Maternal Mental Health

MotherFirst

MATERNAL MENTAL HEALTH STRATEGY:

Building Capacity in Saskatchewan

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A Mother's Story

"After the birth of my daughter I felt constantly drained of energy and was suffocating with constant anxiety. The most awful aspect of my depression was my fits of rages and how I would take them out on my husband and daughter. I felt defeated as a mother because I could not calm and comfort my baby. I was a shell of a person who just did not have the tools to move forward.

I struggled alone for over six months with anxiety, paranoia, and anger. In those moments, I needed to hear from a medical professional that I was legitimately having a difficult time and that there was help. I truly believe that consistent screening and adequate supports would have prevented the extent of my suffering, and the effects on my family.

The most important lesson I have learned throughout my experience with maternal depression is that, just as it takes a village to raise a child, it takes that same village to raise a mother."

Elita, Regina

MotherFirst Working Group

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Minister of Health

SASKATCHEWAN

Legislative Building
Regina, Saskatchewan

A Message from the Honourable Don McMorris
Minister of Health

On behalf of the Government of Saskatchewan and the Ministry of Health, it gives me great pleasure to offer our support for the Maternal Mental Health Strategy: Building Capacity in Saskatchewan, and the ***MotherFirst*** *initiative.*

The provision of mental health services is an integral and important component of the health system in Saskatchewan. Our government is committed to improving access to mental health services, and meeting the health needs of women and their families.

I commend the supporters of this initiative and their efforts to improve the lives of women. Our government and the Ministry of Health support the ***MotherFirst*** *recommendations and offer our commitment to the development of guidelines and policies to ensure each health region is providing the best possible maternal mental health care services.*

Together we can work to increase awareness and promote positive solutions that will improve women's mental health, and ensure healthy, safe environments for Saskatchewan families.

Don McMorris
Minister of Health

Commentary on the MotherFirst Report

From a clinical perspective, the MotherFirst report recommendations are a step in the right direction. Maternal mental health has been largely overlooked as a health priority in the past but has great consequences for the health of our communities. Maternal depression and anxiety is a reality for a large number of women and their children. It is a debilitating illness for the mother and negatively affects the healthy development of their baby.

My colleagues and I welcome the MotherFirst recommendations as they consider the importance of preventative care and focus on reducing the harm of maternal depression and anxiety. Public education, effective screening, and accessible treatment are the cornerstones of good patient care. These early interventions promise to provide mothers with an opportunity to address their mental health, which is a key component to an optimal pregnancy and early parenthood. The long-term development of children will benefit from ensuring a stable, supportive environment.

Ultimately, these policies need to be implemented in order to provide the best start for new moms and their children. It will make a significant contribution to the well-being of all families in Saskatchewan.

Marilyn Baetz, MD FRCPC
Professor and Head, Department of Psychiatry
College of Medicine, University of Saskatchewan

First Nations culture encourages a healthy maternal role, the belief is that a child has many mothers within a family and community. A mother plays an instrumental role in inculcating babies with valuable knowledge until they reach the age of two. It is with anticipation that with the support of these policy recommendations that we can support First Nations women to sustain and maintain their role as mother's and the sole protectors' of our Creator's gifts. With the continued work towards this important step forward we can achieve healthy families in our First Nations communities. We support these policy recommendations for our First Nations women and children, as well as the province as a whole, to ensure a quality approach towards the public health of the community we live. I would like to encourage the children's programs in our First Nation communities to embrace the teachings of our Elders in regards to women living a healthy holistic nutritious lifestyle before and after pregnancy.

Vonnie Francis
Director of Childrens
Programs and Initiatives
Health & Social Development
Federation of Saskatchewan Indian Nations

Health care professionals need consistent guidelines, which are evidence based to ensure that maternal mental health is addressed as a part of regular health exams. The MotherFirst principles of education, screening and early intervention will help address the current gaps within the system and reduce the negative outcomes of maternal mental health problems. This initiative is sure to benefit not only mothers and their babies, but also families and communities as a whole.

Heather Keith, RN(NP) MN
Chairperson, Nurse Practitioners of Saskatchewan

The well-being of mothers and their children during pregnancy and postpartum is of primary importance to public health. It is the most fundamental period of emotional and physical development for children and lays the foundation for future growth. This is highly influenced by the care provided by parents.

We need to make a commitment to ensure the best beginning for every new mother and her child. By providing women with mental health support, the health of Saskatchewan's future generations will be secured. The MotherFirst policy recommendations work to give mothers and their children the care they deserve and need. The recommendations promote health from the very start of life and will ultimately prevent future illness and benefit the health of our communities.

Greg Riehl, RN, BScN, MA
President, Saskatchewan Public Health Association
Faculty, Nursing Division, SIAST

The report, MotherFirst – Maternal Mental Health Strategy: Building Capacity in Saskatchewan presents the recommendations of a diverse group of stakeholders which were developed to improve maternal mental health across the province.

Maternal mental health has a significant impact on the quality of care that might be provided to a child. Untreated maternal depression may lead to serious emotional, physical and economic consequences for mothers, their children, and the families that support them. The report focuses on strategies to overcome potential maternal health problems in pregnant and post partum women through improved access to education, screening and treatment.

The people of Saskatchewan will undoubtedly benefit from a provincial strategy to more consistently identify and treat women with maternal mental health problems such as depression and anxiety.

Grant Stoneham, MD FRCPC
President, College of Physicians and Surgeons of Saskatchewan

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EXECUTIVE SUMMARY

This document presents policy recommendations to assist the Saskatchewan Ministry of Health and First Nations health leaders in improving the identification and treatment of women with mental health problems during pregnancy and the postpartum period.

Maternal mental health is an increasingly urgent health concern. The prevalence of depression and anxiety among women peaks during childbearing years. Every woman is vulnerable to mental health problems during pregnancy or postpartum, but poverty, single status, minority ethnicity, and a history of depression can increase the risk.

Untreated maternal depression and anxiety can impact all aspects of an entire family and is associated with significant personal, social, and economic costs. There is increased risk of pregnancy complications, preterm birth, impaired breastfeeding, and attachment problems. The child of a mother who has struggled with mental health problems can experience developmental and cognitive difficulties. The partners of mothers who are depressed also experience more stress and depression.

Saskatchewan does not currently have a provincial policy regarding maternal mental health, which means many women, their children, and their families suffer without consistent support. Some health regions have developed screening and treatment protocols, but it is essential that every woman have an opportunity to receive a similar level of quality care and support.

The *MotherFirst Working Group* was created to address the issue of inconsistent identification and treatment of women with maternal mental health problems. It brought together interdisciplinary stakeholders, including major professional health associations, community organizations, First Nations groups, and women with lived experience. The group is geographically, culturally, and professionally representative.

Through research and multiple consultations, four key policy areas have been identified to improve maternal mental health for Saskatchewan women. They include increased awareness of maternal mental health, universal screening for depression and anxiety in pregnant and postpartum women, improved access to appropriate treatment, and a provincial strategy to ensure consistent access to maternal health care.

By adopting these policy recommendations, the Government of Saskatchewan will be committing itself to healthy families. It is an opportunity to provide well-being to women and to ensure the best beginnings for our children.

RECOMMENDATIONS

Maternal Mental Health Strategy: Building Capacity in Saskatchewan

Recommendation #1: Education

Increase awareness of the frequency, impact, and treatment of maternal mental health problems, and promote positive mental health through ongoing access to evidence-based materials.

Prevention of maternal mental health problems starts with education. Providing women and their families, health professionals, and the public with information (in print, online, and through educational programs) will establish maternal mental health as a public issue. This will help end the stigma that alienates many women and prevents them from seeking help.

Recommendation #2: Screening

Universal screening for depression and anxiety using the Edinburgh Postnatal Depression Scale (EPDS) in pregnant and postpartum women.

The EPDS will be used consistently at regular intervals during routine health care visits during pregnancy and postpartum. Positive mental health will be promoted with all women. A cut-off score of 12 will be used for a referral to a health professional, while those who score 10 or 11 will have the opportunity for follow-up, and women who score 9 or less will have access to support. Women who score 4 or more on the anxiety subscale will also be offered an opportunity for further support. Partners of women who score positive for depression (12 or more) will also be offered screening.

Recommendation #3: Treatment

Prioritize maternal mental health within Mental Health Services, improve accessibility, and increase treatment options.

Timely treatment is essential to restore the well-being of mothers suffering from mental health problems and to minimize the adverse effects they can have on their infants and families. A stepped-care strategy will provide efficient, cost-effective services by matching the severity of the symptoms to the appropriate level of treatment.

Recommendation #4: Sustainability and Accountability

Implement the MotherFirst policy recommendations and ensure maternal mental health remains a priority within Saskatchewan.

There is a need for policy with dependable guidelines and a system of provincial accountability to ensure each health region is providing the best possible maternal mental health care. Groups will be developed at the provincial and regional levels and will include multiple stakeholders, including First Nations. Improved data collection procedures within the provincial Mental Health Information System will identify and evaluate the impact of the *MotherFirst* recommendations.

PART 1: BACKGROUND AND ANALYSIS

Maternal depression is an increasingly urgent health issue. It is the leading cause of disability for women in their childbearing years (ages 15-44).[7]

Up to 20% of mothers in Saskatchewan may face serious depression and/or anxiety related to pregnancy and childbirth,[2] with potential impact to 2,800 families annually.[3] Untreated maternal mental health problems have serious emotional, social, physical, and economic impact on entire families. Unfortunately, too few of these women receive adequate care, including education, screening, and treatment.

The health system often prioritizes physical health and birthing outcomes over the emotional well-being of mothers; however, there is a large and increasing body of evidence illustrating the interrelationship between mental and physical health.[4]

There is presently a lack of cohesive or consistent prevention, identification, and treatment of maternal mental health problems in our province. Proper care will minimize the effects of maternal anxiety and depression on a woman's health and on the well-being of her baby and family.

This report is a response to the significant concern of multiple stakeholders who work with mothers, infants, and families throughout the province of Saskatchewan. The goal is to increase awareness and access to support for women, to normalize the identification of mental health concerns, and to recognize that a key to healthy families is to ensure the health of the Mother First.

Maternal mental health is important because:[5]

- Every child deserves, and every parent wants to provide, the best beginning in life.
- A mother's mental health can have a significant impact on the quality of care provided to her child and, therefore, on the child's development.
- Early childhood development, particularly in the first months of life, is critical to the long-term health and well-being of children.
- Pregnancy, birth, and early parenthood are periods of significant change for the whole family and can be affected by stress, anxiety, and depression.
- Maternal depression is common, affecting 20% of mothers, their babies, and families. The prevalence of depression among women peaks during pregnancy and the postpartum period.
- Partners of depressed mothers are more likely to suffer from depression themselves.
- Effective prevention and intervention can reduce the suffering of women and the negative effects on child development and family function.

DEFINITION, SYMPTOMS, AND PREVALENCE

The World Health Organization defines maternal mental health as "a state of well-being in which a mother realizes her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her community."[6] This includes an ability to adapt and cope, not simply the absence of mental illness. While this is the optimal emotional state of pregnant women and new mothers, many experience depressive symptoms and anxiety. Maternal mental health problems can occur anytime from conception to one year after birth. *(Appendix A – Terminology Used in the Report)*

Maternal Depression

The World Health Organization identifies depression as the number one cause of disability in women worldwide.[7] Depression during pregnancy is more prevalent than common physical issues such as gestational diabetes.[8] Up to one in five pregnant and postpartum women suffer from depression related to pregnancy and childbirth,[2] meaning approximately 2,800 Saskatchewan women and their families are affected every year.[3] It has been reported that up to 29.5% of socially high-risk pregnant women in

Saskatchewan are depressed.[9] These high numbers may be even more significant as one study determined that only about one third of women with maternal depression sought help.[10]

Maternal depression is diagnosed using the same criteria for major depressive disorder. The *Diagnostic Statistical Manual of Mental Disorders,*[11] a widely-used handbook for mental health professionals published by the American Psychiatric Association, diagnoses a major depressive episode by:

The presence of five or more of the following symptoms during the same 2-week period most of the day and nearly every day, including the first and/or second symptom below:

- Depressed mood;
- Diminished interest or pleasure in all, or most, activities;
- Significant weight loss when not dieting or weight gain, or decrease or increase in appetite;
- Insomnia or hypersomnia;
- Excessive or lowered physical expression/activity;
- Fatigue or loss of energy;
- Feelings of worthlessness or excessive or inappropriate guilt;
- Diminished ability to think or concentrate, or indecisiveness; and
- Recurrent thoughts of death, recurrent suicidal ideation, or suicide attempt.

Symptoms specific to maternal depression include a preoccupation with infant well-being, which can range from over-concern to delusions. Women may have severe anxiety, disinterest in the infant, fear of being left alone with the infant, or over-intrusiveness that prevents adequate infant rest.[11]

One in five mothers suffer from maternal depression
Depression during pregnancy is more common than physical issues, such as gestational diabetes and hypertension

It is sometimes difficult for women to recognize their maternal mental health symptoms as illness rather than inadequacy as a mother. Women with maternal mental health problems face persistent stigma of having depression, intense feelings of guilt and failure, and worries about being perceived unfit to care for a child.[12]

Maternal Anxiety

Anxiety is also a common mood disorder during pregnancy and postpartum, affecting up to 24% of pregnant women.[13] Women are at increased risk of developing or worsening anxiety disorders during pregnancy and postpartum, including panic disorder, obsessive compulsive disorder, post-traumatic stress disorder, social anxiety disorder, and generalized anxiety disorder.[14]

Symptoms of anxiety disorders include excessive worry and difficulty controlling this worry. It is associated with other symptoms, such as restlessness, fatigue, difficulty concentrating, irritability, muscle tension, and sleeping difficulty.[11]

The presence of anxiety is also linked to the development of depression.[15] Women who experience anxiety during pregnancy are three times more likely to report postpartum depression symptoms.[16] This means identifying and treating anxiety early may prevent future depression.[17]

Postpartum Psychosis

Approximately 0.1-0.2% of postpartum women experience postpartum psychosis, which is characterized by agitation, hallucinations, mood swings, and/or bizarre perceptions.[18] This usually occurs within the first few weeks following childbirth, but can also present later in the postpartum year.

Postpartum psychosis is a serious problem that can lead to self-harm, infanticide (murder of a child by its mother in the first year of life), or homicide.[18] Suicide was found to be the leading cause of death in pregnancy and the first year postpartum in the United Kingdom.[19] A high proportion of these cases occur in the context of postpartum maternal mental illness, particularly psychosis.[20,21]

A Mother's Story

"My psychosis hit without warning. My first night of sleep after becoming a mother ended with a violent and bloody nightmare about my newborn son being dead. My next day began with voices telling me to smother my son, and seeing violent bloody pictures. I had enough sanity to recognize this as abnormal and ask for help from the medical staff, but the obsessive thoughts were persistent, horrifying, and relentless. I wanted to run away from my son and scream. I wanted to die because I couldn't fathom living as a shell for the rest of my life."

Carla - Moose Jaw, SK

There have been maternal suicides and attempted infanticides in Saskatchewan, but these are largely unknown due to lack of public reporting of such events out of respect for the family. Death certificates and usual reporting measures may not address the obstetrical status of a woman who harms herself or others. The magnitude of these tragic outcomes on families highlights the need for the *MotherFirst* strategy.

RISK FACTORS

The *MotherFirst Working Group* recognizes the vast spectrum of socio-demographic, cultural, biological, spiritual, psychological, and economic determinants of health that affect the prevalence and treatment of maternal mental health problems.

About half of all women with a previous history of depression will experience maternal depression, and 30% of women diagnosed with postpartum depression had their initial onset of depression during pregnancy.[22] Women who are known to have experienced an episode of postpartum depression have up to a 40% risk of experiencing another postpartum depression and a 25% increased risk of experiencing another episode unrelated to childbirth.[22]

It is important to consider a woman's social, cultural, and economic situation during pregnancy and postpartum. Women can be particularly affected by the loss of an intimate partner relationship, financial difficulties, and family violence.[23] Ethnicity is also significant as Aboriginal women[9] and newcomer or immigrant women[24] are more likely to experience maternal depression. Pregnancy and delivery complications also further the risk of depression.[9] While these risk factors are important to consider, it is essential to recognize that women of all social backgrounds are vulnerable to maternal mental health problems.

Positive Mental Health

This report focuses on strategies to overcome potential mental health problems in pregnant and postpartum women. However, maternal mental health is more than the absence of mental illness. It is a component of overall health that involves individual, physical environment, social, cultural and socio-economic characteristics.[25]

Since the mental well-being of the mother is fundamental to the health of her entire family, it is essential that we promote positive mental health. Resiliency is encouraged through supportive environments and addressing the broader determinants of health.[25]

Positive mental health is believed to be the best way to minimize the risk of mental illness.[26] It can help women cope with the challenges associated with pregnancy and new motherhood, allow them to enjoy this important period of their life to the fullest, and help women recover from mental health problems.

The promotion and maintenance of positive mental health includes: regular and healthy eating, physical activity, sleep, avoiding alcohol and other drugs, coping with stress, and sharing feelings.[26]

A Mother's Story

"My postpartum depression was the deepest and darkest it had ever been. I never wanted to harm my children; I lived in fear that someone else would. Paranoia, fear, and anxiety were my core emotions, and I put on a numb smile for my children.

Even with a history of postpartum depression, I struggled to find help. When I was brave enough to ask for it, I could not find it.

My family physician was our only saving grace. He understood postpartum and how I was feeling. With hesitation, I began the medications he prescribed and the healthy lifestyle suggestions.

I avoided triggers, journaled, ate healthy, exercised, did daily devotions, and got as much rest as possible.

Together, my husband and I found our way out of the darkness by talking with our support team, working hard every day on a healthy lifestyle, praying together, and becoming educated about maternal depression."

Sherry, North Battleford

MATERNAL MENTAL HEALTH AMONG FIRST NATIONS WOMEN

First Nations, Inuit, and Métis mothers have a higher prevalence of maternal depression and anxiety than

women from the general population.[27] This vulnerability stems from an increased exposure to risk factors, such as poverty, violence and abuse, single parenthood, and limited social support.[9] Women also face unique challenges, such as leaving their home communities to give birth and to access specialized health care in urban settings,[28] the residual and intergenerational effects of residential schools, colonization leading to the eradication of traditional practices, and racism.[29] Specific socio-cultural factors related to motherhood include cultural disconnectedness, socio-demographic barriers, and a history of abuse.[30]

Pregnant First Nations women face considerable obstacles to seeking proper care for maternal mental health issues. These barriers include structural challenges (e.g. inadequate finances, lack of child care, and/or transportation), socio-demographic factors (e.g. young age, marital status, educational level), and individual difficulties (e.g. personal perceptions, personal issues).[31]

First Nations women may experience maternal depression differently as it has varying meanings across communities and among women living on and off reserve.[27] Traditional healing practices are holistic and unique in nature as they treat all four aspects of human health: physical, emotional, mental, and spiritual. Traditionally, Elders and Healers work with women throughout pregnancy and the postpartum period to ensure optimal health in all four areas.

Increased Education, Screening, and Services

Despite their increased social risk, First Nations women show considerable resilience for maternal mental health problems. This ability to combat mental health challenges could be further strengthened through improved access to education, screening, and treatment.

Education and positive mental health promotion within communities can inform women of maternal mental health. Culturally specific information is important to increase awareness among First Nations.

There is opportunity to provide effective screening and care for pregnant and postpartum First Nations mothers. The Edinburgh Postnatal Depression Scale has been validated for use among First Nations women in Saskatchewan with an optimal cut-off score of 11.5.[30] As the EPDS does not produce half marks with individual women, a score of 12 is recommended as it will provide good sensitivity for detecting depression in all women. The health services available to First Nations women differ greatly depending on location, on or off reserve. Culturally-responsive methods of treatment and holistic health practices may be divergent among communities; they are based on local practices and the available community supports. In Saskatchewan, these range from home visiting and parent mentor programs to local mental health services.

Community-driven programs, such as the Canada Prenatal Nutrition Program, Community Action Program for Children, the Maternal Child Health Program, and the Fetal Alcohol Spectrum Disorder Program, have made significant strides in improving maternal health and awareness on reserve.

Celebrating the circle of life: Coming back to balance and harmony discusses maternal depression from a First Nations perspective.[32] This publication, produced by the British Columbia Reproductive Mental Health Program, is a culturally sensitive document that may be helpful for First Nations women and those providing prenatal and postnatal health services to them.

Although not specifically recommended in this report, we suggest that First Nations mothers in Saskatchewan would benefit from culturally-appropriate and community-driven strategies to address maternal mental health.

CONSEQUENCES AND SCOPE OF THE PROBLEM

Untreated maternal depression has serious physical, emotional, and economic consequences for mothers, infants, and families.

Impact on Mothers

Maternal mental health problems can affect all aspects of becoming a mother. They can negatively impact her ability to bond, attach, and interact with her infant,[33] which can increase guilt and further depression. There is significant stigma attached to maternal mental health problems, which can leave women feeling isolated and alone. Many women feel ashamed about seeking help and have concerns about being perceived as abusive.[34] There is also a strong fear that their children may be taken away from them if they admit their depression or anxiety.[34]

There are also physical risks associated with maternal mental health problems. Women who are depressed are more likely to use alcohol,[35] drugs, and tobacco during pregnancy[36] and are less likely to have adequate prenatal care.[37] Their pregnancies are more likely to end prematurely and have obstetrical complications.[38, 39] Chronic untreated depression is associated with increased health problems, such as an increased risk of gastrointestinal problems,[40] cardiac events, and other medical problems.[41]

Chronic depression is also associated with changes in the adult brain that contribute to cognitive impairment.[42] There are disturbances in serotonin and norepinephrine levels and increased cortisol levels, which increase the risk for ongoing and worsening depression.[43]

A Mother's Story

"I knew I was in trouble when my racing thoughts and anxiety attacks led me to five days with no sleep and I was on day six without eating. This was a very dark and lonely time for me. I did not see a future as I could see no light.

This was until I was introduced to the women in the postpartum depression support group. I found a place where I could express the feelings I was having without worry of judgment or disappointment.

The facilitators in the group offered education and advice. They were the foundation I so desperately needed. The other mothers offered support and hope, the light I so desperately craved."

Tami - Saskatoon

Impact on Children

Maternal depression is a significant risk factor affecting the healthy development and well-being of infants and young children.[44] The babies of depressed women are at increased risk for preterm birth, low birth weight,[45] and lower Apgar scores (the score assigned to indicate the health of the baby at birth).[45] Breastfeeding can be less frequent and of shorter duration.[46]

Maternal depression is a significant risk factor affecting the healthy development and well-being of children.

Children of mothers who are depressed are more likely to experience growth, attachment, psychological, cognitive, behavioural, and developmental problems than children of mothers who are not depressed.[47, 48] These children are at increased risk of having attention deficit hyperactive disorder,[49] depression, and autism.[50] School readiness is negatively affected[51] and there is a connection with increased criminality.[52]

Long-term physical effects are also possible as there is evidence that the prenatal environment exerts influence on fetal health that, in turn, impacts the health of the adult many decades later.[53]

Impact on Partners

Maternal depression also affects the partners of depressed women. Up to 50% of the partners of women with maternal depression also experience depression.[54] A recent study found that 10% of expectant and new fathers will experience depression, twice that of other men, usually around the third to fourth month after birth of the child.[55] This compounds the impact on infants as both parents struggle to achieve mental well-being.[56] Untreated depression is also correlated with higher rates of marital breakdown.[57]

Economic Impact

There is also a significant economic burden related to maternal mental health problems. Mental illness is estimated to cost $14.4 billion per year in Canada,[58] and it has been estimated that productivity losses from short-term disability due to depression total $2.6 billion annually.[58]

Specific to maternal depression, partners may have decreased work productivity due to providing care to mothers and children, constant stress over family matters, or developing their own depression. This may result in difficulty finding and maintaining employment, income loss due to missed work, and paying for other expenses related to care and treatment.[59]

Maternal mental health problems result in significant economic expense from direct medical costs, decreased work productivity of both parents, and ongoing support for delayed child development.

Workplace productivity may also be reduced for working pregnant women or new mothers returning to work if they suffer with the effects of anxiety and depression.

Difficulties with concentration and decision-making, sleep disturbances, and somatic complaints can affect work quality.

Direct costs to the health care system are also significant. An estimated $20.5 million is spent annually in Ontario on direct medical services for the symptoms of untreated maternal depression in pregnancy.[60] This includes above-average physician visits and hospitalizations as depressed people use health services more frequently.[60, 61] Adjusting this data for Saskatchewan's birth rate would indicate that every year over $2 million is spent on untreated maternal depression during pregnancy. The real cost of untreated maternal depression would be significantly more if costs of postpartum depression were considered. This study also used a relatively low prevalence rate (12%) of maternal depression and did not include any indirect costs of alternative care or the long-term costs carried by families, workplaces, or health care.[60]

The negative effects on children due to maternal depression are costly. Pregnant women with depression are more likely to give birth preterm and deliver low birth weight infants.[45] Preterm deliveries are estimated to cost $10,080 at birth and another $13,215 if the infant is readmitted to hospital during their first year of life.[60] Low birth weight infants are associated with $34,310 of hospital costs at delivery and another $24,937 for additional health care costs during the first year of life.[60] These infants generally require longer hospital stays and admission to neonatal care units at birth. They are hospitalized more often and for long stays in their first year.[62]

Beyond these immediate health costs, there is an additional public burden in addressing the long-term impact of maternal depression on children. The education system, social services, and health care are required to provide services to children who experience adverse effects from maternal depression, such as developmental delays and social difficulties.

The economic burden of maternal depression is multi-faceted. It affects every area of life including work, family, physical health, and social functioning. By addressing maternal mental health problems and providing effective treatment, there is a potential for great savings to employers, families, and public support services such as zealth care.

EXISTING POLICY AND POSSIBLE INTERVENTIONS

Saskatchewan lacks a provincial policy for identifying and treating maternal depression. Each regional health authority has varying practices regarding maternal mental health, but across the province there is neither the expectation nor the requirement to screen pregnant women or new mothers for depression. While some support services and medical treatments are available, they are inconsistent *(Appendix B – Maternal Mental Health Policies and Practices in Saskatchewan).*

British Columbia has a framework for perinatal depression screening and care,[63] and *BestStart* in Ontario held a campaign for postpartum depression in 2007-8. Most of the health regions in Alberta offer universal postpartum depression screening during child immunization visits, and many provinces are working towards making screening standard practice *(Appendix C – Maternal Mental Health Policies and Practices in Canadian Provinces).*

There are several strategies available to improve the maternal mental health of Saskatchewan mothers. Using a mental health promotion model, there are opportunities to reduce the severity of this illness at the primary, secondary, and tertiary levels:[64]

- Education and increased public awareness (primary);
- Screening (secondary); and
- Treatment, early intervention, and recovery (tertiary).

Each of these methods of mental health promotion was considered during the development of this report.

MOTHERFIRST PROCESS

Many interdisciplinary and intersectoral stakeholders have identified maternal mental health problems as a significant health concern in Saskatchewan. There is substantial need for a comprehensive strategy to address this issue given the prevalence and consequences of maternal anxiety and depression and the amenability of these disorders to intervention.

The *Unmasking Postpartum Depression* conference in Regina in October 2009 brought together health practitioners and women of all backgrounds. Experts provided knowledge and participants shared experience in order to build greater awareness of maternal mental

health within Saskatchewan. At the end of this event, the participants called for a comprehensive provincial policy to address maternal mental health within the province. The *MotherFirst Working Group* was formed shortly afterwards to realize this goal.

The strategy presented in this report was developed through broad consultations with stakeholders from our working group and their communities. Working group members were encouraged to seek input to drafts of this report from their various constituencies.

The *MotherFirst Working Group* has support and representation from many professional associations and provincial organizations with an interest in improving the experience and outcomes of pregnancy and motherhood.

The *MotherFirst Working Group* is composed of health professionals in the areas of psychiatry, psychology, nursing, public health, mental health, obstetrics and gynecology, social work, midwifery, lactation, community and child health, and First Nations health. Consultants from the Saskatchewan Ministry of Health were included from the Population Health and the Mental Health Branches.

The working group is geographically representative as there is a member from every health region of the province.

First Nations health was represented by members from the Federation of Saskatchewan Indian Nations, the Public Health Agency of Canada, and the First Nations and Inuit Health Branch.

Mothers who have experienced challenges with maternal mental health were included in this group. Together with their families, they have driven the need for these recommendations and guided their development.

The diverse nature of the *MotherFirst Working Group* speaks to the importance of maternal mental health. The following policy priorities incorporate the results of consultations with these individuals and the groups they represent. They provided research, professional insight, and personal experience essential to the development of this report.

PART 2: POLICY PRIORITIES

RECOMMENDATION #1

Increase awareness of the frequency, impact and treatment of maternal mental health problems, and promote positive mental health through ongoing access to evidence-based materials.

Education, screening, and treatment were identified as the key policy priorities to improve maternal mental health by the participants of the *Unmasking Postpartum Depression* conference in Regina. The following recommendations evolved from these as developed by the *MotherFirst Working Group.* Additionally, they reflect the *Population Health Promotion Framework for Saskatchewan Regional Health Authorities* by addressing prevention, early intervention, and treatment.[64]

The working group also discussed the best approach to implement the recommendations to ensure they are sustainable and accountable. This is considered in Part 3: Governance and Implementation.

EDUCATION (PRIMARY PREVENTION)

Primary prevention starts with education. Increased public awareness will decrease the risk and prevalence of mental health problems in pregnant women and new mothers, which will help to reduce the negative effects on developing children and infants.

It is important to engage all stakeholders in creating awareness, including the greater public, women and their families, and health professionals at all levels. This will effectively establish maternal mental health as a public issue, provide useful and current information, and help to end the stigma that alienates so many women and prevents them from seeking help.

Many mothers, partners, and health professionals lack adequate information about maternal mental health problems. Education needs to include the frequency and risks, symptoms and general consequences, effectiveness of treatment, and access to care.

Best Practice

Mother's groups, such as those in Assiniboia, Mortlach, and Biggar, provide a safe and supportive place for women to share their feelings with new and experienced mothers.

When facilitated at a distance by health professionals, such groups can also provide education and early intervention as well as peer support.

The *MotherFirst* strategy was held concurrently with a professional and public awareness campaign funded by the Canadian Institutes of Health Research. It included Information Cards, Posters, and Fact Sheets developed in conjunction with, and available through, the Saskatchewan Prevention Institute *(Appendix D).* Recent presentations around the province have trained and informed health professionals and other interested audiences about maternal mental health and these recommendations. The keen reception to this campaign has highlighted the need for access to information and ongoing professional development.

Public Awareness Materials

Printed awareness materials need to be available ongoing to care providers and be displayed in places frequented by women and their families, particularly health clinics and doctors' offices, the health regions, and through the various groups that interact with mothers and their care providers.

Maternal mental health needs to be highlighted on the website of the Saskatchewan Ministry of Health, *HealthLine Online*, regional health authorities' websites,

onehealth.ca, and other online sources that serve mothers and their care providers. The *MotherFirst* website, www.skmaternalmentalhealth.ca, provides all of the materials.

Women and Their Families
Women often feel alone when dealing with mental health problems. Accessible information will help them feel less isolated and empower them to self-monitor and reach out for help. Women and their families will get the knowledge and tools they need to recognize problems and access support and treatment earlier. It will encourage positive mental health for the entire family.

Professionals
Regular training on the frequency, impacts, and treatment of maternal depression and anxiety will enable care providers to recognize the signs of maternal mental health problems, perform timely and proper assessments, and make effective referrals or provide treatment.

Curricula
Include specific information about maternal mental health problems and resources in prenatal, postnatal, breastfeeding, and parenting classes. To ensure best practices, health care provider curricula needs to include specific information about the prevalence, features, and treatment of maternal mental health problems and should include opportunities for ongoing professional development.

Research
Maternal mental health research aligns with the priorities of the *Saskatchewan Health Research Strategy.*[65] These priorities include special populations, particularly First Nations; rural, remote, and timely access to primary and mental health services; early child health issues; and the prevention of chronic disease. Ongoing, longitudinal research needs to fully address the determinants of positive maternal mental health as well as problems, promote development in the areas of detection, the effects of maternal mental health problems on women, children and families, as well as best practice treatments in Saskatchewan.

SCREENING (SECONDARY PREVENTION)

Early identification of women at risk for maternal mental health problems helps to prevent worsening symptoms and assists in early intervention.[66] This can reduce the impact of maternal depression on mothers, their children, and the entire family.[67]

RECOMMENDATION #2

Universal screening for depression and anxiety using the Edinburgh Postnatal Depression Scale (EPDS) in pregnant and postpartum women.

Screening is an essential part of prevention and early detection of maternal depression and anxiety. It involves the use of a valid tool to detect symptoms indicating individuals who are at risk of experiencing an illness, in this case maternal mental health problems.[68] A joint statement from the World Health Organization and the United Nations Fund for Population Activities supports early detection of disease with validated screening instruments.[69] The American Psychiatric Association and the American College of Obstetricians and Gynecologists recommend routine screening for depression during pregnancy.[70]

There is an ethical component to screening, especially in health care, as there is a moral obligation to reduce harm.[71] Public policymakers and clinicians have a responsibility to screen for treatable disorders, such as depression, which is prevalent among a population and has negative health implications.[72] Screening for postpartum depression is legally and ethically beneficial as it removes liability for failing to diagnose a serious problem and prevents suffering among women and their families.[72]

Research and clinical practice has demonstrated that the *Edinburgh Postnatal Depression Scale* (EPDS) is a valid, reliable, and efficient method to identify perinatal depression and anxiety *(Appendix E – Edinburgh Postnatal Depression Scale).*[73, 74] It is the primary screening tool used to screen for depressive symptoms in pregnant and postpartum women worldwide. [73, 75, 76] The EPDS is not intended to replace a diagnostic interview with a trained clinician, but it can assist in quickly identifying

those women in need of further assessment for anxiety, depression, and suicidal ideation.[77, 78]

While there are other screening tools,[79] the EPDS is easily administered, scored, and available at no cost.[75] It is culturally sensitive, has been translated into many different languages, and is appropriate for diverse socio-economic and ethnic groups.[80] It can be administered over the telephone, making it accessible to rural or otherwise isolated women.[81]

Most women are very accepting of the EPDS during routine clinic visits,[82] and it offers a valuable opportunity to open the lines of communication to talk about issues that may be of concern to the mother, beyond her physical condition.[8]

The screen is an easy to complete self-report that requires minimal training for administration[84] and time with each woman (approximately 5-10 minutes per screen). While the EPDS is free to access, there are some minimal costs, such as printing or it may be included in electronic prenatal and other medical forms.

While the tool is self-administered and can be used without instruction, materials are being produced that will instruct on the use of the tool for those who may desire more information. *Appendix F – Strengths and Weaknesses of the EPDS* summarizes the literature on the use of the EPDS.

Partners

Given the increased risk of depression in partners of women with maternal depression[54] and the positive effects of paternal mental health on child development in the face of maternal mental health problems,[56, 85] this is an optimal time to screen them as well. Partners can also be screened with the EPDS as it has been validated in this population.[86] The recommended cut-off score for men is lower than in women, at 5 or 6.[86]

UNIVERSAL SCREENING

Use the Edinburgh Postnatal Depression Scale (EPDS) with all pregnant and postpartum women. Positive mental health should be promoted with all women.

Cut-off scores for depression (using all 10 questions):

- Score of 12 or more or a positive answer to question 10
  - Refer for follow-up assessment or treatment
  - Suggest partner be offered the EPDS
- Score of 10–11
  - Repeat screen within two weeks or sooner as determined by the caregiver

Cut-off Score for anxiety (using questions 3, 4, 5):

- Score of 4 or more on these 3 questions
  - Refer for follow-up assessment or treatment

These cut-off scores will remain the same throughout pregnancy and postpartum to ensure consistency and ease administration between practitioners and administrative units.

Positive response to self-harm (question 10)

- Ask if woman has a plan for self-harm or harm to others
  - Follow regional template for accessing help

Frequency: Twice in pregnancy and three times postpartum

Pregnancy (include on the prenatal form):

1. Due to the increased risk for complications in pregnancy, the effects of on the fetus, particularly the increased risk for preterm delivery, we recommend initial screening at the first or second prenatal visit (whatever the gestation of the pregnancy). This visit should also address initial concerns, provide awareness materials, and intervention when necessary
2. At 28 to 34 weeks gestation to optimize mental health prior to postpartum

Include prompts on the prenatal form. Record when complete and woman is referred.

Postpartum:

1. Before discharge from local maternity home visiting/early discharge programs, or within the first 2-3 weeks postpar tum through contact with a public health nurse to monitor for early onset depression and postpartum psychosis
2. At the two-month immunization visit at Child Health Clinics (if missed at two-month visit, do at four months)
3. At the six-month immunization visit at Child Health Clinics

These are the *MotherFirst* Working Group's minimum recommended times for screening in pregnancy and postpartum; however, the EPDS can be used at any time with women at risk. Health regions and First Nations communities can customize the template to direct care providers to specific resources (Appendix G).

Best Practice

The Battlefords Tribal Council Indian Health Services has developed a comprehensive mental health strategy for the women it serves.

Education on maternal mental health is given at prenatal visits and prenatal classes. They use the EPDS, T-ACE, and WAST screening tools with all pregnant women.

If a woman scores 12 or higher on the EPDS, or high on the other screens, they are given the opportunity to engage in counselling. The counsellor will meet them in their own community clinic or make a home visit. Transportation is provided to women if this is a barrier to support.

Policy and practice are being developed to administer the EPDS during the community health nurses' postnatal visits.

Peer support is also available during moss bag-making classes and Nobody's Perfect parenting classes.

Screens for Family Violence and Alcohol Use

The focus of this report is maternal mental health; however, the working group believes that it is important for those who are screening women for depression to consider the strong association of family violence and substance abuse in women who are struggling with anxiety or depression.[35, 87-89]

Women can be screened for family violence using the short form of the *Woman Abuse Screening Tool* (WAST):

1. "In general, how would you describe your relationship: a lot of tension, some tension, no tension?"
2. "Do you and your partner work out arguments: with great difficulty, some difficulty, no difficulty?".[90]

Practitioners can screen for alcohol abuse using brief screening tools such as TWEAK or T-ACE.[91] **T-ACE** is an acronym for 4 items:

T – How many drinks can you hold (score 2 for more than 3)

A - Have you ever been annoyed by people's criticism of your drinking? (yes=1)

C - Are you trying to cut down on drinking? (yes=1)

E - Have you ever used alcohol as an eye-opener in the morning? (yes=1).

A score of 2 or more indicates high risk.[91]

The Saskatchewan Prevention Institute has developed a teaching package for professionals and post-secondary institutions to raise awareness of alcohol risk assessment. This provides specific guidance on how to ask, advise, and assist women, including information on the T-ACE and motivational interviewing.[92]

RECOMMENDATION #3

Prioritize maternal mental health within Mental Health Services, improve accessibility, and increase treatment options.

TREATMENT (TERTIARY PREVENTION)

It is essential to address and treat mental health problems, and restore the well-being of women suffering from mental health problems expediently to minimize the potential for adverse effects on the woman, her infant, and her family.

PRIORITY CARE

Prioritizing the pregnant and postpartum woman within mental health intake and treatment services is paramount because anxiety and depression symptoms can worsen and increase the risk to mother and child if she is put on a lengthy wait list for care.

ACCESS

Every woman needs access to treatment and her care provider should know how to access help. *Appendix G* provides a template, based on these recommendations, for each region to develop a system of screening and referral to access help in a seamless manner.

A list of resources within Saskatchewan is found in *Appendix H.* (Every effort has been made to capture all known resources at the time of printing and does not include private practitioners). This list needs to be

maintained with current resources and made available to women and their care providers. The resource list is also available on the *MotherFirst* website - www.skmaternalmentalhealth.ca.

Best Practice

Prince Albert Parkland Health Region, Mental Health Services, has a social worker who has devoted part of her clinical practice to treating pregnant and postpartum women. They are usually able to access her for care within a week.

OPTIONS

Treatment needs to consider the unique experiences and the physical changes associated with becoming a mother, potential financial and relationship stressors, and her psychological history. Comprehensive assessments and individualized interventions can provide the support that is needed to address health and social disparities. Effective treatment frequently involves a combination of approaches, including support, interpersonal therapy, and medication regimes that are individual from woman to woman.

Many existing evidence-based treatments can improve maternal depression and anxiety. These include psychotherapies, such as cognitive behavioural, interpersonal, and brief symptom therapies and interventions such as bright light therapy.[93,94] Psychosocial and psychological interventions are associated with a reduction in the likelihood of continued depression compared to usual postpartum care.[95]

Support

It is vital that every woman has access to either individual or group support. Support can be provided through groups facilitated by health professionals, peer support systems, or telephone-based programs.[96] Health visitors have been shown to reduce postpartum depression through 'listening visits'.[97] A telephone peer support project is currently underway in Saskatchewan; it offers a way for rural or otherwise isolated women or those who do not like group experiences to get support. Women who have experienced maternal mental health problems often find it rewarding to help other women.[98]

The support and involvement in treatment of a woman's partner is important to increase the chances that she will follow prescribed treatments and recover from maternal depression.[99] With consideration to the woman's preferences, the nature of the relationship, and cultural issues, partner support strengthens her overall support network.[63]

Partners

Given the increased likelihood of partners suffering from depression,[55] involving the partner in treatment options may also have positive effects on their mental health.

Maternal mental health treatment depends on the:[63]

- women's response to treatment for a previous depressive illness
- severity of her illness
- woman's and/or her family's ability to mobilize supports for her and her infant
- woman's preferred treatment choice, balanced by consideration for the safety of both mother and infant
- availability of culturally safe and appropriate services

Medication

Pharmacological treatment is often needed to treat severe depression or anxiety, especially for those women who suffer from more than one mental health problem. The woman, in consultation with her clinician, must always weigh the risks and benefits of all pharmacotherapy during pregnancy and breast-feeding.[100] Encouraging women with a history of depression and those taking medication for depression, anxiety, and bipolar disease to seek advice from their physicians before they become pregnant is an important preventative strategy. If they are concerned about changing or discontinuing medications, a 3-month pre-conceptual trial of taking no medications or changing medications is suggested before trying to become pregnant.[101]

Best Practice

Saskatoon Health Region has developed a Maternal Mental Health Program. The program brings together a psychiatrist, psychologist, and nurse to provide care within a primary health centre.

All family medicine residents in the region have first-hand experience with screening, diagnosis, and treatment of maternal mental health problems.

Care Approach

Given the importance and complexity of treating maternal mental health problems within the context of the family, mental health services need to be well coordinated and integrated. Communication is essential among the various care providers, which includes community groups and organizations, First Nations, multiple health care providers, and branches of the formal health care system. A team of health care professionals offers the most comprehensive approach to maternal mental health care.[102]

Stepped care is characterized by different treatment steps arranged in order of increasing intensity.[103] The goal is to provide efficient, cost-effective services by matching the severity of symptoms to the appropriate level of treatment.[104] Shared care models can make effective use of specialized psychiatric services.[105]

The following model outlines how a stepped-care approach could serve maternal mental health in Saskatchewan. We suggest health regions and First Nations communities adapt the model to meet their own needs.

STEPPED MATERNAL MENTAL HEALTH CARE

SPECIALIST MATERNAL MENTAL HEALTH SERVICES
Prevention and treatment of moderate/severe mental illness; source of information and training to primary and secondary care workers
Care Providers: Psychiatrists, Nurses, Social Workers, Psychologists, Occupational Therapists

SPECIALIST MENTAL HEALTH SERVICES
Assessment and treatment; referral to specialist services and inpatient care
Care Providers: Community Mental Health Teams (Psychiatrists, Nurses, Social Workers, Psychologists, Occupational Therapists)

PRIMARY MENTAL HEALTH SERVICES
Assessment and referral; treatment of mild/moderate mental illness
Care Providers: Physicians, Health Visitors, Midwives, Nurses, Nurse Practitioners,Psychologists, Primary Mental Health Care Workers, Maternal Child Family Health Workers, Elders

GENERAL HEALTH CARE SERVICES
Detection history of and current mental illness; referral and treatments
Care providers: Physicians, Obstetricians, Health Visitors, Midwives, Nurses, Nurse Practitioners, Maternal Child Family Health Workers, Elders, Addiction Workers

Level of Care

Adopted from beyondblue: the national depression initiative, Perinatal Mental Health National Action Plan 2008-2010 Full Report. 2008, Perinatal Mental Health Consortium.

PART 3: GOVERNANCE AND IMPLEMENTATION

RECOMMENDATION #4

Implement the MotherFirst policy recommendations and ensure maternal mental health remains a priority within Saskatchewan.

SUSTAINABILITY AND ACCOUNTABILITY

Maintaining maternal mental health as a priority is paramount for positive outcomes for Saskatchewan women, children, and families. If not addressed now, it will continue to affect the health of future generations. The implementation of awareness, screening, and treatment initiatives needs to be sustainable and include clear lines of accountability.

An overarching provincial strategy is required to provide all women and care providers with consistent policy across the province. Many women receive maternal health care in a different area or region from where they live. Consequently, there is a need for policy with dependable guidelines and accountability to ensure the best possible maternal mental health care to each woman.

Engage Key Stakeholders

Caring for mothers involves many different health services, community organizations, and government agencies. Involvement of multiple stakeholders needs to be ongoing in order to ensure comprehensive programs and services for childbearing women.

Intersectoral collaboration is essential in designing and delivering adequate preventive and restorative measures for maternal depression and anxiety. This reflects the emphasis on intersectoral collaboration in the *Population Health Framework for Saskatchewan Regional Health Authorities*.[64]

Develop Provincial and Regional Groups

In British Columbia, the only Canadian province with a health strategy to address mental health in pregnant and postnatal women, health regions are required to prepare regional plans consistent with the overall policy recommendations put forth. This recognizes the autonomy of the health regions and provides an opportunity for the regions to assess and meet their own particular needs while ensuring that action is taken.[63]

The MotherFirst Working Group supports implementing these policies through an overarching provincial maternal mental health group as well as the formation of regional groups.

Best Practice

Prairie North Health Region has created an active intersectoral Maternal Mental Health Group that presently includes the following stakeholders:

- *Battlefords Tribal Council Indian Health Services – Maternal-Child Program and Counsellor*
- *Nurse Practitioner with Population Health*
- *Primary Health Manager*
- *Primary Health Facilitator*
- *Parent Mentoring Program*
- *Community Health Nurse*
- *KidsFirst Counsellors and Manager*
- *Catholic Family Services*
- *Mental Health*
- *Nursing – Obstetrics*
- *Women's Health & Birthing Centre (Hospital) Manager*
- *Battlefords Early Childhood Intervention Program*

The provincial group will include interdisciplinary stakeholders involved in maternal mental health from throughout the province. It will provide guidance, accurate information, and implementation strategies to the regional

groups. It is important that this group ensure that the regions take action on *MotherFirst* policy priorities and that they remain in the forefront of both maternal and mental health care and research in the province.

The regional groups will represent the needs and priorities of maternal mental health within each health region. This allows for the identification of resources and the development of regionally-specific supports and services. These groups could replace or be in conjunction with existing groups that provide service or care to women with mental health problems.

Data Collection and Evaluation

It is also essential that there is a method of measuring the impact of the *MotherFirst* recommendations. Data collection in the area of maternal mental health is important to identify and evaluate the strengths of these policies.

The existing provincial Mental Health Information System restricts record of diagnoses to certain professionals, and maternal mental health is not separately coded by preconception, pregnancy, and postpartum status.[106] These are significant limitations to the comprehensive collection of information about this population that need to be addressed.
A more accessible and precise data collection procedure is required to determine the prevalence and demographics of maternal mental health and the treatment patterns within Saskatchewan and to ultimately assess the effectiveness of the *Maternal Mental Health Strategy.*

It is proposed that the Mental Health Information System include codes for maternal mental health by pregnancy and postpartum status. This will measure the demographics and trends of the prevalence and treatment of maternal mental health in Saskatchewan.

Best Practice

The Saskatchewan Addictions Advisory Committee is an independent agency that measures the results of related programs, coordinates education campaigns, and oversees treatment initiatives.

Maternal mental health will require a similar provincial group to ensure accurate information, service evaluation, and effective coordination of resources among regions.

PROPOSED ACCOUNTABILITY STRUCTURE

Ministry of Health
Government of Saskatchewan

Provincial Maternal Mental Health Group

Purpose:

1. Support implementation of policy recommendations
2. Advise government and regions on best practices/evidence for sustaining optimal maternal mental health and maternal mental health services
3. Work with existing initiatives (HQC – Depression Collaborative, etc.)
4. Evaluation of impact of recommendations

Representation to include:

Public, Primary, and Mental Health Services
Obstetrics, Psychiatry, and Family Medicine
Early Childhood Intervention Program/KidsFirst
Federal Maternal Child and Mental Health Programs
Federal Canada Prenatal Nutrition Program (FNIH and PHAC)
Provincial Tribal Council representative
Indian Child and Family Services/Child and Family Services
Elder
Health Quality Council
Healthline
Saskatchewan Prevention Institute
Woman/women with Lived Experience
Social Services, Family and Child Services
Newcomer/Immigrant Group
Perinatal Education Program
Others as necessary

Regional Maternal Mental Health Group

Purpose:

1. Implementation of policy recommendations at regional level
2. Develop accessible support and treatment options
3. Communicate with their regional administrators

Sample representation:

Regional Public, Primary and Mental Health Services
Regional Obstetrics, Psychiatry, and Family Medicine
Regional Early Childhood Intervention Program/KidsFirst
Regional, Local, and Federal Maternal Child Health Program
Regional Tribal Council representative
Indian Child and Family Services/Child and Family Services
Elder
Women with Lived Experience
Regional Social Services
Health Quality Council Depression Collaborative
Regional Newcomer/Immigrant Group
Others as necessary

SUMMARY

The following table summarizes the priorities, people, focus, and activities of the *MotherFirst.*

MATERNAL MENTAL HEALTH STRATEGY IN SASKATCHEWAN

	Education	Screening	Treatment	Sustainability and Accountability
Priority	Primary Prevention	Secondary Prevention	Tertiary Prevention	Implementation Governance Maintenance
People	- Women and Their Families - Professionals - Public	Those who care for pregnant and postpartum women	- Peer support groups - Community programs - Crisis services - HealthLine - Formal health services	Multiple stakeholders organized into Advisory Committees at the regional and provincial levels within the Ministry of Health
Focus	- Awareness - Professional Education	Identifying and reducing depression, anxiety, and other maternal mental health problems	- Reduce harm to mother and developing child through treatment - Recovery - Resumption of new level of mental health	Policy implementation and sustainability
Activity	- Provide materials and presentations for increased awareness - Ensure presence in educational programs - Promote positive mental health	- Universal screening and further assessment for at-risk mothers - Provide materials and presentations for increased awareness	- Support, diagnosis, and treatment - Promote positive mental health	- Develop programs and services - Ensure adequate lines of accountability and sustained action

CONCLUSION

This report presents the recommendations of the diverse members and constituencies of the *MotherFirst* Working Group. It is intended to provide the information needed by the Saskatchewan Ministry of Health and First Nations communities to take action to improve maternal mental health across the province.

Due to the significant consequences of untreated maternal depression and anxiety, it is essential that education, screening, and treatment of maternal mental health problems become health priorities. The *MotherFirst* policy recommendations will alleviate the personal, social, and economic costs of maternal depression and anxiety.

Women and their families will receive more comprehensive and preventive health care with the implementation of these recommendations. It is a more holistic approach to the services provided during and after pregnancy and postpartum and will greatly benefit all women and their families.

The Government of Saskatchewan will be committing itself to healthy families by adopting the *MotherFirst* policy recommendations. It is an opportunity to provide better care to women and to ensure the best beginnings for their children. It will be an effective investment in Saskatchewan's mothers and our future generations.

Appendix A: TERMINOLOGY USED IN THE REPORT

Antenatal
Before birth[107]

Anxiety
A mood disorder characterized by excessive worry/anxiety and difficulty controlling this worry. Also associated with other symptoms such as restlessness, fatigue, difficulty concentrating, irritability, and sleeping difficulty[11]

Depression
A mood disorder described as a negative emotional state during which a person feels sad, lonely, or miserable, with a lack of interest in most, or all, activities[108]

Maternal Mental Health
Mental health during pregnancy and after childbirth[109]

Maternal Anxiety
Same diagnosis as used for anxiety disorder, except that the anxiety occurs during pregnancy or the postpartum period

Maternal Depression
Same diagnosis as used for a major depressive disorder, except that the depression occurs during pregnancy or the postpartum period

Perinatal
Around the time of birth.[107] This term may also be used more broadly, including the period of pregnancy to one year after delivery. It may even include the preconception period

Positive Mental Health
Positive mental health involves improved coping with life's challenges and the ability to enjoy life to the fullest[26]

Postnatal/Postpartum
After child birth[107]

Postpartum Psychosis
Psychosis that occurs after giving birth. Symptoms include agitation, hallucinations, mood swings, and/or bizarre perceptions[18]

Pregnancy
The condition of having a developing embryo or fetus within the body; the state from conception to delivery of the fetus. The normal duration is 280 days (40 weeks or 9 months and 7 days)[107]

Prenatal
Occurring before birth[107]

Sensitivity (of a screening tool)
Sensitivity is the proportion of truly diseased persons in the screened population who are identified as diseased by the screening test[110]

Specificity (of a screening tool)
Specificity is the proportion of truly non-diseased persons who are so identified by the screening test[110]

APPENDIX B

Maternal Mental Health Policies and Practices in Saskatchewan*

HEALTH AUTHORITY	PRESENT POLICY	WHAT SCREENING TOOLS ARE USED
ATHABASCA	• Currently working with the MotherFirst Working Group	• Involved with the Health Quality Council and are using the PHQ-2
CYPRESS	• At the present time, no formal written policy or guidelines for maternal depression exist in the region	• There are no standard screening tools used in the women and children's department at this time. • Public health utilizes the EPDS. The form is located in the public health postnatal manual and can be utilized at nursing discretion. There are no specific criteria regarding situations indicating use of the screen. • Inpatient Mental Health utilizes a standardized mental status and psychosocial assessment. Specific PPD screening tools are not utilized at the present time.
FIVE HILLS	• Do have a written policy regarding screening for post-partum depression in Child Health Clinics (CHC)	• Use the EPDS at the 2 month CHC visit
HEARTLAND	• In child health clinic guidelines for Public Health Nurses	• Postpartum mental health is addressed in an ongoing use of the EPDS in the clinical setting, and at the postnatal home visit made by the local PHN. The PHN will introduce the subject by also using the attached Q&A regarding postpartum adjustment
KEEWATIN YATTHE	• no policy statement on maternal mental health or postpartum depression	
KELSEY TRAIL	• No formal policy • Referrals for this type of assessment and treatment are rare • A targeted KidsFirst program based out of Nipawin	• Postpartum women are screened before discharge using Kids First Birth Screen • The EPDS is used by some Public Health Nurses when needed • Saskatchewan In-Hospital Birth Questionnaire asks about prior postpartum depression and mental illness. PHNs get this screen • Some use the PHQ-9 to assess for all depression

IS THERE ANY FORM OF SCREEN ON THE PRENATAL FORM	FORMAL SUPPORTS AND SERVICES	EDUCATIONAL RESOURCES/ CAMPAIGNS
	• An itinerant Mental Health Therapist in our communities	• There has not been any campaigns of this nature in the communities
	• Individualized support and treatment is provided through adult mental health clinicians for clients referred to mental health • No formal supports or programs focused specifically on maternal mental health exist within the health region at the present time. Women identified to require support are referred by physicians, NP's or public health nurses to community or inpatient mental health	• Public health nurses currently discuss postpartum depression during pre-natal classes • Post natal mothers receive printed educational material "Breaking the silence – understanding postpartum disorders" during a visit from the public health nurse approximately 1-2 weeks post delivery • Inpatient mental health utilizes a printed self-care package from B.C. – "Self Care program for Women with Postpartum Depression and Anxiety". The package provides information and resources for both postpartum mothers and partners/ family members.
• Do not screen prenatally for depression	• Formal services for women with post partum depression include psychiatry and clinical counseling at Mental Health and Addictions Services • We refer our mothers to either their family physician or Mental Health Intake, there is a PPD support group in Moose Jaw	• Attended the "Smiling Mask" conference • Presentations with Dr. A. Bowen and the Smiling Mask Authors in April 2010.
	• Maternal Child Health under Public Health Services has postnatal support (home visits and phone calls) • Referrals to the appropriate health professional in the region to assist a client access other services	
	• CPNP in Ile a la Crosse, Beauval, La Loche and Mental Health Counselors in communities. • A prenatal nutrition program in certain communities which is a major support for women during pregnancy and provides a healthy social "space" for many who are at risk	• Use a book from Public Health of Canada, "Postpartum Depression - A guide for front-line health and social service providers" • Discussed at prenatal class and at postnatal visit. Mention the EPDS
• We assess all parents entering KidsFirst with an in-depth assessment common to all KidsFirst targeted programs, which is completed by our mental health counselor • The EPDS is also used occasionally as required • The Parent Mentoring Program registration asks about depression	• Services would be delivered by Mental Health and Addictions based on initial intake and assessment • Formal support would be provided via staff of contract support if required • Kids First program in Nipawin would have supports • Our practice is to refer first to our mental health counselor (there is no waiting list to see our counselor) who will then refer for more in-depth medical and psychiatric support if required. Our program also provides respite childcare to help the mother who is experiencing depression seek all the support she is eligible for and lower the stress level in the home. • We also partner with another agency to offer a mom's support group. We offer both childcare and transportation for this group.	• Mental Health Counselor has been to conferences focusing on maternal depression • Public Health has a list of educational handouts regarding postpartum depression • Pamphlets and posters distributed to MD and NP offices and community service locations

APPENDIX B

Maternal Mental Health Policies and Practices in Saskatchewan*

HEALTH AUTHORITY	PRESENT POLICY	WHAT SCREENING TOOLS ARE USED
KELSEY TRAIL CONTINUED		
MAMAWETAN CHURCHILL RIVER		
PRAIRIE NORTH	• Nothing specific to maternal mental health • Working with MotherFirst group to develop policy	
PRINCE ALBERT PARKLAND	• PAPHR Postpartum Initiative started in 2005 as a response to one of the goals of the Maternal Child Accreditation Team	• Screening occurs during a maternity visiting program where Public Health and Mental Health work together to identify at-risk groups and target within the hospital. The screen is comprised of 4 key questions from PASCAN; any red flags are followed up by the home visiting nurse within approximately 2 weeks. If red flags are still present, the EPDS is given; if they score 12 or greater, they are referred to Mental Health where intervention is offered
REGINA QU'APPELLE	• The In-Hospital Birth Questionnaire (IHBQ) has been implemented since 2002 • There does not seem to be a policy around this, but there is a signed agreement with KidsFirst. All women who give birth in hospital are offered the voluntary questionnaire which has one question regarding PPD • Awaiting MotherFirst Strategy	• EPDS is the screening tool of choice • The provincial IHBQ - one question (11) refers to mental health issues; the question (11C) specifically asks if the woman has experienced PPD or postpartum psychosis in past pregnancies. This question could qualify a woman to be assessed by targeted KidsFirst, i.e. if women only score positive on the PPD question, since it has a weight of 9 it would ensure that there would be follow up. In non-targeted areas the follow up would have to be done by Public Health • IHBQ questions (11C) only identifies women who have previously experienced PPD, not just general depression, which would mean that first-time mothers would not be identified as at-risk
SASKATOON	• Current protocol for intake to the Post Partum Depression Support Program and the Maternal Mental Health program is to screen each person using the EPDS • Public Health Nurses utilize the EPDS to screen on a discretionary basis	• EPDS

IS THERE ANY FORM OF SCREEN ON THE PRENATAL FORM	FORMAL SUPPORTS AND SERVICES	EDUCATIONAL RESOURCES/ CAMPAIGNS
	• We also partner with another agency to offer a mom's support group. We offer both childcare and transportation for this group. • Public Health Nursing at each postnatal contact, typically starting within 4-7 days of receiving file from Maternal Visiting Program at approximately 10 days postpartum up until 6 weeks. Screening then occurs at each CHC visit during the first year (2 months and up) • Other CBOs that offer services are Native Coordinating Council and Family Connections • If individual scores 10 or higher on EPDS a voluntary referral is sent to Mental Health	
	• No formal supports, but women are referred to physicians or mental health based on screening results	• There have been some community education sessions • A brochure on PPD is available to the public
	• evening prenatal classes, teen prenatal and prenatal night out • Public Health and Family Futures/CPNP	• links on website for healthy pregnancy • Maternal Visiting Program (765-6034) • Public Health Nursing (765-6500) • Mental Health Centre (765-6055) • Mobile Crisis (764-1011)
• No consistent screening but some Nurse practitioners and PHNs use EPDS • KidsFirst does a prenatal assessment, utilizing EPDS and including questions regarding history of depression	• There are a few resources available for mild to moderate cases of maternal depression; and mental health services currently provide service for the more emergent/serious situations. • Smiling Mask website and presentations (www.smilingmask.com) • Public Health and the University may be looking at the development of a treatment support group • La Leche League (breastfeeding supports) • Rural Mental Health Services - through normal intake process • Yorkton - Women's Wellness Centre - In the process of hiring a Community Support Worker • Prenatal classes, Parenting Plus - home visitation, Maternity visiting program, Healthiest Babies Possible/Baby's Best Start - CPNP, breastfeeding information (from rqhealth.ca)	• Held a pre-conference session to the Unmasking Postpartum Depression Conference last fall, which was attended by approx. 500 people • Women's and Children's Health Conferences • SK Energy Series, before 2001 • Public Health staff in-services • Each PHN has a copy of the book "Postpartum Depression and Anxiety" from the Pacific Postpartum Support Society
• Saskatoon Health Region utilizes the provincial physician forms Antenatal 1 & 2 which include questions about depression but no formal screen	• Healthy Mother Healthy Baby provides support and outreach services to high risk pregnant women. They liaise with other agencies to provide comprehensive support to women with health issues • The Maternal Health Program provides individual psychiatry, psychology, and nursing services for persons identified as having maternal mental health difficulties Mental Health and Addiction Services prioritize women with maternal mental health difficulties when necessary	• Tips and questions on the website • SHR Maternal Child Unit Brochure • The Postpartum Depression Support Program (PPDSP) brochure and poster are widely distributed throughout the city • The PPDSP facilitator is available for public education upon request • The PPDSP maintains a small lending library for group participants

APPENDIX B

Maternal Mental Health Policies and Practices in Saskatchewan*

HEALTH AUTHORITY	PRESENT POLICY	WHAT SCREENING TOOLS ARE USED
SUN COUNTRY	• If/How PHNs screen is up to their discretion	• Although not routinely used, there is a PPD test and handout
SUNRISE	• Public Health currently does not have any specific written policies	• Public Health Nursing is aware of EPDS tool but is not formally using it. Use of this tool was discussed in the past but it was decided there is no point in using a screening tool if we cannot make a referral. Currently it is the policy of the Mental Health Services that only a physician or the client themselves can refer to Mental Health for postpartum depression. They will not accept referrals from a Public Health Nurse or any other health professional
FIRST NATIONS AND INUIT HEALTH AND FEDERATION OF SASKATCHEWAN INDIAN NATIONS	• Policy and Practices vary widely among First Nation communities ***The following points are from different tribal councils throughout the province, which highlights the variation in the policy and practice***	• The EPDS was discussed at a few nurses' meetings, but there was debate about how beneficial/effective its use would be • The CHNs do several screens for every women on their prenatal intake, including TACE, WAST and EPDS (use a cut-off score of 12 for referral) • No policy or guideline in place for the MCH Parent Mentors to screen for PPD, yet MCH works with the CHN's who currently screen & make referrals (for supports or PM visits) based on their screening results

IS THERE ANY FORM OF SCREEN ON THE PRENATAL FORM	FORMAL SUPPORTS AND SERVICES	EDUCATIONAL RESOURCES/ CAMPAIGNS
	• Healthy and Home offers a weekly, facilitated Postpartum Depression Support Group accessed by self-referral.-Services within Saskatoon Health Region work collaboratively to enhance access to the most timely and appropriate maternal mental health resource	
• No health related information, only personal contact information	• No formal groups • A non-profit in Weyburn-Family Place has a 'Smile and Tears Toddler Romp' which provides friendship and support to moms	• Nothing recent • Use materials produced by other groups • 'Unmasking PPD' conference was very helpful in gathering resources • included in Parental Support program at Child Health Clinics
• On physicians' prenatal screening forms there are questions re: previous history of postpartum depression. We have a registration form for prenatal classes but there is no questions on it re: history of depression	• Women concerned about postpartum depression would have to wither contact the intake worker at Mental Health or see family doctor and request a referral to mental health. • Not aware of any support groups in the community	• Not aware of any campaigns for public or professionals in the region
• Some CHNs screen on prenatal intake, as well as a screen for abuse • The Case Management forms that are in the process of being implemented with FHQTC Parent Mentors will include the EPDS assessment • The EPDS is a standard part of the prenatal visit	• If any woman needs any type of assistance/service, they can be referred to their family physician for follow up • Mental Health Counselors off reserve and Mental Health Therapists on reserve • One tribal council has connections to the Women's Health Clinic at ANHH (Women's Helper/Midwife or N.P), referrals can be made to MSB Approved therapists in communities or outside and White Raven therapists located at ANHH. • Paraprofessional home visitors, CHNs and Elders • FASD Prevention Workers, Nutritionists, Exercise Therapists • Prenatal and parenting classes	• The topic has been addressed at monthly prenatal education sessions, and in workshops in the second year post MCH program. In the past there have been informational sessions on PPD at the CPNP conference. • Screening is currently assessed by the CHN's, although in the process of organizing a PPD informational day for the Parent Mentors which includes training on utilizing the EPDS assessment tool • There are a few handouts available through the Education Resource Centre to address the topic at postnatal visits (the info is standard content for postnatal package) • Prevention Institute Materials

*** This information is limited by the responses received from various contacts in the Health Regions from October 2009 - July 2010.**

APPENDIX C

Maternal Mental Health Policies and Practices in Canadian Provinces, Territory, or Organizations*

PROVINCE, TERRITORY, ORGANIZATION	POLICY FOR POSTPARTUM/ PERINATAL DEPRESSION	PRACTICE
ALBERTA	• Regional • The former Alberta Mental Health Board and health regions developed Advancing the Mental Health Agenda: A Provincial Mental Health Plan for Alberta. There are references to postnatal depression, screening, and parenting programs in the plan • No official provincial policy on screening and treatment of maternal depression, although before the creation of Alberta Health the regions did agree to universally screen postpartum throughout the province	• Screening is included in regular protocol, but this is not an official provincial position • Most women are screened at the 2 month immunization contact, but procedure can vary among zones
BC	• First province with mandated universal screening: the Perinatal Depression Framework http://www.health.gov.bc.ca/library/publications/year/2006/MHA_PerinatalDepression.pdf	• Universal screening of women at 28-32 weeks of pregnancy and again at six to eight weeks postpartum using the EPDS • Diagnostic follow-up when women score 13 or higher or answer positive to self-harm item. Follow-up with women who score 9-12
MANITOBA	• Regional • No provincial policy (combined responsibility of public and mental health)	• Most regions do not have any specific policies or protocols, but about 1/3 of the regions do • The Program Director of Women's Health advised that the WRHA does not use the EPDS or PHQ-9. Mothers are screened through public health nurse visits and a brochure would be distributed to families. A Toolkit is used by public health nurses and staff to guide their work with perinatal families. Some professionals within the WRHA likely make use of the formal screening tool, but this is not formally required or recorded. • Regions outside Winnipeg created their own version of a brochure with local contacts, etc.
NEW BRUNSWICK	• Regional; however, there is a group advocating for the implementation of a province-wide policy	• EPDS is administered by public health nurses with new mothers who are clients of NB's Early Childhood Initiative (ECI) program. This is done in some regions routinely and in others when the mother has disclosed issues with mood, sadness or other distressing thoughts following pregnancy • There are questions related to PPD done at the visit in the hospital after birth. This is part of the liaison role of the public health nurses in NB
NEWFOUNDLAND LABRADOR	• Regional	• Community health nurses screen high-risk women with the EPDS. Soon all pregnant women will be referred to community health nurses and part of the visit will be depression questions but not the EPDS at this point, although looking at including the EPDS.

SPECIAL SERVICES (E.G. GROUPS, HOTLINE)	TOOL USED (E.G. EPDS)	RESEARCH/AWARENESS CAMPAIGNS
• Special Services (e.g. groups, hotline) • Specific/Regional Programs (including support groups) are available through both Mental Health Services and Pregnancy and Childbirth Services • Health Link, 24-hour, 7 days a week telephone service. Registered Nurses provide advice and information about health symptoms and concerns. • Health Link helps clients find appropriate services and health information • There are also a host of regional hotlines and services. For example, in Edmonton, individuals have access to a 211 information centre service. The Foothills Medical Centre in Calgary has a Women's Mental Health Clinic.	• The most common screening tool used by Alberta Health Services is the EPDS • The Alberta Prenatal Record has "mental health/depression" questions in the Medical History and "postpartum depression" questions in the Postpartum/Newborn Topics. • Section on "mental and emotional health" on the healthy mother, healthy baby questionnaire	• Alberta Postpartum Depression Network
• Local and regional services vary, but there are resources for mothers who screen positive with the EPDS	• EPDS	• Framework was published in 2006 after extensive consultations • Education is included as a recommendation
• Different services through regions • Winnipeg has various resources for support: http://www.wrha.mb.ca/healthinfo/prohealth/files/MentalHealth_Perinatal.pdf	• EPDS, but not required	• Manitoba Maternal Child Health Task Force includes PPD in one of its initiatives, but is not a specific direction • The Quick Reference is distributed to healthcare providers throughout the WRHA and includes information on maternal depression
• There was a research project in partnership with the University of New Brunswick and the Department of Health and Regional Health Authorities, which had nurses hired to screen mothers at Public Health immunization clinics. It was called the MOM (Mothers Offering Mentoring) and offered access to mothers who had been screened into the program as peer supports. The project was led by Dr Nicole Letourneau, University of New Brunswick • A current project called Sustainable Telephone Based Support for Mother's with Postpartum Depression has been accepted and funded to have the provincial Telecare line accessed for professional supports for mothers experiencing any symptoms or signs of PPD. This project is currently under development	• EPDS	• Dr. Nicole Letourneau's research team at UNB • There has been provincial training of professionals and paraprofessionals and mothers in partnership with the mentioned projects. A large conference was held in 2005
• Healthy Beginnings provided by Health and Community Services • GEMMA: A society for the promotion of infant mental health • www.gemma-nl.org	• EPDS	

APPENDIX C

Maternal Mental Health Policies and Practices in Canadian Provinces, Territory, or Organizations*

PROVINCE, TERRITORY, ORGANIZATION	POLICY FOR POSTPARTUM/ PERINATAL DEPRESSION	PRACTICE
NOVA SCOTIA	• Regional • Currently there is no provincial policy or framework. The need for one has been discussed in the past, but has not yet made it onto the priority list	• The EPDS screening tool is used by RMH, Public Health Nursing, some FDs who have been to teaching sessions • The Parkyn Screening Tool from the OBS floor at South Shore Regional Hospital is administered after a mother gives birth. There is a category in the screening tool that flags mothers with a history of depression/anxiety. Staff can also add comments on the short term needs page if they feel it is pertinent. This allows better support to the mother upon discharge. There is also excellent communication with the SSRH OBS floor and they may flag a mom who may needs additional supports; we can then follow up with in-home support, collaborate with physicians and make referrals, if needed
NORTHWEST TERRITORIES	• Awaiting response	
NUNAVUT	• Awaiting response	
ONTARIO	• BestStart, Nexus • Regional responsibility	• Regional responsibility • Middlesex-London uses the standardized Ontario Antenatal Record 1 in intake with Question #33 under Psychosocial in the category Emotional/Depression. Also ask #35, which is Family Violence, a known cause of depression • Sudbury: EPDS used by family doctor prenatally and 6 weeks postpartum • Hamilton: 2 question screen and PHQ-9 with family physicians (not EPDS, although advocated for). EPDS is used postpartum at the last visit (6 weeks) or sooner if it seems indicated. If English is perhaps an issue, ask verbally in plain language instead • Also use the Healthy Babies, Healthy Children Prenatal Screen which has a box to check for Emotional/Depression • Middlesex/London: Use the four key questions (PASS-CAN) for the majority of women during the postpartum period (phone, clinic, or home visit); would then determine whether or not an EPDS should be done. There are also nurses who use Cheryl Beck's PDSS (Postpartum Depression Screening Scale) to guide their practice interventions
PEI	• Regional • Currently there is no provincial policy, frameworks, or guidelines for maternal/perinatal/postpartum depression although this is an area that has been considered an area of importance	• No consistent practice
QUEBEC	• Regional • (awaiting further response)	

SPECIAL SERVICES (E.G. GROUPS, HOTLINE)	TOOL USED (E.G. EPDS)	RESEARCH/AWARENESS CAMPAIGNS
• The only formal support at the provincial level is the Reproductive Mental Health team at the IWK Health Centre. The RMH team is very small, so its capacity to expand its services in a true, province -wide capacity is limited by resources • There is a place on the province-wide Reproductive Care Program that asks about mental health concerns, but it is not always consistent as to the completion of that inquiry. Within the IWK Health Centre and the GPs who deliver from here, attention to mental health history and symptoms is reasonably high • There is certainly the ability to link women with Mental Health Services prenatally/ postpartum. In fact, there has been a partnership with Mental Health to prioritize the referrals process, postpartum, for those who are most concerning	• The EPDS, but it is not a Public Health Approved Tool; thus, it is not used • Parkyn Screening Tool	• There has been education (public/nursing/pharmacist/mental health association, etc.) over the past 10 years • Public Health and Health Promotion Divisions both give materials that address maternal mental health to all new mothers. • The RMH team is just beginning to work on a collaborative project to develop a toolkit for the community and professionals regarding awareness, screening and education on maternal mental health under the auspices of the Public Health Agency of Canada. Once the project is completed, PHAC will be able to share the tool kit
• Regional responsibility, for example • Middlesex-London has a number of supports for women and families experiencing perinatal mood and anxiety problems: • Mother Reach HOPEline • Mother Reach Postpartum Drop-in (weekly; peer and professional support) • Mother Reach Fathers/Couples support sessions (www.helpformom.ca) • The London Mental Health Crisis Service, Canadian Mental Health Association, and Telehealth provide crisis support/ intervention for women and families in London	• Varies among regions, but may include the PHQ-2, EPDS, PASS-CAN, question on antenatal record	• Best Start had a province-wide awareness campaign (http://www.beststart.org/resources/ppmd/index.html) • CAMH publication (http://www.camh.net/Publications/CAMH_Publications/Postpartum_Depression/) • North Outreach for Mothers with PPD (funded by ON Trillium Foundation) • A few conferences • Tool kit for perinatal mood disorders, media campaign • Southwest Ontario - "Mother Reach" awareness coalition in London and Middlesex county • Training in Ontario for midwives at the university level regarding perinatal depression and screening for it • University of Toronto-Dr Cindy-Lee Dennis
• There are no formal supports or services for women experiencing postpartum depression. A referral of this nature would be considered a high priority for follow-up. Concerns would be dealt with on an individual basis.	• The EPDS and PHQ-2 have been forwarded to the Family Health Centres in the province but there is no provincial guideline around consistent use. • There is no screen on the prenatal record; however in 2000 the province introduced an adapted version of the ALPHA tool from the University of Toronto for screening all pregnant women. The screen is referenced on the prenatal record. There have been some problems with having this tool used consistently as recommended.	• Nothing to date, although some initial review has been done of the Ontario Best Start Program - Life With a New Baby is Not Always What You Expect. This DVD is being used in some public health nursing offices.

APPENDIX C

Maternal Mental Health Policies and Practices in Canadian Provinces, Territory, or Organizations*

PROVINCE, TERRITORY, ORGANIZATION	POLICY FOR POSTPARTUM/ PERINATAL DEPRESSION	PRACTICE
SASKATCHEWAN	• Regional (See Appendix B: Maternal Mental Health Policies in Saskatchewan)	
YUKON	• Awaiting response	
PUBLIC HEALTH AGENCY OF CANADA (PHAC)	• Regarding screening, diagnosis and direct services for mental health in women, the role of the federal government is limited, given that the provision of health care services in Canada falls under the jurisdiction of the provinces and territories • The Canadian Perinatal Surveillance System (CPSS) is a national surveillance effort of the PHAC to monitor and report on determinants and outcomes of maternal, fetal and infant health in Canada	• A national survey entitled Maternity Experiences Survey (MES) was developed to cover topics including maternal mental health, such as postpartum depression, previous depression and support, stress and social support, pain management, support in labour and birth experiences, and satisfaction with care

SPECIAL SERVICES (E.G. GROUPS, HOTLINE)	TOOL USED (E.G. EPDS)	RESEARCH/AWARENESS CAMPAIGNS
• The MES is a national survey developed and implemented by PHAC's CPSS. It includes more than 300 questions relating to Canadian women's experiences with pregnancy, labour and birth, and the early postpartum period • More than 6,000 women aged 15 years and over who had recently given birth were interviewed	• EPDS	• PHAC has produced the handbook: The Sensible Guide to Pregnancy • The guide provides information on several topics, including emotional health for a healthy pregnancy • The MES found that overall, 7.5% of women scored 13 or higher on the EPDS, and 8.6% scored 10-12 (indicative of risk for postpartum depression) • At some point prior to pregnancy, 15.5% of women had been prescribed antidepressants or been diagnosed with depression

*** This information is limited by the responses received from various provinces, territories, and the organizations from October 2009-July 2010.**

APPENDIX D

Awareness Materials

Maternal Mental Health

1 in **5** women in Saskatchewan experience **depression during pregnancy (antenatal depression)** or **after pregnancy (postpartum depression).**

Are you enjoying pregnancy or being the mother of a new baby?

If you answered "no" to this question, you might be depressed.

Having several of the following symptoms for more than two weeks could mean you are depressed ...

- ❑ Less interest in things you usually like
- ❑ Crying for no reason
- ❑ Irritable, angry, or more sensitive
- ❑ More tired or hyper
- ❑ Not sleeping or sleeping too much
- ❑ Problems concentrating
- ❑ Not able to cope
- ❑ Anxious or panicked
- ❑ Thoughts of harming yourself, your baby, or others

If you think you might be depressed, talk to someone, ask for help.

For help, contact:

- A health care professional - your doctor, nurse, or midwife
- Healthline: **1-877-800-0002**

Depression is **treatable** and **there is help!**

www.skmaternalmentalhealth.ca

Taking Care of You

- Be kind to yourself
- Ask for and accept help with baby and housework
- Keep active ... go for a walk
- Get enough sleep - at least 6 hours in a 24 hour period
- Eat healthy and regularly
- Avoid alcohol, tobacco, and other drugs
- Take medications as prescribed
- Try yoga or other activities to help you relax
- Look for a support group or other supports in your community
- Talk to a health care provider

Partners, family, and friends, you can also help ...

- Listen to her and support her feelings
- Ask her how you can help
- Encourage her to seek professional help
- Develop a relationship with your baby
- Educate yourself about maternal mental health

Partners can also experience depression ... it is important that they also get the support they need.

For more information, visit the following websites:

Saskatchewan Maternal Mental Health
www.skmaternalmentalhealth.ca

Best Start Resource Centre
www.lifewithnewbaby.ca

For information about medication use in pregnancy and while breastfeeding:

Saskatchewan Drug Information Services
1-800-655-DRUG (3784)

MotherFirst

University of Saskatchewan

saskatchewan preventioninstitute
our goal is healthy children

CIHR IRSC

RBC Foundation

SPHA

Saskatchewan Psychiatric Association

Maternal Mental Health

Antenatal and Postpartum Depression

Having a baby is expected to be a happy, exciting time, yet as many as 1 in 5 women experience depression during or after pregnancy.

- Antenatal depression is when a woman has persistent symptoms of depression during pregnancy.
- Postpartum depression is when a woman has persistent symptoms of depression anytime in the first year after the birth of her baby.

Antenatal and Postpartum depression can be very serious conditions, affecting the health of the mother, baby, and other family members.

What are the Risk Factors for Developing Maternal Depression?

- Past depression or psychiatric problems
- History of childhood abuse
- Partner conflict or family violence
- Unplanned pregnancy
- Substance abuse and smoking
- Poverty
- Lack of social support
- New immigrant
- Member of a visible minority
- Teenage pregnancy

Some women may find themselves feeling depressed even if they have none of these risk factors. Any woman can become depressed.

What Impact can Untreated Maternal Depression have on a Mom, her Baby, and her Family?

- Inadequate prenatal or postpartum care for mom and baby
- Unborn babies can be affected by the mother's stress hormones and chemicals
- Increased risk of baby being born early or too small
- Increased risk of poor bonding between baby and mother
- Breastfeeding less and for a shorter time
- Partners are 50% more likely to be depressed themselves
- Possible long-term effects on children's health and development

How is Maternal Depression Treated?

Self-Care

- Be kind to yourself
- Ask for and accept help with baby and housework
- Keep active - go for a walk
- Get enough sleep - at least 6 hours in 24 hours
- Eat healthy and eat regularly
- Avoid alcohol, tobacco, and drugs
- Take medications as prescribed
- Try yoga or other activities to help you relax
- Look for a support group or other supports in your community
- Talk to a health care provider

Professional Help

Includes: counseling, facilitated support groups, and medications, often used in combination. If you are currently taking prescribed medication to help your mood, do not stop without talking to your doctor.

Partners, family and friends can also help. They can ...

- Listen to her and support her feelings
- Ask her how they can help
- Encourage her to seek professional help
- Develop a relationship with the baby
- Educate themselves about maternal mental health
- Get the support they need

For help, contact:

- Your doctor, nurse, midwife or support worke
- Healthline (anytime): 1-877-800-0002

Think you might be depressed? Try the survey on the other side.

CIHR IRSC
RBC Foundation
MotherFirst
University of Saskatchewan
Saskatchewan Prevention Institute
Our Goal is Healthy Children
SPHA
Saskatchewan Psychiatric Association

APPENDIX E

Edinburgh Postnatal Depression Scale (EPDS)[77]

		Score
1.	**I have been able to laugh and see the funny side of things:**	
	As much as I always could	0
	Not quite so much now	1
	Definitely not so much now	2
	Not at all	3
2.	**I have looked forward with enjoyment to things:**	
	As much as I ever did	0
	Rather less than I used to	1
	Definitely less than I used to	2
	Hardly at all	3
3.	**I have blamed myself unnecessarily when things went wrong:**	
	Yes, most of the time	3
	Yes, some of the time	2
	Not very often	1
	No, never	0
4.	**I have been anxious or worried for no good reason:**	
	No, not at all	0
	Hardly ever	1
	Yes, sometimes	2
	Yes, very often	3
5.	**I have felt scared or panicky for no very good reason:**	
	Yes, quite a lot	3
	Yes, sometimes	2
	No, not much	1
	No, not at all	0
6.	**Things have been getting on top of me:**	
	Yes, most of the time I haven't been able to cope at all	3
	Yes, sometimes I haven't been coping as well as usual	2
	No, most of the time I have coped quite well	1
	No, I have been coping as well as ever	0
7.	**I have been so unhappy that I have had difficulty sleeping:**	
	Yes, most of the time	3
	Yes, sometimes	2
	Not very often	1
	No, not at all	0

Anxiety Subscale
(score of >4 on items 3, 4, 5 signals risk for anxiety)

		Score
8.	**I have felt sad or miserable:**	
	Yes, most of the time	3
	Yes, quite often	2
	Not very often	1
	No, not at all	0
9.	**I have been so unhappy that I have been crying:**	
	Yes, most of the time	3
	Yes, quite often	2
	Only occasionally	1
	No, never	0
10.	**The thought of harming myself has occurred to me:**	
	Yes, quite often	3
	Sometimes	2
	Hardly ever	1
	Never	0

TOTAL SCORE: _____

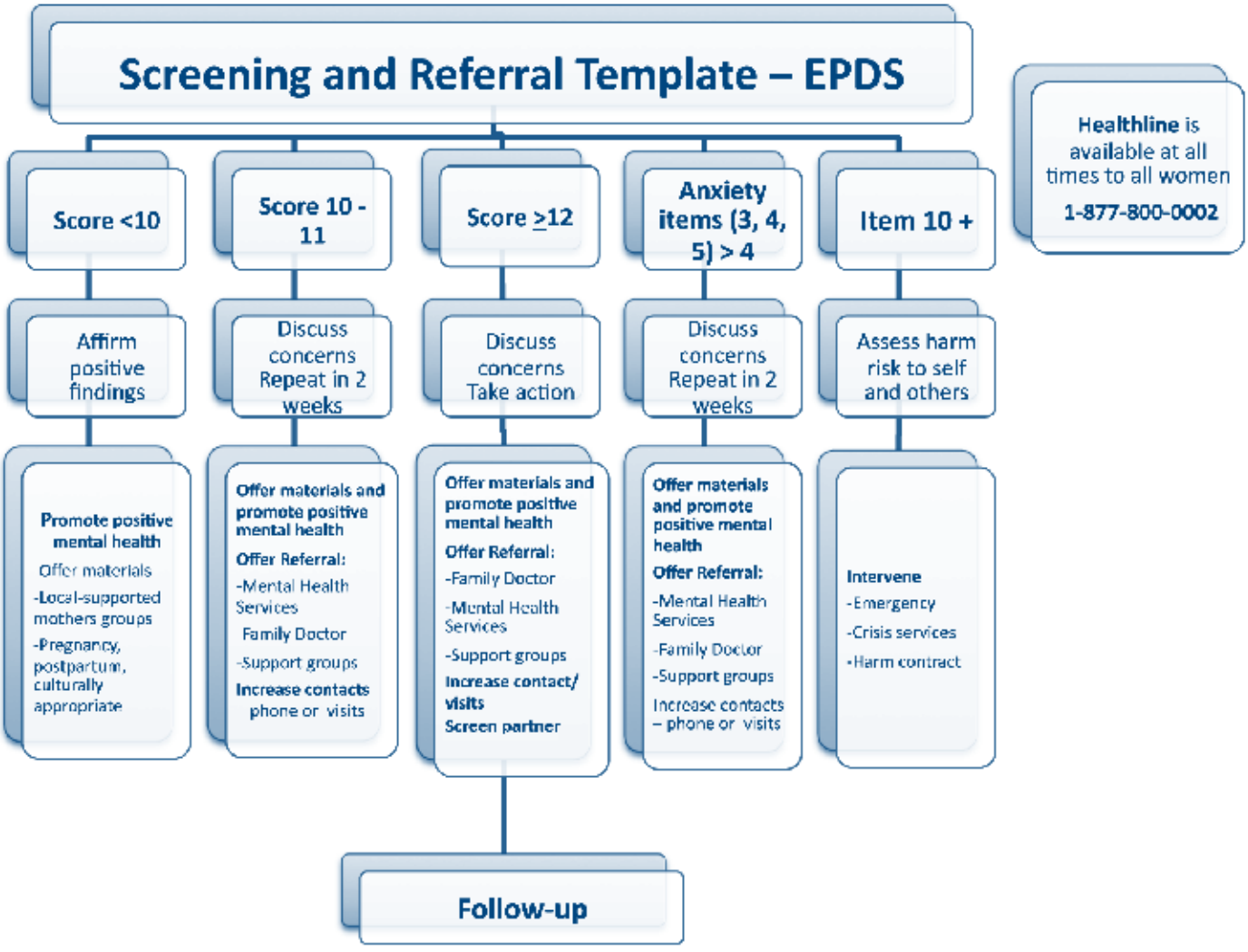
APPENDIX F

Strengths and Weaknesses of Universal Screening Using the Edinburgh Postnatal Depression Scale (EPDS)

PROS	CONS
Universal screening, by increasing contact, reduces stigma by checking all families[111]	Could induce fear of stigma among women, and be less than acceptable for women[112]
Enables access to a large number of women[67]	False positives (between 30 - 70%) could lead to unnecessary and inappropriate treatment[84]
Opens a line of communication with the mother[83]	Dependent on truthful answers, but stigma exists[112]
Will help raise awareness among health professionals and patients[113]	Medical health practitioners must be trained to properly administer test[84]
Can shift focus from solely the child to include the well being of mothers[114]	May over-pathologize perinatal stress[115]
Efficient and feasible method way to improve identification of maternal mental health problems[116]	Women may prefer to talk about their experience rather than fill out a questionnaire[112]
Increase the recognition, diagnosis and treatment of maternal depression and anxiety[74]	Over-diagnosis could overwhelm health services [84]
Opportunity for early detection and treatment minimizes negative effects on mother and family[67]	May reduce women's decision making power over their own health and health care
Identifying women at risk can prevent depression [66]	Screening alone does not improve treatment (need adequate community and health supports)[117]
EPDS is a reliable, valid screening tool with good sensitivity and specificity [76,75]	may not be an equally valid screening tool across all settings and contexts[118]
EPDS is culturally sensitive, has been translated into more than 30 languages and used with diverse socioeconomic and ethnic groups[119]	Some perceive it as unethical to screen unless the skills and resources are available to provide treatment
EPDS is available for free, easy to use and score[66]	Cost (screening materials, training, time)
EPDS is a reliable instrument for repeated evaluations of depressive symptoms[75]	
EPDS widely recommended[120]	
EPDS performs better compared to the PHQ-9 and PPDS[80]	
EPDS asks women about self harm[77]	

APPENDIX G

Screening and Referral Template



APPENDIX H

Resources in Saskatchewan

Healthline 1-877-800-0002 and **Healthline Online** http://www.health.gov.sk.ca/healthline-online are available to everyone in Saskatchewan at any time. For help where you live, please see below

Region	Mental Health Services	Emergency Numbers	KidsFirst	Other
Athabasca	Black Lake (306) 439-2200	Northern Crisis Line (collect) (306) 425-4090 Suicide Prevention 1-866-848-8299	Northern Saskatchewan (306) 235-5436 or (306) 425-8033	Stony Rapids Family Wellness Program (306) 439-2123 www.athabascahealth.ca
Cypress	Centralized Intake; Swift Current (306) 778-5280	Swift Current Hospital Inpatient (306) 778-9522		Parent Mentoring Program Swift Current (306) 778-5280 Canadian Mental Health Association (CMHA) Swift Current (306) 773-0766 www.cypresshealth.ca
Five Hills	Centralized Intake; Moose Jaw (306) 694-0379 or (306) 691-6464	Inpatient/After Hours (306) 691-6473 or Moose Jaw Union Hospital (306) 691-6458	Moose Jaw (306) 692-1204 or (306) 694-8336	CMHA Moose Jaw (306) 692-4240 www.fhhr.ca Parent Mentoring Program Moose Jaw (306) 692-0579
Heartland	Centralized Intake 1-866-268-9139	During business hours 1-866-268-9139 After hours Healthline 1-877-800-0002		Early Childhood Therapist (306) 882-6413 ext 280 CMHA--Kindersley (306) 463-8052 www.hrha.sk.ca Parent Mentoring Program Unity (306) 228-2666 ext. 349 Parent Mentoring Program Biggar (306) 948-5623

Region	Mental Health Services	Emergency Numbers	KidsFirst	Other
Keewatin Yatthe	Buffalo Narrows 1-866-848-8011 or (306) 235-5800 La Loche 1-888-688-7087 or (306) 822-3200 Ile-a-la-Crosse 1-866-848-8299 or (306) 833-5500 Beauval 1-866-848-8022 or (306) 288-4800	Northern Crisis Line (collect) (306) 425-4090 Suicide Prevention 1-866-848-8299	Northern Saskatchewan (306) 235-5436 or (306) 425-8033	Beauval Moms & Tots (306) 288-2274 www.kyrha.ca Parent Mentoring Program Ile-a-La-Crosse (306) 833-2313
Kelsey Trail	Hudson Bay/ Porcupine Plain (306) 865-4262 Melfort (306) 752-8767//8760 Nipawin (306) 862-9822 Tisdale (306) 873-3760 Hudson Bay (306) 865-4262	Intake during business hours (306) 765-6055	Regional Coordinator (306) 873-8289 Nipawin (306) 862-6222	Marguerite Riel Centre (306) 752-4950 Parent Mentoring Program Nipawin (306) 862-3820 www.kelseytrailhealth.ca
Mamawetan Churchill River	Creighton (306) 688-8620 La Ronge 306) 425-4840 Pinehouse (306) 884-5670 Sandy Bay (306) 754-5400	La Ronge Health Centre (306) 425-2422	La Ronge (306) 425-2051 Pinehouse (306) 425-2051 Creighton (306) 688-6620 Sandy Bay (306) 688-6620	www.mchrra.sk.ca

Region	Mental Health Services	Emergency Numbers	KidsFirst	Other
Prairie North	Battlefords Mental Health Centre (306) 446-6500 Counseling - Meadow Lake (306) 236-1580 Lloydminster (306) 820-6250	Battlefords Union Hospital Inpatient Care (306) 446-6623 Healthlink Alberta 1-866-408-5465	Meadow Lake (306) 236-6441 North Battleford (306) 446-6012	CMHA North Battleford (306) 445-7177 www.pnrha.ca Parent Mentoring Program North Battleford (306) 446-6400 ext. 6443 Parent Mentoring Program Lloydminster (306) 820-6236 Parent Mentoring Program Meadow Lake (306) 236-1581
Prince Albert Parkland	Mental Health Outpatient (306) 765-6055 or (306) 765-6055 out of town Inpatient (306) 765-6053	Mobile Crisis (306) 764-1011 Prince Albert Victoria Hospital (306) 765-6000	Prince Albert (306) 765-6656	Maternal Visiting (306) 765-6034 Public Health Nurse (306) 765-6500 Community Mental Health Nurse- Spiritwood (306) 883-4462 Family Futures Program (306) 763-0760 Parent Mentoring Program Spiritwood (306) 883-4463 CMHA Prince Albert (306) 763-7747 www.paphr.sk.ca
Regina Qu'Appelle	Regina Mental Health Clinic (306) 766-7800 Inpatient Mental Health Services (306) 766-4608 Outpatient (306) 766-3929 Emergency Psychiatric Nurse (306) 766-4342	Regina General Hospital Inpatient (306) 766-4321 Mobile Crisis after hours (306) 766-7800	Regina (306) 766-6796	Parent Mentoring Program (306) 766-6115 Maternity Visiting (306) 766-3700 Healthiest Babies (306) 766-7677 Four Directions (306) 766-7540 Parenting Plus Grenfell (306) 697-4048 CMHA Regina (306) 525-9543 www.rqhealth.ca Public Health Nursing (306) 766-7533 Mother's Heal Support Group (306) 766-6787

Region	Mental Health Services	Emergency Numbers	KidsFirst	Other
Saskatoon	Mental Health Services (306) 655-7950 Intake Worker (306) 655-1530 Humboldt (306) 682-5333 Rosthern (306) 232-4305 Lanigan (306) 365-3400	Crisis Intervention (306) 933-6200 Dube Inpatient Centre-Royal University Hospital (306) 655-0700	Saskatoon (306) 655-3311	Saskatoon Postpartum Depression Support Group (306) 221-6806 Maternal Mental Health Program (306) 655-4250 /966-8229 CMHA Saskatoon (306) 384-9333 www.saskatoonhealthregion.ca Parent Mentoring Program (306) 232-6001 ext. 28
Sun Country	Intake Worker (306) 842-8665 or 1-800-216-7689 Weyburn Mental Health Centre (306) 842-8671	Healthline after hours 1-877-800-0002	Carlyle (306) 453-2071	Smiles and Tears Toddler Romp support, Weyburn (306) 842-7477 CMHA Weyburn (306) 842-3096 www.suncountry.sk.ca Parent Mentoring Program, Weyburn (306) 842-8668
Sunrise	Yorkton Mental Health Centre (306) 786-0589 or (306) 785-0558	Yorkton Regional Health Centre (306) 782-2401	Yorkton (306) 783-1946 or (306) 783-0383	Yorkton: Women's Wellness Centre (306) 782-0665 CMHA Yorkton (306) 621-5925 www.sunrisehealthregion.sk.ca Parent Mentoring Program (306) 782-1205

APPENDIX H

Resources in Saskatchewan

RESOURCES FOR FIRST NATION COMMUNITIES IN SASKATCHEWAN

South First Nations Communities

Band Name	Health Centre Phone Number (ask for a nurse)
Carry the Kettle	(306) 727-2101
Cote	(306) 542-4074
Cowessess	(306) 696-2263
Day Star	(306) 835-2884
Fishing Lake	(306) 338-2680
Gordon	(306) 835-2020
Kahkewistahaw	(306) 696-2660
Kawacatoose	(306) 835-2720
Keeseekoose	(306) 542-3430
Key	(306) 594-2291
Kinistin	(306) 878-8181
Little Black Bear	(306) 334-2306
Muscowpetung	(306) 723-4506
Muskowekwan	(306) 274-4640
Nekaneet	(306) 662-5022
Ochapowace	(306) 696-3557
Ocean Man	(306) 457-4160
Okanese	(306) 334-2532
Pasqua	(306) 332-3763
Peepeekisis	(306) 334-2780

Band Name	Health Centre Phone Number (ask for a nurse)
Pheasant Rump	(306) 462-4808
Piapot	(306) 781-4833
Sakimay	(306) 697-2970
Standing Buffalo	(306) 332-4681
Starblanket	(306) 334-2206
White Bear	(306) 577-4482
Yellow Quill	(306) 322-2041

North First Nations Communities

Band Name	Health Centre Phone Number (ask for a nurse)
Ahtahkakoop	(306) 468-2747
Beardy's & Okemasis	(306) 476-4402
Big Island Lake (Joseph Bighead)	(306) 839-2330
Big River	(306) 724-4664
Birch Narrows	(306) 894-2112
Black Lake	(306) 284-2020
Buffalo River	(306) 282-2011
Canoe Lake	(306) 829-2140
Clearwater River	(306) 822-2378
Cumberland House	(306) 888-4778
English River	(306) 396-2072
Flying Dust	(306) 236-9501
Fond Du Lac	(306) 686-2003
Hatchet Lake	(306) 633-2167
Island Lake (Ministikwin)	(306) 831-2265
James Smith	(306) 886-2454
Lac La Ronge Indian Band Health Services	(306) 425-3600
James Smith	(306) 886-2454

Band Name	Health Centre Phone Number (ask for a nurse)
Lac La Ronge Indian Band Health Services	(306) 425-3600
Little Pine	(306) 398-2525
Little Red	(306) 982-4294
Lucky Man	(306) 374-2828
Makwa Sahgaiehcan	(306) 837-2208
Mistawasis	(306) 466-4720
Montreal Lake (William Charles)	(306) 663-5995
Moosomin	(306) 386-2223
Mosquito, Grizzly Bear's Head, Lean Man	(306) 937-3149
Muskeg Lake	(306) 466-4914
Muskoday	(306) 764-8774
One Arrow	(306) 423-5493
Onion Lake	(306) 344-2330
Pelican Lake	(306) 984-4716
Peter Ballantyne	(306) 953-4425
Poundmaker	(306) 398-2266

APPENDIX H

Resources in Saskatchewan

North First Nations Communities

Band Name	Health Centre Phone Number (ask for a nurse)
Red Earth	(306) 768-3617
Red Pheasant	(306) 937-2531
Saulteaux	(306) 386-1037
Shoal Lake	(306) 768-3457
Stanley Mission Health Services Inc.	(306) 635-2090
Sturgeon Lake	(306) 764-935(1)(2)
Sweetgrass	(306) 937-2115
Thunderchild Human Services Corporation	(306) 845-4330
Wahpeton	(306) 922-6772
Waterhen Lake	(306) 236-3258
Whitecap/Dakota	(306) 373-4600
Witchekan Lake	(306) 883-2552

Mental Health crisis services are available for Status First Nations women through the Non-Insured Health Benefits Unit of Health Canada. This service provides up to six hours of counseling until the client has access to regular counseling services. The phone number is 1-306-780-5441

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