

UK National Screening Committee (UK NSC)

Screening for Antenatal and Postnatal Mental Health Conditions

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Aim

We are providing an update on the public consultation phase of the evidence map on screening for antenatal and postnatal mental health conditions and requesting feedback on the responses drafted.

Background

The 2019 UK NSC evidence summary screening for antenatal and postnatal mental health problems was carried out by Solutions for Public Health and it concluded that:

- There was a large volume of evidence about adverse outcomes associated with mental health conditions experienced by women during pregnancy and postpartum that was applicable to the UK population.
- There was a lack of evidence for effective screening tests for common mental conditions such as generalised anxiety disorder, panic disorder, phobias, social anxiety disorder, obsessive compulsive disorder (OCD) and post-traumatic stress disorder (PTSD) during pregnancy. Screening tools that could be used as part of an overall screening programme were identified, such as the Edinburgh Postnatal

Depression Scale (EPDS). However, the positive predictive values for detecting major depressive disorder reported in the included studies were low suggesting that a high proportion of women with a positive screen referred for a full psychological assessment would likely not have a major depressive disorder.

- The effectiveness of pharmacological and non-pharmacological interventions for women with screen-detected antenatal mental health conditions and postnatal depression was very limited. There was some evidence that cognitive behavioural therapy is likely to lead to a small reduction in the severity of the condition.
- That mental health services in the UK were not implementing the NICE guidance in its entirety.

Currently, population screening for antenatal and postnatal mental health conditions is not recommended based on conclusions drawn from the 2019 evidence summary.

2025 Evidence Map

The UK NSC evidence team commissioned an evidence map to review the volume and type of evidence available on antenatal and postnatal mental health conditions in 2025. The evidence map was conducted by the Solutions for Public Health. The following five questions were addressed to capture evidence that had been published since the last review:

1. What is the volume and type of evidence on the reported accuracy of screening tools to detect common mental health conditions during pregnancy?
2. What is the volume and type of evidence on the reported accuracy of screening tools to detect postnatal depression?
3. What is the volume and type of evidence on the benefits of pharmacological and non-pharmacological intervention (alone or in combination) in women with screen-detected common mental health conditions during pregnancy?
4. What is the volume and type of evidence on the benefits of early pharmacological and non-pharmacological intervention (alone or in combination) in women with screen-detected postnatal depression?
5. Is there evidence that clinical detection and management currently well implemented in the UK?

Summary of Findings

Question 1

Six studies were identified for this question covering different screening tools for depression, anxiety, OCD and mood. No evidence was identified on screening tools for panic disorder, phobias, social anxiety disorder or PTSD. The systematic reviews with meta-analysis included some UK data and the remaining evidence was from countries comparable to the UK. Although the volume of evidence identified overall was considered sufficient for further review in an evidence summary, many of the studies included in the systematic reviews and meta-analysis were published prior to the 2019 evidence summary and the evidence available for each individual screening tool is limited and with mixed results in terms of accuracy.

Question 2

Three studies were identified for this question on screening tools for postnatal depression. One large international individual participation data (IPD) meta-analysis of the EPDS in combined pregnant and postpartum women (with UK data) and a secondary analysis of this dataset, plus a primary diagnostic accuracy study from the USA evaluating the Beck Depression Inventory (BDI)-II and the Postpartum Depression Screening Scale (PDSS) in postpartum women. The studies included in the IPD meta-analysis were published prior to the 2019 evidence summary. No evidence was found on the optimum screening time point. Overall, the volume and type of evidence was insufficient to justify commissioning an evidence summary for this question.

Question 3

Eight randomised controlled trials (RCTs) reporting outcomes of non-pharmacological interventions for screen-detected pregnant women were included for this question, along with 1 prospective cohort study that reported outcomes for both pharmacological and non-pharmacological intervention for screen-detected pregnant women. These women were screened for depression and/or anxiety. No studies were identified considering the effectiveness of women with screen-detected panic disorder, phobias, social anxiety disorder, OCD or PTSD.

One RCT was conducted in the UK with the remainder conducted in countries that are comparable to the UK. The studies covered a variety of different interventions with most authors claiming some improvement with interventions relative to usual care and others reporting more mixed results. Most of the outcomes reported related to the mother

however, longer term outcomes for the baby and child were also identified. No studies reported outcomes for adolescents.

The volume of evidence identified for this question was sufficient for further consideration in an evidence summary. However, it is uncertain whether the type of evidence identified is likely to lead to a change in the UK NSC's current position.

Question 4

Six RCTs reporting outcomes of non-pharmacological interventions for screen-detected women with postnatal depression were included for this question. No studies were identified that report-ed outcomes for screen-detected women with postnatal depression following treatment with well recognised pharmacological interventions.

One RCT was conducted in the UK with the remainder conducted in countries that are comparable to the UK. The studies covered a variety of different interventions with some authors claiming some improvement with interventions relative to usual care and others reporting more mixed or less promising results. Most of the outcomes reported related to the mother however, longer term outcomes for the baby and child were also identified. No studies reported outcomes for adolescents.

The volume of evidence identified for this question was sufficient for further consideration in an evidence summary. However, it is uncertain whether the type of evidence identified is likely to lead to a change in the UK NSC's current position.

Question 5

In summary, no new evidence was identified to determine whether the clinical detection and management of mental health conditions is currently well implemented in the UK. The evidence identified was limited to experiences of services for small numbers of individuals. The search period for this evidence map (2018 to 2025) includes the years in which the COVID-19 pandemic impacted the delivery of services. This may be a factor in the lack of studies about the implementation of services identified for inclusion in the evidence map.

There was considered to be insufficient volume and type of evidence to justify commissioning an evidence summary for this question.

Conclusions

The volume of new evidence identified for the questions relating to screening tools to detect common mental health conditions during pregnancy and interventions for screen-detected mental health conditions in pregnancy and postpartum is sufficient for further

consideration in an evidence summary. However, it is unclear that the type of evidence available is likely to impact on current recommendations on screening for antenatal and postnatal depression. In contrast, the volume of new evidence relating to the accuracy of screening tools for postnatal depression was limited and no new evidence about whether the clinical detection and management of mental health conditions is currently well implemented in the UK was identified. With this in mind, it is uncertain that commissioning a full, more sustained review of screening for antenatal and postnatal depression would be justified at the current time.

Recommendations

On the basis of this evidence map, the volume and type of evidence relating to screening for antenatal and postnatal depression is currently insufficient to justify an update review at this stage and so should be re-considered in 3 to 4 years' time.

Public Consultation

A 3-month public consultation was hosted on the [UK NSC GOV.UK website](https://www.gov.uk/government/consultations/uk-national-screening-committee-consultation-on-antenatal-and-postnatal-depression-screening) from 10th November 2025 to 2nd February 2026. The UK NSC consulted on the findings of the evidence map and the recommendation not to screen for antenatal and postnatal screening for mental health conditions in the UK. Direct emails were sent out to 13 stakeholders (Annex A). A total number of 6 consultation responses were received (Annex B) from individuals at the following organisations:

- Royal College of General Practitioners (RCGP) x 2
- City St George's, University of London
- University of Huddersfield
- British Psychological Society
- General Practitioners Championing Perinatal Care (GPCPC)

Key points raised by stakeholders are summarised below

1. There was some support for the recommendations of the evidence map. Some potential implementation issues of a screening programme for antenatal and postnatal mental health conditions were raised. These included access, equity, resources, workforce capacity (midwives, health visitors, GPs, perinatal mental health teams). Also included were issues of governance, referral pathways, and safety (ensuring that positive screens lead to timely, appropriate support) and indirect benefits of screening.

2. Some stakeholders raised points related to screening for specific target populations. This included individuals with learning disabilities, people who are neurodivergent, individuals experiencing pregnancy loss, and parents of babies admitted to neonatal care. The point was made that outcome studies may rely on samples that under-represent precisely those populations for whom screening may have the greatest potential value.

Response: The scope of the current evidence map was limited to the general antenatal population. The recommendations in this review do not extend to the assessment of particular sub-groups. For screening in these groups to be considered by the UK NSC, we recommend stakeholders submit a proposal through the [UK NSC open call for topics](#).

3. Some stakeholders did not think the evidence map fully reviewed the topic literature in enough detail.

Response: The purpose of the evidence map is to assess the volume and type of evidence for specific questions on a topic. It is not in the remit of an evidence map to explore a topic in depth and conduct detailed analyses of the identified literature. If the volume and type of evidence identified was sufficient for the questions asked in the evidence map, then further evidence synthesis work would be recommended.

4. There was concern that several research studies were not included in the evidence map that had relevant material and would be important additions.

Response: The list of references provided were sent to the supplier to review. They provided further information on whether these studies were identified in the literature search and reasons for exclusion (Annex B). In summary, all the papers that were identified in the literature search did not meet the inclusion criteria for the evidence map. A few other studies were not picked up by the search, as they were published outside of the search period. These did not contain new data which would have changed the conclusions of the relevant questions or the overall recommendation.

5. There was a call for clarity to distinguish between routine assessment, such as found in the Maternal Care Bundle, and population screening. It was believed that it would be helpful to communicate the differences between these as the current landscape can appear confusing.

Response: There is an important distinction between screening and clinical care. The UK NSC only makes recommendations on screening and does not review or make changes to clinical care practice, such as is found within the Maternal Care

Bundle. There is currently no population screening programme for antenatal and postnatal mental health conditions. The results of this latest evidence map do not change this nor impact routine assessments in clinical care.

6. Some stakeholders thought that the new evidence on treatments for screen-detected mental health conditions warranted a change in the recommendation.

Response: The current UK NSC recommendation not to screen is not based on a single criterion, such as there been treatments available for a condition. If there is a large amount of evidence for treatment but not enough evidence for a suitable test, then the UK NSC recommendation will be unlikely to change.

7. Some stakeholders described a strategy for screening which combined screening with facilitated access to care and cited evidence from US studies. It was argued that this type of evidence was underrepresented in the UK NSC evidence map.

Response: It is important to note that screening programmes recommended by the UK NSC include tests, treatment and follow-up. Access to care is already a core part of any UK screening programme.

8. Stakeholders suggested certain conditions such as Trauma and PTSD, Perinatal Anxiety and Perinatal OCD were omitted.

Response: While the evidence map primarily focuses on depression and anxiety, in the summary of findings for Question 2 (Page 10) most of the conditions including OCD and PTSD are considered within the screening tools that were evaluated in the studies identified in the evidence map.

9. It is stated in the view of the GPs Championing Perinatal Care (GPCPC) Board that screening for perinatal mental health (PMH) disorders with the screening tools that are currently available for use is unlikely to meet the criteria of the UK NSC. Therefore, the UK NSC might not be the correct forum to assess the suitability of PMH screening tools for use within the UK general population. The GPCPC also mention that while the routine enquiry on a woman's mental health is crucial, they were of the view that the use of screening tools is not likely to be the most effective way to do this.

Response: The evidence map does not aim to assess the screening tools in detail but rather, at this stage, review whether there is enough evidence of the evaluation of screening tools in research studies to justify further evidence synthesis work.

10. It was mentioned that perinatal trauma (which includes birth related trauma and conditions such as infertility and hyperemesis gravidarum) as a specific mental health problem should be reviewed when subsequent UK NSC reviews take place.

Response: When the next evidence review is commissioned, these comments will be considered within the review process.

Fetal Maternal Child Health Reference Group (FMCH) Meeting 29/04/2026

- The FMCH members confirmed that they were happy with the responses to the consultation comments received.
- The FMCH members agreed with the recommendation that, the findings of this evidence map are unlikely to impact the current recommendation on screening for antenatal and postnatal mental health conditions as limited evidence was identified and that this topic should ideally be re-considered in 3 to 4 years time.

UK NSC Meeting June 25/06/2026

UK NSC members are asked:

- The UK NSC members confirmed that they are happy with the consultation responses.
- The UK NSC members agreed to the recommendation that, due to insufficient volume of evidence and a lack of relevant populations in identified studies, no further evidence synthesis work be undertaken and that this topic should ideally be re-considered according to the regular processes of the UK NSC.

Annex A: List of organisations contacted

1. Association for Improvements in the Maternity Services
2. Institute of Health Visiting
3. Mind
4. Royal College of General Practitioners
5. Royal College of Obstetricians and Gynaecologists
6. Royal College of Physicians
7. Royal College of Physicians and Surgeons of Glasgow
8. Royal College of Physicians of Edinburgh
9. Royal College of Psychiatrists
10. The British Psychological Society
11. British Association of Perinatal Medicine
12. British Maternal & Fetal Medicine Society
13. Maternal Mental Health Alliance

Annex B: Review of additional papers provided by stakeholders

Table 1: Papers within the search period referenced in the feedback but not included in the map

Reference	Identified by the map search?	Reason for exclusion
Meades R, Sinesi A, Williams LR, Delicate A, Cheyne H, Maxwell M, Alderdice F, Jomeen J, Shakespeare J, Yuill C, Ayers S; MAP Study Team. Evaluation of perinatal anxiety assessment measures: a cognitive interview study. BMC Pregnancy Childbirth. 2024 Jul 27;24(1):507.	This study was identified by the searches and considered for inclusion in the evidence map.	This study was excluded because it is about determining the acceptability and ease of use of anxiety measures, not their diagnostic accuracy. This study does not meet the inclusion criteria for the evidence map as it does not address any of the map questions.
Ayers S., Coates R., Sinesi A., Cheyne H., Maxwell M., Best C., McNicol S., Williams L.R., Uddin N., Hutton U., Howard G., Shakespeare J., Walker J.J., Alderdice F., Jomeen J., and the MAP Study Team (2024). Assessment of perinatal anxiety: diagnostic accuracy of five measures. Br J Psychiatry, 224(4):132-138	This study was identified by the searches and considered for inclusion in the evidence map.	This study was not included in the evidence map because 38.6% of the study population used to assess diagnostic accuracy were described as having a previous mental health disorder and 31.2% had a previous miscarriage or stillbirth. The population of interest for the questions on the accuracy of screening tools is women without any previous clinical diagnosis of mental health problems and without experience of miscarriage or stillbirth. This study reports diagnostic accuracy for several measures of anxiety and depression. Data are not separately reported for pregnancy and post-partum. The study reports mixed results for diagnostic accuracy for the different measures against a range of cut-off values.

Reference	Identified by the map search?	Reason for exclusion
		If this study had been included in the evidence map it would not have changed the conclusions for question 1 or question 2. In addition, it would not have changed the overall conclusion about assessing the evidence base further to check if more recent evidence is likely to impact the UK NSCs current recommendation on screening for antenatal and postnatal depression.
Arora IH, Woscoboinik GG, Mokhtar S, Quagliarini B, Bartal A, Jagodnik KM, Barry RL, Edlow AG, Orr SP, Dekel S. A diagnostic questionnaire for childbirth related posttraumatic stress disorder: a validation study. Am J Obstet Gynecol. 2024 Jul;231(1):134.e1-134.e13.	This study was identified by the searches and considered for inclusion in the evidence map.	This study was excluded because it explores the diagnostic accuracy of a measure to detect PTSD following childbirth against a reference standard of clinical interview. The scope of the evidence map does not include tools to detect postnatal PTSD. The study also used the EPDS to assess postnatal depression. This aspect of the study is out of scope because it assesses the correlation between EPDS and the PTSD screening tool. It does not assess the diagnostic accuracy of the EPDS against a reference standard of clinical interview.
Pisavadia K, Spencer LH, Tuersley L, et al Health economic evaluations of preventative care for perinatal anxiety and associated disorders: a rapid review. BMJ Open 2024;14:e068941.	This study was identified by the searches and considered for inclusion in the evidence map.	This study was excluded because it is a rapid review of health economic evaluations of preventative care for mental health problems. This study does meet the inclusion criteria for the evidence map as it does not address any of the map questions.

Reference	Identified by the map search?	Reason for exclusion
Silverwood V, Bullock L, Jordan J, Turner K, Chew-Graham CA, Kingstone T, Dawson S. Non-pharmacological interventions for the management of perinatal anxiety in primary care: a meta-review of systematic reviews. BJGP Open. 2023 Sep 19;7(3):BJGPO.2023.0022.	This study was identified by the searches and considered for inclusion in the evidence map.	This study was excluded because it provides a descriptive overview of interventions with no indication that any of the included studies were about the treatment of women with screen-detected mental health problems.
Fellmeth G, Harrison S, Quigley MA, Alderdice F. A Comparison of Three Measures to Identify Postnatal Anxiety: Analysis of the 2020 National Maternity Survey in England. Int J Environ Res Public Health. 2022 May 28;19(11):6578.	This study was identified by the searches and considered for inclusion in the evidence map.	This study was excluded because it explores concordance between different measures for detecting postnatal anxiety. It does not assess the diagnostic accuracy of the measures against a reference standard of clinical interview. It is also noted that the scope of the evidence map does not include tools to detect postnatal anxiety.
Fellmeth G, Opondo C, Henderson J, Redshaw M, Mcneill J, Lynn F, Alderdice F. Identifying postnatal depression: Comparison of a self-reported depression item with Edinburgh Postnatal Depression Scale scores at three months postpartum. J Affect Disord. 2019 May 15;251:8-14.	This study was identified by the searches and considered for inclusion in the evidence map.	This study was excluded because it explores concordance between different measures for detecting postnatal depression. It does not assess the diagnostic accuracy of the measures against a reference standard of clinical interview.
Silverwood VA, Bullock L, Turner K, Chew-Graham CA, Kingstone T. The approach to managing perinatal anxiety: A mini-review. Front Psychiatry. 2022 Dec 15;13:1022459.	This paper was not detected by the search because it is a narrative review of the literature	This study was not assessed for inclusion in the evidence map as it is a narrative review of the literature and was excluded on the basis of study type as higher level evidence was available.

Reference	Identified by the map search?	Reason for exclusion
Harrison S, Pilkington V, Li Y, Quigley MA, Alderdice F. Disparities in who is asked about their perinatal mental health: an analysis of cross-sectional data from consecutive national maternity surveys. BMC Pregnancy Childbirth. 2023 Apr 27;23(1):263.	This paper was not detected by the search because it does not use any of the screening terms used to detect relevant studies in the title/abstract/keywords	This study was not assessed for inclusion in the evidence map. This paper by Harrison et al 2023 is similar to the paper by Martin-Key et al 2021 which was mentioned in the evidence map for question 5 alongside other papers which were briefly summarised (rather than fully included with abstract reporting tables) because they provided relevant information but did not fully address the map question. Both Martin-Key et al 2021 and Harrison et al 2023 report data on the proportion of women asked about their mental health during pregnancy and after birth. The paper by Martin-Key et al also provided some additional data on diagnosis and referral. The most recent data in both papers was from 2020. If detected, Harrison et al 2023 would have been mentioned in the evidence map in question 5 to supplement the information provided by the paper by Martin-Key et al 2021. This would not have changed the conclusion for question 5 or the overall recommendation.
Ayers S, Sinesi A, Meade R, Cheyne H, Maxwell M, Best C, McNicol S, Williams LR, Hutton U, How-	This paper was not detected by the search because it does not use any of the screening	This study was not assessed for inclusion in the evidence map.

Reference	Identified by the map search?	Reason for exclusion
ard G, Shakespeare J, Alderdice F, Jomeen J; MAP Study Team. Prevalence and treatment of perinatal anxiety: diagnostic interview study. BJPsych Open. 2024 Dec 13;11(1):e5	terms used to detect relevant studies in the title/abstract/keywords	This study interviewed a sample of women participating in a research study to examine the prevalence of anxiety disorders and the proportion of women who wanted or received treatment. If detected, this study might have been mentioned in the user experience section of question 5 alongside other similar papers that were briefly summarised. This would not have changed the conclusion for question 5 or the overall recommendation.
Ayers S, Sinesi A, Coates R, Cheyne H, Maxwell M, Best C, McNicol S, Williams LR, Uddin N, Shakespeare J, Alderdice F; MAP Study Team. When is the best time to screen for perinatal anxiety? A longitudinal cohort study. J Anxiety Disord. 2024 Apr;103:102841	This paper was not detected by the broader searches for test or treatment studies because it does not use any of the diagnostic accuracy or treatment terms used to detect relevant studies in the title/abstract/keywords. The paper would have been detected by the implementation search, however, this search had a UK filter applied and the paper does not have any terms in the title/abstract/keywords to indicate that it is a UK study.	This study was not assessed for inclusion in the evidence map. The main aim of the study as stated in the abstract was to determine the optimal time to screen for perinatal anxiety to identify women with anxiety disorders and if detected would have been considered for relevance to questions 1 and 2. If assessed for question 1 about screening tools in pregnancy the paper would not be included as the study did not report any of the PICO outcome measures and 39.9% of the population had a previous mental health disorder. If assessed for question 2, (specifically the sub-question about the optimum timing of screening), it would have

Reference	Identified by the map search?	Reason for exclusion
		been excluded as it concerns tests for postnatal anxiety and not postnatal depression which is the PICO condition of interest for this sub-question.
Sinesi A, Constantinou G, Yuill C, Meades R, Cheyne H, Maxwell M, Best C, Ayers S, Shakespeare J, Alderdice F, Jomeen J, Howard G. Implementing routine assessment of perinatal anxiety: case studies. Health Soc Care Deliv Res. 2025 May;13(32):1-17.	This paper was not detected by the search because it does not use any of the screening terms used to detect relevant studies in the title/abstract/keywords.	This study was not assessed for inclusion in the evidence map. This study interviewed healthcare professionals about the acceptability and feasibility of implementing a new perinatal anxiety assessment in healthcare services. If detected, this study might have been mentioned in the user experience section of question 5 alongside other similar papers that were briefly summarised. This would not have changed the conclusion for question 5 or the overall recommendation.
Osório FL, Rossini Darwin AC, Bombonetti EA, Ayers S. Posttraumatic stress following childbirth: psychometric properties of the Brazilian version of the City Birth Trauma Scale. J Psychosom Obstet Gynaecol. 2022 Sep;43(3):374-383	We apply the OECD filter developed by information specialists working on NICE guidelines to our searches when a PICO specifies UK comparable countries (https://pub-med.ncbi.nlm.nih.gov/34285668/). This provides a proxy for similar countries but papers are still assessed for prioritisation against the topic and question and other studies identified. Brazil is one of the countries that would be	This paper does not meet the inclusion criteria for the evidence map.

Reference	Identified by the map search?	Reason for exclusion
	excluded by the OECD filter and the paper by Osório et al 2022 was not returned by the searches. The study is about PTSD following childbirth which is not in scope for either question 1 or question 2 as it does not meet their inclusion criteria for intervention and population.	

Table 2: Papers referenced in the feedback that were published outside of the search period

Reference	Assessment against the map inclusion criteria	Assessment in relation to the current map conclusion?
Ayers S, Meades R, Sinesi A, Cheyne H, Maxwell M, Best C, et al. Identifying acceptable and effective methods of assessing perinatal anxiety: the MAP study. Health Soc Care Deliv Res 2025;13:(32):1–44.	This paper was published in September 2025 after the map search date. This paper is a summary of the methods and outcomes of the four work packages included in the methods of assessing perinatal anxiety (MAP) study. It does not appear to include any data not already available in other publications.	The information provided in this paper is available from other studies which were individually considered as part of the evidence map process. The consideration of this paper, had it been published within the search window, would not have changed the current map conclusions or recommendation.
Pisavadia K, Doungsong K, Ezeofor V, Spencer LH, Tuersley L, Best C, Meades R, Ayers S, Hutton U, Moran PM, Shakespeare J, Sinesi A, Edwards RT; MAP ALLIANCE study team. Healthcare use and costs of perinatal anxiety: a UK NHS perspective. BMC Health Serv Res. 2025 Sep 3;25(1):1183.	This paper was published in September 2025 after the map search date. This paper is a cost of illness analysis and would not have met the inclusion criteria for the evidence map as it does not address any of the map questions.	This paper does not meet the inclusion criteria for the evidence map.
Hutton, U., Delicate, A., Moran, P.M. et al. Healthcare professionals' views on barriers, facilitators and optimisation of care for perinatal anxiety: a qualitative investigation. BMC Health Serv Res,	This paper was published online in January 2026 after the map search date. This paper reports interviews conducted with healthcare professionals in 2023. If published within the search window, this paper would have been considered against question 5 and would probably have been mentioned in the section	The consideration of this paper, had it been published within the search window, would not have changed the overall conclusion for question 5 or the overall recommendation.

Reference	Assessment against the map inclusion criteria	Assessment in relation to the current map conclusion?
2026; https://doi.org/10.1186/s12913-025-13930-z	about user experiences to supplement the studies already identified.	

Annex C: Consultation comments

1. Smita Thakur, RCGP Clinical Advisor and College Representative, RCGP

Key issues, challenges & evidence gaps highlighted

- The 2025 evidence map found that there is still insufficient high-quality evidence that screening tools for perinatal mental health (e.g., for depression/anxiety) are accurate enough when used broadly across the general population.
- There remains no clear consensus on how best to follow up or treat screen-detected cases, particularly balancing risks and benefits for parent and baby when considering interventions during pregnancy or early motherhood.
- The evidence map noted that while many studies exist, few specifically address long-term outcomes, safety, or implementation feasibility for a nationwide screening programme.
- Important issues around equity, access, and systemic capacity – including sufficient perinatal mental-health services, timely referral pathways, and ability to provide sensitive care – remain a concern.

What's at stake (why this matters)

- Approximately a quarter of women experience mental-health problems during pregnancy or the postnatal period (depression, anxiety, PTSD, etc.).
- Early detection – if effective – could enable timely support via psychological, social, or medical interventions, reducing maternal morbidity and mortality, improving parent and infant outcomes. However, poorly validated screening may generate false positives or negatives, causing unnecessary anxiety or missed cases.
- The decision will influence national perinatal care policy, funding, and how universal primary care (GPs, midwives, health visitors) integrates mental-health support in antenatal and postnatal pathways – with implications for equity, workload, and service design.

What you could do if responding to the consultation

- Routine screening should be introduced • Using screening tools, assessment pathways, and follow-up care is necessary (e.g., Whooley questions, GAD-2, EPDS, structured follow-up). • Address Concerns around access, equity, resources, workforce capacity (midwives, health visitors, GPs, perinatal mental health teams). • The need for culturally-sensitive, person-centred care, especially for vulnerable or

minority communities. • Governance, referral pathways, and safety (ensuring that positive screens lead to timely, appropriate support).

What this means for GPs and primary-care professionals

- As trusted points of contact, GPs may increasingly be asked to discuss, screen or refer for mental health during pregnancy and after birth – understanding the consultation and potential changes is important for future readiness.
- The outcome may shape how perinatal mental-health services are structured: whether screening becomes routine or remains targeted based on risk/history.
- If adopted, services will likely need robust referral pathways, greater collaboration (with midwives, health visitors, perinatal specialists), and resources to support women identified at screening.

2. Susan Ayers, Professor of Maternal & Child Health, XXX XXX

We welcome the opportunity to comment on the 'Screening for Antenatal and Postnatal Mental Health Conditions: Evidence Map 2025' and acknowledge the work undertaken by the UK National Screening Committee (UK NSC) to collate and summarise recent evidence to inform policy considerations.

However, we are concerned that important and relevant bodies of UK-based research have not been incorporated into the Evidence Map, and that these omissions have implications for the conclusions drawn. The Evidence Map concludes that the current volume and type of evidence relating to screening for antenatal and postnatal depression and anxiety is insufficient to support commissioning a full evidence review at this time. This conclusion appears to be based on an incomplete capture of the existing literature, particularly in relation to perinatal anxiety and other related conditions.

Notably, two major programmes of research funded by the National Institute for Health and Care Research (NIHR) for £2.4 million that were designed specifically to address these questions in relation to perinatal anxiety have not been included. The MAP and MAP ALLIANCE studies [1,2] provide comprehensive information on assessment of perinatal anxiety, as well as relevant information on perinatal depression and postpartum PTSD, yet do not appear to have been incorporated into the Evidence Map.

Together, these studies provide high-quality empirical evidence on diagnostic performance, optimal timing for screening, acceptability, feasibility, health service use, costs, and implementation. This evidence is directly relevant to the screening questions posed in the Evidence Map, in particular Question 1 (accuracy of screening tools); Question 2 (utility of screening tools); Question 3 (benefits of intervention); and Question 5 (whether detection and management are well implemented).

We outline below selected findings in relation to each question in the Evidence Map. This is not intended to be an exhaustive account, but rather an illustration of some of the relevant evidence base.

Question 1: What is the volume and type of evidence on the reported accuracy of screening tools to detect common mental health conditions during pregnancy?

The MAP research programme evaluated five assessment tools for common mental health conditions in the perinatal period: the Whooley questions, the Clinical Outcomes in Routine Evaluation (CORE-10), Generalised Anxiety Disorder scales (GAD-2, GAD-7), and the Stirling Antenatal Anxiety Scale (SAAS). The programme specifically examined diagnostic accuracy, optimal timing of assessment, implementation in routine care, and acceptability to pregnant and postpartum women and healthcare professionals. Research was

conducted in the UK (England and Scotland) with large samples, using a reference standard of diagnosis confirmed by clinical interviews.

The MAP research programme found that:

- Routine assessment of perinatal anxiety was acceptable to women and generally viewed positively; all measures evaluated were acceptable and easy to use [3]
- Diagnostic accuracy for depression was acceptable for the CORE-10, SAAS, GAD-7 and Whooley questions [4]
- Diagnostic accuracy for anxiety disorders was greatest for the SAAS and CORE-10 [4]
- The same cut-off scores were optimal for identifying anxiety or depression disorders across measures [4]
- The GAD-2 and GAD-7 demonstrated poorer diagnostic accuracy and acceptability [3,4], despite being clinically recommended by NICE for assessing perinatal anxiety [5]
- Higher anxiety scores on all measures were associated with greater functional impairment, poorer quality of life, and increased desire for treatment [6]

In addition, there is a body of literature on the assessment of traumatic birth experiences and post-traumatic stress symptoms or disorder (PTSD) in the perinatal period. PTSD assessment is included in several clinical guidelines [9,10]. Widely used measures of perinatal PTSD include the City Birth Trauma Scale (City BiTS), Impact of Events Scale (IES/IES-R), Primary Care PTSD Scale (PC-PTSD), and PTSD Checklist for DSM-5 (PCL-5). An increasing number of studies have examined the validity and utility of these instruments in perinatal populations, including evaluation of diagnostic performance [11,12]. This literature is relevant to the broader consideration of screening and assessment within the Evidence Map but is not included.

Question 2: What is the volume and type of evidence on the reported accuracy of screening tools to detect postnatal depression?

The rationale for restricting Questions 2 and 4 to postnatal depression is not clear. The MAP research programme provides relevant evidence on both perinatal anxiety and depression, including:

- Diagnostic accuracy for depression was acceptable for the CORE-10, SAAS, GAD-7 and Whooley questions [4]
- Diagnostic accuracy for anxiety disorders was greatest for the SAAS and CORE-10 [4]

- The same cut-off scores were optimal for identifying anxiety or depression [4]

The MAP programme also provides evidence on optimal timing of screening, which is specified as a sub-question in the Evidence Map:

- Early pregnancy was the optimal time for identifying women with anxiety disorders and those who wanted treatment [7]
- This finding was consistent across all five assessment measures evaluated [7]

Question 3: What is the volume and type of evidence on the benefits of pharmacological and non-pharmacological intervention (alone or in combination) in women with screen-detected common mental health conditions during pregnancy?

It is unclear why this question is restricted to pregnancy, given that the onset of perinatal mental health conditions can occur at any point across the perinatal period. The MAP ALLIANCE programme examined patterns and costs of healthcare use among women with perinatal anxiety (for themselves and their infants) [2]. Relevant findings include a rapid review of cost-effectiveness evidence, which showed:

- Most economic evaluations of interventions focus on postnatal depression, with fewer evaluations of interventions for perinatal anxiety [13]
- Health economic studies suggest that postnatal depression is associated with increased costs, and interventions for postnatal depression are largely cost-effective [13]

Research by Silverwood and colleagues is also relevant here, including a meta-review of non-pharmacological interventions for perinatal anxiety [14] and a mini-review on approaches to managing perinatal anxiety [15].

Question 5: Is there evidence that clinical detection and management are currently well implemented in the UK?

Many findings from MAP and MAP ALLIANCE are relevant to this question. Findings on women's experiences showed:

- Women with perinatal anxiety used more healthcare services and had higher healthcare costs six months postpartum compared to women without anxiety [16]
- Most women with anxiety disorders who wanted treatment reported receiving care [17], but not all women wanted treatment

- Acceptability of care pathways for perinatal mental health varied. Key issues raised included lack of information about available care, lack of continuity of healthcare professional, perceived stigma and a desire for support before treatment [18]

MAP and MAP ALLIANCE findings on implementation of routine assessment and health professionals views include:

- Many healthcare professionals do not use standardised questions or scales when enquiring about mental health with perinatal women and have received little training in perinatal mental health [19]
- Healthcare professionals identified barriers that limited their ability to provide care for women with perinatal anxiety, including a lack of training and resources [19]
- Implementation of routine assessment of perinatal anxiety using the SAAS showed it was feasible and acceptable to health professionals [8]
- A guide to implementation of routine assessment using the SAAS was developed and is available [8]

Research from Alderdice and colleagues at the National Perinatal Epidemiology Unit is also relevant here, with findings from population-based surveys on the proportion of women who are asked about their mental health [20] as well as comparisons of different assessment measures [21,22].

Conclusion

The UK NSC Evidence Map represents an important step towards summarising recent research in this area. However, the omission of key studies addressing screening methods, diagnostic accuracy, acceptability, and real-world implementation within UK health systems weakens the basis for the conclusion that further review is not yet justified.

Given that the stated purpose of the Evidence Map is to determine whether a more detailed review should be commissioned, failure to identify relevant primary and synthesis research risks underestimating the existing evidence base and limits the document's ability to inform the UK NSC's decision-making, potentially undermining the validity of the UK NSC's decisions.

To strengthen the Evidence Map and future review processes, we recommend:

1. Greater transparency regarding how evidence was identified and excluded (e.g., clarification of the PICO criteria outlined in Figure 1 that resulted in 3,868 of 3,892 unique references being excluded), particularly in relation to highly relevant

omissions such as the MAP and MAP ALLIANCE programmes and other research outlined above.

2. Broader consideration of the available evidence, as well as the wider range of perinatal mental health conditions and assessment, including within Questions 2 and 4, rather than the current narrow focus on postnatal depression.

We hope these comments are helpful and would be happy to provide further information or support for this process if needed.

Yours sincerely,

Professor Susan Ayers, on behalf of the MAP and MAP ALLIANCE Research Teams

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3. XXXX XXXX, Reader in Health Research, XXXX XXXX

Overall approach. Even with a full review, it seems unlikely that the UK NSC's position will change, given its emphasis on minimising false positives (i.e. a focus on high specificity). For many practitioners and families, the realities are instead: 1) concerns with false negatives and 2) concerns with onward follow-up and treatment within a clear and reliable pathway, 3) concerns with time (and wider resource) available for practitioners to identify and respond to mental health need (including that our investment in specialist provision has not been matched within universal services). Furthermore, there are disparities relating to these areas, for example people in marginalised groups are less likely to be asked about their mental health, to feel safe enough to disclose their difficulties, and to receive onward referral and uptake. Any future work in this area needs to place a strong emphasis on equity and the lived realities of those navigating the system.

Clarity about screening vs. assessment. We are in a position where existing national policy and the new Maternal Care Bundle advocate for routine assessment, yet the UK NSC does not screening. It would be helpful to communicate the differences between these, using accessible and compassionate language for both practitioners and families. Without this clarity, the current landscape can appear confusing and may seem less committed to perinatal mental health than broader policy intentions suggest. It may also reduce the ability of service commissioners and managers to make the case for investment in perinatal mental health care, including within universal services.

Future evidence summaries and family-focused care. Future summaries should also consider mental health of non-birthing parents (including fathers and LGBTQ+ co-parents). There is relevant research available on this, e.g. <https://doi.org/10.3389/fpsy.2020.585479>

4. Adrian Hayter, Medical Director of Clinical Policy, RCGP

Section and / or page number	Text or issue to which comments relate	Comment <i>Please use a new row for each comment and add extra rows as required.</i>
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.

5. Pollyanna Hopkins, Senior Public Affairs and Policy Advisor, British Psychological Society

UKNSC Consultation Response – This response has been led by the Faculty of Perinatal Psychology, British Psychological Society, and is submitted on behalf of the British Psychological Society.

Our comments do not propose a method for screening, or who should be doing that screening, as we consider that a separate issue to the central question of should there be screening.

1. Do you believe the UKNSC should screen for antenatal and postnatal mental health conditions?

Yes. From a perinatal psychology perspective, we support a recommendation to screen for antenatal and postnatal mental health conditions. However, we believe the evidence base should be interpreted in light of international research that conceptualises screening as part of a screening-plus-engagement-with-treatment package, rather than as a standalone detection exercise.

A substantial body of work, particularly from the United States over the past 15+ years, evaluates whether systematic screening combined with facilitated access to care improves clinical outcomes, service engagement, and equity of access. This literature is highly relevant to the UK context and should be considered central to the screening recommendation. Please see references for further information.

2. Screening, safety, and health 2. Screening, safety, and health inequalities as a starting position

Screening is not a neutral technical intervention. It operates within maternity and mental health systems shaped by structural inequities in access, trust, continuity, and responsiveness.

Evidence from MBACE-UK and multiple national maternity inquiries (including Ockenden, Kirkup, and Amos) consistently demonstrates that those at highest risk of adverse outcomes – including people from racially marginalised groups, those living in socioeconomic deprivation, migrants, individuals with insecure housing, and those with prior trauma – are also those least likely to have their distress recognised, believed, or responded to.

This raises a critical interpretive issue for the screening evidence: many validation and outcome studies rely on samples that under-represent precisely those populations for whom screening may have the greatest potential value.

When implemented within effective care pathways, screening has the potential to function as a health equity intervention by:

Creating structured opportunities for disclosure

Reducing reliance on subjective judgement alone

Supporting earlier access to care for those who face systemic barriers

However, when evidence is derived from non-representative samples, it remains unclear whether reported benefits generalise to the populations most affected by perinatal mental health inequalities.

3. Evidence base under-represented in the review: screening as part of a care pathway

The UKNSC evidence review focuses predominantly on the psychometric performance of individual tools (sensitivity, specificity, and diagnostic accuracy). While necessary, this omits a major body of international evidence that evaluates screening as a system-level intervention, in which detection is paired with active care coordination and facilitated access to treatment.

US-based research, including work led by Massachusetts General Hospital and public health-embedded programmes (e.g., Byatt and colleagues), evaluates outcomes such as:

Uptake of mental health treatment following screening

Engagement and retention in care

Symptom improvement over time

Differential effects in low-income and ethnically diverse populations

This literature is particularly relevant to perinatal mental health, where difficulties are frequently comorbid, transdiagnostic, and shaped by social adversity. In this context, sensitivity and engagement with care may be more clinically and ethically meaningful outcomes than diagnostic specificity alone.

We recommend the UKNSC explicitly reviews this screening-plus-treatment literature, as it directly addresses whether screening improves real-world outcomes at a population level – the central policy question for a national recommendation.

4. Representativeness, access, and acceptability in marginalised populations

A further gap in the review is limited attention to acceptability and accessibility of screening, particularly among groups who experience barriers to engagement with maternity and mental health services.

Evidence suggests that:

Low-income and racially marginalised populations experience both higher prevalence of perinatal mental health difficulties and lower access to treatment

Trust, cultural safety, and perceived consequences of disclosure strongly influence willingness to engage with screening and follow-up care

Digital and self-report modalities may increase acceptability for some groups, while exclusion from digital access may further marginalise others

These factors are not peripheral to screening effectiveness. If screening is not acceptable or accessible to those most at risk, population-level benefits are likely to be overstated.

5. Definition of the perinatal population used for the evidence review: omission of pregnancy loss (particularly before 12 weeks when they would be seen in maternity and neonatal contexts)

The review largely defines the perinatal population in relation to pregnancy and the postnatal period following live birth. This framing excludes or marginalises groups with well-established elevated psychological risk, including:

Individuals experiencing pregnancy loss (miscarriage, recurrent loss, stillbirth, termination for medical reasons)

Parents of babies admitted to neonatal care, including non-birthing parents

Both populations show significantly higher rates of anxiety, depression, trauma-related distress, and complicated grief, as well as increased vulnerability in subsequent pregnancies and parenting transitions.

From an evidence perspective, this raises a substantive gap: screening studies rarely include or stratify these high-risk groups, despite their prevalence and clinical vulnerability. We recommend the UKNSC consider whether the current definition of “perinatal” used in the review is too narrow to inform a population-level screening recommendation.

6. Beyond depression: missing evidence on trauma, anxiety, and OCD

While we recognise that the review reflects a depression-dominated evidence landscape, notable omissions remain relevant to the screening decision:

Trauma and PTSD: A substantial proportion of perinatal distress is trauma-related, particularly following obstetric complications, pregnancy loss, and neonatal admission.

Perinatal anxiety: Recent diagnostic accuracy and acceptability studies indicate anxiety is highly prevalent and not reliably captured by depression-focused measures alone.

Perinatal OCD: Research suggests screening accuracy improves when perinatal-specific symptom content is included, particularly for intrusive thoughts that may otherwise go undisclosed.

This raises a policy concern that a screening recommendation narrowly focused on depression risks systematically under-identifying a large proportion of clinically significant perinatal distress.

7. Capturing distress beyond diagnostic thresholds

Emerging evidence, including from neonatal and marginalised populations, highlights that some groups experience high levels of psychological distress that do not map cleanly onto standard diagnostic categories or thresholds.

Recent work in neonatal settings demonstrates the value of needs-based and relational assessment approaches that capture:

Emotional burden

Social adversity

Trauma exposure

Practical and relational stressors

This literature raises an important question for the screening evidence base: whether outcome studies relying solely on disorder-specific measures may underestimate benefit for populations whose distress is complex, cumulative, and context-driven.

8. Digital self-report and engagement evidence

The review gives limited attention to digital screening modalities, despite a growing body of evidence that digital platforms can support:

Repeated self-monitoring over time

Engagement among partners and non-gestational parents

Structured disclosure in psychologically safer formats

Feasibility and mixed-methods studies suggest that digital screening can function not only as a detection tool but also as a mechanism for ongoing engagement with care, particularly when embedded in linked referral pathways.

This evidence is directly relevant to screening-plus-treatment models and warrants explicit inclusion in the review.

9. Summary: implications for the screening recommendation

From a perinatal psychology perspective, the key policy question is not only whether screening tools can detect symptoms, but whether systematic screening improves engagement with care and outcomes at a population level, particularly for those at highest risk and lowest access to services.

We believe the evidence review would be strengthened by:

Inclusion of international screening-plus-treatment studies, particularly from the US

Greater attention to representativeness and inequalities in study populations

Explicit consideration of pregnancy loss and neonatal populations

Broader inclusion of trauma, anxiety, and perinatal-specific symptom profiles

Consideration of acceptability and accessibility as core components of screening effectiveness

Addressing these gaps would provide a more robust, policy-relevant evidence base to inform a national recommendation.

Some key references that the committee may wish to review:

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6. XXXX XXXX, GPCPC

Section and / or page number	Text or issue to which comments relate	Comment
		<i>Please use a new row for each comment and add extra rows as required.</i>
5	Summary	Our view as a Board is that screening for perinatal mental health (PMH) disorders with the screening tools that are currently available for use is unlikely to meet the criteria of the UK National Screening Committee (NSC), as such we are not sure that the UK NSC is the correct forum to assess the suitability of PMH screening tools for use with the UK general population. Current screening tools are not sufficiently inclusive for all women (and birthing people) and women who wish to avoid detection of having a PMH diagnosed know how to answer screening questions to avoid being identified as having a PMH issue (Silverwood et al 2019, Oh et al 2020). Current tools recommended by NICE Clinical Guidance 192: Antenatal and Postnatal Guidance (NICE,2014) have not been validated for use in a perinatal population, and we therefore do not know if they are actually appropriate for use with perinatal women with relation to both sensitivity and specificity screening criteria. We feel that routine enquiry around a woman's mental health is crucial, but use of screening tools is not likely to be the most effective way to do this. Women should be routinely asked about their mental health in every consultation, by all different healthcare professionals that she may come into contact with, making every contact count. We disagree with the final statement that 'no further evidence synthesis work on screening for antenatal and postnatal

		mental health conditions should be commissioned at the present time'. PMH affect 25.8% women (GOV, 2025) which is a significant proportion of the general population. The most recent MBRRACE report (MBRRACE 2025) highlights the impact of maternal suicide as one of the leading causes of death in the perinatal period and therefore this should be considered a priority going forwards. References GOV, 2025 - https://www.gov.uk/government/publications/perinatal-mental-health-condition-prevalence/estimated-prevalence-of-perinatal-mental-health-conditions-in-england-2016-to-2019 MBRRACE 2025 Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2021-23. https://www.npeu.ox.ac.uk/mbrance-uk/reports/maternal-reports NICE (2014) <i>Overview Antenatal and postnatal mental health: clinical management and service guidance Guidance NICE</i>. Available at: https://www.nice.org.uk/guidance/cg192 Oh, S. <i>et al.</i> (2020) 'Exploring women's experiences of identifying, negotiating and 436 managing perinatal anxiety: A qualitative study', <i>BMJ Open</i>, 10(12), pp. 1–8. doi: 10.1136/bmjopen-2020-040731. Silverwood <i>et al.</i> (2019) 'Healthcare professionals' perspectives on identifying and managing perinatal anxiety: A qualitative study', <i>British Journal of General Practice</i>, 69(688), pp. E768–E776. Available at: https://doi.org/10.3399/bjgp19X706025.
6	Paragraph 3	We feel that the omission of considering perinatal trauma (which includes birth related trauma and conditions such as infertility and hyperemesis gravidarum) as a specific mental

		health problem should be reviewed when subsequent UK NSC reviews take place.
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