UK National Screening Committee

Consultation Comments Pro-forma

Screening for Antenatal and Postnatal Mental Health Conditions Evidence Map

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Do you consent to your name being published on the UK NSC website alongside your response?	**Yes**		

Section and / or page number	**Text or issue to which comments relate**	**Comment** *Please use a new row for each comment and add extra rows as required.*
General		The College broadly agrees with the conclusions of the evidence map. However, we are concerned that this type of evidence synthesis may not fully capture some of the important wider impacts associated with screening for antenatal and postnatal mental health conditions. In particular, the current reliance on case-finding approaches places significant responsibility on individual healthcare professionals to ask about mental health. In practice, this can lead to variability in whether and how women are asked, with a risk that some women are not identified and experience harm through under-diagnosis. This potential negative externality of non-systematic approaches does not appear to be fully considered. Conversely, there may be broader benefits of routine screening that extend beyond the direct identification of mental health conditions. For example, structured and routine questioning about mental health may help women feel more able to disclose other sensitive issues related to pregnancy and the postnatal period, such as domestic abuse, which is known to be under-identified when not asked about proactively. These potential indirect benefits are also not well reflected in the current analysis.

		Given the complexity and sensitivity of perinatal mental health, the College considers that a more holistic view of the evidence would be valuable when assessing the case for or against screening. This should include consideration of both the risks of inconsistent case-finding and the wider system-level and relational impacts of routine screening on disclosure, engagement, and safety.
General		We note that the evidence map does not explicitly address the needs of people with a learning disability or those who are neurodivergent. We are concerned that the absence of reference to reasonable adjustments and accessibility adaptations risks overlooking an important group for whom standard screening tools may not be appropriate or equitable. It would be helpful for the evidence map to acknowledge the need for screening approaches and tools to be adapted to ensure accessibility for people with additional needs. For example, easy-read versions of commonly used measures such as the GAD-7 and PHQ-9 are already available, whereas it is unclear whether equivalent adapted versions of the EPDS exist or are recommended. Explicit consideration of the availability, validity and implementation of adapted tools would support more inclusive practice. We therefore recommend that the evidence map recognises learning disability and neurodivergence as relevant considerations, and highlights the importance of reasonable adjustments to screening processes to avoid exclusion, misinterpretation of results, or inequitable access to care.
Page 10		We would add that identifying mental distress of any kind may be as important as making a specific psychiatric diagnosis. While the EPDS is noted to have high sensitivity and specificity for major depressive disorder, its positive predictive value is limited because of the low prevalence of major depressive disorder in the perinatal population. As a result, a substantial proportion of women who screen positive and are referred for further assessment do not meet formal diagnostic criteria for major depressive disorder. However, many of these individuals nevertheless experience significant psychological distress, including anxiety disorders, trauma-related symptoms, adjustment difficulties, or distress associated with social adversity, sleep deprivation, or the broader

		perinatal transition. In this context, tools such as the EPDS may be better understood not as diagnostic instruments, but as pragmatic ways of identifying women with clinically relevant distress who may benefit from additional support, monitoring, or intervention. We agree that routine, population-wide screening using questionnaire-based tools is not straightforward. Existing measures are not sufficiently sensitive or specific for all presentations, and mental health services are already under significant pressure, with limited access to timely care. These constraints need to be considered alongside the evidence on screening effectiveness. That said, we believe there is an important distinction between formal screening programmes and the routine clinical practice of asking about mood and mental wellbeing as part of a consultation. When concerns are raised within a clinical interaction, healthcare professionals are able to assess severity, functional impact, risk, and the potential benefit of tailored support, drawing on clinical judgement rather than relying solely on questionnaire thresholds. Mental health screening therefore differs fundamentally from screening for physical conditions, and any approach to perinatal mental health needs to recognise the value of skilled clinical assessment embedded within routine care, rather than focusing exclusively on diagnostic case-finding.
Page 20		Why is it uncertain whether the evidence identified in this question would lead to a change in the UK NSC's position? It seems like there are a number of new studies that show evidence of beneficial effect of treating screen detected mental health conditions.
Question 4	**Overall Research Question**	We recognise that several new studies suggest a beneficial effect from treating screen-detected perinatal mental health conditions. However, it remains uncertain whether this evidence would lead to a change in the UK NSC's position because much of it demonstrates benefit from treatment rather than from screening itself.

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