

Sequential and Coordinated Screening

Opening the Conversation

Risk factors:

- Psychiatric history in parents, psychological trauma
- Stressful life events
- Lack of family or social support
- Socioeconomic difficulties
- Conflictual relationship with the co-parent
- Domestic violence
- Lack of partner support
- High-risk pregnancy (maternal age, multiple pregnancy, unplanned pregnancy, complications, etc.)
- Excessive or unexplained infant crying

Main protective factor:

Family or social support (practical help with parenting and a substitute caregiver who can look after the infant).

Key moments for detection (sequential screening):

- Prenatal consultation
- Pregnancy-related Sick leave
- Maternity stay
- Infant health visits (from 15 days of age): remember to assess parents as well
- Postpartum consultation

Indirect signs:

- Concerning the parents / the child / interactions
- Functional signs in the parent and/or the child
- Discrepancy between reported symptoms and clinical observations
- Repeated consultations
- Excessive anxiety or difficulty reassuring a parent about minor concerns

A tool to support screening and follow-up:

The Edinburgh Postnatal Depression Scale (EPDS): urlr.me/34mABk

A simple self-administered questionnaire, completed in less than 5 minutes, non-judgmental, and internationally validated for use in the perinatal period.

Breaking down barriers in screening within the healthcare team (shared detection):

Building and strengthening information sharing.

Patient resources

- **Non-medical support website offering information, listening services, and advice in cases of maternal distress: maman-blues.fr**
- **Allô Parent-Bébé : 0 800 00 34 56**
- **Free and confidential helpline for suicidal risk: 3114 (24/7, 7 days a week)**
- **Baby blues and postpartum depression: 1000-premiers-jours.fr**

References

- **Screening for perinatal depression – EPDS scale: urlr.me/34mABk**
EPDS Edinburgh
- **Maternity and perinatal care: summary table of therapeutic approaches in mental health: urlr.me/UmqZ25**
Assurance Maladie - 08/2023
- **Mental health: therapeutic approach in the context of maternity and perinatal care: urlr.me/c4vTr7**
Assurance Maladie - 08/2023
- **Medical, psychological and social support for women, parents and their child in situations of vulnerability during pregnancy and postnatal care – clinical practice recommendations: urlr.me/Hzsruh**
Haute Autorité de Santé - 02/2024
- **Major depressive episode in adults: management in primary care: urlr.me/kPRdjH**
Haute Autorité de Santé - 11/2017
- **Perinatal psychiatric care pathway: from screening to treatment: urlr.me/RrMA6c**
Sutter-Dallay AL, Coicaud M, Chevrier A, Sentilhes L, Dallay D.
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Perinatal depression

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Half of perinatal depression cases go undiagnosed and untreated.

It is a “silent crisis” that requires a coordinated team-based response.

The perinatal period spans from the beginning of pregnancy through the child’s first year of life.

Perinatal depression refers to a major depressive episode (MDE) occurring at any time during this period. It is characterized by the usual diagnostic criteria for depression, including:

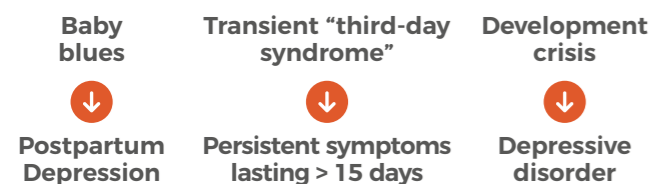
Usual criteria

Emotional, cognitive, and physical symptoms with functional impairment.

Possible specific associated features:

Child-focused anxiety, intrusive obsessive fears (phobias of impulsion), and physical pain.

Following childbirth, emotional difficulties may occur along a continuum ranging from normal emotional adjustment to clinical depression:

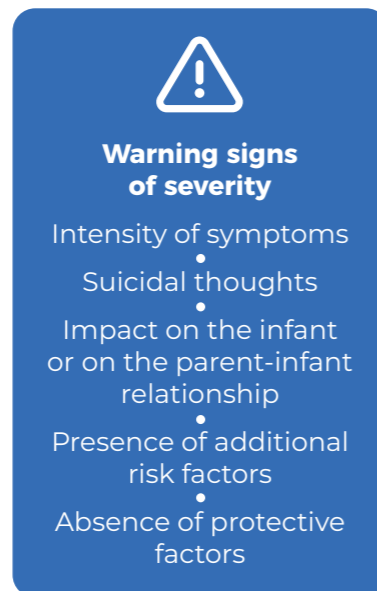


The impacts on individuals and their interactions are threefold:

- **The mother or parent** experiencing depression, with an elevated risk of recurrent major depressive episodes;
- **The child**, who faces a higher risk of developmental difficulties;
- **The co-parent** and partner.



Qui est concerné ?
10 à 20% des mères
ou des co-parents



Multidisciplinary management

Involving parents and those close to the child
Keeping the door open

What is the role of the general practitioner?



Screening



Diagnosis



Treatment



Referral
and guidance



Coordination
of care

Towards better interprofessional practice: what are the needs of general practitioners?

Identify available resources (services and professionals) locally that can contribute to building a care team (CPTS, maternal and child health services, perinatal networks, medical, psychological and social support staff, and other healthcare professionals).

Work in a multidisciplinary team, with a clear understanding of each professional's role, using patient-centred coordination tools and shared information systems.

Rely on evidence-based medicine.

What are the objectives?

Joint care targeting three dimensions:

- **Parent(s)** : to prevent the risk of complications and recurrence of mood disorders
- **Child** : to prevent the risk of developmental disorders
- **Parent-child relationship and family dynamics**: to maintain the parent-child bond and prevent the risk of family and environmental exhaustion.

Coordinated care and follow-up

- **Graduated and sequential (the right care at the right time)**: the care strategy varies according to the assessment of the major depressive episode (MDE) and its severity.
- **As a team, with the support of local professionals trained and aware of joint care**: specialist physicians, midwives, pediatric nurses, psychologists, home care and family support workers (TISF), educators, maternal and child health services, early medical and social intervention centres (CAMSP), social and administrative support services, and local community organisations. Perinatal mental health units will contribute to the management of the most severe cases¹.

What treatments are available?

Non-pharmacological interventions

- **Adapted physical activity** (effective for mild to moderate depressive episodes)
- **Healthy eating and good sleep hygiene**, including reducing the consumption of psychoactive substances that may disrupt them (tobacco, alcohol, cannabis, etc.)
- **Relaxation techniques** and stress management strategies
- **Addressing basic needs**: support with parenting and daily life management, for example by encouraging parents to use parent-child support centres or to connect with parenting associations
- **Involving family and friends** to combat social isolation, provide parenting support, and ensure sufficient sleep, etc.
- **Specific relational and social care through** local perinatal support services (hospital-based, outpatient, or community-based).

Psychotherapy

- **Cognitive-behavioural therapies and interpersonal therapies**: first-line treatment for mild to moderate depressive episodes. In cases of severe depressive episodes or if there is no improvement, referral to a mental health professional is recommended.
- **Supportive therapy**, provided by a general practitioner or another trained mental health professional.

Pharmacological treatments

In cases of moderate to severe depressive episodes, and depending on severity, **antidepressant treatment may be initiated**, such as paroxetine or sertraline, both of which have minimal transfer into breast milk during breastfeeding². Whenever possible, it is recommended to continue the treatment that was effective before pregnancy.

Referral to a psychiatrist in a collaborative approach

Referral to a psychiatrist should be made immediately **in cases of severe depressive episodes**, moderate to high suicide risk, or lack of improvement. Depending on the severity, **admission to a specialist unit** may then be considered. Hospital discharge should be coordinated in collaboration with the general practitioner and other primary care providers.

¹ - Directory of perinatal care networks in France: urls.fr/vUinQq
² - Prescribing guidance website: psychotropes.fr