Summary of Discussions

Topic A: Professionally led Postpartum Support Groups
Note Taker:

Suggestions made regarding existing programs and resources:

Participants began this discussion by surfacing a number of questions related to postpartum support groups. What are challenges of these groups? What are solutions, new ideas for support groups? How do you structure groups? As well, they looked at how to best use the present resources and how to seek additional funding.

In reviewing these issues a number of ideas were offered. For example, it was suggested that funding proposals should consider all aspects of running a drop-in centre (cost of food, transportation, childcare and facilitation). The cost of transportation could be covered through social services via Public Health. All of these services and supports would help to increase accessibility and attendance.

In terms of structure one idea was to offer 10 topics over 6 weeks to a closed group. On the other hand, a 10 week structured program is offered in Sarnia. However, if a client needs services immediately, they are seen on an individual basis. Topics for discussion could include education and support (based on Pacific Postpartum Departmental Groups)

Discussions around who should facilitate (professional vs. peer), led to the suggestion of peer-led training for groups. Some felt that a male facilitator would be helpful. In general though it was felt that the role of the facilitator is to ensure positive discussions that avoid male/female “bashing”. In fact, the point was raised that holding “couples evenings” would help marriages. Similarly, regular monthly “family sessions” might increase attendance by fathers.

The advantages of open vs. closed groups (drop in vs. registered) was also explored, as was the issue of how to increase attendance and engage clients. In general clients hear about support groups early on through PP/PHN and then at OEYC. Referrals are also made through HBHC staff. Partnering with FHV also brings Moms to the group. Nevertheless it was thought that additional education for agency staff would help to increase referrals to PPD support groups.

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Participants discussed the beauty of partnerships and the benefits they bring, including an ability to do more and to address liability issues, as well as a potential increase in funding. Clients are provided with "one-stop-shopping" to obtain the information and resources they need. Examples of such partnerships included Toronto Public Health Coalition with Toronto East General Hospital and South Riverdale Community Health Centre. This could be a future recommendation for the Reproductive Life Stages Program at Women's College Hospital/Sunnybrook Hospital. We could also explore other programs such as what is offered through "our sisters' place" through the Mood Disorders Association of Ontario.

Looking at the issue of peer v. professional facilitators, some felt that while professional facilitators are able to be objective and ask leading questions, peer-led sessions can be more subjective. Boundaries for all involved need to be clear from the beginning in all types of support.

A number of issues were raised, including:

- Childcare
- Locations
- Number of Human Resources
- Group Size
- Wait Lists
- Length of stay in support group

Topic B: Developing Care Paths and Guidelines
Note Taker: Kim Marshall

Suggestions made regarding existing programs and resources:

Participants shared that they occasionally receive calls from Moms suffering from PPD. They try to educate Moms over the phone and make referrals to HBHC, EAP, physicians, and mental health clinics. Breastfeeding issues are addressed by staff on the PHN information line.

It seems that the telephone is a crucial way for moms to connect to the assistance they need. One advantage is that it provides anonymity. However, when the Region is so larger accessibility is a barrier. *

One suggestion made regarding addressing gaps in developing care paths is to develop provincial/federal care path/guidelines that are followed by every nurse and health care provider. One possibility was to use CAMH guidelines.

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Topic C and D: Education of Volunteers and Peer Support
Note Taker: Tosca Milanovic
Note: Taker: Sue Gierszewski

Suggestions made regarding existing programs and resources:

In discussing the best way to train volunteers around PPMD a number of factors were raised. For example, volunteers need access to constant support and ongoing training/education. As well there should be clear expectations about their role. In general though volunteers do not meet with Mom until at least the 8th week and consequently it was felt that police screening was not required. However, it was also suggested that volunteer could be used to provide child care for group meetings.

They also need to be trained to be cautious regarding things like self-disclosure and boundary setting as some client are very needy and may need to be restricted to 1 – 2x / week in general. As well it was thought to be important to assist volunteers in knowing how to determine if a woman has been "healed".

While one group suggested that Best Start could provide resources and hands-on help, other resources were discussed. For example, Oakville OEYC has a planning support group that meets twice a month and provides child care, whereas the Guelph program offers group and telephone peer support at once weekly meetings. However it was noted that Guelph had problems keeping up with inquiries from telephone volunteers but had good attendance at their monthly meetings. In at least one case it was reported that telephone volunteers were trained by PASS – CAN.

A number of discussions advocated to have Cindy Lee's peer support 4 hour training program implemented while others suggested the 6 week session training (once / well) for recovered moms in Calgary. The Pacific PP Support Society was also discussed as a valuable resource.

In general there was felt to be a lack of referral sources and of genuine recognition for the work done by volunteers. Providing food over the lunch hour is certainly something that could be considered for future training programs.

Suggestions made regarding addressing gaps on that topic:

While two of the groups did not provide suggestions, one offered a number of ideas that included have peer support built into the existing groups, and providing training in crisis planning and communications. As mentioned above, volunteers should be trained to establish and adhere to boundaries in their interactions with clients. The issue of liability

by agencies and organizations was also raised, specifically in relation to the selection and acceptance of volunteers by the agencies.

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Topic E: Creative Ways to Access Funding
Note Taker: Monica Irwin

One of the challenges faced by agencies is finding permanent, sustainable funding. Unfortunately government funding usually covers start up costs, but not operating costs. A number of creative options for fund raising were shared, including enhancing collaborations, particularly with For-Profit organizations (eg. Communications companies, Huggies, Drug Companies that make the two part prenatal vitamins, etc.) In addition to traditional events, such as golf tournaments and garage sales, it was suggested that a percentage of the profits from other events could be given to charity. It was also suggested that Moms could be asked to make a donation to cover some of the costs associated with providing support.

Another challenge relates to the writing of proposals, which requires specific skills and language. While some were willing to share the proposals (eg. Judy Jeswiet and the PMD support group proposal) it was also pointed out that proposals are difficult to work on as a group. It requires time and ability to focus as well as the right language. Agencies need to learn how to write good proposals, and it was suggested that it would be helpful to have something that is Ontario wide so that each area does not invent their own. Some believe that Best Start should put together a training program on how to write proposals and access funders.

Another participant indicated that the Research and Development program in their Health Unit helped to write the Trillium Grant proposal. Apparently Charity Village offers courses and lists all kinds of funding opportunities.

Mental Health is part of the new mandatory programs for Public Health. This could be a ray of hope that funding will come, although some felt that these programs are not expensive to run.

Cord Blood Banks have been funding some perinatal programs and may be an option when looking for private sponsors.

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Topic F: Provincial Perinatal Mental Health Network
Note Taker: Paola Ardiles

While it was suggested that Health Nexus could take on the coordination needed to create this network, participants agreed that it would be necessary to get this issue on

the political agenda to secure the resources and funding needed to support such a position. One approach would be to frame the issue where the current funding priorities lie, such as early childhood development.

The goal would be to gather together the key people and organizations at the local and regional levels to create an advocacy group with the ability to move into the political arena. For example, it would be helpful to recruit a key stakeholder such as a physician ((obstetricians, paediatrician) or national body like the CMHA, whose voice is more likely to be heard. It would also be helpful to find champions who would be able to involve other sectors.

Clear objectives and priorities for the network might include:

- Sharing resources / information while avoiding duplication
- Share best practices
- Capacity building / training
- Focus on promotion and prevention
- Children's services, Judicial, Education

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Topic G: Inter-Agency Collaboration
Note Taker: Amanda Allison

Suggestions made regarding existing programs and resources:

There are many benefits to inter-agency collaboration, including the ability to identify gaps and to "homogenite" the language. The overall goal is to ensure there is consistent messaging and care.

One suggestion was the introduction of the concept of antenatal doula support which is being considered by CAPPA Canada as a support option for women throughout the perinatal period.

Another initiative being undertaken by Niagara is the establishment of a community coalition which is currently working on an inventory of services.

Suggestions made regarding addressing gaps on that topic:

There were a number of gaps identified including "medical high risk" (i.e. a pregnant women's cancer, pre-eclampsia) and specific populations such as dads and single moms. These were suggested as programming areas that need more supports and could be taken on by collaboratives. Additionally there is an opportunity to find strategies that will increase the involvement of moms and consumers in inter-agency collaboration. One question that remains to be answered was whether or not coalitions should be made public.

It was agreed that there is a need for consistent, ongoing provincial funding, and that agencies should continue to look for funding opportunities to continue inter-agency initiatives. It was suggested that monthly meetings of 1.5 hours would be easier to commit to, and agencies could send alternative representatives if the usual member is unable to attend.

Best Start has a role to play in providing consultations for interagency collaboration and should continue to find ways to increase physician engagement. Some ideas to achieve this goal were:

- Make contact with secretaries to make aware of available resources
- Build relationships with front line staff in physician's office (i.e. nurse, assistant)
- Find a physician as advocate to inform other physicians
- Tap into medical school curriculum

Topic H: Health Care Provider Education
Note Taker: Francine Sakalauskas

Pathway for reporting / accessing help

One discussion group explored the question of an appropriate "pathway" for reporting symptoms. Whether the health care provider is a doctor, nurse or student, it is important that they recognize the need to report their concerns about patient behaviours/fears/anxieties as quickly as possible.
Two related topics concern the importance of keeping well documented written records of concerns, as well as access to written resources. One example would be making resources for PPD, referral places and supports for clients and patients available via the internet.

Additionally there was some concern about keeping up with the referrals, both in terms of responses but also in documenting the numbers to support efforts to try to shift government funding based on needs.

Educating Health Care Practitioners

Another concern was raised around helping health care providers gain the expertise needed to work with this population. They need to understand that these women are terrified. The statistics suggest that 1/10, 1/20 cases are serious enough to need attention; 30% of women have severe anxiety post partum. A system needs to be developed to provide health care providers with the information and resources they need to effectively care for this population. It was suggested that education could be part of the CAS phone call.

Educating Moms

Women need to know how common these problems with depression are. They should be educated to realize that they can be treated and that they won't have their baby's taken away just because they have this "problem".

While self-education is possible as a health care provider, moms also need to be educated. Unfortunately many health care providers are working with patients that have no family doctors. This complicates matters as there can be a high risk of anxiety and depression particularly in the NICU setting. What's normal and what's not? This makes interdisciplinary work and communication with others around PPD issues, even more important.

Educating Physicians

One thing participants agreed on is the need to provide physicians with more information and resources to ensure they are "on board" and can effectively care for /treat their patients. For example, they can be educated around acceptable medications for mood disorders during pregnancy and breast feeding. As well, other health care providers and staff can be educated to know what to pay attention to when screening patients. One suggestion was to use triage nurses to prioritize patients so that those with the most severe symptoms can be brought in more quickly. In general, there is a greater chance that they will ask about psychosocial symptoms if they know where they can refer the patient to.

Suggestions for educating medical professionals include the use of case examples (specific instances of individuals experiencing a real anxiety episode such as suicide or infanticide). It was felt that the details of such "typical case histories" would break through the "cognitive barrier" of the medical profession with their graphic images of death and dismemberment. Of course providing statistics is an important aspect of educating health care providers. However, it is also critical to provide them with details of the pathway (screen -> referral resources / instructions for referrals)

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Topic J: Working with Partners and family members
Note Taker:

Support system is needed for families.

Some participants shared their good experiences related to HBHC screening. Screening revealed that clients were depressed and there were concerns with medication, missing cues for baby care, accepting information and talking with other parent to encourage taking meds.

Much of the discussion centred around the role of “dad” and the need to see them as part of the solution. Some fathers feel they are stigmatized if they look outside for help. There are social expectations placed on them, such as being the “fixer” or the “gatherer”.   Dad’s need to be given the tools and resources (pamphlets, information) before baby is born so they know what PPD is, and what they can do to be supportive rather than critical. CAS can help to teach father’s what they role can be, encouraging them to listen to mother and not give advice. They could also be gatekeepers of visitors, and offer mothers a “dose of reality”, encouraging them to seek the support they need. This might include reaching out to extended family members to get support.

When there are additional family concerns and issues, or custody arrangements in place, this can add stress and blame. CAS can add to this stress. As well there is the stress of Dad having to go back to work, or being asked how often they call home when they do go back to work.

One important word of advice was to educate, and not make assumptions. Use strength-based capacity assessments as a tool.

Finally, it was suggested that it is beneficial for parents or family members to read to the child in their own language.

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Topic K: Strategies to promote attachment parenting
Note Taker: Barb Radmore
Note Taker: Cheryl Peltier

A number of discussions included a focus on teaching Mom’s to recognize or read baby’s cues and needs, while helping them to differentiate between unrealistic expectations and goals set by society.

Taking a “strength-based” approach to parenting was another suggestion, while other ideas included role playing, modelling of “appropriate” attachment activities and using video tapes to show positive interactions between Mom and baby. In addition to teaching Moms about attachment parenting, it was suggested that Public Health Nurses should also be educated about this issue.

The approach should be non-intrusive while engaging Moms in the process of identifying for themselves what works for them and what would be helpful. It was felt that a booklet for parents would also be helpful but is currently lacking in the health promotion community. The Best Start Resource Centre is currently translating one of its French resources “bébé veut” into English. This brochure helps parents understand what their baby is “saying” to them.

During pregnancy and in the immediate postpartum period parents should be taught how to hold and connect with their babies. Several suggestions for accomplishing this included promoting “skin-to-skin” contact at birth, bringing in a baby to show Mom’s what attachment looks like, and employing role models. When possible, it is a good idea to let moms take the lead in this. Baby/infant massage is also a strategy that can be taught easily, stimulates and soothes the baby and increases mother/infant attachment.

The La Leche League could help to provide both breastfeeding support groups and peer support.

Links with other community programs was encouraged (OEYC, Mother Goose, etc.) Some community partners have successful programs that could be shared (e.g. “Feelings after Birth program run in Wellington and Dufferin; Valley Infant Program, Brant’s PPMD group etc.)

Some felt that the “right from the start” program was too negative.

Suggestions made regarding addressing gaps on that topic:

A number of suggestions were made regarding how to address gaps in this area. Primary among them was the suggestion that, instead of expecting others to fix the gaps, we should work directly with the young mothers, who often have not been exposed to babies until they have had one. In some cases a home visit is a more comfortable setting for them to talk about their concerns. Other specific ideas included:

- Infant massage
- Parenting Groups
- Small Cell Groups
- Baby’s Second Night – to help parents and nurses understand infant behaviour in the first few days and nights.
- Decreased visiting in hospital or even at home may be strategy for some moms
- Websites for moms such as: KellyMom.com
- Using Family Home Visitors though HBHC programs
- Using and enhancing Ontario Early Years programs such as the PPD support group at Brant OEYC.

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