



Perinatal Mental Health Toolkit for Ontario Public Health Units

Module 5.1: Building a
Community System of Care

Module 5.2: Developing a
Public Health Care Pathway

November 2018

Modules 5.1 (Building a Community System of Care) and 5.2 (Developing a Public Health Care Pathway) are part of the Perinatal Mental Health Toolkit for Ontario Public Health Units. To view the full document and additional resources please visit [Healthy Human Development Table Toolkit webpage](#).

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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 UK⁴ 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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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.

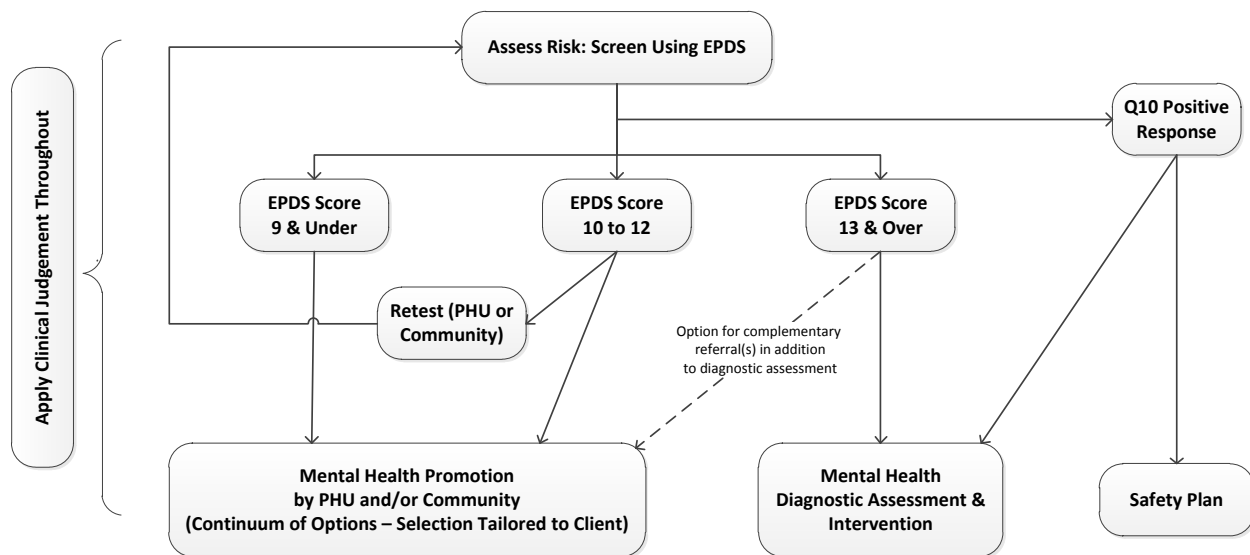
Creating a PHU's Perinatal Mental Health Service Pathway begins with planning. This includes completing a situational assessment (Module 3.1), along with a population health assessment and related surveillance (Module 3.2). This should include engaging the community (Modules 4.1 and 4.2) with a view 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 RAO 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 there is no conclusive evidence regarding the specific timing during these periods (particularly during the	Rated*: BP

HHDT Statement	Description	Rating
	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 is 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 and intervention.	Rated*: EB

*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 outcomes¹⁴ (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 plan²

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
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:	RNAO ⁴	Ia, Ib, IV

Recommendation	Source	Evidence Grade*
<ul style="list-style-type: none"> <input type="checkbox"/> Time for self (level of evidence= IV); <input type="checkbox"/> Exercise (level of evidence = Ia); <input type="checkbox"/> Relaxation (level of evidence = Ib); and <input type="checkbox"/> Sleep (level of evidence = Ia, 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 participate in efforts such as research and program evaluation, as feasible, that will build evidence and	Rated*: BP

HHDT Statement	Description	Rating
	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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