Healthy Human Development Table

Perinatal Mental Health Toolkit for Ontario Public Health Units

Overview: Module 1

November 2018

Module 1: The Overview is part of the Perinatal Mental Health Toolkit for Ontario Public Health Units. To view the full document and additional resources please visit Healthy Human Development Table Toolkit webpage.

Acknowledgements

The Healthy Human Development Table (HHDT) members would like to thank the Public Health Unit staff and partner organizations for providing the practice examples included in this toolkit. The HHDT would also like to thank Public Health Ontario for providing secretariat support for the development of this toolkit. The views expressed in this toolkit are those of the HHDT and do not necessarily reflect those of Public Health Ontario.

How to cite this document:

Healthy Human Development Table. Perinatal mental health toolkit for Ontario public health units. Toronto, ON: Healthy Human Development Table; 2018.

Disclaimer

The views expressed in this Toolkit are the views of the project team, and do not necessarily reflect those of Public Health Ontario. The Toolkit is not a product of the Ministry of Health and Long-Term Care (MOHLTC). The MOHLTC is not responsible for the Toolkit or its contents. The MOHLTC does not provide any representations, warranties or guarantees with respect to the Toolkit, its quality or its accuracy. MOHLTC has not critically assessed the content of the Toolkit, nor has it evaluated any potential alignment between the content of the Toolkit and any policies or directives issued by the Government of Ontario.

Contents

Introduction

This section is part of the Healthy Human Development Table (HHDT) Perinatal Mental Health Toolkit. The purpose of this Toolkit is to build capacity and advance practice across Ontario public health units (PHUs). Using these modules, PHUs can plan and deliver a comprehensive, evidence-based and best practice approach to perinatal mental health promotion – one that is customized to meet the unique needs of their communities. Users are strongly encouraged to review all the modules.

The first section includes the background and introductory details for the Toolkit, including the purpose, objectives, and audience (Module 1.1). Module 1.2 provides the background of the Healthy Human Development Table and the membership list as of March 2018. Module 1.3 outlines the methodology used to develop the Toolkit, along with a list of external reviewers. The final module in this section (Module 1.4) is the glossary, which reviews the important terms and definitions used throughout the toolkit.

Module 1.1: Toolkit Purpose, Objectives, and Audience

Purpose

The purpose of the Perinatal Mental Health Toolkit is to build capacity and advance practice among Ontario public health units (PHUs). Using these modules, PHUs can plan and deliver a comprehensive, evidence-based and best practice approach to perinatal mental health promotion – one that is customized to meet the unique need of their communities. The Toolkit has been developed by the Healthy Human Development Table (HHDT) with secretariat support from Public Health Ontario (PHO). For more information on the HHDT, see module 1.2.

Objectives

The objectives of the Perinatal Mental Health Toolkit are to:

1. Advance public health access to research and resources
2. Serve as a practical reference to support PHUs to use evidence-based, best-practice information and resources in their perinatal mental health programming.
3. Support decision-making, planning and policy development in local PHUs.
4. Enhance efforts to build community capacity, advance system planning, and support effective collaboration among key health and social service system stakeholders.

Audience

The primary audience is PHU management and planners who work in areas related to perinatal mental health (e.g. mental health, reproductive health, maternal health, family health). This Toolkit is meant to be a resource to guide public health policy and practice planning and decision-making.

Beyond that, the Toolkit provides valuable information on the importance of perinatal mental health, evidence to support policy and practice decisions and field examples to support implementation. That will be valuable background for front-line staff who deliver perinatal mental health services, primarily public health nurses.

Even PHUs that are already engaging in perinatal mental health promotion may benefit from critically assessing their activities in relation to the information and statements in the Toolkit.

Some modules are particularly relevant to other health unit professionals such as epidemiologists, health promoters, and evaluators who support the planning, monitoring and evaluation of public health services.

Other public health decision-makers at the Ministry level may find this resource applicable to their work. In addition, primary care providers and community partners may use this Toolkit to better understand the role of public health professionals, to advance their collaboration with public health, and to guide their own practice as it relates to perinatal mental health.

How to Use

The Toolkit is a collection of modules that describes a comprehensive population health approach to perinatal mental health promotion. Module 1 offers context, methodology and a glossary. Module 2 describes the importance of perinatal mental health as a public health issue, and the role of public health in perinatal mental health promotion. Each of the remaining modules describes one activity of a comprehensive approach:

- Module 3.1: Completing a situational assessment
- Module 3.2: Conducting population health assessment and surveillance
- Module 4.1: Building community collaboration and capacity
- Module 4.2: Promoting public education and awareness
- Module 5.1: Building a community system of care
- Module 5.2: Developing a public health care pathway

Each of the above modules clearly describes the role of public health in relation to that activity and is structured to include:

- A common introductory paragraph.
- A description of the focus of the module.

- A summary of key points and/or HHDT Statement(s) that relate specifically to the activity.
- The evidence that supports the activity and related statement(s).
- Practice examples from Ontario PHUs that illustrate the activity. PHUs and other partners developed these examples independently. They are not products of the HHDT, nor has the HHDT evaluated or critically assessed the quality of these examples. They do not represent the full range of perinatal mental health activities that are currently engaged in by health units in Ontario.

Users are strongly encouraged to review all the modules and to avoid selectively using individual modules.

Healthy Human Development Table Statements

This section explains the nature of the statements that appear in the modules. Through the review of the evidence and best practice and the production of this Toolkit, the HHDT developed the following statements for public health practice in Ontario related to perinatal mental health promotion. These statements are presented as they relate to the specific modules. Each statement has also been graded according to the following categories:

Table 1.1.1: HHDT Statement Grades

Grade	Description
Evidence-based (EB)	This HHDT statement is based on recommendations in the Centre of Perinatal Excellence (COPE)[1] Registered Nurses' Association of Ontario (RNAO)[2] and/or US Preventive Services Task Force (USPSTF)[3] Guidelines. These were all supported by evidence that public health could effectively apply in perinatal mental health promotion.
Best or Promising Practice (BP)	This HHDT statement is based on recommendations in the COPE,[1] RNAO,[2] and/or USPSTF[3] Guidelines that were identified as a best or promising practice. Public health could effectively apply them in perinatal mental health promotion.
HHDT Consensus (HHDT-C)	This HHDT statement reflects HHDT consensus related to a comprehensive public health approach to perinatal mental health promotion.

Use of the Term “Woman” in this Toolkit

This Toolkit generally uses the term “woman” to refer to the person giving birth. However, perinatal depression may also be experienced by transgender men (born female but identifying as male).[4] Transgender men who have or are undergoing transition may become pregnant and give birth. It is the intent of the Toolkit to be inclusive of all birthing persons. Where possible, this Toolkit uses the terms “parent”, “person” or “individual”. The exception is when research articles and guidelines specifically describe women as the subjects. The Toolkit is also meant to be inclusive of non-birthing partners[5,6] and adoptive parents.[7]

References for Module 1.1

1. Austin M-P, Highet N; Expert Working Group. Mental health care in the perinatal period: Australian clinical practice guidelines [Internet]. Melbourne, AU: Centre of Perinatal Excellence (COPE); 2017 [cited 2018 May 16]. Available from: http://cope.org.au/wp-content/uploads/2014/03/National-Perinatal-Mental-Health-Guideline-Final.pdf

2. Registered Nurses' Association of Ontario. Assessment and interventions for perinatal depression. 2nd ed. Toronto, ON: Registered Nurses' Association of Ontario; 2018.

3. Siu AL, US Prevention Services Task Force (USPSTF). Screening for depression in adults: US Preventive Services Task Force recommendation statement. JAMA. 2016; 315(4):380-7. Available from: https://jamanetwork.com/journals/jama/fullarticle/2484345

4. Adams ED. If transmen can have babies, how will perinatal nursing adapt? MCN Am J Matern Child Nurs . 2010;35(1):26–32.

5. Singley DB, Edwards LM. Men's perinatal mental health in the transition to fatherhood. Prof Psychol Res Pr. 2015;46(5):309–16.

6. Steele LS, Ross LE, Epstein R, Strike C, Goldfinger C. Correlates of mental health service use among lesbian, gay, and bisexual mothers and prospective mothers. Women Health. 2008;47(3):95–112.

7. Mott SL, Schiller CE, Richards JG, O'Hara MW, Stuart S. Depression and anxiety among postpartum and adoptive mothers. Arch Womens Ment Health. 2011;14:335–43. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3433270/

Module 1.2: The Healthy Human Development Table

Background

The Healthy Human Development Table (HHDT) was convened in 2013 as one of five collective impact tables in response to the Strategic Plan for Ontario's Public Health Sector: *Make No Little Plans*.[1] This plan identified the need to optimize healthy human development, through a collective focus on early child development, including mental wellness and resiliency.[1] The HHDT was comprised of representatives from multiple organizations with the Ministry of Child and Youth Services (MCYS) providing backbone support. The HHDT's membership has evolved over time and backbone support was shifted from MCYS to PHO in 2015. As of March 2018, the HHDT is comprised of representatives from Ontario public health units (PHUs); PHO; and academic and community leaders in early child development, child mental health and related fields.

Identifying an Area of Focus

Given the breadth of healthy human development issues that PHUs address, the first task of the HHDT was to select a specific area of focus.

This began with a rigorous mapping exercise using a matrix tool. The tool appraised potential areas of focus based on need, impact, capacity, and opportunities for collaboration. The HHDT then engaged with the public health community through interactive workshops at relevant conferences to gather more information about the priorities of the field.

The HHDT hosted presentations from subject matter experts to better understand where its efforts could have the most meaningful impact. This process led the HHDT to determine that its area of focus would be perinatal mental health.

Surveying Public Health Units

The next step was to learn more about the current state of perinatal mental health promotion by Ontario PHUs. The HHDT considered two surveys regarding mental health practices of PHUs:

1. Pathways to Promoting Mental Health: A 2015 Survey of Ontario Public Health Units
2. HHDT Survey of Ontario Public Health Family Health Managers

The first survey was the Centre for Addiction and Mental Health's *Pathways to Promoting Mental Health: A 2015 Survey of Ontario Public Health Units*.[2] This was a survey of all 36 PHUs in Ontario, which asked questions about mental health promotion programming. This survey identified that 37% of the adult mental health programs in PHUs are aimed at parents or postnatal individuals and 35% of these programs are directed at pregnant individuals.[2] This means that a large proportion of mental health promotion work being conducted by PHUs is already aimed at pregnant individuals, new parents, and their families.

The HHDT also wanted to learn more about the types of programs offered to parents in the perinatal period. This information was gathered in November 2015 through a questionnaire developed by the HHDT and distributed to family health managers of all PHUs. Twenty-eight out of 36 PHUs responded (68%). They reported that they offer perinatal mental health programs or initiatives related to:

- data collection (74%of respondents)
- health promotion and educations (85%of respondents)
- primary screening (93% of respondents)
- secondary screening (93% of respondents)
- intervention and referral (89% of respondents)

All PHUs that responded are doing work in this area. However, the survey discovered that PHUs are not consistently interpreting and/or applying best practices in the identification, referral and/or treatment or referral of individuals at risk for, or experiencing symptoms of, perinatal depression.

Taking Action

The survey findings, coupled with targeted consultation with PHU leadership and staff, led the HHDT to determine that PHUs in Ontario could benefit from the creation of a perinatal mental health Toolkit. Such a Toolkit would build capacity and advance consistency among PHUs by developing a comprehensive approach to, and the use of, evidence-based best practices in perinatal mental health programming. Module 3.1 describes the development of the Toolkit.

References for Module 1.2

1. Ontario. Ministry of Health and Long-Term Care. Make no little plans: Ontario's public health sector strategic plan. Toronto, ON: Queen's Printer for Ontario; 2013. Retrieved October 31, 2018: http://www.ontla.on.ca/library/repository/mon/27004/321617.pdf

2. Centre for Addiction and Mental Health (CAMH) Health Promotion Resource Centre. Pathways to promoting mental health: a 2015 survey of Ontario public health units. Toronto, ON: CAMH; 2015. Available from: https://www.porticonetwork.ca/web/camh-hprc/pathways-to-mhp

Background Research

At the request of the HHDT, Public Health Ontario (PHO) conducted research and produced two reports that contributed significantly to the development of the Toolkit modules:

1. Evidence Brief: Exploring Interventions to Address Perinatal Mental Health in a Public Health Context[1]
2. The ADAPTE Report: Screening for Perinatal Depression[2]

1. Evidence Brief: Exploring Interventions to Address Perinatal Mental Health in a Public Health Context[1]

This brief is a summary of evidence informed by rapid knowledge synthesis methods. The HHDT used the brief to inform Module 2.1 in this Toolkit.

2. The ADAPTE Report: Screening for Perinatal Depression[2]

This report was primarily produced to inform the development of a public health care pathway, although it has also served to inform other modules of the Toolkit.

It was envisioned to be an adaptation of existing evidence-based clinical guidelines to the Ontario public health context. As such, the AGREE II tool was used to critically appraise guidelines.[3] The ADAPTE process was used to provide "a systemic approach to adapting guidelines in one setting for use in a different cultural or organizational context."[4] PHO conducted this work for the HHDT, which is detailed in a separate report.[2]

Key components of the process include:

1. Identifying pertinent existing guidelines:

- BC Reproductive Mental Health Program; Perinatal Services BC. Best practice guidelines for mental health disorders in the perinatal period. Vancouver, BC: Perinatal Services BC; 2014.[5]
- Registered Nurses' Association of Ontario. Assessment and interventions for perinatal depression. 2nd ed. Toronto, ON: Registered Nurses' Association of Ontario; 2018.[6]

- Melbourne, Australia beyondblue: the national depression initiative. Clinical Practice Guidelines: depression and related disorders – anxiety, bipolar disorder and puerperal psychosis in the perinatal period, 2011.[7] And the updated edition: Austin M-P, Highet N, the Expert Working Group. Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline. Melbourne, AU: Centre of Perinatal Excellence (COPE); 2017.[8]
- Siu AL, US Preventive Services Task Force (USPSTF). Screening for depression in adults: US Preventive Services Task Force Recommendation Statement. JAMA 2016;315(4):380-387.[9]

2. Appraising guideline quality using the AGREE II tool.[3]
3. Comparing guidelines' recommendations for specific pathway components (see Appendix A for a summary of guideline evidence grading systems).
4. Assessing the acceptability and applicability of the recommendations.

Substantial differences existed among the four guidelines with respect to:

- Comprehensiveness – the extent that a range of screening-related issues are addressed
- Granularity – the level of detail of depth practice recommendations
- Rigour – the process used to gather and synthesize the evidence and formulate the recommendations.

Overall, the beyondblue Guideline from Australia[7] had the best combination of the three desired guideline characteristics. Following the completion of the ADAPTE report, the beyondblue Guideline was updated as the COPE Guideline.[8] The latter's recommendations were used to inform the development of this Toolkit. The BC Reproductive Mental Health Program[5] Guidelines are comprehensive and granular, but lack a defined approach to the review and application of evidence for its recommendations. It therefore scored lowest for rigour. In contrast, the USPSTF recommendation[9] had a highly rigorous process, but only addresses whether or not screening should occur. The RNAO Guideline[6] had the highest rigour and was comprehensive, but did not address some fundamental practice issues such as which screening tool to utilize. A draft version of the 2018 RNAO Guideline was made available to the HHDT in advance and was used to inform the development of this Toolkit. The final version of the RNAO Guideline was reviewed to ensure alignment.

Development of the Toolkit Content

Importance of Perinatal Mental Health Module

The key points and evidence from the above sources were a starting point for drafting the content of the Importance of Perinatal Mental Health module. Following a review of the initial draft module, the HHDT working group decided to update the evidence regarding the importance of, and influences on, early child development, including the role of parental depression. That involved undertaking targeted literature reviews for specific issues using Web of Science Core Collection Database, as well as a grey literature search. This update also included checking references of key publications for any related and relevant articles.

The Comprehensive Public Health Approach to Perinatal Mental Health

The comprehensive public health approach to perinatal mental health described in this Toolkit reflects common logic model components for public health programs. It is informed by these frameworks:

- population health approach[10]
- the Ottawa Charter for Health Promotion[11]
- public health actions to improve health inequity[12]

As such, the comprehensive population health modules of this Perinatal Mental Health Toolkit are:

- completing a situation assessment (Module 3.1)
- conducting population health assessment and surveillance (Module 3.2)
- building community collaboration and capacity (Module 4.1)
- promoting public education and awareness (Module 4.2)
- building a community system of care (Module 5.1)
- developing a public health care pathway (Module 5.2)

The content of the modules was developed through key informant interviews with members of the HHDT and other key stakeholders. Current practice examples were sought for illustrative

purposes and are included in the relevant modules. Note that it was beyond the scope of this initiative to quality assess or evaluate the practice examples.

Members of the HHDT reviewed the statements in each module. For the development of the public health care pathway, the ADAPTE report's analysis of existing guidelines' recommendations were reviewed at an in-person meeting of the HHDT. For each aspect of the pathway, the HHDT reviewed the existing statements and level of evidence, as well as whether it was applicable (i.e., whether PHUs are able to put it into practice) for the Ontario public health system context. Feasibility and system impacts were informed by analysis of projected positivity rates and positive predictive values of different cut-off values for the EPDS. This discussion reinforced the importance of including a module to build a community system of care so that community resources would exist to refer screen-positive individuals. In response to some HHDT members' interest in the opportunity of screening in the immediate post-partum period in conjunction with the HBHC program, evidence regarding this issue was sought and included in the final ADAPTE report. Utilizing the ADAPTE report's findings, the HHDT reached agreement through consensus on whether to include, adopt or adapt an existing evidence-based recommendation.

To supplement the existing guidelines, HHDT members identified relevant, recent literature syntheses. That included Canadian recommendations for managing perinatal depression,[13] the use of psychosocial assessment tools,[14] and the effectiveness of psychological and psychosocial interventions.[15]

External Review of Toolkit

HHDT members identified individuals to review a draft version of this Toolkit. The pool of reviewers was intended to reflect public health frontline staff and management from a range of different PHU settings. This pool included reviewers from both urban, and rural PHUs, and reflected the extent of existing PHU engagement in perinatal mental health programming.

To get feedback from individuals from key stakeholder organizations, HHDT developed a questionnaire (see Appendix B) with support from PHO. Responses informed the final Toolkit, with some feedback to consider for future improvements of the Toolkit. The final Toolkit was approved by the HHDT on January 26, 2018 with subsequent specific content edits confirmed through electronic communication with the HHDT.

Questions looked at the quality, timeliness, responsiveness, format, ease of use and potential applications of the Toolkit. Reviewers could also suggest what content could be deleted, added or updated in each module. The response was strongly positive:

- 89% of external review survey respondents rated the overall quality of the Toolkit as high or very high.
- 88% of external review survey respondents rated their satisfaction with the Toolkit as high or very high.
- 100% of external review survey respondents strongly agreed that the topic of the Toolkit was timely.
- 89% external review survey respondents agreed or strongly agreed that the Toolkit was responsive to their needs.
- 78% external review survey respondents agreed or strongly agreed that the Toolkit would make their perinatal mental health work both easier and more effective.
- The majority of external review survey respondents identified that they would us the Toolkit to:
    - enhance programs/services
    - enhance collaboration with staff and external partners
    - build the capacity of the staff and external partners.
- 100% of external review survey respondents agreed or strongly agreed that the Toolkit design was appealing and that it was written in user-friendly language.

Specific comments were also received regarding each individual module and were addressed where feasible.

The HHDT greatly appreciates the time and attention that all of these external reviewers committed to providing detailed feedback on the Toolkit:

Yona Attis, RN, BScN
Public Health Nurse, Healthy Families, Haliburton, Kawartha, Pine Ridge District Health Unit

Diane Bewick, BScN., RN. MSN, DPA, CCHN
Adjunct Professor, Western University

Shelly Brown, RN, BNSc
Program Manager, Health Promotion, Hastings Prince Edward Public Health

Jaime Charlebois, RN, BScN, PNC(C), MScN
Perinatal Mood Disorder Coordinator, Orillia Soldiers' Memorial Hospital

Hiltrud Dawson, RN, BTech (neonatal nursing), IBCLC
Health Promotion Consultant, Health Nexus, Best Start Resource Centre

Neshma Dhanani, RN, BScN, MPH
Chair, Reproductive Health Work Group - OPHA

Sheryl Farrar, MHSc CHE
Program Manager, Health Promotion, Hastings Prince Edward Public Health

Mary Ann Gatbonton, RN, BScN, CCHN(c)
Member, Reproductive Health Workgroup - OPHA

Tracey Hall-Beavis, BScN, RN
Public Health Nurse, Healthy Families, North Bay Parry Sound District Health Unit

Nancy McGeachy, RN, BScN, MHS
Chief Nursing Officer, Hastings Prince Edward Public Health

Dorothea Service, RN, MN
Health Promotion Manager, Healthy Families, Haliburton, Kawartha, Pine Ridge District Health Unit

Jackie Whittingham, MSW, MHSc
Program Manager, Health Promotion, Hastings Prince Edward Public Health

Early Child Development Team,
Ministry of Children and Youth Services

Appendix A: Summary of Evidence Grading Systems of Existing Guidelines

BC Reproductive Mental Health Program; Perinatal Services BC

This guideline did not have an evidence grading system.

Source: BC Reproductive Mental Health Program; Perinatal Services BC. Best practice guidelines for mental health disorders in the perinatal period. Vancouver, BC: Perinatal Services BC; 2014.

Registered Nurses' Association of Ontario

The RNAO used the following evidence grading system adapted from:

- Scottish Intercollegiate Guidelines Network. SIGN 50: a guideline developer's handbook. Edinburgh, GB: SIGN; 2011. Available from: http://www.sign.ac.uk/assets/sign50_2011.pdf
- Pati, D. A framework for evaluating evidence in evidence-based design. HERD. 2011;4(3):50-71.

Table A1: RNAO Evidence Grading System

Levels of Evidence	Source of Evidence
Ia	Evidence obtained from meta-analysis or systematic reviews of randomized controlled trials, and/or synthesis of multiple studies primarily of quantitative research.
Ib	Evidence obtained from at least one randomized controlled trial.
IIa	Evidence obtained from at least one well-designed controlled study, without randomization.
IIb	Evidence obtained from at least one other type of well-designed quasi-experimental study, without randomization.
III	Synthesis of multiple studies primarily of qualitative research.
IV	Evidence obtained from well-designed non-experimental observational studies, such as analytical studies or descriptive studies, and/or qualitative studies.
V	Evidence obtained from expert opinion or committee reports, and/or clinical experiences of respected authorities.

Source: Registered Nurses' Association of Ontario. Assessment and interventions for perinatal depression. 2nd ed. Toronto, ON: Registered Nurses' Association of Ontario; 2018.

Centre of Perinatal Excellence (COPE), Australia

This guideline used four types of guidance:

Table A2: COPE Grading System

Grade	Description
Evidence-based recommendation (EBR)	A recommendation formulated after a systematic review of the evidence, with a clear linkage from the evidence base to the recommendation using GRADE* methods and graded either: **Strong** – implies that most/all individuals will be best served by the recommended course of action. Used when confident that desirable effects *clearly* outweigh undesirable effects or, conversely, when confident that undesirable effects clearly outweigh desirable effects. **Conditional** – implies that not all individuals will be best served by the recommended course of action. Used when desirable effects *probably* outweigh undesirable effects, or when undesirable effects probably outweigh desirable effects.
Consensus-based recommendation (CBR)	A recommendation formulated in the absence of quality evidence, after a systematic review of the evidence was conducted and failed to identify sufficient admissible evidence on the clinical question.
Practice Point (PP)	Advice on a subject that is outside the scope of the search strategy for the systematic evidence review, based on expert opinion and formulated by a consensus process.

***GRADE:** Grading of Recommendations, Assessment, Development and Evaluations

Source: Austin M-P, Highet N; Expert Working Group. Mental health care in the perinatal period: Australian clinical practice guideline. Melbourne, AU: Centre of Perinatal Excellence (COPE); 2017.

US Preventive Services Task Force (USPSTF)

This guideline group uses the following evidence rating scheme:

Table A3: USPSTF Grading System

Grade	Definition	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate-to-substantial.	Offer or provide this service.
C	The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgement and patient preferences. There is moderate certainty that the net benefit is small.	Offer or provide this service for selected patients depending on individual circumstances.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit, or that the harms outweigh the benefits.	Discourage the use of this service.
I statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality or conflicting, and the balance of benefits and harms cannot be determined.	Offer or provide this service.

Source: Siu AL, US Preventive Services Task Force (USPSTF). Screening for depression in adults: US Preventive Services Task Force recommendation statement. JAMA. 2016;315(4):380-7.

The levels of certainty regarding net benefit is also defined:

Table A4: USPSTF Levels of Certainty

Level of Certainty	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors such as: • the number, size, or quality of individual studies • inconsistency of findings across individual studies • limited generalizability of findings to routine primary care practice • lack of coherence in the chain of evidence As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: • the limited number or size of studies • important flaws in study design or methods • inconsistency of findings across individual studies • gaps in the chain of evidence • findings not generalizable to routine primary care practice • lack of information on important health outcomes More information may allow estimation of effects on health outcomes.

Source: Siu AL, US Preventive Services Task Force (USPSTF). Screening for depression in adults: US Preventive Services Task Force recommendation statement. JAMA. 2016;315(4):380-7.

Appendix B: External Review Questions

The following questions were provided to the External Practitioner Reviewers through an online survey.

5. Overall, how would you rate the quality of the Toolkit?
    a. Very high
    b. High
    c. Moderate
    d. Low
    e. Very low
6. Overall, how would you rate your satisfaction with this Toolkit?
    a. Very high
    b. High
    c. Moderate
    d. Low
    e. Very low

7. To what extent do you agree or disagree with the following statements?

Survey Item	Strongly Agree	Agree	Disagree	Strongly Disagree
a. The topic of the Toolkit is timely.				
b. This Toolkit is responsive to my needs related to perinatal mental health.				
c. Using this Toolkit would improve the quality of work I do related to perinatal mental health.				
d. Using this Toolkit would make it easier to do my work related to perinatal mental health.				
e. Using this Toolkit would make my work related to perinatal mental health more effective.				

Please provide any additional comments regarding your responses above:

8. In what ways do you anticipate you would use this Toolkit? (check all that apply):

    a. Improve your own practice or performance

    b. Adapt the Toolkit for your own use

    c. Inform internal policies and procedures

    d. Enhance programs and/or services your organization provides

    e. Build capacity with staff and/or external partners

    f. Enhance collaboration with staff and/or external partners

    g. Share the Toolkit with staff and/or external partners

    h. Conduct research activities (e.g., activities related to a funded research proposal, knowledge synthesis projects)

    i. Other (please describe):

9. To help us better understand how the Toolkit will be used, please provide some specific examples of how you have used or plan on using the information provided in this Toolkit. Please do not specify names, organizations or other direct identifiers in your responses.

10. To what extent do you agree or disagree with the following statements?

Survey Item	Strongly Agree	Agree	Disagree	Strongly Disagree
f. The format of the Toolkit allowed me to find information easily.				
g. The design of the Toolkit was appealing.				
h. The Toolkit used language that was understandable to me.				
i. Using this Toolkit would make it easier to do my work related to perinatal mental health.				
j. Using this Toolkit would make my work related to perinatal mental health more effective.				

Please provide any additional comments regarding your responses above:

11. Would you change the length of the Toolkit?

    a. Yes, I would prefer a shorter and less extensive Toolkit

    b. Yes, I would prefer a longer, more detailed Toolkit

    c. No, I like the length of the Toolkit

    d. I don't know

    e. Other, please specify:

12. What topics or content were missing that you would like to see covered? What changes (if any) would you make to the following sections of this resource? Please provide comments regarding content to be deleted, added and/or updated.

Module	Recommended Content to be Deleted, Added and/or Updated
1.1 Overview	
1.2 About the HHDT	
1.3 Methodology	
1.4 Glossary	
2.1 Importance of Perinatal Mental Health	
2.2 Role of Public Health	
3.1 Completing a Situational Assessment	
3.2 Conducting Population Health Assessment and Surveillance	
4.1 Building Community Collaboration and Capacity	
4.2 Promoting Public Education and Awareness	
5.1 Building a Community System of Care	
5.2 Developing a Public Health Care Pathway	

13. Please provide any additional comments regarding the Toolkit which you would like to share.

References for Module 1.3

1. Ontario Agency for Health Protection and Promotion (Public Health Ontario), Mensah G, Singh T. Evidence brief: Exploring interventions to address perinatal mental health in a public health context. Toronto, ON: Queen's Printer for Ontario; 2016. Available from: https://www.publichealthontario.ca/en/eRepository/Evidence_Brief_Perinatal_Mental_Health_2017.pdf

2. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Screening for perinatal depression: adapting existing guidelines to the Ontario public health system context. Toronto, ON: Queen's Printer for Ontario; 2018 Available from: https://www.publichealthontario.ca/en/eRepository/adapte-screening-perinatal-depression.pdf

3. Brouwers MC, Kho ME, Browman GP, Burgers JS, Cluzeau F, Feder G, et al. AGREE II: advancing guideline development, reporting and evaluation in health care. CMAJ. 2010;182(18):E839-42. Available from: http://www.cmaj.ca/content/182/18/E839.long

4. ADAPTE Collaboration. Guideline adaptation: a resource toolkit [Internet]. 2nd ed. Perthshire, Scotland: Guideline International Network; 2009 [cited 2018 May 14]. Available from: http://www.g-i-n.net/document-store/working-groups-documents/adaptation/adapte-resource-toolkit-guideline-adaptation-2-0.pdf

5. BC Mental Health and Substance Use Services, Perinatal Services BC. Best practice guidelines for mental health disorders in the perinatal period [Internet]. Victoria, BC: Provincial Health Services Authority; 2014 [cited 2018 May 16]. Available from: http://www.perinatalservicesbc.ca/Documents/Guidelines-Standards/Maternal/MentalHealthDisordersGuideline.pdf

6. Registered Nurses' Association of Ontario. Assessment and interventions for perinatal depression. 2nd ed. Toronto, ON: Registered Nurses' Association of Ontario; 2018.

7. Austin M-P, Highet N; Guidelines Expert Advisory Committee. Clinical practice guidelines: depression and related disorders – anxiety, bipolar disorder and puerperal psychosis – in the perinatal period. Melbourne, AU: beyondblue; 2011.

8. Austin M-P, Highet N; Expert Working Group. Mental health care in the perinatal period: Australian clinical practice guideline [Internet]. Melbourne, AU: Centre of Perinatal Excellence (COPE); 2017 [cited 2018 May 16]. Available from: http://cope.org.au/wp-content/uploads/2017/10/Final-COPE-Perinatal-Mental-Health-Guideline.pdf

9. Siu AL; US Preventive Services Task Force (USPSTF). Screening for depression in adults: US Preventive Services Task Force recommendation statement. JAMA. 2016;315(4):380-7. Available from: https://jamanetwork.com/journals/jama/fullarticle/2484345

10. Public Health Agency of Canada (PHAC). Population health approach: the organizing framework [Internet]. Ottawa, ON: Public Health Agency of Canada; 2013; [cited 2017 Sep 11]. Available from: http://cbpp-pcpe.phac-aspc.gc.ca/population-health-approach-organizing-framework/

11. World Health Organization. The Ottawa charter for health promotion: an international conference on health promotion. Presented at: First International Conference on Health Promotion. 1986 Nov 17-21; Ottawa, ON. Available from: https://www.canada.ca/en/public-health/services/health-promotion/population-health/ottawa-charter-health-promotion-international-conference-on-health-promotion.html

12. National Collaborating Centre for Determinants of Health. Integrating social determinants of health and health equity into Canadian public health practice: environmental scan 2010 [Internet]. Antigonish, NS: National Collaborating Centre for Determinants of Health, St. Francis Xavier University; 2011 [cited 2018 May 16]. Available from: http://nccdh.ca/resources/entry/scan

13. MacQueen GM, Frey BN, Ismail Z, Jaworska N, Steiner M, Lieshout RJ, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) 2016 clinical guidelines for the management of adults with Major Depressive Disorder: section 6. Special populations: youth, women, and the elderly. Can J Psychiatry. 2016;61(9):588-603. Available from: http://journals.sagepub.com/doi/pdf/10.1177/0706743716659276

14. Felice E, Agius A, Sultana R, Felice EM, Calleja-Agius J. The effectiveness of psychosocial assessment in the detection and management of postpartum depression: a systematic review. Minerva Ginecol. 2017 Jun 09 [Epub ahead of print].

15. Dennis CL, Hodnett E. . Psychosocial and psychological interventions for treating postpartum depression. Cochrane Database Syst Rev. 2007;(4):CD006116.

Module 1.4: Glossary

Introduction

This module focuses on the range of terms that describe perinatal mental health/illness. This glossary provides the terms and definitions used in this Toolkit. PHUs can use this glossary to ensure the consistent use of terms across the health unit and among community partners.

Care pathway:

A structured plan for the integrated multi-disciplinary approach to a health issue, which advances a consistent, standardized, criteria-based response to that issue.

Clinical judgement:

"Cognitive or thinking process used for analyzing data, deriving diagnoses, deciding on interventions, and evaluating care."[1]

Comprehensive public health approach:

Common logic model components for public health programs informed by the following frameworks: population health approach, the Ottawa Charter for Health Promotion, and public health actions to improve health inequity.

Edinburgh Postnatal Depression Scale (EPDS):

A 10-item, self-report questionnaire and validated screening tool used worldwide to improve the detection of postnatal depression in individuals living in the community. The items include questions referring to maternal feelings during the past seven days, including depressed mood, the inability to feel pleasure, guilt, anxiety, and thoughts of self-harm.

Mental health:

"A state of well-being in which an individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or his community".[2]

Mental health promotion:

The process of enhancing the capacity of an individual or community to take control over their life and improve their mental health. Mental health promotion strategies include fostering individual resilience and supportive environments, while respecting culture, equity, social justice, interconnections and personal dignity.

Paternal perinatal depression:

Depression symptoms that occur in biological or adoptive fathers between the time of conception to the end of the first year postpartum. Symptoms include moodiness, lethargy, lower impulse control, increased irritability and hyperactive behaviour, and displays of anger.

Perinatal anxiety:

A range of anxiety disorders, which includes obsessive compulsive disorder, panic disorder, posttraumatic stress disorder, generalized anxiety disorder, separation anxiety disorder, and/or specific phobias that occur from pregnancy to 12 months postpartum.

Perinatal depression:

Signs and symptoms range in severity and may include: persistent sadness; despondency; fatigue, loss of interest or pleasure; loss of appetite; sleep disturbances; tearfulness; poor concentration and memory; difficulty making decisions; irritability; feelings of guilt or worthlessness; incessant worrying about the baby; feelings of inadequacy and inability to cope with the infant; and suicidal ideation.

Perinatal mood disorders:

A range of mild-to-severe mental health conditions such as anxiety, depression, and postpartum psychosis. Can occur any time during pregnancy or within the first year postpartum.

Population health approach:

Activities focused on upstream efforts to promote health and prevent diseases, improve the health of populations and reduce the differences in health among groups by addressing equity issues and the social determinants of health.

Postpartum blues:

The most common perinatal mood disturbance. Usually appears within the first few hours to days after birth, and usually does not last longer than two weeks. May be characterized by tearfulness for no apparent reason, unstable moods, irritability, fatigue, anxiety, confusion and appetite disturbances.

Postpartum depression:

Depression symptoms that occur at any time over the first year postpartum.

Postpartum (puerperal) psychosis:

A rapid clinical onset of delusions, hallucinations, severe and rapid mood swings, confusion, memory loss, disorientation, insomnia, and obsessive preoccupation about the baby. Symptoms can appear within 72 hours to four weeks postpartum. Requires immediate medical attention and hospitalization.

Prenatal (antenatal) depression:

Depression symptoms that present at any time during the pregnancy.

Psychosocial assessment:

A nursing assessment or series of questions that identifies psychosocial risk factors. In this case, conducted during the perinatal period. Questions may collect information about: the pregnancy and postpartum experience; history of present illness (onset, symptoms, severity); psychiatric history and treatments; medical/surgical history; allergies; medication list; alcohol and recreational drugs; family psychiatric history; violence risk assessment; relationship with partner; occupational history; educational history; developmental history; spiritual assessment; cultural assessment; financial assessment; coping skills; interests; and abilities

Situational assessment:

A systematic process to gather, analyze, synthesize and communicate data to inform planning decisions.

References for Module 1.4

1. Stedman's medical dictionary for the health professions and nursing. 7th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2012. Clinical judgement; p. 346.

2. World Health Organization (WHO). Mental health: strengthening our response [Internet]. Geneva: World Health Organization; 2016 [cited 2018 May 14]. Available from: http://www.who.int/mediacentre/factsheets/fs220/en/