment to parenting more difficult. *Unlike screening, psychosocial assessment does not set out to identify women with a possible diagnosis of a particular condition at the time of assessment*. Rather it gives us a multidimensional picture of the woman's psychosocial circumstances which can then be used to make decisions about best care options. Given its multidimensionality, it is essential that it be undertaken as part of an integrated care program (see definition below). Psychosocial assessment may be undertaken as part of clinical interview or using a structured tool.

5. *Depression Screening:* Screening for current depression is generally considered as *one* component of psychosocial assessment in the perinatal context, and should not be seen as the only aim of such assessment. Screening can be *universal,* i.e. done in *all* women. This is in contrast to *targeted* screening that is only undertaken in high risk groups (e.g. young, single, substance using mothers). Screening should only take place where a validated, acceptable & user-friendly screener is integrated with further diagnostic assessment and treatment (as appropriate), dependent on 'screen positive' status [24, 25]. Screening tools are used for the detection of symptoms *likely to be associated with* a diagnosis, using an optimal cut-off score. Importantly, a *screener is not a diagnostic tool*. Diagnosis requires a full clinical assessment.

6. *'Integrated' care*: the use of this term in the perinatal setting highlights the importance of:

a) Integration across health care disciplines and between primary and secondary/tertiary health care systems;

b) Integration between components of a psychosocial assessment program: including the assessment itself (including depression screening) ; clinician training and supervision; clear clinician decision making guidelines round appropriate care planning and referral pathways;

c) Integration across time periods (antenatal and postnatal) and service settings (e.g., hospital and community);

d) Integration of psychosocial assessment with 'mainstream' (physical) maternity and postnatal care.

The current debate

Two key themes in current debate among perinatal clinicians, researchers, and policy-makers are: 1) the benefits (clinical and cost) vs. harms of a) universal psychosocial assessment and b) depression screening; and 2) undertaking such activity in resource-constrained settings.

1. *The benefits vs. harms of universal psychosocial assessment and depression screening:*

The debate in relation to *universal depression screening* encompasses a number of factors: the potential *misuse* of a screener as a diagnostic tool (leading to misdiagnosis and increased prevalence reporting); or *inaccuracy* as a result of lack of robustness in terms of the screener's psychometric properties i.e., sensitivity, specificity, and positive predictive value (PPV i.e. the number of 'positive screeners' who actually have a diagnosis), and clinically optimal cut-off point. The most recent

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) *Opening up the conversation* about psychosocial issues including those that impact the family more broadly (e.g., intimate partner violence, supports, help-seeking) and that can be addressed by non-mental health trained care providers.

b) *Raising awareness and educating* pregnant women/mothers and their carers about the fact that psychiatric and psychosocial conditions deserve to be treated; that difficulties in the parent-infant interaction may arise at this time; and that effective treatments and supports are available, should these problems arise.

The debate relating to *universal psychosocial assessment* is less contentious and tends to centre on the need to define methodologies and care models (e.g., use of structured questionnaires versus general unstructured enquiry, within an integrated care model) that are suited to local circumstances. Examples of structured psychosocial assessment tools include the ALPHA[32], ANRQ [33] and ARPA [34].. Where psychosocial assessment programs are undertaken, primary care clinicians will need adequate psychosocial assessment skills *training* and ongoing *clinical supervision* from the mental health sector. Such integrated assessment care models, which *must include a substantial training component*, have begun to be implemented in Australia especially in maternity, and early childhood settings, but have yet to be evaluated [33-35].

Ultimately training and support for the primary health sector is likely to reduce the frequency of referrals to mental health services as these practitioners become more confident and skilled with managing women with milder psychosocial risk and depression or anxiety.

Of relevance to the debate, is the growing evidence that low intensity interventions (e.g., internet based programs), social support, peer support and self-help are effective in the management of milder mood or adjustment disorders [36-38], and may circumvent the perceived increased workload for the health care sector as a whole. Ultimately long-term follow up studies are needed to evaluate the benefits and costs for the wellbeing of mothers, infants and families and society.

2. *Psychosocial assessment and depression screening in resource-constrained countries:*

In most of the 112 low and lower-middle income countries (where the majority of the world's women live) there are insufficient services for safe pregnancy and birth let alone recognition of psychosocial problems. In some settings the mental health services are limited to custodial institutions which provide poor quality and at times what would be considered, by world standards,

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.

In summary 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 favour of undertaking universal psychosocial assessment in perinatal women, as long as it takes place within an integrated care model. It is generally recognised by clinicians that such assessment holds intrinsic value in terms of educating women and families and ‘starting the conversation’ about psychosocial issues. How exactly this takes place must be decided at a local health service level (see Box below for more detail).

Future Directions: building the evidence base

In order to inform clinicians looking for guidance & policy makers in setting funding priorities we need:

- Develop and evaluate methods for undertaking integrated psychosocial assessment (including structured assessment tools and training programs) appropriate to specific settings and health service organisational structures.
- Develop a range of evidence-based treatment options to support routine assessment; from self-help, low intensity interventions to increased access to specialist perinatal and infant mental health services.
- Collect cost-effectiveness data pertaining to the outcomes of both mothers and infants both in relation to depression screening and broader psychosocial assessment.
- Build evidence in resource-constrained countries and validate appropriate instruments to improve recognition of psychosocial morbidity. Consideration also needs to be given to engagement in violence reduction strategies and sector wide education about universal emotional needs that are likely to benefit many women without the need for individual treatment.

Guiding principles underpinning Universal Psychosocial Assessment & Depression Screening Programs –
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Where the provision of universal psychosocial assessment and care for perinatal women in the primary care setting is being considered, the following principles need to be considered:

- The value of combining assessment of both the *physical and emotional* health and welfare of women in the perinatal period.
- The impact of psychosocial morbidity on the *transition to parenthood* and *infant attachment and development.*
- *Universal psychosocial assessment programs* that combine evaluation of the psychosocial context/risk factors *and* detection of possible current depression; as well as integrating assessment with further care.
- There is *no one model for psychosocial assessment*. Local methods for psychosocial assessment that are acceptable, easy to administer and interpret, and can be integrated within local care models/programs, will work best.
- *Timing and frequency of assessment*: ideally both in pregnancy (as part of routine maternity care) and at an appropriate time postpartum (e.g. 3 months).
- Adequate *training and support of primary health care providers (*undertaking integrated psychosocial assessment) by the mental health sector is <u>essential</u>.
- Enquiry about a history of *past mood disorder or puerperal psychosis* should be included within all psychosocial assessment; given its greatly increased risk of recurrence in the postnatal period.
- The *safety of mothers and infants* needs to be taken into consideration at all times.
- Not undertaking psychosocial assessment because of the complexity of issues it may uncover, and/or lack of psychosocial resources, overlooks the critical role of psychosocial wellbeing in maternal and infant outcomes. Such assessment holds intrinsic value in terms of educating women and families and 'starting the conversation' about psychosocial issues.
- Mobilizing social supports will be a key first line of intervention, and is independent of formal professional input.
- Programs need to facilitate access to a range of low cost, primary care psychosocial interventions that can assist women with problems in the mild to moderate range (the majority of cases).
- A collaborative approach to management, where the mother's preferences with respect to referral options and/ or treatment plan are taken into account, should be adopted.
- Programs need to ensure that perinatal psychosocial care is culturally responsive and family-centred.
- Optimally there should be provision of referral by the primary sector to specialist perinatal psychosocial services with consideration of a stepped care model approach.
- There is a need to develop the evidence base to address the best approach to psychosocial assessment programs & appropriate care models suited to local needs; as well as consideration of evaluating the costs versus the benefits.

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APPENDIX

Summary of National level Clinical Practice Guidelines for psychosocial assessment and Depression Screening (see also Table 1)

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 the ante- and postnatal periods for identifying possible depression (and anxiety) using the usual cut-off score postpartum;
   - Identify the value of using a structured psychosocial assessment tool in conjunction with the EPDS, and that such tools are acceptable to women and clinicians.

   English and Welsh Guidelines *(NICE 2007; under review; next version due 2015)*
   - Recommend against routine use of EPDS although it may be used as an 'adjunct' to psychosocial assessment;
   - Endorse the use of two specific questions -the '*Whooley questions*'- for the detection of possible current depression in the perinatal period as follows: *During the past month have you often been bothered by: 1) feeling down, depressed or hopeless? 2) Having little interest or pleasure in doing things? If yes to either of 1 or 2, would you like help with these issues?*
   - In addition to the Whooley questions, endorse enquiry about past or family history of severe psychosocial disorder.
   - Use of stepped care and managed network models are recommended.
   - The Guidelines do not include specific mention of infant or family as part of the model of care.

   Scottish Guidelines (SIGN 2012)
   - Recommend enquiry about depressive symptoms in pregnancy and postnatally, though noting that their SLR did not yield sufficient evidence to recommend specific tools (eg. EPDS).
   - EPDS and Whooley questions may be used to monitor and facilitate discussion of emotional issues.
   - Screen for risk of early postpartum major mental disorder.
   - The Guidelines recommend that, where there is evidence of impairment in the mother-infant relationship, additional interventions specifically directed at that intervention, should be offered.

TABLE 1 Current Clinical Practice Guidelines: Approach and main elements of models of care and psychosocial assessment

Guideline & Methodology	Overall Approach	Main Model Elements	Psychosocial Assessment Recommendations
British *Antenatal & Postnatal Mental Health* CPGs (NICE 2007; under review for 2014 update) SLR informs Graded Recommendations evidence multidisciplinary advisory	Coordinated network of health professionals & organisations from 1^0,2^0,3^0 settings (*Managed network* model) *stepped-care* model (1^0 -> 3^0)	• Common network elements, but precise referral protocols vary • Pathways of care to specialist & 2nd opinion from 10 setting using set protocols • Shared care protocols & training programs ?; multidisciplinary meetings	• **Whooley Qs** *1) symptoms depression, hopelessness or anhedonia in past month*; 2) *Past & family history of serious MHI* used to predict episode severe MHI • *May use EPDS* but *only as adjunct* • No enquiry re broad psychosocial risk • Little to no focus on mother-infant bond, family
Scottish ***Management of Perinatal Mood Disorders*** (SIGN 2012) SLR informs Recommendations & Good Practice Points	National Managed Clinical Network to establish Standards for specialist care, pathways for referral and management, competencies for professionals, & equitable access to services.	• Discussion of options and collaborative Multidisciplinary meetings • Criteria for a)care within 10 setting b) psychosocial referral • Model supported by staff education	• Routine enquiry about depressive symptoms in pregnancy and postnatal period. • EPDS or Whooley Qs may be used to aid enquiry on emotional issues. • Screen for risk of early postpartum major mental disorder. • Little to no focus on mother-infant interaction, or impact on family
Australian *CPGs for Perinatal Depression & Related Disorders* (2011) plus multidisc advisory. SLR informs graded Recommendations + Good Practice Points	ICP according to need (from mild or at risk cases to severe MHI or complex comorbidity) psychosocial support clinical capacity of 10 health care; provide training & supervision & 2^0 & 3^0 treatment options Family centered approach.	• Clear criteria for management within 10 care and for referral to psychosocial services • Most care provided through 10 health care; supported by psychosocial services • Case plan for women with severe MHI • Multidisciplinary case conferences • Model supported by staff education & supervision	• Routine psychosocial assessment using structured Qs covering broad risk factors for psychosocial morbidity and EPDS (for symptoms of depression and anxiety) in pregnancy and 6-12 weeks p-p • Identify both MHI and risk for poor adjustment to parenting • Specific focus on mother-infant interaction, parenting and impact on family