Healthy Human Development Table

Perinatal Mental Health Toolkit for Ontario Public Health Units

November 2018

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Contents

1.0 Overview 1

Module 1.1: Toolkit Purpose, Objectives, and Audience 2

Module 1.2: The Healthy Human Development Table 7

Module 1.3: Methodology to Develop the Toolkit 10

Module 1.4: Glossary 26

2.0 Perinatal Mental Health 30

Module 2.1: The Importance of Perinatal Mental Health 31

Module 2.2: The Role of Public Health 49

3.0 Planning 56

Module 3.1: Completing a Situational Assessment 56

Module 3.2: Conducting a Population Health Assessment and Surveillance 66

4.0 Population Health Promotion Strategies 82

Module 4.1: Building Community Collaboration and Capacity 82

Module 4.2: Promoting Public Education and Awareness 94

5.0 Individual Care 104

Module 5.1: Building a Community System of Care 104

Module 5.2: Developing a Public Health Care Pathway 114

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

Module 1.3: Methodology to Develop the Toolkit

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:

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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.

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

3. 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:

4. 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):

5. 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.

6. 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:

7. 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:

8. 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	

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

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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.

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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.

This section on Perinatal Mental Health includes two modules. Module 2.1, The Importance of Perinatal Mental Health, focuses on the concerns, risk factors, and potential impacts of perinatal mental health as a public health issue. Module 2.2 provides an overview of the role of public health in promoting perinatal mental health, and identifying and supporting parents at risk for, or experiencing, symptoms of perinatal depression. Additionally, the second module provides an overview of all the HHDT statements described in detail throughout the Toolkit.

Introduction

This module focuses on perinatal mental health – concerns, risk factors and potential impacts – as a public health issue. It serves as a background to the other Toolkit modules.

This module, in the context of public health in Ontario, can help PHUs to:

- build rationale for the importance of perinatal mental health as a public health issue (e.g., Board of Health reports)
- develop business cases for program development and funding
- share material with partners to strengthen community collaboration on this issue
- develop key messages for communication campaigns

The Healthy Growth and Development Standard of the *Ontario Public Health Standards*[1] has a stated goal: "To achieve optimal preconception, pregnancy, newborn, child, youth, parental, and family health." This module establishes that perinatal mental health is an important public health issue that addresses the topics of growth and development, healthy pregnancies, mental health promotion, and positive parenting. This module will help PHUs to:

- increase community partner knowledge about the factors associated with the promotion of healthy growth and development
- increase individual and family knowledge related to healthy growth and development
- increase public knowledge about the importance of creating safe and supportive environments

Considering the impact of perinatal mood disorders on fetal development and child health and growth and development (see below), perinatal mental health and chronic disease prevention also align. Research in the areas of adverse child experiences and toxic stress, with a mother who is experiencing a perinatal mood disorder, has demonstrated impacts on cardiovascular, gastrointestinal, and/or respiratory functioning in later life.[2-4]

HHDT Key Messages

- Perinatal mental health is an important public health issue because of its multiple impacts on the entire family, especially the parent-child dyad, and has a significant societal cost.
- Perinatal mood and anxiety disorders range in severity and include postpartum blues, perinatal anxiety, perinatal depression, paternal depression, and postpartum psychosis.
- The risk factors for perinatal mood disorders are similar to those for depression in the general population, and differ according to various demographic and socio-cultural elements (e.g. gender, population, age, and socio-economic status). Some risk factors are unique to perinatal depression, including a past history of depression or anxiety.
- Depression has the highest disease burden for women internationally. It is particularly serious during the perinatal period, due to the vulnerability of the infant and the impact on the family during this critical time.
- Understanding of the extent of the impact of parental depression on child development is still growing; however, emerging evidence shows that persistent depression beyond the postnatal period has a significant impact on long-term child health and development.

Perinatal Mental Health

The WHO defines mental health as "a state of well-being in which every 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 her or his community."[5]

The Mental Health Commission of Canada reported approximately 6.8 million people (19.8% of the population) people living with a mental illness in Canada in 2011. That's more than three times the numbers who live with type 2 diabetes and almost five times as high as people living with heart disease.[6] These figures are most likely underreported; as many as 50% of women and men may not categorize their challenges as mental illness and overlook seeking help.

According to the Ontario Better Outcomes Registry & Network (BORN) Information System in 2015, maternal mental health concerns affect 15.8% of mothers. Anxiety during pregnancy affects 9.1% and depression during pregnancy affects 7.7%.[7] The rates are the highest for

mothers under 25, with 14.3% experiencing anxiety and 13.8% experiencing depression during pregnancy.[7]

Pregnancy and the first-year postpartum are particularly vulnerable times for mental health in a family. This is a period of time when parents likely have extreme fatigue, while experiencing the pressures and concerns of caring for a new infant and changes in their family relationships. Any one of these situations makes dealing with and diagnosing depression more challenging.[8]

Beyond the potentially difficult changes in sleep patterns, emotional responses, household responsibilities and appetite, some parents may also develop a perinatal mood disorder (PMD). These include mild-to-severe mental health conditions (see below) such as anxiety, depression and postpartum psychosis. They can occur at any time during pregnancy or within the first year postpartum.[9-11] Perinatal anxiety disorders are a common comorbidity to depression, yet have been studied less.[8] These conditions create symptoms that can have significant impacts on themselves and other members of their household and family.[12] Although perinatal anxiety disorders are beginning to receive more research attention, the majority of this section focuses on perinatal depression and its associated risks, impacts and costs.

Postpartum Blues or "Baby Blues"

This is the most common perinatal mood disturbance, affecting an estimated 50%- 80%of women.[11] It is considered to be a part of normal postpartum adjustment. Baby blues is different from PMDs and unrelated to psychiatric history.[9,13] The blues most commonly appear within the first few hours to days after birth. They may be characterized by tearfulness for no apparent reason, unstable moods, irritability, fatigue, anxiety, confusion and appetite disturbances.[13-15] Symptoms usually do not last longer than two weeks or require intervention.

Perinatal Anxiety

It is important to be aware of anxiety as a co-morbidity or separate morbidity in the perinatal period. That's because of its potential impact on the severity of symptoms of depression, challenges with appropriate treatment strategies, and increased risk for suicide.[16]

Perinatal anxiety refers to a range of anxiety disorders: obsessive compulsive disorder, panic disorder, post-traumatic stress disorder, generalized anxiety disorder, separation anxiety disorder and/or specific phobias occurring during the perinatal period.[17,18] Prenatal anxiety can

also present with unique concerns. The predominant feature is recurring thoughts about the fetus, worry that something might be wrong with the pregnancy, and concern regarding their parental competency.[21,22] Anxiety may increase the number of visits to the health care provider and increase the risk of obstetric complications such as more frequent than usual nausea and vomiting and increased fetal movements.[19,21,22] Following the birth of the baby, the symptoms of anxiety (like depression) may increase due to the physical, psychological and social transitions of parenthood.[21]

Perinatal Depression

Health care providers use discrete diagnostic criteria to determine types and categories of depression. For public health purposes, it is most helpful to be aware that depression exists on a spectrum, mild-to-severe, with severe depression potentially leading to death (suicide or infanticide).[11]

Signs and symptoms of perinatal depression are similar to those of depression occurring at other times in life. This 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.[14,18,19]

The uniqueness of the perinatal period is related to the timing for awareness and intervention. Pregnancy and postpartum are potential “trigger times” for those at risk of depression, with implications as well for the family and children.

Prenatal (Antenatal) Depression

Depression during pregnancy may have multiple consequences, including prolonged sick leave, inadequate prenatal care, negative expectations of motherhood, difficulties transitioning to parenthood, substance abuse, and the risk of developing other forms of distress.[8,19] Prenatal depression is a leading risk factor for postpartum depression, especially when left untreated. It can lead to chronic or recurring depression that can affect the woman throughout her life.[8,19]

Studies have found that the prevalence of prenatal depression can range from 7.4 to 18% (depending on the population, time period included, and method of assessment), and that

54.2% of women with postpartum depression had depression previously (either during pregnancy or prior).[22,23] The prenatal time period is an important opportunity for raising awareness and identifying risk.

Postpartum (Postnatal) Depression

Postpartum depression is the most common disorder postnatally.[8] While symptoms can occur at any time over the first year postpartum, they usually start within the first four weeks after delivery, and most develop within 12 weeks.[14] Depression is the most common disability in women of childbearing age, whether or not they are pregnant or have children.[23] The World Health Organization reports that "depression is the leading cause of disease burden for women in both high-income and low- and middle-income countries".[24] The seriousness of parental depression and its impact on the family is directly related to its timing.

Postpartum (Puerperal) Psychosis

This is the most rare but severe form of PMD (0.1% – 0.5%), with a rapid clinical onset that requires immediate medical attention and hospitalization.[11,14] Symptoms can appear within 72 hours to four weeks postpartum.[11]

Postpartum psychosis is characterized by delusions, hallucinations, severe and rapid mood swings, confusion, memory loss, disorientation, insomnia, and obsessive preoccupation about the baby.[11,18] If left untreated, psychosis can be a potential risk factor for self-harm, suicide, or harm to the infant or other children, including infanticide.[11] The symptoms of postpartum psychosis are urgent indications for referral to medical care.

Paternal Perinatal Depression

Evidence and understanding of paternal depression is expanding. Recent studies have begun to elucidate risk factors for perinatal depression in men, which appear to have similarities to women but may differ in terms of onset and severity.[25]

Paternal perinatal depression focuses on men's experiences with depression and anxiety from their partner's first trimester of pregnancy to age 1 of the baby.[26] An international meta-analysis found rates of paternal perinatal depression to be 10% overall, with occurrences highest from 3-

6 months postpartum. This rate is higher than the rate of depression among men in the general population (5%-6%) in a similar demographic.[27]

Depression among men has been found to be underdiagnosed and under-reported. It also presents differently.[26] Similarly to women, men can present with moodiness and lethargy; however, men are more likely to have lower impulse control, increased irritability and hyperactive behaviour, and displays of anger.[26]

Depression and anxiety among men can be difficult to diagnose, as screening tools are tailored to female expressions of depression. In addition, depression in men can be masked by interpersonal conflict, difficulties sleeping, and avoidance behaviours (e.g., drug and alcohol use, and preoccupation with work).[26] Fathers who experience depression and anxiety are less likely to have effective interpersonal support systems, or to adopt positive coping strategies. They're also more likely to be socially isolated, which can be harmful for themselves and their families.[26,28] Men are at greater risk for depression and anxiety if they have a history of depression, are experiencing unemployment, and/or have difficult partner or family relationships.[25]

Risk Factors for Perinatal Depression

Regardless of the time of their presentation, specific risk factors contribute to the increased possibility and/or severity of depression. The causes of PMDs are complex. The following table lists common risk factors,[10] which should be seen as such rather than as determinants of illness.

Table 2.1.1: Strong, Moderate, and Weak Risk Factors for Perinatal Depression[10]

Strong Risk Factors	Moderate Risk Factors	Weak Risk Factors
• A history of psychiatric illness, including depression or anxiety at any time, including, but not limited to, during the perinatal period • Prenatal symptoms of anxiety • The onset of depression during pregnancy or postpartum	• Stressful life events (e.g., relationship breakdown or divorce, losing a job, incarceration, housing insecurity) • Refugee or immigrant status • Low social support or perception of low support • Unfavourable obstetric outcome(s) • Low self-esteem • A history of physical or sexual abuse during childhood or adulthood • Intimate partner violence • A history of reproductive trauma (e.g., infertility) • Grief related to miscarriage, stillbirth, or infant loss • Substance use, including the use of tobacco	• Low socio-economic status • Lack of significant other or partner; single parent • Pregnancy, as defined by the person, as unplanned or unwanted • Breastfeeding challenges, including a lack of social support or support by a health-care provider

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

Socio-cultural Issues

Research demonstrates that perinatal depression exists across cultures, can affect women and men of all ages, ethnicities, and levels of education, and can also affect parents through adoption.[29] Perinatal depression is a universal experience, although it may be described and labelled differently in each context. It is important to recognize that many circumstances and contexts shape a person's response to pregnancy and parenthood, as well as the type of care they require if they have a PMD. For example, transgender men (biological women who have transitioned to the male gender)[30] and lesbian, gay or bisexual parents may experience perinatal

depression at higher rates than the heterosexual population.[31] Indigenous women, adolescent women, women with histories of addiction, immigrants, refugees, and individuals with disabilities also have a higher risk of PMDS.[10]

The interplay of the social determinants of health, including cultural, social, and systemic factors, can compound depression. One Canadian study found that immigrant women from minority groups had higher rates of postpartum depression (25%) than Canadian-born women (11.2%) and immigrants from majority groups (8.3%).[32] Other compounding factors include stressors such as migration stress, domestic violence, language barriers, unemployment or underemployment, legal status concerns, and family separation.[32] There is a dearth of reliable, current data relating to most of these demographic categories.

Cultural factors can have a strong influence on perinatal mental health outcomes, and are correlated with the amount of support received from family and friends.[33] For example, immigrants who are removed from traditional family and cultural support tend to experience higher levels of perinatal depression.[32,33] Some cultural practices mitigate depression, through family support and a prescribed period of rest and caregiver for the mother.

When expectations of support and care are unmet, or relationships with the mother's caregivers are stressful or negative, there is a detrimental effect on perinatal mental health.[33] This risk highlights the need for culturally relevant and sensitive education and interventions.[32,33]

Each community and health unit has a different demographic composition. It's important to understand the profile of an individual's community, and the resources available for each population. A situational assessment can help to determine that, inform a comprehensive population health promotion approach (see module 3.1), and tailor community and public health care pathways (see modules 5.1 and 5.2).

Impacts of Perinatal Depression

Women's Functioning

PMD can have a profound impact on women's overall health, through a negative effect on their abilities to perform self-care, interact socially with other adults, and care for their homes.[7] The new responsibilities and extreme fatigue associated with caring for a new baby, which can

strain any parental or family relationship, is compounded in cases of PMD.[12] Longer term, perinatal depression can have a negative impact on return to previous occupational activities. That, in turn, can affect an individual life, income, and access to insurance, pension and health benefits.[8,12]

Suicide, while a serious perinatal risk, is a lower risk for women with depression during pregnancy and in the first year postpartum compared to nonpuerperal time periods.[14]

Fetal Development

Left untreated, people with prenatal depression or anxiety may eat poorly, miss prenatal appointments, or use coping mechanisms such as tobacco or alcohol. That, in turn, may lead to increased risk of preeclampsia, premature delivery, low birth weight, spontaneous abortion, and fetal death.[8,34]

Emergent research is improving the understanding of how the environmentally-dependent developing brain "architecture" (total brain connections, also known as connectome) is influenced, even down to the level of single gene expression.[35] Epigenetics is the branch of science that studies the mechanisms by which gene expression is changed without modifying the underlying genetic sequence of the DNA. It studies the influences that change gene expression, such as environment or heredity.

Emerging evidence in the field of behavioural or social epigenetics describes how epigenetic changes can occur as the result of life experiences.[36] For instance, it explains the chemical mechanism of how nurture impacts or alters (dims or amplifies) nature.

Genetic variability has a role. However, maternal stress during pregnancy can influence future reactivity to stress, by potentially altering the developing neural circuits that control neuro-endocrine responses and affect epigenetic modifications of DNA.[2,3] In other words, as a fetus grows, the ways its brain reacts to stress may change depending on the level of stress experienced by the mother. [4]

Physiologic responses to stress include increased levels of hormones such as cortisol and adrenaline. In small amounts these stress hormones are essential to survival. However, high levels or prolonged exposure can lead to over-activation of the stress-mediating system, which

can permanently reprogram the functioning of the hypothalamic-pituitary-adrenal (HPA) axis.[2,3] In short, prenatal depression and anxiety and increased levels of cortisol, is linked to altered neonatal neuro-behaviours and lower levels of serotonin in newborns.[37] These conditions point to associations with infant temperament and child behavior problems such as Attention Deficit Hyperactivity Disorder (ADHD), but we don't know enough about biological mechanisms and their lifelong effects to speak confidently about exact impacts.[2,38] Still, early identification and connection with women who are depressed, and/or at risk for depression, during or before pregnancy can reduce this potential harm to the developing child.

Quality of Mother-child Interactions

In terms of the mother-child dyad, mothers with postpartum depression are less likely to:

- initiate or continue breastfeeding, or feed exclusively[39,40]
- perform self-care, which can translate into less than ideal care for the baby
- attend well-child visits
- complete immunizations
- use home safety devices
- have their infant use back sleep positions
- consistently use a car seat
- engage in enriching activities like reading, singing or outdoor activities[9,41]

From the earliest newborn period, infants are very sensitive to the emotional states of their mothers and other significant caregivers. They need external regulation and caregivers to respond to their needs. Infants convey their needs through variations in how they cry, arouse, react or other behaviours.[42]

Healthy attachment is formed when parents learn to effectively respond to the cues of their baby; that's necessary for health brain development of the child.[4,34] There is a "serve and return" of attachment, which refers to the signals the baby "serves" (cooing, arousing, crying), and the process of parents learning to respond increasingly effectively to those cues (the "return"). When this is disrupted, dysregulation can increase and impact the baby's ability to learn self-soothing

or be regulated.[36] This can present a challenge for any parent, much more so for one struggling with a mood disorder.

An inability to read cues, which maternal depression can cause, may also contribute to toxic stress in infants and children.[4,36] Toxic stress is considered to be exposure to chronic and unrelenting stress caused by various experiences, including repeated abuse, extreme poverty, parental substance abuse, or severe maternal depression, without the protection from a supportive adult relationship.[4,36]

Toxic stress activates the body's stress response system experienced in utero and early childhood, damages developing brain architecture, and becomes embedded in multiple organ systems.[3] These effects increase the risk for poor physical and mental health, including poorer cardiovascular functioning, and higher rates of gastrointestinal and respiratory infections.[2,4] There is still much to discover on this topic, including prevalence rates and the burden of disease.

Infant and Child Development

The literature reveals a well-established connection between untreated perinatal depression and negative child development.[14] Infants exposed to PMD experience sleep problems, temperamental difficulties, excessive crying or colic, poor cognitive functioning, and emotional maladjustment.[14] Maternal distress has been associated with detrimental effects of infant cognitive, psychomotor, and behavioural development.[42,43]

Having a parent with mental health problems is considered an adverse childhood experience.[4] Such experiences have impacts on behaviour, physical and mental health, educational achievement, and social and health realities for life.[4,44] Children whose mothers have PMD have been shown to have an increase in multiple health issues, including behavioural and emotional difficulties, such as violence and conduct disorders.[14,28,44] Studies have shown that children with parents with PMD have a higher prevalence of anxiety disorders, and psychiatric and medical disorders in adolescence.[14,17]

There is also a growing body of evidence showing that paternal depression, like maternal depression, is associated with an increased risk of cognitive, behavioural and mood issues in

children and adolescents.[45] Hyperactivity in boys and social and emotional development in girls has been shown to be particularly sensitive to depression and anxiety in their fathers.[26,34]

Increasing evidence points to the persistence of depression, beyond the postnatal period, as the most important mediator of child developmental challenges.[23,42] This is particularly true in relation to child cognitive development.[34] Not surprisingly, the risk of poor child outcomes is compounded when both parents experience depression.[45,46]

Partners and Other Family Members

Partners can also be seriously impacted by perinatal depression. They are often the first to experience the effects of the symptoms, and may be required to take on additional roles in the home to support the family. Maternal depression is associated with higher levels of marital/partner conflict and affectionless control, reduced family cohesion, warmth, and expressiveness, and increased disorganization in family activities and roles.[47] Similarly, paternal perinatal depression is associated with increased disharmony in partner relationships, particularly with higher levels of criticism present.[48]

Studies continue to show at least moderate correlation between maternal depression and paternal depression.[46] This finding does not imply causality, but is important when considering the family as a whole and the impacts on the child.[27]

Other family members may feel helpless and not know how to support the depressed parent. These feelings may compound when the partner is also depressed, and the family requires increased support from the extended family. Grandparents may be needed to take on the role of caregiving for the infant and/or other children.[12] Having someone in the family who can provide support for that nurturing bonding relationship is important. Conversely, research has shown that positive social support networks lead to better mental health (i.e., through improved ability to cope with stressful life events, additional financial support, and access to resources for appropriate parenting methods).[49]

Societal Costs

There is no specific data on the societal costs of perinatal depression in Canadian women. However, the Mental Health Commission of Canada has estimated that the economic cost to Canada of all mental health problems and illnesses to be at least $50 billion annually.[6] That

includes health care, social services, income support, as well as a cost to business of $6 billion lost productivity.[6]

Perinatal mood disorders contribute to these costs and there are estimates from other jurisdictions. In 2012, Deloitte Access Economics estimated that in Australia the societal cost specifically related to perinatal depression was $433.42 million ($4,509 per person with PMD).[50] Their estimate includes direct financial costs of health services (i.e., primary care, specialist, medications, hospitals), indirect financial costs (i.e., lost earnings, the cost of informal care provided by family members/others), and the costs to the wider community (i.e., increased taxes to cover health care delivery).[50] As well as financial costs, the report equates PMD to a loss of 20.7 DALYs (disability-adjusted life years), a significant disease burden.[50]

In 2014, the Maternal Mental Health Alliance of the UK commissioned a report on the costs of perinatal mental health problems.[51] They concluded that the combined costs of perinatal depression, anxiety, and psychosis amounted to £8.1 billion per one-year cohort of births, or just under £10,000 for every birth; 72% of this cost related to adverse impacts on the child.[51] The report suggested that providing perinatal mental health care (including preventative and early treatment measures) at the level and standard recommended by national guidance would cost £400 per average birth. The report argues, “because the costs of perinatal mental health problems indicate the potential benefits of intervention, even a relatively modest improvement in outcomes would be sufficient to justify the additional spending on value for money grounds.”[51] It’s reasonable to assume that the same premise would hold true in Canada.

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Module 2.2: The Role of Public Health

Introduction

This module provides an overview of the role of Ontario PHUs in promoting perinatal mental health, and identifying and supporting parents at risk for, or experiencing, symptoms of perinatal depression.

This module, in the context of public health in Ontario, can help PHUs to:

- support program development
- provide background for the development of a program business case
- communicate with frontline staff regarding the role of public health in relation to this issue
- share material with community partners to increase their understanding of the role of public health in this issue

The Healthy Growth and Development Standard of the *Ontario Public Health Standards*[1] has a stated goal: "To achieve optimal preconception, pregnancy, newborn, child, youth, parental, and family health." As described in module 2.1, perinatal mental health is an important public health issue that addresses the topics of growth and development, healthy pregnancies, mental health promotion, and positive parenting.

This Toolkit may also be informative to the planning and delivery of the Healthy Babies Healthy Children (HBHC) program. The comprehensive population health promotion approach described in this Toolkit has greater breadth than the individual service delivery model of the HBHC program. Still, there may be opportunities to integrate components of these modules (particularly module 5.2 *Developing a Public Health Care Pathway*) into the screening and home visiting provided to HBHC clients.

Finally, following this approach can:

- provide information on the extent and geographic distribution of perinatal mental health issues; and

- support PHUs to collaborate with other providers in the community, by describing the current assets and gaps in identifying, diagnosing and treating parents with perinatal mental health issues.

Table 2.2.1: HHDT Statement #1

HHDT Statement	Description	Rating
HHDT Statement #1	HHDT consensus supports public health units to address perinatal mental health within their healthy growth and development programming and engage in population health promotion strategies to address it.	Rated*: HHDT-C

*See Module 1.1 for evidence grade definition

Public Health's Role in Addressing Perinatal Mental Health

Module 2.1 establishes the importance of perinatal mental health as a women's health issue and one with a significant impact on the healthy growth and development of infants and children, family functioning, and society as a whole. This is a broad health system issue; public health can play a unique role as part of a system-wide response.

The work of public health is grounded in the population health approach, focused on upstream efforts to:

- promote health and prevent diseases
- improve the health of populations
- reduce the differences in health between groups by addressing equity issues and the social determinants of health (SDOH)[1]

The factors contributing to these health issues are complex. As such, public health applies comprehensive approaches that typically combine population health assessment and surveillance, education and awareness, policy and advocacy, collaboration and partnerships, and direct service delivery. This Toolkit describes public health's role in three areas: planning, population health strategies, and service to individual clients/families.

Planning

Modules 3.1 and 3.2 of this Toolkit detail how PHUs can conduct a situational assessment, and population health assessment and surveillance, around perinatal mental health/perinatal

depression in their communities. In these modules, the HHDT makes three statements for PHU action regarding their planning role.

Table 2.2.3: HHDT Statements #2-4

HHDT Statement	Description	Rating
HHDT Statement #2	HHDT consensus supports public health units to complete a situational assessment as the first step in a comprehensive population health promotion approach to perinatal mental health.	Rated*: HHDT-C
HHDT Statement #3	HHDT consensus supports public health units to conduct a population health assessment related to perinatal mental health, in collaboration with their LHIN(s), primary care providers, and community partners, as appropriate.	Rated*: HHDT-C
HHDT Statement #4	HHDT consensus supports public health units to identify, collect, and regularly monitor appropriate indicators and sources of data related to risk factors and/or symptoms of perinatal mental health.	Rated*: HHDT-C

*See Module 1.1 for evidence grade definition

Population Health

Modules 4.1 and 4.2 of this Toolkit provide information about the role of public health in building community collaboration and capacity, and promoting public education and awareness of perinatal mental health. This is where public health nurses, with their extensive knowledge of their communities and partners, can play a key role. The HHDT has three statements for Ontario PHU action regarding their role in these areas.

Table 2.2.4: HHDT Statements #5-7

HHDT Statement	Description	Rating
HHDT Statement #5	HHDT consensus supports public health units to engage with their LHIN(s), primary care providers, community service partners, and clients to address perinatal mental health promotion service planning and delivery in their communities.	Rated*: HHDT-C
HHDT Statement #6	HHDT consensus supports public health units to provide ongoing professional development on perinatal mental health to, at a minimum, all public health professionals who work with pre- and postpartum individuals and families.	Rated*: HHDT-C
HHDT Statement #7	HHDT consensus supports public health units to explore	Rated*:HHDT-C

HHDT Statement	Description	Rating
	opportunities to raise public awareness about perinatal mental health.	

*See Module 1.1 for evidence grade definition

Service to Individual Clients/Families

Public health can play a key role in promoting perinatal mental health in the population. Still, primary care providers generally have the main responsibility for detecting and managing women with perinatal mental health issues. Nevertheless, public health can promote perinatal mental health by working closely with a range of health partners (i.e., physicians, nurse practitioners, midwives, CCACs, and organizations addressing the SDOH) to develop community systems of care. This will ensure that parents at risk of or experiencing perinatal mental health problems can access appropriate supports and services.

Each PHU has unique community needs and priorities, resources, capacities, partnerships, and services. The reach of HBHC, and the extent to which PHUs can offer individual service delivery beyond HBHC, varies. However, all PHUs have opportunities to engage individuals during the perinatal period.

For example, preconception health initiatives, as well as prenatal supports through a wide variety of programs/services such as the Canadian Prenatal Nutrition Program (CPNP) and HBHC are programs targeted at higher risk populations. Health information lines and PHU websites are available universally for both prenatal and postpartum populations.

As part of the HBHC program, universal screening identifies families to offer an in-depth assessment that may lead to home visiting services. In addition, postpartum and breastfeeding support services, and early parenting programs, may offer opportunities to screen during the perinatal period. Again, public health nurses are key service providers in these program areas.

Module 5.1 of this Toolkit describes the role of public health in facilitating the development of a community system of care for parents at risk for, or experiencing, symptoms of perinatal depression. Module 5.2 provides the information and evidence necessary for PHUs to make decisions about screening and the development of health unit care pathways. In these modules, the HHDT makes nine statements for Ontario PHU action.

Table 2.2.5: HHDT Statement #8-16

HHDT Statement	Description	Rating
HHDT Statement #8	Best or promising practices support public health units to engage with LHIN(s), primary care providers, and community services to identify and articulate a community system of care for individuals who are at risk of, or are experiencing, symptoms of perinatal depression.	Rated*: BP
HHDT Statement #9	Best or promising practices support public health units to implement screening activities as part of an established perinatal mental health community and public health system of care that supports assessment, diagnosis, treatment and follow-up.	Rated*: BP
HHDT Statement #10	Existing evidence supports public health units to screen pre- and postnatal women as a means of identifying women who are at risk for, or are experiencing, perinatal depression.	Rated*: EB
HHDT Statement #11	Best or promising practices support public health units to screen during the prenatal period and, where possible, at 6-12 weeks postpartum; taking into consideration that there is no conclusive evidence regarding the specific timing during these periods (particularly during the immediate postpartum period).	Rated*: BP
HHDT Statement #12	Existing evidence supports public health units to use the Edinburgh Postnatal Depression Scale (EPDS) as an evidenced-based screening tool, effective in identifying women at risk for, or experiencing, symptoms of perinatal depression.	Rated*: EB
HHDT Statement #13	Existing evidence supports public health units to establish a score of 13 or more on the EPDS to trigger a referral to primary care and/or community services for assessment and intervention.	Rated*: EB
HHDT Statement #14	Best or promising practices support public health units to build the capacity of their Public Health Nurses (including HBHC) to administer and interpret screening results using clinical judgement, within the context of a psychosocial assessment of the woman and an assessment of the mother-infant dyad.	Rated*: BP
HHDT Statement #15	Existing evidence supports public health units to include evidence-based and promising practice interventions in self-care, family and peer support, and psychoeducation as part of their care pathways and in coordination with the community	Rated*: EB

HHDT Statement	Description	Rating
	system of care.	
HHDT Statement #16	Best or promising practices support public health units to participate in efforts such as research and program evaluation, as feasible, that will build evidence and contribute to identifying promising practices regarding public health approaches to perinatal mental health promotion and interventions.	Rated*: BP

*See Module 1.1 for evidence grade definition

Public Health Workforce

A comprehensive approach to perinatal mental health, as described in the modules of this Toolkit, requires a knowledgeable, multi-disciplinary team of public health professionals. Public health nurses who deliver direct service programs (including HBHC) will likely play a key role in identifying parents who are at risk for, or are experiencing, perinatal depression.

The public health roles described in the other modules (i.e., conducting situational assessments, and population health assessment and surveillance, facilitating community collaboration, building care provider and system capacity, and promoting public awareness) may require additional skill sets. This need may include health promoters, epidemiologists, physician engagement staff, health equity advisors, and others.

References for Module 2.2

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Module 3.1: Completing a Situational Assessment

Introduction

This module 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.

This module focuses on the role of Ontario PHUs in completing a situational assessment. This module, in the context of public health in Ontario, can help PHUs to:

- support program development
- provide background for developing a program business case
- share material with and/or engage with community partners to increase their understanding of perinatal mental health in their community

The Population Health Assessment Standard of the *Ontario Public Health Standards* requires boards of health to "assess current health status, health behaviours, preventive health practices, risk and protective factors, health care utilization relevant to public health, and demographic indicators, including the assessment of trends and changes."[1]

Completing a situational assessment is the first step in assuring that perinatal mental health programs and services are informed by evidence – the very foundation of effective public health practice.

Table 3.1.1: HHDT Statement #2

HHDT Statement	Description	Rating
HHDT Statement #2	HHDT consensus supports public health units to complete a situational assessment as the first step in a comprehensive population health promotion approach to perinatal mental health.	Rated*: HHDT-C

*See Module 1.1 for evidence grade definition

What is a Situational Assessment?

To understand a region's unique needs and identify existing perinatal mental health services, it is important to conduct a situational assessment. This is "a systematic process to gather, analyze, synthesize and communicate data to inform planning decisions."[2] The results can be used to identify community assets, needs, populations of interests, trends and priorities,[2] which can be used for priority setting and decision-making.[2]

In the context of perinatal mental health, a situational assessment is a useful way of determining what types of mental health services exist for parents and their families in a region. There can be significant regional variability between PHUs regarding what types of perinatal mental health services are available. A situational assessment can help PHUs make decisions to inform their own care pathways, based on the resources available in their specific regions. For more information about care pathways see Modules 5.1 and 5.2 of this Toolkit. PHUs can also use the information gathered during a situational assessment to strategically plan services. For example, if certain populations or geographical regions have a greater need for perinatal mental health services, targeted interventions may be warranted.

Public Health Ontario's *Focus On: Six strategic steps for situational assessment*[2] details a six-step process to guide public health practitioners. The following section outlines what to consider. Please refer to the full report for more information. The model is laid out in sequential order, but conducting a situational assessment can be an iterative process.

The needs of stakeholders both within an organization and in the larger community should be considered at every step of this process. Stakeholders are more likely to support the results of a situational assessment and act upon them if they feel they were engaged, kept informed and involved in the project.

Applying the Six-step Model for Conducting a Situational Assessment to Perinatal Mental Health

Step 1: Identify Key Questions to be Answered

Consider three broad questions at this step. Within those broad questions, there are specific questions related to perinatal mental health that may be help focus the question. It is not necessary for the situational assessment to answer all of the questions below. Generate a list of potential questions and prioritize them based on your organizational needs, resources, and project timelines.

1. What is the situation?
    a. What is the impact of perinatal mood disorders in this community (i.e., prevalence, severity)?
    b. Which populations or communities are at a higher risk of developing perinatal mood disorders?
    c. What organizations provide services related to perinatal mental health monitoring, screening, treatment and referral?
    d. What services does the PHU currently provide related to PMH monitoring, screening, treatment and referral?
    e. What do community partners currently know about perinatal mental health?
    f. What does the public currently know about perinatal mental health?
2. What influences are making the situation better or worse?
    a. What are the social, political, and economic conditions that impact perinatal mental health?
    b. What conditions address and support healthy perinatal mental health?
    c. What conditions negatively impact perinatal mental health?

3. What possible actions can be taken to address the situation?

    a. What does the evidence say could be possible solutions to support perinatal mental health?

    b. Is perinatal mental health on the public agenda (locally, provincially, or nationally)?

    c. What is the cost of the problem (e.g. social, human, financial)?

    d. What is the cost of doing nothing about the problem?

The remaining steps will focus on this question: Which organizations provide services related to perinatal mental health monitoring, screening, treatment and referral?

Step 2: Develop a Data Gathering Plan

Identify sources of evidence that you can use to answer the question(s) prioritized in Step 1. For example, if the aim of the situational assessment is to learn more about the range of services provided in a community, you could conduct an environmental scan (via an online survey, a search of community partner websites, targeted phone calls or emails, key informant interviews, or a combination of these methods). Table 3.1.2 provides additional examples of common data sources used in a situational assessment.

Table 3.1.2: Examples of Data Sources

If you want…	Type of Data	Data Gathering Method	Examples of Sources
Information about community needs	Community health status indicators	Literature search/review	• Local board of health • Community health status reports • Rapid risk factor surveillance system (RRFSS) • PHO Snapshots (BORN; HBHC-ISCIS; Intellihealth) • Canadian Community Health Survey (CCHS) • Public Health Agency of Canada (PHAC) InfoBase
Information about what conditions (social or organization environment, or at the broader public policy level) are causing or helping to alleviate the situation	Environmental scan	Focus group, key informant interviews	• Staff from community service organizations that are already working on the problem • Project team • Local public health epidemiologist • Members of the intended audience • Municipal planning department • LHINs
Information about what evidence exists to support various courses of action	Best practice synthesis and guidelines, summaries of systematic reviews	Search of databases populated with guidelines or pre-appraised systematic reviews	• National Guidelines Clearinghouse • Turning Research into Practice (TRIP) • Healthevidence.org
Guidance about the nature and scope of the final program	Review of stakeholder mandates, policies, guidelines, etc.	Internal document review	• Organizational strategic plans • Professional standards and guidelines • Organizational budgets • Funder information

Adapted from Public Health Ontario's Online Health Program Planner.[3]

Step 3: Gather the Data

Collect information using the methods outlined in the plan developed in Step 2. To determine which organizations provide services related to perinatal mental health monitoring, screening, treatment and referral, an environmental scan would be the principal data collection method. In this case, staff training may be required to ensure that information from all relevant community partners is collected using consistent methods.

Step 4: Organize, Synthesize and Summarize the Data

Once the data has been gathered, it needs to be cleaned and analyzed, perhaps using an existing framework or template. In the case of an environmental scan, it may be useful to organize the data based on the level of service provided. For example, you might choose to group community partners by the severity of cases treated by each organization. This type of categorization could be useful at a later stage in program development, when a community is establishing its system of care (Module 5.1) and the PHU is developing its care pathway (Module 5.2).

Step 5: Communicate the Information

Relevant audiences should be informed of the results of the situational assessment. Consider the needs of each audience when determining how to communicate the results of the situational assessment. Create summary documents and visuals to communicate key messages.

An Ontario Health Promotion E-bulletin article contains useful guidance for communicating findings to diverse stakeholder groups.[4]

Step 6: Consider How to Proceed with Planning

Determine how to use the findings of the situational assessment. For example, an environmental scan might reveal that a local hospital hosts a cognitive behavioural therapy group for women whose Edinburgh Postpartum Depression Scale (EPDS) screen indicates that they are at risk for perinatal depression. A PHU may choose to develop a partnership that allows them to refer women to that program.

Practice Examples from the Field

The following practice examples can help PHUs to understand and consider how to apply key concepts from this module. These examples were independently developed by PHUs and other partners. They are not products of the HHDT, nor has the HHDT evaluated or critically assessed their quality.

North Simcoe Muskoka:

Perinatal Mood Disorder Coalition – Situational Assessment

The North Simcoe Muskoka Perinatal Mood Disorder (NSM PMD) Coalition is a regional group with representation from public health, family health teams, community health centres, midwifery, doulas, Community Care Access Centres, Canadian Mental Health Association, EarlyOn Child and Family Centres, Indigenous/Metis agencies, individuals with lived experience, and other child and family services. The work of this group is coordinated by a regional perinatal mood disorder (PMD) coordinator, employed by Orillia Soldiers' Memorial Hospital.

Perinatal mental health was identified as a priority by the North Simcoe Muskoka Local Health Integration Network (NSM LHIN) in 2015. The PMD coordinator conducted a situational assessment related to PMD supports within NSM, the gaps for referral and services and also for the purpose of developing a community care pathway. An initial informal consultation with PMD service providers in NSM revealed that major barriers existed across the region, with frontline workers and health care providers being able to access appropriate referrals for their clients.

This was largely accomplished through dissemination of a survey created using the Survey Monkey Platform (see attached survey and results documents for more information) and distributed to care providers (family physicians, obstetricians, midwives, nurse practitioners, psychiatrists, psychologists, and psychotherapists) via members of the NSM PMD Coalition. Survey results indicated that:

- 80% of health care providers (HCPs) believe that inadequate PMD services exist in NSM.
- 70% of HCP would like more training/education on PMD.
- Many family physicians lack the resources to provide options other than pharmacotherapy.

- HCPs stated a very strong need for NSM PMD programming to support women and families locally.

The NSM PMD coalition used this information to determine their next steps and ultimately to create a community service pathway in collaboration with their care providers (see Module 5.1 for a practice example related to the development of this document).

Attachments:

- Service map
- Summary of survey results/ survey template

For more information:

Please contact the North Simcoe Muskoka LHIN at northsimcoemuskoka@lhins.on.ca or the Perinatal Mood Disorder Coordinator, Jaime Charlebois, at jpcharlebois@osmh.on.ca.

Simcoe Muskoka District Health Unit:

Effective Psychological and Psychosocial Interventions to Prevent Perinatal Depression and Anxiety Disorders Rapid Review

As stated in this module, a literature review may be required to better understand the research base related to issue. In 2016, Simcoe Muskoka District Health Unit conducted a rapid review to answer the research question*: What are the effective psychological or psychosocial interventions to prevent diagnoses perinatal mood disorders?* It should be noted that while a rapid review is not, by itself a comprehensive situational assessment, it can provide valuable information that contributes to the completion of a situational assessment.

Attachments:

- SMDHU's Rapid Review Full Report

Region of Peel:

Use of Services by Immigrant Women with Symptoms of Postpartum Depression: A Rapid Review

A rapid review is not, by itself, a comprehensive situational assessment. However, it can provide valuable information that helps to define the key question; that's step 1 of a situational

assessment. A rapid review was conducted in 2014 with the aim of determining strategies to assist immigrant women to have better access to services in the Region of Peel. Click the links below to see the summary report and full report.

Attachments:

- Peel's Rapid Review One Page Summary
- Peel's Rapid Review Full Report

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Introduction

This module 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.

This module focuses on role of Ontario PHUs in conducting a population health assessment, including the collection and analysis of data in relation to perinatal mental health. This module, in the context of public health in Ontario, can help PHUs to:

- support program development
- provide background for developing a program business case
- identify populations at risk for perinatal anxiety and/or depression, and reduce health inequalities
- monitor and communicate trends in perinatal mental health

The *Ontario Public Health Standards* (OPHS) describe population health assessment as "the measurement, monitoring, analysis, and interpretation of population health data and knowledge and intelligence about the health status of populations and subpopulations, including social determinants of health and health inequities."[1] Completing a population health assessment is a critical step in assuring that perinatal mental health programs and services are tailored to the community.

Table 3.2.1: HHDT Statement #3

HHDT Statement	Description	Rating
HHDT Statement #3	HHDT consensus supports public health units to conduct a population health assessment related to perinatal mental health, in collaboration with their LHIN(s), primary care providers, and community partners, as appropriate.	Rated*: HHDT-C

*See Module 1.1 for evidence grade definition

Table 3.2.2: HHDT Statement #4

HHDT Statement	Description	Rating
HHDT Statement #4	HHDT consensus supports public health units to identify, collect, and regularly monitor appropriate indicators and sources of data related to risk factors and/or symptoms of perinatal mental health.	Rated*: HHDT-C

*See Module 1.1 for evidence grade definition

Provincial Data Sources

To deliver effective perinatal mental health programming, PHUs can leverage relevant provincial and local data sources available in their communities. There is currently no ongoing provincial population health monitoring of postpartum depression or related mood disorders in the perinatal period.[2] However, PHUs can access some data sources that contain indicators related to perinatal mental health:

- Better Outcomes Registry Network (BORN)
- Healthy Babies, Healthy Children- Integrated Services for Children Information System (HBHC-ISCIS)
- Rapid Risk Factor Surveillance System (RRFSS)
- Health care administrative data[2]

PHO Snapshots provide access to several relevant indicators from BORN, HBHC-ISCIS, and the Ontario Ministry of Health and Long-Term Care, IntelliHEALTH Ontario.

Better Outcomes Registry Network (BORN)

BORN is a mandatory provincial registry and network that collects data related to pregnancy, birth and childhood.[3] The BORN Information System (BIS) provides some indicators related to

perinatal mental health. For more information on how to access the BIS, visit the BORN website.

BORN indicators related to PMH can be accessed at the PHU-level by using the Public Health Ontario (PHO) Snapshots tool[4]. This tool provides information on four indicators related to PMH.

Table 3.2.3: BORN Indicators

Indicator	Numerator	Denominator
Maternal mental health concerns during pregnancy	Individuals who gave birth who reported any mental health concerns during pregnancy (i.e., anxiety, depression, history of postpartum depression, addiction, bipolar disorder, schizophrenia, other). (BORN Dimension: maternal health history, mental health concern.)	Individuals who gave birth. (BORN Measure: number of pregnancies – women who gave birth.)
Anxiety during pregnancy	Individuals who gave birth who reported anxiety during pregnancy. (BORN Dimension: mental health concerns, anxiety.)	Individuals who gave birth. (BORN Measure: number of pregnancies – women who gave birth.)
Depression during pregnancy	Individuals who gave birth who reported depression during pregnancy. (BORN Dimension: mental health concerns, depression.)	Individuals who gave birth. (BORN Measure: number of pregnancies – women who gave birth.)
History of post-partum depression	Individuals who gave birth who reported post-partum depression after a previous birth. (BORN Dimension: mental health concerns, post-partum depression.)	Individuals who gave birth. (BORN Measure: number of pregnancies – women who gave birth.)

Adapted from PHO Maternal Health Snapshot metadata[4]

BORN captures data prenatally as well as at the time of birth, so can be useful for gathering information related to both the prenatal and immediate postpartum period. However, it does not capture data on post-partum health following hospital discharge. The indicator “history of post-partum depression” could suggest risk for developing postpartum depression based on experience during previous pregnancies. However, this indicator would not capture any information related to the experience of first-time parents.

Healthy Babies, Healthy Children- Integrated Services for Children Information System (HBHC-ISCIS)

HBHC is a home visiting program that all 36 PHUs deliver to help children get a healthy start in life.[5,6] To determine eligibility, women in the prenatal, postpartum and early childhood period are screened using a 36-question tool. Rates of screening vary across time periods and across health units. In the prenatal and early childhood period, screening is largely opportunistic; in the postpartum period the goal is universal screening.

Question 27 on this screening tool asks if the client or parenting partner has a history of depression, anxiety, or other mental illness.[5-7] This question broadly identifies mental illness and does not specifically refer to mental illness experienced during the perinatal period. However, this data source is still worth considering. Depression is often a recurrent disorder. A history of depression can be a strong risk factor for developing depression during the perinatal period.

Some clients have an infant at risk for poor child developmental outcomes, and go on to receive more services through HBHC. For those clients, additional information related to perinatal mental health may be attainable. For example, clients who receive an in-depth assessment (IDA) are asked about depression during pregnancy and their ability to cope with stress.[5] HBHC staff are certified to use standardized, evidence-based assessments in their ongoing work with families. These tools, such as the Parent-Child Interaction Feeding and Teaching Scales, may provide further detailed information related to parent-child attachment.

For more information on the screen and programming, visit the Ministry of Children, Community and Social Services’ website:[6]

Rapid Risk Factor Surveillance System (RRFSS)

The RRFSS is a collaborative of public health units that collects ongoing health-related surveillance data.[8] Public health units who pay the required fee to join can contribute to the selection of health indicators measured in each round of surveying. The Institute for Social Research at York University conducts the telephone-based surveys on behalf of each participating public health unit. In the past, surveys have gathered information related to knowledge and awareness of postpartum depression and baby blues.[2] One barrier to using this data source is that there is no provincial comparator data available. The related costs also may be prohibitive for some public health units.

For more information visit the RRFSS website.

Health Care Administrative Data

Some health care administrative databases capture information that may be useful when reporting about perinatal mental health.[2] Although not all administrative data in Ontario are accessible, PHUs can access some through dissemination tools such as IntelliHEALTH ONTARIO.[2] Relevant databases include:[2,9]

Table 3.2.4: Healthcare Administrative Data

Database	Brief Description
Discharge Abstract Database (DAD)	Acute care hospitalization data
National Ambulatory Care Reporting System (NACRS)	Emergency department visit data
Ontario Mental Health Reporting System (OMHRS)	Hospitalization data for designated mental health beds

PHUs may be able to combine indictors from these databases to report on perinatal mental health issues. For example, by linking OMHRS and DAD databases, one could determine how many individuals had been admitted to a hospital for depression (OMHRS) within one year of delivery (DAD).[2] However, because OMHRS only captures hospitalized cases of depression, this method can only be used to monitor the most severe cases. An exploratory analysis indicated that data examined using this method yielded very low case counts[2] and was not particularly informative.

For more information on these administrative databases and how to access them, consult Ministry of Health and Long-Term Care's *Health Analyst Toolkit* [9]

Association of Public Health Epidemiologists in Ontario (APHEO) – Core Indicators Project

The Core Indicators Project aims to provide a go-to resource for public health epidemiology in Ontario. This mission is fulfilled on a voluntary basis by the development and sharing of population health indicator definitions and metadata, trusted for population health assessment in Ontario PHUs.[10] Efforts have been made to ensure the core indicators are relevant and reflective of the current public health mandate (i.e., OPHS).

Under the Core Indicators Workgroup, perinatal mental health content falls under the responsibility of the Reproductive Health Core Indicators Subgroup. They recently developed a core indicator on maternal mental health during pregnancy. It outlines how PHUs can analyze data from the BORN Information System (BIS).[11] This indicator definition for mental health during pregnancy is comparable to that shown in the PHO Snapshots described earlier.

The APHEO BORN Public Health work group advocates for access to and use of BORN data for public health purposes, and to establish an effective mechanism for communication between member agencies (BORN, PHUs, and PHO).[12] This group is continually working to improve access and usefulness of the data available to PHUs through the BORN Information System (BIS) public health standard reports, as well as the public health data cube. The group has documented an inventory of known "issues" with the BIS. Each year, the group works with BORN to negotiate enhancements to the BIS for public health users. It has also recently developed a BORN user guide for PHU epidemiologists and data analysts.[13]

Plans for Data Collection

Canadian Health Survey on Children and Youth (CHSCY)

Statistics Canada has begun piloting a new survey: the Canadian Health Survey on Children and Youth (CHSCY). This national telephone-based survey will measure health-related information for children aged 1—17.[14] For children 1—12, the person most knowledgeable (PMK), often the child's parent, will complete the questionnaire.

To leverage this contact, the HHDT recommended that CHSCY include questions related to the PMK's mental health during the first year of the child's life. These questions may provide a good approximation of parental depression during the postpartum period.

Statistics Canada has confirmed that it will include these two questions in the upcoming CHSCY:

1. In the first year of this child's life, how often did you feel down, depressed, or hopeless?
    a. Always
    b. Often
    c. Sometimes
    d. Rarely
    e. Never
2. In the first year of this child's life, how often did you have little interest or little pleasure in doing things?
    a. Always
    b. Often
    c. Sometimes
    d. Rarely
    e. Never

These questions were adapted from the depression screen known as the Patient Health Questionnaire-2 (PHQ-2).[15] An individual answering "often" or "always" to either question is classified as experiencing self-reported depression. The CHSCY lacked the space to use a longer and more accurate depression screening tool. Still, studies have shown that the PHQ-2 is appropriate for the postpartum period,[16,17] and can provide a good approximation of self-reported depression.[18]

Statistics Canada has not released the results of their pilot or information about when this survey will be conducted. For updates on the status visit the Statistics Canada website[19] .

Local Data Collection

Current provincial data sources do not provide any direct measure of perinatal mood disorders. Therefore, collection of local data is needed to help fill this data gap at a population health level. PHUs can partner with other organizations in their communities to share this task.

PHUs who would like to develop a Population Health Assessment and Surveillance plan, or wish to know more about York Public Health's data process, can contact: Valerie D'Paiva, Child and Family Health Manager at valerie.d'paiva@york.ca or Denis Heng, Epidemiologist at denis.heng@york.ca.

Practice Examples from the Field

The following practice examples can help PHUs to understand and consider how to apply key concepts from this module. These examples were independently developed by PHUs and other partners. They are not products of the HHDT, nor has the HHDT evaluated or critically assessed their quality.

To determine if any PHUs were involved in any local data collective initiatives related to perinatal mental health, the HHDT put out a request through APHEO and the Central West Perinatal Mood Disorder Network. No PHUs reported surveillance activities directly related. However, there were interesting examples of local data collection around the mental health and development of children.

Wellington-Dufferin-Guelph:

Coalition for Report Cards on the Well-Being of Children – Youth Survey

The Wellington-Dufferin-Guelph (WDG) Coalition for Report Cards on the Well-Being of Children is a committee of community service providers, committed to raising the profile of children by collecting data, examining trends, and reporting on the state of their well-being.[20]

In an effort to meet the data needs of their community, the coalition produces and maintains an online data portal organized into five domains related to child well-being: education, health, living environment, safety and social relationships.[21] To learn more about this work or to access their data portal, visit the Wellington-Dufferin-Guelph Report Card Website.

In 2011, the coalition began administering the WDG Youth Survey to improve the quality and variety of local indicators related to the health and well-being of youth. The coalition decided to adapt an existing youth survey developed by the Halton Our Kids Network. Since 2011, the coalition has administered this survey to Grade 7 and 10 students twice (2011-12 and 2014-15 school years). The third edition, of this survey is planned for the 2017-18 school year. This edition will also survey grade 4 students.

There are three versions of the survey, one tailored to each grade level. Each version gathers information related to family and friends, school and the community, physical and mental health, and protective and risk behaviours. Many of the indicators captured in this survey are reported on the WDG Report Card Website. You may also access the 2014-15 WDG Youth Survey to learn more about the specific questions asked.

There are indicators that are specifically related to the mental health featured in the WDG Youth Survey. The survey includes questions which pertain to:

- stress
- self-esteem
- suicidal thoughts
- self-rated mental health[22]

These indicators are all reported alongside other mental health measures on the WDG Report Card Website's data portal.

To learn more, about the WDG Youth Survey contact the WDG Coalition for Report Cards on the Well-Being of Children using their online question submission form.

Attachments:

- Grade 7 and 10 WDG Youth Survey

York Region Public Health – Early Development Instrument

It is well documented that perinatal depression and anxiety can have child development consequences including poor cognitive, behavioral and emotional outcomes.

These altered developmental trajectories for children may include: difficult temperament, insecure attachment, difficulty regulating emotions, risk of ADHD and conduct disorders, and risk of depression/anxiety.[23-26] Health surveillance and overlaying data sets have enabled us to effectively consider local needs and plan our service delivery sites for our mental health and wellness groups.

The Early Development Instrument (EDI) is a population-level research tool completed by kindergarten teachers that measures children's ability to meet age appropriate developmental expectations in a number of domains.[27]

By providing a kindergarten benchmark for monitoring child development trajectories, EDI data contributes developmentally-based indicators that, combined with additional indicators, can inform research and policy about the outcomes of the early years and predictors of later development. It also provides a neighbourhood level indicator that can be used to target early years programming. The EDI social competence and emotional maturity domains directly align with objectives of York Region Public Health's Bounce Back and Thrive! (BBT) program, an evidence-based 10-week resiliency skills group for parents/caregivers.[28]

An evaluation of the BBT showed that, by the end of the program, the greatest positive change in attitudes related to resilience and parenting were observed in parents with the least 'resilient' attitudes at the beginning. Similarly, the greatest improvements in the Depression Subscale scores were observed for parents who scored most poorly at the beginning of the program.[2]

York Region Public Health regularly accesses EDI results and maps the top and bottom ranked EDI neighbourhoods within the various EDI domains to visualize the spatial distribution of these leading and lagging EDI neighbourhoods (see Figures 3.2.1 and 3.2.2). This allows us to better understand specific community characteristics that may contribute to the variation of EDI results across our public health unit. By considering EDI results in our program planning, we are better able to apply a health equity lens to our service delivery within different service areas including establishing BBT service delivery sites to those neighbourhoods that have lower EDI scores in the social competence and emotional maturity domains.

For more information about developing a Population Health Assessment and Surveillance plan or to learn more about the data overlap processes, contact Valerie D'Paiva, Child and Family

Health Manager at valerie.d'paiva@york.ca or Denis Heng, Epidemiologist at denis.heng@york.ca

Figure 3.2.1: "Lagging" York Region Early Development Instrument neighbourhoods: The Regional Municipality of York. Early Development Instrument (EDI) 2015 results.

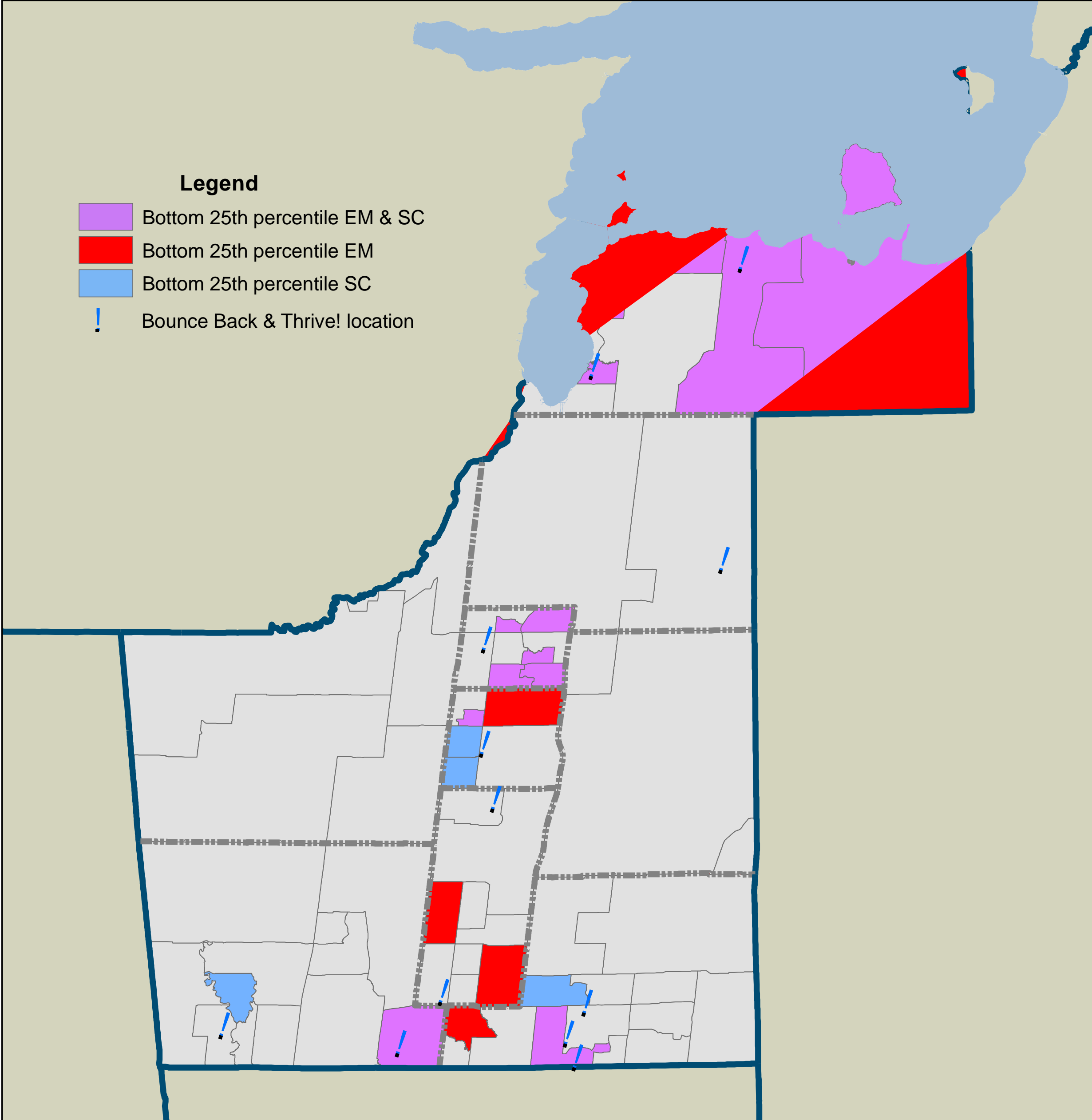
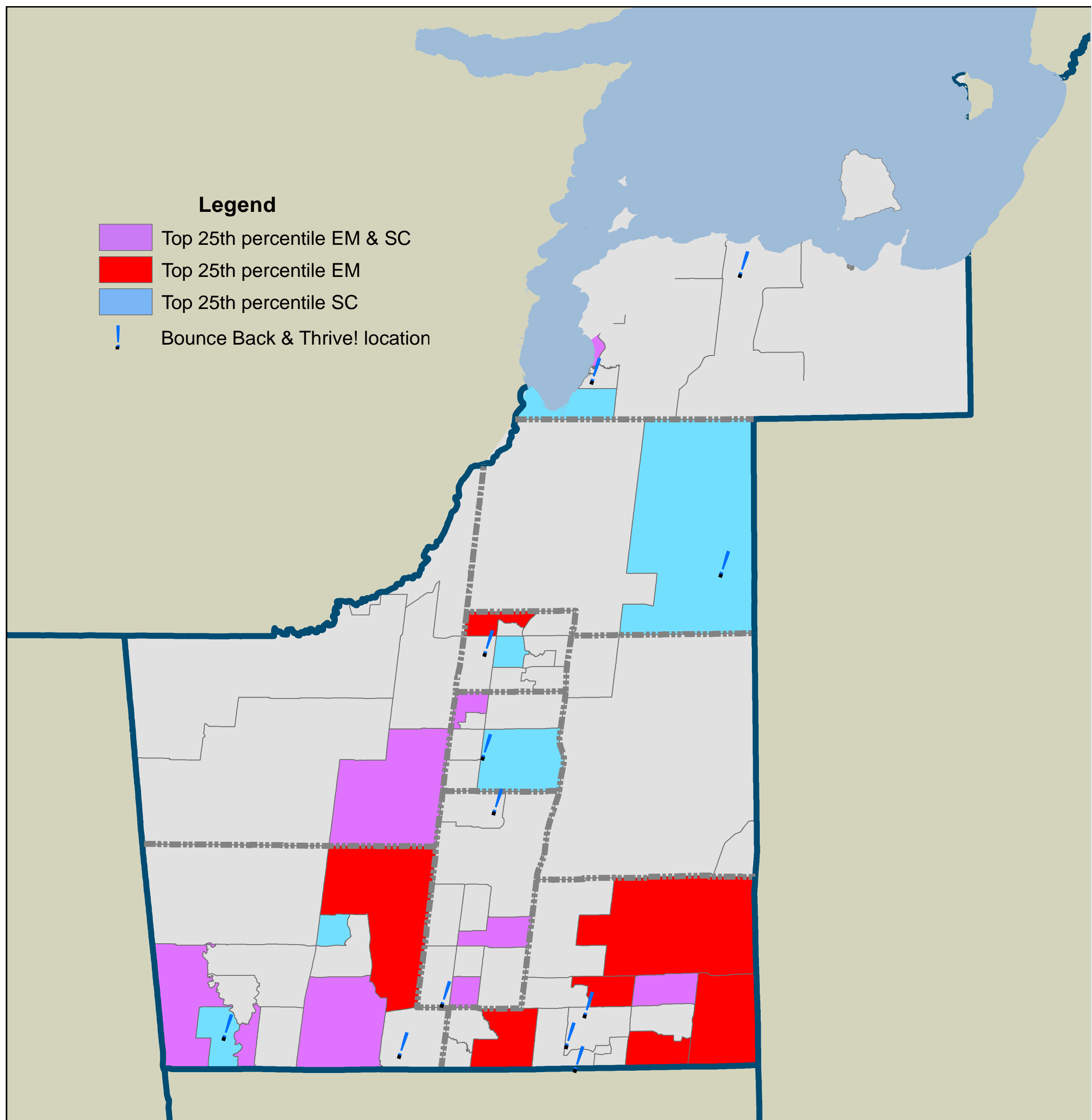


Figure 3.2.2: "Leading" York Region Early Development Instrument neighbourhoods



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Module 4.1: Building Community Collaboration and Capacity

Introduction

This module 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.

This module focuses on the role of Ontario PHUs in engaging with their primary care providers and community service partners to address perinatal mental health in their communities. This module, in the context of public health in Ontario, can help PHUs to:

- develop a strategy to outreach to, and collaborate with, community partners regarding perinatal mental health
- develop a strategy for engaging with primary care providers
- make a commitment to the professional development of their staff
- consider their role in capacity-building and professional development of community partners

The Healthy Growth and Development Standard of the *Ontario Public Health Standards* requires boards of health to consult and collaborate "with local stakeholders in the health, education, municipal, non-governmental, social, and other relevant sectors."[1] Such community consultation and collaboration are critical to planning and implementing a comprehensive population health promotion approach to perinatal mental health.

Community Collaboration

Table 4.1.1: HHDT Statement #5

HHDT Statement	Description	Rating
HHDT Statement #5	HHDT consensus supports public health units to engage with their LHIN(s), primary care providers, community service partners, and clients to address perinatal mental health promotion service planning and delivery in their communities.	Rated*: HHDT-C

*See Module 1.1 for evidence grade definition

Comprehensive and coordinated perinatal mental health care and support requires resources and infrastructure from a range of organizations,[2] both within and outside public health. Many agencies and professionals play important roles in supporting parents and families affected by perinatal mood disorders. They all need to work together to increase the availability of seamless and responsive perinatal mental health care.

Several benefits and types of community collaboration have been identified and can be applied to a community approach to perinatal mental health promotion.

Benefits of Collaboration:[3]

- synergy
- community awareness
- share resources
- overcome obstacles
- avoid duplication
- access to constituents
- access to funding sources

The most important benefit of collaboration is advancing a high-quality, integrated approach to service for individuals at risk for, or experiencing, symptoms of perinatal depression.

Types of Collaboration:[3]

- networks
- alliances

- coalitions
- partnerships
- full collaboration (e.g., joint service delivery through integrating resources, training, finances, governance, etc.)

The type of collaboration that effectively address perinatal mental health will vary from community to community. Collaborations may evolve over time as they mature and services expand.

Within a community collaboration, Ontario public health professionals possess the knowledge and skills to assume many roles:[3]

- convener and catalyst (critical during early planning)
- conduit
- funder
- technical assistance provider
- capacity builder (addressed in more detail later in this module)
- partner
- advocate
- organizer and facilitator (may be essential to ensuring ongoing efforts to advance the integration and quality of care)

When engaging in collaboration, think about the need or possibility to:

- Tailor to meet the unique needs of specific groups and/or professions, e.g., creating a primary care coordinator role if working with primary care providers.
- Integrate work on perinatal mental health promotion into existing community partnerships. For example, a Best Start Network that has a subcommittee on reproductive and/or early parenting issues could opt to focus their efforts on perinatal mental health.

- Use more than one network/committee to meet the unique and diverse needs of multiple communities (e.g., Francophone, Aboriginal, LGBTQ, different geographic parts, etc.).

Community Collaboration Practice Examples from the Field

Several communities across Ontario have established partnerships to better understand their local capacity for perinatal mental health. The following practice examples can help PHUs to understand and consider how to apply key concepts from this module. These examples were independently developed by PHUs and other partners. They are not products of the HHDT, nor has the HHDT evaluated or critically assessed their quality.

North Simcoe Muskoka Perinatal Mood Disorder (NSM PMD) Coalition

In the North Simcoe Muskoka (NSM) Local Health Integration Network's (LHIN's) service area, perinatal mood disorder was identified as a priority. NSM partners recognized the need for capacity-building at the community and agency level and across other sectors servicing women, families and children.

For this reason, the North Simcoe Muskoka (NSM) perinatal mood disorder (PMD) Coalition was developed with the purpose of creating sustainable, culturally safe and innovative ways of working together. This work required a lead agency, core service providers and cross-sectoral partners. Connecting with Simcoe Muskoka District Health Unit was integral to understanding the current state of services, programming, community resources, and stakeholders in the NSM.

A Health Equity Impact Assessment (HEIA) was conducted to create an understanding of vulnerable populations that existed across NSM, and to ensure all agencies and community members were considered in the process.

Three steering committees form the NSM PMD Coalition (representing the five geographic planning areas within NSM LHIN and four First Nations groups):

- Barrie/Collingwood/Midland/Penetanguishene
- Muskoka/Orillia
- First Nations, Métis, Inuit (FNMI)

The goals of the coalition are to:

1. Create a better understanding of existing and needed community supports for local women and their families pertaining to PMD.
2. Increase awareness of PMD: identification, appropriate screening, and treatment/ intervention by primary care and community partners to support recovery.
3. Advocate for appropriate, effective and timely treatment and intervention services for individuals and families experiencing PMD.

The NSM PMD chair has an ongoing responsibility to:

- strengthen relationships with local, provincial and international partners
- facilitate meetings as needed;
- use and disseminate best-practice information to educate, advocate for and empower community partners and families;
- consider and address systemic challenges surrounding service delivery

Please refer to Module 3.1 for an additional practice example related to the NSM PMD Coalition.

Attachments:

- NSM PMD Coalition Terms of Reference

For more information, contact the North Simcoe Muskoka LHIN at northsimcoemuskoka@lhins.on.ca, or contact the Perinatal Mood Disorder Coordinator, Jaime Charlebois, at jpcharlebois@osmh.on.ca.

Algoma District: You Are Not Alone (YANA) Coalition

In Algoma, the You Are Not Alone (YANA) Coalition emerged from the Northeastern Ontario Postpartum Mood Disorder (PPMD) Project. It focused on raising awareness of PPMD and making recommendations to improve culturally responsive services and supports in the area. Algoma was one of eight different community steering committees participating in the Northeastern Ontario PPMD Project, which included service providers and women with lived experience. Public health served as the backbone organization of this initiative.

YANA provides an opportunity for community partners to coordinate their expertise in addressing PPMD, with the added depth of drawing on the lived experience at the table. YANA has given a voice to the families and contributes to reducing the shame and stigma of experiencing a mental health illness. The YANA committee includes a range of community partners such as:

- Algoma Public Health
- Algoma Family Services
- Canadian Mental Health Association
- Child Care Algoma
- Early ON Child and Family Centres
- parents with lived experiences
- Sault Area Hospital
- The Pregnancy Centre

Initial YANA outcomes included:

1. Developing a care pathway to help guide professionals, families and community members.
2. Organizing a Photo Voice Project, using photography, to showcase lived experiences of PPMD in a number of communities and venues.

YANA has also been involved in a number of initiatives related to promoting community awareness of PMD such as showing a film related to PMD (*Dark Side of the Full Moon*) at a local film festival and coordinating an expert panel discussion following the screening. They have also planned events for awareness days such as Parental Mental Health Day and Bell Let's Talk Day.

One of the next steps for YANA is conducting a formal evaluation related to their key objective of creating PPMD-informed communities.

Attachments:

- Coalition Terms of Reference

For more about the YANA Coalition, contact Algoma Public Health at 705-942-4646, or contact the project lead, Laurie Zeppa, Director of Community Services, at lzeppa@algomapublichealth.com.

For updates on their activities, visit their Facebook page.

Timiskaming: Postpartum Mood Disorder Program

The district of Timiskaming received financial support to develop a postpartum mood disorder (PPMD) program through the Ontario Government's Best Start initiative. In 2006, the Timiskaming Health Unit (THU) entered into an agreement with the District of Timiskaming Social Services Administration Board to implement a PPMD program. It included education and awareness, screening and referral and treatment/interventions. The funding agreement continued for 11 years, ending in 2017.

THU mental health clinicians were initially trained in pre- and postnatal mood changes counselling to provide services to PPMD clients referred from health care partners or self-referred. THU's Healthy Babies Healthy Children (HBHC) staff integrated screening into the prenatal period and postnatally at 48 hours, 6-8 weeks and six months using the Edinburgh Postnatal Depression Scale (EPDS).

Partnerships were underscored in the agreement and integral to local PPMD program planning and implementation to assist with culturally and linguistically informed decisions and services, reduce barriers to accessing services, and improve coordination and collaboration.

A PPMD Advisory Committee was formed at the onset of the program development. This committee eventually dissolved as partners were coming together as part of a broader Perinatal Coalition. That's where collaboration and coordination could be fostered, and gaps and opportunities that occur related to PPMD could be identified. Partners worked together to draft local Indigenous and Francophone PPMD pathways. The utility and impact of the pathways has not yet been assessed.

Early in the program, an education and awareness campaign was a priority. This campaign included posters, radio, newsprint ads, a local highway billboard and information sessions. Local lived experiences with PPMD were also captured through Photo Voice as part of a Northeastern PPMD Strategy project (www.ppmd.ca).

A program evaluation was conducted during the first two years (2007/08) and an evaluation report was published and shared (2011). Further formal evaluation has not occurred. However, PPMD related indicator metrics from THU (screening/identification, referral and treatment) are monitored and shared with local committee partners. Two reports summarizing this data for various time periods have been created.

Timiskaming's PPMD program continues and is currently under review in light of evolving evidence, funding and mandate changes, and the divestment of the THU mental health and addictions program (funded by the Northeast Local Health Integration Network) to the Canadian Mental Health Association.

Physician Outreach Community of Practice

A number of PHUs across Ontario have developed a dedicated role to engage and collaborate with primary care practitioners, including but not limited to physicians. This role has a dual function: 1) to better engage primary care partners to enhance seamless and responsive care; and 2) to provide inter-professional education and capacity building opportunities.

Primary care engagement leads or coordinators (titles vary among health units) are responsible for creating and maintaining relationships with primary care providers in their region. They also provide staff across their organizations with advice, strategies and introductions that assist them in successfully engaging primary care providers. Many of these individuals also organize public health hosted events that their local doctors can attend, such as Continuing Medical Education (CME) accredited education sessions.

In Ontario, these professionals have formed a community of practice (CoP), co-facilitated by representatives from Public Health Ontario (PHO) and Niagara Region Public Health & Emergency Services. Public health units in this CoP report that having a dedicated staff person who has protected time and resources to engage primary care has led to a marked improvement in their ability to carry out projects that involve primary care. There is not currently a systematic evaluation of the effectiveness of this role or the CoP itself, but individuals in this role continually share insights and success stories within the CoP.

For more information:

If your PHU is considering investing resources in engaging primary care in your community, or if you would like to know more about the Physician Outreach CoP, contact Helen Anderson, Education Specialist at PHO: Helen.Anderson@oahpp.ca.

Community Capacity-Building

Table 4.1.2: HHDT Statement #6

HHDT Statement	Description	Rating
HHDT Statement #6	HHDT consensus supports public health units to provide ongoing professional development on perinatal mental health to, at a minimum, all public health professionals who work with pre- and postpartum individuals and families.	Rated*: HHDT-C

*See Module 1.1 for evidence grade definition

All professionals who interact with parents and families in the perinatal period need access to ongoing training and support to develop effective, responsive and accessible services.[3] Providers need to be aware that parents may be reluctant to disclose their struggles and concerns around poor perinatal mental health. It is the providers' role to make discussions of perinatal mental health part of routine care and support.[5]

Access to ongoing training and support enhances provider capacity, by raising awareness and increasing knowledge, competency and comfort around issues of perinatal mental health[5]. Several studies have demonstrated that training programs attended by health professionals lead to:

- an improvement in knowledge and skills
- an increased likelihood to cover sensitive issues, carry out mental health assessment, detect depressive symptoms, and offer an intervention for depression
- an improvement in clinical processes though skills and knowledge development, including incorporating screening and assessment into standard practice approaches
- better mental health outcomes in women under their care, measured using a variety of rating scales[5]

Public health staff can play an important role in providing ongoing training and mentoring to staff within health units and with community agencies that support perinatal populations. Professional development/training strategies include:

- in-person training sessions
- online training and self-education modules
- webinars
- communities of practice
- regional networks

Training and support can include general education and awareness, and specific training and competency development (e.g., in woman-centered care, joint decision-making, communication skills, and psychosocial assessment).[2,4,5,6]

Table 4.1.3: Other Guidelines' Capacity Building Recommendations

Recommendation	Source	Evidence Grade*
All health professionals providing care in the perinatal period should receive training in woman-centred communication skills, psychosocial assessment and culturally-appropriate care.	COPE[5]	CBR
Where possible, health professionals providing care in the perinatal period should access training to improve their understanding of the challenges of caring for women with schizophrenia, bipolar disorder, and borderline personality disorder.	COPE[5]	PP
Participate in ongoing professional development to enhance knowledge and skills in mental health services and supports for perinatal depression.	RNAO[2]	Ia, IIb, IV

*See Module 1.3 Appendix A for evidence grade definition

Capacity-Building Practice Examples from the Field

Communities across the province are engaging in professional capacity-building efforts with different audiences and community partners. The following practice examples can help PHUs to understand and consider how to apply key concepts from this module. These examples were independently developed by PHUs and other partners. They are not products of the HHDT, nor has the HHDT evaluated or critically assessed their quality.

Toronto Public Health:

Steps to Wellness – Supporting Women with Postpartum Depression and Anxiety – A Professional Guide

As a RNAO Best Practice Spotlight organization, TPH implemented the Best Practice Guideline (BPG) for postpartum depression. Part of the implementation of the BPG involved increasing capacity of PHNs to have evidence-informed interventions to support women experiencing perinatal mood disorders.

"Steps to Wellness – Supporting Women with Postpartum Depression and Anxiety – Professional Guide" (2011) was developed to increase PHN's ability to use evidence-informed interventions to provide information, guidance and direction to women experiencing postpartum depression and anxiety.

"Steps to Wellness" is based on the NURSE program model developed by Dr. Deborah Sichel and Dr. Jean Watson, ensuring the biopsychosocial/cultural needs of each client are considered. This professional resource focuses on aspects of self-care (nourishment, understanding, rest and relaxation, support and spirituality, and exercise) and infant attachment to promote healing and well-being. The guide supports PHNs to promote appropriate and effective self-care activities to women who may be experiencing depression or anxiety.

Next steps are currently underway to review "Steps to Wellness" to update references and resources in 2018.

To learn more about the Steps to Wellness, contact Toronto Public Health or Susan Biglieri, Manager Child Health & Development, Toronto Public Health at 416-397-4788.

References for Module 4.1

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Module 4.2: Promoting Public Education and Awareness

Introduction

This module 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.

This module focuses on the role of Ontario PHUs in raising public awareness about perinatal mental health. This module, in the context of public health in Ontario, can help PHUs to:

- plan perinatal mental health promotion public education campaigns
- identify key messages for these campaigns
- ensure that these key messages are consistent across PHUs

A program outcome of the Healthy Growth and Development Standard of the *Ontario Public Health Standards* is that “individuals and families are aware of the factors associated with healthy growth and development, and the importance of creating safe and supportive environments that promote healthy growth and development.”

Table 4.2.1: HHDT Statement #7

HHDT Statement	Description	Rating
HHDT Statement #7	HHDT consensus supports public health units to explore opportunities to raise public awareness about perinatal mental health.	Rated*: HHDT-C

*See Module 1.1 for evidence grade definition

Key Messages for Public Education

Module 2.1 provides information on the importance of perinatal mental health. Key messages to frame public education campaigns may include:

- Perinatal mental health is an important public health issue because of its multiple impacts on the entire family, especially the parent-child dyad and the resulting significant cost to society.
- Perinatal mood disorder concerns range in severity. They include postpartum blues, perinatal anxiety, perinatal depression, paternal depression, and postpartum psychosis.
- The risk factors for perinatal mood disorders are similar to those for depression in the general population. Risk factors differ according to various demographic and socio-cultural elements such as gender, population, age, and socio-economic status.
- Depression has the highest disease burden for women internationally. It is particularly serious during the perinatal period due to the vulnerability of the infant and the impact on the family during this time.
- Public health understanding of the extent of the impact of parental depression on child development is still growing. However, emerging evidence shows that persistent depression beyond the postnatal period has a significant impact on long-term child and health development outcomes.

Studies have identified primary prevention strategies for perinatal mood disorders, such as perinatal depression.[2,3] However, a rapid review of this topic in 2016 found relatively few studies that examine the effectiveness of interventions to prevent perinatal depression. The studies that do exist use weak methodologies.[3] Despite this limitation, public health can have an impact on perinatal mood disorders at the population level by:

- developing and delivering accessible public education and awareness materials[4]
- designing effective public awareness campaigns

Increasing awareness of the prevalence of perinatal depression, and the existence of effective treatment options, may help to decrease stigma and encourage self-monitoring and early help-seeking behaviours.[5] Individuals with perinatal depression often experience intense feelings of guilt and failure, as well as concerns about being perceived as unfit to care for their child.[5,6] These issues are often compounded by a lack of awareness of available resources and services.

Developing and Delivering Accessible Public Education and Awareness Materials

Parents often feel alone when they experience perinatal mental health problems. Accessible and accurate information can help to decrease isolation and empower parents to self-monitor and reach out for help.[7] To do that, use a range of approaches:

- make print materials available in environments that parents and families frequent, such as PHUs, doctors' offices, early child development centres, hospitals, etc.
- offer user-friendly platforms for internet-based education materials
- incorporate information about perinatal mental health into PHU-led prenatal, postnatal, breastfeeding and parenting classes

Designing Effective Public Awareness Campaigns

Public health practitioners can use many existing resources to guide the design of effective awareness campaigns. Public Health Ontario has developed a 12-step framework for developing health communication campaigns.[8] This tool helps practitioners think through important concepts such as including stakeholders, tailoring messages for audiences, and creating clear objectives. Please see the full resource for more details.

The World Health Organization (WHO) also uses a comprehensive framework when designing its communication campaigns.[9] At the centre are six principles indicating that public health campaigns should be:

- accessible
- actionable
- credible and trusted
- relevant
- timely
- understandable

Many of the concepts can be translated to local public health practice.

Planning for a public health awareness campaign should include program evaluation. Evaluations can aid in decision-making and designing future programming, and it can inform continuous quality improvement efforts.

Practice Examples from the Field

The following practice examples can help PHUs to understand and consider how to apply key concepts from this module. These examples were independently developed by PHUs and other partners. They are not products of the HHDT, nor has the HHDT evaluated or critically assessed their quality.

City of Toronto – Perinatal Mood Disorders: A Board of Health Report

This report was written by Toronto Public Health to raise the awareness of City of Toronto Board of Health regarding the issue of perinatal mood disorders. The report is based on the Public Health Ontario/HHDT Evidence Brief: Exploring Interventions to Address Perinatal Mental Health in a Public Health Context.[10]

World Maternal Mental Health Day Social Media

There is a growing international movement to promote awareness of perinatal mental health using health communication campaigns. For example, World Maternal Mental Health Awareness Day (the first Wednesday in May) is widely recognized by countries around the world.[7] Several communities across Ontario participated in the 2017 World Maternal Mental Health Awareness Day (WMMHAD). They shared messages on social media and worked in collaboration with local partners to create awareness-raising and education events that focus on destigmatizing perinatal mood disorders, and local resources.

Figure 4.2.1: Social Media Posts Related to World Maternal Mental Health Awareness Day

Algoma Public Health @AlgomaHealth · 3 May 2016
May 4th, 2016 marks the first World Maternal Mental Health Day.
#maternalMHmatters

Toronto Public Health
May 3

Like Page

Today is World Maternal Mental Health Day. Let's support mothers & end the stigma. http://ow.ly/XOf5C #maternalMHmatters

734 Reactions 10 Comments 371 Shares

Let's Talk Parenting
May 3

No health without mental health! World Maternal Mental Health Day #maternalMHmatters ask a new mom how she is really feeling#reduceMHstigma

Halton Region Health Department World Maternal Mental Health Day

To capitalize on the opportunity to increase awareness of WMMHD, the Halton PMD Coalition decided to celebrate this day by holding different events in different communities. The goal was to increase awareness of maternal mental health promotion, as well as destigmatize maternal mental illness. The planned events were organized to include members of the community who were anywhere on the spectrum from mental illness to wellness.

As a result, the four Early Years Centres in Burlington, Oakville, Milton, and Georgetown took the lead in planning their events. Halton Region's PHN Lead for PMD assisted by linking flyers from each event to the Region's social media platforms (Facebook and Twitter), connecting different community members with the Ontario Early Years Centres (OEYCs), and ensuring that members of two peer support groups were informed of the events. As well, one-time funding from a previous PMD event was disbursed amongst the groups to assist with costs.

On the first Wednesday of May, four events promoting WMMHD took place:

- Burlington: Approximately 40 mothers, babies, and relatives walked in the neighbourhood, then returned to the OEYC for refreshments and a brief informational talk from a local children's mental health worker.

- Oakville: Eight mothers from the PMD support group joined in with another 20 mothers for a planned nature walk.
- Milton: Ten women including mothers and OEYC staff members attended a tea that offered a resource display and children's activity.
- Georgetown: Twenty-five mothers, family members, and a dog walked in the neighbourhood, carrying signs with the WMMHD logo. They then returned to the OEYC where refreshments were served and participants and staff members added words of encouragement for new mothers to a large banner to be displayed at the OEYC.

On June 8 OEYC staff and other members of the Halton PMD coalition came together to share impressions of the events and possible outcomes. Most OEYCs were pleased with the attendance and ensuing discussions that took place. Social media was used by some OEYCs to share pictures of their events. The groups talked about getting the momentum going sooner in future years and inviting more community partners (e.g., midwives and doulas) to join. They also engaged in brainstorming regarding promoting the events using community contacts and media.

To learn more, contact Halton Region at accesshalton@halton.ca or the PMD Lead, Janet Siverns, at Janet.siverns@halton.ca.

Attachments:

- Cumberland OEYC- Stroller walk flyer
- Georgetown Links2Care OEYC- Community walk flyer
- Milton- Afternoon tea event flyer

Toronto Public Health – Maternal Mental Health Matters (Subway and Digital Media Campaign)

Toronto Public Health (TPH) delivered a promotional campaign titled Maternal Mental Health Matters using social media, Facebook, Instagram, Twitter and the TPH website during Mental Health Week in May annually since 2015. The purpose of the campaign was to bring awareness to World Maternal Mental Health Day and Mental Health Week. A larger promotional campaign, completed for the first time in 2017, included platforms such as, posters, billboards, and underground digital screens in the Toronto subway system, two local newspapers, and

throughout the city in hospitals, community centres, libraries, health centres, and midwifery clinics. Focus groups were conducted to select an image for the campaign with two additional ethnic image posters distributed in a targeted approach in two Neighbourhood Improvement Areas (NIAs).

The campaign resulted in very strong public engagement levels, showing one of the highest ranked posts for engagement of any TPH campaign. The number of visitors to the TPH postpartum depression website (toronto.ca/health/ppd) increased nine-fold during the campaign. On May 3, 2017, TPH's Maternal Mental Health Awareness Campaign was a trending topic on Twitter for the first time.

Toronto Public Health received an overwhelming response to the campaign locally, nationally, and internationally. The Maternal Mental Health Matters multi-faceted campaign was very successful in bringing awareness to perinatal mood disorders, as evidenced by positive poster response, social media and web trend stats, and social media following. Next steps include ongoing monitoring of the impact of the social media campaign, continued outreach efforts to newcomers to Canada who are at greater risk of perinatal mood disorders, and repeating this campaign style approach on a yearly basis.

Attachments:

- Toronto Public Health subway and digital media campaign poster

To learn more about Toronto's Healthy Matters campaign, contact Toronto Public Health at 311@toronto.ca, or Susan Biglieri, Manager Child Health & Development, at Susan.Biglieri@toronto.ca or 416-397-4788.

Public Health Unit Online Education Resources

A number of PHU webpages provide information about perinatal mental health. Many of these sources are written for the public, but some organizations also provide information for targeted populations, such as health care providers. Exploration of the following links to four PHUs' webpages can provide ideas about how PHUs can present perinatal mental health education resources:

- Durham Region District Health Unit

- Middlesex London Health Unit
- Region of Peel
- Toronto Public Health.

References for Module 4.2

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Module 5.1: Building a Community System of Care

Introduction

This module 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.

This module focuses on the need for a community system of care to support individuals who are identified as at risk for, or experiencing, symptoms of perinatal depression.

PHUs can use the information and evidence in this module to work with LHINs, primary care physicians and community service partners in developing a perinatal mental health community system of care, in tandem with their own public health care pathway (see module 5.2).

Given the variations in services across the province, this part of a comprehensive approach to perinatal mental health is critical. It identifies community services that public health nurse can refer clients to, and identifies gaps in service that collaborative advocacy efforts can address.

A program outcome of the Healthy Growth and Development Standard of the *Ontario Public Health Standards* is that "individuals and families have increased knowledge, skills and access to local supports to effectively foster healthy growth and development at different life stages, and progress through the transitions between these stages."[1] Developing an organized system of care related to perinatal mental health can help increase knowledge, skills and access to local supports for individuals and families.

Table 5.1.1: HHDT Statement #8

HHDT Statement	Description	Rating
HHDT Statement #8	Best or promising practices support public health units to	Rated*: BP

HHDT Statement	Description	Rating
	engage with LHIN(s), primary care providers, and community services to identify and articulate a community system of care for individuals who are at risk of, or are experiencing, symptoms of perinatal depression.	

*See Module 1.1 for evidence grade definition

The Stepped Care Model

A range of interventions is necessary to effectively support, assess and treat individuals at risk for, or experiencing, perinatal depression. These interventions range in complexity and intensity, and can be considered within the context of a "stepped care model."

Stepped care is an evidence-based, staged or hierarchical system of intervention levels that can be matched to an individual's needs.[2] One individual might require brief, non-intensive interventions that the public health provider can initiate. Another might need the coordinated, ongoing efforts of a variety of professionals, which may or may not involve ongoing participation by a public health practitioner.

The success of this stepped care model is based on these principles:[3]

- Depression screening and psychosocial assessment need to be followed up with effective pathways to accessible care.
- Care pathways need to be appropriate to the woman's circumstances and respect her beliefs.
- Collaborative multidisciplinary care is essential to effective and appropriate interventions and good perinatal mental health outcomes.
- A depression management plan may include a range of treatment options and interventions.
- Knowledge of the larger health system, and local referral pathways to care for different levels of risk, is an imperative component of an effective public health approach for perinatal mental health.
- A range of pathways is needed, based on the severity and complexity of the mental health issue.

The following diagram of a mental health stepped care model from the UK[4] is for illustrative purposes - it is neither exhaustive nor prescriptive of providers and their roles in the Ontario context.

Figure 5.1.1: Mental Health Stepped Care Model

Focus of the intervention	Nature of the intervention
STEP 4: Severe and complex* depression; risk to life; severe self-neglect	Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multiprofessional and inpatient care
STEP 3: Persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions; moderate and severe depression	Medication, high-intensity psychological interventions, combined treatments, collaborative care** and referral for further assessment and interventions
STEP 2: Persistent subthreshold depressive symptoms; mild to moderate depression	Low-intensity psychosocial interventions, psychological interventions, medication and referral for further assessment and interventions
STEP 1: All known and suspected presentations of depression	Assessment, support, psychoeducation, active monitoring and referral for further assessment and interventions

Source: National Institute for Health and Care Excellence (NICE). Depression in adults: recognition and management. Clinical guideline (CG90) [Internet]. London, UK: National Institute for Health and Care Excellence (NICE); 2018 [cited 2018 May 30]. Available from: https://www.nice.org.uk/guidance/cg90. Used with permission.

Note: Public Health's role in this model is primarily at Steps 1 and 2 (see more in Module 5.2)

A System of Care

To deliver the full range of services described in the Stepped Care Model, a variety of social and health care service providers need to work together. The benefits of inter-professional collaboration and professional development in the provision of perinatal mental health services are well documented.[5] Collaborative, interdisciplinary care is essential to achieving good outcomes. Coordination among a range of sectors (including public health, primary care, hospital and community-based maternity services and specialist care) can support effective prevention, identification and treatment strategies.[3] When all community partners work together to support and promote health, it is called a community system of care or community

service pathway. Within the community system of care, public health can develop a public health care pathway, which is described in module 5.2.

A care pathway is a "structured approach on a common issue that aims to strengthen consistent, seamless support and care."[6] It is a "detailed local pathway that builds on good practice and evidence and endorses the practice of joint working and encourages an integrated approach to service delivery."[6] A 2010 Cochrane Review identified five criteria for a clinical/care/service pathway. The intervention:[7]

1. Is a structured multidisciplinary plan of care.
2. Is used to channel the translation of guidelines or evidence into local structures.
3. Details the steps in a course of treatment or care in a plan, pathway, algorithm, guideline, protocol or other "inventory of actions".
4. Has timeframes or criteria-based progression (i.e., steps are taken if designated criteria are met).
5. Aims to standardize care for a specific clinical problem, procedure or episode of healthcare in a specific population.

Role of Public Health

PHUs can play a key leadership role by working with a variety of partners to establish community partnerships and coalitions. These can address a comprehensive range of health promotion and population health strategies to support and promote perinatal mental health (see also Module 4.1). Often, a primary focus for community coalitions is creating a community service pathway. It provides detail and guidance on the range of services and supports available, with clear criteria and referral processes.

In the efforts to promote perinatal mental health, PHUs can lead a range of interventions (e.g., community education, screening and assessment, individual or group interventions, policy development, advocacy, etc.). PHUs can also coordinate with other interventions (e.g., referrals to other community services, including collaboration with primary care).[8]

Module 5.2 provides guidance for public health professionals to implement evidence-based practices in screening, identification and appropriate interventions. When an individual is identified as at risk for perinatal depression (through screening or clinical judgement), the next step is to determine their need for follow-up care. This requires a pathway of care, or a "map" to act as guide to accessing the most appropriate care, services and support.[3,9] This module addresses the steps involved in creating a community system of care.

Steps to Building a Community System of Care

Step 1: Situational Assessment

The first step involves conducting a situational assessment to identify and engage key stakeholders in the community who play important roles in supporting and promoting perinatal mental health. Module 3.1 describes how to conduct a situational assessment, and a range of tools and examples of this process.

Step 2: Build a Local Coalition

Before a realistic and effective community system of care can be created, a good sense of existing services and practices is needed, as well as the range of stakeholders who deliver them. PHUs can identify key partners and build a local coalition that:

- enhances perinatal mental health promotion and population health activities
- promotes sharing of innovative practices
- reduces duplication
- facilitates links between services in a timely manner
- supports a client-centered approach to care

Conducting a situational assessment will help identify key partners and stakeholders to engage.

Examples of local service providers:

- primary care practitioners
- mental health services

- maternity care providers (e.g., midwives, obstetricians)
- local LHINs
- local hospitals
- child protection and family support services
- other community and non-governmental organizations serving mothers and families such as: settlement services, parenting resources and early child development centres, child care, community centres, recreation facilities, etc.
- regional Ministry of Health and Long-Term Care and Ministry of Children and Youth Services offices

Examples of regional/provincial/national service providers

- Ministry of Child and Youth Services
- Ministry of Health and Long-Term Care
- Federal maternal and child services and mental health services working with local First Nations communities

For additional ideas and tips on strategic planning to create effective community coalitions, see Module 4.1 and the planning guide Maternal Depression- Making a Difference through Community Action: A Planning Guide.

Step 3: Create a Community System of Care

A community system of care or service pathway puts the person at the centre. It is focused on ensuring that the individual is able to access the right services at the right time, according to their needs and preferences. It is also focused on establishing a comprehensive inventory of current services and partnerships and outlining the role of each organization. Community coalitions can create a community system of care that includes the range of relevant services and supports for individuals who are at risk for, or are experiencing, symptom of perinatal depression; providing details about accessibility.

Step 4: Roll Out the Community System of Care or Pathway

Once the community has come together to establish their system of care for individuals at risk for or experiencing symptom of perinatal depression, it is critical to communicate it widely. Community service providers and primary care providers who have regular contact with pre- and postnatal parents need to know where to refer them for assessment, support and/or treatment. This step may also include community service provider capacity-building (see Module 4.1).

Step 5: Evaluate, Monitor and Update the System of Care

The process of building the community system of care will likely identify gaps in services. This creates an opportunity to work together as a community to explore ways to fill these gaps and advocate for new funding and services. As community services evolve and, hopefully grow, it is recommended to routinely evaluate, monitor and update the system or pathway of care.

Practice Examples from the Field

The following practice examples can help PHUs to understand and consider how to apply key concepts from this module. These examples were independently developed by PHUs and other partners. They are not products of the HHDT, nor has the HHDT evaluated or critically assessed their quality.

Niagara Region Public Health & Emergency Services: Care Pathway

Niagara Region Public Health & Emergency Services has described a public health care pathway that also includes a listing of appropriate community mental health support services.

The pathway, in the format of a flow chart, includes information on:

- assessment
- referral and support
- suicide/infanticide risk assessment and response
- community mental health supports

The accompanying guidelines include information on:

- risk factors
- contributing factors
- signs and symptoms
- treatment requirements
- client support
- referral from health care providers
- screening
- support
- script for research study recruitment

Attachments:

- Care Pathway for Identifying and Supporting Women with Perinatal and Postpartum Mood Disorders
- Guidelines for Identifying and Supporting Women with Perinatal and Postpartum Mood Disorders

North Simcoe Muskoka Local Health Integration Network:

Perinatal Mood Disorder Community Service Data Collection

In the North Simcoe Muskoka Local Health Integration Network's (LHIN's) service area, perinatal mood disorder was identified as a priority. One of the activities of the North Simcoe Muskoka Perinatal Mood Disorder Coalition was to collect data that identified existing PMD services across NSM, from intake to recovery that could be used to establish a community care pathway. The pathway would be a data-driven, evidence-based, decision-making tool. The tool would support clinicians with clearly defined referral options each leading to improvements in the clinical response to PMD.

Attachment:

- PMD Care Pathway Coalition Questionnaire

For more, contact the North Simcoe Muskoka LHIN at northsimcoemuskoka@lhins.on.ca, or contact the Perinatal Mood Disorder Coordinator, Jaime Charlebois, at jpcharlebois@osmh.on.ca.

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Module 5.2: Developing a Public Health Care Pathway

Introduction

This module 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.

This module focuses on the role of Ontario PHUs in screening, referring and supporting prenatal and postnatal individuals for risk or symptoms of perinatal depression. PHUs can use the information and evidence in this module to:

- decide how to integrate perinatal depression screening into existing programming
- ensure that screening practices are based on evidence/best practice
- identify appropriate screening follow-up through developing a public health care pathway

A program outcome of the Healthy Growth and Development Standard of the *Ontario Public Health Standards* is that "Board of health programs and services are designed to address the identified needs of the community, including priority populations, associated with healthy growth and development."

Background

In the HHDT survey, health units identified that they are engaged in services such:

- screening (most with the Edinburgh Prenatal Depression Screening tool)
- developing educational resources
- facilitating peer support activities
- participating in research to evaluate therapy options

However across the province, considerable variation was noted in the timing, frequency, and interpretation of screening programs and in the delivery and/or participation in follow-up interventions. That variation occurs sometimes within the Healthy Babies Healthy Children (HBHC) program, and sometimes in other programs such as prenatal education, breastfeeding support, and/or positive parenting programs.

This module provides HHDT statements and related evidence that will support Ontario PHUs in their decision-making related to planning and providing services to individuals who are at risk for, or are experiencing, symptoms of perinatal depression. This should serve to foster consistency of practice across Ontario health units, and advance the integration of perinatal mental health services into the full range of healthy growth and development services offered by PHUs.

The evidence that informs the HHDT statements in this module has primarily been drawn from three existing evidence-based best practice guidelines:

- 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; 2017 (referred to as COPE in this module).[2]
- The United States Prevention Services Task Force Guidelines (referred to as USPSTF in this module).[3]
- RNAO Best Practice Guidelines: Assessment and Interventions for Perinatal Depression (referred to as RNAO Guideline in this module). References to the RNAO Best Practice Guideline in this module utilize the 2018 version of the RNAO Guideline,[4] which were updated subsequent to the writing of the PHO ADAPTE report.[5]

Each of the HHDT statements in this module have been rated based on the following rating definitions:

Table 5.2.1: 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

Grade	Description
	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.

Following each HHDT statement, you will see: the supporting evidence; and a summary of the related best practice guideline recommendations and evidence grade. For details on the definition of these grades, see Appendix A of Module 1.4 (Methodology).

Note that this module primarily refers to women who are at risk for, or experiencing, symptoms of perinatal depression. To date, all of the research related to screening and follow-up has involved prenatal and postpartum women.

Pathway Framework

As described in Module 5.1 *Establishing a Community System of Care*, a care pathway is a "structured approach on a common issue that aims to strengthen consistent, seamless support and care."[6] It is a "detailed local pathway that builds on good practice and evidence and endorses that practice of joint working and encourages an integrated approach to service delivery."[6]

A 2010 Cochrane Review identified five criteria for a clinical/care/service pathway. It's one where the intervention:[7]

1. Is a structured multidisciplinary plan of care.
2. Channels the translation of guidelines or evidence into local structures.
3. Details the steps in a course of treatment or care in a plan, pathway, algorithm, guideline, protocol or other "inventory of actions."

4. Has timeframes or criteria-based progression (i.e., taking steps if designated criteria were met).
5. Aims to standardize care for a clinical problem, procedure or episode of healthcare in a specific population.

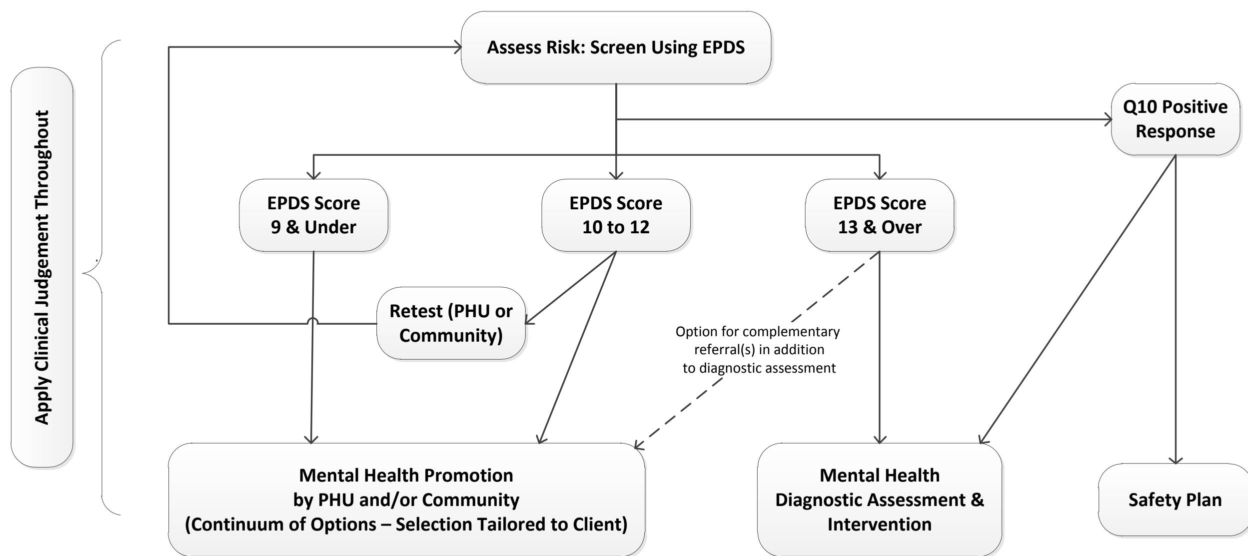
Creating a PHU's Perinatal Mental Health Service Pathway begins with planning. This includes completing a situational assessment (Module 3.1), along with a population health assessment and related surveillance (Module 3.2). This should include engaging the community (Modules 4.1 and 4.2) with a view to establishing a community system of care (Module 5.1).

A PHU unlikely has the expertise or capacity to delivery service at all five steps of the Mental Health Stepped Care Model (Module 5.1 and later in this module). Therefore, it is critical to identify community service partners who can provide mental health diagnostic assessment and intervention services, and include them in the planning process.

Figure 5.2.1 shows a framework for developing public health perinatal mental health care pathway has been designed to:

- advance a consistent approach to perinatal mental health care pathways across the province
- allow PHUs to customize their framework in response to the unique needs of the communities they serve and the resources available to them

Figure 5.2.1: Framework for a Public Health Perinatal Mental Health Care Pathway



It may also be necessary to have variations of the pathway to reflect the needs of specific communities (e.g., Indigenous, Francophone, LGBTQ+) and/or geographic areas (e.g., rural, urban) that each health unit serves.

It will be necessary to develop PHU-specific policies, procedures, and/or guidelines that support their perinatal mental health care pathway. Many of the components that need to be included in these policies/procedures/guidelines are described in this module. However, it may necessary to add specific details that reflect the unique nature of each PHU and/or community. Additionally, PHUs may opt to include additional components that were not specifically addressed in this module. Components of a perinatal mental health care pathway policy/procedure/guideline may include (but are not limited to):

- timing of the screening
- administering the EPDS tool
- completing a psychosocial assessment and applying clinical judgement to interpret results
- interpreting the score
- administering a follow-up re-screen
- communicating with the screened woman about her score, risk factors, follow-up, etc.

- communicating with the screened woman's family and/or physician (with her consent) about her score, risk factors, follow-up, etc.
- responding to a positive score on question #10 and developing and implementing a safety plan
- making referrals in accordance with care pathway and community system of care
- documenting

Precisely who will plan and deliver the activities identified in this framework will depend on the organizational structure of each health unit. Service delivery to perinatal parents can be aligned with the individual service delivery model of the Healthy Babies Healthy Children (HBHC) program. Consider too integrating all or some components of the pathway with other services, such as prenatal and healthy pregnancy, breastfeeding, preparation for parenting and positive parenting services.

It is likely that such a care pathway will be delivered by public health nurses. Consequently, this module is consistent with the RNAO Best Practice Guideline: Assessment and Intervention for Perinatal Depression.[4] Where the RNAO Guideline is applicable to all nurses, this module provides a unique public health perspective.

Public health nurses will play a key role in screening. However, it is likely that other public health care service providers (e.g., lactation consultants, dietitians, health promoters, HBHC family home visitors) will have a role in the PHU health promotion activities that are part of the pathway. This module may also be relevant to service providers in other health care and community settings.

Each of the boxes/activities of this Pathway framework is described in detail below.

Screening

Assess Risk: Screen Using EPDS

The Public Health Perinatal Mental Health Care Pathway begins with identifying individuals at risk for, or experiencing, perinatal depression. Some clients who are already receiving public health services may self-identify, and some may be identified by a public health service provider in the course of receiving service. However, this section of the module focuses on providing

health units with the evidence required to make a decision about screening activities. This includes decisions about whether to screen, when to screen and what screening tool to use.

Whether to Screen?

Table 5.2.2: HHDT Statement #9

HHDT Statement	Description	Rating
HHDT Statement #9	Best or promising practices support public health units to implement screening activities as part of an established perinatal mental health community and public health system of care that supports assessment, diagnosis, treatment and follow-up.	Rated*: BP

*See description at beginning of this module

Table 5.2.3: HHDT Statement #10

HHDT Statement	Description	Rating
HHDT Statement #10	Existing evidence supports public health units to screen pre- and postnatal women as a means of identifying women who are at risk for, or are experiencing, perinatal depression.	Rated*: BP

*See description at beginning of this module

The USPSTF, COPE and RNAO Guidelines all recommend screening for perinatal depression. The recent systematic review conducted by the USPSTF identified six trials that assessed the effectiveness of screening for perinatal depression. They showed a moderate net benefit of 18-59% relative reduction with screening programs or a 2.1-9.1% absolute reduction in the risk of depression at follow-up compared with usual care.[3] As a result, the "USPSTF concludes that with at least moderate certainty that there is a moderate net benefit to screening for depression in pregnancy and postpartum women who receive care in clinical practices that have CBT or other evidence-based counselling available after screening."[3]

The RNAO Guideline recommends to "routinely screen for risk of perinatal depression, using a valid tool, as part of prenatal and postpartum care."[4] The COPE Guidelines advocate for screening, particularly in light of "increased awareness of the prevalence of not only antenatal and postnatal depression but also anxiety, further research into the effectiveness of screening tools, and the increased range and availability of innovative methods of screening."[2] Furthermore, the COPE Guidelines highlight the high levels of acceptability of perinatal mental

health screening among health professionals and women identifying that "fewer than 4% of women refuse health professional-initiated screening."[2] For example, a recent Canadian study "found that 99% of pregnant women who had not been screened would have been comfortable with health professional-initiated screening and 97% of those who had been screened reported the same."[8]

What's less clear is the question of what, and to what extent, community-based diagnostic and intervention services need to be in place. The COPE Guideline states that "systems need to be in place to ensure that appropriate health professionals are available to provide follow-up care if required and to assist if there are concerns for safety of the woman, the fetus or infant or other children in the woman's care."[2] Similarly, the USPSTF recommends that "screening be implemented with adequate systems…and clinical staff to ensure that patients are screened, and if screened positive are appropriately diagnosed and treated with evidence-based care or referred to a setting that can provide the necessary care."[3] "These essential functions can be provided through a wide range of arrangements of clinician types and settings." [3] As noted earlier, the USPSTF based their recommendation on the net benefit to screening in the perinatal period for women who receive care in clinical practices that have CBT or other evidence-based counselling available.[3] The RNAO Practice Guideline states that "in regions lacking mental health services and supports in perinatal depression, the expert panel recommends continued screening and advocacy for local integrated services."[4]

The implication is that when deciding whether to screen, PHUs begin their planning to address perinatal mental health in a comprehensive manner with a focus on population health assessment (Module 3.2), capacity building (Module 4.1), community system of care planning (Module 5.1) and the development of their own public health perinatal mental health care pathway. This will ensure that there is a plan in place for women who are screened, and guide action on identifying and developing new or expanded services for women who screen positive.

When to Screen?

Table 5.2.4: HHDT Statement #11

HHDT Statement	Description	Rating
HHDT Statement #11	Best or promising practices support public health units to screen during the prenatal period and, where possible, at 6-12 weeks postpartum; taking into consideration that	Rated*: BP

HHDT Statement	Description	Rating
	there is no conclusive evidence regarding the specific timing during these periods (particularly during the immediate postpartum period).	

*See description at beginning of this module

Once a health unit has made the decision to screen (within the context of a population health approach to addressing perinatal mental health, and the existence of a community system of care and public health care pathway), consider the timing of the screening.

Among the six screening trials examined by the USPSTF, one study was with prenatal women at 25 weeks gestation and the other five conducted baseline screening with women 4-8 weeks postpartum. The USPSTF identified that "there is no clear evidence regarding the optimal timing and interval for screening."[3] The COPE Guidelines state that all women should be screened "at least once, preferably twice, in both the antenatal period and the postnatal period (ideally 6-12 weeks after the birth)," and then again during the first year post delivery.[2] The RNAO Guideline states that the "evidence on the optimal timing and frequency of perinatal depression screening in inconsistent… no recommendations regarding specific frequency and timing can be made."[4]

The HBHC program offers Ontario PHUs an opportunity to integrate perinatal mental health screening into the required universal postpartum screening. Consequently, specific attention was paid to exploring the evidence related to screening for risk of, and/or symptoms of, perinatal depression during the immediate postpartum period. No direct evidence currently exists. None of the screening trials that demonstrated the effectiveness of screening were conducted during the immediate postpartum period.

A limited number of validation studies use non-English language EPDS to screen in the immediate post-partum period. However, they assessed outcomes of major and minor depression or any depressive disorder, in which an EPDS cut-off of 10 is typically used. Overall, no validation studies of the English-language EPDS were found that screened for major depression with a cut-off score of 13 or greater, which were done during the immediate postpartum period.[9] Two validation studies of the EPDS using major depression as an outcome included a small number of women from the immediate postpartum period and did not report their results separately for this time period. A challenge to screening women in the immediate

postpartum period is that this is when baby blues typically occur. In addition, screening in the immediate postpartum period could potentially miss women who develop depression after that time point.

The decision about the timing of public health screening will also be influenced by how the health unit plans to access pre- and post-natal women. Universal screening holds the greatest potential to identify women at risk of or experiencing depression. However, it is the most resource- intensive. Consequently, health units may opt to screen targeted populations of women and/or all women who participate in an existing program (e.g., prenatal education, breastfeeding clinic, parent support line). In addition, PHUs do not need to be the only service provider in the community who is screening. Other community service providers, including primary care providers, may be engaged in screening activities as part of the community system of care.

How to Screen?

Table 5.2.5: HHDT Statement #12

HHDT Statement	Description	Rating
HHDT Statement #12	Existing evidence supports public health units to use the Edinburgh Postnatal Depression Scale (EPDS) as an evidenced-based screening tool, effective in identifying women at risk for, or experiencing, symptoms of perinatal depression.	Rated*: EB

*See description at beginning of this module

As stated previously, the USPSTF identified six trials that assessed the effectiveness of screening for perinatal depression, all using the EPDS. The COPE Guidelines also focus on the EPDS and recommend "the EPDS to screen women for a possible depressive disorder in the perinatal period."[2] While the RNAO Guideline does not recommend a specific screening tool, this is because "the research questions that shaped the systematic reviews focused on the identification of effective interventions to support the screening and assessment for perinatal depression."[4]

Public health nurses are skilled in the ability to engage with and collect assessment information from clients and therefore well suited to administer the EPDS. This ability is supported by the RNAO Guideline that identifies the nursing considerations for administering a perinatal depression screening test. They state that "when administering a perinatal depression screening

tool, nurses and the interprofessional team must i) recognize the person's information and support needs, ii) recognize the person's readiness for perinatal depression screening, and iii) integrate the person's cultural background and practices."[4]

Summary of Evidence Related to Screening

Table 5.2.6: Summary of Other Guidelines' Recommendations Related to Screening

Reccomendation	Source	Evidence Grade*
The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up. Note: based on net benefit to screening for depression in pregnant and postpartum women who receive care in clinical practices that have CBT or other evidence-based counselling available after screening.	USPSTF[3]	B
Routinely screen for risk of perinatal depression, using a valid tool, as part of prenatal and postpartum care.	RNAO[4]	Ia, IV, V
Use the Edinburgh Postnatal Depression Scale (EPDS) to screen women for a possible depressive disorder in the perinatal period.	COPE[2]	Strong EBR
Complete the first antenatal screening as early as practical in pregnancy and repeat screening at least once later in pregnancy.	COPE[2]	CBR
Complete the first postnatal screening 6-12 weeks after birth and repeat screening at least once in the first postnatal year.	COPE[2]	CBR

*See Module 1.3 Appendix A for evidence grade definition

Interpreting Screening Results

Following screening, the next step is to interpret the results. This includes determining which EPDS scores represent risk and/or actual symptoms of depression, and the use of clinical judgement (including a psychosocial assessment), to decide about the appropriate response.

EPDS Score of 13 or Over

Table 5.2.7: HHDT Statement #13

HHDT Statement	Description	Rating
HHDT Statement #13	Existing evidence supports public health units to establish a score of 13 or more on the EPDS to trigger a referral to primary care and/or community services for assessment	Rated*: EB

HHDT Statement	Description	Rating
	and intervention.	

*See description at beginning of this module

The cut-off score for risk and/or actual symptoms of major depression varies among PHUs using the EPDS tool to screen. The evidence points to using a cut-off score of 13 for detecting symptoms of major depression in both the antenatal and postnatal periods.[3] The USPSTF identifies that an EPDS score of 13 is effective in identifying women with likely major depression while avoiding false positives.[3] Similarly, 13 is the cut-off recommended by the COPE Guidelines.[2] This cut-off does not mean that all women who score 13 or more are experiencing major depression; about 35%-50% of women with a score of 13 or more will have major depression (so conversely, 50-65% of women with a score of 13 or more will not have major depression).[10] Consequently, determining whether a woman has major depression requires a referral for diagnostic assessment and, if necessary, treatment. Based on the outcome of the diagnostic and intervention services, it may be appropriate at times to also refer this mother to public health and community-based mental health promotion supports. For simplicity, this additional option is not shown in Figure 5.2.1.

EPDS Score of 10-12 → Repeat Screen

For a score of 10-12, there is a lack of clarity in the evidence regarding appropriate follow-up. The COPE Guidelines include a consensus-based recommendation: “For a woman with an EPDS score between 10-12, monitor and repeat the EPDS in 2-4 weeks as the score may increase subsequently.”[2]

Depending on the screening model a health unit adopts, and the range of services they provide, repeating the EPDS may or may not be feasible. For example, it may be possible to repeat an EPDS administered by a public health nurse on a client receiving high-risk HBHC home visiting on a subsequent visit. However, it may not be possible to repeat an EPDS administered with a client attending a drop-in breastfeeding clinic. In this case, arrangements may exist within the community system of care to refer the client to a community service provider (e.g., family physician).

EPDS Score of 9 and Under

The EPDS identifies that women who score under 10 on the tool are not at risk. These women can manage the stress of being a new mother through the promotion of positive mental health and self-care strategies, e.g., getting sleep, asking friends and family for help, drinking plenty of fluids, eating a good diet and getting exercise.[11] Women can be made aware of sources of information and community supports. If they develop increased symptoms or concerns, they should seek assistance.

Positive Response to Q10 → Safety Plan

Question 10 asks whether the woman has experienced any thoughts of harming herself in the past 7 days. Any positive response (yes, quite often or sometimes) to this question requires further follow-up, regardless of overall EPDS score. These women should be managed in accordance with the PHU's suicide prevention policy and procedures, including the development of a safety plan for the woman and her child(ren). It is likely this includes an immediate and urgent referral to diagnostic and intervention services. This is also required when the woman has, or is suspected to have, a recurrence or new onset of severe mental health disorder (e.g., bipolar disorder, psychosis). An immediate referral to Child Welfare is required too if the health care professional believes there is risk of harm to the infant and/or other children in the woman's care.

Apply Clinical Judgement throughout Process

Table 5.2.8: HHDT Statement #14

HHDT Statement	Description	Rating
HHDT Statement #14	Best or promising practices support public health units to build the capacity of their Public Health Nurses (including HBHC) to administer and interpret screening results using clinical judgement, within the context of a psychosocial assessment of the woman and an assessment of the mother-infant dyad.	Rated*: BP

*See description at beginning of this module

Clinical judgement is defined as the "cognitive or thinking process used for analyzing data, deriving diagnoses, deciding on interventions, and evaluating care."[12] In the context of the public health care pathway, clinical judgement is the process by which a health professional (i.e.,

public health nurse) collects a range of data (including psychosocial information), analyses and interprets that data, develops a (nursing) diagnosis and identifies an appropriate course of action.

While the Framework provides guidance on interpreting the EPDS scores, clinical judgement is needed to identify an appropriate course of action. For example, for scores less than 13, professionals can highlight a range of potential mental health promotion activities. Furthermore, there may be clinical suspicion based on the psychosocial assessment that a woman may be under-reporting her symptoms, or that her EPDS score is elevated because of a recent time-limited stressor. In addition, the developers of the EPDS suggest "caution when interpreting the scores of mothers who are non-English speaking and/or use English as a second language or are multicultural."[11] Tailor the course of action accordingly in such circumstances. Public health nurses possess the skills necessary to apply clinical judgement to interpreting the screening results and identifying appropriate follow-up.

Applying clinical judgement related to the Public Health Perinatal Mental Health Care Pathway requires a psychosocial assessment of the woman and an assessment of the mother-child unit. This is generally a nursing assessment or series of questions that identifies psychosocial risk factors (Module 2.1) in the perinatal period.[13] Details may include:

- the pregnancy and postpartum experience
- history of present illness-on set
- symptoms
- severity
- psychiatric history and treatments
- medical/surgical history
- allergies
- medication list
- alcohol and recreational drug use
- 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

Clinical judgement also pertains to the dyad. There is increasing evidence that poor maternal health can disturb the mother-infant relationship, potentially with long-term effects and poor infant outcomes[14] (Module 2.1). When women experience mental health disorders in the postnatal period, give consideration to the infant's well-being and the quality of mother-infant interaction. The COPE Guidelines state that it is important to see the mother and infant together and observe their interaction.[2]

While all PHNs possess the ability to complete a psychosocial assessment, the degree of training that will be required to ensure that PHNs have the skill to conduct a psychosocial assessment specific to perinatal women and to assess the mother and infant dyad will depend on the screening model that the PHU has developed as part of their care pathway. For example, PHNs who deliver the HBHC program have been trained and certified through Nursing Child Assessment Satellite Training (NCAST) and complete a detailed psychosocial assessment through the HBHC In-depth Assessment (IDA). PHN who do not deliver the HBHC program may require additional training. It should also be noted that it may not always be possible to complete a comprehensive psychosocial assessment or to observe the mother-infant dyad (e.g. if the screening is done over the phone). In these cases, the health unit pathway will need to consider a means of follow-up with the mother, such as referral to HBHC, other PHU family health services, or community resources.

Summary of Evidence Related to Screening Interpretation

Table 5.2.9: Summary of Other Guidelines' Recommendations Related to Screening Interpretation

Recommendation	Source	Evidence Grade*
Arrange further assessment of perinatal women with an EPDS score of 13 or more.	COPE[2]	Strong EBR
For a woman with an EPDS score between 10 and 12, monitor and repeat the EPDS 2-4 weeks later as her score may increase subsequently.	COPE[2]	CBR
Repeat the EPDS at any time in pregnancy and in the first postnatal year if clinically indicated.	COPE[2]	CBR
For a woman with a positive score on Question 10 on the EPDS undertake or arrange immediate further assessment and, if there is any disclosure of suicidal ideation, take urgent action in accordance with local protocol/policy.	COPE[2]	CBR
Assess the mother-infant interaction as an integral part of postnatal care and refer to a parent-infant therapist as available and appropriate.	COPE[2]	PP
Assess psychosocial risk factors as early as practical in pregnancy and again after birth.	COPE[2]	PP
Consider language and cultural appropriateness of any tool used to assess psychosocial risk.	COPE[2]	CBR

*See Module 1.3 Appendix A for evidence grade definition

Referring for Support, Diagnosis and Intervention

This part of the Public Health Perinatal Mental Health Care Pathway must closely align with the community system of care. This is necessary to ensure that services/resources are available to partners at all levels of the Mental Health Stepped Care Model (Figure 5.2.2). As noted in Module 5.1, the Stepped Care Model highlights, from a system-wide perspective, the types of providers and their differing, but complementary roles with respect to mental health. As this particular diagram is from the UK,[15] it is neither exhaustive nor prescriptive of providers and their roles in the Ontario context.

Figure 5.2.2: Mental Health Stepped Care Model

Focus of the intervention	Nature of the intervention
STEP 4: Severe and complex* depression; risk to life; severe self-neglect	Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multiprofessional and inpatient care
STEP 3: Persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions; moderate and severe depression	Medication, high-intensity psychological interventions, combined treatments, collaborative care** and referral for further assessment and interventions
STEP 2: Persistent subthreshold depressive symptoms; mild to moderate depression	Low-intensity psychosocial interventions, psychological interventions, medication and referral for further assessment and interventions
STEP 1: All known and suspected presentations of depression	Assessment, support, psychoeducation, active monitoring and referral for further assessment and interventions

*Complex depression includes depression that shows an inadequate response to multiple treatments, is complicated by psychotic symptoms, and/or is associated with significant psychiatric comorbidity or psychosocial factors.

** Only for depression where the person also has a chronic physical health problem and associated functional impairment.

Source: National Institute for Health and Care Excellence (NICE). Depression in adults: recognition and management. Clinical guideline (CG90) [Internet]. London, UK: National Institute for Health and Care Excellence (NICE); 2018 [cited 2018 May 30]. Available from: https://www.nice.org.uk/guidance/cg90. Used with permission.

In advance of screening, PHUs need to determine the range of interventions that they will provide. The decision to engage in screening activities establishes the health unit's role in Step 1 of the Mental Health Stepped Care Model. PHUs can also play an important role, along with community partners, in delivering Step 2 interventions.

Mental Health Promotion

There is a broad range of possible mental health promoting programs and services. Overall, the extent to which they have been researched, and the state of existing evidence for their effectiveness, are currently limited. For PHUs offering mental health promoting programs and services as part of their Public Health Perinatal Mental Health Care Pathway, the extent to

which these are offered to a particular client depends on the EPDS score and psychosocial assessment, as well as observations of the mother-infant dyad.

A mother with an EPDS score of under 10 can be made aware of public health and community resources that are available to promote positive mental health and healthy growth and development. Consensus from the COPE Guidelines supports that a mother with an EPDS score of 10-12 should be rescreened in 2-4 weeks to determine if her symptoms are worsening.[2] Public health (if feasible) or another community provider (including the family physician) could conduct this screening. To augment existing supports the mother may also be referred, with her consent, to public health and/or community resources and services. These may include:

- healthy growth and development and/or mental health promotion strategies/programs, that can be universal or targeted to high risk population
- interventions/programs that are targeted to perinatal women at risk for or experiencing mild symptoms of perinatal depression

To the extent that it is feasible, these resources and services should be available in a format that meets the client's needs; addressing access (e.g., transportation, child care), format (e.g., individual/group, print/web-based), language and culture.

Table 5.2.10: HHDT Statement #15

HHDT Statement	Description	Rating
HHDT Statement #15	Existing evidence supports public health units to include evidence-based and promising practice interventions in self-care, family and peer support, and psychoeducation as part of their care pathways and in coordination with the community system of care.	Rated*: EB

*See description at beginning of this module

Self-Care Strategies

Self-care strategies have the benefit of being low-cost, low-risk and self-administered interventions. All prenatal and postpartum women can benefit from engaging in self-care strategies during the challenging transition to parenthood. However, their effectiveness is difficult to measure. There is limited consistent evidence that relaxation, physical activity, healthy eating and healthy sleep habits promote good mental health in women at risk for, or

experiencing, systems of perinatal depression. The limited evidence is due to challenges of small samples sizes, high withdrawal rates, few trials, and weak-to-moderate methodological quality.[4]

The COPE Guidelines state that during pregnancy or following the birth of a baby, many aspects of a woman's life may be disrupted and can contribute to impaired mental health.[2] Similarly, the RNAO Guideline recommends that nurses "promote self-care strategies for persons at risk for or experiencing perinatal depression."[4]

Family and Peer Support

The PHO Evidence Brief on perinatal mental health interventions in a public health context found mixed results for the effectiveness of social support interventions.[9] "While some women experienced more positive feelings and reduced depressive symptoms, others experienced no benefits."[9]

The COPE Guidelines identify that significant others and extended family members can be:

- a vital part of a woman's care
- an important determinant of whether she seeks access to services and the success of her treatment plan[2]

The RNAO Guideline states that "when a person's partner, family members, or social network demonstrate a lack of understanding and compassion, are non-supportive or are abusive, persons with postpartum depression symptoms can experience further isolation and stigma."[4]

Both the COPE and RNAO Guidelines recommend encouraging the involvement of members of the woman's family and friends early in her care.

With respect to peer support, the evidence is also mixed. That's primarily because there is relatively little evidence on the variety of ways that women can access peer support: formal and informal, in person, by phone, through web-based programs, and lay or professionally facilitated.[16] The COPE Guidelines recommend advising women of the potential benefits of a social support group.[2] RNAO recommends encouraging women with symptoms to seek support from others.[4]

Public health can support women at risk for, or experiencing, perinatal depression by encouraging and facilitating familial and/or peer support. This can take a variety of forms, depending on available resources, such as:

- including family members in screening, education and treatment planning
- self-care strategies involving others (e.g., exercising with peers)
- referring screened women to community programs
- providing screened women with information about reliable web-based programs (e.g., Women's College Hospital Mothers Matter online support program for new mothers)
- planning and facilitating health-unit-delivered peer support programs by phone or in person

Psychoeducation

Psychoeducational interventions are defined as the provision of education and resources regarding emotional well-being. These can range from low-intensity activities such as the print materials or one-time information sharing, to higher intensity activities such as individual counselling and structured discussion groups.

Both RNAO and COPE recommend psychoeducational interventions.[2,4] The COPE recommendation is based on an evidence review by the UK's National Institute for Health and Care Excellence (NICE) of cognitive behavioural therapy or interpersonal psychotherapy (CBT/IPT)-informed psychoeducation, which indicated high-quality evidence from five studies for reductions in depressive symptoms that were statistically significant, but not necessarily clinically meaningful.[17]

Summary of Evidence Related to Mental Health Promotion

Table 5.2.11: Summary of Other Guidelines' Recommendations Related to Mental Health Promotion

Recommendation	Source	Evidence Grade*
At every antenatal or postnatal visit, enquire about women's emotional well-being.	COPE[2]	PP

Recommendation	Source	Evidence Grade*
Provide women in the perinatal period with advice on lifestyle issues and sleep, as well as assistance in planning how this advice can be incorporated into their daily activities during this time.	COPE[2]	PP
Promote self-care strategies for persons at risk for or experiencing perinatal depression including: - Time for self (level of evidence= IV); - Exercise (level of evidence = Ia); - Relaxation (level of evidence = Ib); and - Sleep (level of evidence = Ia, IV).	RNAO[4]	Ia, Ib, IV
Provide all women with information about the importance of enquiring about, and attending to, any mental health problems that might arise across the perinatal period.	COPE[2]	CBR
Advise women with symptoms of depression in the postnatal period of the potential benefits of a social support group.	COPE[2]	Conditional EBR
Encourage persons with perinatal depression symptoms to seek support from their partner, family members, social networks and peers, where appropriate.	RNAO[4]	Ia, Ib, IV
Provide or facilitate access to psychoeducational interventions to persons at risk for or experiencing perinatal depression.	RNAO[4]	Ib

*See Module 3.1 Appendix A for evidence grade definition

Mental Health Diagnostic Assessment and Intervention

Women with an EPDS Score of 13 and higher should be referred to mental health diagnostic assessment and intervention services.[2,3] It is also possible that women with a lower score would be referred based on the PHN's clinical judgement.

There is no specific recommendation regarding the role of public health with respect to delivering psychosocial and/or psychological interventions, beyond referral to available community services as identified in the community service pathway. However, there is a history of some PHUs participating in pilot projects and/or research on psychological treatments. In addition, some PHUs have described being a partner in community-based treatment programs. Therefore, a brief description of the evidence related to non-directive counselling and psychological therapy is provided below.

Non-directive counseling

The Cochrane review describes non-directive counseling as being "based on the understanding that, in many situations, people can resolve their own problems and the counsellor's role is to encourage the person to express their feelings but not suggest what decision the person should make. By listening and reflecting back what the person reveals to the counsellor, the counsellor helps them to explore and understand their feelings and make the decision that is best for them."[16]

The RNAO Guideline identifies that "non-directive counselling reduces perinatal depression symptoms, however, the findings are limited".[4] The RNAO Guideline also states that non-directive counselling "can be effectively provided as a type of psychosocial support for postpartum depression in both individual and group formats, and it can be facilitated by trained nurses or members of the interprofessional team".[4]

Psychological Therapy

The 2016 Canadian Network for Mood and Anxiety Treatments (CANMAT) Guidelines make evidence-based recommendations for the treatment of major depressive disorders. First-line treatment for mild-to-moderate depressions is CBT or IPT.[10] The PHO Evidence Brief identifies positive results for psychological interventions: "Pooled data from multiple studies reported that psychological interventions had a greater effect size than usual care in reducing perinatal common mental disorders."[9] Similarly, the RNAO Guideline identifies that CBT "can be used effectively as a first-line treatment for persons with mild to moderate perinatal depression; for those with severe symptoms, psychotherapy can be effective when combined with medications."[4]

Summary of Evidence Related to Referral and Interventions

Table 5.2.12: Summary of Other Guidelines' Recommendations Related to Referral and Interventions

Recommendation	Source	Evidence Grade*
Provide structured psychoeducation to women with symptoms of depression in the perinatal period.	COPE[2]	Strong EBR
Recommend individual structured psychological interventions (cognitive behavioural therapy or interpersonal psychotherapy) to women with mild to moderate depression in the perinatal period.	COPE[2]	Strong EBR
Provide or facilitate access to professionally-led psychosocial interventions, including non-directive counselling, for persons with perinatal depression.	RNAO[4]	Ia, Ib
Provide or facilitate access to psychotherapies, such as cognitive behavioural therapy or interpersonal therapy, for perinatal depression.	RNAO[4]	Ia, Ib

*See Module 3.1 Appendix A for evidence grade definition

The Public Health Perinatal Mental Health Care Pathway framework presented in this module gives PHUs a tool for developing their own care pathway, guided by evidence and best practice. Health units can use this information to help decide how to engage individual women at risk for and/or experiencing symptoms of perinatal depression. When making decisions about referral and interventions, in the context of a comprehensive population health promotion approach to perinatal mood disorders, coordination with available primary care and community services and resources will be important.

Involvement in Research and Evaluation

The limited state of existing evidence for the effectiveness of perinatal mental health promotion gives public health an opportunity to participate in research and program evaluation to build the evidence base for these approaches. Similarly, more information is needed on the effectiveness of, and feasibility for, public health involvement in providing psychological therapy and other interventions.

Table 5.2.13: HHDT Statement #16

HHDT Statement	Description	Rating
HHDT Statement #16	Best or promising practices support public health units to	Rated*: BP

HHDT Statement	Description	Rating
	participate in efforts such as research and program evaluation, as feasible, that will build evidence and contribute to identifying promising practices regarding public health approaches to perinatal mental health promotion and interventions.	

*See description at beginning of this module

Practice Examples from the Field

The following practice examples can help PHUs to understand and consider how to apply key concepts from this module. These examples were independently developed by PHUs and other partners. They are not products of the HHDT, nor has the HHDT evaluated or critically assessed their quality.

Niagara Region Public Health & Emergency Services-Care Pathway:

Identifying and Supporting Women with Perinatal and Postpartum Mood Disorders

Niagara Region Public Health & Emergency Services has developed a detailed perinatal mood disorder care pathway which provides clear direction and information about:

- assessment guidelines
- referral and support guidelines
- community mental health support services
- crisis and emergency support services
- positive response to EPDS Question #10 action

Niagara Region Public Health & Emergency Services has also developed Public Health Nurse Guidelines to support the care pathway that addresses:

- risk factors
- signs and symptoms
- treatment
- client support

- referrals from primary healthcare providers
- screening
- support
- research recruitment for a study of a non-medication treatment for PPD (women over 18 years of age who have given birth within the last 12 months are eligible)

Attachments:

- Niagara Region Public Health Nurse (PHN) Guidelines
- Niagara Region PHN Guidelines Supporting the Care Pathway for Identifying and Supporting Women with Perinatal and Postpartum Mood Disorders

To learn more about these resources, contact Niagara Region Public Health & Emergency Services, or Anne Biscaro, Chief Nursing Officer and Director, Family Health at anne.biscaro@niagararegion.ca.

Peel Health – Peel Perinatal Mood Disorder Pathway for Family Health Public Health Nurses

This care pathway provides family health public health nurses with criteria-based direction on how to identify, screen and respond to clients at risk for perinatal mood disorder. The pathway is applied to clients who are pregnant or had a baby in the past 52 weeks. These clients are asked four key questions; the answers to which can trigger screening using the Edinburgh Postnatal Depression Scale tool. PHN action is based on EPDS scores of 12 or more (nine or more for the translated tool) and/or a positive response to question #10. (Note: this care pathway currently uses a cut-off score of 12 – the health unit has indicated that it will be reviewing that practice based on the evidence provided in this Toolkit.)

Attachment:

- Peel Perinatal Mood Disorder Pathway for Family Health Public Health Nurses

To learn more, contact Region of Peel – Public Health, Family Health Multichannel Contact Center at 905-799-7700.

Physician Referral Letters

Ottawa Public Health

Ottawa Public Health has developed a form letter that supports public health nurse referral of Healthy Babies, Healthy Children clients to primary care providers. When a client has a positive EPDS score, the PHN encourages his/her client to access her care provider for a more comprehensive assessment.

Based on client preference and consent, the client may take a copy of her EPDS to her physician herself, or, with her consent, it may be faxed by the PHN to the physician. Follow-up is then ensured with the client and her care provider. This facilitates communication regarding the mental health of the client, including providing a copy of the EPDS. The letter is available in French and English.

Attachments:

- Physician Referral Letter – English
- Physician Referral Letter – French

To learn more, contact Louise Gilbert, Clinical Nurse Specialist, Healthy Growth and Development, Ottawa Public Health at louise.gilbert@ottawa.ca.

York Region Public Health – Health Care Provider Letter

To better engage health care providers in supporting women with depression and signs and symptoms of anxiety in the perinatal period, York Region Public Health created a Health Care Provider (HCP) Letter. When public health nurses (PHNs) offer the HCP letter, the PHNs will:

- facilitate a conversation with their clients to address any concerns they might have about bringing the letter to their HCP; and
- follow up after the letter has been taken to the client's HCP to ensure there is no negative impact on the client.

The original copy of the HCP letter is attached to the EPDS and given to the client so she has the option of taking these to her HCP to discuss what follow up may be needed, particularly if her

score is remaining the same or increasing. PHNs will use their judgement in deciding to speak with the client's HCP and faxing the EPDS directly to the HCP.

Attachments:

- York Region Client Follow-up – EPDS Tool

To learn more, contact Valerie D'Paiva, Child and Family Health Manager, York Region Public Health at valerie.d'paiva@york.ca.

York Region Public Health – Transition to Parenting

York Region Public Health (YRPH) is committed to supporting families experiencing challenges with the transition to parenting or coping with perinatal mood disorders (PMD) anxiety and/or depression. To support families, YRPH began offering the Transition to Parenting (TTP) program in 2001.

TTP is a 12- week psycho-education group for new and expecting parents offered across the Regional Municipality of York. TTP promotes positive parenting and coping skills among new parents. The target audience of the program includes higher risk new mothers, specifically women experiencing PMD, anxiety and/or depression in York Region.

The TTP program was evaluated to determine if the program was meeting its objectives of increasing knowledge, confidence, coping skills, enhancing parent relationships and providing an opportunity for participants to share experiences. A mixed method approach used qualitative and quantitative data collected from participating parents over five years from January 2011 to December 2015 (note: this did not include all participants).

Highlights of results from the Edinburgh Postnatal Depression Scale (EPDS) scores include:

- For each year and for all years combined, before-program EPDS scores are higher than after-program median scores. A higher EPDS score represents a higher possibility or probability of depression.
- Median scores for each year and when all years were combined, decreased to below a score of 10. Based on the findings, the EPDS scores for each year, and when all years

were combined, were statistically significantly lower after attending the TTP program as all p-values were lower than 0.01.

To learn more, contact York Region Public Health at accessyork@york.ca or the project lead, Valerie D'Paiva, Manager, York Region Public Health, at valerie.d'paiva@york.ca.

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