Canadian Task Force
on Preventive Health Care

Guideline on screening for depression during pregnancy and the postpartum period

Putting Prevention into Practice

Use of slide deck

- These slides are **public** after guideline release to help with dissemination, uptake and implementation into primary care practice
- Some or all of the slides may be used in educational contexts

Canadian Task Force
on Preventive Health Care

Perinatal and postpartum depression screening working group

Task Force members

Eddy Lang
Heather Colquhoun
John C. Leblanc
John Riva

Task Force spokespersons

Eddy Lang
Emily G. McDonald
Guylene Theriault (French)

External Support

Public Health Agency of Canada

- Greg Traversy
- Casey Gray

Evidence Review and Synthesis Centre

- Ottawa Hospital Research Institute (OHRI)

Content experts

- Bianca Lauria-Horner
- Scott Patten
- Simone Vigod
- Brett Thombs

Overview of webinar

- **Presentation**
  - Background
  - Methods
  - Recommendation
  - Evidence
  - Rationale
  - Knowledge gaps
  - Knowledge translation tools
  - Conclusions

- **Questions and answers**

Canadian Task Force
on Preventive Health Care

Background

Depression in pregnancy

- Depression in pregnancy or in the first year after childbirth is a serious concern
- If detected, there are effective treatments

Canadian Task Force
on Preventive Health Care

Diagnostic criteria for depression

- Depressed mood or less interest in activities
- Significant distress or functional impairment almost daily for 2 weeks

Canadian Task Force on Preventive Health Care

Diagnostic criteria for depression

- At least 5 symptoms:
  - Significant weight or appetite change
  - Insomnia or hypersomia
  - Fatigue, energy loss
  - Psychomotor agitation or retardation
  - Feelings of worthlessness
  - Poor concentration
  - Suicidal ideation

Prevalence in pregnancy/postpartum

- Point prevalence ranges from 1% to 6% from 1st trimester to 1 year post-partum
- 2008 US national survey of 14000+ people 18-50 years:
  - 12 month period prevalence:
    - 8% in pregnant people, 9% post-partum vs. 8% in nonpregnant people

Post-partum depression

Depression can have significant negative impact on the individual and baby:

- Parent-infant interactions
- Relationship with partners
- Reduced breastfeeding
- Poor parent-infant bonding
- Developmental delays for baby

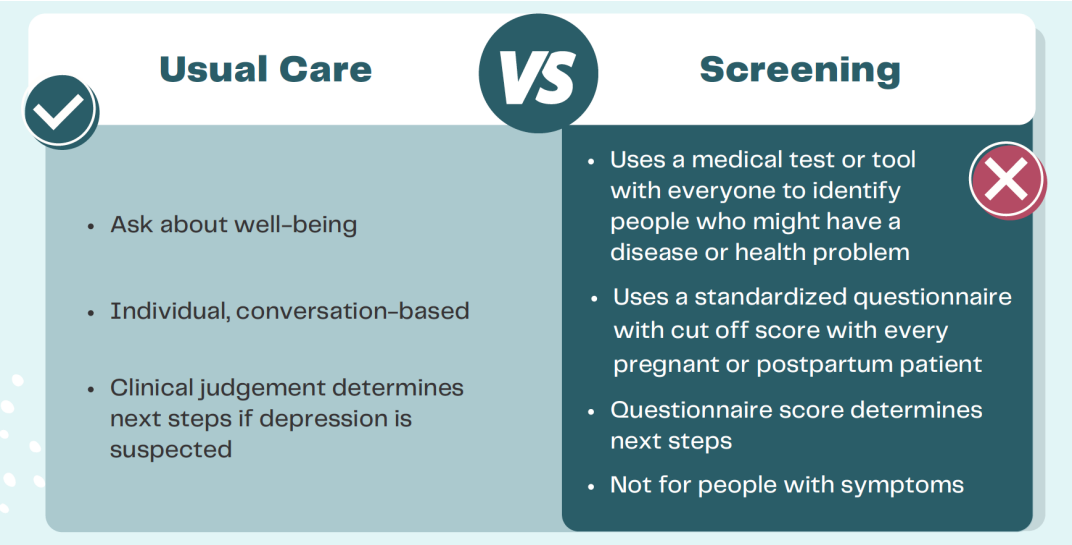
Postpartum depression vs. "baby blues"

- It is normal and common to have what is often called “baby blues” shortly after giving birth
  - Feelings of sadness, anxiety, and/or being upset with their baby or partner.
    Other symptoms include unexpected crying, trouble sleeping, or loss of appetite.
  - Brought on by a large change in hormones after birth, loss of sleep, and increased stress.
  - 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.

Usual care vs. screening

Usual clinical care

- Discussion with patient about:
  - Current mood and well-being
  - History of mental illness
  - Symptoms, if any



What is screening for depression?

- Routine use of questionnaire or small set of questions with a cut off score for every pregnant and postpartum patient to identify unrecognized depression

- Further investigation of patients with scores above specific cut-off

What is screening?

This differs from

- Using questionnaires as prompts for discussion
- Information gathering forms used to assess symptoms or monitor treatment

Goal of screening

- To improve mental health in patients with depression that would not have been recognized without screening

Information on Screening

Key Points:

- Some health issues could be caught early in people without symptoms using screening tests.
- However, not all screening tests that detect diseases earlier improve health outcomes.
- Screening is only warranted if it improves health outcomes compared to other ways of finding disease.

The Task Force produces evidence-based guidelines for preventive health care. Guidelines provide recommendations on whether or not to offer screening to certain groups.

There can be some confusion around what is meant by screening. Below is some information to help clarify.

Screening:

- ✓ Uses a medical test or tool to identify people at risk of a specific disease or health problem. They may be at a higher risk based on factors like age or sex.
- ✓ Is for people who do not show symptoms of a disease or health problem. Test may occur during a primary care visit.
- ✓ Result can be positive, negative, or uncertain. Screening indicates a possible health problem when the result is positive.
- ✓ Positive result will lead to more testing to confirm the diagnosis. Additional testing could be more intensive and invasive.

- Example of screening test: Occult blood testing every 2 years for individuals 60-74 years old

Screening is <u>not</u>:

- × For people who are showing symptoms of a disease or health problem.
- × Used to provide a definite diagnosis. Making a definitive diagnosis requires confirmatory tests, such as a biopsy.
- × The only way to identify conditions. Often, conditions are identified once symptoms are apparent.

- For an individual presenting to their family doctor because of blood in their stools, occult blood testing is NOT an example of screening.

To access our guidelines, tools, and resources, visit our website at www.canadiantaskforce.ca

Canadian Task Force on Preventive Health Care

Current Canadian guidance

Usual clinical care

- 10 provinces and territories suggest asking patients about depression, anxiety or mood as part of usual clinical care
- Guidance documents include best practice recommendations, care pathways and perinatal records

Current Canadian guidance

Screening tools

- Nine provinces and territories suggest primary care professionals use screening tools in pregnancy or postpartum
  - Edinburgh Postnatal Depression Scale (EPDS)

Guideline rationale: updated guidance

2013 – Task Force recommended against screening in pregnant and postpartum individuals

Practice varies across Canada

New guidance with patient input needed

Guideline scope

Targeted to:

- Primary care health professionals
- Policymakers
- Patients

Target Population	• Pregnant people and those up to 1 year postpartum • People who may have elevated risk of depression (e.g., trauma in early life, family history of depression)
Not covered by this guideline	• People with personal history of depression • Current diagnosis or treatment of depression or mental health disorder

Methods

Canadian Task Force on Preventive Health Care

- Independent body of 12-15 clinicians and methodologists

- **Mandate**:
  - Develop evidence-based clinical practice guidelines to support primary care providers deliver preventive healthcare
  - Ensure dissemination, uptake and implementation of guidelines

Evidence Review and Synthesis Centres (ERSC)

- Independent systematic review (SR) of the literature based on the working group's analytical framework
- Present evidence with GRADE tables to inform Task Force guidelines
- Participate in working group and Task Force meetings (non-voting)

Task Force Guideline Development Process

Canadian Task Force on Preventive Health Care

Task Force

15 primary care and prevention experts from across Canada

1. Topic Selection
2. Evidence Synthesis
3. Guideline Development
4. Dissemination

Patients and Public

Supported by:
Global Health and Guidelines Division (PHAC)
&
Evidence Review and Synthesis Centres

With input from:

Clinical Stakeholders
- Health Professional Associations
- College of Family Physicians of Canada
- Peer Reviewers
- Clinical Experts
- Specialty Physicians
- Allied Health Care
- Program Developers

External Stakeholders
- Government
- Non-governmental organizations
- Academic Institutions
- Policymakers

Internal Stakeholders
- Task Force Staff
- Knowledge Translation Program St. Michael's Hospital
- Clinical Prevention Leaders
- Fellows

Patients & Public
- Task Force Public Advisors Network (TF-PAN)
- Canadian Public

Guideline review process

- **Internal review process involving**:
  - ✓ Guideline working group and other Task Force members
  - ✓ Content experts who support the working group
- **External stakeholder review undertaken at key stages**:
  - ✓ Protocol, systematic review(s) and guideline
- **External stakeholder reviewer groups:**
  - ✓ Generalist and disease-specific stakeholders
  - ✓ Academic peer reviewers
- ***CMAJ*** undertakes an independent peer review process to review guidelines before accepting for publication

GRADE - rating evidence and grading recommendations

1. Certainty of Evidence

Certainty that the available evidence **correctly reflects the true effect**

High, Moderate, Low, Very Low

2. Strength of Recommendation

Certainty of **supporting evidence**

- Balance between **desirable** and **undesirable**
- Patient **values** and **preferences**
- **Wise use of Resources**

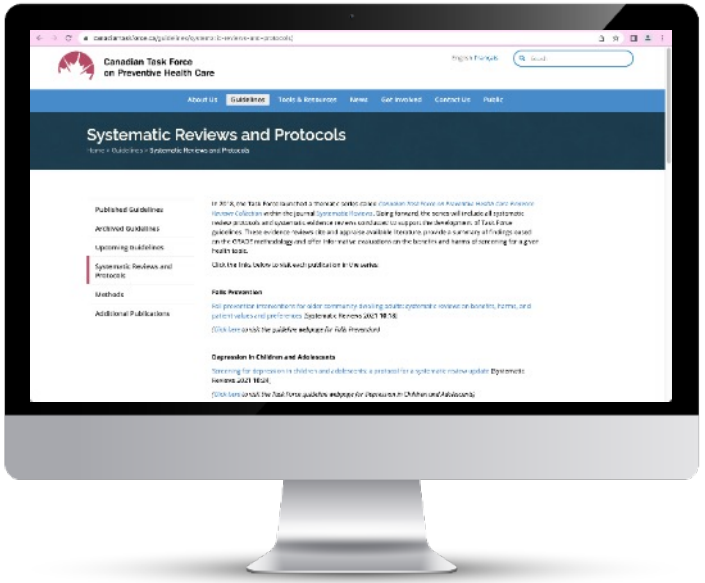
Strong, Conditional

Canadian Task Force on Preventive Health Care

Screening effectiveness systematic review

1: Review will be published in *Systematic Reviews*

- All reviews available on the Task Force website: https://canadiantaskforce.ca/guidelines/systematic-reviews-and-protocols/



Patient engagement

- Recruited via Craigslist, Kijiji and other sites
- 2 phases of focus groups at St. Michael's Hospital, Toronto

Patient engagement

Phase 1:

- 15 participants (6 pregnant, 9 postpartum, all self-identified as female)
- Rated importance of outcomes in deciding whether to be screened

Phase 2:

- 14 participants (4 pregnant, 10 postpartum, all self-identifed as female)
- Rated importance of outcomes with evidence for benefits and harms of depression screening from systematic review

Recommendation

Recommendation

- We **recommend against the use of screening questionnaires with cut-off scores** for all pregnant and postpartum people up to 1 year after childbirth

  (*Conditional recommendation; very low-certainty evidence)*
- We **emphasize usual care that includes questions about, and attention to, mental health and well-being** in pregnancy and the postpartum period

It is uncertain whether screening all individuals during this period would confer benefit above usual clinical care.

Implementation

- Clinicians in primary care settings are advised to exercise usual clinical care to ask about mood and well-being
- **Given the health implications of depression, it is essential that providers exercise clinical vigilance regarding mental health**

Implementation

- Jurisdictions may reconsider screening in settings where it is currently used
- If desired, clinicians may consider using questionnaires for discussion prompts (without engaging in formal screening by using cut off score for subsequent actions)

Implementation

> "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."
>
> – Pregnancy and Postpartum Depression Working Group

Evidence

Available Evidence

Postpartum

- **1 RCT that evaluated systematic depression screening of 462 postpartum women two months after giving birth using the EPDS in Hong Kong**
- Data on the outcomes of screening that were evaluated at 6 months after giving birth were very uncertain due to very serious risk of bias issues as well as imprecision due to only having one small trial.
- This very low certainty means that the true effects of screening are likely substantially different from the study data

Available Evidence

Pregnancy

- **No trials comparing depression screening with questionnaire to no screening in pregnancy**

Patient values and preferences

Patient values and preferences

Participants expressed concern that:

- They may not recognize their symptoms of depression or
- May lack initiative to seek care from primary care clinician

Patient values and preferences

- In survey, rated preference for screening fairly high

However

- During focus groups to explore survey ratings, participants had **strong preference for discussion with their healthcare provider about mood and well-being** which is different than a formal screening process

Patient values and preferences

- Patients felt a discussion about depression with a health care provider in pregnancy and after giving birth is critical

Feasibility and acceptability

- The Task Force believes a recommendation against screening with questionnaire and cut-off is feasible
  - Extent to which primary care clinicians are currently using questionnaires is **unknown**
  - Primary care providers are **trained in recognizing** signs and symptoms of depression

- Supporting discussions about mental health and well-being in the context of usual care is consistent with patient values and should be acceptable to most.

- The Task Force recognizes that the recommendation against may contradict practice/policy in some regions

Equity

- Some marginalized people report barriers to disclosing mental health symptoms or concerns to health care providers e.g.,
  - Unsure how to raise topic of depression
  - Concerns about stigma
  - Aversion to medications, psychotherapy
- The recommendation against could result in some people with depression being missed
- However, these barriers to disclosure might still exist with a questionnaire

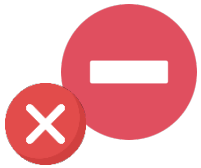
Rationale

Rationale

- **Conditional recommendation** based on very low-certainty evidence on benefits and limited evidence of harms
  - 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
- No evidence of harms identified in systemic review, but some evidence from other sources

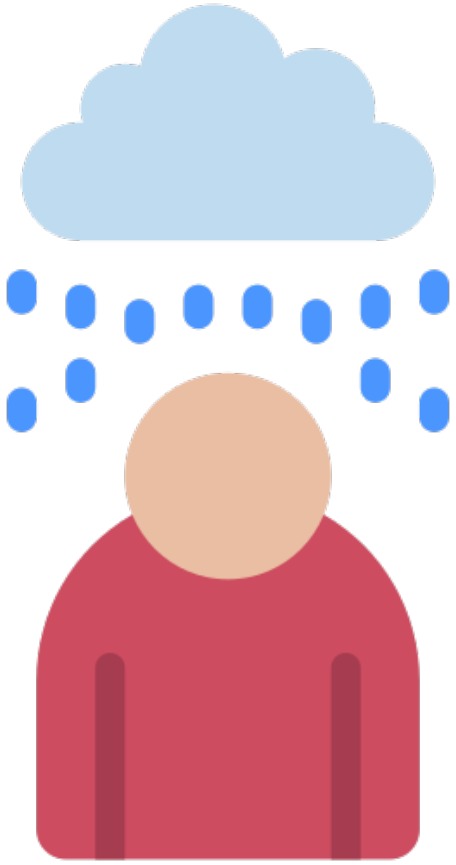
Rationale

- 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 	**87** true negatives 

Rationale

- 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



Rationale

- Potential unintended harms:
  - Time and focus on screening could detract from other health concerns at primary care visit
  - Screening could lead to false positives, false negatives, unnecessary referrals, overdiagnosis
  - Resource implications as 10% of all patients screened with questionnaire and cut-off require more assessment or referral

Rationale

- 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

Gaps and next steps

Knowledge gaps

- Very little evidence
- Only 1 RCT assessing benefits of screening with questionnaire vs. no screening

More research is needed

- Outcomes should include maternal and infant benefits and harms

Tools

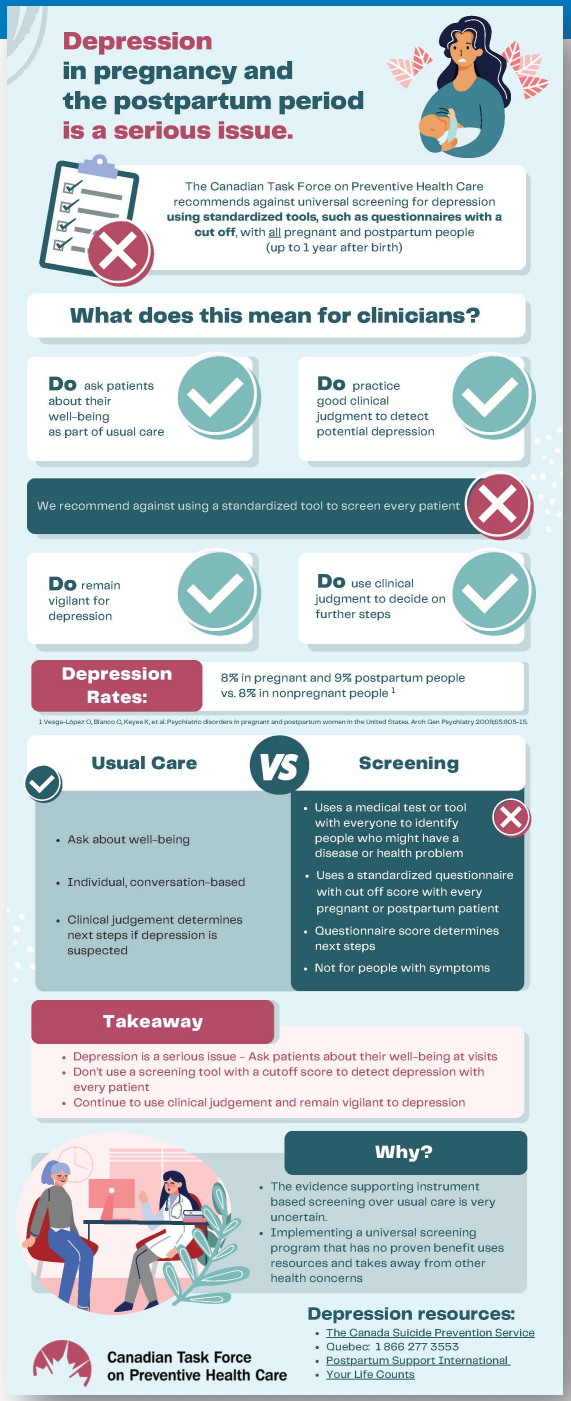
Knowledge translation (KT) tools

Knowledge Translation Tools

- KT tools to **help clinicians and patients understand** the depression screening guideline
- At publication, tools will be **freely available** for download in both **French** and **English** at: http://canadiantaskforce.ca

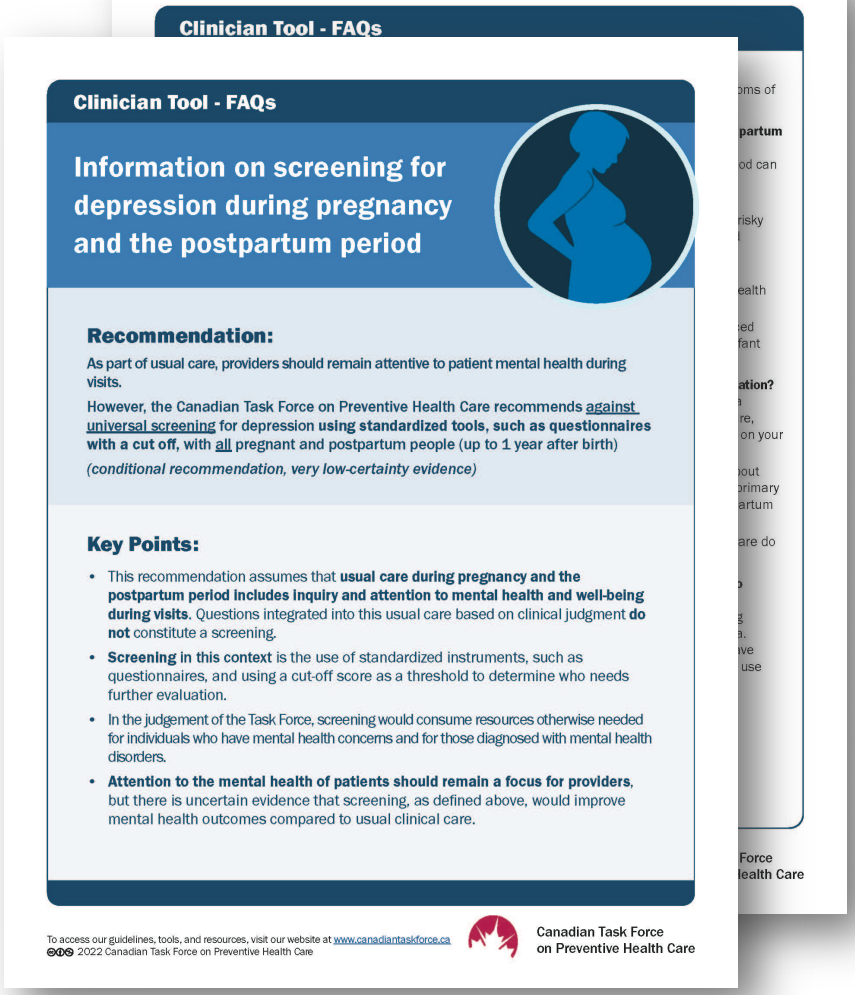
Tools

- Clinician infographic
- Patient-facing web page and tools



Canadian Task Force on Preventive Health Care

Tools



Clinician Tool - FAQs

Information on screening for depression during pregnancy and the postpartum period

Recommendation:

As part of usual care, providers should remain attentive to patient mental health during visits.

However, the Canadian Task Force on Preventive Health Care recommends against universal screening for depression **using standardized tools, such as questionnaires with a cut off**, with all pregnant and postpartum people (up to 1 year after birth)

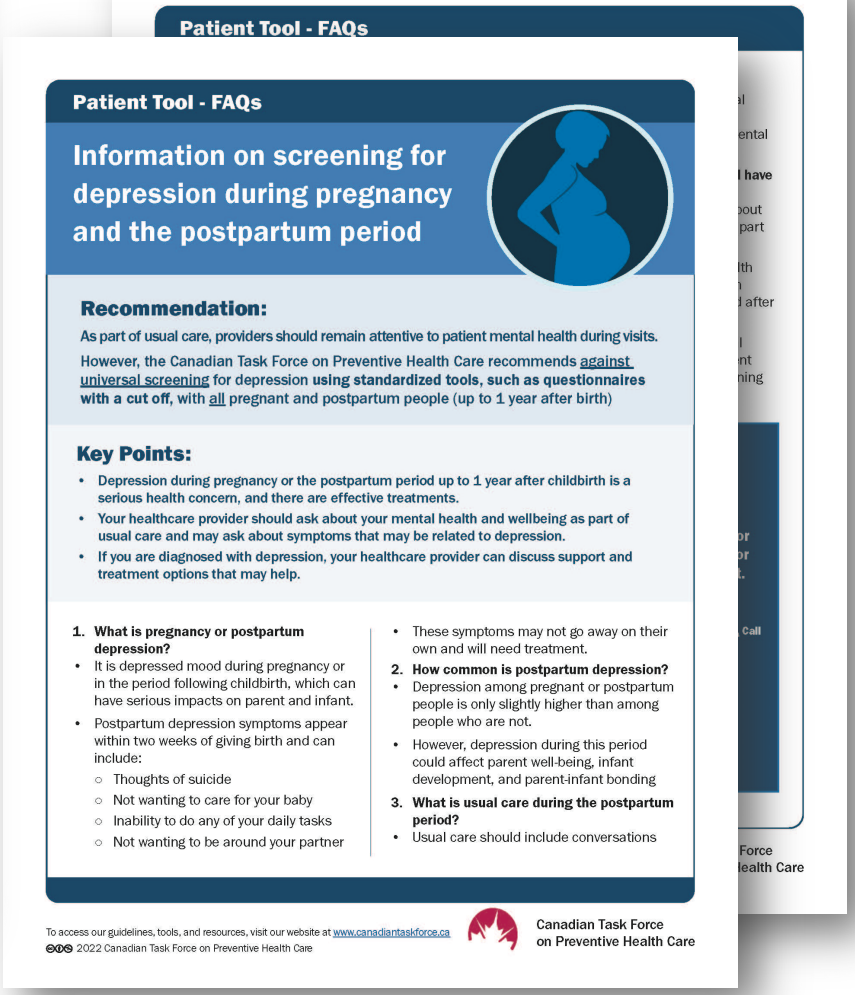
(conditional recommendation, very low-certainty evidence)

Key Points:

- This recommendation assumes that **usual care during pregnancy and the postpartum period includes inquiry and attention to mental health and well-being during visits**. Questions integrated into this usual care based on clinical judgment **do not** constitute a screening.
- **Screening in this context** is the use of standardized instruments, such as questionnaires, and using a cut-off score as a threshold to determine who needs further evaluation.
- In the judgement of the Task Force, screening would consume resources otherwise needed for individuals who have mental health concerns and for those diagnosed with mental health disorders.
- **Attention to the mental health of patients should remain a focus for providers**, but there is uncertain evidence that screening, as defined above, would improve mental health outcomes compared to usual clinical care.

To access our guidelines, tools, and resources, visit our website at www.canadiantaskforce.ca

Canadian Task Force on Preventive Health Care



Patient Tool - FAQs

Information on screening for depression during pregnancy and the postpartum period

Recommendation:

As part of usual care, providers should remain attentive to patient mental health during visits.

However, the Canadian Task Force on Preventive Health Care recommends against universal screening for depression **using standardized tools, such as questionnaires with a cut off**, with all pregnant and postpartum people (up to 1 year after birth)

Key Points:

- Depression during pregnancy or the postpartum period up to 1 year after childbirth is a serious health concern, and there are effective treatments.
- Your healthcare provider should ask about your mental health and wellbeing as part of usual care and may ask about symptoms that may be related to depression.
- If you are diagnosed with depression, your healthcare provider can discuss support and treatment options that may help.

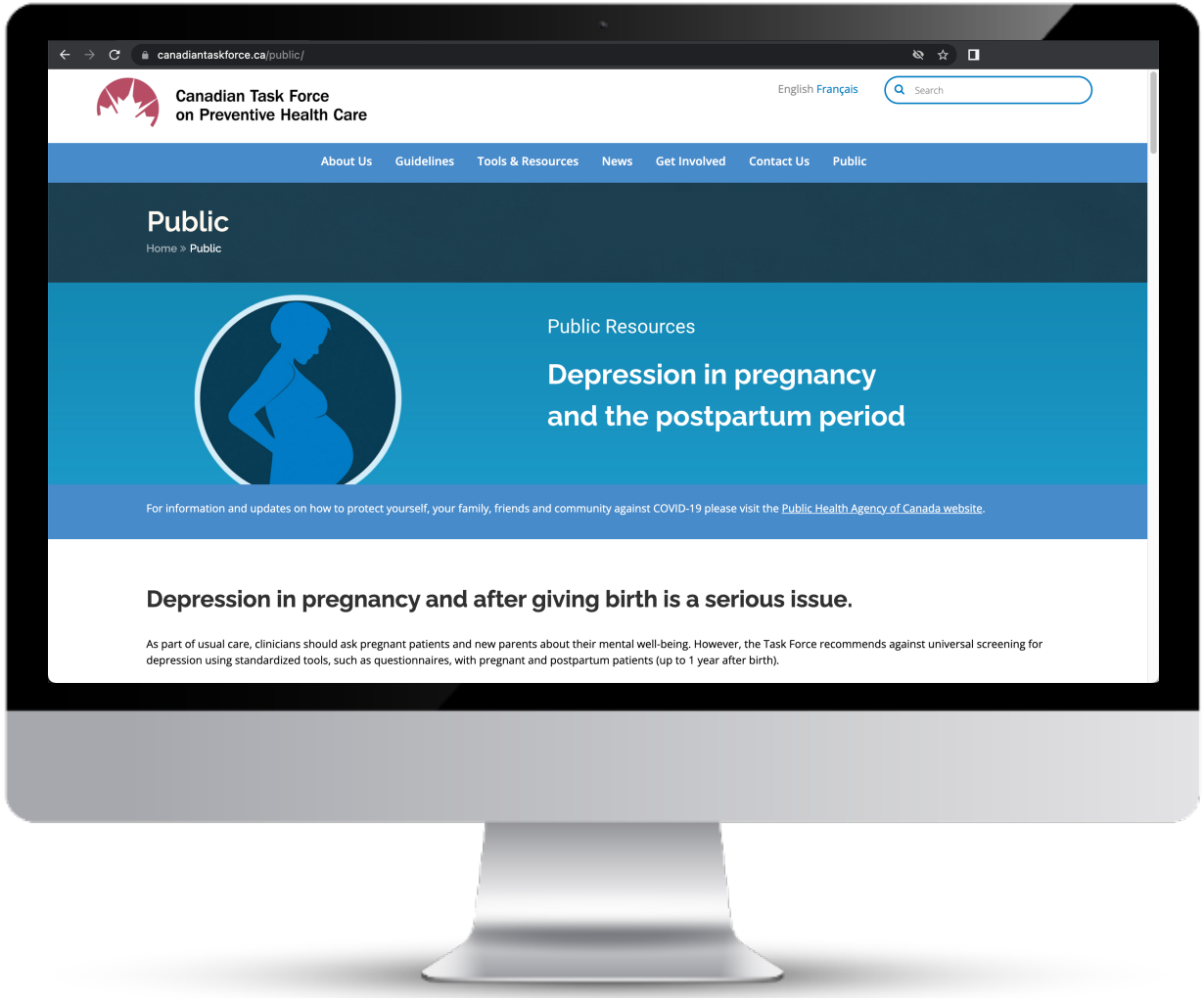
1. **What is pregnancy or postpartum depression?**
   - It is depressed mood during pregnancy or in the period following childbirth, which can have serious impacts on parent and infant.
   - Postpartum depression symptoms appear within two weeks of giving birth and can include:
     - Thoughts of suicide
     - Not wanting to care for your baby
     - Inability to do any of your daily tasks
     - Not wanting to be around your partner
   - These symptoms may not go away on their own and will need treatment.
2. **How common is postpartum depression?**
   - Depression among pregnant or postpartum people is only slightly higher than among people who are not.
   - However, depression during this period could affect parent well-being, infant development, and parent-infant bonding
3. **What is usual care during the postpartum period?**
   - Usual care should include conversations

To access our guidelines, tools, and resources, visit our website at www.canadiantaskforce.ca

Canadian Task Force on Preventive Health Care

Canadian Task Force on Preventive Health Care

Tools


canadiantaskforce.ca/public/
Canadian Task Force
on Preventive Health Care
English Français
Search
About Us
Guidelines
Tools & Resources
News
Get Involved
Contact Us
Public
Public
Home » Public
Public Resources
Depression in pregnancy
and the postpartum period
For information and updates on how to protect yourself, your family, friends and community against COVID-19 please visit the Public Health Agency of Canada website.
Depression in pregnancy and after giving birth is a serious issue.
As part of usual care, clinicians should ask pregnant patients and new parents about their mental well-being. However, the Task Force recommends against universal screening for depression using standardized tools, such as questionnaires, with pregnant and postpartum patients (up to 1 year after birth).

Communications

Social media posts

News release

Stakeholder communications

Follow @cantaskforce

Conclusions

Task Force recommends

- **Ask about** the mental health and well-being of patients at visits during pregnancy and the postpartum period
- **Don’t use** a screening instrument or tool with a cut-off score to detect depression
- **Use all clinical information** to make a mental health assessment

Usual clinical care and vigilance to patient mental health in pregnancy and postpartum period

> Depression in pregnant and postpartum people is devastating, with a massive burden for families and it's critical to detect it. We need to do all we can to support and treat people with depression. Exercising good clinical practice where clinicians ask about and are alert to changes in physical and mental health symptoms of their patients is key. ”
>
> – Dr. Eddy Lang, chair, PPPD Working Group

More information

For the guideline, related clinician and patient tools, visit :

- http://canadiantaskforce.ca

Questions and answers

The GRADE system

The "GRADE" system:

Grading of
Recommendations
Assessment
Development &
Evaluation

GRADE process - define and collect

- **Define** questions re: populations, alternative management strategies and patient-important outcomes
- **Characterise** outcomes as critical or important to developing recommendations
- Systematic **search** for relevant studies
- **Estimate** effect of intervention on each outcome based on pre-defined criteria for eligible studies
- **Assess** certainty of evidence associated with effect estimate

GRADE – rating certainty of evidence

GRADE Approach:

- Hierarchy of evidence certainty: RCTs > Observational studies

- Rating of certainty by outcome is reduced based on:
  - Study limitations (Risk of Bias)
  - Imprecision
  - Inconsistency of results
  - Indirectness of evidence
  - Publication bias likely

Direct vs. indirect evidence

- **Direct evidence** –studies examining the effects of **screening vs. no screening** or usual care

- When direct evidence is **unavailable**, the Task Force may also examine indirect evidence

- **Indirect evidence** is less certain:
  - ✓ **linked** to the outcome of interest (e.g. depression symptoms are dependent on the effectiveness of treatment) ***or***
  - ✓ **related** to the screening intervention of interest

Other screening recommendations

Other national screening recommendations

US Preventive Services Task Force

- Recommends screening pregnant and postpartum individuals, assuming adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up

---

UK National Screening Committee

- Recommends against systematic antenatal and postnatal population screening program for mental health problems

---

National Institute for Health and Care Excellence (England)

- Recommends considering using the EPDS or PHQ-9 as part of a full assessment if the individual answers positively to questions about recent depression symptoms

---

Scottish Intercollegiate Guidelines Network

- Enquiry about depressive symptoms should be made, at minimum, on booking in and postnatally at 4 to 6 weeks and 3 to 4 months. The EPDS may be used in the antenatal and postnatal period as an aid to clinical monitoring and to facilitate discussion

---

Centre of Perinatal Excellence (Australia)

- Recommend screening using the EPDS