**Script for Guideline on screening for depression during pregnancy and the postpartum period**

[Slide 1]

* The Canadian Task Force on Preventive Health Care
* Guideline on screening for depression during pregnancy and the postpartum period

[Slide 2]

* These slides are made available publicly following the guideline’s release as an educational support to assist with the dissemination, uptake and implementation of the guidelines into primary care practice.
* Some or all of the slides in this slide deck may be used in educational contexts.

[Slide 3]

* Task Force members who made up the working group for this guideline are: Eddy Lang, Heather Colquhoun, John C. Leblanc, John Riva
* Task Force spokespersons are: Eddy Lang, Emily G. McDonald, Guylène Thériault.
* Content experts were Bianca Lauria-Horner, Scott Patten, Simone Vigod, Brett Thombs. Content experts are external advisors to the working group and do not vote or have input on the direction or strength of recommendations.

[Slide 4]

Overview of the Webinar

* Presentation
	+ Background on depression during pregnancy and the postpartum period
	+ Methods of the CTFPHC
	+ Recommendation
	+ Results
	+ Rationale for recommendations
	+ Knowledge gaps and next steps
	+ Other national depression screening recommendations for pregnant and postpartum individuals
	+ Conclusions
* Questions and Answers

[Slide 5]

* Background

[Slide 6]

* Depression during pregnancy and the post partum period is a serious health concern that can be treated if we are able to detect it.

[Slide 7]

* Depression during pregnancy and the post partum period is a serious health concern that can be treated if we are able to detect it.

[Slide 8]

* Symptoms may include significant weight or appetite change, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or guilt, reduced concentration or indecisiveness, and thoughts of death or suicidal ideation.

[Slide 9]

* The available estimates of the prevalence of depression in the pregnancy or postpartum period vary.
* A systematic review from 2005 estimated that the point prevalence of major depression during pregnancy and postpartum ranges from 1% to 6% at different time points (from the first trimester of pregnancy to one year postpartum).
* A 2008 national survey from the USA reported that the 12-month period prevalence of depression was 8% among pregnant individuals and 9% in postpartum individuals, compared to 8% among non-pregnant individuals.

[Slide 10]

* Depression during pregnancy and the postpartum period can have far-reaching impacts on the childbearing individual and their infant individually, as well as parent-infant interactions and relationships with partners.
* Consequences for the childbearing individual include:
	+ increased likelihood of future anxiety or depression
	+ lower quality of life
	+ increases in risky behaviours (e.g., tobacco smoking or alcohol consumption)
	+ suicidal ideation
* Impacts on the infant could include:
* delays in physical and mental development including cognitive and language development
	+ overall infant health concerns
* Impacts on parent-infant interactions can include:
	+ reduced breastfeeding
	+ poor parent-infant bonding

[Slide 11]

* It is normal and common to have what is often called “baby blues” a couple days after giving birth.
* These are feelings of sadness, anxiety, and/ or being upset with their baby or partner. Other symptoms include unexpected crying, trouble sleeping, or loss of appetite.
* It is mostly brought on by a large change in hormones after birth, loss of sleep, and increased stress.
* These symptoms often get better within 1 - 2 weeks without any treatment.
* Postpartum depression shares a lot of symptoms with “baby blues”, but it can be much more intense and requires treatment.

[Slide 12]

* Usual clinical care during pregnancy and the postpartum period should include discussion with pregnant or postpartum people about their history of mental illness, current symptoms and well-being.

[Slide 13]

* In addition to usual clinical care, screening for depression would involve the systematic administration of a screening instrument (most commonly a questionnaire or small set of questions) with a pre-defined cut-off score to all pregnant or postpartum people in a particular setting such as a clinic.
* Individuals who meet or exceed the cut-off score would be considered “screen positive” and would be further evaluated to see if they meet diagnostic criteria for depression, whereas those below the cut-off score would be “screen negative” and would not be further evaluated.
* Common depression screening instruments include the Patient Health Questionnaire (PHQ), and the Edinburgh Postnatal Depression Scale (EPDS) for postpartum and pregnant individuals.

[Slide 14]

* We draw a distinction between standard questions posed in a systematic screening context and those integrated into usual care based on how a practitioner makes judgement about next steps. In systematic sceening, all patients meeting the cut-off score would be considered “screen positive”, and would be investigated further with diagnostic approaches.
* In contrast, making a judgement about a patient’s status after a personalized assessment based on all information available to a practitioner would be considered as routine clinical care and not screening. For example, if a provider were to ask a patient “over the last 2 weeks, how often have you been bothered by: Little interest or pleasure in doing things; feeling down, depressed, or hopeless”, and then proceed using their clinical judgment based on the patient’s responses along with other information about the patient, this would not be considered screening given this would be a flexible and personalized approach as opposed to the systematic and structured approach of screening using an instrument with a cut-off score.
* Once a clinician suspects depression and begins to investigate it, they are engaging in a diagnostic process whether or not they used a formal depression screening tool.
	+ Note that depression symptom questionnaires can also be used for several purposes other than screening, including as part of a diagnostic assessment of people suspected of having depression, to track treatment progress or to check for relapse among people known to have depression.

[Slide 15]

* The goal of screening would be to identify and help individuals who, without a screening protocol, would have been identified later in their illness or not at all.

[Slide 16]

[Slide 17]

* Ten provinces and territories in Canada provide guidance documents (e.g., best practice recommendations, care pathways, perinatal records) that suggest asking patients about current depression, anxiety, or mood during pregnancy or the postpartum period as part of usual clinical care.

[Slide 18]

* Nine provinces and territories provide guidance documents that suggest primary care providers (e.g., public health nurses, family physicians, midwives) screen patients with instruments such as the EPDS during pregnancy or the postpartum period.
* This guidance includes recommended cut-off scores and follow-up actions as part of screening.
* Among these nine provinces and territories, seven also provide a place to enter scores for depression screening instruments in medical record forms used during pregnancy or the postpartum period.
* Guidance on which questionnaires to use, when to administer them, and pre-defined cut-off scores varies across provinces and territories.

[Slide 19]

* In 2013, the Canadian Task Force on Preventive Health Care recommended against screening for depression among perinatal or postpartum individuals.
* Given that practice continues to vary in Canada, updated guidance was developed based on a review of benefits and harms of screening, and taking into account patient preferences, to  provide clarity for providers.
* This guideline replaces the recommendation for pregnant and postpartum individuals from the 2013 guideline.

[Slide 20]

* This recommendation provides guidance to primary care health professionals (e.g., clinicians, nurses, midwives or other providers who could serve as first point of contact for care during pregnancy or the postpartum period), policymakers, and patients on screening (as defined above) for depression in individuals during pregnancy and up to 1 year postpartum.
* The scope of this recommendation also extends to individuals who may be at an elevated risk of depression (e.g., trauma in early life, family history of depression.
* This recommendation does not extend to individuals with a personal history or current diagnosis of depression or another mental health disorder, those currently receiving assessment or treatment for mental health disorders, those receiving care in psychiatric or other mental health settings, or those who are seeking services due to symptoms of depression. This guideline does not address depression treatment.

[Slide 21]

* Methods

[Slide 22]

* The Canadian Task Force on Preventive Health Care is an independent body of up to 15 clinicians and methodologists.
* The mandate is to develop evidence-based clinical practice guidelines that support primary care providers in the delivery of preventive healthcare.
* Ultimately the goal of the Task Force is to improve the health of Canadians by making sure that primary care providers have access to clinical prevention guidelines that are based on the best available evidence.

[Slide 23]

* The Task Force works with Evidence Review and Synthesis Centres (ERSCs) who independently review the evidence.
* The ERSCs undertake a systematic review of the literature based on the analytical framework and prepare the final report and GRADE tables. GRADE: Grading of Recommendation, Assessment, Development and Evaluation.
* They also participate in working group and Task Force meetings (non-voting).

[Slide 24]

* This infographic provides an overview of the TF guideline process and who provides critical input at the topic selection, evidence synthesis, guideline, and dissemination stages. This includes a variety of internal and external stakeholder (more detail on next slide).

[Slide 25]

* The TF review process includes:
	+ Internal review by the guideline working group and all other Task Force members
		- The Task Force also engages specialists/content experts to act as advisors to the working group throughout the process. Content experts are involved in meetings and review key documents, but do not vote or have input into the direction or strength of recommendations.
	+ External review is undertaken at 3 key stages:
		- Protocol, systematic review(s) and guideline
* External stakeholder reviewer groups include:
	+ Generalist and disease specific stakeholders
	+ Academic peer reviewers
* CMAJ undertakes an independent peer review process to review guidelines before accepting for publication.

[Slide 26]

*What are we grading?*

**1. Certainty of Evidence**

Degree of confidence that the available evidence **correctly reflects the theoretical true effect** of the intervention or service

*High, moderate, low, very low*

**2. Strength of Recommendation**

The balance between the **certainty of supporting evidence**; the certainty about the **balance between desirable and undesirable** effects; the certainty/variability in **values and preferences** of individuals; and the certainty about whether the intervention represents a **wise use of resources**

*Strong and conditional*

[Slide 27]

* The systematic review that informed this guideline will be published in the journal Systematic Reviews at the same time that the guideline is published.
* Reviews that inform Task Force guidelines can be found on the Task Force website, or through the journal’s Task Force collection.

[Slide 28]

* Patients were engaged in guideline development, recruited via advertisements on public advertisement websites (i.e., Craigslist and Kijiji), through two phases of focus groups conducted by the Knowledge Translation group at St. Michael’s Hospital.

[Slide 29]

* Phase 1 – during protocol development
	+ 15 participants (6 pregnant and 9 postpartum, all identifying as female) assessed the importance of key outcomes in deciding whether to be screened for depression via online survey.
	+ This was followed by three focus groups and two interviews via teleconference to gather these participants’ rationale for their ratings and discuss factors that impacted the importance of outcomes.
	+ Outcomes rated as critical or important by focus group participants (described below) and working group members were considered during guideline development.
* Phase 2 – after the systematic review was complete
	+ 14 different participants (4 pregnant and 10 postpartum, all identifying as female) were asked to rate the importance of outcomes when presented with synthesized evidence for benefits and harms of depression screening via online survey.
	+ This was followed by four focus groups and two interviews via teleconference to gather participants’ rationale for their ratings and discuss factors that impacted the importance of outcomes.
	+ Phase 2 allows us to identify whether patients, fully informed of the estimated benefits and harms from the review, might rate the importance of outcomes differently.

[Slide 30]

* Recommendation

[Slide 31]

* *The task force recommends against instrument-based depression screening using a questionnaire with cut-off score to distinguish “screen positive” and “screen negative” administered to all individuals during pregnancy and the postpartum period (up to 1 year after childbirth) (conditional recommendation, very low-certainty evidence).*
* This recommendation assumes that, as part of usual care during pregnancy and the postpartum period, care providers will inquire about and be attentive to mental health and wellbeing.

[Slide 32]

* The term ‘screening’ in this recommendation refers to a routine process in which primary care providers administer an instrument such as a questionnaire to every pregnant or postpartum individual not already reporting symptoms of depression and then use a cut-off score to determine a follow-up action for those at or above the cut-off score.
* The task force definition of screening in this context means that the recommendation against screening emphasizes the importance of good clinical practice where clinicians should inquire and be alert to changes in physical and mental health symptoms of their patients.
* Given the health implications of depression during pregnancy and the post-partum period, it is essential that providers inquire about and be attentive to mental health and wellbeing.

[Slide 33]

* As screening practices vary across Canada, jurisdictions may reconsider the use of such screening in settings where it is currently implemented.
* If providers are uncertain about how to engage in these discussions with patients, they may consider referring to questionnaires for discussion prompts (without engaging in formal screening by using the questionnaire score for determining subsequent actions).

[Slide 34]

* “The task force recommends against the addition of such a screening process because of the absence of evidence that it adds value beyond discussions about overall well-being, depression, anxiety and mood that are currently a part of established perinatal clinical care.”

[Slide 35]

* Results

[Slide 36]

* We found 1 randomized controlled trial that evaluated systematic depression screening among postpartum individuals (described as “mothers” or “women” in the study) in Hong Kong (*n* = 462).
* Participants were randomized to receive screening with the EPDS by nurses (n=231) or no such screening (n=231) at 2 months postpartum. Both groups received usual clinical care, including inquiring about feelings, appetite, sleep, childcare, and suicidal ideation.
* All participants identified as potentially depressed (based on EPDS score ≥10 or clinical assessment in the intervention group or based on clinical assessment alone in the control group) were to be offered counselling or management by a community psychiatric team.
* Outcomes were assessed at 6 months postpartum (i.e. 4 months after randomization).
* Data on the critical and important outcomes were very uncertain, including for:
	+ Number depressed
	+ Depression symptoms
	+ General health score
	+ Reported or observed capacity to parent
	+ Parent-child stress
	+ Marital stress
	+ Infant hospitalizations
* The effects of screening on all of these outcomes were very uncertain due to very serious risk of bias concerns (use of self-reported outcome measures and selective outcome reporting) as well as imprecision concerns due to there being only a single small trial.
* This very low certainty means that the true effects of screening are likely substantially different from the study data.
* There was low certainty evidence indicating little to no difference in mean infant body weight at 6 months.
* No adverse events were noted in the study.

[Slide 37]

* We did not find any trials that compared questionnaire-based depression screening to no screening during pregnancy.
* We also did not identify any trials evaluating other outcomes of interest (i.e. suicidality, false positive screens, overdiagnosis, overtreatment, or labelling/stigma) (in either population).

[Slide 38]

* Patient values and preferences

[Slide 39]

* Participants expressed concerns that they might not recognize their own symptoms of depression or take the initiative to seek input from their primary care provider and expressed a preference for being screened.

[Slide 40]

* Although participants rated their preference to be screened quite high, during focus groups, it was noted that "participants felt most strongly about having a discussion with a healthcare provider about their mental health and wellbeing" and that "discussion about depression with a primary health care provider during the pregnancy and [postpartum] period is critical," which does not suggest a formal screening process.

[Slide 41]

* Thus, patient engagement suggested that discussions with healthcare providers about depression are important to patients.

[Slide 42]

* In the judgement of the task force, a recommendation against screening is feasible.
* Primary care providers are trained in the signs and symptoms of depression during pregnancy and the postpartum period, as well as processes for assessment, treatment, and referral (as required) as part of usual clinical care.
* The extent to which primary care providers are using questionnaire-based screening across Canada as part of usual clinical care is unknown.
* Given the results of our patient engagement, the Task Force judges that the recommendation against screening for depression using questionnaires administered to all pregnant and postpartum people should be acceptable to most patients as long as providers continue to inquire about mental health and wellbeing as part of usual care.
* The task force recognizes that a recommendation against screening may contradict current practice or policy in some jurisdictions. As such, they recognize that some providers may feel discomfort about de-implementing screening due to concerns about ‘missing’ cases of this important health issue.

[Slide 43]

* The impact on equity of a recommendation against screening is unknown.
* Some marginalized individuals report barriers to disclosing depressive symptoms or concerns with their health care provider (e.g., being unsure how to bring up the topic of depression, concerns about stigma, aversion to antidepressant medications or psychotherapy), in which case a recommendation against screening may result in some individuals with depression not being identified, although some of these barriers may still exist when using screening questionnaires.

[Slide 44]

* Rationale for recommendation

[Slide 45]

* This conditional recommendation is based on the very low-certainty evidence on the effect of screening on benefit outcomes and limited evidence of harms.
* The supporting systematic review suggests that the additional benefit of screening all patients with a questionnaire with a cut-off score compared to usual care (which should include inquiry into mood and mental health) during primary care visits is very uncertain.
* Although no evidence was found on the harms of screening in our systematic review, evidence from other sources described below suggest the time and focus on screening could reduce opportunities to discuss other aspects of health during a perinatal primary care encounter as providers would be evaluating and potentially referring all patients who screen positive, in many cases unnecessarily.
	+ Screening could lead to an increase in false positives, false negatives, unnecessary referrals and diagnostic evaluation, and overdiagnosis for some patients.

[Slide 46]

* A false positive can occur when the patient meets a screening cut-off score and is sent for additional psychiatric evaluation, which finds they do not actually meet the diagnostic criteria for depression.
* A recent individual patient data meta-analysis provides accuracy information for the EPDS, the tool used in the one trial we identified. Based on a prevalence of 8%, screening 100 patients with the EPDS using the common cut-off score of 13 would result in 5 true positives, 3 false negatives, 5 false positives, and 87 true negatives, meaning that some patients who are screened will be sent for an unnecessary additional assessment.

[Slide 47]

* Overdiagnosis could occur in patients with mild temporary symptoms, who might meet a screening cut-off score, leading to further evaluation and possible referral to specialty mental health services, but who would not benefit as the symptoms would subside on their own.

[Slide 48]

* Given the significant challenges to accessing mental health services in Canada, the unnecessary redirection of resources from the treatment of patients with mental health disorders could be an unintended harm of screening.
* Spending even 1-2 minutes per clinical encounter reviewing the results of a formal screening instrument with no proven value could consume a significant amount of time during a 15-minute encounter. In the task force’s view, this could detract from the ability of the clinician to have a meaningful and empathetic discussion about the health of the patient.
* Given that about 10% of all patients screened using a questionnaire and cut-off score would have to receive additional assessment or referrals, the resource implications also extend beyond the initial clinical encounter.

[Slide 49]

* The task force is mindful of the resource constraints faced by our primary health care system and as such makes recommendations against interventions when the resource implication of a particular health intervention are certain to be important and benefits have not been demonstrated, hence the conditional recommendation against screening.

[Slide 50]

* Knowledge gaps and next steps

[Slide 51]

* There is only 1 randomized controlled trial assessing the benefits and harms of questionnaire-based screening for depression versus no screening during the postpartum period
* There were none during pregnancy.
* Trials that compare screening to usual clinical care, where those identified as depressed in either arm receive the same level of care, are needed in order to isolate the effectiveness of screening as an intervention
	+ The outcomes examined in these trials should include both maternal and infant-related benefits and harms
* As experiences of pregnancy and the postpartum period can vary based on factors such as culture, ethnicity, socioeconomic status, geographic region, and other social determinants of health, studies that reflect and provide evidence for the diversity of the Canadian population would also be helpful

[Slide 52]

* Tools

[Slide 53]

* Knowledge translation (KT) tools

[Slide 54]

* Knowledge Translation
	+ An infographic and FAQs for clinicians and patients have been developed to help understand the guideline.
	+ After the public release, these tools will be **freely available** for download in both **French** and **English** on the website: [http://canadiantaskforce.ca](http://canadiantaskforce.ca/).

[Slide 55]

* The infographic was developed to help clinicians with the takeaway message for practice

 [Slide 56]

* Clinician and patient FAQs to guide discussions with patients

 [Slide 57]

* Public page with accessible, relevant resources for patients

 [Slide 58]

[Slide 59]

* Conclusions

[Slide 60]

* It is important that this conditional recommendation against screening is not interpreted as a recommendation against inquiry into mental health and wellbeing. The Task Force recommends against systematic screening using instruments with cut-off scores but emphasizes the importance of inquiry and attention to mental health and wellbeing during pregnancy and the postpartum period.

 [Slide 61]

[Slide 62]

* For more information on the details of this guideline please see:
	+ Canadian Task Force for Preventive Health Care website: [http://canadiantaskforce.ca](http://canadiantaskforce.ca/)

[Slide 63]

* Thank you
* Questions and answers