

Creating Circles of Support

for Pregnant Women and New Parents



A manual for service providers supporting women's
mental health in pregnancy and postpartum

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We especially want to thank the experts in the field, who generously provided their time and experience. They greatly contributed to the content of this manual and allow the readers to see a variety of perspectives on how “Circles of Support” can be created. Their advice and comments have also been expressed in the Examples from the Field and the “Bright Circles” throughout the manual. We could not possibly include all the wonderful programs in Ontario, but attempted to provide readers with a cross section of programs. Contact information about the featured programs is found in Part Four of this resource.

About this Manual

Screening, assessment and treatment of women with mood and anxiety issues during the perinatal period has gained momentum in Ontario over the last few years. Support has been recognized as an integral part of prevention and recovery. Many agencies aim to provide support to pregnant women, new mothers and their families. This manual is intended for health and social service providers working with pregnant women, new mothers and their families. It defines support and the circle of support women need during the perinatal period. It provides evidence and ideas from the literature and practice on how to help women create their own circle of support.



The information in the manual was gathered from many sources including academic literature, program evaluations, guidelines and interviews. And, although the concept of providing support is not new in perinatal mental health, research of effective practices is still emerging. Research has shown that providing individualized support is a promising strategy in the prevention and treatment of perinatal mental health concerns. We may expect programs and services that recognize and provide a measure of individualized support to be most effective and have provided a variety of resources and examples in this manual to assist service providers.

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Introduction

“Women suffer in silence” is a refrain often heard at perinatal mental health education forums. However, the entire family endures hardship when one or both parents struggle with poor mental health. The idea of a circle of support for an expectant or new mother and her family stems from our recognition that medical care alone is not enough to address depression, anxiety and other perinatal mental health concerns. What is it like for her at home when she leaves the physician's office? All too frequently, additional support for the family is needed. To our awareness, this manual is the first to discuss **what is support** [Part One: Perinatal Mental Health Concerns and Definition of Support] and **what types of support** can aid pregnant women or new mothers and their families when a significant perinatal mood disturbance occurs [Part Two: Creating Circles of Support].



Sara and Mo (names have been changed) had unplanned six-month old twins and a two year old boy. The situation at home was chaotic and grim: the parents were struggling to care for their family while dealing with their individual health issues and marital conflict. The babies were colicky and needed constant care. The two year-old was a beehive of activity and wanted attention. The grandparents could provide only limited assistance, and the couple, living on one income, was unable to hire additional help or access daycare. Sara, alone at home, was exhausted and depressed and Mo, under pressure at work and at home, was also struggling with moderate depression. How to help them?

Brainstorming with a friend and a public health home visitor and a bit of persuasion brought fast and much-needed relief. A short note was delivered to the neighbours' mailboxes on their street asking for volunteer assistance with childcare. One neighbour, having children of her own, offered to take the two-year old for a few hours two afternoons during the week, and one of the grandmothers gave assistance for the other weekday afternoons. A retired couple living nearby offered to walk the babies in a stroller. An arrangement was made with a local high school whereby two senior students helped with the babies at home some afternoons during the week for several weeks in exchange for school credit. This allowed Sara to have a break at home for two or three hours each weekday afternoon. Another neighbour dropped off oven-ready meals. Mo was encouraged to take the two-year old out to the playground on weekends or the Ontario Early Years Centre for one-on-one parent time. A therapist was contracted to make several house-calls for marital counselling (covered by Mo's work benefits), and the family home visitor, engaged through the Healthy Babies Healthy Children program, stopped by on a regular basis.

The inspiration for this manual arises out of our collective experience in working with women and families experiencing perinatal mental illness. The issue of **support** is rising in importance as many in Ontario [Part Three: Examples from the Field], across Canada, and around the world are looking at the care of women with perinatal mood disorders. To-date, much progress has been made from research related to risk factors, prevalence, detection, identification, and treatment of mood problems occurring during pregnancy or postpartum. Our aim is to enhance and extend this work, and to provide women, their families and healthcare providers with many **sources of information** [Part Four: Resources], as well as thought-provoking material about creating circles of support.

Leslie Born, MSc, PhD

Part One: Perinatal Mental Health Concern and Definitions of Support

Women's mental health, including the prevalence of mood and anxiety disorders across the lifespan, is a growing public health concern (Steiner, Dunn, & Born, 2003). Not only are chronic depression and anxiety taking a heavy toll on women, we are also keenly aware of their impact on children and families (Brandt, 2008).

History and Prevalence

The relationship between the postpartum period and psychiatric disorders has been noted since the time of Hippocrates (Demand, 1994). Mental health concerns have been identified as the most common complication during pregnancy and postpartum, with challenges to identification and diagnosis (Born, Zinga, & Steiner, 2004). More and more research is providing evidence that enhanced diagnosis, improved treatment options and early support will improve outcomes for the mother, her infant and the entire family and that health and social service providers are deciding to get involved much earlier.



The prevalence of postpartum depression is 13% postpartum (Brockington, 2004), and 10% of mothers require interventions during pregnancy (Johanson, Chapman, Murray, Johnson, & Cox, 2000). Higher rates are reported in adolescents (Mehta & Sheth, 2006). A range of perinatal anxiety disorders that include generalized anxiety, post-traumatic stress disorder, obsessive compulsive disorder, obsessions of child harm, panic disorder and a range of phobias is also common during the perinatal period. Their prevalence has been noted at 4–8%, but they are currently thought to be under-recognised and under-diagnosed. Some women experience significant irritability during pregnancy or postpartum, and while less well known, it can be as disruptive to health and daily function (Born et al., 2008).

All of these can range from mild to severe. Medical emergencies, such as postpartum psychosis, often related to manic depression, are relatively rare with an incidence of 1-2 per 1000 births (ibid).

Risk factors

Although perinatal mental health concerns can surface at any time, some women are more likely to be affected. Research studies have tried to identify who is at increased risk. Data from two large meta analyses and more recent studies show that women with one or more risk factors have a statistically increased chance of developing postpartum depression compared with women with none of the these factors (Ross, Dennis, Robertson Blackmore, & Stewart, 2005).

Strong risk factors include:

- depression or anxiety during pregnancy
- family history of depression
- previous history of depression or other mental health issue
- recent stressful life events
- lack of social support (perceived or received).

Moderate risk factors include:

- maternal personality (worrier, anxious, nervous)
- low self-esteem
- relationship difficulties.

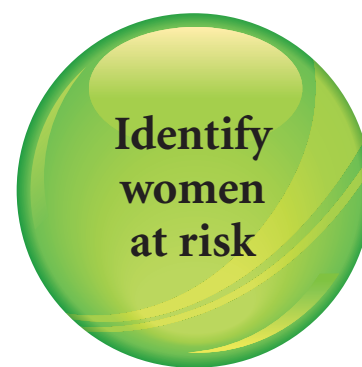
Weak risk factors include:

- low socio-economic status or change in socio-economic status
- obstetrical and pregnancy complications.

The following have no effect on perinatal mental health: ethnicity, maternal age (except teens), sex of child (except in some cultures), level of education or number of children (ibid).

The Postpartum Depression Predictors Inventory (Beck, 1998; Beck, 2002) was developed as a tool for healthcare professionals. It identifies the following factors to assess: the woman's relationship with her partners, her problem-solving style, her informal support system including friends with whom to talk, her previous psychiatric history, her self-esteem, marital status, social economic status and whether the pregnancy was unplanned or unwanted.

For practitioners who are not familiar with postpartum mood and anxiety disorders, key resources are listed in the resource section.



Theoretical Perspectives

Several etiological models are used in understanding perinatal mental health concerns, which are seen as bio-psycho-social in origin. The biological model suggests that hormonal changes during pregnancy and postpartum, along with predisposing genetic factors, contribute to perinatal mood and anxiety disorders (Holton, 2001). The stress and coping models link perinatal mental health issues to psychological stressors. Socially, the adjustment to motherhood can be a difficult process, highlighting the incongruence between the image of the serene, fulfilled mother and the realities of motherhood.

Social Support During Adolescence

A study looking at pregnant teens' experiences of receiving support shows how adolescents "piece together" the support they need from adults, peers and partners. Affecting this support were their relationships with their families and their babies' fathers, threats to their safety and their socio-economic status. The authors say the most striking finding of the study is the resilience and positive expectations the teens have – adolescent pregnancy can be a motivator for positive behaviour change.

(Logsdon, Gagne, Hughes, Patterson, & Rakestraw, 2004)

The literature emphasizes how social support, both formal and informal, helps women adjust to motherhood, assists women as they undergo hormonal changes and psychological stressors and promotes good mental health in new parents. It is also associated with higher indicators of maternal, child and family well-being.

So, *what is support*? It has been defined as a well-intentioned action given willingly to a person with whom there is a personal relationship that produces an immediate or delayed positive response (Huprey, 1998). It affects health in two ways: the direct-effect view is that it may have a beneficial effect on psychological health (Cassel, 1974); the buffering view states that social support mitigates the negative effect of stress on health (Cobb, 1976).



Supports

A 2008 paper describes the development, reliability and validity of a new instrument designed to assess aspects of social support related to the postpartum period. The scale, known as the Postpartum Social Support Questionnaire, consists of four factors: partner support, parent support, in-law support and extended family and friends support.

(Hopkins & Campbell, 2008)

We know support helps pregnant women and parents with newborns. While there are no randomized controlled trials endorsing universal postpartum support, a 2006 systematic review showed home visitation or peer support produced a reduction in depression scores, using the Edinburgh Postnatal Depression Scale for women at high-risk of postpartum depression and anxiety (Shaw, Levitt, Wong, & Kaczorowski, 2006). And while this manual will cite evidence for known clinical treatments such as cognitive and interpersonal therapies, it will also provide better practice guidelines for a variety of other interventions used in many community settings.

Underlying many of the creative ideas and programs is the theory of self-management which is becoming more prevalent in primary care and health promotion. These self-management principles empower women and validate a woman's desire to control her own treatment. (McGowan, 2008). Supported self-management outlines the concept where the individual participates in treatment to manage a chronic health condition and what various service providers can do to facilitate self-management. Programs are based on developing the confidence and motivation of the client to use her own skills and strength, information and professional services to take control over her own health. It is a useful approach to the building of individualized supports for women and families.



Self-Management Guide

The British Columbia Reproductive Mental Health Program has developed a guide about self-care for women with perinatal depression and anxiety. The British Columbia Provincial Government has included this self-management model in its four pillar framework: Addressing Perinatal Depression: A Framework for BC's Health Authorities. The pillars consist of

- education and prevention,
- screening and diagnosis,
- treatment and self-management and
- coping and support networks.

(see resources)

Using the concept of supported self-management, practitioners working with new parents and families affected by or at risk for perinatal mental health concerns, can assist them in creating their own individualized circle of support.

Collaborative Self-Management

Patients making daily decisions about their illness, such as depression and anxiety, “self-manage” their illness. The patient-professional relationship involves collaborative care and self-management education. Patients learn to problem solve, and develop self-efficacy to reach their goals. Evidence from controlled clinical trials suggests that programs teaching self-management skills are more effective than programs providing only patient information and education.

(Bodenheimer, Lorig, Holman, & Grumbach, 2002)

Support as a Healing Strategy

In sickness and in health, across the lifespan, women define themselves in terms of their relationships and connections to other people (Gilligan, 1982). As part of their connections, women typically receive and provide social support (Logsdon, 2005). The transition through pregnancy to parenthood is a time when social supports are associated with a woman's ability to cope (Cutrona, 1982). Support comes from many areas: the partner (emotional); friends or home help (instrumental such as help with chores), peers (informational) and professional (therapeutic interventions), but is not limited to one type of support coming from one person.

Social support has been associated with health and avoidance of disease in research studies since the 1970s (Cassel, 1974) and is associated with positive self-evaluation of parenting skills and lower stress levels (Reece, 1993). Logsdon's Postpartum Support Questionnaire is based on the premise that social support has a buffering effect between stress and health or illness outcomes (Logsdon, 2003). The mother's perception of the amount of positive support she receives is key (Hung, 2004). Logsdon and McBride (1994) classify social support into four categories (separate from professional support):

1. Material (meals, laundry, money, care of other children, taking on mother's duties)
2. Emotional (encouraging, affection, approval, feelings of togetherness)
3. Informational (sharing information, finding new information, helping to solve problems)
4. Comparison (help given by someone in a similar situation)

Logsdon cautions that social support is expected to vary by culture. Role expectations for partners or other close relatives can vary (ibid). This includes how independently the mother is expected to function. There is considerable variation by culture of the importance of the individual within a group (e.g. the mother might not feel free to ask for help in a culture where group needs are considered above individual needs). Partner support may take on increased importance for immigrant women whose family and friends remain in the country of origin (Zeklowitz et al., 2008).



Partner Support

A 2006 study examined the influence of maternal perceptions of conflict and partner support on the development of depressive symptoms in the first eight weeks postpartum. The study found that women with depressive symptoms at eight weeks postpartum had significantly lower perceptions of relationship-specific and postpartum-specific support from their partner and significantly higher levels of relationship conflict than women with no depressive symptoms. The study concluded that maternal perceptions of partner support through problem-focused information and positive feedback are important in determining maternal mental health. In the antenatal period, health care providers could teach couples ways to provide feedback and communicate expectations, especially those relating to infant care. Emotional support will help the mother feel accepted and cared for. Partners should also help with household tasks and infant care to protect the mother from becoming overwhelmed.

(Dennis & Ross, 2006)

Part Two: Creating Circles of Support

In this manual, we have conceptualized healing supports in the following four categories:

- instrumental,
- informational,
- emotional and
- therapeutic support.

We will explain them in more detail with some ideas and options to try. This is meant to be a guide; care providers and parents will have many other practical ways of helping families. The bright circles throughout part one, two and three are quotes and tips from the practitioners who contributed to this manual.



Instrumental support

This refers to practical help given to the mother and her family. One of the best pieces of advice to give to partners is to let the mother focus on resting and feeding the baby, while the partner or significant other takes care of everything else. Lack of sleep is common for parents of newborns, due to the demands of feeding schedules and infant care. However, the relationship between sleep and depression is complex. Lack of sleep has been observed to be both a risk factor for and a consequence of depression (McCall, 2008). Options should be explored to help the mother increase her sleep. Strategies that have been beneficial to some mothers include: sleeping when the baby

sleeps, having naps during the day, limiting visitors and phone calls. At times, the partner can help by giving one of the night-time feeds so the mother can get a longer stretch of sleep. The mother can express milk during the day for one of the night-time feedings. If anxiety is a problem and the mother is unable to relax enough to get back to sleep after feedings, relaxation therapy or a mild sedative may be helpful.

Sleep

A critical review done by Ross, Murray, & Steiner (2005) looked at the relations between sleep and postpartum depression, and sleep-based interventions for the treatment and prevention of perinatal mood disorders. Evidence-based research in this field is limited. The review indicated the interaction between sleep and perinatal mood disorders is significant. Reduction of sleep-deprivation during the perinatal period may offer a cost-effective method for the prevention, and potential treatment of postpartum depression and psychosis. As well, improvements in the child's sleep have been associated with improvements in maternal depression.

Some hospitals in Ontario have implemented strategies to minimize sleep-deprivation during the postpartum stay. These include maternal choice regarding whether the infant rooms in or stays in the nursery, increased duration of the hospital stay and limited visiting hours.

(Ross et al., 2005)

**Assess sleep,
it is vital.**

Instrumental support can also be offered by extended family members, or paid help such as a home-care company, night nurse or postpartum doula. Spending a little bit of money or using family or community resources during those first few weeks helps get the mother off to a good start. This type of help can consist of cooking or ordering in meals, hiring a childcare worker for other siblings or paying a dog walker. Mothers who are used to doing everything may need a bit of coaxing to accept an extra set of hands around the house. They may need help, to assess the support they receive and ensure they accept and receive non-judgmental support.

Breastfeeding

A 2007 study looked at patterns of exclusive breastfeeding, combination feeding and exclusive bottle-feeding among a sample of 122 women at 2-4 weeks postpartum with positive depressive symptoms. Severity of depression was not significantly related to breastfeeding. Older maternal age, living with a partner, and higher income were positively related to breastfeeding.

This study's results indicate it is possible to maintain breastfeeding in the context of symptoms of depression. The level of breastfeeding may be affected in some cases, but complete weaning is not necessary or desirable. Being able to continue breastfeeding may be emotionally beneficial for many women.

It is important to assess breastfeeding intent and continuation in conjunction with postpartum depression and anxiety, and to consider what breastfeeding means for the mother. Recognizing and treating postpartum mood and anxiety disorders can enhance the breastfeeding relationship, resulting in health benefits for mothers and infants, and increased satisfaction for mothers.

(McCarter-Spaulling & Horowitz, 2007)

Breastfeeding is beneficial to both mother and infant, and thus should be thoroughly supported. Sometimes breastfeeding is the only positive thing a depressed mother believes she is doing well. It may also be the only time she feels connected to and bonded with her infant. Breastfeeding hormones are known to promote feelings of relaxation, well-being and increase deep sleep (Blyton, Sullivan, & Edwards, 2002). Many medications can be used safely while breastfeeding. Regarding the use of medications during breastfeeding, please contact Motherisk for information on this topic (see resources). If breastfeeding is not a positive experience for the mother and this is increasing her symptoms of depression or anxiety, she should be given the option to discontinue or consider partial breastfeeding. Discontinuation of breastfeeding can lead to feelings of guilt that need to be addressed as well.



More on Breastfeeding


There is no conclusive evidence linking breastfeeding issues and postpartum depression or anxiety, says psychiatrist Dr. Ariel Dalfen, who notes that many cite nursing issues as a huge trigger. Intense pressure to breastfeed triggers feelings of guilt and inadequacy for those who can't or choose not to nurse. Those feelings, in turn, can trigger depressive episodes and severe anxiety. For women with histories of sexual abuse, breastfeeding can be uncomfortable. Dalfen also notes that depression can follow weaning due to the hormone shift in women vulnerable to mood changes related to hormonal fluctuation.

(Dalfen, 2009)

Informational support

New parents need learning opportunities to help them master the learning curve of parenthood. Parents facing perinatal mood and anxiety disorders are even more in need of information about what the mother is going through and extra advice on coping and self-care. In addition, informational support can help them realize other parents are going through similar situations. Contacting a local public health unit or the hospital where the baby was born can provide community links them to programs providing such opportunities or take-home resources.

This type of support can be offered through classes for expecting and new parents, postpartum depression support groups or presentations on perinatal mental health. Books, printed resources and the internet can be an important source of help to parents who are housebound for the first few weeks. Directing parents to respected websites can be useful, as the overload of information online can also be a stressor.



Provide prenatal education and information to partners and other family members.

Prevention of Postpartum Depression

A 2005 study of psychosocial and psychological interventions to prevent postpartum depression in mothers with risk factors concluded that diverse interventions do not significantly reduce the number of women who develop postnatal depression. This meta analysis, looking at 15 trials, showed the only intervention that had a clear preventive effect was intensive postpartum support provided by a health professional. In addition, individual interventions were more effective than group interventions.

(Dennis, 2005)

Emotional support

New parents need emotional support. They need to be validated that they are doing a good job. A comment that often brings relief is “new babies don’t come with a manual.” Mothers often feel they are supposed to know how to take care of an infant simply because they are female. New parents benefit from spending time with other new parents to share experiences, and from the support of family and friends who already have children.



Impact on Children

In addition to treating the mother, attention should be paid to the infant’s cognitive, social and emotional development. Infants learn a style of interaction that transfers to their subsequent interactions with other people.

Severe, untreated or under-treated depression can impact children. Direct work on parenting may be needed to support aspects of the mother-child interaction, including help in developing nurturing and intimate relationships with their babies.

(Puckering, 2005)

Mothers with emerging symptoms of perinatal mood and anxiety disorders also benefit from supportive (also called non-directive) counselling. This is the “here and now” talk therapy, as opposed to in-depth, “explore your past” counselling techniques. Shaw et al. (2006) recommend that more qualitative and non-randomized control trials may add significant insights into the benefits of perinatal support.

In-home Treatment

A 2009 randomized trial evaluated the benefits of two interventions by health visitors (these are similar to public health nurses in Canada) for postnatal women. 2749 women were allocated to receive the intervention. The health visitors identified depressive symptoms using the Edinburgh Postnatal Depression Scale, a screening tool for depression in the perinatal period. The health visitors were trained in cognitive behavioural or person-centred principles of counselling and used these in subsequent home visits. The study found that training health visitors to assess women, identify symptoms of postnatal depression, and deliver counselling sessions based on psychotherapies was clinically effective at six and 12 months postpartum compared with usual care.

(Morrell et al., 2009)

Therapeutic support

When treatment is required, many women choose professional therapy, or a combination of therapy and medication. A key member of the mother's "circle of support" therefore, is her physician or nurse practitioner, who can diagnose perinatal mood or anxiety disorders and recommend treatment options. This may include evidence-based therapies for depression and anxiety, such as cognitive behavioural and interpersonal therapy, and adjunct treatments such as massage, exercise, and meditation.

Collaborative Self-Management Support

Collaborative self-management support requires strong relationships built among members of the health care team, including the patient and the family. This shifts health care from a provider or system-centred model to a client and family-centered model. All members of the team share information and expertise, develop goals, and create plans to guide care at home and in clinical settings.

(McGowan, 2008)

Dennis and Chung-Lee (2006) conducted a qualitative systematic review, addressing maternal treatment preferences. Women want "talk therapies" and the opportunity to talk about their feelings with an empathic listener. The review showed that support from other new parents aids recovery, and that attending support groups is a common treatment preference. Stress is relieved by getting out and talking to others, which then enhances coping at home (ibid). However, since getting out to programs or clinics can be difficult, the authors conclude home-based services such as telephone-based support should be available.

Counselling

Counselling is of benefit as a stand-alone treatment for postpartum depression. A 2003 review reports that psychotherapeutic interventions for the acute treatment of postpartum depression are strongly supported by empirical data. The data suggests that psychotherapy should be considered a first-line treatment. There is some emerging data supporting the use of psychotherapy as a means of preventing perinatal mood and anxiety disorders.

(Stuart, O'Hara, & Gorman, 2003)



Perinatal Circle of Support

This circle shows the four areas of support women need with several examples in each category. While support cannot always be classified as coming from one segment, mothers will need support from all four areas. The support may be given by her family and friends, her community or the larger system including health and social service providers. It is important to assess where her supports are strong and which areas will need to be populated with additional support. While we recognize that there is much overlap in reality, this description of the four areas will help practitioners assess and strengthen the mother's existing support system and assist her in creating a complete circle of support. We must also consider that partners may need support as well. Part Three of this manual, showcasing examples from the field, demonstrates how programs can provide and enhance support from more than one segment of the circle.

More on Interventions

A 2008 database of the meta analysis of randomized, controlled studies on the psychological treatment of depression is available online. The paper looks at 149 controlled and comparative studies. The database is to be updated annually.

(Cuijpers, van Straten, Warmerdam, & Andersson, 2008)

Part Three – Examples from the Field

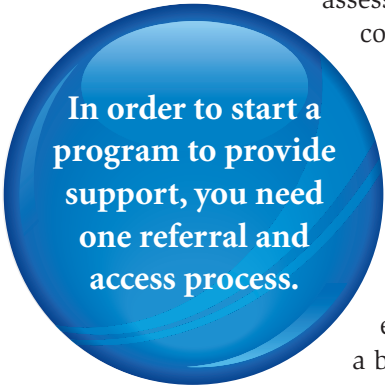
The following section showcases examples from various agencies and regions of Ontario. These examples will help you plan, develop and implement programs and services for mothers and families affected by postpartum mood disorders. It is not a full listing of all available programs in Ontario. Contact information for these program and some others are listed in part 4, the resource tool kit. The examples are grouped under the following:

- A. Main Stream Services (public health, hospital-based, primary care)
- B. Partnerships and Coalitions
- C. Services with a Population Focus
- D. Services with a Children’s Focus
- E. Specialty (psychiatry) Services
- F. Peer Support Services

A. Main Stream Services (public health, hospital-based, primary care)

1. Healthy Babies Healthy Children – Niagara Region

One of the most important supports for new families, across the province, is through local public health units. Through the universal Healthy Babies Healthy Children program (HBHC), all consenting mothers receive a postpartum contact by a public health nurse within 48 hours of their discharge from hospital. Maternal and infant health assessments are completed at this initial contact, including an evaluation of concerns related to postpartum mood and anxiety disorders. Home visits are also offered, where further assessment, counselling, support and information about community services is provided. HBHC can also be accessed during pregnancy.



In order to start a program to provide support, you need one referral and access process.

In the Niagara Region, public health offers a support group for mothers with postpartum depression and anxiety. It is led by a public health nurse and trained peer volunteers who have experienced perinatal mental health concerns. Prenatal workshops and classes also provide education about these topics. Supportive home visiting is offered within a blended model involving a public health nurse and family home visitors.

Niagara Region also offers a parent-talk information line providing a central intake. This allows Niagara HBHC to link pregnant mothers and new parents with crisis care, medical intervention and the HBHC program. Transportation to services is an issue and HBHC offers extra support through in-home visiting. Nurses also work in collaboration with other service providers in the home, such as those from “Impact”, a home-visiting, mental health program.

In-home Treatment

A 2005 study looked at in-home delivery of cognitive behavioural therapy (CBT) for 26 mothers with depression. It led to a substantial reduction in depressive symptoms from pre-treatment to post-treatment. Home visitation addresses some of the formidable barriers to obtaining effective treatment. These barriers include: mistaking symptoms as normal, stigma, lack of family support, transportation and childcare, fear of treatment, and non-adherence to treatment requirements. CBT has been shown to be consistently effective in the treatment of depression by focusing on altering irrational cognitions. Offering this type of psychotherapy at home is emerging as a promising intervention strategy for this population.

(Ammerman et al., 2005)

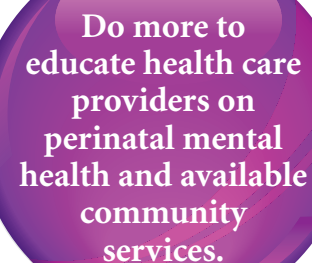
Niagara Public Health and the community coalition, involving 20 community service partners who serve mothers with perinatal mood and anxiety disorders, are also embarking on a service link with Women's College Hospital in Toronto. The goal is to provide expert psychiatric and perinatal psychiatric consultations to local family practitioners. A team will advise the family physician through video or teleconference on best practices for mothers. "Niagara is extremely under-served in terms of family physicians and psychiatrists. It's a big gap for us helping these mothers", states Fiona Burgi, one of the HBHC managers and past chair of the coalition.

2. Women's Health Centre – St. Joseph's Health Centre, Toronto

One of the few postpartum support programs in Toronto is offered by the Women's Health Centre at St. Joseph's Hospital. This program serves pregnant and postpartum women facing mood disturbances. The program also provides a mothers' weekly support group based on the Pacific Postpartum Society's model, and short-term counselling for couples. They offer information nights for couples, family members and other healthcare providers. The staff is also involved in research and public awareness. Support is offered for other organizations wanting to start similar programming. This program is staffed by a social worker and a nurse, and operates from a feminist perspective, addressing all the determinants of health. Its counselling component is evidence-based and includes Cognitive Behavioural Therapy, Intrapersonal Psychotherapy, art therapy, mindfulness and relaxation training.

A unique service offered by the program is long-distance telephone support. A large number of clients are seen a few times in person, and then further supported by telephone. Clients phone from areas as far away as Thunder Bay, Nova Scotia and Oklahoma. Grazyna Mancewicz has been a social worker with the program for many years. She noted that, in her experience, clients stay in telephone counselling longer than face-to-face. She also has trained "telephone buddies" (women who have experienced perinatal mood or anxiety disorders) who offer support to others.

This urban program is rare, in that it can provide services to women without status in Canada who lack health insurance. It also serves many women facing discrimination, poverty and those with trauma histories. A large number of clients are immigrant women who lack English language skills. Staff uses interpreters, translators and "lots of pictures." Populations that are difficult to reach include immigrants and newcomers, women with low levels of literacy, women with less awareness of perinatal mood and anxiety disorders (such as those who don't attend prenatal or childbirth classes) and those who lack awareness of the Canadian health system overall.



Do more to
educate health care
providers on
perinatal mental
health and available
community
services.

The program operates with the support of the larger hospital in which they are located and collaborates with Toronto Public Health. Mancewicz states: “The work of the public health nurses is absolutely crucial. I can’t tell you how much they facilitate awareness. Very often, the public health nurse brings a woman by hand, in person, if the woman was too anxious or depressed to come on her own.”

Help-Seeking Barriers

A 2006 systematic review examined help-seeking barriers and the acceptability of postpartum depression treatment approaches. It found a common barrier was women’s inability to disclose their feelings, often reinforced by family members and health professionals’ reluctance to respond to their needs. Other barriers include lack of knowledge about postpartum depression and the acceptance of myths, rendering mothers unable to recognize they are depressed. It also showed women prefer talk therapies to pharmacological interventions.

(Dennis & Chung-Lee, 2006)

Staff conduct a client satisfaction survey as part of their program evaluation and collect evaluations of their family information nights. Mancewicz sees these family interventions as an area of neglect in this field, as most of the focus is on the women. She believes that preventive interventions are also a high priority. They should include partners and other family members, who may more readily identify the mother as high-risk, and be able to begin building a network of prenatal support.

3. Family Physician Services and Programs for Fathers

Family physicians assess, diagnose and treat patients with perinatal mental health concerns. Dr. William Watson, a family physician associated with St. Michael’s Hospital in Toronto, has developed expertise in perinatal mental health. As a family physician, he practices from a bio-psycho-social perspective. He points out that patients come in with medical complaints such as chronic pain or headaches, but may have underlying psycho-social issues that need to be addressed. If a client is suffering from perinatal

mood or anxiety disorders it is up to the family physician to assess the primary complaint and underlying issues and make a correct diagnosis.

He also teaches medical students, interns and residents. He points out that students and new interns often don’t understand the emphasis on psycho-social assessment. Many times they tell him later, “I didn’t know, I would need to know so much of this stuff.” He has been one of the authors who developed a workbook called “Working with Families” used by medical students at the University of Toronto (see resources) and available to anyone.



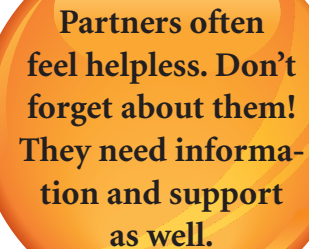
Help for Fathers

Fathers rarely access parenting information. Tailored information for fathers delivered via email and internet may provide an alternative route for support for fathers. A study that looked at fathers' readiness to use electronic information tailored to their perspectives, showed this method may increase their access to useful knowledge and support.

(Fletcher, Vimpani, Russell, & Keatinge, 2008)

Dr. Watson has experience facilitating a father's group "After Baby Comes", and is involved with the Father's Involvement Research Association (FIRA) connected with the University of Guelph. While, as a group, fathers are hard to reach, Dr. Watson believes more is needed to support them. "They like practical tips: playing with your kids, dealing with finances. You have to make your program active and entertaining to keep them there."

Dr. Watson sees the development of Family Health Teams as a great opportunity to blend primary care, public health and Early Years services. "These are the three services that are the keystones to supporting families with perinatal mood and anxiety disorders."



Partners often feel helpless. Don't forget about them! They need information and support as well.

B. Partnerships and Coalitions

4. East Toronto Postpartum Adjustment Program

The City of Toronto offers a postpartum support group and program through its Public Health Department in partnership with other agencies. The program offers a variety of services: intake, assessment, advocacy, referrals, support group, education, and partner support. Crisis intervention and education to professionals is also included.

The catchment for the program is part of the City of Toronto. The program serves women with infants up to the age of one and is delivered in English, but clients can be referred to public health for home visiting with an interpreter. However, in this multi-cultural neighbourhood, serving clients only in English is seen as a barrier.

The program is provided through a partnership arrangement with Toronto East General Hospital, Toronto Public Health, South Riverdale Community Health Centre, and Alternatives East York Community Mental Health Centre. A future link with a family health team is also being considered. Funding comes through the partner agencies.

The main program consists of closed groups for postpartum mothers. The curriculum covered in the group is client-centred and based on an individual assessment of each client done by a public health nurse and a social worker. Future plans include a formal evaluation of the program.



Build community awareness.

Jessie Scott, a reproductive and infant health nurse, sees a need for additional groups for teens and non-English speaking women. Also, women are coming to her program late in their infant's first year when they are close to returning to work. It does not give them enough time to build supportive relationships with others in the group. "That's why we do a lot of education and awareness raising, to help professionals make the referral early or women to call early." Other barriers she sees are long wait lists and lack of respite care for families.

More on Adolescents

A 2008 study examined the connections between depressive symptoms in adolescent mothers and their perceived maternal caretaking ability and social support. The study of 168 teen mothers showed increased depressive symptoms associated with decreased perceived maternal caretaking ability. It concluded that depression is associated with decreased maternal confidence in the ability to parent and decreased perceived maternal social support. It also concluded that social support can have a moderating effect on the relationship of maternal self-esteem and depression.

(Cox et al., 2008)

Scott also provides training within Toronto Public Health on perinatal mental health. She suggests that others wanting to start programs follow the partnership model: it builds sustainability, and the combination of nursing and social work provides a "dual sense of care that is vital to these women."

5. People Matter

People Matter is a private practice in an area encompassing the districts of Muskoka, Parry Sound, Temiskaming and Nipissing. It provides services to families facing postpartum mood disturbances free of charge. The service is contracted through the municipalities with some funding through the provincial Best Start strategy. Partners include health units, municipal mental health services, and community counselling centres.

You need three teams – medical, therapeutic and support – behind the family to help them be successful.

This practice provides an example of "full spectrum" services, including community education, a toll-free number, fax- and web-based referral service, screening, assessment and both individual and group treatment. Pre- and post-intervention questionnaires are used to evaluate therapeutic outcome and client satisfaction.

Key to the People Matter program is a "three-team approach" to treatment which includes a medical team, a therapeutic team and a support team.

"So when I have a client referred to me, I immediately start to build that team behind the family" states social worker, Linda Rankin. Services are available to the Aboriginal, English and Francophone communities in her area.

People Matter has an extensive referral system in place; grandmothers, fathers, family physicians, public health nurses, Ontario Early Years Centre staff, infant development workers, and children's aid workers will connect mothers to the program. Outreach to promote the program, includes massive mailings of referral forms and educational materials to "every professional we can think of". Each community receives information packages about this program. This is followed up with educational talks to parent groups and professionals. Ms Rankin also participates in training family physicians around the province. Some of her materials have been published in the Ontario College of Family Physicians' Healthy Child Development training manual: Facing the Challenges.

This service provides transportation and childcare, the two biggest needs due to the breadth of the geographic region. The budget includes funds for taxi services to bring mothers to the program if required. Funding is also the key barrier faced by People Matter. More money would allow for an expansion of the program to serve more regions.



6. Beyond the Blues Postpartum Depression Group – Thunder Bay District

Thunder Bay has a postpartum depression committee which plays a large role in the running of the postpartum depression support group. The committee involves a variety of service agencies including physicians from a shared care mental health clinic, and staff from a counselling centre whose time is donated to help facilitate the group. A women's program from the aboriginal women's health centre, child protection agency and a community health centre are also represented. Ontario Early Years Centres and Best Start hubs provide childcare and early childhood education workers for the children of women in the group. A community mental health service is responsible for the centralized intake process and wait list and is also represented on the committee. The intake coordinator is from public health and has a nursing and mental health background.

Referrals to the support group come from many community agencies, including Aboriginal services, the courts and child welfare agencies. Some referrals come from a crisis response system that answers calls from women with perinatal mental health issues.

Staff provides education sessions to pregnant and new mothers and organizations that provide services for families. They also participate in case conferences to enhance support and treatment for identified or at risk pregnant or postpartum mothers.

The committee has set up systems with the local hospital to support clients experiencing crisis. Triage policies have been established. "There's a lot of work done there to make sure women aren't turned away – that they get seen. Especially when it's so hard for them to make the initial step to go in the first place," intake coordinator, Susan Andrew-Cotter says.

**Include funding
for transportation
and childcare.**

Supports offered to any service provider connected with the group include training on interpreting screening tools, group facilitation and perinatal mental health information. Training sessions are also offered to the peer support workers, mothers who have experienced perinatal mental health issues and now co-facilitate the group. The committee recently assisted one of the local Indian Friendship Centres to establish a postpartum mood disorders support group for Aboriginal women.

C. Services with a Population Focus

7. Public Health Home Visits for Francophones – Middlesex London


Program offerings for clients from specific populations or those with special needs are few and far between. The Healthy Babies Healthy Children program of the Middlesex London Health Unit links two French speaking public health nurses with French speaking clients. Issues facing French speaking clients include the impacts of the language barrier, as well as the culture shock for those who are recent immigrants. One of the public health nurses, Gaetane Blom, notes it is helpful to provide services in the client's own language: "One mother, whose English was pretty good, but not perfect, told me that she just could not find the words in English to express how she was feeling."

Cultural and Language Barriers

A 2007 study examined the barriers and challenges health care workers faced in working with a recent immigrant population suffering from postpartum depression. The study identified practical barriers and culturally determined barriers. Practical barriers included knowing where and how to access services. Cultural barriers included fear, stigma and lack of validation of depressive symptoms by family and society. Professional limitations included fear of incompetence, language barriers, and inadequate assessment tools. Social/cultural barriers included the experience of cultural uncertainty and language difficulties.

(Teng, Robertson Blackmore, & Stewart, 2007)

The public health nurses partner with Le Carrefour Des Femmes Du Sud Ouest De l'Ontario (CSSOO). This agency provides services across South-Western Ontario to women experiencing abuse, violence and depression. The public health nurse may act as the case manager when partnering with CSSOO.



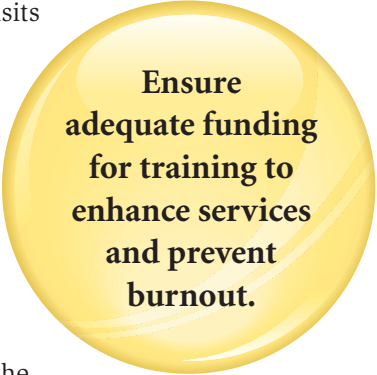
**Tell clients:
you're not alone,
there is help; you
will get better!**

To provide services in French, Blom uses a variety of handouts and brochures in French on topics such as breastfeeding, postpartum depression and parenting. She also refers to a French daycare and a French resource centre. All the brochures on perinatal mental health developed by the health unit are available in French, including those for partners and grandparents.

8. Ontario Federation of Indian Friendship Centres – *Healthy Babies Healthy Children*

The Ontario Federation of Indian Friendship Centres offers a culturally-specific Healthy Babies Healthy Children service across the province. Aboriginal HBHC is offered at 14 sites in Ontario. Services to women, who have been identified with perinatal mental health concerns, are provided through home visits and group work. The success of groups is dependent on the community; in some they work well; in others an individual approach is better suited to the culture. The Friendship centres are located off reserve, therefore transportation problems result in many families only being able to be served through home visits.

Nicole Meawasige, HBHC trainer for the province, offers training twice a year in each Friendship centre, and has a training manual for her programs available through the Federation. However, she notes there is a lack of mental health services in the Aboriginal communities – only three of the Federation sites have mental health workers, and the Federation overall has only five to six mental health specialists. High caseloads and high-needs clients also lead to a high turnover rate of front-line staff.



**Ensure
adequate funding
for training to
enhance services
and prevent
burnout.**

9. Safe Passage – Services for Victims of Abuse

The London, Ontario area hosts a special program, Safe Passage, for women with a history of trauma and abuse. Safe Passage provides counselling, a 24-hour crisis line and “trauma-informed” doula services. Staff assists with prenatal issues and birth planning and counselling and is actively involved in the early postpartum period. The program services the London area, but provides telephone support elsewhere. Women, who give their infants up for adoption or whose infants are apprehended by child protection, are also supported through this program. The agency would like to expand their services to women who have experienced miscarriage, abortion or stillbirth.

The service collaborates with other service providers, such as those in the violence against women sector, and volunteer doula services. Jodi Hall, manager of the program, points out, “There is no bridge between the traditional birth community and the trauma experts.”

The service lacks stable funding, but relies on fund-raisers, training fees and doulas willing to volunteer their time.

Hall suggests that healthcare providers seek training or consultations from the violence against women’s sector in order to better understand and support the ways in which trauma manifests on women during pregnancy, labour and birth. “Our experience demonstrates that the women most impacted, in terms of frequency and severity of perinatal mood and anxiety disorders, are the most disenfranchised, most traumatized of the women we see. Remember, birth brings with it a magnitude of transitions. Birth is not only the birth of the baby, but also the birth of a mother.”



**Link mothers
with supports and
services that are
appropriate to where
they are in their
illness and personal
experience.**

D. Services with a Focus on Children

10. St. Clair Child and Youth Services Postpartum Adjustment Program

This multi-disciplinary Postpartum Adjustment Program in Lambton County (South-Western Ontario) provides a range of support and treatment services under the umbrella of children's mental health. Postpartum mood and anxiety disorders are regarded as a family issue, requiring a multifaceted and integrated approach that supports healthy child development.

The program offers education, screening and trauma-informed assessment, advocacy, counselling (including approaches such as Cognitive Behavioural Therapy, Interpersonal Psychotherapy and mindfulness), family support and education, postnatal yoga and nutrition, facilitated support groups, and services specific for teen parents. The program is uniquely positioned to help women make seamless connections as needed with staff in related programs such as infant development, mother-infant services, family drop-in, infant massage, intensive mental health services for children birth to six, and evidence-based parenting programs geared toward parents of young children.

Creative Interventions

A 2004 literature review looked at non-biological treatments for postpartum depression. It included interpersonal therapy, cognitive behavioural therapy, peer and partner support, nondirective counselling, relaxation/massage, infant sleep interventions, infant mother relationship therapy, and maternal exercise. From this review no conclusions can be reached about the effectiveness of most of these treatments, and randomized controlled trials are needed but a lack of social support is a significant predictor of postpartum depression.

(Dennis, 2004)

Women are encouraged to self-refer, but requests for service also come from public health, family members, Best Start hubs, Ontario Early Years Centres, midwives, physicians, Children's Aid workers, the Canadian Mental Health Association, and private counsellors. Internal referrals come from colleagues within this children's mental health organization such as social workers, addictions counsellors, infant development specialists, and prevention workers.

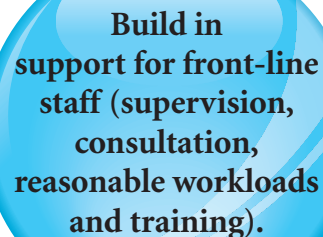


Recognizing the challenges of reaching a large rural county, and the well-known reticence of women to disclose that they may be experiencing postpartum mood difficulties, this program has historically gone to where young families gather. The agency runs "Child Check Clinics" in tandem with Best Start hubs, and family drop-in programs in both urban and rural areas. The program's success is largely due to effective, collaborative relationships established with a host of community partners.

The Postpartum Adjustment Program is grateful for funding from a variety of sources including Ministry of Children and Youth and the County of Lambton, through the Provincial Best Start Initiative. Donations, while not a major source of funding, have supplemented funding for specific projects within the program. Where possible, the program actively pursues a strategy of seeking partnerships in areas such as cost-sharing. For example, the cost and distribution of educational resources has been shared by working with the local hospitals and public health agency. Education and awareness efforts in Lambton County, and provincially, have resulted in an increasing demand for services. Yet, future sustainability is a realistic concern.

Staff from this program attend and host training on perinatal mood and anxiety disorders. Staff receive training specific to their role, such as training in group process, Interpersonal Psychotherapy, Cognitive Behavioural Therapy, and trauma. The agency is currently moving toward a consistent evaluation of service outcomes to build on current qualitative data.

This service reflects a program model that is holistic in nature, with a mind-body wellness and whole family approach. The program has evolved in part through feedback from women themselves. Women who have recovered from perinatal mood and anxiety disorders frequently stay in contact with the agency and are eager to assist as they can.



**Build in
support for front-line
staff (supervision,
consultation,
reasonable workloads
and training).**

11. Children's Aid Society

Child protection agencies frequently work with mothers facing perinatal depression and anxiety. Social worker Lissa Clowater, with the Children's Aid Society (CAS) of Nippissing/Parry Sound, notes that CAS workers play a supportive role when perinatal mental health issues are identified. However, as one of the mother's greatest fears is losing custody of her child, "CAS is often viewed in very negative terms by families we are working with."

Services provided by child protection agencies vary depending on the jurisdiction. However, they all provide protection for the child's wellbeing. Whenever possible this is achieved within the child's family and extended support system.

"It's important for family members to group around the mother affected by perinatal mood and anxiety disorders, and for communities to support families, assisting these mothers." When the family accepts the CAS involvement, the workers can "do whatever is needed" to support the mother. This can include helping to coordinate other community services for the family or providing the means for a breastfeeding mother to pump milk for a child in a placement apart from her.



**Build
community
partnerships.**

Parents With Mental Illness

Mental illness symptoms of all types may interfere with a parent's understanding of a child's emotional and physical needs. In addition, mental illness symptoms can keep a parent from being able to attend to and respond to a child. Psychiatric symptoms can be associated with child abuse or neglect, and in some cases mental illness symptoms may lead to safety concerns. Problematic parenting styles in parents with mental illness can increase the child's risk for problems while adequate parenting styles appear to confer some protection to at-risk children.

The American Academy of Child and Adolescent Psychiatry says the following are helpful to children: simple information about the cause and symptoms of their parent's illness, help and support from family members, a stable home environment, a sense of being loved by the ill parent, a strong relationship with another healthy adult, and positive peer relationships.

Parents may benefit from assistance in talking with their children about their illness in an age-appropriate manner.

(Brunette & Jacobsen, 2006)

Clowater sits on the local perinatal mental health network. She cites a need for a more “formalized set of services” for mothers in her region. Families as well as service providers would also benefit from more education. Recently she linked a private practice counsellor specializing in perinatal mental health with CAS frontline workers to provide training.

12. First Three Years – Make the Connection

First Three Years is an organization involved with children one to three years of age and their parents. First Three Years offers staff training in a parenting program called “Make the Connection”. There are two stages; one for infants and one for 12-24 months-olds. Make the Connection is an attachment-based program aiming to enhance the parent-infant relationship and thereby aids the development of a secure attachment.



Attachment

A person who has developed an attachment to a specific person feels secure when this person is there and anxious when she or he is not. Attachment to the primary care-giver is developed in infancy through predictable, nurturing responses by the care-giver to the infant's needs. This in turn, makes the infant respond to his or her caregiver. Affectionate and responsible parents provide a secure base for children to explore their world. Women who suffer from perinatal mood and anxiety disorders may have unenthusiastic perceptions of their infants and of themselves as a mother causing them to respond less readily. Mothers with anxiety may exhibit intrusive parenting behaviours. These behaviours can cause the mother to have a much harder time formulating attachment bonds with their newborns. Newborns, in turn, may have difficulties forming a secure attachment with their mother.


Home visitors or other service providers can aid the mother in attaching and communicating with their newborns. Self-esteem is improved by emphasizing any attempts at bonding made by the new mother. Coaching can empower the new mother identify signals and cues from her infant, and respond appropriately using face, touch and voice to stimulate the baby. Infant massage can also improve bonding. Mentors who have previously experienced perinatal mood and anxiety disturbances can support the attachment process by acting as role models. If needed, extended family or friends can also be recruited to help interact with the infant so the infant is able to form a secure attachment with another caregiver.

(Zauderer, 2008)

This preventive program is designed to serve high-risk families. Group facilitators are provided with a curriculum for the nine week program, which they offer in their own communities. Make the Connection is available across Canada. It can be offered out of centres such as the Early Years Centres or customized for organizations such as CAS, teen centres or adoptive parent agencies.

Research done by First Three Years, on a similar program with group sessions and videotaping has shown “very positive outcomes for parent-child interactions.” Other research has shown that the facilitator relationship and supportive engagement with the parents was key.

Suggesting Make the Connection to parents can be a first step to further services. Attending a parenting program can be an easier entry for some parents because there is no screening. “There is no stigma about why parents are there.” states co-director Claire Watson.



**Tell mothers:
everyday counts
towards forming
a secure
attachment.**

E. Specialty Services

13. Perinatal Women's Health Clinic – Psychiatry Services

The Perinatal Women's Health Clinic at Mount Sinai Hospital, specializes in treating women with pre and post-natal mood disturbances. It is one of several hospital based perinatal psychiatry programs in Ontario. Only a small percentage of women see a psychiatrist. This is in part due to the fact that there are limited numbers of psychiatrists, especially in under-served areas and in part because mothers are reluctant to see a psychiatrist. Not every mother with perinatal mood or anxiety disorders needs to see a



Encourage
mothers to tell
someone.
“Don’t keep it
to yourself!”

psychiatrist. Those who need to consult a psychiatrist, says Dr. Ariel Dalfen, are patients who have tried other things, such as groups, or have been treated by the family physician, and find they are not getting better. As well, women who are not able to function, to take care of themselves or their baby, even with the help of available supports, or those exhibiting bizarre behaviour need psychiatric evaluation. She advises patients and their families not to be afraid of psychiatry. Referrals to a psychiatrist might only involve a short-term relationship because treatments can work quickly. The patient is still in the care of the family physician.

Dr. Ariel Dalfen is a psychiatrist at the clinic and author of a book for women and families “When Baby Brings the Blues” (Dalfen, 2009). She emphasizes that patients have a lot of control over their treatment. They can refuse it, inquire about options, ask questions and practice the self-management techniques that support their healing. She encourages mothers to use supports from health care providers, family circle and friends. Her advice to mothers is: “There’s a lot of evidence to show that medications are safe. Don’t be afraid of treatments.”

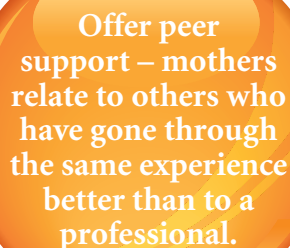
Her messages to family practitioners is to take perinatal mood and anxiety disorders seriously. “Be aware of it. Don’t dismiss it as normal. Learn about the illness. Don’t be afraid to treat it.” Resources for healthcare providers include internet sites from professional organizations, and continuing education events.

F. Peer Support Services

14. Our Sisters’ Place – Education, Peer Support and Online Support

Many clients facing perinatal mental health issues get support through formal or informal peer support groups. Our Sister’s Place, part of the Ontario Mood Disorders Association (MDAO), offers such a group to women. Manager Donnett Bailey says: “The idea is talking to someone who’s been there.”

The organization also offers a library, fact sheets and websites. Women can access an online forum through the website. Peer support volunteers also staff a telephone line. Staff, including the executive director, provides education to other organizations through training and other supports.



Offer peer
support – mothers
relate to others who
have gone through
the same experience
better than to a
professional.

Because of the anxieties new parents face, getting to a group is not always possible. “We know that many people will not come out, so we try and have a phone service, we try and have an online service, we mail things out to people and all of our services are free of charge. So it’s just being flexible,” Bailey explains.

As a provincial organization, MDAO provides help to anyone across Ontario interested in starting peer support groups. The organization also has a manual on how to start a peer support group. Staff offers advice on how to seek out resources, and work with community partners and already established programs. They also offer training and education to service providers. One of the key issues is educating service providers is to be sensitive to women and women’s needs.

15. Peer Telephone Support Trial

Peer telephone support has also been found to be effective in preventing or reducing postpartum depression and anxiety. In the recently completed trial, mothers who had experienced postpartum depression and anxiety, offered peer support to others through a telephone service.


Non-biological Interventions

A randomised controlled trial conducted across Ontario has concluded that telephone-based peer-support can be effective in preventing postnatal depression among women at high risk. More than 700 women participated. They received mother-to-mother support from trained volunteers who had previously experienced and recovered from self-reported postnatal depression and attended a four hour training session. Outcomes were measured with the Edinburgh Postnatal Depression Scale (EPDS), structured clinical interviews, state-trait anxiety inventory, a loneliness scale and use of health services. The mothers were followed up at 12 weeks and 24 weeks postpartum. At 12 weeks, 14 per cent of women in the intervention group and 25 per cent in the control group had an EPDS score > 12. For ethical reasons, participants identified with clinical depression at 12 weeks were referred for treatment, resulting in no differences between groups at 24 weeks. Of the 221 women in the intervention group who received and evaluated their experience of peer support, more than 80 per cent were satisfied and would recommend this support to a friend.

(Dennis et al., 2009)

Mirjana, one of the volunteers' prime motivations was to ensure that other mothers "had a better experience than I had." She believes this model of telephone support allows women to open up due to the confidential nature of the telephone relationship.

In this role, she used her research skills to find other supports in the community, such as the 519 Community Centre, a resource centre for the lesbian, gay, bisexual and transgendered community, family resource centres, and midwifery collectives. Making referrals is important when the woman has needs that are beyond the role of a peer support person, "so we don't overstep our boundaries." And when the helping relationship ends, she knows it is a good thing. "Women will cut that relationship when they are ready to move on. I take it as a good sign."



**You are never
alone; there
is always help
available.**

Physical Activity as an Intervention

There is now evidence to support the role of exercise for mild postpartum mood disorders and as an additional treatment for more severe cases. A literature review looks at the potential role of exercise, particularly pram walking (also called strollercize), as an adjunct treatment for postpartum depression. Two random controlled trials in Australia support exercise as a useful adjunctive treatment for women with postpartum depression. Given some women's reluctance to use medication postpartum, the study suggests exercise deserves further exploration.

(Daley, MacArthur, & Winter 2007)



16. Life With a Baby – by Mothers for Mothers

Life with a Baby is an interesting style of non-profit organization whose aim is to link mothers by organizing events in local neighbourhoods. The service is promoted online.

Each organizer in the network helps to set up a variety of educational or social events for mothers and children aged 0-6, providing instrumental and social support. They range from simple supports such as a toy exchange and grocery deals of the

week to walking programs and workshops such as Infant First Aid. Events to help mothers get out, such as “mom’s night out” or “let’s go for a walk”, are also organized.

This is a helpful model of support that could be set up in any community, bringing mothers and their young children out of the house. The wide variety of offerings this grass-roots program provides can be helpful to many mothers and increase their support network.

Applying Theory and Practice Examples

We thank all of the experts in the field who contributed to this manual. Please feel free to contact them for ideas on how to replicate these programs in your community. You can also contact your local hospital, public health unit or community information centre for more information about programs and services related to perinatal mental health.

So far, the manual has provided readers with relevant theory and creative and useful ideas from practitioners in the field. Our hope is that you will take what you need and look further into ideas that might work in your organization. In Part Four – Resources, we provide information about training manuals, non-academic readings and, of course, the many, many websites that have useful information on this topic.

**Help women
practice self-care
and do things
for themselves.**

Part Four – Resources

This section contains a chart with information about the programs and services featured in chapter three. It also includes information about other resources, such as policies, interesting articles, websites and links to other community initiatives. These additional resources will give you a greater understanding of perinatal mental health, and will assist you in planning, implementing and evaluating your own program to create circles of support for pregnant women and new families.

Programs and Services Featured in Part III

Organization/Program	Contact Information	Region/Area	Type of Program
A. Main Stream Services (public health, hospital-based, primary care)			
1. Niagara Region Healthy Babies Healthy Children	www.niagararegion.ca living – public health-pregnancy children and families – important parenting issues	Central South – Niagara Region	Public health services
2. St. Joseph's Healthcentre, Women's Health Centre	www.stjoe.on.ca Programs – Women's, children's and families' health – Women's Health Centre	Toronto – West side of Toronto, GTA and beyond	Hospital based and funded program
3. Family Practice Services and After Baby Comes Father's Program	St. Michael's Hospital, Toronto (416) 360-4000	Toronto	Partnership of family practice physician and social work department (not running group at present)
B. Partnerships and Coalitions			
4. East Toronto Postpartum Adjustment Program	www.srchc.ca	Toronto – East side of Toronto	Partnership of Toronto East General Hospital, Toronto Public Health, South Riverdale Community Health Centre and York Community Services
5. People Matter	www.peoplematter.ca	Central East and North – Muskoka, North Bay and Parry Sound District, and Temiskaming District	Private practice but funded through a partnership of Parry Sound – Muskoka Early Years System, North Bay District Health Unit and Muskoka – Parry Sound Community Mental Health Services
6. Beyond the Blues – Thunder Bay District Postpartum Depression Group	www.tbdhu.com Healthy babies, healthy families – prenatal – postpartum depression and other mood disorders	North – Thunder Bay District	Community coalition with services and responsibilities shared between partners
C. Services with a Population Focus			
7. Healthy Babies Healthy Children – French Services	www.healthunit.com Healthy Babies Healthy Children – Public Health Nurse Visit	South-West – Middlesex-London	Public Health Services with French Language Services

Organization/Program	Contact Information	Region/Area	Type of Program
C. Services with a Population Focus (continued)			
8. Aboriginal Healthy Babies Healthy Children	www.ofifc.org	Ontario	Mothers' and childrens' programs for the Aboriginal population
9. Safe Passage Services for victims of abuse	www.safepass.org	South-West Middlesex-London and beyond	A non-profit program providing non-judgmental support, shelter, counselling, and resources to women and families affected by domestic violence through counsellors and trauma informed doula services
D. Services with a Focus on Children			
10. St. Clair Child and Youth Services	www.stclairchild.ca Postpartum adjustment services	South-West – Lambton County	Children's mental health service
11. Nipissing and Parry Sound District CAS	www.parnipcas.org	North – Parry Sound and Nipissing District	Child Protection Services
11b. Ontario Association of Children's Aid Societies	www.oacas.org	Ontario	Child Protection Services
12. First Three Years Make a Connection	www.firstthreeyears.org	Ontario	Non-profit organization that focuses on providing expertise to the community in the area of attachment, communication and learning.
E. Specialty Services			
13. Mt. Sinai Hospital, Maternal Infant Program and Perinatal Psychiatry	www.mountsinai.on.ca/care/psych/patient-programs/maternal-infant-perinatal-psychiatry	Toronto and beyond	Hospital based psychiatry services
F. Peer Support Services			
14. Our Sisters' Place	www.oursistersplace.ca	Ontario	A program of the Mood Disorders Association of Ontario that provides support to women who are dealing with problems related both to mood and to hormonal changes including an online support group
15. Telephone Peer Support Trial	Cindylee.dennis@utoronto.ca	Ontario	Telephone peer support, research project – now completed
16. Life with a Baby	www.lifewithababy.com	GTA – could be replicated anywhere	Grassroots – peer support organization

Policies

Addressing Perinatal Depression A Framework for BC's Health Authorities Produced by BC Reproductive Mental Health Program: BC Women's Hospital & Health Centre, an Agency of the Provincial Health Services Authority in partnership with the BC Ministry of Health, Mental Health and Addictions Branch and Healthy Children, Women and Seniors Branch. July, 2006
www.hls.gov.bc.ca/maternal/initiatives/index.html

Newsletters

PPMD Connection – A Newsletter from the Peel Postpartum Mood Disorder Program.
Contact: www.pmdinpeel.ca

IMPrint is the newsletter of Infant Mental Health Promotion, Department of Psychiatry & Community Health Systems Resource Group, The Hospital for Sick Children.
Contact: www.sickkids.ca/imp

Articles of Interest

Brandi, R., (2008). Application of attachment theory to maternal unresponsiveness: A model program for postpartum depression. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, Vol. 68(9-B), 2008, pp. 6290

Brunette, M.F. & Jacobsen, T. (2006). *Children of Parents with Mental Illness, Current Clinical Practice: Psychiatric Disorders in Pregnancy and the Postpartum*, Ed V. Hendrick Totowa, NJ Humana Press.

McGowan, P. (2008). *Self management: A Background Paper* is available online from the University of Victoria's Centre on Aging. See New Perspectives: International Conference on Patient Self-Management

White, C. (2008). How you can build your own social support network – an essay meant as a prevention strategy for pregnant or new mothers. Published online at: www.postpartum.net/resources/women-mothers/build-network.

Wisner, K. & Logsdon, M., (2008). Web-based education for postpartum depression: conceptual development and impact; Archives of Women's Mental Health. Also published online by Springer.

Research – Evaluations and Scans

KFL&A Public Health completes regular evaluation questionnaires with participants of their Mothers Helping Mothers peer support group.
Contact: www.kflapublichealth.ca

Leeds, Grenville & Lanark District Health Unit; *Needs-Impact-Based Planning Model for the Prevention of Postpartum Depression*. (2004).
www.healthunit.org

Middlesex London Health Unit has full evaluation report for the ECD project that included a postpartum depression campaign and many other services for families with perinatal mental health issues. It also includes evaluations on their drop in program.
www.healthunit.com “No Need to Despair”.

Toronto Public Health; An Environmental Scan of Postpartum Depression-Related Services in Toronto: Key Findings.
Contact: www.toronto.ca/health/

University of Saskatchewan, Community-University Institute for Social Research conducted a Postpartum Depression Support Program Evaluation in 2004.
www.usask.ca/cuisr

Resources for Professionals

Best Start Resource Centre; *Life with a new baby is not always what you expect* – booklet, fact sheets, desk reference, posters, fridge magnets and a training video for professionals.
www.beststart.org/resources/index.html

Best Start Resource Centre and the Self Help Resource Centre, (2005). *Self-Help/Peer Support Strategies in Maternal, Newborn and Family Health: examples from the professional landscape*. www.selfhelp.on.ca or www.beststart.org/resources/index.html

Cindy-Lee Dennis, (2008) *Mothers Helping Mothers with Postpartum Depression – Peer Volunteer Training Manual*.
Contact: cindylee.dennis@utoronto.ca

Ontario College of Family Physicians, Healthy Child Development Committee; *Facing the Challenges – level II healthy child development manual*. Revised 2007, Toronto, OCFP, includes sections on postpartum depression, attachment and fathering.

Ross, L., Dennis, C-L., Robertson Blackmore, E. & Stewart, D. E., (2005); *Postpartum Depression: A guide for front-line health and social service providers*. Toronto: Centre for Addiction and Mental Health.

Watson, W., McCaffery, M.; *Working with Families: Case-based Modules on Common Problems in Family Medicine*. Includes a section on postpartum adjustment.
Contact: www.uoftbookstore.com

Zuehlke Jessica B., *Traditional and non-traditional techniques for women with postpartum depression: an integrative group treatment manual*, University of Hartford Psy.D. Dissertation, 3298752

Best Practice Guidelines

Ontario's Registered Nurses Association,
Best Practice Guidelines; *Interventions for Postpartum Depression* (2005).
Contact: <http://www.rnao.org>

Patient Guides and Printed Resources for Mothers and Families

Best Start Resource Centre; *Life with a new baby is not always what you expect*; booklet, fact sheets, and a video.

www.beststart.org/resources/index.html

British Columbia's Reproductive Mental Health Program has a patient guide "Self-care Program for women with postpartum depression and anxiety".
www.bcwomens.ca/Services/HealthServices/ReproductiveMentalHealth/SelfCare.htm.

Health Resources and Service Administration:
Depression during and after pregnancy: A resource for women, their families and friends.
www.mchb.hrsa.gov/pregnancyandbeyond/depression

Pacific Postpartum Support Society; *Postpartum Depression and Anxiety – a self-help guide for mothers*.
www.postpartum.org

Canadian Programs that Specialize in Women's and Perinatal Mental Health

www.bcwomens.ca/Services/HealthServices/ReproductiveMentalHealth/default.htm
British Columbia Reproductive Mental Health Program
Vancouver, B.C.
(604) 875-2025

www.mountsinai.on.ca/care/psych/patient-programs/maternal-infant-perinatal-psychiatry
Perinatal Mental Health Program
Mount Sinai Hospital
Toronto, ON
(416) 586-4800 x 8419

www.womenscollegehospital.ca/health/index.html
Reproductive Life Stages Program
Women's College Hospital
Toronto, ON
(416) 323-6400 x 5635

www.uhn.ca/clinics_&_services/clinics/womens_mental_health.asp
Women's Mental Health Clinic
Toronto General Hospital
Toronto, ON
(416) 340-3048

Ottawa Regional Perinatal Mental Health Program
The Ottawa Hospital – General Campus
(613) 737-8010

www.stjoes.ca
Women's Health Concerns Clinic
St. Joseph's Healthcare Hamilton
Hamilton, ON
(905) 522-1155 x 33031

Reproductive Mental Health Service
IWK Health Centre
Dep't of Psychiatry
Dalhousie University
Halifax N.S.
(902) 470-8098

Regional Resources

Algoma District Public Health has developed a services directory. www.algomapublichealth.com/

Durham Region's Public Health Department has a Community Services Guide for Postpartum Mood Disorders. They also have "Just Ask" resources for physicians and a brochure with self-care tips. www.region.durham.on.ca/health

Halton region offers support through the public health department and peer facilitated groups "Moms Supporting Moms". For more information check: www.halton.ca/news/MediaShow.cfm?MediaID=2008-04-30-11-26-07

KFLA Public Health Unit has developed a letter to physicians with the EPDS, posters, a decision tree for assessment and referral of women with possible PPD. www.kflapublichealth.ca – parents and caregivers – postpartum mood disorders

Kingston's Postpartum Adjustment Coalition has developed program guidelines for its Mother's Helping Mothers group, a counselling resource list, a program brochure and community resources. <http://kingston.cioc.ca/record/KGN0347>

London and Middlesex has an Inventory of Programs and Services covering therapist/counsellors and other mental health resources. They also have a variety of resources in English and French for clients and professionals and a drop-in group for mothers. www.helpformom.ca

Niagara Region has a Curriculum Overview for its "Nurture Yourself" parenting workshop, handouts and a Facilitator's Background Information document. They also have a Care Pathway for assessment and intervention of perinatal mood disorders. www.regional.niagara.on.ca/government/health/default.aspx

North Bay Parry Sound District also has a listing of services at <http://www.healthunit.biz>

Northwestern Health Unit offers postpartum depression information and groups as needed. www.nwhu.on.ca/csg-ppdsg.php

Ottawa is home to the Family Services à la famille Ottawa. They offer individual and group mental health counseling. www.familyservicesottawa.org

Oxford County's Department of Public Health has a Health Babies Health Children Manual and resources for its Mother Reach Postpartum Depression program www.county.oxford.on.ca

Peel Postpartum Mood Disorder Program is an initiative of Success by 6, a collaborative of more than 40 community partners. The perinatal mood and anxiety program offers resources and a website with information and an online tutorial about postpartum mood disorders at www.pmdinpeel.ca

Peel Region is home to Credit Valley Hospital www.cvh.on.ca with a Women's Reproductive Mental Health Program. It serves Clients residing within the Mississauga/Halton LHIN or have delivered at CVH or have physician has privileges at CVH through a multidisciplinary team. Treatment includes individual and group therapy.

Sudbury Regional Hospital's Community Mental Health Service offers Early Interventions Perinatal Mental Health. Contact: (705) 523-4988.

Sudbury District and the Cochrane/Timmins/Timiskaming have community resource directories at www.cmha.sudbury.on.ca/default.aspx. A French version is also available.

York Region Health Services offers a 12 week transition to parenting group. For information call Health Connections at 1-800-361-5653.

More Online Resources

American College of Obstetricians and Gynecologists (ACOG)
www.acog.com

Association of Local Public Health Agencies
www.alphaweb.org/ont_health_units.asp

Best Start Resource Centre
www.beststart.org and www.lifewithnewbaby.ca

Canadian Association of Social Workers
www.casw-acts.ca

Canadian Medical Association
www.cma.ca

Canadian Mental Health Association
www.cmha.ca

Canadian Paediatric Society
www.cps.ca

Canadian Psychiatric Association
www.cpa-apc.org

Canadian Psychological Association
www.cpa.ca

Centre for Addiction and Mental Health
www.camh.net

Dad's Adventure
www.newdads.com

Depression During Breastfeeding
www.pregnancyanddepression.com/breastfeeding

First Three Years
www.firstthreeyears.org

Institute for Healthcare Information
www.ihl.org/IHI/Topics/ChronicConditions/AllConditions/Changes/Self-Management.htm

Invest in Kids
www.investinkids.ca

Marcé Society
www.marcesociety.com
International Society for research of perinatal mood and anxiety disorders

MedEd Postpartum Depression
www.mededppd.org

Mental Health Services Information Ontario
www.mhsio.on.ca
English/French – online directory of mental health services in Ontario

Mood Disorders Association of Ontario
www.mooddorders.on.ca and
www.checkupfromtheneckup.ca

Motherisk
www.motherisk.org
Information on safety/risk of drugs during pregnancy and lactation for mothers and professionals. Includes information on anti-depressants.

National Alliance on Mental Illness
www.nami.org

National Centre for Fathering
www.fathers.com

Online PPD Support Group
www.ppdsupportpage.com

Ontario Federation of Indian Friendship Centres
www.ofifc.org

Ontario Self Help Network, part of the Self Help Resource Centre
www.selfhelp.on.ca

Our Sisters' Place – women's program of the Ontario Mood Disorders Association
www.oursistersplace.ca

Pacific Postpartum Support Society
www.postpartum.org

Panic Centre
www.paniccentre.net
Online cognitive behavioural therapy, support group and help for professionals

Perinatal Bereavement Services of Ontario
www.pbso.ca

Postpartum Stress Centre
www.postpartumstress.com

Postpartum Support International
www.postpartum.net

Reaching In Reaching Out
[www.reachinginreachingout.com/
resources-articles.htm](http://www.reachinginreachingout.com/resources-articles.htm)
a program that builds resiliency in
children and adults

Self Management
www.collaborativeselfmanagement.org
Information on self management

Society of Obstetricians and Gynaecologists
of Canada
www.sogc.org

Well Postpartum Weblog – Integrative Approaches
to Maternal Mental Health
www.wellpostpartum.com
Blog on complementary and non-pharmacological
approaches to maternal mental health

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by/par health  santé

Best Start Resource Centre is a key program of Health Nexus (Ontario's longstanding health promotion organization), and is funded by the Government of Ontario. It is a provincial resource centre that supports service providers to implement effective health promotion programs for expectant and new parents, newborns, and young children.