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Assessment and Interventions for Perinatal Depression

Second Edition



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Assessment and Interventions for Perinatal Depression

Second Edition

Greetings from Doris Grinspun,

Chief Executive Officer, Registered Nurses' Association of Ontario



The Registered Nurses' Association of Ontario (RNAO) is delighted to present the second edition of the clinical best practice guideline *Assessment and Interventions for Perinatal Depression*. Evidence-based practice supports the excellence in service that health professionals are committed to delivering every day. RNAO is delighted to provide this key resource.

We offer our heartfelt thanks to the many stakeholders who are making our vision for best practice guidelines a reality, starting with the Government of Ontario for recognizing RNAO's ability to lead the program and for providing multi-year funding. For their invaluable expertise and leadership, I want to thank the co-chairs of the expert panel—Dr. Angela Bowen (Professor, College of Nursing and Department of Psychiatry, University of Saskatchewan) and Dr. Phyllis Montgomery (Professor, School of Nursing, Laurentian University). Thanks to RNAO staff Katherine Wallace (Guideline Development Lead), Glynis Gittens (Project Coordinator), Laura Ferreira-Legere (Lead Nursing Research Associate), Greeshma Jacob (Nursing Research Associate), Dr. Lucia Costantini, (Former Associate Director of Guideline Development, Research and Evaluation), Dr. Valerie Grdisa (Former Director, International Affairs and Best Practice Guidelines) and the rest of the RNAO Best Practice Guidelines Research and Development Team for their intense work in the production of this Guideline. Special thanks to the members of the RNAO expert panel for generously providing their time and expertise to deliver a rigorous and robust clinical resource. We couldn't have done it without you!

Successful uptake of best practice guidelines requires a concerted effort from educators, clinicians, employers, policy-makers and researchers. With their unwavering commitment and passion for excellence in-patient care, the nursing and health-care communities have provided the expertise and countless hours of volunteer work essential to the development and revision of each best practice guideline. Employers have responded enthusiastically by nominating best practice champions, implementing guidelines, and evaluating their impact on patients and organizations. Governments at home and abroad have joined in this journey. Together, we are building a culture of evidence-based practice.

We invite you to share this guideline with your colleagues from other professions because we have so much to learn from one another. Together, we must ensure that the public receives the best possible care every time they come in contact with us—making them the real winners in this important effort!

A handwritten signature in black ink that reads "Doris Grinspun". The signature is written in a cursive style with a long horizontal flourish underneath.

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How to Use This Document

This nursing **Best Practice Guideline (BPG)**^{G*} is a comprehensive document that provides resources for evidence-based nursing practice. It is not intended to be a manual or “how-to” guide, but rather a tool to guide best practices and enhance decision-making for **nurses**^G, the **interprofessional team**^G, educators, policy-makers, **persons**^G, and **families**^G in the assessment and **interventions**^G for **perinatal depression**^G. This BPG should be reviewed and applied in accordance with the needs of individual organizations or practice settings and the needs and preferences of persons and their families accessing the health system. In addition, it offers an overview of appropriate structures and supports for providing the best possible care, based on evidence.

Nurses, the interprofessional team, and administrators who lead and facilitate practice changes will find this document invaluable for developing policies, procedures, protocols, educational programs, assessments, interventions, and documentation tools. Those who provide direct care will benefit from reviewing the recommendations and supporting evidence. We encourage practice settings to adapt the BPG in formats that are feasible for daily use.

If your organization is adopting this BPG, we recommend that you follow these steps:

1. Assess your existing policies, procedures, protocols, and educational programs in relation to the recommendations in this Guideline.
2. Identify existing needs or gaps in your policies, procedures, protocols, and educational programs.
3. Note the recommendations that are applicable to your setting and that can be used to address your organization's existing needs or gaps.
4. Develop a plan for implementing the recommendations, sustaining best practices, and evaluating outcomes.

Implementation science resources, including the Registered Nurses' Association of Ontario (RNAO) *Toolkit: Implementation of Best Practice Guidelines* (1), are available at www.RNAO.ca. In addition, all of the RNAO BPGs are available for download on the RNAO website at RNAO.ca/bpg. To locate a particular BPG, search by keyword or browse by topic.

We are interested in hearing how you have implemented this Guideline. Please contact us to share your story.

* Throughout this document, terms in **bold** marked with a superscript G (^G) can be found in the Glossary of Terms ([Appendix A](#)).

Purpose and Scope

RNAO's BPGs are systematically developed, evidence-based documents that include recommendations for nurses, the interprofessional team (including, but not limited to physicians, midwives, social workers, lactation consultants, and psychologists), educators, policy-makers, and persons and their families to improve outcomes on specific clinical and healthy work environment topics (2). This BPG replaces the RNAO BPG *Interventions for Postpartum Depression* (3). The purpose of this BPG is to present evidence-based recommendations for nurses and the interprofessional team across all care settings to enhance the quality of their practices to support the reduced incidence of perinatal depression through the implementation of five components of care: routine **screening**^G, assessment, prevention, coordinated **interventions**^G, and evaluation. In this BPG, perinatal depression refers to a mood disorder occurring during pregnancy and postpartum, up to one year following childbirth. Where applicable, depression occurring only during pregnancy (i.e., **prenatal depression**^G) or postpartum (i.e., **postpartum depression**^G) is identified.

RNAO convened an expert panel in 2015 consisting of a group of individuals across a variety of health-care settings with expertise in perinatal depression. The RNAO expert panel was interprofessional: it was comprised of nurses and members of the interprofessional team who hold clinical, administrative, and academic positions. The expert panel has experience working with persons with perinatal depression and their families in different health-care settings such as acute, community, public, and primary health care, and organizations, including associations and teaching institutions.

The scope of this BPG recognizes perinatal depression as the most commonly occurring mood disorder during pregnancy and postpartum, as determined through findings in evidence in this area and RNAO expert panel consensus. As such, all other perinatal mood disorders (e.g., postpartum psychosis) or anxiety, as either a co-morbidity or sole morbidity, were excluded. Furthermore, while recognition is given to the impact that perinatal depression can have on partners, infants, other children, and families (as defined by the person), the scope of this BPG is limited to the person at risk for or experiencing perinatal depression.

As an overarching principle, the expert panel asserted that all persons who are at risk for or are experiencing perinatal depression must have access to available routine screening, assessment, prevention, intervention, and evaluation, using evidence-informed approaches. Such an approach creates opportunities to address a person's perinatal depression needs and goals, improve outcomes, and mitigate risks associated with a lack of treatment.

Types of Recommendations

The recommendations in this BPG apply to clinical care in a range of community and health-care settings. All of the recommendations are based on findings from **systematic reviews**^G on the most effective clinical assessments and interventions, educational approaches, and organization and system policy strategies.

Most of the recommendations in this BPG pertain to depression throughout pregnancy and postpartum. The exception is where the evidence is focused on either pregnant or postpartum persons, in which case the recommendation specifies it as either for prenatal or postpartum depression. The recommendations are provided at three levels.

- **Practice recommendations^G** are directed primarily to nurses and the interprofessional team who provide care to pregnant and postpartum persons at risk for or experiencing perinatal depression across health system settings (e.g., acute care, home health care) and in the community (e.g., primary care and public health). All of the recommendations are applicable to the scope of practice of registered nurses, registered practical nurses, and nurse practitioners.
- **Education recommendations^G** are directed to those responsible for educating nurses and the interprofessional team, such as educators, quality improvement teams, managers, administrators, and academic and professional institutions. These recommendations outline core training strategies required for postsecondary curriculum, ongoing education, and professional development.
- **Organization and System Policy recommendations^G** apply to managers, administrators, and policy-makers responsible for developing policy or securing the supports required within health-care organizations for implementing best practices.

Recommendations in the three areas (practice, education, and organization and system policy) focus on evidence-based strategies that nurses and the interprofessional team require for perinatal depression screening, assessment, prevention, interventions, and evaluation. Additionally, the recommendations describe the necessary resources for coordinated mental health services and supports in perinatal depression across regions and communities. As such, the three types of recommendations should be implemented together for optimal effectiveness.

Recommendations pertaining to screening and assessment tools integrate the reviewed literature but do not include a preference for any one tool. Organizations are encouraged to choose a screening and assessment tool supported by evidence. Examples of tools for perinatal depression screening or assessment are included in [Appendix E](#) and [Appendix F](#).

Various factors will affect the implementation of the recommendations in this BPG. These include individual organizations' policies and procedures, government legislation, and the demographic and socio-economic characteristics of the person accessing mental health services and supports in perinatal depression.

Discussion of Evidence

The Discussion of Evidence that follows each recommendation statement has five main sections:

1. The “Evidence Summary” outlines the supporting research from the systematic review(s) that directly relates to the recommendation.
2. “Benefits and Harms” inform any aspect of care that promotes or deters from the health and well-being of a person with perinatal depression. Content in this section includes research from the systematic review(s).
3. “Values and Preferences” denote the prioritization of approaches that facilitate health equality and the importance of consideration for desired care. Content for the “Values and Preferences” section may or may not include research from the systematic review(s). When applicable, the RNAO expert panel and **stakeholders^G** contributed to these areas.
4. “Practice Notes” highlight pragmatic information for nurses and the interprofessional team. This section may include supportive evidence from other sources (e.g., other BPGs or the RNAO expert panel).
5. “Supporting Resources” includes a list of relevant research studies, resources, and websites that support clinical practice, education, and organization and system policy recommendations. Content listed in this section was not part of the systematic review and was not quality appraised. As such, the list is not exhaustive and the inclusion of a resource in one of these lists does not imply an endorsement from RNAO.

Use of the Term “Person” in this BPG

It is recognized that perinatal depression is not solely experienced by pregnant and postpartum women, but that it also may be experienced by others who may not find identifiers such as ‘woman’, ‘she’ or ‘mother’ representative or inclusive (4). With respect to this consideration, the term “person”, or “parent” is used whenever possible. Further discussion of diverse populations and perinatal depression is found in [Appendix D](#).

RNAO Guidelines and Resources That Align with This Guideline:

The following RNAO BPGs and resources may further inform nurses and the interprofessional team when implementing this Guideline:

- *Toolkit: Implementation of Best Practice Guidelines (2012)*
- *Developing and Sustaining Interprofessional Health Care (2013)*
- *Social determinants of health^G (2013)*
- *Working with Families to Promote Safe Sleep for Infants 0 – 12 Months of Age (2014)*
- *Engaging Clients Who Use Substances (2015)*
- *Person- and Family-Centred Care (2015)*
- *Intra-Professional Collaborative Practices among Nurses (2016)*
- *Crisis Intervention for Adults Using a Trauma-Informed Approach (2017)*
- *Integrating Tobacco Interventions into Daily Practice (2017)*
- *Implementing Supervised Injection Services (2018)*
- *Breastfeeding – Promoting and Supporting the Initiation, Exclusivity, and Continuation of Breastfeeding for Newborns, Infants, and Young Children (2018)*

A reference list and collection of appendices follow the guideline’s recommendations and discussions of evidence. [Appendix B](#) details the BPG development process and [Appendix C](#) describes the process utilized for the systematic reviews and search strategies. The remaining appendices include resources related to the screening, assessment, prevention, interventions, and evaluation of perinatal depression.

Interpretation of Evidence

Levels of evidence are assigned to each study to denote the research design. Higher levels of evidence indicate that fewer potential sources of bias influenced the research findings, thus reducing alternative explanations of the phenomenon of interest. Levels of evidence do not reflect the quality of individual studies or reviews.

In some cases, guideline recommendations are assigned more than one level of evidence. This reflects the inclusion of multiple studies to support the recommendation. For transparency, the level of evidence for each component of the recommendation statement is identified in the discussion of evidence.

Table 1: Levels of Evidence

LEVEL	SOURCE OF EVIDENCE
Ia	Evidence obtained from meta-analysis^G or systematic reviews of randomized controlled trials^G , and/or synthesis of multiple studies primarily of quantitative research.
Ib	Evidence obtained from at least one randomized controlled trial.
IIa	Evidence obtained from at least one well-designed controlled study^G without randomization.
IIb	Evidence obtained from at least one other type of well-designed quasi-experimental study^G , without randomization.
III	Synthesis of multiple studies primarily of qualitative research^G .
IV	Evidence obtained from well-designed non-experimental observational studies, such as analytical studies^G or descriptive studies^G , and/or qualitative studies.
V	Evidence obtained from expert opinion or committee reports, and/or clinical experiences of respected authorities.

Sources: Adapted by the RNAO Best Practice Guideline Research and Development team from Scottish Intercollegiate Guidelines Network. SIGN 50: a guideline developer's handbook. Edinburgh (UK): Scottish Intercollegiate Guidelines Network; 2011; and Pati D. A framework for evaluating evidence in evidence-based design. HERD. 2011;21(3):105-12.

Quality of Evidence

The quality of each research study was determined using critical appraisal tools. Quality was ranked as high, moderate or low and cited in the discussion of evidence. The **validated^c** and published quality appraisal tools used to judge the methodological strength of the studies included The Critical Appraisal Skills Program (CASP) for primary studies and Assessing the Methodological Quality of Systematic Reviews (AMSTAR) for systematic reviews. The quality rating was calculated by converting the score on the appraisal tool into a percentage.

When other guidelines informed the recommendation and discussion of evidence, the Appraisal of Guidelines for Research and Evaluation Instrument II (AGREE II) tool was used to determine the quality rating. **Tables 2 and 3** highlights the scores required to achieve a high, moderate, or low-quality rating.

Table 2: Quality Rating for Reviews using Critical Appraisal Tools

QUALITY SCORE ON APPRAISAL TOOLS	OVERALL QUALITY RATING
Greater than, or equal to, a converted score of 82.4 per cent	High
A converted score of 62.5–82.3 per cent	Moderate
Less than, or equal to, a converted score of 62.4 per cent	Low

Table 3: Quality Rating for Guidelines using the AGREE II tool

QUALITY SCORE ON THE AGREE II	OVERALL QUALITY RATING
A score of 6 or 7 on the overall guideline quality	High
A score of 4 or 5 on the overall guideline quality	Moderate
A score of less than 4 on the overall guideline quality	Low (Not used to support recommendations)

Summary of Recommendations

This guideline replaces the RNAO BPG *Interventions for Postpartum Depression* (3).

PRACTICE RECOMMENDATIONS		LEVEL OF EVIDENCE
Research Question #1: In the area of perinatal mental health, what are effective screening and assessment strategies for identifying symptoms of depression during pregnancy and postpartum for up to one year after childbirth?		
1.0 Assessment	Recommendation 1.1: Routinely screen for risk of perinatal depression, using a valid tool, as part of prenatal and postpartum care.	la, IV, V
	Recommendation 1.2: Conduct or facilitate access to a comprehensive perinatal depression assessment with persons who screen positive for perinatal depression.	IIb, IV, V
Research Question #2: In the area of perinatal mental health, what are effective interventions for persons experiencing depression during pregnancy and postpartum for up to one year after childbirth?		
2.0 Interventions	Recommendation 2.1: Collaborate with the person to develop a comprehensive person-centred plan of care, including goals, for those with a positive screen or assessment for perinatal depression.	la, IV, V
	Recommendation 2.2: Implement prevention strategies for perinatal depression to reduce the risk of illness progression.	la, Ib, IIb
	Recommendation 2.3: Promote self-care strategies for persons at risk for or experiencing perinatal depression including: <ul style="list-style-type: none"> ■ Time for self (level of evidence= IV); ■ Exercise (level of evidence = Ia); ■ Relaxation (level of evidence = Ib); and ■ Sleep (level of evidence = Ia, IV). 	la, Ib, IV
	Recommendation 2.4: Encourage persons with perinatal depression symptoms to seek support from their partner, family members, social networks and peers, where appropriate.	la, Ib, IV

PRACTICE RECOMMENDATIONS		LEVEL OF EVIDENCE
2.0 Interventions	<p>Recommendation 2.5:</p> <p>Provide or facilitate access to psychoeducational interventions to persons at risk for or experiencing perinatal depression.</p>	Ib
	<p>Recommendation 2.6:</p> <p>Provide or facilitate access to professionally-led psychosocial interventions, including non-directive counselling, for persons with perinatal depression.</p>	Ia, Ib
	<p>Recommendation 2.7:</p> <p>Provide or facilitate access to psychotherapies, such as cognitive behavioural therapy or interpersonal therapy, for perinatal depression.</p>	Ia, Ib
	<p>Recommendation 2.8:</p> <p>Support informed decision-making and advocate for access to pharmacological interventions for perinatal depression, as appropriate.</p>	Ia, Ib
	<p>Recommendation 2.9:</p> <p>Facilitate informed decision-making regarding the use of complementary and alternative medicine therapies for perinatal depression.</p>	Ia
	<p>Recommendation 2.10:</p> <p>Evaluate and revise a plan of care for perinatal depression, in collaboration with the person, until goals are met. Include the person’s partner, family, and support network, where applicable.</p>	V

EDUCATION RECOMMENDATIONS		LEVEL OF EVIDENCE
<p>Research Question #3: What education and training in perinatal depression are required to ensure the provision of effective assessment and interventions among nurses and the interprofessional team?</p>		
<p>3.0 Education</p>	<p>Recommendation 3.1 Develop educational programs on perinatal depression care incorporating both theory and clinical practice into undergraduate nursing and other allied health professional pre-licensure curricula.</p>	IV
	<p>Recommendation 3.2: Participate in ongoing professional development to enhance knowledge and skills in mental health services and supports for perinatal depression.</p>	Ia, IIb, IV
	<p>Recommendation 3.3: Perform regular self-reflection on attitudes and beliefs regarding perinatal depression.</p>	Ia, IV
ORGANIZATION AND SYSTEM POLICY RECOMMENDATIONS		LEVEL OF EVIDENCE
<p>Research Question #4: How do health-care organizations and the broader health-care system ensure optimal prevention, assessment, and interventions for perinatal depression?</p>		
<p>4.0 Organization and System Policy</p>	<p>Recommendation 4.1 Implement comprehensive and coordinated mental health services and supports for perinatal depression across communities to support care strategies provided by nurses and the interprofessional team.</p>	Ib, IV

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RNAO is committed to obtaining feedback from (a) nurses from a wide range of practice settings and roles, (b) knowledgeable administrators and funders of health-care services, and (c) stakeholder associations as part of the guideline development process. For this Guideline, stakeholders representing diverse perspectives were solicited* for their feedback, and RNAO wishes to acknowledge the following individuals for their contribution.

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Reviewers are asked to read a full draft of the BPG and participate in the review prior to its publication. Stakeholder feedback is submitted online by completing a survey questionnaire. The stakeholders are asked the following questions about each recommendation:

- Is this recommendation clear?
- Do you agree with this recommendation?
- Is the discussion of evidence thorough and does the evidence support the recommendation?

Stakeholders also participated in validating the quality indicators developed to evaluate this BPG's implementation by completing a survey questionnaire. The stakeholders assessed certain validation criteria on a 7-point Likert scale for each quality indicator.

The surveys also provide an opportunity to include comments and feedback for each section of the BPG. Survey submissions are compiled and feedback is summarized by the RNAO Best Practice Guidelines Research and Development Team. The team and the members of the RNAO expert panel review and consider all feedback and, if necessary, modify the BPG content recommendations and indicators prior to publication.

Stakeholder reviewers have given consent to the publication of their names and relevant information in this BPG. **Stakeholder reviewers' details are current as of the time of their review.**



Background Context

Perinatal depression is a type of a mood disorder that occurs during pregnancy and postpartum up to one year following childbirth (5 – 7). Perinatal depression is recognized as one of the most commonly occurring mental illnesses and, in developed countries, the most frequently under-diagnosed pregnancy complication (5 - 7). It is a significant cause of disease burden globally as measured by health-care costs, morbidity, mortality, and the number of years lost to disease; in the province of Ontario, an estimated \$20,000,000 is spent annually on complications of untreated or discontinued prenatal depression treatment, such as preterm and/or low birth weight infants (8 - 9). Globally, approximately 10 per cent of persons during pregnancy and 13 per cent during early postpartum in industrialized countries will experience a mental illness, primarily depression (10). Depression can present at different time points during pregnancy and/or postpartum; it may be a chronic mental illness that continues during pregnancy and postpartum, a new condition during pregnancy or postpartum, or a relapse (11). Perinatal depression results in both short- and long-term adverse consequences for the person; those consequences can extend to the person's partner, family members, and social network (6, 12). These consequences make it essential that nurses and the interprofessional team have the knowledge and skills to competently screen, assess, prevent, intervene, and evaluate perinatal depression (6 – 7).

Any psychiatric disorder can occur during pregnancy or postpartum. The Background Context section outlines perinatal depression symptoms and risk factors. Adjustment disorder, perinatal anxiety, and postpartum psychosis are briefly introduced however their specific implications for perinatal practices are beyond the scope of this BPG. The section begins with a description of postpartum blues, a very common mild mood change. It is included in the Guideline to differentiate it from perinatal mood disorders spectrum.

Mild Mood Changes

Postpartum Blues

It is important to differentiate postpartum depression from postpartum blues, a very common presentation with a prevalence of 30 to 75 per cent across diverse **cultures**^G that typically occurs in the first three to five days postpartum and resolves spontaneously within two weeks (6). Symptoms of postpartum blues may include tearfulness, agitation, mood swings, generalized anxiety, acute disturbances in appetite and sleep, a perception of being overwhelmed and uncertain, and irritability (6). Despite this, postpartum blues is not a mild form of depression, and it is not part of the perinatal mood disorders spectrum. It is unrelated to stress or psychiatric history and it does not impair the person's ability to take care of themselves or their infant or cause suicidal ideations (6). Postpartum blues can be attributed to the rapid decrease in estrogen and progesterone levels following childbirth as the symptoms typically worsen in the first week and then dissipate once hormonal levels stabilize (6, 13). Care for postpartum blues includes recognition, reassurance, education, and awareness that it can be a risk factor for postpartum depression (6, 13).

Mood Disorders

Perinatal Depression - Prenatal Period

The prevalence of prenatal depression in Canada can vary depending on the population studied and the **screening tool**^G used (14). For example, in 2014 the Public Health Agency of Canada reported a prevalence of ten per cent; whereas a longitudinal community sample indicated a rate of 14.1 per cent in early pregnancy and 10.4 per cent in late pregnancy (15). Despite the high prevalence, persons at risk are often not detected or treated (14).

Treatments for prenatal depression include psychotherapies and pharmacological approaches, depending on the severity of symptoms and responsiveness to treatment. Care options may be complex and limited due to concerns of potential harm to the developing fetus or available supports and services (16). As such, nurses and the interprofessional team must actively support pregnant persons in **informed decision-making^G** regarding their care (16 - 17). Careful consideration of the risks and benefits to the person and the fetus are essential (18).

Undetected and/or untreated depression during pregnancy can contribute to complications such as reduced attendance at prenatal appointments, increased tobacco or alcohol use, higher risk of preterm labour, or low birth weight (6, 14, 16 - 17, 19). In identifying these complications, however, linkages to social determinants of mental health are indicated (20). Persons who face social inequalities (such as poverty, **discrimination^G**, and trauma) are at increased risk of mental illnesses, particularly those experiencing multiple inequalities, and that for interventions to be effective and to avoid further inadvertent discrimination, they must acknowledge the complex underlying causes and contributors to depression. For example, missed prenatal appointments may be due to precarious work and fear of job loss or living in poverty and being unable to afford transportation; continued or increased use of tobacco during pregnancy may be a coping strategy to reduce hunger pangs or manage stressful emotions (20 - 21).

Perinatal Depression - Postpartum Period

Postpartum depression is the most common complication of childbirth with approximately half of the cases starting in the prenatal period (5 - 6). Prevalence rates vary; in Canada, data from the Canadian Maternity Experience Survey indicated a rate of 8.46 per cent of possible depression as measured on the Edinburgh Postnatal Depression Scale (EPDS) (with a total score of 10 - 12) and 8.69 per cent of probable depression (with a total score of 13 or greater) (22). In the United States, a 21 per cent prevalence rate of postpartum depression was found during the first year following childbirth (23). The findings indicated that the majority developed depression following childbirth (40.1 per cent), as opposed to prenatally (33.4 per cent), or pre-conceptually (i.e., prior to pregnancy; 26.5 per cent).

Qualitative research on postpartum depression provides insight into person's lived experiences and reflects the illness and recovery continuum (24). Four different and unique phases have been identified that describe the journey from illness to recovery for postpartum depression:

1. **Spiralling downward:** the experience of emotions, such as anxiety, feeling overwhelmed, isolation and guilt.
2. **The incongruity between expectations and reality of motherhood:** the experience of conflicting expectations and fear of being labelled.
3. **Pervasive loss:** a sense of loss (including loss of self, control, relationships with others, and voice).
4. **Making gains:** the experience of struggling to survive, reaching out for help and reintegration, and change.

Symptom recognition, support, and treatment are essential as a lack of care leads to adverse outcomes, including further isolation, helplessness, and hopelessness (25). Untreated postpartum depression can result in a person feeling a lack of bonding, gratification, or fulfillment in their role as a parent or miss cues for their infant, such as hunger or other needs (26 - 27). For children of parents with untreated depression, there is an increased risk of behavioural problems and delayed language, motor, social, and cognitive development (26, 28). In the long-term, children can be at higher risk of continued emotional issues or exhibiting aggressive behaviours as adults (26).

Perinatal Depression Symptoms

Although symptoms of postpartum depression vary for each person, they typically begin within the first four to six weeks following birth, but they can occur at any time within the first year following childbirth (23, 29). Criteria of symptoms of perinatal depression are varied, depending on the source. For example, the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders - 5 (DSM-5) identifies perinatal depression as a type of major depressive disorder with a peripartum onset, and symptoms occurring on a daily or near-daily basis over a two-week time frame or longer (29). Criteria for a diagnosis of perinatal depression, according to the DSM-5, include experiencing either a depressed mood or a loss of interest or pleasure in activities previously enjoyed, in addition to other symptoms including:

- difficulties with sleep (insomnia or hypersomnia), almost every day;
- a weight loss or gain of at least five percent or more over one month not due to dieting or overconsumption;
- observed agitation;
- loss of energy or fatigue on a daily basis;
- difficulties with concentration or decisiveness;
- feelings of worthlessness or inappropriate guilt; or
- recurring thoughts of death or suicidal ideation with or without a specific plan (29).

Table 4 lists additional signs and symptoms of perinatal depression categorized here according to mood, thoughts, and physical health/behaviours.

Table 4: Moods, Thoughts, and Physical Health/Behaviours Associated with Perinatal Depression

MOODS	THOUGHTS	PHYSICAL HEALTH/ BEHAVIOURS
<ul style="list-style-type: none"> ■ Sadness ■ Loss of interest or pleasure (anhedonia) ■ Feelings of guilt ■ Mood swings ■ Anxiety ■ Hopelessness ■ Fear of being alone with the baby due to difficulties with coping 	<ul style="list-style-type: none"> ■ Difficulties with concentration ■ Low self-esteem ■ Loss of focus ■ Difficulties with decision-making and thought processes ■ Suicidal ideation ■ Excessive worrying ■ Irritability ■ Self-doubt in activities, such as care-taking of the infant 	<ul style="list-style-type: none"> ■ Loss of appetite ■ Changes in physical appearance ■ Sleep disturbances ■ Tearfulness ■ Low energy

Sources: Banti S, Borri C, Camilleri V, et al. Perinatal mood and anxiety disorders. Clinical assessment and management. A review of current literature. Ital J Psychopath. 2009;15(4):351–366; O’Hara MW, McCabe JE. Postpartum depression: Current status and future directions. Annu Rev Clin Psychol. 2013; 9:379–407; and Zauderer C, Davis W. Treating postpartum depression and anxiety naturally. Holist Nurs Pract. 2012;26(4):203–209.

Some symptoms of perinatal depression, such as sleep disturbances and irritability, are also common in pregnancy therefore the severity and impact on functional status need further assessment to determine whether they are depression symptoms or normal transition. Similarly, as feelings experienced during infant care-taking, such as self-doubt or worrying, can resemble perinatal depression, it is important that nurses and the interprofessional team are educated on the differences to be able to determine if a depression is developing or not (6 – 7, 30).

Although symptoms of perinatal depression may vary, there can be commonalities in how persons express or describe their symptoms as listed in **Table 5**.

Table 5: Examples of Statements Suggesting Depression Symptoms

DEPRESSION SYMPTOM	EXAMPLE OF STATEMENTS TO DESCRIBE THESE SYMPTOMS
Low energy, lethargy	<i>“Everything is an effort.”</i>
Low self-esteem	<i>“I am a failure as a parent, person, and spouse.”</i>
Sadness	<i>“I want to cry all the time.”</i>
Suicidal ideation	<i>“I think everyone would be better off without me.”</i>
Anxiety, regret, remorse	<i>“I have made a terrible mistake.”</i>
Loss of focus, disorientation, confusion	<i>“I feel like I am living in a fog.”</i>

Source: Accortt E, Wong M. It is time for routine screening for perinatal mood and anxiety disorders in obstetrics and gynecology settings. *Obstet Gynecol Surv.* 2017;72(9):553-568.

Risk Factors for Perinatal Depression

The etiology of perinatal depression is unique for each person and often multi-factorial (6, 31). As such, life circumstances and situations that affect mental health and depression risk must be recognized. Through the processes of history taking, screening, and assessment for perinatal depression, awareness of risk factors can support the identification of those factors and the potential need for and benefits of interventions (20).

Several recommendations in this BPG refer to persons at risk for perinatal depression and recognize the impact that multiple or intersecting risk factors, including the social determinants of mental health, have on increasing the risk of perinatal depression. Those living with social inequities may be at highest risk (6, 20, 32). For example, persons such as new immigrants who experience barriers to accessing mental health services and supports due to factors such as services not available in their first language or low decision-making power in a family can be at higher risk for perinatal depression (33).

Table 6 lists the risk factors for perinatal depression as categorized in three levels: strong, moderate, and weak. In listing the risk factors, those identified as the strongest are characterized as variables with the highest likelihood of perinatal depression; moderate risks are those with a medium level of risk; and weak risk factors are those with the lowest risk for perinatal depression. Examples of risk factors are provided, but they are not meant to be exhaustive of all possibilities.

Table 6: Risk Factors for Perinatal Depression

STRONG RISK FACTORS	MODERATE RISK FACTORS	WEAK RISK FACTORS
<ul style="list-style-type: none"> ■ A history of psychiatric illness, including depression or anxiety at any time, including, but not limited to, during the perinatal period ■ Prenatal symptoms of anxiety ■ The onset of depression during pregnancy or postpartum 	<ul style="list-style-type: none"> ■ Stressful life events (e.g., relationship breakdown or divorce, losing a job, incarceration, housing insecurity) ■ Refugee or immigrant status ■ Low social support or perception of low support ■ Unfavourable obstetric outcome(s) ■ Low self-esteem ■ A history of physical or sexual abuse during childhood or adulthood ■ Intimate partner violence ■ A history of reproductive trauma (e.g., infertility) ■ Grief related to miscarriage, stillbirth, or infant loss ■ Substance use, including the use of tobacco 	<ul style="list-style-type: none"> ■ Low socio-economic status ■ Lack of significant other or partner; single parent ■ Pregnancy, as defined by the person, as unplanned or unwanted ■ Breastfeeding challenges, including a lack of social support or support by a health-care provider⁶

Sources: Bhat A, Byatt N. Infertility and perinatal loss: When the bough breaks. *Curr Psychiatry Rep.* 2016;18(3):1-11; Ferszt G, Hickey J, Seleyman K. Advocating for pregnant women in prison: the role of the correctional nurse. *J Forensic Nurs.* 2013;9(2):105-10; Hamdan A, Tamim H. The relationship between postpartum depression and breastfeeding. *Int J Psychiatry Med.* 2012;43(3):243–259; Kozinszky Z, Dudas RB, Devosa I, et al. Can a brief antepartum preventive group intervention help reduce postpartum depression symptomatology? *Psychother Psychosom.* 2012;81(2): 98–107; Lancaster CA, Gold KJ, Flynn HA, et al. Risk factors for depression symptoms during pregnancy: A systematic review. *Am J Obstet Gynecol.* 2010;202(1):5–14; and O’Hara MW, McCabe JE. Postpartum depression: Current status and future directions. *Annu Rev Clin Psychol.* 2013; 9:379–407.

Adjustment Disorders

Adjustment disorders are common and can present with depressed mood (including perinatal depression), anxiety, or both (29). The diagnostic features of adjustment disorder, as identified by the American Psychiatric Association in the DSM - 5, includes emotional or behavioural symptoms in response to a specific stressor, such as a developmental event (e.g., becoming a parent) or other event (e.g., a “difficult” birth or a pregnancy loss) in which the person’s distress response exceeds what would normally be expected in intensity, quality, or duration or when it negatively impacts function (29). The disorder occurs within three months from the time of the stressor and resolves within six months after the stressor.

Perinatal Anxiety

In comparison to perinatal depression, perinatal anxiety is less understood (34). As it is a precipitating factor for postpartum depression, nurses and the interprofessional team must assess anxiety symptoms as either a co-morbidity with postpartum depression, or a separate condition in the perinatal period (34).

The prevalence and type of anxiety during pregnancy and postpartum varies across study populations (34). It is estimated that up to 10 per cent of pregnant women will experience a generalized anxiety disorder (i.e., a type of anxiety with non-specific worries regarding several aspects of life) and up to five per cent will experience a panic disorder (i.e., a type of anxiety characterized by sudden excessive fear) (34).

Anxiety disorders can present clinically with symptoms such as agitation, cognitive distortions, constant worry, racing thoughts, shortness of breath, heart palpitations, and restlessness (34). For pregnant persons experiencing anxiety, they can present with unique concerns and behaviours, such as:

- Recurring thoughts about the fetus that may interfere with the person's role and social functioning and that contribute to generating a heightened emotional state (34).
- Experiences of panic and concerns of panic attacks complicating the pregnancy (34).
- More frequently reported nausea and vomiting (34).
- Requesting more prenatal appointments than others (34).
- Increased absences from work due to difficulties coping with the normal physiological changes associated with pregnancy (34).
- Increased reports concerning fetal movements (increased or decreased) (35 – 36).

During labour, anxiety-related complications may include premature labour, including premature rupture of membranes, low birth weight infants, or a higher risk of birth via caesarean section (35 - 37). In postpartum, symptoms of anxiety may be aggravated by sleep deprivation, caring for a newborn, or the associated physical, psychological, and social transitions of parenthood (34).

Perinatal anxiety can be correlated with depression during pregnancy and postpartum (38). There is a positive correlation between developing anxiety disorders in late pregnancy for persons who experience depression concurrently (39). Late prenatal anxiety symptoms are also predictive of worsening depression symptoms in the first three months postpartum (30, 39).

To measure perinatal anxiety, a screening tool, such as the EPDS, can be used as it measures both depression and anxiety symptoms (37). A valid tool specific to perinatal anxiety has not been established in the evidence as the feasibility and utility of screening for anxiety is still being determined (37).

Postpartum Psychosis

Postpartum psychosis is the rarest and most severe form of postpartum psychiatric illness occurring in 0.1 to 0.5 per cent of persons (6, 30). It is a psychiatric emergency of an acute psychotic event with a rapid clinical onset; symptoms typically present within the first two to four weeks following birth (6, 40). It is a state in which a person has bizarre delusions or hallucinations (e.g., the baby is a devil) and/or disorganized speech, thoughts, or behaviours (6, 30). The person experiences overwhelming confusion and intense changes in their emotional state, such as mood swings (6). Postpartum psychosis requires an urgent psychiatric assessment most often in an acute care setting. An untreated psychosis is a potential risk factor for self-harm, suicide, or harm to the infant or other children, therefore, supervision is required to protect the person (6, 30, 41).

Due to the psychotic state, a partner or family member may need to advocate or seek mental health services or supports for perinatal depression as the affected person may be unaware of their condition or unable to access services (6, 30). Prognosis is typically favourable, with a full recovery once the postpartum psychosis has been identified and treated (6, 30). The underlying cause of postpartum psychosis is unknown, but persons with a history of bipolar disorder or a previous postpartum psychosis have an increased risk (6, 30).



Guiding Frameworks

The following frameworks were used to guide the systematic reviews and the development of recommendations: social determinants of mental health, **person-centred care**^G, and informed decision-making. Each framework provides fundamental prerequisite knowledge as a background to the clinical topic. It is recommended that nurses and the interprofessional team receive adequate education and training through professional development with respect to these guiding frameworks and apply them in their daily practice.

Social Determinants of Mental Health

When working collaboratively with persons who are at risk for or experiencing perinatal depression, it is essential to recognize the social determinants that affect their health and well-being, including their mental health (20). These determinants include a person's place of birth, where they grew up and currently live, their work, age and other economic, social, cultural, political and environmental forces and conditions (42). Social determinants of mental health include health inequities that are modifiable as they are derived from social inequalities (20, 42). They are systemic in their distribution across the population and are inherently unfair and unjust (43). Public policies, including those on mental health services and supports for perinatal depression, can address the inequitable division of power and resources and improve conditions of daily life across the lifespan, including during pregnancy and postpartum, and in multiple sectors and levels in areas such as work, education, and social programs (20, 42).

Nurses and the interprofessional team must recognize the significance of the social determinants of mental health to effectively advocate for and work towards eliminating health inequities (44). Knowledge of the impact of social determinants of mental health needs to be incorporated into all of the components of perinatal depression care (screening, assessment, prevention, interventions, and evaluation).

Person-Centred Care

Person-centred care is an approach to care that is beneficial to persons at risk for or experiencing perinatal depression. It focuses on coming to know the **whole person**^G, their experiences of health, and the role of the partner and family in the person's life (including the role they may play in supporting the person to achieve health) (45 - 46). Person-centred care is organized around and with the person that reflects their needs, culture, value, beliefs, and changing health states (47). It respects a person's preferences, demonstrates **cultural sensitivity**^G and **cultural awareness**^G, and involves the sharing of power within a **therapeutic relationship**^G to improve clinical outcomes and satisfaction with care (48). It is a shift away from the biomedical model, where the person is viewed within a disease context as someone who must be diagnosed and treated (45 - 46). For further details regarding the role of nurses and the interprofessional team and the provision of **person- and family-centred care**^G, refer to the 2015 RNAO clinical BPG *Person- and Family-Centred Care* at <http://rnao.ca/bpg/guidelines/person-and-family-centred-care>

Informed Decision-Making

Throughout the perinatal period, pregnant and postpartum persons make decisions regarding their care. These decisions may be influenced by their beliefs, values, and social circumstances. It is the responsibility of nurses and the interprofessional team to facilitate informed decision-making by collaborating with persons and families (where applicable), and by providing evidence-based information (49). Nurses have an ethical responsibility to recognize, respect, and promote a person's right to make informed decisions (49).

The Association of Women's Health, Obstetrical and Neonatal Nurses (AWHONN) identifies informed decision-making as a key value of perinatal nursing practice (50). It states that perinatal nurses should:

- Respect and promote the autonomy of women, helping them to meet their health needs by obtaining appropriate information and services.
- Provide women and families with evidence-based information to facilitate informed decision-making.
- Work in partnership with women and their families by respecting their view and supporting their choices, whenever possible.
- Advocate for women, newborns, and families within the context of law and institutional processes.
- Work in collaboration with other health-care providers to support the care choices of women and families, whenever possible (49, p.22).



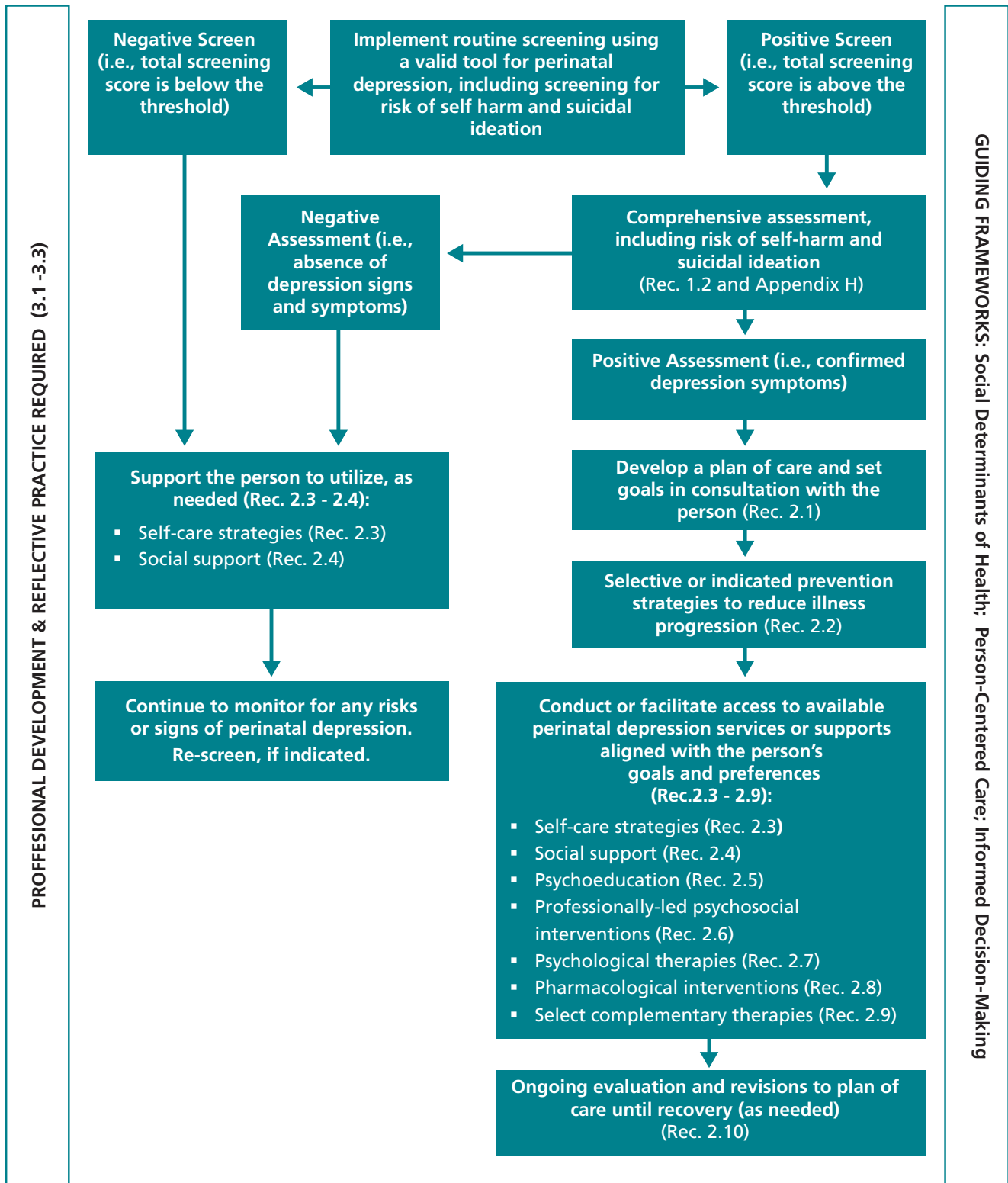
Algorithm for Perinatal Depression Care

The expert panel developed an algorithm that depicts all of the practice and education recommendations for this guideline. The algorithm embodies the guiding principles of a person-centred approach, informed decision-making and the social determinants of mental health as factors that influence health outcomes. It should be utilized across all practice settings in which care is provided to persons during pregnancy and postpartum up to one year following childbirth (**Figure 1**, on the following page). In communities where there is limited access to and/or available mental health services and supports for perinatal depression, the algorithm can guide the mobilization and plan for these essential services.

The algorithm includes strategies for the five components of perinatal depression care described in this BPG: screening, assessment, prevention, interventions, and evaluation. Perinatal depression care begins with routine screening with a follow-up assessment indicated for those with a positive screen. The selection of the screening tool and its associated cut-off score is recommended to be chosen based on research findings and supported by organizational policies. **Appendix G** discusses considerations for the selection of a perinatal depression screening tool by organizations.

Following the routine screening, persons who have a negative screen (i.e., a total score below a threshold) are provided knowledge of self-care strategies and the benefits of social support. For persons with a positive screen (i.e., a total score above a threshold) and a positive assessment to identify perinatal depression, mental health services and supports will be selected collaboratively including psychosocial, psychological, pharmacological, or psychoeducational therapies, in addition to examples and benefits of self-care strategies and psychosocial support, or select complementary therapies. Ongoing evaluation and revisions to the plan of care are required, including determining the effectiveness of the services and supports, until recovery is achieved.

Figure 1: Algorithm for Perinatal Depression Care



*If at any step in the implementation of this algorithm you have reasonable grounds to suspect that an infant or child is or may be in need of protection, promptly report your suspicions, concerns, and the information on which they are based to your local child protection services.

Practice Recommendations

RESEARCH QUESTION #1:

In the area of perinatal mental health, what are effective screening and assessment strategies for identifying symptoms of depression during pregnancy and postpartum for up to one year after childbirth?

RECOMMENDATION 1.1:

Routinely screen for risk of perinatal depression, using a valid tool, as part of prenatal and postpartum care.

Level of Evidence for Summary: Ia, IV, V

Quality of Evidence for Summary: High = 1; Moderate = 3; Low = 1; Guideline: High = 1

Discussion of Evidence:

Evidence Summary

The expert panel strongly recommends routine screening for perinatal depression for all pregnant and postpartum persons up to one year following childbirth as it remains under-recognized and untreated as a mental illness, despite available treatments. Routine screening of perinatal depression provides a mechanism for early identification of those in need of further assessment, care planning, and initiation of mental health services and supports, (where appropriate) to reduce the adverse health outcomes for the person, their infant, and family in the short- and long-term (51 - 52). Furthermore, early interventions through routine screening can reduce **stigma**^G, break down barriers associated with the identification of a mental illness, and detect nearly 50 per cent of persons with perinatal depression (53). Routine screening is also positively associated with increased detection (in comparison to standard care that is often reliant upon the health-care providers' clinical judgment or history taking) and a significant decrease in depression symptoms (51).

A specific screening or assessment tool for perinatal depression is not promoted in this Guideline, because the research questions that shaped the systematic reviews focused on the identification of effective interventions to support the screening and assessment for perinatal depression. Instead, examples of valid screening tools discussed in the literature are included in **Appendix E**, including the EPDS.

Screening by Nurses and the Interprofessional Team in a Variety of Settings

Screening for perinatal depression can be conducted effectively by trained nurses and members of the interprofessional team in a variety of settings offered in-person and via telephone (51, 54). Examples include primary care and pediatric settings (e.g. well-baby care clinics, emergency departments), as well as the person's residence (51, 54).

To be effective, screening should be part of a comprehensive strategy that includes coordinated follow-up, regardless of the results of the screen (55). Screening cannot be done in isolation without access to follow-up assessment and referrals, where indicated. In regions lacking mental health services and supports in perinatal depression, the expert panel recommends continued screening and advocacy for local integrated services. Alternative formats of perinatal depression screening such as via telephone or internet can be considered. Nonetheless, as part of an informed consent process prior to screening, transparency regarding available supports and services should be included.

Perinatal Depression Screening Frequency and Timing

Evidence on the optimal timing and frequency of perinatal depression screening is inconsistent. For example, in an obstetric setting, screening was scheduled twice prenatally (i.e., at the first visit and at 26 – 28 weeks gestation) and once in the postpartum period at three to eight weeks following childbirth (51). A primary care setting screened once routinely at two to three weeks postpartum (26) and at one, three, and six months postpartum in a well-baby child setting (55). The US Preventative Services Task Force, American Academy of Pediatrics, and the American College of Obstetricians and Gynecologists support universal screening at least once or more during the perinatal period, but do not recommend a specific time point (51, 55). Further details regarding these associations' recommendations for perinatal depression screening frequency and timing can be found in the 'Supporting Resources' section. As the findings are not consistent, no recommendations regarding specific frequency and timing can be made.

Responding to Screening Risk for Maternal Self-harm or Suicide

Many screening tools for perinatal depression include one or more question(s) pertaining to a potential risk of self-harm or suicide (56). A positive screen for suicide or self-harm, regardless of whether the total screening score is above or below the threshold, warrants a **comprehensive assessment**^G of risk by the nurse and the interprofessional team; this includes evidence of suicidal thoughts, plan, lethality, and means (56). Additionally, inquiries must be made about any safety risks to the infant and other children (where applicable), as their safety is paramount (56). These steps must be followed by the nurse and the interprofessional team whenever they are required, regardless of the stage of the screening, assessment, prevention, intervention, and evaluation. More information pertaining to responding to maternal suicidal ideation can be found in [Appendix H](#).

Benefits and Harms

A qualitative study indicated that persons who were screened for perinatal depression experienced distress and discomfort when asked about previous traumatic histories or concerns of suicidal thoughts due to the personal nature of these events (57). Further, some participants reported regret in disclosing a history of depression or anxiety as they felt health-care providers focused too much on this aspect of their health history.

Values and Preferences

Acceptance of perinatal depression screening is enhanced when nurses establish a therapeutic relationship with the person and a full explanation of the use of the screening tool is provided. For example, qualitative findings indicate that persons were more accepting of perinatal depression follow-up screening and assessment when they were conducted by a health-care provider whom they knew and trusted (58).

Practice Notes

Screening Scores

In regards to screening scores, evidence of moderate and strong quality indicates that the following nursing considerations should be taken:

- The total score and the interpretation of the results—and, where indicated, the follow-up—are ideally discussed immediately after the screening tool has been completed (59).
- For persons with scores above the cut-off value indicating a positive screen, support, information about depression, and an individualized plan of care are essential (59). The nurse or member of the interprofessional team must be cognizant that a positive screen may trigger fears, such as being labelled as an incompetent parent, having their infant apprehended or experiencing difficulties securing work or crossing borders (59).
- The total screening score needs to be interpreted cautiously. Scores below the screen's cut-off value warrant further assessment if clinical judgment suspects the presence of depression symptoms (53). Scores above the cut-off value indicate further assessment as this will include persons who are not depressed; that this is a function of the sensitivity of a screening tool, which allows it to better ensure that those at higher risk are detected (53). In these cases, the nurse or member of the interprofessional team can offer reassurance to a person that a positive screen is not a determination of depression, and that further assessment should identify and confirm their lack of risk of depression.

Considerations for Administering a Perinatal Depression Screening Tool

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

I. RECOGNITION OF THE PERSON'S INFORMATION AND SUPPORT NEEDS

Begin the screening process with a general discussion about the person's mental health and well-being. This discussion can be part of an initial visit, according to the judgment of the nurse or member of the interprofessional team (56).

Fully explain the purpose of the screening tool so that the person has been informed of the nature and intention of the tool to support consent and acceptance (57, 59). Ensure that the person understands that an elevated score above the threshold is not diagnostic nor an indication for treatment; instead, it is an indication for further assessment (11).

Take measures to support the person's comfort and privacy during the administration of the screening tool. This includes having an open dialogue about any concerns the person may have about the screening process or remaining flexible regarding the timing and use of the screen (59).

Recognize that screening for perinatal depression can be perceived as intrusive (57). The style, approach, and displayed trustworthiness by the health-care provider are critical to ensuring that the person feels empowered and supported to seek help where indicated (57).

A demonstration of a caring and empathic attitude, an unrushed environment, and a displayed interest in the person and their screening score can facilitate support and minimize any shame or stigma that the person may feel when discussing concerns about their mental health (59).

As part of a relational practice that applies a person-centred, holistic approach, seek to contextualize the person's lived experience and health care needs. Incorporate an understanding of personal, interpersonal, and social factors by recognizing any inequities and social structures that may influence the process of screening and screening outcomes (59 - 60).

II. RECOGNITION OF THE PERSON'S READINESS TO BE SCREENED

Communicate to the person that the completion of the screening process is voluntary and requires their consent (57). The person maintains the right to refuse or decline to answer any (or all) of the components of the screening tool.

To provide consent, persons must be made fully aware of how the screening tool will be used during the plan of care, including possible follow-up (57).

A person's consent to complete a screening process does not imply consent for any further follow-up. This is true regardless of the score and screening assessment, except in cases of an identified urgent risk of self-harm, suicide, infanticide, or harm to others (57).

When consent has not been given, inquire about any changes in mood or the presence of any depression symptoms can be made in lieu of a formal screening process. The offer for formal screening should be made at a follow-up visit if the person gives consent (57, 59).



III. INTEGRATION OF THE PERSON'S CULTURAL BACKGROUND AND PRACTICES

Nurses and the interprofessional team must recognize and integrate cultural awareness and sensitivity throughout the screening process. Pregnant and postpartum persons may experience and express depression signs and symptoms differently, depending on their culture (61).

To engage in culturally sensitive care, the following components are integral:

- Recognize that persons who are less proficient in the language where they are residing or who are recent immigrants are at increased risk of perinatal depression (48).
- Seek to establish a therapeutic relationship by overcoming language difficulties by establishing trust and making a connection with the person as the quality of the relationship is central to effective screening, assessment, and possible intervention. By demonstrating compassion and genuine interest in getting to know the individual's culture, life circumstances, and way of parenting, the person can be empowered. Being available, receptive, and responsive is also important (48).
- Interpreters may be helpful, but the nurse or member of the interprofessional team need to pay attention at each encounter to any verbal or non-verbal signs of perinatal depression. Observe for signs such as the person appearing tired or having a stiff facial expression or blankness in the eyes. The person may appear to have a lack of interest in their infant or be slow to respond to their cues. Behaviours suggestive of perinatal depression include being quiet, not asking any questions or offering only brief answers, seeming hurried at visits, or, conversely, having many questions and worries and constantly seeking help or reassurance (48).
- If a screening tool is used with a cultural interpreter, the validity of the tool may be threatened. Additional explanation and clarification may be needed (48). The selection of the screening tool must consider available languages and the validity of the translated tool (61). See **Appendices E and G** for further details on perinatal depression screening tools.
- A screen with a total score of zero would suggest absolutely no risk of perinatal depression. However, the score may instead reflect, in some cultures, a shame and guilt associated with having a mental illness. In such cases, observance of signs and symptoms of perinatal depression and the establishment of a therapeutic relationship is essential to be able to talk to the person regarding their mental health. Use of tacit knowledge based on a health-care providers' practice and experience may also be beneficial to the interpretation of mood (48).
- For some persons, being given practical advice and direction by a health-care provider regarding their plan of care was perceived as helpful (48).

See **Appendix D** (Diversity among Persons with Perinatal Depression) and the 'Supporting Resources' section for further details on cultural considerations in mental health services and supports in perinatal depression.

Supporting Resources

RESOURCE	DESCRIPTION
SUPPORT BY THE INTERPROFESSIONAL TEAM FOR ROUTINE PERINATAL DEPRESSION SCREENING	
<p>American College of Obstetricians and Gynecologists. Screening for perinatal depression. Committee Opinion No. 630. <i>Obstet Gynecol.</i> 2015;125:1268-1271. Available from: https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression</p>	<ul style="list-style-type: none"> ■ Recommendations from the American College of Obstetricians and Gynecologists on perinatal depression screening including that it should be strongly considered, at a minimum, once during the perinatal period using a standardized and validated tool.
<p>Earls F, The Committee on Psychosocial Aspects of Child and Family Health. Clinical report – Incorporating recognition and management of perinatal and postpartum depression into pediatric practice. <i>Pediatr.</i> 2010;126:1032-1039. Available from: http://pediatrics.aappublications.org/content/126/5/1032</p>	<ul style="list-style-type: none"> ■ Routine screening for postpartum depression in pediatric settings is recommended as postpartum depression can have adverse effects on infants and children, such as a shorter duration of breastfeeding and an increased risk of child abuse and neglect.
<p>Association of Women’s Health Obstetric and Neonatal Nurses. Mood and anxiety disorders in pregnant and postpartum women. <i>J Obstet Gynecol Neonatal Nurs.</i> 2015;44:687-689. Available from: https://onlinelibrary.wiley.com/doi/full/10.1111/1552-6909.12734</p>	<ul style="list-style-type: none"> ■ Recommendations from the Association of Women’s Health Obstetric and Neonatal Nurses include support for routine screening in pregnancy and postpartum, implementing staff training and education on mood disorders, and support for staff to conduct or facilitate access to follow-up care for persons with positive screens for depression.

SUPPORT BY THE INTERPROFESSIONAL TEAM FOR ROUTINE PERINATAL DEPRESSION SCREENING

Marsay C, Manderson L, Subramaney U. Changes in mood after screening for antenatal anxiety and depression. *J Reprod Infant Psychol*. 2018; Mar 30:1-16. Available from: <https://www.tandfonline.com/doi/abs/10.1080/02646838.2018.1453601>

- A study examining pregnant persons' experiences of being screened for prenatal depression and anxiety.
- Results indicate that screening appeared to improve outcomes as participants described positive experiences such as gaining self-awareness and knowledge, validation from a health-care provider, and self-agency to seek out support from others.
- The results may be due to measurement reactivity.

CULTURAL CONSIDERATIONS AND PERINATAL DEPRESSION SCREENING

Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. *CMAJ*. 2011;183(12):E824-E925. Available from: <http://www.cmaj.ca/content/183/12/E824>

- Routine screening for depression is recommended, in settings where integrated treatment programs are available.

Carteret M. Cross-cultural use of the Edinburgh Postnatal Depression Scale [Internet]. [place unknown]: Dimensions of Culture; 2018. Available from: <http://www.dimensionsofculture.com/2018/03/screening-for-pregnancy-related-depression-in-private-practice-settings-cross-cultural-considerations/>

- Depression can be conceptualized, explained, and reported differently across cultures.
- Examples of expressions of postpartum depression include feelings of sadness regarding the infant's gender or delays or problems in the naming of the baby.

IMPLEMENTING PERINATAL DEPRESSION SCREENING

DC Collaborative for Mental Health in Pediatric Primary Care. Perinatal mental health toolkit for pediatric primary care: overview and primer [Internet]. Washington (DC): DC Collaborative for Mental Health in Pediatric Primary Care; 2017. Available from: <https://www.dchealthcheck.net/documents/PMH-Toolkit-V-2-2.pdf>

- A resource geared to pediatric primary care providers in the promotion of mental health.
- Recommends screening for postpartum depression at the one, two, four, six, and twelve-month visit.
- The resource includes examples of standardized responses to EPDS scores indicating a negative screen, at-risk screen, and a probable screen.
- The resource also includes an action crisis plan in cases of reported self-harm or harm to others.

Irwin-Vitela L. People-centered screening and assessment. Module 4: Edinburgh Postnatal Depression Scale, EPDS [Video]. Milwaukee (WI): Wisconsin Department of Children and Families, the University of Wisconsin-Milwaukee Child Welfare Training Partnership (MCWP), and Common Worth, LLC; 2016. Available from: <https://www.youtube.com/watch?v=JBgVlaBg-aU>

- An evidence-based PowerPoint presentation on the EPDS.
- Includes a simulation of screening for postpartum depression using the EPDS.
- Emphasizes the role of reflective practice by the provider.

RECOMMENDATION 1.2:

Conduct or facilitate access to a comprehensive perinatal depression assessment with persons who screen positive for perinatal depression.

Level of Evidence for Summary: IIb, IV, V

Quality of Evidence for Summary: High = 1; Moderate = 1; Guidelines High = 1; Moderate = 1

Discussion of Evidence:**Evidence Summary**

In cases of a positive screen for perinatal depression and consent by the person, a follow-up comprehensive assessment is indicated (56 – 57, 62). Persons need to be aware of the types of questions that make up the assessment, and that some areas may be of a more sensitive and personal nature (57). While persons may consent to be assessed, their experiences may influence their decisions of whether to pursue mental health services and supports or adhere to the plan of care, where treatment is indicated (57). Accordingly, skills such as respect and empathy from nurses and the interprofessional team are essential (57).

A comprehensive assessment seeks to confirm signs, symptoms, and severity of perinatal depression within an overall health assessment and may include the following components:

- The results of the screening tool, which can facilitate a more in-depth discussion of mood and any changes in symptoms that the person has noticed (62).
- Risk factors for perinatal depression, especially for persons with strong risk factors that suggest a high likelihood of perinatal depression (such as a history of a mood disorder, depression, or anxiety during a previous pregnancy) (56). A listing of risk factors for perinatal depression is included in the **Background Context** section (p. 21).
- Emotional status, such as recurring periods of sadness, discouragement, irritation, disappointment, or difficulties with decision-making (56).
- Somatic concerns, such as changes in sleeping and eating patterns or periods of crying (56).
- Physical status, including nutritional intake, activity level, or any physical health problems (56).
- Health inequities associated with a history of mental illness, marginalization, or stigma (63).
- Disparities, such as poverty, as well as inequities such as disability, incarceration, or food insecurity (63).
- Contributory psychosocial factors, such as a lack of social support, negative attitude towards pregnancy, history of substance use, history of current or past abuse or trauma, low socio-economic status, or being a refugee or a recent immigrant (56).
- A risk assessment of self-harm, self-neglect, suicidal ideation, or thoughts of harming the infant or other children (56). **Appendix H** describes the nurse and the interprofessional team's responses to an identified suicide risk.

Benefits and Harms

A qualitative study examined the perspectives of pregnant and postpartum persons who had a psychosocial assessment conducted by child and family health nurses (57). Participants reported that they were accepting of psychosocial assessments that included questions regarding a history of abuse, interpersonal violence, or depression. However, some persons felt the questions were intrusive, particularly if the health-care provider appeared to be insensitive or lacked empathy.

Assessment for perinatal depression requires nurses and the interprofessional team to demonstrate compassion and trust. The approach taken by the nurse and the interprofessional team can impact the person's experience of being assessed and what is reported (57). In cases where trust was developed, the person was more likely to disclose sensitive issues, such as depression, feel empowered, and be more likely to engage in follow-up care. See **Recommendation 3.2** for a discussion of the importance of ongoing professional development to provide perinatal depression assessment and interventions.

Values and Preferences

An evaluation study conducted suggests that persons were accepting of an assessment of perinatal depression by their primary care provider (64). Participants reported such assessments to be accessible and not stigmatizing.

Practice Notes

Examples of assessment tools for perinatal depression varied in the evidence. These tools were developed to assess pregnant persons for the presence of psychosocial risk factors associated with perinatal mental health disorders, including depression (65). However, there is insufficient evidence that supports or refutes the use of a psychosocial assessment tool in the assessment of perinatal depression (40). Examples of assessment tools for perinatal depression are included in **Appendix F**.

The assessment of perinatal depression was found to be feasible in primary care settings with the following components:

- A user-friendly assessment tool that was brief and semi-structured.
- A streamlined process using an algorithm to guide decisions regarding referral to mental health services based on symptom severity, where indicated.
- Guidelines on antidepressant medication for prescribing health-care providers.
- Rapid access to expert mental health consultants either via telephone or internet to support on-site treatment.
- A checklist to support documentation.
- A referral pathway to off-site consultants in cases of severe symptoms or complex co-morbidities (64).

Supporting Resources

RESOURCE	DESCRIPTION
<p>Mother Reach London & Middlesex. Postpartum mental health assessment flow chart [Internet]. London (ON): Mother Reach London & Middlesex; 2012.</p>	<ul style="list-style-type: none"> ■ A flowchart for the assessment of postpartum depression. ■ A decision tree for assessment and intervention of women with thoughts of harming themselves and/or their child(ren).
<p>Registered Nurses' Association of Ontario. Nursing towards equity: applying the social determinants of health in practice (Internet). Toronto (ON): Registered Nurses Association of Ontario; 2016. Available from: https://rnao.ca/bpg/courses/nursing-towards-equity-applying-social-determinants-health-practice</p>	<ul style="list-style-type: none"> ■ A free online course to support enhanced knowledge and skill in applying the social determinants of health and health inequities in clinical practice. ■ An examination of health and health inequities may be a component of perinatal depression assessment.

RESEARCH QUESTION #2:

In the area of perinatal mental health, what are effective interventions for persons experiencing depression during pregnancy and postpartum for up to one year after childbirth?

RECOMMENDATION 2.1:

Collaborate with the person to develop a comprehensive person-centred plan of care, including goals, for those with a positive screen or assessment for perinatal depression.

Level of Evidence for Summary: Ia, IV, V

Quality of Evidence for Summary: High = 2; Guidelines: High = 1; Moderate = 3

Discussion of Evidence:**Evidence Summary**

In collaboration with the person at risk for, or experiencing perinatal depression, nurses and the interprofessional team must create a plan of care using a person-centred approach. Through purposeful discussions, the person is supported to choose available options for mental health services and supports in local community programs, primary care, home health, public health, or acute care settings (62).

Collaborative care^G planning integrates holistic, humane, respectful, and ethical components from a person-centred approach (47). It includes the establishment of individualized goals for perinatal depression and addressing any barriers to accessing mental health services and supports for perinatal depression—such as direct costs for transportation or child care necessary for attending clinic visits or the availability of services—to develop a unique care plan that realistically reflects the individual’s concerns, preferences, needs, and options (57). Taking a collaborative approach better ensures that the person is central to care planning and goal setting.

The success of a collaborative partnership between the person, the nurse, and the interprofessional team in care planning necessitates:

- Recognition that the person’s partner, family, or social network is central to their care and may influence whether or not to seek or continue care. As part of a family-centred approach, the partner, family, or social network may aid in the care and support of the affected person, the infant or other children (where applicable). They, therefore, need to understand the plan of care and how they can constructively and practically support the person (40).
- Clarification of roles and responsibilities of the involved interprofessional team and the available resources (66).

Careful attention must be paid to fears of stigma or labelling—or to feelings of shame—related to initiating interventions for perinatal depression (66). The nurse and the interprofessional team should observe, ask, or listen for any feelings of anxiety, fear, threat, guilt, hostility, or denial throughout care planning—if detected, these emotions or coping strategies must be addressed. Since persons typically have many questions regarding available mental health services and supports and the implications for pregnancy or postpartum, it is important to take the time to address any worries, questions, concerns, and potential consequences. The care plan must reflect informed decision-making and personal preference and be regularly updated, as needed. Taking these steps to assess psychological readiness to initiate and engage in mental health services and supports and to assist with care transition can help to support the individual, thus increasing the likelihood of improving health outcomes and reaching goals (66).

Care Planning Following an Assessment of Perinatal Depression

An individualized plan of care should be developed with the person based on the outcome of a screening and/or comprehensive assessment for perinatal depression and clinical judgment. Examples of five potential outcomes with suggested follow-up strategies are listed in **Table 7**. In each case, the expert panel recommends a collaborative approach that supports person-centred care and informed decision-making. The care plan needs to be documented, reviewed, and revised, as required, according to the person's response to the intervention(s) or changing needs (67).

Benefits and Harms

When referring to a mental health specialist, attention should be paid to any sensitive personal information (e.g., history of trauma or abuse) that has been disclosed in confidence, to determine whether this history can also be shared. Recognizing these issues will ensure maintenance of the therapeutic relationship and preserve ongoing trust between the person and the interprofessional team (40).

Values and Preferences

The person must be supported to determine their preferences, concerns, and priorities in regards to their plan of care (62). The person's partner and other family members (where applicable) may also be included and/or participate in this process (47).



Table 7: Clinical Considerations Following a Screening and/or an Assessment for Perinatal Depression

PERSON'S SCREENING AND/OR ASSESSMENT RESULT(S)	CLINICAL CONSIDERATIONS
<p>Consent not given for screening or assessment.</p>	<ul style="list-style-type: none"> ■ Maintain contact and continue to support the person for the duration of care during pregnancy or postpartum, as appropriate (62, 68). ■ Explore any changes in mood, any concerns about depression symptoms, and how the person is coping with the transitions of pregnancy or as a new parent (as needed) (62, 68). ■ Remain vigilant for any possible developing symptoms of depression and discuss them with the person (68). ■ Incorporate holistic approaches to detecting signs of depression. Observe the person's appearance, mood, and interactions with their infant or family members for any depression symptoms (69). ■ If a person reports any concerns about possible depression symptoms, encourage follow-up, including screening or conducting or facilitating access to further assessment, as clinically indicated (62, 68).
<p>A screen negative (i.e., screening results below cut-off score).</p>	<ul style="list-style-type: none"> ■ Provide ongoing care as usual to support the person. ■ Encourage the person to engage in self-care activities and seek out social support as prevention strategies (56). ■ Continue to observe for any presence of altered mood, thoughts, perceptions, and at-risk behaviours (56).
<p>A positive screen (i.e., screening results above cut-off score).</p> <p>The follow-up assessment does not identify perinatal depression.</p>	<ul style="list-style-type: none"> ■ Review the results of the assessment and the lack of perinatal depression symptoms. Encourage and answer any questions or concerns they might have (40). ■ Reinforce that any screening tool has false positives. ■ Provide care listed under "No confirmed perinatal depression symptoms" (above) (56, 62).
<p>A positive screen (i.e., screening results above cut-off score).</p> <p>The assessment identifies perinatal depression.</p>	<ul style="list-style-type: none"> ■ Review the results of the assessment and the confirmation of perinatal depression symptoms. Encourage and answer any questions or concerns raised (40). ■ In collaboration with the person, develop a plan of care based on the results to determine suitable mental health services and supports for perinatal depression and care goals. Revise, as needed. ■ Include a copy of the assessment results in the person's chart and provide a copy to the person (56).

RECOMMENDATIONS

PERSON'S SCREENING AND/OR ASSESSMENT RESULT(S)	CLINICAL CONSIDERATIONS
<p>A screening or assessment indicating risk of self-harm (regardless of results of screening or assessment results)</p>	<ul style="list-style-type: none"> ■ Develop a documented care plan in collaboration with the person. Ensure care plan goals and outcomes are communicated to the primary care provider (67). ■ Conduct a risk assessment with the individual to survey areas of potential risk, such as self-harm, self-neglect, suicidal thoughts and intent, or any risks to others (including the infant or other children, where applicable) (56). See Appendix H (Responding to an Identified Risk of Maternal Suicide) for an example. ■ Report a positive screen or assessment for self-harm to the primary care provider (56). ■ In the event of an urgent or immediate risk of self-harm, arrange access to care regardless of whether consent has been given. This will necessitate an urgent psychiatric assessment likely in an acute care setting (such as an emergency department) (56). ■ In the event that there is an identified or suspected neglect or abuse of the newborn, infant, or other children, report concerns immediately to the local child protection agency (56). ■ In the event of a suspected or identified risk of self-harm of low or medium risk, perform the following steps: <ul style="list-style-type: none"> □ Encourage the person to utilize their support network to reduce isolation. □ Discuss available mental health services and supports, and where needed, facilitate access with the person's consent (56). ■ To build and encourage social support, ask the person if there is anyone whom they wish to have included in their care. This recognizes the positive impact of social support (56). Involve the person's partner and family members, where indicated (56). ■ Include a copy of the plan in the personal record and to the referring clinician. Offer a copy to the person, their partner, and family, where applicable (56).

Practice Notes

To develop a comprehensive and person-centred plan of care for perinatal depression, the following practices were identified as central:

- Discuss all treatment options that are appropriate and the availability of trained and local health-care providers. This will ensure that the individual is aware of the full spectrum of mental health services and supports, interventions, and potential outcomes. Support the individual's right to choice, the timing of care, and the selection of tailored approaches (where available) (40).
- Provide a full explanation of what an intervention or treatment option entails in order to support informed decision-making (47, 57). Providing a person with details related to their treatment options follows a participatory model of decision-making and respects their right to self-manage their care (including the right to decline or accept care components or the timing of care, unless where court-mandated). By making persons more aware of the expectations and demands of a particular treatment, they can determine if it is feasible for them and compatible with their defined care goals and priorities (47, 57). For example, a person considering group cognitive behavioural therapy (CBT) should be made aware that this typically involves participation in weekly two hour sessions for between eight to 12 weeks. Furthermore, the person should know that participants are asked to share their experiences with others in a group setting and that there can be additional costs, such as transportation or child care, to access services (70 - 72). Further details regarding CBT are discussed in **Recommendation 2.7**.

Supporting Resources

RESOURCE	DESCRIPTION
<p>Arthur E, Seymour A, Dartnall M, Beltgens P, Poole N, Smylie D, North N, Schmidt R. Trauma informed practice guide. Vancouver (BC): British Columbia Centre of Excellence for Women’s Health; BC Ministry of Health, Mental Health and Substance Use Branch; and Vancouver Island Health Authority, Youth and Family Substance Use Services; 2013. Available from: http://bcccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf</p>	<ul style="list-style-type: none"> ■ A resource to support the integration of trauma-informed principles into practice including collaboration in care choices. Depression, including perinatal depression, can be a response to trauma. ■ The guide includes practical suggestions to support collaborative approaches to care planning and guidelines for screening for trauma. ■ Examples of statements that explicitly support collaboration in care planning include: <ul style="list-style-type: none"> □ <i>‘I’d like to understand your perspective.’</i> □ <i>‘Let’s look at this together.’</i> □ <i>‘Let’s figure out the plan that will work best for you.’</i> □ <i>‘What is most important for you that we should start with?’</i> □ <i>‘It is important to have your feedback every step of the way.’</i> □ <i>‘This may or may not work for you. You know yourself best.’</i> □ <i>‘Please let me know at any time if you would like a break or if something feels uncomfortable for you. You can choose to pass on any question.’</i> □ <i>Use appropriate metaphors: ‘You are the expert or the driver. I can offer to be your GPS or map to help guide you to available resources etc.’</i>
<p>Canadian Mental Health Association Ontario. Advancing equity in Ontario: understanding key concepts [Internet]. Canadian Mental Health Association Ontario: [place unknown]; 2014. Available from: http://ontario.cmha.ca/wp-content/uploads/2016/07/Advancing-Equity-In-Mental-Health-Final1.pdf</p>	<ul style="list-style-type: none"> ■ A resource examining mental health and equity. Marginalized groups are more likely to experience mental illness. ■ Persons who experience mental health illnesses such as perinatal depression can experience additional inequities which can influence whether their decisions regarding screening, assessment, and interventions for perinatal depression. ■ Stigma has resulted in persons with mental illness being discriminated or socially isolated. Examples include: <ul style="list-style-type: none"> □ Being denied housing or being harassed by landlords; □ Increased likelihood of being unemployed, not hired or promoted; and □ Experience discrimination in criminal justice or health care services. <p style="text-align: right;">Continued →</p>

RECOMMENDATIONS

RESOURCE	DESCRIPTION
	<ul style="list-style-type: none"> ■ Suggested strategies to promote equity and mental health include: <ul style="list-style-type: none"> □ Recognize the importance of equitable processes in mental health policy and planning; □ Expand the evidence on equity and mental health through data collection and knowledge exchange; □ Engage those with lived experience in mental illness in policy, planning and service delivery; □ Build healthy communities by recognizing the social determinants of health; and □ Challenge discrimination, exclusion, and stigma by supporting the human rights and access mechanisms for people with lived experience of mental illnesses.
<p>BC Reproductive Mental Health Program. Perinatal depression treatment options [Internet]. Vancouver (BC): BC Reproductive Mental Health Program; date unknown. Available from: https://reproductivementalhealth.ca/sites/default/files/uploads/resources/files/perinatal_depression_treatment_options_fact_sheet.pdf</p>	<ul style="list-style-type: none"> ■ A two-page fact sheet summarizing perinatal depression treatment options.
<p>World Health Organization. Social determinants of mental health [Internet]. Geneva (CH). World Health Organization; 2014. Available from: http://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf;jsessionid=7E14520A2E67C6FA0FBBAB1A9E719FCD?sequence=1</p>	<ul style="list-style-type: none"> ■ A paper from the World Health Organization on social determinants of mental health. ■ Comprehensive strategies must be prioritized to prevent mental illnesses and promote mental health at the population level across the lifespan. This requires acting on the social determinants of health – such as access to secure housing and food, discrimination, or poverty. Such as approach recognizes that mental illness is triggered by the social, economic, and political conditions under which persons reside. Systematic inequalities negatively contribute to mental illnesses. ■ Pregnancy and postpartum are times of risk for mental illness. They are also times when intervention strategies including prevention can be effective at promoting mental health and reducing mental illness.

RESOURCE	DESCRIPTION
<p>NICE Clinical Guidelines, No. 136. National Collaborating Centre for Mental Health (UK). Service user experience in adult mental health: Improving the experience of care for people using adult NHS mental health services. Leicester (UK): British Psychological Society; 2012. Available from: https://www.ncbi.nlm.nih.gov/books/NBK327301/</p>	<ul style="list-style-type: none"> ■ A chapter from a mental health clinical guideline from the United Kingdom focusing on requirements for high-quality user experience for transfers of care (e.g., from primary care to a mental health specialist). ■ Recommendations for mental health providers regarding service users' needs during transfers of care or discharge include: <ul style="list-style-type: none"> □ Recognize that a transfer of care to a mental health service or support can evoke strong reactions or emotions. □ Provide clear information on all possible support options available to the person after the transfer of care. □ Involve persons in decisions regarding their care and respect their preferences. □ Provide emotional support, empathy, and respect. Be aware that transfers of care can raise feelings of abandonment or supported in a punitive manner.

RECOMMENDATION 2.2:

Implement prevention strategies for perinatal depression to reduce the risk of illness progression.

Level of Evidence for Summary: Ia, Ib, IIb

Quality of Evidence for Summary: High = 5; Moderate = 5; Low = 5

Discussion of Evidence:**Evidence Summary**

Prevention strategies for perinatal depression aim to preserve the well-being of the person and mitigate any adverse effects of the mood disorder (73 - 74). Implementing prevention or early intervention strategies creates an opportunity to support the person at risk for, or starting to develop perinatal depression symptoms, and ameliorate or decrease their risk of illness progression (73 - 74). Prevention strategies in health care can be categorized according to the target population (71, 75). Those categories are as follows:

- Universal prevention is directed at a whole population (e.g., all pregnant persons) or community samples irrespective of risk indicators (i.e., none to several). As an approach, universal prevention offers benefits including reduced stigma, a modest reduction in population prevalence, and more likelihood of being used. This is done through strategies such as health promotion (71, 74 - 78).
- Selective prevention is aimed at those with risk factors who are identified through self-reporting, screening, or history taking (71).
- Indicated prevention focuses on persons with early signs and symptoms of a condition, but are not currently in an illness state (71).

Universal Prevention Interventions for Perinatal Depression

There is limited evidence supporting universal prevention for perinatal depression; interventions targeting a whole population or community can be costly and study results demonstrate inconsistency in reducing risks (74 - 78). For example, a nurse-led gender-informed psychoeducational programme for couples focusing on strengthening partner relationships and coping with unsettled infant behaviours (crying, sleep challenges or difficulties with feeding) did not demonstrate a difference in screened depression scores post-intervention when compared to controls (75). Another study found no significant difference in preventing depression symptoms to six months postpartum for those who received education by nurses on postpartum depression prior to discharge from a childbirth setting when compared to standard care (77). The study concluded that selective prevention that prioritized those who were at increased risk (e.g., low socio-economic status or prenatal history of anxiety or depression) may be more effective than a universal educational intervention.

Nonetheless, there are examples of effective universal prevention strategies such as listening and home visits (76). A nurse-led structured education prevention intervention for postpartum persons demonstrated significantly lower depression scores post-intervention when compared to controls (78). In another study implementing universal prevention, pregnant persons who attended multiple prevention sessions using psychoeducation and psychotherapy strategies had a significant decrease in depression symptoms, in comparison to the control group, at six weeks postpartum (63). Participants learned about postpartum depression screening and coping skills, recognizing distress and seeking help, developing social support, and relaxation techniques.

Selective and Indicated Prevention Interventions for Perinatal Depression

Persons at risk for or starting to develop early signs of perinatal depression may benefit from a variety of prevention interventions, including psychoeducation and psychotherapies, as discussed below (79 – 82). These can be offered in multiple and diverse settings by nurses and the interprofessional team (79 - 80).

Psychoeducation

Psychoeducation as a prevention strategy that incorporates health education and informational support has been demonstrated as an effective prevention strategy (63, 83). For example, postpartum persons with low-income had fewer depression symptoms at six months following a behavioural psychoeducation intervention provided in a hospital setting prior to discharge (82). Participants and their partners learned about triggers of depression symptoms, the benefits of social support and the need to conserve personal resources as a coping strategy. They were provided written information and a list of resources, in the event of problem developing. In addition, a follow-up phone call was provided two weeks post-discharge to assess participants' depression symptoms, level of coping and other needs.

Psychotherapies

Various psychotherapies—including non-directive counselling, CBT, and Interpersonal Therapy (IPT)—were found to be effective as prevention strategies (71, 81). Non-directive counselling provides empathic listening and reflection. CBT targets cognitive distortions, negative emotions, and resulting behaviours. IPT focuses on communication and interactions with others to strengthen relationships (81, 84). These forms of psychotherapy—when delivered by trained nurses and members of the interprofessional team—can be provided in either individual or group formats during pregnancy or postpartum (71, 81, 84). For example, a study of pregnant persons on social assistance who received an IPT-orientated intervention in addition to standard prenatal care demonstrated a significantly lower rate of depression symptoms at six months postpartum and marginally significant lower levels at 12 months postpartum, when compared to controls (85). The intervention was structured and provided in small groups over multiple sessions that included learning IPT-skills such as improving relationships and enhancing social support. In another study, participants at risk for postpartum depression but had not developed depression symptoms were randomized to receive either standard nursing care or an intervention of learning cognitive problem-solving skills (81). The results indicate a reduction for both groups in depression symptoms, as measured by the Beck Depression Inventory pre- and post-intervention.

The Timing of Prevention Strategies during the Perinatal Period

The optimal timing for prevention interventions is unclear from the evidence (i.e., during pregnancy or during postpartum) as the findings are conflicting (71, 86). Timing may depend on the type of prevention strategy implemented and individual response. For example, interventions for postpartum depression prevention were found to be more effective when conducted following birth, because the interventions when conducted prenatally were felt to be less relevant to the participants (71). In contrast, other studies noted the efficacy of preventative interventions that were administered prenatally using strategies that promoted coping techniques, engaged partner support (such as psychoeducational programs) and included exercise programs (63, 84). An intervention of discharge education on postpartum depression in a maternity unit that was not found to demonstrate statistical significance concluded that timing may not have been optimal as persons in the immediate and early postpartum may be distracted by their recovery from birth, caring for an infant, and seeing visitors (77). Additionally, the study participants may have been unable to take in and recall the education due to factors such as fatigue or pain. Given these considerations, education on postpartum depression may be better offered prenatally and addressed briefly in the postpartum unit, with further follow-up post-discharge.

Selective Prevention Strategies Tailored for Perinatal Depression for Populations Experiencing

Social Inequities

Selective prevention strategies tailored to populations who experience social inequities (identified in the evidence as those who are socially disadvantaged persons with lower socio-economic status, adolescents with limited social support, and racialized persons) have shown statistically significant reduction in depression symptoms, when compared to controls (71, 79, 81 – 83, 87). For example, CBT was found to be effective for Latina postpartum women with low-income who had significantly lower scores on the Beck Depression Inventory post-intervention (81). Study participants were taught strategies including mood regulation, self-efficacy skills to enhance confidence, and parenting skills to promote bonding (81).

Prevention interventions can be modified and culturally adapted for populations who experience social inequities to promote desired inclusivity and relevance, including through methods such as providing the intervention in the participants' first language or adjusting the content to reflect values, beliefs, and culture (81). These modifications support cultural awareness and recognize the social determinants of mental health. They seek to provide community-level prevention interventions tailored to persons that recognize and address their health inequities and unique needs (81).

Notwithstanding the amount of research on prevention strategies for perinatal depression, there are limitations that reduce the generalizability and strength of the findings (63, 73 – 74, 84). The methodological quality and rigour of the prevention studies are mixed, with weaker studies being more likely to demonstrate significant findings (79). Inclusion criteria of study participants varied widely, such as adolescent persons to those over 18 years, depression symptoms ranging from mild to severe, or persons with high- or low-risk pregnancies (73, 79, 84). Other limitations include a lack of multi-site trials, small sample sizes, self-reported symptoms of depression, high attrition rates, and publication bias (63, 73, 84).

Benefits and Harms

CBT, delivered via group format is noted to have added benefits, including expanded social support, increased cost-effectiveness, and improved accessibility (71).

Values and Preferences

Prevention strategies that include cultural adaptations are preferred when they fit the needs of the study population (79). Overall, the integration of tailored approaches to populations can increase rates of study recruitment, enrollment, attendance, and intervention satisfaction.

Practice Notes

Examples of discussion topics presented in psychoeducation interventions for perinatal depression included:

- Information about sadness, depression, psychosis, and treatment of postpartum depression.
- A review of modifiable risk factors for postpartum depression and ways to reduce these factors.
- The role and significance of available peer or partner support.
- Strategies for stress management and coping.
- Awareness of available local resources.
- Tips for differentiating normal postpartum adjustment and somatic symptoms from postpartum depression (63, 78, 83).

Supporting Resources

RESOURCE	DESCRIPTION
<p>Werner E, Miller M, Osborne LM, Kuzava S, Monk C. Preventing postpartum depression: Review and recommendations. <i>Arch Womens Ment Health</i>. 2015;18(1):41-60. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4308451/</p>	<ul style="list-style-type: none"> ■ A literature review of 45 trials on psychological (i.e., IPT and CBT) and psychosocial (i.e., prenatal and postpartum classes and postpartum support) methods of postpartum depression prevention. ■ Many of the interventions were effective that used either an individual or group format. All focused on the person. ■ Emerging evidence suggests focusing on the person/ infant dyad may be more effective as infants with poor sleep behaviour or fussiness are positively associated with postpartum depression symptoms. Techniques to promote sleep and reduce fussiness may be an effective prevention approach.
<p>Dennis C-L. Best evidence for the detection, prevention, and treatment of perinatal depression [Internet]. Toronto (ON): Best Start Resource Centre; 2014. Available from: https://www.beststart.org/events/2014/bsannualconf14/webcov/Presentations_ForParticipants/New/C3_PPD-BestStart%20February%202014.pdf</p>	<ul style="list-style-type: none"> ■ A slide presentation based on a Cochrane Review on perinatal depression, including prevention strategies. ■ A beneficial effect of prevention strategies for depression symptoms was found.

RECOMMENDATION 2.3:

Promote self-care strategies for persons at risk for or experiencing perinatal depression including:

- Time for self (level of evidence = IV).
- Exercise (level of evidence = Ia).
- Relaxation (level of evidence = Ib).
- Sleep (level of evidence = Ia, IV).

Level of Evidence for Summary: Ia, Ib, IV

Quality of Evidence for Summary: High = 2; Moderate = 5; Low = 3

Discussion of Evidence:**Evidence Summary**

The evidence supports the promotion of self-care strategies for all persons at risk for or experiencing perinatal depression symptoms through an informed decision-making process by nurses and the interprofessional team (88 - 89). Self-care strategies, such as time for self, exercise, relaxation, and sleep reflect a holistic and comprehensive approach to perinatal depression interventions that are accessible to most persons which promote autonomy (88). Due to limitations with the findings, nurses and the interprofessional team need to discuss the intervention's effectiveness, study limitations, and any potential side-effects or contraindications of the various self-care strategies in order to support informed decision-making.

Self-care strategies for perinatal depression may be perceived of as beneficial for their ability to be self-administered in a person's home and used in privacy as well as safe, with few or no potential adverse effects or risks (88 - 89). While self-care strategies can be incorporated by any pregnant or postpartum person to optimize health, they can be especially helpful for those at risk for or experiencing perinatal depression (88 - 89). For these persons, self-care strategies can be used as a means of independently managing symptoms, promoting personal empowerment, and supporting improved overall health and well-being (88 - 89). Examples of self-care are varied and must be defined and selected by the person. It is essential that nurses and the interprofessional team, and the person's partner, family, and social network are aware of the need for and benefits of self-care and actively support and encourage regular self-care practices (90).

Self-Care Strategies**Time for Self**

Time for self allows persons the opportunity to engage in self-care activities, such as going for a walk, spending time with others, having a bath, or going to the gym, as a preventative or therapeutic measure for perinatal depression (89). It relieves a person temporarily from their daily responsibilities such as caring for their infant and other children or dependents, housework, cooking or paid work. Time for self recognizes that perinatal depression does not occur in isolation and that there are associated contributory factors such as available social support, personal relationships, income, or stressors arising from isolation, chronic sleep deprivation, and infant fussiness (89). Supporting persons to have time for self requires partners who are willing to share equitably in the practical and emotional care of an infant. This can contribute to the health of both parents and their offspring (89).

An inverse dose-response relationship between depression symptoms at six months postpartum and the frequency of time for self was found (89). The study's results found that ten per cent of participants who had less than once every two weeks for time for self had depression symptoms, versus less than six per cent who had weekly time for self. Those who reported never having time for self had the highest prevalence of depression symptoms at 15 per cent.

Although the study on time for self was one of the first to find an association with postpartum depression, there are important limitations (89). The study sample was mostly persons over the age of 30 years who had university-level education and established social support. The generalizability of the effectiveness of time for self may not apply to specific groups of persons who do not share the sample's characteristics and/or who experience social inequities.

Exercise

Pregnant and postpartum women who engage in exercise appear to benefit from a reduction in depression symptoms (91 - 92). Studies have shown that physical activities—such as walking, aerobics, aqua-based, stretching, and instructor-led or home-based programs—are effective in preventing and treating perinatal depression (91 - 92).

The generalizability of the findings on exercise is limited because of studies that included persons who were receiving concurrent treatments (e.g., pharmacotherapy), making it difficult to draw conclusions about the independent effects of exercise. Additionally, there were limited studies on prenatal depression and the inclusion criteria for persons with depression symptoms were inconsistent (91 - 94).

Relaxation

Relaxation techniques have been shown to effectively promote well-being and relieve pain and other stressors (95). A RCT using a relaxation technique for pregnant persons hospitalized for high-risk pregnancies (e.g., diabetes, hypertension, or hemorrhage risk) had significantly reduced depression scores (95). These results are considered important as persons with high-risk pregnancies are at an increased risk of perinatal depression. Participants were taught the Benson relaxation technique by nurses which included 10 – 20 minutes daily of muscle relaxation, breathing awareness, and word repetition for five days. The results also indicated decreased feelings of anxiety and nervousness. Relaxation was found to be a simple, cost-free and non-stigmatizing practice that can be done on a daily basis with no evidence of harms.

Sleep

Regular sleep cycles are recognized as beneficial for the promotion of overall physical and mental health and disease prevention (96 - 97). Sleep for persons with a newborn or an infant can be challenging as hours of sleep are frequently shorter in duration which can be a contributing factor for postpartum depression (96). Sleep can be particularly challenging for those who have disordered sleep patterns for day and night or 'fussy' infants (97). A persistent lack of sleep, combined with depression symptoms, needs to be identified promptly to avoid developing chronic sleep problems and worsening symptoms of depression (97).

Study limitations for the body of evidence on self-care strategies include small sample sizes, few randomized trials, high withdrawal rates, short follow-up timelines, and weak-to-moderate methodological quality (88, 94). Variances can be found as some studies examined a self-care strategy as a monotherapy, while others used a combination of other approaches or used self-care strategies as an adjunct to psychological or pharmacological treatments, thus introducing potential confounders or biases. Furthermore, criteria for participant inclusion in studies varied, ranging

from persons with self-reported symptoms to those who had screened positive using a valid screening tool to those with a confirmed diagnosis of depression. In the future, there is a need for well-designed large controlled trials to strengthen the findings on self-care strategies and perinatal depression (88).

Benefits and Harms

Unless medically contraindicated, perinatal persons who engage in regular physical activity have benefits in mood and an increase in social support, coping, and improved functioning (91 - 94). Thirty minutes of daily exercise is recommended to support mental health, particularly for depression, although more evidence is needed to support this guidance (91 - 92).

Values and Preferences

Among the many care approaches for perinatal depression, there may be a preference among pregnant and postpartum persons for self-managed approaches (as opposed to pharmacological or psychological interventions) (88). This may be attributed to personal preference, concerns about the perceived complications or risks from medication exposure during pregnancy or lactation, or difficulties accessing psychosocial or psychological treatment(s) (e.g., geographical distance, costs, wait lists, child care, stigma, or available local resources) (88).

Practice Notes

Examples of Self-Care Strategies with Limited Evidence

It is important to support persons with perinatal depression to make informed decisions regarding their choice of self-care strategies. Within these care planning discussions, nurses and the interprofessional team should be aware that there is a lack of demonstrated and consistent effect of some self-care strategies or there are significant limitations that suggest caution when determining generalizability and clinical effectiveness (88, 94, 98 - 102).

Examples of self-care strategies for perinatal depression with limited evidence or inconsistent findings include yoga, omega-3 fatty acids, iron supplementation, chamomile tea, and newborn skin-to-skin contact (88, 94, 98 - 104). Key limitations include the following:

- As a self-care approach, yoga can have many benefits including reduced levels of stress, anxiety, pain, and sleep disturbances (100). Relaxation states can be improved (100). Nonetheless, the optimal frequency of practice for yoga is not known with the number of sessions per study varying widely, nor its impact as a self-care modality on postpartum depression (100 - 102). Additionally, the impact of components of yoga (such as mindfulness, exercises, and relaxation techniques) or specific types of yoga on depression symptoms are not known (102).
- Omega-3 fatty acids, including those found in fish sources (i.e., eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA)) have demonstrated inconsistent results in randomized trials with significant and non-significant changes in mean depression scores, versus placebo. Further studies are needed that feature larger sample sizes, longer study durations, and consistent dosing to determine the effect (88, 94). In the interim, a healthy balanced diet emphasizing good nutrition is encouraged in order for individuals to achieve better health (40).
- A randomized placebo-controlled trial examined the effects of iron supplementation for non-anemic postpartum persons for six weeks, versus placebo, on confirmed depression symptoms (103). Results indicated a significant decrease in depression symptoms and an improvement in iron stores. However, further studies are needed to examine other factors that may have influenced outcomes and whether side-effects of iron supplementation causes any harms to the person or their infant (if breastfeeding).

- A small randomized trial found drinking one cup of chamomile tea consistently for two weeks significantly reduced short-term depression symptoms and improved sleep deficiencies for postpartum persons (104). However, the effects were not seen once the participants stopped drinking the tea and further studies are needed. The researchers conclude that the tea may be useful as a supplementary approach and suggest that the positive effects of the tea may be due to apigenin, a flavonoid, which has a slight sedative effect to aid sleep and perhaps help with depression symptoms.
- Skin-to-skin contact with newborns may be an effective strategy for reducing depression symptoms as it can create a positive feeling of bonding with the infant and enhanced mood (98). The wide variances in mean skin-to-skin contact time, from two to six hours daily, make it challenging to be able to make any recommendations regarding the optimal amount of contact time (98 - 99).

To promote time for self, nurses and the interprofessional team can encourage, educate, and support persons to:

- Ensure regular time for self, at a minimum of a weekly basis or more, as available.
- Recognize time for self as a step towards protecting and promoting mental health and well-being and to reducing depression symptoms.
- Value time for self as a low-cost and low-intensity prevention strategy.
- Enlist ongoing support from their social network (where applicable) such as friends, neighbours, and paid childcare to ensure planned and regular time for self.
- Encourage partners to share in the emotional and practical responsibilities of childcare and housekeeping.
- Recognize that persons who face social inequities may face challenges having time for self due to the realities of their lives (89).

To promote and support regular and healthy sleep patterns, nurses can educate persons who are at risk for or experiencing perinatal depression symptoms to implement the following:

- Avoid alcohol or caffeine.
- Engage in some physical activity in the late afternoon or early evening.
- Awaken at approximately the same time each morning to establish a daily routine (when possible).
- Get up and move to another room until feeling sleepy if not asleep within 15 minutes.
- Have a light snack or warm milk before going to sleep.
- Encourage short naps during the day to cope with disrupted sleep at night.
- Access the person's partner, family, social network, or a postpartum doula to allow for times with uninterrupted sleep (when possible).
- Practice stress reduction and relaxation exercises (e.g., deep breathing, imagery, or progressive muscle relaxation) (56).

Supporting Resources

RESOURCE	DESCRIPTION
<p>Family Services Ottawa. Resource booklet: Postpartum distress, depression and/or anxious moods [Internet]. Ottawa (ON): Family Services Ottawa; 2017. Available from: http://familyservicesottawa.org/wp-content/uploads/2017/04/PPDinfopackage-2017.pdf</p>	<ul style="list-style-type: none"> ■ A resource booklet developed for mothers who are experiencing postpartum depression or anxiety. ■ The booklet includes a section on self-care with suggestions on how to reduce stress, establish support systems, and cope with anxiety.
<p>Best Start Resource Centre. Managing depression: a self-help skills resource for women living with depression during pregnancy, after delivery and beyond [Internet]. Toronto (ON): Best Start Resource Centre; 2014. Available from: https://www.beststart.org/resources/ppmd/DepressionWorkbookFinal_15APR30.pdf</p>	<ul style="list-style-type: none"> ■ A workbook for a person living with perinatal depression symptoms that focuses on depression management skills and lifestyle changes.
<p>Pacific Post Partum Support Society. Postpartum depression & anxiety: a self-help guide for mothers. 7th ed. Vancouver (BC): Pacific Post Partum Support Society; 2014.</p>	<ul style="list-style-type: none"> ■ A practical guide for purchase for persons who are experiencing postpartum depression and anxiety. ■ The ‘little purple book’ includes information on what helps to get through depression and anxiety and recovery.
<p>Minnesota Department of Health. Maternal well-being plan [Internet]. St. Paul (MN): Minnesota Department of Health; 2016. Available from: http://www.health.state.mn.us/divs/cfh/topic/pmad/content/document/pdf/wellbeing-eng.pdf</p>	<ul style="list-style-type: none"> ■ A well-being plan for postpartum persons that focuses on sleep, nutrition, social support, and physical activity. ■ A brief tool for persons to identify their well-being strategies and signs of depression or anxiety are included.
<p>Royal College of Psychiatrists. Postnatal depression [Internet]. London (UK): Royal College of Psychiatrists; 2018. Available from: https://www.rcpsych.ac.uk/healthadvice/problemsanddisorders/postnataldepression.aspx</p>	<ul style="list-style-type: none"> ■ An overview of postpartum depression including signs and symptoms and treatment options. ■ Includes suggestions for self-help.

RECOMMENDATION 2.4:

Encourage persons with perinatal depression symptoms to seek support from their partner, family members, social networks and peers, where appropriate.

Level of Evidence for Summary: Ia, Ib, IV

Quality of Evidence for Summary: High = 1; Moderate = 4

Discussion of Evidence:**Evidence Summary****Support from Partners, Family Members, and Social Network**

Persons with postpartum depression symptoms need and benefit from social support from partners, family members, and social networks (e.g., friends, community partners, or work colleagues), where appropriate (105). This type of support can improve a person's ability to cope with their depression symptoms (105).

Peer Support

Peer support offers encouragement and understanding from individuals who may have had similar experiences with depression symptoms (106 - 108). This type of relationship is unique, and it differs from a therapeutic relationship with a nurse or member of the interprofessional team as those professionals are not typically perceived by persons as having a shared lived experience of postpartum depression (107).

Peer support for perinatal depression may be effectively delivered in-person, via telephone, through online discussion boards of postpartum groups (106 - 108). Telephone-based peer support increases accessibility and reduces the stigma that is sometimes encountered with in-person interactions (107). It is difficult, however, to determine the independent effects of peer support as many of the interventions described in the evidence were multi-modal (e.g., peer support and CBT or parent-infant dyad therapy).

Peer Support via Online Discussion Forums

Accessing the Internet or interactive web-based interventions (i.e., technology-enabled care) provides a readily available mechanism for many postpartum persons to seek and obtain peer support through online discussion forums (106, 108). Websites with chat rooms for persons with postpartum depression symptoms offer advantages to users including mitigating barriers to treatment (including cost, travel, stigma, or childcare needs, where applicable) and providing access to support for a self-determined duration and frequency (108).

Pilot studies^G suggest a feasibility and willingness for persons with perinatal depression symptoms to access and utilize web-based interventions, although the studies' findings are limited and inconclusive (106). Other studies have found that participation in online communities was effective in reducing postpartum depression symptoms (106, 108).

Many online discussion forums for postpartum depression have quality mechanisms to create safe and supportive online environments for participants that appear to contribute to positive outcomes (106, 108). These include expert

moderators in chat rooms that monitor online discussions and watch for any signs of abusive or inappropriate postings, access to a live trained coach, and integration of evidence-based approaches. In the absence of these mechanisms, it is feasible that the outcomes may not be duplicated, and nurses and the interprofessional team should encourage persons to seek safe and supportive online environments.

Benefits and Harms

An identified benefit of interacting with peers who share similar experiences of perinatal depression includes gaining knowledge and improved feelings of hopefulness regarding overcoming the depression symptoms (107). However, it is important to note that a peer who has a history of depression may also render that person less able or available to provide support due to their own mood disorder (70, 107). Training and support for peers can mitigate some of these effects.

When a person's partner, family members, or social network demonstrate a lack of understanding and compassion, are non-supportive or are abusive, persons with postpartum depression symptoms can experience further isolation and stigma (70). A lack of support by the person's partner, family members, or social networks, can be the result of various causes, including being unsure how to help, normalizing or minimizing depression symptoms in a belief that depression is not a mental illness that requires that requires treatment or having a lack of empathy and/or unresolved trauma leading to abusive behaviour. Regardless of the underlying cause(s), the lack of partner, family, or social network support may cause persons with postpartum depression to rely more on other people, including peer support (70, 107). In situations where there is no available social support, symptoms of depression may worsen (107).

Values and Preferences

Face-to-face individual support in a person's home was valued for being easily accessible and timely. Group support was preferred for sharing coping strategies and normalizing feelings of depression (105).

Persons reported that they valued the following actions to feel supported: 1) listening to and acknowledging their feelings, 2) reassurance that their experiences are not unusual, and 3) offering a sense of hope that things can get better with support and treatment (105).

Practice Notes

Types of partner, family and social network support that persons with postpartum depression symptoms may find helpful include:

1. Informational (i.e., giving advice and guidance on topics such as postpartum depression symptoms to reduce feelings of inadequacy, shame or embarrassment).
2. Instrumental (i.e., helping and assisting with practical tasks, such as housework or infant care).
3. Emotional (i.e., providing care, empathy, and compassion through active listening).
4. Affirmational (i.e., acknowledgment and validation of the experience of depression) (105).

Supporting Resources

RESOURCE	DESCRIPTION
<p>Partners to parents [Internet]. Melbourne (AU): Partners to Parents; c2016. Available from: http://www.partnerstoparents.org/</p>	<ul style="list-style-type: none"> ■ An evidence-informed website with strategies on how partners can support each other when becoming parents. ■ Includes a focus on perinatal depression and anxiety symptoms and risk factors.
<p>Best Start Resource Centre. Creating circles of support for pregnant women and new parents: A manual for service providers supporting women’s mental health in pregnancy and postpartum [Internet]. Toronto (ON): Best Start Resource Centre; 2009. Available from: https://www.beststart.org/resources/ppmd/pdf/circles_of_support_manual_fnl.pdf</p>	<ul style="list-style-type: none"> ■ A manual for health and social service providers to help pregnant and postpartum persons, including those with perinatal depression, to create a circle of support. ■ A listing of resources of services in Ontario, Canada.

RECOMMENDATIONS

RECOMMENDATION 2.5:

Provide or facilitate access to psychoeducational interventions to persons at risk for or experiencing perinatal depression.

Level of Evidence for Summary: Ib

Quality of Evidence for Summary: High =1; Moderate = 2

Discussion of Evidence:**Evidence Summary**

As an intervention, psychoeducation involves nurses and the interprofessional team providing information, support, health education, and teaching about specific physical or mental health conditions. The goal of psychoeducation is to engage in a dialogue with the person to promote their improved understanding and awareness of a health condition and available treatment options, as well as to decrease stressors from a lack of information (83, 109).

Through psychoeducational interventions, pregnant and postpartum persons gain knowledge of depression, including associated modifiable risk factors (e.g., physical symptoms, low social support, and infant factors), coping and self-care strategies, risks of untreated depression, and tips for accessing local perinatal depression resources (83, 109 - 110). Persons learn how family dynamics can change with the arrival of a newborn, steps for building self-efficacy and help-seeking behaviours, and the role and importance of partner involvement and support (109). Through psychoeducation, depression symptoms, as measured by valid screening tools such as EPDS, are reduced post-intervention when compared to controls who received standard care (109).

Using multi-modal approaches, a variety of psychoeducational interventions have been found to be effective in reducing depression symptoms in pregnancy and postpartum, including:

- Educational session(s) to promote **health literacy**^G (109).
- Self-help workbooks and other written information to support health education and reinforce teachings (110).
- Raised awareness about treatment options and available local resources (109).

Benefits and Harms

Benefits of psychoeducational interventions for persons with perinatal depression include:

- An improved understanding and awareness of perinatal depression and coping strategies (110).
- A higher level of self-efficacy, where a person feels more confident in their ability to care for their infant and transition to the role of parent (109).
- An increased awareness of resources available from professionals and non-professionals, as well as self-help tools (8).
- An improved ability to develop a nurturing relationship with the infant (109).

Values and Preferences

A community-based RCT found that participants who received a postpartum psychoeducation intervention within the first two weeks postpartum had lower scores of depression symptoms at six and 12 weeks postpartum (75). Participants reported satisfaction with the psychoeducation intervention, which included a home visit, follow-up telephone calls, and an educational booklet. Study participants felt that psychoeducation should be part of standard care and that longer follow-up (beyond the first two weeks postpartum), either as home visits or telephone calls would be beneficial for those who develop postpartum depression later in the first year following childbirth.

A Cochrane Review on postpartum psychoeducation interventions which included a physical assessment component delivered by nurses at home versus at hospital did not demonstrate improved depression scores by mode of delivery (111). Nonetheless, home visits were positively associated with individualized approaches, improved access (by eliminating some barriers such as transportation and childcare), and timely initiation and continuation of care.

Practice Notes

In the context of nursing care, psychoeducational interventions for perinatal depression can be:

- Incorporated into routine clinical care, both verbally and through written materials (109 - 110).
- Delivered briefly and provided in a variety of settings, including prenatal and postpartum groups (109).
- Used to promote help-seeking behaviours, leading to earlier disclosures and potentially improved outcomes (109).
- Offered as a stand-alone intervention or as an adjunct to other interventions (such as psychological and pharmacological treatments), depending on the results of the comprehensive assessment and the identified needs and preferences of the person (83).
- Provided to either a pregnant person or to the person and their partner. A controlled trial found that lifestyle-based education to either the person and/or their partner reduced mean depression symptoms as measured by the EPDS, in addition to anxiety, during pregnancy (112). Topics reviewed in the intervention included sleep, nutrition, physical activity, self-concept, and sexuality. The participation of partners was viewed as beneficial as it provided the pregnant person with psychosocial support.

Supporting Resources

RESOURCE	DESCRIPTION
Corey E, Thapa S. Postpartum depression: an overview of treatment and prevention. Geneva (CH): World Health Organization; 2011. Available from: https://www.gfmer.ch/SRH-Course-2011/maternal-health/pdf/Postpartum-depression-Corey-2011.pdf	<ul style="list-style-type: none"> ■ A PowerPoint presentation summarizing evidence-based postpartum depression prevention and treatment options. ■ Prevention strategies target at-risk populations, versus the general postpartum population and include psychosocial and psychological interventions.

RECOMMENDATION 2.6:

Provide or facilitate access to professionally-led psychosocial interventions, including non-directive counseling, for persons with perinatal depression.

Level of Evidence for Summary: Ia, Ib

Quality of Evidence for Summary: Moderate = 1; Low = 2

Discussion of Evidence:**Evidence Summary**

Non-directive counselling provides support through empathy, active listening, encouragement, collaborative problem-solving, and developing positive therapeutic relationships where persons are encouraged to find solutions or approaches that work for them (113 - 114). This type of intervention is suitable for those who do not require care by a mental health diagnostician (such as a psychologist, psychiatric mental health nurse practitioner, or psychiatrist) (113). Non-directive counselling can be effectively provided as a type of psychosocial support for postpartum depression in both individual and group formats, and it can be facilitated by trained nurses or members of the interprofessional team (115).

Non-directive counselling reduces perinatal depression symptoms, however, the findings are limited (113). Persons who received non-directive counselling through listening visits during pregnancy by nurses had decreased EPDS scores in postpartum, compared to those who did not receive the counselling intervention (114). A RCT from Norway found that persons with elevated depression screening scores who received non-directive counselling from public health nurses in well-baby clinics had significantly reduced depression screening scores at three and six months postpartum (113). The number of sessions delivered by public health nurses was designed around the individualized needs of the person; some participants only received one counselling session but were thought to have benefited because of awareness of available support.

Benefits and Harms

Further evaluation of supportive counselling by participants is needed to identify if there are any harms that can develop from this type of social support intervention (113).

Values and Preferences

To effectively provide non-directive counselling, the nurse must integrate the values of being humane, authentic and person-centred through self-awareness, self-acceptance, and openness with the person, according to psychologist Rogers (113).

Practice Notes

When using non-directive counselling, nurses need to ensure that they take the following steps:

- Establish and maintain a therapeutic relationship with the person.
- Focus on the person's experience and their ability to problem-solve and manage their own situations.
- Ensure a clear understanding of the person's perspective.
- Be non-judgmental through supportive and empathic listening.
- Treat the person with regard and respect.
- Be open and transparent in all communications.
- Refer to additional supports (such as a mental health diagnostician, i.e., psychiatrist, psychologist, psychiatric-mental health nurse practitioner) where indicated, in cases of moderate-to-severe depression or worsening symptoms.
- Refer and facilitate access to an urgent care facility in cases of identified self-harm or suicidal ideation or risk (113 – 114, 116).

Examples of topics discussed during a non-directive counselling session may include:

- The person's thoughts and emotions.
- Transitioning to the parental role.
- Changing dynamics in family relationships.
- Problem-solving.
- Encouragement of positive approaches (114).

Supporting Resources

RESOURCE	DESCRIPTION
The Australian College of Mental Health Nurses. Non-directive counselling: what it is [Internet]. Deakin West (AU); c2018. Available from: http://www.acmhn.org/contact-the-australian-college-of-mental-health-nursing	<ul style="list-style-type: none"> ■ A discussion paper on the components of non-directive counselling including neutrality, autonomous decision-making and tailoring sessions to individuals' circumstances and needs.
Braddell A. Citizen's guide to non-directive coaching [Internet]. Leicester (UK): Learning and Work Institute; 2017. Available from: https://www.learningandwork.org.uk/wp-content/uploads/2017/08/LW-Coaching	<ul style="list-style-type: none"> ■ A research-based resource on principles of non-directive counselling. ■ The resource is based in concepts of adult learning.

RESOURCE	DESCRIPTION
<p>World Health Organization. Thinking healthy: A manual for psychosocial management of perinatal depression (WHO generic field-trial version 1.0). Geneva (CH): World Health Organization; 2015. Available from: http://www.who.int/mental_health/maternal-child/thinking_healthy/en/</p>	<ul style="list-style-type: none"> ■ A manual on the psychosocial management of perinatal depression. ■ Includes tips for good communication strategies including: <ul style="list-style-type: none"> □ Arrange the meeting time in consultation with the person. □ Stress that all communications will remain confidential and that the person has a right to privacy, unless in urgent situations of identified risk of harm to the person, infant, or another child. □ Sit at the person’s level speaking in a friendly, non-judgmental tone. □ Encourage the person to talk openly. Use open-ended questions to explore feelings. □ Stay positive, even if persons do not show any signs of change. This will encourage the person to keep on trying despite their challenges.
<p>Terrazas C, Segre L, Wolfe C. Moving beyond depression screening: integrated perinatal depression treatment into OB/GYN practices. Prim Health Care Res Dev. 2018;12:1-9. Available from: https://www.ncbi.nlm.nih.gov/pubmed/29429427</p>	<ul style="list-style-type: none"> ■ A RCT examined the effect of listening visits in obstetrician/gynecologist (OB/GYN) clinical settings. ■ The results indicated that listening visits were feasible and acceptable on-site in an OB/GYN practice setting for persons with mild to moderate perinatal depression as determined by a valid screening tool (e.g., EPDS). Persons received up to six weekly listening visits lasting up to 50 minutes by trained social workers, nurses, or physicians. The health-care providers’ training included empathetic responding, active listening, and collaborative problem-solving. ■ Offering listening visits in an OB/GYN clinic was preferred by participants as it overcame barriers to accessing psychosocial care for perinatal depression such as mistrust of behavioural health specialists, stigma and shame of receiving mental health services and supports, and logistical barriers to care.

RECOMMENDATION 2.7:

Provide or facilitate access to psychotherapies, such as cognitive behavioural therapy or interpersonal therapy, for perinatal depression.

Level of Evidence for Summary: Ia, Ib

Quality of Evidence for Summary: Moderate = 8; Low = 5

Discussion of Evidence:**Evidence Summary****Cognitive Behavioural Therapy (CBT)**

CBT is a type of short-term psychotherapy that focuses on the interaction of thoughts, emotions, and behaviours (115). It has been found to be significantly beneficial as a treatment of perinatal depression in both group and individual formats (115). Positive effects were seen immediately following the intervention and, to a lesser extent, up to six months and beyond, as measured by various depression scales, in comparison to standard treatment (115). As a type of psychotherapy, it can be used effectively as a first-line treatment for persons with mild to moderate perinatal depression; for those with severe symptoms, psychotherapy can be effective when combined with medications (117).

Providers of CBT include nurses and other members of the interprofessional team, such as psychiatrists, psychologists, occupational therapists, social workers, and general practitioners (11, 71, 118). CBT can be provided in a flexible manner in a variety of settings such as acute, primary, and community care services, via telephone, and in person's homes (118). It can also be provided in rural areas where access to mental health services and supports may be limited or where transportation or geography is a barrier (118). No meaningful differences in effectiveness were found for one type of traditional psychotherapy (i.e., CBT versus IPT) for postpartum depression (11).

In their role of facilitating access to CBT, nurses can educate persons with perinatal depression symptoms about the key components of this type of psychological intervention which are summarized below. These include types of CBT techniques, timing, the severity of depression symptoms, individual versus group CBT, therapist-assisted internet CBT program, and costs.

Types of CBT Techniques

Types of CBT techniques that were found to be effective for perinatal depression symptoms varied and often were multi-pronged with structured sessions that followed a treatment manual (11). Examples of techniques used in CBT include psychoeducation as well as the following:

- Cognitive restructuring challenges negative thought patterns of a person's sense of self, their world, and their future. These thought patterns act as a filter of experience and can predispose the risk of developing a depression (11, 115).
- Problem-orientated CBT involves learning skills such as goal setting, managing stress, identifying and replacing negative thoughts, solving problems, breaking tasks into smaller components, and parenting skills (11). These skills resulted in higher levels of self-esteem, less stress, and negative thinking. This type of CBT was found to significantly reduce prenatal depression symptoms, compared to standard care (118).

- Behavioural activation teaches skills to address behaviours such as interpersonal conflict or avoidance as a coping mechanism that has contributed to depression symptoms. Persons are taught skills to engage in rewarding activities and reduce avoidance of conflict or difficult situations and increase their social supports (11, 74). Behavioural activation has been found to be as effective as antidepressants for adults with depression symptoms (74).
- Mindfulness-based CBT is the least studied of CBT-related interventions for perinatal depression (119). It involves learning skills through verbally-guided sessions to support being present, non-judgmental, accepting of present moment experiences, and developing an awareness of physical responses (such as breath) to reduce rumination and negative or self-critical thoughts (119).

Timing

CBT may be used in both pregnancy and postpartum (71). Significantly decreased depression symptoms were demonstrated when compared to those of control groups, however, CBT may be more effective when initiated in the postpartum than during pregnancy (71).

The Severity of Depression Symptoms

A RCT found pregnant persons who screened as low to moderate risk for depression who received CBT had significantly decreased depression symptoms as measured by EPDS, in comparison to controls who received standard approaches to care (118). The largest improvement in depression symptoms scores was seen with those who were able to continue to use CBT skills following the conclusion of the intervention time period (118). Similarly, a narrative review found CBT to be an effective intervention for mild to moderate postpartum depression, but could not confirm this effect with severe symptoms (116). CBT may also not be effective for pregnant persons who have identified risk factors for depression but who have not yet developed symptoms (e.g., they have total EPDS scores lower than an assigned cut-off score of 10, suggesting a low risk for depression) (120).

Individual versus Group CBT

CBT can be offered in either individual or group format. Persons may experience difficulties talking in a group setting as this format requires participants to openly share their experiences of depression and to apply CBT techniques (121). Reluctance to participate in group CBT may also be influenced by stigmatization, although this requires further investigation (116). Group CBT uses fewer resources and offers participants an opportunity to meet others and build their social network. Nonetheless, the decision of individual versus group CBT needs to be carefully weighed by each person to determine the best choice (121).

Therapist-assisted Internet CBT Programs

Online CBT programs reported a significant reduction in depression symptoms when the psychotherapy was augmented with individualized support through weekly email contact or telephone check-ins (122).

Costs

CBT requires time and commitment, and it may have associated financial costs for travel or child care expenses (121). Many CBT series includes eight to 12 consecutive sessions which may be a challenge for persons to complete due to competing demands of caring for an infant or another child or other responsibilities. Poor conformity rates (i.e., regular and consecutive attendance at the CBT sessions) may negatively impact the benefits of CBT (121).

Study Limitations

Despite the efficacy of CBT for perinatal depression, there are some important limitations that should be considered. In much of the evidence, the specific components of CBT varied, as only some studies used a structured and consistent approach detailing each session's content, participant exercises, and objectives in a manual (121, 123). This creates potential confounders when attempting to determine which of the components of CBT are most effective (121, 123). It is unclear whether CBT—particularly in a group format—is suited to all persons, or if it may be a better approach at certain stages of recovery from depression (121, 123).

Interpersonal Psychotherapy (IPT)

IPT is a type of short-term psychotherapy that focuses on current concerns, such as social functioning, conflicts, role transitions, grief, and interpersonal deficits (11). IPT has been found to be an effective intervention for depression in both the non-perinatal and perinatal population, as it examines how a person's communications and interactions with others impact their mental health (11, 81). It has been found to be an effective type of psychotherapy in either individual or group formats both in-person and via telephone to address perinatal depression symptoms using practical approaches and addressing current personal challenges related to the transition to parenthood.

Benefits and Harms

Demonstrated benefits of IPT for the treatment of postpartum depression symptoms include the following:

- It is an effective first-line treatment for postpartum depression. Significant improvements have been demonstrated in reducing symptom severity, improving recovery, and increasing psychosocial adjustment, when comparing pre-treatment depression scores to those post-treatment, or to controls (81).
- It can be facilitated by a variety of trained health-care providers, including nurses, psychiatrists, psychologists, and general practitioners (81).
- It has generalizable findings across populations as many rigorous studies use treatment manuals that outline and detail session objectives and content allowing for comparisons of similar study interventions (123).

Values and Preferences

Although social support in group settings can be valuable to the person with postpartum depression symptoms, some persons prefer privacy, individual attention, and confidentiality (70). Group settings can be challenging with regards to logistics as meeting times may not suit the person's schedule; in this case, individual sessions may be preferred.

Evidence indicates a preference for psychotherapies, versus medication, due to concerns of risks during pregnancy or lactation (11).

Practice Notes

An example of content for a brief six-session CBT program facilitated by a social worker and a peer for pregnant persons included the following (118):

SESSION NUMBER	CONCEPTS DISCUSSED
One	<ul style="list-style-type: none"> ■ Introduction; ■ Symptoms of depression; ■ Goal setting; and ■ The relationship between thoughts, feelings, and behaviours.
Two	<ul style="list-style-type: none"> ■ Stress reduction, coping, and relaxation techniques; ■ Self-monitoring of distorted and negative thinking; and ■ Increasing positive self-talk and affirmations.
Three	<ul style="list-style-type: none"> ■ Enhance communication skills in the person’s social network; ■ Evaluating relationships; and ■ Intimate partner violence and safety planning.
Four	<ul style="list-style-type: none"> ■ Enhancing open communication in the person’s relationships; ■ Risk factors for prenatal depression and what can help mitigate these risks; and ■ Signs and symptoms of postpartum depression.
Five	<ul style="list-style-type: none"> ■ Grief, loss and spirituality; and ■ Practice negative thought-stopping techniques and increase positive self-talk and affirmations.
Six	<ul style="list-style-type: none"> ■ Signs and symptoms of postpartum depression; ■ Evaluation of the six sessions; and ■ Goal setting to manage role transition to parenthood.

RECOMMENDATIONS

Supporting Resources

RESOURCE	DESCRIPTION
TRAINING FOR NURSES AND THE INTERPROFESSIONAL TEAM IN CBT	
<p>Centre for Addiction and Mental Health. Cognitive behaviour therapy certification program for nurses and other health-care providers [Internet]. Centre for Addiction and Mental Health; c2018. Available from: https://www.camh.ca/en/education/continuing-education/continuing-education-programs-and-courses/cognitive-behavioural-therapy-cbt-certificate-program</p>	<ul style="list-style-type: none"> ■ A website outlining the course requirements to complete certification in CBT for nurses and other health-care providers.
<p>Ontario Agency for Health Protection and Promotion (Public Health Ontario), Mensah G, Singh T. Evidence brief: Exploring interventions to address perinatal mental health in a public health context. Toronto, ON: Queen’s Printer for Ontario; 2016. Available from: https://www.publichealthontario.ca/en/eRepository/Evidence_Brief_Perinatal_Mental_Health_2017.pdf</p>	<ul style="list-style-type: none"> ■ An evidence brief on interventions to address perinatal mental health in a public health context. ■ Psychosocial and psychological interventions were found to be effective in addressing perinatal depression symptoms.
<p>The BC Reproductive Mental Health Program. Coping with depression in pregnancy and following the birth: A cognitive-behaviour therapy-based self-management guide for women [Internet]. Vancouver (BC): BC Mental Health & Addiction Services; 2011. Available from: https://www.beststart.org/events/2014/bsannualconf14/webcov/Presentations_ForParticipants/New/C3_PPD-BestStart%20February%202014.pdf</p>	<ul style="list-style-type: none"> ■ A self-help workbook to learn skills using CBT-based principles to prevent or manage perinatal depression symptoms. ■ The resource also includes information for health-care providers.
<p>World Health Organization. Thinking healthy: A manual for psychosocial management of perinatal depression (WHO generic field-trial version 1.0). Geneva (CH): World Health Organization; 2015. Available from: http://www.who.int/mental_health/maternal-child/thinking_healthy/en/</p>	<ul style="list-style-type: none"> ■ A resource for community health-care providers in primary care settings who have no prior knowledge or experience in mental health care. ■ The manual outlines evidence-based approaches using CBT techniques and low-intensity psychological interventions. ■ The manual is relevant for perinatal depression with modules on the person’s mental health, their relationship with the baby, and their relationship with people around them during pregnancy to eight to ten months postpartum.

RESOURCE	DESCRIPTION
TRAINING FOR NURSES AND THE INTERPROFESSIONAL TEAM IN CBT	
<p>Posmontier B, Neugebauer R, Stuart S, et al. Telephone-administered interpersonal psychotherapy by nurse-midwives for postpartum depression. <i>J Midwifery Womens Health</i>. 2016;61(4):456-466. Available from: https://onlinelibrary.wiley.com/doi/pdf/10.1111/jmwh.12411</p>	<ul style="list-style-type: none"> ■ A study involving certified American nurse-midwives who provided IPT via telephone to postpartum persons with depression. ■ The results indicate a significant reduction in depression scores at eight and 12 weeks, compared to the control group. ■ IPT delivered via telephone by certified nurse-midwives was found to be an effective and acceptable method of reducing the severity of depression symptoms.
<p>World Health Organization and Columbia University. Group interpersonal therapy (IPT) for depression (WHO generic field-trial version 1.0). Geneva (CH): World Health Organization; 2016. Available from: http://apps.who.int/iris/bitstream/handle/10665/250219/WHO-MSD-MER-16.4-eng.pdf;jsessionid=72F542A8C0F2457C767034C4ED6220E8?sequence=1</p>	<ul style="list-style-type: none"> ■ A manual on group IPT for depression. The manual does not include specific recommendations for perinatal depression. ■ May be used by facilitators including supervised nurses or psychosocial staff who may not have prior training in mental health as a tool to support scaling up services for mental health in health-care settings.
<p>Dennis CL, Ravitz P, Zupancic J, et al. Telephone-based interpersonal psychotherapy by trained non-specialist nurses for the treatment of postpartum depression: A nation-wide randomised controlled trial [unpublished manuscript]. Toronto: University of Toronto; 2018.</p>	<ul style="list-style-type: none"> ■ A RCT examining telephone-IPT by trained non-specialist nurses for the treatment of postpartum depression. ■ Participants were socially and ethnically diverse living in rural and remote areas. ■ The intervention consisted of 12 weekly sessions or standard care. ■ The results indicate that participants in the IPT group were 4.5 times less likely to be clinically depressed at 12 weeks post-intervention, versus controls. It is effective for postpartum depression.

RESOURCE	DESCRIPTION
TRAINING FOR NURSES AND THE INTERPROFESSIONAL TEAM IN CBT	
<p>College of Nurses of Ontario. Psychotherapy and the controlled act component of psychotherapy [Internet]. Toronto (ON): College of Nurses of Ontario; 2018. Available from: http://www.cno.org/en/learn-about-standards-guidelines/educational-tools/ask-practice/answers-to-your-questions-about-psychotherapy/</p>	<ul style="list-style-type: none"> ■ Psychotherapy as a controlled act was proclaimed by Ontario’s provincial regulatory body on December 30, 2017. ■ The Regulated Health Professions Act, 1991 (RHPA) defines the controlled act as “Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual’s serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual’s judgment, insight, behaviour, communication or social functioning.” ■ The controlled act of psychotherapy includes the following components: <ol style="list-style-type: none"> 1. You are treating a client. 2. You are applying a psychotherapy technique. 3. You have a therapeutic relationship with the client. 4. The client has a serious disorder of thought, cognition, mood, emotional regulation, perception or memory. 5. This disorder may seriously impair the client’s judgment, insight, behaviour, communication or social functioning.

RECOMMENDATIONS

RECOMMENDATION 2.8:

Support informed decision-making and advocate for access to pharmacological interventions for perinatal depression, as appropriate.

Level of Evidence for Summary: Ia, Ib

Quality of Evidence for Summary: High =2; Guidelines: High = 1; Moderate = 1

Discussion of Evidence:**Evidence Summary****Nurses Supporting Persons Considering Pharmacological Interventions**

As part of the interprofessional team providing mental health services for perinatal depression, nurses must be able to support pregnant and postpartum persons in making informed decisions pertaining to pharmacological interventions (124). The decision regarding the use, continuation, or discontinuation of medications for perinatal depression is, therefore, one that must be considered individually by the person and the primary health-care provider prescribing the medication. It should weigh all the potential risks and benefits related to the person's history, available resources, and preferences (40, 56, 124).

Key Pharmacological Nursing Considerations for Perinatal Depression

In collaboration with the interprofessional team, nurses must be cognizant of the use of pharmacological approaches for perinatal depression, which include the following:

- Pharmacological approaches are generally for those with moderate to severe depression or for those whose depression has not responded to psychological or other non-pharmacological approaches.
- Episodes of depression can vary and may have spontaneous remissions, but they can still leave a person at risk for recurrence.
- Safety concerns about the presence or absence of pharmacological treatment may vary across the perinatal period, and by the individual person.
- Discussions pertaining to pharmacological approaches may differ depending on whether the person is pregnant or lactating.
- Each person must be made aware of potential side-effects of medications, their interactions with other medications, and delays in the onset of a response. Until a response from medications becomes effective, additional support is recommended.
- Medications should be chosen with the lowest known risk.
- Dosages of medications for perinatal depression may need to be adjusted due to the pharmacokinetics and pharmacodynamics of pregnancy and lactation.
- Discontinuation of medications can increase the risk of worsening symptoms and relapse of illness.
- The understanding of long-term pediatric neurodevelopmental effects is very limited and more evidence in this area is needed.
- The presence or absence of pharmacological, versus non-pharmacological, treatments for perinatal depression may impact the interactions and bonding between a person and their infant (40, 56).

Individualized Variables Pertaining to Pharmacology

Perinatal depression pharmacological interventions are influenced by the unique needs of each person. These variables may include:

- The severity of illness.
- The timing during pregnancy.
- The inclusion or exclusion of lactation.
- Personal preference.
- Other prescriptions and side effects.
- Any history of substance use.
- Previous use of and response to anti-depressants, and/or other medications used for depression treatments.
- Any past or current history of depression (125).

Evolving Evidence on Pharmacological Approaches

Evidence about pharmacological approaches does not support blanket recommendations for all persons. Instead, the evidence offers the following guiding principles:

- An improved understanding of risks and benefits are needed to be able to better inform pharmacological approaches.
- There are obstetrical and fetal risks associated with any medication exposure, but, these risks may cause fewer complications than the absence of medications.
- There is more evidence available about the efficacy of psychosocial and psychological interventions for perinatal depression.
- There are no zero-risk options.
- Decisions need to be made on an individualized case-by-case basis.
- A delay or absence of treatment can be associated with deleterious consequences for a person, the infant, partner, family, and significant others (where applicable) (40, 56).

The literature on perinatal depression pharmacology is continuing to grow. Nurses and the interprofessional team must maintain current knowledge and awareness of the complexities surrounding pharmacological interventions for perinatal depression in order to support informed decision-making. The considerations for each person must be considered carefully, examining all possible options, services, supports, and preferences.

Benefits and Harms

Persons can be averse to pharmacological treatment during pregnancy or lactation, due to fear, stigma, or lack of knowledge (126). In response, persons need to be listened to and have their concerns addressed. In contrast, a rapid decision to treat with pharmacological interventions without listening to the needs of the person and responding to any fears can negatively impact or erode a therapeutic relationship (126).

Values and Preferences

Findings from a multi-center randomized trial indicated a preference for psychosocial interventions (i.e., listening visits), versus antidepressants, for the treatment of postpartum depression (125). The rationale for the preference for psychosocial interventions included concerns of antidepressant exposure while breastfeeding, stigma, and the potential for medication dependence and side-effects. However, there was an acceptance of pharmacotherapy as a treatment approach to postpartum depression when necessary.

Practice Notes

Decision-making regarding the use of medications for depression during pregnancy is complex. Evidence suggests that the provision of information and implementing a collaborative decision-making process were the two most important factors for pregnant persons with depression symptoms who were considering antidepressant treatment (124, 126). Although most nurses are not in the primary role of prescribing medications for perinatal depression, they must have the knowledge, skills, and judgment to support informed decision-making and access to pharmacological interventions, including being able to do the following in an effective manner:

- Use a collaborative care approach through consultation with the interprofessional team.
- Carefully assess the state of a person's knowledge about the indications for a pharmacological treatment and address any questions or concerns within their scope of practice. Have current knowledge of existing mental health services and supports, and their associated potential benefits and risks.
- Assist with accessing up-to-date information from evidence-based sources about the efficacy, safety, and risks of each pharmacological treatment.
- Promote an individualized written plan of care as the standard that includes discussion of the full spectrum of care options.
- Ensure that all members of the interprofessional team are kept current with the treatment plan throughout the perinatal period.
- Establish and maintain follow-up to assess for initial response, potential side-effects, and outcomes in collaboration with the interprofessional team.
- In addition to pharmacological approaches, promote healthy lifestyle choices such as stress reduction, nutrition, sleep, exercise, and minimizing any tobacco or alcohol exposure (40, 56, 62, 126 - 127). **Recommendation 2.3** includes a further discussion on self-care strategies.

Supporting Resources

RESOURCE	DESCRIPTION
<p>MacQueen G, Frey B, Ismail Z et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) 2016 clinical guidelines for the management of adults with major depressive disorder: Section 6. Special populations: Youth, women, and the elderly. <i>Can J Psychiatry</i>. 2016;61(9):588-603. Available from: http://journals.sagepub.com/doi/abs/10.1177/0706743716659276#articleCitationDownloadContainer</p>	<ul style="list-style-type: none"> ■ The revised Canadian guidelines on the treatment of mood and anxiety, including perinatal depression. ■ The guideline recommendations for prenatal depression include professional psychotherapy (i.e., CBT or IPT in individual or group format) as the first-line treatment. Second-line treatment includes pharmacologic approaches, except in situations of severe depression in which case second-line treatments are moved up as first-line despite a lack of research for this population. ■ A similar approach to postpartum depression is indicated with additional medications suggested as second-line treatments. ■ Recommendations are also included for depression treatment during lactation.
<p>National Institute for Health and Care Excellence. Antenatal and postnatal mental health: clinical management and service guidance. [place unknown]: National Institute for Health and Care Excellence; 2018 (updated Dec 2014). Available from: https://www.nice.org.uk/guidance/cg192</p>	<ul style="list-style-type: none"> ■ A guideline from the United Kingdom that discusses clinical considerations for persons who are using medications for depression treatment prior to conception, during pregnancy and postpartum. ■ The guideline recommends providing a discussion of treatment options that include the benefits of medication, the consequences of no treatment, the harms associated with treatment and what might happen if medication is changed or stopped.

RECOMMENDATIONS

RECOMMENDATION 2.9:

Facilitate informed decision-making regarding the use of complementary and alternative medicine therapies for perinatal depression.

Level of Summary for Evidence: Ia

Quality of Evidence for Summary: High = 1; Low = 5

Discussion of Evidence:**Evidence Summary**

The expert panel supports a recommendation that nurses and the interprofessional team—including, but not limited to, physicians, midwives, massage therapists, chiropractors, and physiotherapists—provide guidance regarding the use of complementary and alternative medicine (CAM) therapies to persons at risk for or experiencing perinatal depression symptoms. In recognition of this interest, education about the collective body of evidence in CAM therapies for perinatal depression is indicated. To support informed decision-making, persons must be made aware of the limited evidence that is mostly of low quality with inconclusive results (79, 88, 94, 96, 101). Further studies are needed to determine the efficacy, risks, and benefits of CAM therapies for perinatal depression.

Massage Therapy

There are inconsistent findings on massage as a CAM therapy for perinatal depression (79, 88, 101). A significant decrease in depression symptoms was found in a RCT when massage was provided by the person's partner (88). Another study found pregnant persons who received bi-weekly massage therapy had significantly reduced mean depression scores when compared to controls who received standard prenatal care (101). Similarly, a review found a significant decrease in depression symptoms among adolescent parents who received bi-weekly massages (79). However, other studies have found no significant difference in depression symptoms, including when massage therapy was compared to acupuncture (88).

Bright Light Therapy

In the general adult population, bright light therapy has been found overall to be effective in treating depression, particularly for a seasonal affective disorder (96). The exact mechanism of action has not been determined; it is suggested that bright light therapy supports the correction of circadian rhythms or melatonin regulation (96). For pregnant and postpartum persons, bright light therapy is thought to help offset the limited amount of light that persons can experience due to disordered sleep patterns and daytime napping, co-morbidities, and hormonal imbalances (96). However, study findings are inconclusive regarding the efficacy of bright light therapy for perinatal depression (88, 122). A systematic review found one of three studies on bright light therapy that demonstrated a significant difference post-treatment as well as remission following five weeks of treatment (122). The other two trials, however, did not demonstrate differences between the treatment and control groups.

Nurses and the interprofessional team need to educate pregnant and postpartum persons about the potential benefits, logistical challenges, and adverse effects associated with bright light therapy as a CAM therapy for perinatal depression. This will help persons determine whether this approach is appropriate for them.

Acupuncture

As a treatment, traditional Chinese acupuncture is believed to support the correction of the imbalanced flow of energy in the body caused by disease and trauma (93). As there are only a few studies examining acupuncture and perinatal depression that are published in non-Asian languages, the findings are limited and inconsistent (88, 94, 122). Acupuncture was not found to significantly reduce depression symptoms when compared to massage therapy or sham acupuncture (88, 94, 122). Further studies in this area that demonstrate efficacy are necessary to support acupuncture as an effective CAM therapy for perinatal depression.

Benefits and Harms

The benefits of bright light therapy, as a non-pharmacological treatment, include accessibility, cost-effectiveness, and privacy, as well as the ability to purchase the necessary equipment without a prescription (88, 96). Despite these benefits, there may be logistical challenges with bright light therapy as it typically requires 30 to 60 minutes of exposure time daily for up to six weeks (96). This time commitment may pose difficulties for some new parents who are already busy caring for a newborn or infant. There may also be adverse effects—including headaches, eye strain, nausea, anxiety, fatigue, disturbed sleep, and agitation—that may affect treatment conformity, overall experience, and effectiveness (88, 96).

Acupuncture is generally approached with caution for pregnant persons because of the potential for stimulation of acupuncture points that may cause uterine contractions (94).

Values and Preferences

As an adjunctive treatment approach, CAM therapies including massage, bright light therapy, and acupuncture may be of interest to persons with perinatal depression symptoms as they are perceived of as “natural” and safe (88). Nurses and the interprofessional team need to recognize this preference and support and facilitate evidence-informed decision-making regarding the use of CAM therapies.

Practice Notes

National survey data from the United States on the use of CAM therapies during pregnancy and postpartum indicated the following:

- In comparison to non-pregnant persons, use of CAM therapies was the same prenatally, but less during the postpartum period. CAM use during pregnancy was perceived to be advantageous in comparison to pharmacological approaches.
- Use of CAM therapies was highest among persons who were white, had a higher income and education, and had self-reported symptoms of depression, anxiety or sleep problems.
- Mind-body practices (e.g., meditation, yoga, support groups) were the most frequently reported CAM therapies during pregnancy and postpartum, compared to manipulation (chiropractic or osteopathic care, massage) and body-based practices and biologically-based therapies (e.g., dietary supplements) (128).

Supporting Resources

RESOURCE	DESCRIPTION
<p>Deligiannidis KM, Freeman MP. Complementary and alternative medicine therapies for perinatal depression. <i>Best Pract Res Clin Obstet Gynaecol.</i> 2014;28(1):85-95. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3992885/</p>	<ul style="list-style-type: none"> ■ A review article examining the evidence on CAM therapies for perinatal depression. ■ Benefits and risks of CAM therapies should be discussed in addition to other non-CAM treatments. ■ Response to CAM therapies should be regularly monitored using validated tools so that if a therapy is determined to not be efficacious, other CAM therapies or non-CAM therapies should be considered.
<p>Nguyen J. A literature review of alternative therapies for postpartum depression. <i>Nurs Womens Health.</i> 2017;21(5):348-359. Available from: https://nwhjournal.org/article/S1751-4851(17)30217-9/fulltext</p>	<ul style="list-style-type: none"> ■ A literature review discussing the use of CAM therapies for postpartum depression. ■ Various CAM-related interventions are reviewed including yoga, expressive writing, oxytocin nasal spray, bright light therapy, and lavender tea. ■ Seven RCTs on CAM therapies demonstrated inconclusive results. However, the studies had many limitations including small sample size and varying inclusion criteria (depression measurement tools and cut-off scores, study populations, and severity of symptoms).

RECOMMENDATION 2.10:

Evaluate and revise a plan of care for perinatal depression, in collaboration with the person, until goals are met. Include the person's partner, family, and support network, where applicable.

Level of Evidence for Summary: V

Quality of Evidence for Summary: Expert panel with Guidelines: High = 1; Moderate = 1

Discussion and Summary from Expert Panel and Supporting Guidelines

The RNAO expert panel and clinical guidelines on perinatal depression recommend evaluating a person's plan of care, goals, and response to mental health services and supports and self-care measures (56, 127). Evaluation can be used to inform next steps and facilitate continuity of care and collaboration from nurses and the interprofessional team (56, 127). Where identified by the person, their partner, other family members, or social network can also be included throughout the process (56, 127).

Benefits and Harms

Regular follow-up visits are necessary to assess the extent to which the person is able to follow the recommendations of treatment and evaluate outcomes (i.e., symptom improvement or worsening) (127).

Values and Preferences

To be effective and support a person-centred approach, the evaluation of care and any revisions to a plan of care must be done collaboratively with the person with input from nurses and the interprofessional team (56, 127).

Practice Notes

Evaluation promotes a comprehensive assessment—as determined and indicated by the person's current needs and goals—to determine response(s), progress, and necessary follow-up. Through evaluation, the following components of care, where applicable, can be reviewed and appraised:

- The person's experience of perinatal depression services and supports and any concerns or questions.
- The level of agreement and suitability of all treatment(s), services, and supports, as well as whether other resources are indicated.
- The person's response to treatment(s), services, and supports and whether their depression symptoms are improving or worsening (as determined by self-assessment and/or a screening or assessment tool, such as EPDS).
- The level of contact with nurses and members of the interprofessional team (i.e., the frequency of visits) and whether or not it is sufficient.
- The presence of indications that other mental health services or supports should be started or discontinued.
- Any concerns about the risk of self-harm, suicide, or harm to the infant or children.
- The need for continued support and evaluation until the person's goals has been reached (56, 127).

Supporting Resources

RESOURCE	DESCRIPTION
<p>McCall-Hosenfeld JS, Phiri K, Schaefer E, Zhu J, Kjerulff K. Trajectories of depression symptoms throughout the peri- and postpartum period: Results from the First Baby Study. <i>J Womens Health</i>. 2016;25(11):1112-1121. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5116682/</p>	<ul style="list-style-type: none"> ■ A cohort study of over 3000 pregnant persons who were screened for depression symptoms prenatally and up to 12 months postpartum, using the EPDS. ■ Factors associated with the highest odds of a continued postpartum depression at 12 months included a history of depression or anxiety, inadequate social support, and unattached marital status. ■ Most of the study participants' depression symptoms had stabilized over time or were decreased at one year postpartum. ■ A small number of participants developed postpartum depression symptoms at six months and had worsened symptoms at one year postpartum. ■ The researchers concluded that continued screening and assessment of depression symptoms at multiple time points in the first year postpartum is indicated.
<p>Giallo R, Pilkington P, McDonald E, Gartland D, Woolhouse H, Brown S. Physical, sexual and social health factors associated with the trajectories of maternal depression symptoms from pregnancy to 4 years postpartum. <i>Soc Psychiatry Psychiatr Epidemiol</i>. 2017;52(7):815-828. Available from: https://www.ncbi.nlm.nih.gov/pubmed/28451700</p>	<ul style="list-style-type: none"> ■ A cohort study of Australian pregnant persons in their first pregnancy who were repeatedly screened for depression symptoms starting in pregnancy to four years postpartum. ■ Physical, sexual, emotional and social factors were found to be associated with the trajectories of depression symptoms. ■ The researchers concluded that health-care providers need to include an assessment of physical, social, and sexual health in pregnancy and postpartum as these factors contribute to the trajectories of postpartum depression.

RECOMMENDATIONS

Education Recommendations

RESEARCH QUESTION #3:

What education and training in perinatal depression are required to ensure the provision of effective assessment and interventions among nurses and the interprofessional team?

RECOMMENDATION 3.1:

Develop educational programs on perinatal depression care incorporating both theory and clinical practice into undergraduate nursing and other allied health professional pre-licensure curricula.

Level of Evidence for Summary: IV

Quality of Evidence for Summary: Moderate = 2

Discussion of Evidence:

Evidence Summary

Evidence supports the integration of theory and clinical practice opportunities for the care of perinatal depression into the undergraduate curricula for nursing and other allied health professional programs (129 - 130). By graduation, nursing students develop, at an entry-level, specialized knowledge and the ability to apply that knowledge in areas such as psychopathology, which can include perinatal depression (131). To achieve this, a review of theoretical concepts and opportunities for clinical practice must be included in curricula that integrate the role of nurses and the interprofessional team (130). This will ensure that nurses and allied health professionals have at least a novice level of understanding of the complexities of perinatal depression as a mental illness.

Benefits and Harms

The evaluation of educational interventions was limited to students' perspectives. No studies examined the effects of education on the recipients of care. Therefore, further studies are needed to determine the benefits or harms in this area.

Values and Preferences

Evaluation data on an educational intervention designed to enhance midwives and midwifery students' knowledge of prenatal and postpartum depression indicated that the majority of participants favoured the intervention as a means of enhancing their knowledge of perinatal depression and the emotional care of pregnant and postpartum persons (129).

Practice Notes

To achieve entry-level understanding of perinatal depression, an overview of the following topics should be included in undergraduate nursing and other allied health professional curricula:

- The continuum of perinatal depression as a mental illness (132).
- Societal and cultural attitudes towards perinatal depression (133).
- Recognition of potential complications of perinatal depression during pregnancy and postpartum (130).
- Valid screening and assessment tools (53, 132).

- Prevention approaches (129).
- Mental health service and support options, including self-care strategies, psychological, and psychosocial supports (132).
- Knowledge of recognized evidence-based resources that investigate the safety, benefits, and risks of pharmacology related to exposures to medications during pregnancy and/or breastfeeding (129).
- Perinatal depression-related suicide (133).
- Assigned roles and responsibilities of the interprofessional team in care planning (e.g., referring to a mental health specialist or mental health service) (129 - 130).
- The development and use of referral pathways in care management, where available (129, 133).
- Knowledge of local resources for perinatal depression (129).
- Psychological wellbeing of the health-care provider (133).

To support recognition of tailored and individualized plans of care for perinatal depression, the curricula should also integrate:

- An understanding of how a person's context (e.g., cultural beliefs, immigration or refugee status, socio-economic status, and social/spiritual realms) influences perception, experience, and the realities of symptoms and illness, as well as preferences for mental health services and supports (129 - 130).
- The inclusion of authentic cases or testimonials reflecting lived experiences of perinatal depression (129 - 130).

Instructional strategies should support entry-level **competencies**^G in perinatal depression care including communication skills, screening, assessment, prevention, interventions, and evaluation. To achieve this, teaching modalities can include role-playing, demonstrations, simulations, self-reflection, and review of case scenarios or vignettes through instructor-led activities and discussion. Where possible, a presentation by a perinatal depression researcher can also be incorporated as an educational delivery method (129 – 130, 132). Supervised clinical placement opportunities also support the development of knowledge and skills. Further information regarding practice education in nursing is available through the 2016 RNAO BPG *Practice Education in Nursing*, available at <http://rnao.ca/bpg/guidelines/practice-education-nursing>

Diverse educational methods should be used to support an understanding of perinatal depression such as multi-faceted, blended, or interactive components (e.g., face-to-face learning, eLearning or web-based courses, or webinars) (129 – 130, 132). Perinatal depression care components may also be integrated into other health sciences courses focusing on mental health, infant development, infant-child relationships, risk management, or illness processes (e.g., pathophysiology) (129 – 130, 132).

Supporting Resources

RESOURCE	DESCRIPTION
<p>Anonymous. Community home visit with postpartum patient for nursing students. Adaptation of California Simulation Alliance. Simulation Scenario Template [Internet]. [place unknown]: [publisher unknown]; 2014.</p>	<ul style="list-style-type: none"> ■ A teaching guide for educators of nursing students who are preparing to conduct postpartum community home visits. ■ The resource is meant to be used in a simulation setting and includes a scenario overview, curriculum integration, script scenario, and appendices.
<p>National League for Nursing. Jenny Brown simulation #3 [Internet]. Washington (DC): National League for Nursing; c2018. Available from: http://www.nln.org/professional-development-programs/teaching-resources/veterans-ace-v/unfolding-cases/jenny-brown</p>	<ul style="list-style-type: none"> ■ A teaching resource using a simulation of an early postpartum patient with a prenatal history of depression and anxiety that has a newborn with a congenital anomaly. ■ The simulation includes screening for risk of postpartum depression.
<p>Jones CJ, Creedy DK, Gamble JA. Australian midwives' knowledge of antenatal and postpartum depression: a national survey. <i>J Midwifery Womens Health</i>. 2011; 56(4):353-61. Available from: http://www.academia.edu/23395130/Australian_Midwives_Knowledge_of_Antenatal_and_Postpartum_Depression_A_National_Survey</p>	<ul style="list-style-type: none"> ■ A study to determine Australian midwives' (including student midwives) current level of knowledge of perinatal depression from the Australian postpartum depression national guideline 'beyondblue'. ■ The study includes 20 multiple-choice questions and answers on perinatal depression that were used to evaluate knowledge.

RECOMMENDATION 3.2:

Participate in ongoing professional development to enhance knowledge and skills in mental health services and supports for perinatal depression.

Level of Evidence for Summary: Ia, IIb, IV

Quality of Evidence for Summary: High = 1; Moderate = 3; Low = 2

Discussion of Evidence:**Evidence Summary**

Nurses and the interprofessional team need continuing education and training to support effective screening, assessment, prevention, interventions, and evaluation for perinatal depression (134). Training for nurses and interprofessional teams increases their competencies in perinatal depression care and contributes to improved clinical effectiveness, through the development of specialized knowledge and skills in perinatal depression (134 - 135).

Following an educational intervention, nurses and the interprofessional team demonstrated clinical competencies in perinatal depression care including the following:

- Enhanced understanding of perinatal depression and increased confidence in screening, assessment, and interventions (130).
- Improved communication skills, active listening, and evidence-based knowledge (130).
- Higher rates of screening, positive screens, and referrals post-educational intervention (135).
- An increase in confidence in discussing postpartum depression and self-care strategies (135).
- Enhanced communication skills and knowledge of signs and symptoms (135 - 136).
- Higher frequency, use, and documentation of evidence-based interventions (such as emotional support and counselling) (135).
- Greater frequency in inquiring about sensitive mental health related-topics, conducting more mental health assessments, and detecting depression symptoms more readily, as well as an increased ability to offer a wide range of treatments (135).
- Improved delivery of coordinated care services and adherence to defined care pathways, where available (135).
- Reduced depression symptoms as measured by EPDS at six and twelve month's postpartum. In a randomized trial, British health visitors received training in assessment skills, identifying depression symptoms and providing CBT or a person-centred approach. Both approaches demonstrated benefits to the study participants (137).

Components of an effective perinatal depression educational program**Who**

Training facilitated by recognized perinatal mental health practitioners or specialists should be provided to nurses and interprofessional teams who work together in a variety of health-care settings where pregnant, intrapartum, or postpartum persons seek maternity or mental health care (135). This will reduce learning in silos and improve collaborative approaches in perinatal depression (135).

What

Educational programs should include training on best practices, as reflected in clinical guidelines, systematic reviews, and other evidence-based knowledge products. Topics can include symptoms of perinatal depression, treatment options, crisis situations, and the impact of perinatal depression on the person and their infant (135).

When

The provision of staff training should occur as part of orientation. It should take place at least annually to provide clinical updates and support current knowledge (138).

How/Teaching Modalities

Programs should feature the use of blended learning techniques that include face-to-face options (e.g., educational programs, conferences, or seminars), and online learning (e.g., eLearns, web-based courses, and webinars) that are interactive and non-didactic (135).

Benefits and Harms

A study examining primary maternity health-care providers' knowledge of perinatal depression found that the majority of the respondents underestimated 1) the percentage of persons with prenatal depression who subsequently attempted suicide and 2) were unaware of risk factors or available treatments (129). A lack of knowledge regarding suicide risk associated with depression symptoms can increase the likelihood of missed or delayed treatment and can contribute negatively to long-term health outcomes for the person and their family.

Values and Preferences

An audit to determine nurses' training needs in providing mental health services and supports, including for depression and anxiety, indicated a preference for face-to-face training in a classroom environment to be able to receive feedback as part of the learning process (132). Survey results indicated that e-learning programs were also acceptable as part of a package of learning.

Practice Notes

Examples of professional development curricula for perinatal depression for nurses and the interprofessional team include the following:

- Practitioner roles, history taking, treatment options, physical/emotional changes, self-harm/suicide, legal and professional policies, and therapeutic relationships (139).
- Identification of depression symptoms through valid screening and assessment tools (137).
- Effective interventions, including active listening, coping enhancement, CBT and IPT components (130).
- Case studies detailing the impact of depression on the person, their partner, and family (135).
- Evaluation of perinatal depression knowledge using modalities, such as multiple-choice questions (129).
- Awareness and knowledge of broader psychosocial issues, including the social determinants of health (such as poverty or precarious work or housing) and their impact on perinatal depression risk and outcomes (136). Skills in advocacy for persons with perinatal depression who experience social inequities should be taught (20).
- Awareness of prenatal depression to support the need for prevention, early detection, and intervention (129).
- Updates on intervention modalities, including pharmacology and its implications during pregnancy and postpartum (including lactation), as well as non-pharmacological approaches (129 - 130).
- Fundamentals of counselling skills (130).

Supporting Resources

HEALTH-CARE PROVIDER PERINATAL DEPRESSION TRAINING

Postpartum Support International [Internet]. Portland (OR): Postpartum Support International; [date unknown]. Available from: <http://www.postpartum.net/professionals/certification/>

- A website with webinar presentations and certification training, including in perinatal mental health.

The Marcé Society for Perinatal Mental Health [Internet]. Brentwood (TN): The International Marcé Society for Perinatal Mental Health; c2018. Available from: <https://marcesociety.com/>

- A website with resources including educational presentations and research links on perinatal mental health.

Faculty of Medicine UBC CPD eLearning. Not just the blues: perinatal depression and anxiety [Internet]. Vancouver (BC): University of British Columbia; undated. Available from: <https://elearning.ubccpd.ca/enrol/index.php?id=101>

- An online continuing medical education course available at no cost that provides an overview of perinatal depression.
- Topics reviewed include common risk factors, screening, treatment approaches, and treatment planning.

Association of Women’s Health, Obstetric, and Neonatal Nurses. Standards for perinatal nursing practice and certification in Canada. Second edition [Internet]. Washington (DC): Association of Women’s Health, Obstetric, and Neonatal Nurses; 2009. Available from: http://www.capwhn.ca/uploads/documents/Perinatal_Standards_Canada.pdf

- Standards of optimal practice for perinatal nurses based in current research and clinical practice.
- The best interests of the individual are considered central to practice.

HEALTH-CARE PROVIDER PERINATAL DEPRESSION TRAINING

Centre of Perinatal Excellence. Basic skills in perinatal mental health [Internet]. Flemington (AU): Centre of Perinatal Excellence; date unknown. Available from: <http://training.cope.org.au/p/cope-basic-skills-in-perinatal-mental-health>

- A free three-part module online course from Australia for health professionals that includes a review of the following topics:
 - An overview of mental health disorders.
 - Psychosocial assessment and screening.
 - Referral and treatment.

e-Learning for Healthcare. Perinatal mental health [Internet]. London (UK): NHS Health Education England; 2018. Available from: <https://www.e-lfh.org.uk/programmes/perinatal-mental-health/>

- A four-part module series from the NHS for health visitors (a type of specialist community public health nurse) on perinatal depression as a mental health disorder, tips for recognizing perinatal depression, and interventions.
- Open access perinatal mental health sessions are also available on this webpage.

RECOMMENDATION 3.3:

Perform regular self-reflection on attitudes and beliefs regarding perinatal depression.

Level of Evidence for Summary: Ia, IV

Quality of Evidence for Summary: Moderate = 2; Low = 1; Guidelines: High = 1

Discussion of Evidence:**Evidence Summary**

It is important for nurses and the interprofessional team to reflect on their personal attitudes and beliefs regarding perinatal depression as perceptions learned over time can affect how persons with perinatal depression symptoms are viewed, responded to, or provided with care; this, in turn, can influence the quality of care outcomes (130, 140). Through **reflective practice**^G, nurses can provide higher quality care to the diverse populations that they serve (141). The reflection and recognition of judgmental attitudes pertaining to persons who may be experiencing perinatal depression can help nurses and the interprofessional team ensure they provide holistic, culturally-sensitive, and person-centred care (47, 130).

Culturally, there can be an overriding expectation and intrinsic belief that becoming a parent is fulfilling and joyful, making perinatal depression seem like a contradiction of this perception. As a result, those experiencing perinatal depression may question their worth and value as a person and a parent. Negative self-perceptions may make pregnant or postpartum persons hesitant to seek services and supports for their perinatal depression symptoms (140). A similar belief and attitude may be shared by nurses and the interprofessional team and this can negatively contribute to care provision and poorer outcomes (130, 140). Studies demonstrate that nurses—particularly those working in maternity and mental health specialties—and other members of the interprofessional team such as general practitioners, midwives, social workers, and multicultural workers can hold strong feelings about persons with perinatal depression (130, 140). These attitudes or judgments can be expressed in a variety of viewpoints:

- The assertions that care for perinatal depression is beyond the scope of practice for those who are not mental health specialists (130, 140).
- A lack of recognition of how gender inequality and the social determinants of health can act as significant contributory factors to perinatal depression (40).
- A lack of regard for, or integration of, a person's social, spiritual, or cultural beliefs—or their life context—into care planning (40, 56).
- A reluctance to make a referral to a mental health specialist for fear that the person will experience stigma or judgment due to a potential or actual mental illness diagnosis (130).
- A fear of disclosure of a possible or realized infanticide or suicide (140).
- A fear of potential legal or ethical implications for nurses who report perinatal depression symptoms to child protection services (140).
- A worry that reporting perinatal depression will negatively impact a therapeutic relationship with the person (140).

There is a wide range of attitudes that nurses and members of the interprofessional team may have when caring for persons with perinatal depression (130, 140). Education and training may help to challenge and address these negative viewpoints and promote understanding and self-reflection (130, 135, 140).

Benefits and Harms

Findings from focus groups indicate that when nurses have negative attitudes regarding mental illnesses, including perinatal depression, timing and referrals to mental health services and supports can be delayed with potentially adverse consequences to the person and their family (140).

Values and Preferences

Mental health nurses indicated in a focus group a preference for working in settings with on-site multidisciplinary teams who provide care for persons with perinatal depression (140). The participants reported that this was beneficial to both persons and staff as referrals to mental health specialists were given high priority resulting in shorter wait times. Stigma towards mental illnesses and accessing mental health services and supports were reduced.

Practice Notes

Reflective practice can be an effective strategy to address attitudes towards caring for persons with perinatal depression. Reflective practice is an iterative process that integrates theoretical concepts with clinical practice to enhance critical thinking (142). It is emerging as a promising teaching and learning modality for nurses working in mental health care. Tools to support reflective practice include journaling, learning circles, peer sharing, and simulation with standardized patients.

Supporting Resources

RESOURCE	DESCRIPTION
<p>Registered Nurses' Association of Ontario. RNAO nurse educator mental health and addiction resource [Internet]. Toronto (ON): Registered Nurses' Association of Ontario; 2017. Available from: http://rnao.ca/sites/rnao-ca/files/Nurse_Educator_MHA_Resource.pdf</p>	<ul style="list-style-type: none"> ■ A resource to support educators to effectively integrate mental health and addiction knowledge and skills into the undergraduate nursing curriculum. ■ The resource is based on the Canadian Association of Schools of Nursing (CASN) and the Canadian Federation of Mental Health Nurses (CFMHN) Entry-to-Practice Mental Health and Addiction Competencies for Undergraduate Nursing Education in Canada (2015) and supporting research. ■ Includes self-reflection activities in areas such as depression.
<p>Ontario Human Rights Commission. Policy on preventing discrimination based on mental health disabilities and addictions [Internet]. [place unknown]: Ontario Human Rights Commission; 2014. Available from: http://www.ohrc.on.ca/sites/default/files/Policy%20on%20Preventing%20discrimination%20based%20on%20mental%20health%20disabilities%20and%20addictions_ENGLISH_accessible.pdf</p>	<ul style="list-style-type: none"> ■ The Ontario Human Rights Code (the Code) protects people with mental health disabilities and addictions from discrimination and harassment under the grounds of disability. ■ The Code makes it public policy in Ontario to recognize the inherent dignity and worth of every person and to provide equal rights and opportunities without discrimination. ■ The resource recognizes that persons may be afraid to disclose a mental illness due to fears of being labelled, experience negative attitudes from others, lose their jobs or housing, or experience unequal treatment in services.

Organization and System Policy Recommendations

RESEARCH QUESTION #4

How do health-care organizations and the broader health-care system ensure optimal prevention, assessment, and interventions for perinatal depression?

RECOMMENDATION 4.1:

Implement comprehensive and coordinated mental health services and supports for perinatal depression across communities to support care strategies provided by nurses and the interprofessional team.

Level of Evidence for Summary: Ib, IV

Quality of Evidence for Summary: High = 2; Moderate = 4; Guidelines: High = 1; Moderate = 1

Discussion of Evidence:

Evidence Summary

The expert panel strongly asserts that comprehensive and coordinated mental health services and supports for perinatal depression that encompass screening, assessment, prevention, intervention, and evaluation are critical to maximizing access, timely follow-up and referral pathways, and avoiding sporadic or inconsistent care approaches. Clinical settings for pregnant and postpartum persons must commit to allocating the necessary resources and supportive infrastructure in order to achieve the implementation of best practices in mental health services and supports for perinatal depression (143). Planning and priority setting are required to ensure that the necessary human, material, and fiscal resources are earmarked annually for perinatal depression in mental health services and supports. Across health settings, perinatal depression care, beginning with routine screening, must be a standard component of care for pregnant and postpartum persons, and not be provider dependent (144 - 145). As such, nurses, primary care providers, social workers, psychologists, mental health specialists (e.g., clinical nurse specialists, psychiatrists), and administrators must work collaboratively to support timely recognition of and interventions for perinatal depression, where indicated (145 - 146).

Evidence supports models of care such as integrated care and/or collaborative care to optimize perinatal depression and mental health services and supports using a holistic approach (8, 143 – 145, 147). To facilitate treatment initiation and usage, as well as accessibility, mental health services and supports for perinatal depression should be integrated with other perinatal health-care services, where possible (145). The benefits of integrated mental health services and supports for perinatal depression include a nearly four-fold increased likelihood of persons to follow-up for treatment as on-site, co-located, or coordinated mental health services were perceived as accessible, convenient, and less disjointed from primary care (145). Integrated mental health services reduce barriers such as a lack of trust of health-care providers who are not part of the person's primary health-care team, stigma and accessibility (145). In cases where integrated care is not available, health-care providers, social services, and mental health services and supports need to work in partnership with funding bodies to support the development of a responsive mental health service infrastructure (146).

To support **evidence-based practice^G** in perinatal depression, empirical data over the past decade supports the collaborative care model (CCM), a type of integrated care (143). Components of CCM include a person-centred model of care in which a plan of care is developed, support and treatment are provided, follow-up visits to evaluate response are sustained, and revisions to the plan of care are made, as needed (143). In the care of perinatal depression, CCM has been found to be effective in primary care settings when provided by social workers, physicians, and nurses who have specialized knowledge of depression care (143). A study comparing perinatal depression outcomes in a CCM, versus routine primary care, found higher quality of health care and more adherence to quality metrics including earlier follow-up, three or more follow-up contacts within three months of a diagnosis for postpartum depression, and regular follow-up screening during the first year postpartum to monitor for any changes in mood (147). CCM involved a team approach of coordinated care by primary care providers, mental health specialists for consultation, and care managers, including nurses. The site implemented routine screening, follow-up, and monitoring, implementation of evidence-based guidelines, integration of care managers for psychoeducation and care coordination, and access to a psychiatrist, where indicated. Despite these findings, there are limited high-quality studies on the effectiveness of CCM for perinatal depression and much of the studies examine American programs, therefore, the findings may or may not be applicable to other health-care systems (143, 145 - 147).

Elements of a Comprehensive and Coordinated Perinatal Depression Program

The implementation of comprehensive and coordinated mental health services and supports for perinatal depression requires a multi-prong approach that includes the integration of i) interprofessional care and ii) referral pathways across communities.

Interprofessional Care

In general, interprofessional care requires coordination and collaboration to provide quality care within and across settings and sectors to support strategies for care (145 – 147). In the context of perinatal depression, the integration of interprofessional care has demonstrated the following advantages:

- Quicker access to mental health services and supports for perinatal depression through more timely and systematic follow-up which contributes to improved quality care and better health outcomes (147).
- Simplified referral processes and the promotion of continuity of care through collaborative approaches (8).
- Improved consistency with treatment modalities, including, where applicable, pharmacological treatments (127).
- Established collaborative mental health services for perinatal depression to support the local community, mental health, and maternity practitioners and the coordination of care (56).

Referral Pathways Across Communities

To support coordinated referral pathways for perinatal depression services and supports across communities, the following strategies were found effective (8, 143):

- Documentation of standards of practice that include care plans for perinatal depression and the monitoring of clinical outcomes.
- Available information packages, fact sheets, self-assessment forms, resources and a referral guide available in multiple languages for pregnant and postpartum persons. Promotional materials that recognize perinatal depression as the leading complication of childbirth can be helpful to increase awareness.
- Streamlined referral and screening processes, using an interprofessional team approach.
- Access to mental health specialists and diagnosticians in real-time for maternity care providers. Delays in access to mental health care can also be attributed to insurance issues, long wait times for appointments, and few specialists who care for perinatal persons.

- Access to health records, preferably electronic, to support communications between mental health and obstetric health-care providers regarding the mental health assessment and treatment plans and time lags. Information technology specialists can support improved communications across multidisciplinary teams and timely follow-up.
- Access to coordinated local resources and mental health services and supports—either within one organization, in collaboration with other agencies, or across communities or regions.
- Immediate access to a mental health specialist such as a psychiatrist via telephone or in-person consultation to support multi-disciplinary health-care providers in their delivery of perinatal depression care components. This would increase access to mental health care and reduce wait time burden on psychiatrists.

Benefits and Harms

Collaboration between health-care providers in primary care, public health, community services, mental health, and academia can strengthen perinatal depression screening, referrals and service delivery (146).

Values and Preferences

Persons with postpartum depression valued the convenience of optional phone contact by a care manager, versus visits always being conducted in-person in the clinical setting (147). Accessibility to care was also found to increase receptiveness to treatment for postpartum depression and reduce the need for additional visits through other medical appointments.

Practice Notes

To achieve increased awareness and accessibility to mental health services and supports for perinatal depression, the following strategies can be incorporated:

- Integrate nurses as leaders in an interprofessional approach to mental health services and supports for perinatal depression (143).
- Advocate for access to publicly funded mental health services and supports for perinatal depression in order to reduce wait times and delay in onset of care (8).
- Identify local community supports and programs to address service gaps and limited access.
- Establish centralized referral processes with access to services and supports, including available urgent appointments (8).
- Develop care algorithms, including actions to be taken in the event of an urgent situation such as an immediate harm, suicide, or infanticide risk being suspected or detected (148).
- Use print, social media, or public health campaigns incorporating evidence-based educational materials to promote perinatal depression as a public health concern.
- Integrate mental health services and supports for perinatal depression using a variety of approaches that are flexible and individualized through in-person, via telephone, and home visits, where available (8).

Supporting Resources

RESOURCE	DESCRIPTION
<p>Echo: Improving women's health in Ontario and the Postpartum Depression Standards Project Core Committee. The organization of perinatal mental health services in Ontario: Recommendations for service, education and training, policy and research [Internet]. [place unknown]: [publisher unknown]; 2012. Available from: http://www.ontla.on.ca/library/repository/mon/27001/320565.pdf</p>	<ul style="list-style-type: none"> ■ A white paper reflecting a roundtable discussion of practice and thought leaders in the area of perinatal mental health. ■ Recommendations include service provision, education, and training, policy, and research.
<p>The RAND Corporation. A toolkit for implementing parental depression screening, referral and treatment across systems [Internet]. Santa Monica (CA): RAND Corporation, Community Care Behavioural Health Organization, and The Alliance for Infants and Toddlers, Inc.; 2012. Available from: https://www.rand.org/content/dam/rand/pubs/tools/TL100/TL102/RAND_TL102.pdf</p>	<ul style="list-style-type: none"> ■ A toolkit developed to provide information and resources for implementing depression screening as an early intervention. ■ Cross-system referral collaborations and implementing relationship-based care are described.

RECOMMENDATIONS

Research Gaps and Future Implications

The RNAO Best Practice Guideline Research and Development Team and the expert panel identified priority areas for future research, as outlined in **Table 8**. Studies conducted in these areas would provide further evidence to support perinatal depression care. The list is not exhaustive; other areas of research may be required.

Table 8: Priority Research Areas for Each Research Question

RESEARCH QUESTION	PRIORITY RESEARCH AREA
<p>Research Question #1:</p> <p>In the area of perinatal mental health, what are effective prevention, screening and assessment strategies for identifying symptoms of depression during pregnancy and postpartum for up to one year after childbirth?</p>	<ul style="list-style-type: none"> ■ Effective prevention strategies for perinatal depression, including considerations regarding timing, delivery, and access. ■ Effective screening programs for perinatal depression, including components such as timing and cultural appropriateness. ■ Valid screening tools for perinatal anxiety. ■ Large multi-site trials on screening programs that also include assessment and treatment outcomes.
<p>Research Question #2:</p> <p>In the area of perinatal mental health, what are effective interventions for persons experiencing depression during pregnancy and postpartum for up to one year after childbirth?</p>	<ul style="list-style-type: none"> ■ Effective complementary therapies, including massage, bright light therapy, and acupuncture. ■ Sleep amounts to reduce the risk of perinatal depression. ■ Further research on treatment options and timing, in relation to effectiveness.
<p>Research Question #3:</p> <p>What education and training in perinatal depression are required to ensure the provision of effective assessment and interventions among nurses within the scope of their practice?</p>	<ul style="list-style-type: none"> ■ Canadian studies on effective introductory and continuing education programs on perinatal depression for nurses and other health-care providers.

RESEARCH QUESTION	PRIORITY RESEARCH AREA
<p>Research Question #4:</p> <p>How do health-care organizations and the broader health-care system ensure optimal prevention, assessment, and interventions for perinatal depression?</p>	<ul style="list-style-type: none"> ■ Impact of organized care pathways, including mental health services and supports for persons with perinatal depression and their families in rural and remote areas. ■ The effectiveness of collaborative care delivery models that support the assessment of and interventions for perinatal depression. ■ Health-service policies that improve accessibility and utilization of mental health services for perinatal depression.

Table 8 is an attempt to identify and prioritize the research needed with respect to perinatal depression. Many of the recommendations in this BPG are based on quantitative and qualitative research evidence; others are based on the other clinical guidelines or RNAO expert panel opinion. Further substantive research is required to expand the body of knowledge.

Implementation Strategies

Implementing BPGs at the point of care is multi-faceted and challenging; it takes more than awareness and distribution of guidelines for practice to change. BPGs must be adapted for each practice setting in a systematic and participatory way, to ensure recommendations fit the local context (149). The *RNAO Toolkit: Implementation of Best Practice Guidelines* provides an evidence-informed process for doing this (see [Appendix L](#)) (1).

The *Toolkit* is based on emerging evidence that successful uptake of best practice in health care is more likely when:

- Leaders at all levels are committed to supporting guideline implementation;
- Guidelines are selected for implementation through a systematic, participatory process;
- Stakeholders for whom the guidelines are relevant are identified and engaged in the implementation;
- Environmental readiness for implementing guidelines is assessed;
- The guideline is tailored to the local context;
- Barriers and facilitators to using the guideline are assessed and addressed;
- Interventions to promote the use of the guideline are selected;
- Use of the guideline is systematically monitored and sustained;
- Evaluation of the guideline’s impact is embedded in the process; and
- There are adequate resources to complete all aspects of the implementation.

The *Toolkit* uses the “Knowledge-to-Action” framework to demonstrate the process steps required for knowledge inquiry and synthesis (150). It also guides the adaptation of the new knowledge to the local context and implementation. This framework suggests identifying and using knowledge tools, such as guidelines, to identify gaps and to begin the process of tailoring the new knowledge to local settings. **Figure 2** depicts the framework, outlining the knowledge creation and action cycle process.

RNAO is committed to widespread deployment and implementation of our BPGs. We use a coordinated approach to dissemination, incorporating a variety of strategies, including:

1. The Nursing Best Practice Champion Network[®], which develops the capacity of individual nurses to foster awareness, engagement, and adoption of BPGs;
2. BPG Order Sets[™] provide clear, concise, actionable intervention statements derived from the practice recommendations. BPG Order Sets can be readily embedded within electronic records, but may also be used in paper-based or hybrid environments; and
3. The Best Practice Spotlight Organization[®] (BPSO[®]) designation, which supports implementation at the organization and system levels. BPSOs focus on developing evidence-based cultures with the specific mandate to implement, evaluate, and sustain multiple RNAO BPGs.

In addition, we offer annual capacity-building learning institutes on specific BPGs and their implementation.

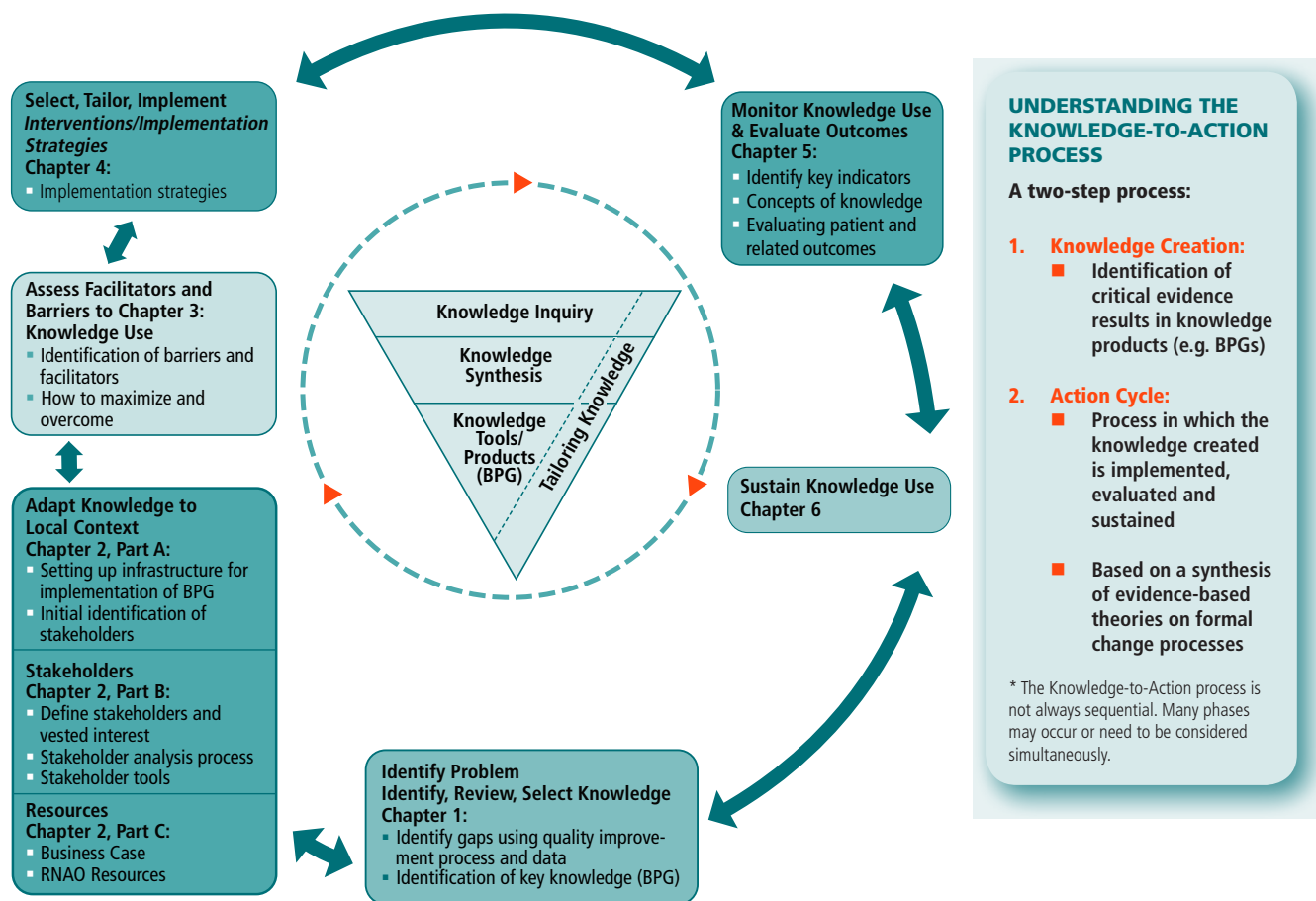
Information about our implementation strategies can be found at:

- RNAO Best Practice Champions Network: www.RNAO.ca/bpg/get-involved/champions
- RNAO BPG Order Sets: <http://rnao.ca/ehealth/bpgordersets>
- RNAO Best Practice Spotlight Organizations: www.RNAO.ca/bpg/bpso
- RNAO capacity-building learning institutes and other professional development opportunities: www.RNAO.ca/events

Figure 2: Knowledge-to-Action Framework

RECOMMENDATIONS

REVISED KNOWLEDGE-TO-ACTION FRAMEWORK



Adapted from “Knowledge Translation in Health Care: Moving from Evidence to Practice”. S. Straus, J. Tetroe, and I. Graham. Copyright 2009 by the Blackwell Publishing Ltd. Adapted with permission.

Guideline Evaluation

The Donabedian model informs the development of measures for evaluating and monitoring quality health care (151). The model consists of three categories including structure, process, and outcome. Structure describes the required attributes of the health system, organization, or academic institution, for example, physical, human, information and financial resources. Process measures examine the health care activities provided to, for, and with persons or populations. The measures are directly associated with the recommendation statements and support process improvement. Outcome analyzes the effect of quality care on the health status of persons and populations and measures overall guideline implementation success (152). For additional information refer to the RNAO *Toolkit: Implementation of Best Practice Guidelines, Second Edition* (1).

Tables 9, 10, and 11 provide structure, process, and outcome measures to assess guideline implementation success. It is important to evaluate evidence-based practice changes when implementing a guideline. Select the measures most relevant to the practice setting. The data repositories/indicator libraries available for perinatal depression are outlined to support data collection, measurement, quality improvement and evaluation.

Table 9: Structure Measures

STRUCTURE MEASURES	MEASURES IN DATA REPOSITORIES/ INSTRUMENTS
Percentage of nurses and the interprofessional team who received education and training on perinatal depression care	New

Table 10 supports evaluation of practice changes during implementation. The measures are directly associated with the recommendation statements and support process improvement.

Table 10: Process Measures

RECOMMENDATION	PROCESS MEASURES	MEASURES IN DATA REPOSITORIES/ INSTRUMENTS
1.1	Percentage of persons with documented screening for risk of perinatal depression	New
2.1	Percentage of persons with a documented plan of care for perinatal depression symptoms	New
2.5	Percentage of persons with documented perinatal depression symptoms who received psychoeducational interventions	New
2.7	Percentage of persons with documented perinatal depression symptoms who received Cognitive Behavioural Therapy (CBT) and/or Interpersonal Psychotherapy (IPT)	New

Table 11 provides potential outcome measures to assess overall Guideline success.

Table 11: Outcome Measures

OUTCOME MEASURES	MEASURES IN DATA REPOSITORIES/ INSTRUMENTS
Percentage of persons who screened positive for perinatal depression symptoms	Partial BORN ¹
Percentage of persons who screened positive for risk of self-harm	OPR ²

1 Better Outcomes Registry & Network (BORN)
 2 Ontario Perinatal Record (OPR)

Other RNAO resources for the evaluation and monitoring of BPGs:

- Nursing Quality Indicators for Reporting and Evaluation[®] (NQuIRE[®]), a unique nursing data system housed in the International Affairs and Best Practice Guideline Centre, allows BPSOs to measure the impact of BPG implementation by BPSOs worldwide. The NQuIRE data system collects, compares, and reports data on guideline-based nursing-sensitive process and outcome indicators. NQuIRE indicator definitions are aligned with available administrative data and existing performance measures wherever possible, adhering to a ‘collect once, use many times’ principle. By complementing other established and emerging performance measurement systems, NQuIRE strives to leverage reliable and valid measures, minimize reporting burden and align evaluation measures to enable comparative analyses. The international NQuIRE data system was launched in August 2012 to (i) create and sustain evidence-based practice cultures, (ii) optimize patient safety, (iii) improve patient outcomes, and (iv) engage staff in identifying relationships between practice and outcomes to advance quality and advocate for resources and policy that support best practice changes (151). Please visit [RNAO.ca/bpg/initiatives/nquire](https://rnao.ca/bpg/initiatives/nquire) for more information.
- BPG Order Sets embedded within electronic records provide a mechanism for electronic data capture of process measures. The ability to link structure and process indicators with specific client outcome indicators aids in determining the impact of BPG implementation on specific client health outcomes. Please visit [RNAO.ca/ehealth/bpgordersets](https://rnao.ca/ehealth/bpgordersets) for more information.

Process for Update and Review of Best Practice Guidelines

RNAO commits to updating its BPGs as follows:

1. Each BPG will be reviewed by a team of topic area specialists every five years following publication of the previous edition.
2. The RNAO International Affairs and Best Practice Guidelines (IaBPG) Centre staff regularly monitor for new systematic reviews, randomized controlled trials, and other relevant literature in the field.
3. Based on that monitoring, staff may recommend an earlier revision period. Appropriate consultation with members of the original expert panel and other specialists and experts in the field will help inform the decision to review and revise the BPG earlier than planned.
4. Three months prior to the review milestone, the staff begins planning the review by doing the following:
 - a. Inviting specialists in the field to participate in the expert panel. The panel will be comprised of recommended specialists and experts including those with lived experienced or consumer advocates.
 - b. Compiling feedback received and questions encountered during the implementation. This includes comments and experiences of BPSOs and other implementation sites regarding their experience.
 - c. Compiling new clinical BPGs in the field and conducting a systematic review of the evidence.
 - d. Developing a detailed work plan with target dates and deliverables for developing a new edition of the BPG.
5. New editions of BPGs will be disseminated based on established structures and processes.

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Appendix A: Glossary of Terms

Analytical studies: Analytical studies test hypotheses about exposure–outcome relationships. The investigators do not assign an intervention, exposure, or treatment, but do measure the association between exposure and outcome over time using a comparison group (153). Analytical study designs include case-control studies and cohort studies.

Best practice guideline: Best practice guidelines are systematically developed, evidence-based documents that include recommendations for nurses and the interprofessional team, educators, leaders and policymakers, persons and their families on specific clinical and healthy work environment topics. BPGs promote consistency and excellence in clinical care, health policies and health education ultimately leading to optimal health outcomes for people and communities and the health-care system (2).

Cohort study: An observational study in which a defined group of people (the cohort) is followed over time either prospectively or retrospectively (154).

Collaborative care: A model of care in which a team of health-care providers works together to treat individual patients within one or more care setting(s). Such an approach may facilitate systematic care planning, consultation, follow-up, and monitoring (147, 155).

Competencies: The integrated knowledge, skills, abilities, attitudes, and judgment required to practice nursing safely and ethically in a designated role or setting (131).

Comprehensive assessment: A comprehensive assessment is a biological, psychosocial, social, and spiritual nursing assessment of an individual that “includes a health history and physical examination; considers the psychological, emotional, social, spiritual, ethnic, and cultural dimensions of health; attends to the meaning of the individual’s health-illness experience; and evaluates how all of this affects the individual’s daily living” (156, p. 174).

Controlled study: A clinical trial in which the investigator assigns an intervention, exposure, or treatment to participants who are not randomly allocated to an experimental and control group (154).

Cross-sectional studies: A study measuring the distribution of some characteristic(s) in a population at a particular point in time (also called a “survey”) (154).

Culture: Refers to the shared and learned values, beliefs, norms, and ways of life of an individual or group. It influences thinking, decisions, and actions (141).

Cultural awareness: The first step towards achieving cultural safety. It can be built by observing activities and how people participate in them and involves being able and willing to recognize and accept difference within a population (172).

See *culture, cultural humility, cultural safety, cultural sensitivity*

Cultural humility: A process of self-reflection to understand personal and systematic biases that maintain inequities across racial or ethnic groups (158 - 159).

Cultural safety: An outcome based on respectful engagement that recognizes power imbalances that are inherent in the health-care system (141 - 159).

See *culture, cultural awareness, cultural humility, cultural sensitivity*

Cultural sensitivity: Refers to an awareness, understanding, and attitude toward culture, and it places the focus on the self-awareness and insight of the health-care provider (141, 159).

See *culture, cultural awareness, cultural sensitivity*

Descriptive studies: A study that generates a hypothesis and describes characteristics of a sample of individuals at one point in time. The investigators do not assign an intervention, exposure, or treatment to test a hypothesis, but merely describe the characteristics of a sample from a defined population. Descriptive study designs include cross-sectional studies (153 - 154).

Discrimination: The Ontario Human Rights Code states that “every person has the right to equal treatment with respect to services, goods, and facilities without discrimination on the grounds of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status, or disability” (160, s. 1).

Education recommendations: Statements of educational requirements and educational approaches or strategies for the introduction, implementation, and sustainability of the best practice guideline.

Evidence-based practice: The integration of the methodologically strongest research evidence with clinical expertise and patient values; unifies research evidence with clinical expertise and encourages the inclusion of patient preferences (161).

Family: Whomever the person defines as being his or her family. Family members can include parents, children, siblings, partners, neighbours, and significant people in the person’s community (47).

Health-care provider: In this guideline, the term refers to regulated health-care providers or professionals who provide care and services to persons and their families in any setting (acute, home health care, primary care, and community) (47).

Health literacy: The knowledge and competencies (accessing, understanding, appraising, and applying health information) that a person requires to make decisions and meet the complex demands of their changing states of health (illness and disease) and wellness (prevention). There are two levels of health literacy:

1. the functional level, in which the person possesses the basic reading and writing skills required to understand any information given; and
2. the interactive level, in which the person possesses more advanced skills that allow them to participate in making decisions regarding their health care, including the ability to analyze health and wellness information critically and to make effective use of it (162).

Informed decision-making process: The steps a person goes through to make decisions about their care. The quality of the decision-making process can be determined by evaluating the process itself. This means asking the person making the decision to evaluate the following:

- Whether they received enough information (specialized knowledge) to make a decision.
- Whether the information was given without bias or an attempt to sway the person toward a particular option.
- Whether the information included an explanation of the benefit(s), harms(s), and scientific uncertainties, and whether alternative options were provided for consideration.
- Whether the person's values and goals were considered.
- Whether the person was given enough time to make the decision.
- Whether the person was included in the decision-making process to their preferred degree of participation (163).

Interprofessional team: A team comprised of multiple health-care providers who work collaboratively to deliver comprehensive and quality health care and services to people within, between, and across health-care settings (47).

Interventions: Encompasses specific treatment strategies, therapies, or techniques that are used in this Guideline for perinatal depression.

Meta-analysis: A systematic review that uses statistical methods to analyze and summarize the results of the included studies (154).

See *systematic review*

Nurses: Refers to registered nurses, licensed practical nurses (referred to as registered practical nurses in Ontario), registered psychiatric nurses, and nurses in advanced practice roles (such as nurse practitioners and clinical nurse specialists) (131).

Organization and system policy recommendations: Statements of conditions required for a practice setting that enables the successful implementation of the best practice guideline. The conditions for success are largely the responsibility of the organization, although they may have implications for policy at a broader governmental or societal level.

Perinatal depression: A common mental illness occurring during pregnancy and postpartum, up to one year following birth. When left untreated, perinatal depression is associated with negative outcomes for the person, their infant, other children, partner, and other family members, where applicable (6). A detailed description of perinatal depression, including symptoms and risk factors, is provided in the Background Section (p.21 - 27).

Person: In this Guideline, a person is an individual with whom health-care providers establish a therapeutic relationship for the purposes of partnering for perinatal depression health care. The term is meant as inclusive of the following: parent, mother, woman, patient, resident, and consumer or any other identifier as determined by the individual (164 - 165).

Person-centred care: An approach to care within which the person is viewed as a whole. The process of coming to know the whole person is nurtured through the formation of a therapeutic relationship between the person, those who are significant to them, and health-care providers. This approach to care involves advocacy, empowerment, and mutual respect as well as an understanding of the person's right to be autonomous, self-determining, and actively involved in decisions about their health (illness and wellness) (47).

Person- and family-centred care: A person- and family-centred approach to care demonstrates certain practices that put the person and their family members at the centre of health care and services. Person- and family-centred care respects and empowers individuals to be genuine partners with health-care providers for the benefit of their health. The approach includes the following common themes and attributes:

- Fostering relationships and trust.
- Empowering the person to be actively involved in making decisions regarding their health care (e.g., independence, autonomy, and the right to self-determination).
- Sharing of evidence-based options for care, education, and information that are unbiased, clear, and comprehensive in order to support the person in making decisions.
- Respecting the person and personalizing care by promoting the person's strengths, self-knowledge, preferences, and goals for care in a way that is based on their beliefs, values, culture, and their experience of health.
- Providing physical comfort within an environment that is conducive to healing.
- Offering emotional support and sympathetic presence.
- Ensuring continuity of care during transitions.
- Ensuring the person's ability to access care and services when needed.
- Partnering with the person and their family in health system reform to improve the quality, delivery, and design of health care and services at all levels (micro, meso, and macro).
- Communicating effectively within a therapeutic relationship to promote true health-care partnerships.
- Caring for individuals, their families, and their communities by addressing determinants of health (health promotion and disease prevention) (47).

Pilot studies: A type of study design that is important in the development of new knowledge. Pilot studies are designed to determine the feasibility of a research approach (e.g., recruitment, retention, assessment, and implementation) using a new intervention prior to running a larger scale study. Pilot studies are not intended for hypothesis testing (166).

Prenatal depression: A depression occurring during the perinatal period, specifically during pregnancy.

Practice Recommendation: A statement of best practice directed at nurses and the interprofessional team that enables the successful implementation of the BPG.

Postpartum depression: A depression occurring during the perinatal period, specifically during the postpartum period up until one year following childbirth.

Qualitative research: An approach to research that seeks to convey how human behavior and experiences can be explained within the contexts of social structures and using an interactive and subjective approach to investigate and describe phenomena (167).

Quasi-experimental study: A type of study design that estimates causal effects by observing the exposure of interest, but the experiments are not directly controlled by the researcher and do not involve randomization (e.g., before-and-after designs) (168).

Randomized controlled trial (RCT): An experiment in which the investigator assigns one or more interventions, to participants who are randomly allocated to either the experimental group (receives the intervention) and the comparison (conventional treatment) or control group (no intervention or placebo) (154).

Reflective practice: The process of examining one's actions and experiences for the purpose of developing one's practice and clinical knowledge with the outcome of acquiring a new understanding and appreciation of the situation (169).

Reliability (Reliable): The degree to which results from a measurement procedure can be reproduced with minimal measurement error (154).

See *validated*

Screening tool: A screening tool is intended to detect emerging (typically pre-symptomatic) health problems for early treatment and to improve health outcomes. The performance of a screening tool should be based on the adequacy of the screen to detect the health problem (170).

Social determinants of health: The conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at the global, national and local levels. The social determinants of health are mostly responsible for health inequities – unfair and avoidable differences in health status seen within and between countries (10)

Stakeholder: An individual, group, or organization with a vested interest in the decisions and actions of organizations. A stakeholder may attempt to influence decisions and actions (171). Stakeholders include all individuals or groups who will be directly or indirectly affected by the change or solution to the problem.

Stigma: The negative, unfavourable attitudes and the behaviour they produce associated with a particular trait displayed by or activity engaged in by an individual or group (165).

Systematic review: A comprehensive review of the literature that uses a clearly formulated question and systematic and explicit methods to identify, select, and critically appraise relevant research. A systematic review collects and analyzes data from the included studies and presents them, sometimes using statistical methods (154).

See *meta-analysis*

Therapeutic relationship: A purposeful, goal-directed relationship between the health-care provider and the person accessing the health system for care and treatment that is grounded in an interpersonal process directed at advancing the best interest and health outcome of the person (164, 172).

Validated (Validity): The degree to which a measurement is likely to be true and free of bias (154).

See *reliable*

Whole person: All of the components—biological, psychological, emotional, physical, personal, social, environmental, and spiritual—that make up a person. Caring for the whole person entails coming to know the person with respect to all of these components and treating them holistically (rather than treating only their illness or disease) (173 - 174).

Appendix B: Best Practice Guideline Development Process

RNAO is committed to ensuring that every BPG is based on the best available evidence. To meet international standards, a monitoring and revision process has been established for each guideline every five years.

RNAO assembled a panel of experts who represent a range of sectors and practice areas (see the “RNAO Expert Panel,” p. 15). Systematic reviews of the evidence was based on the purpose and scope of this Guideline, and it was supported by the four research questions listed below. The systematic reviews were conducted to capture relevant peer-reviewed literature published between 2006 and July 2018.

The following research questions were established to guide the systematic reviews:

1. In the area of perinatal mental health, what are effective screening and assessment strategies for identifying symptoms of depression during pregnancy and postpartum for up to one year after childbirth?
2. In the area of perinatal mental health, what are effective interventions for persons experiencing depression during pregnancy and postpartum for up to one year after childbirth?
3. What education and training in perinatal depression are required to ensure the provision of effective assessment and interventions among nurses within the scope of their practice?
4. How do health-care organizations and the broader health-care system ensure optimal prevention, assessment, and interventions for perinatal depression?

The RNAO Best Practice Guideline Research and Development Team and expert panel worked to integrate the most current and best evidence, and to ensure the validity, appropriateness, and safety of the BPG recommendations.

Appendix C: Process for Systematic Review and Search Strategy

Guideline Review

The RNAO Best Practice Guidelines Research and Development Team searched an established list of websites for guidelines and other relevant content published between 2006 and 2016. This list was compiled based on knowledge of evidence-based practice websites, recommendations from the literature, and key websites related to perinatal depression (see **Figure 3**).

Detailed information about the search strategy for existing guidelines, including the list of websites searched and inclusion criteria are available online at www.RNAO.ca

The RNAO Guideline Lead and two RNAO Nursing Research Associates critically appraised six international guidelines using the Appraisal of Guidelines for Research and Evaluation Instrument II (175). From this review, the following four guidelines were selected to inform the recommendations and discussions of evidence:

1. beyondblue. Clinical practice guidelines for depression and related disorders—anxiety, bipolar disorder and puerperal psychosis—in the perinatal period. A guideline for primary care health professionals. Melbourne (AU): Beyondblue; 2011. Available from: <http://resources.beyondblue.org.au/prism/file?token=BL/0891>
2. National Institute for Health and Care Excellence. Antenatal and postnatal mental health: clinical management and service guidance. London (UK): National Institute for Health and Care Excellence; 2014. Available from: <http://nice.org.uk/guidance/cg192>
3. Scottish Intercollegiate Guidelines Network. SIGN 127: Management of perinatal mood disorders. Edinburgh (SCT): Scottish Intercollegiate Guidelines Network; 2012. Available from: <https://www.sign.ac.uk/sign-127-management-of-perinatal-mood-disorders.html>
4. Trangle M, Gursky J, Haight R, et al. Health care guideline: Depression in primary care. Bloomington (MN): Institute for Clinical Systems Improvement; 2016. Available from https://www.icsi.org/guidelines_more/catalog_guidelines_and_more/catalog_guidelines/catalog_behavioral_health_guidelines/depression/

The exclusion of guidelines under the Appraisal of Guidelines for Research and Evaluation Instrument II (175) was due primarily to their lack of a systematic review, as well as low scores from two independent reviewers or having a minimal focus on perinatal depression (e.g., the guideline had a broad focus on maternal mental health or prenatal or postpartum care with only a brief discussion of perinatal depression).

Systematic Review

A comprehensive search strategy was developed by the RNAO's Best Practice Guideline Research and Development Team and a health sciences librarian based on inclusion and exclusion criteria created with the RNAO expert panel. A search for relevant articles published in English between 2006 and 2015, was applied to the following databases: Cumulative Index to Nursing and Allied Health (CINAHL), Cochrane Central Register of Controlled Trials (CENTRAL), Cochrane Database of Systematic Reviews (CDSR), EMBASE, MEDLINE, MEDLINE in Process, PsycINFO, and ERIC (for research question 3 only). In addition to this systematic search, panel members were asked to review personal libraries for key articles not found using the above search strategies. These articles underwent the same screening process as the articles retrieved through database searching (see **Figure 4**).

Detailed information about the search strategy for all four systematic reviews, including the inclusion and exclusion criteria and search terms, is available online at <https://rnao.ca/bpg/guidelines/assessment-and-interventions-perinatal-depression>.

Once articles were retrieved, the records were divided among two RNAO Nursing Research Associates and the RNAO Guideline Development Lead, all of whom are nurses holding master's degrees. The RNAO Nursing Research Associates and the RNAO Guideline Development Lead independently assessed the eligibility of the studies according to the pre-established inclusion and exclusion criteria. All screening was performed independently by at least two reviewers and any discrepancies between each pairs' results were tie-broken by the individual who did not review that group of articles.

Quality appraisal scores for 26 articles (a random sample of 20 per cent of the total yield of included articles) were independently assessed by each Nursing Research Associate. Acceptable inter-rater agreement (kappa statistic, $K = 0.88$) justified proceeding with quality appraisal and data extraction by dividing the remaining studies equally between the Nursing Research Associates (176). Research summaries of the literature findings were completed and used to describe the results in narratives. The comprehensive data tables and research summaries were provided to all expert panel members for review and discussion.

Systematic Review Updates

Prior to publication, the systematic review informing the practice recommendations for this Guideline was updated. The purpose of the systematic review update was to ensure that any relevant research supporting or contesting the existing practice recommendations, published since the initial search was conducted in 2015, was incorporated into the Guideline. A search for relevant articles published in English between May 1, 2015, and July 14, 2017, was applied to the following databases: CINAHL, MEDLINE, and the Cochrane Library. A total of 347 articles were retrieved, with 333 remaining following duplicate removal. One Nursing Research Associate and the Guideline Development Lead screened all 333 records for inclusion. Twenty-five full texts were agreed upon and further screened for relevance by the Nursing Research Associate and the Guideline Development Lead. Fifteen articles were included in the systematic review update and quality appraised by one Nursing Research Associate. In total, eight studies of strong and moderate quality were included in the Guideline (see **Figure 5**). The included research articles continued to support the current practice recommendations within the Guideline and are incorporated within the pertinent discussions of evidence.

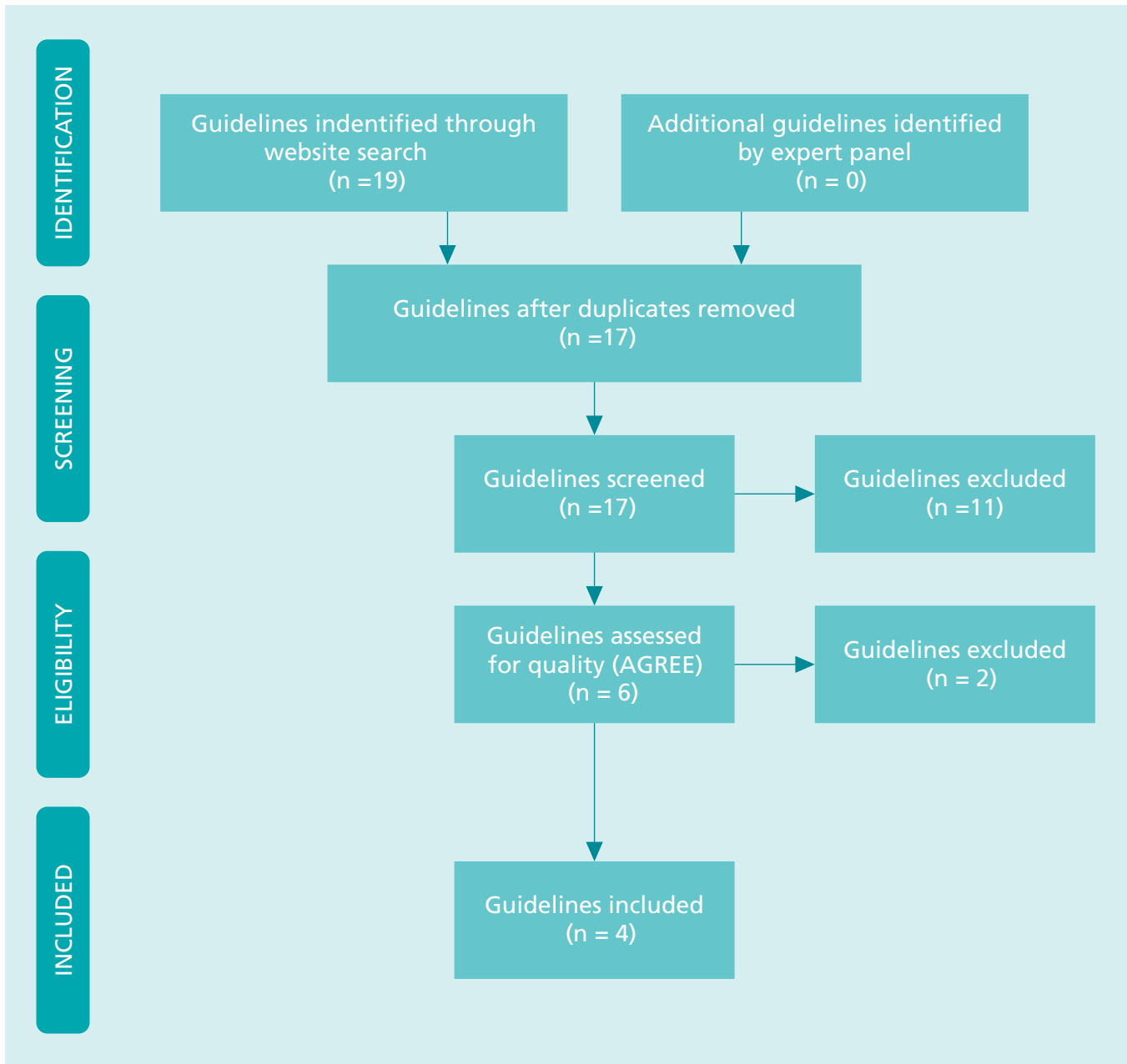
Subsequent to this initial update and prior to publication, the systematic reviews informing the practice, education, and organization and system policy recommendations for this Guideline were updated. The purpose of this second update was to ensure that any relevant research supporting or contesting all the existing recommendations on perinatal depression, published within the last five years was incorporated into the Guideline. A search for relevant articles published in English between January 2013 and July 2018 was applied to the following databases: Cumulative Index to Nursing and Allied Health (CINAHL), Cochrane Central Register of Controlled Trials (CENTRAL), Cochrane Database of Systematic Reviews (CDSR), EMBASE, MEDLINE, MEDLINE in Process, PsycINFO, and ERIC (for research question 3 only). A total of 23664 articles were retrieved, with 17894 remaining following duplicate removal. One Nursing Research Associate and the Guideline Development Lead screened all 17894 records for inclusion. A total of 371 full texts were agreed upon and further screened for relevance by the Nursing Research

Associate and the Guideline Development Lead. Thirty-five articles were included in the systematic review update and quality appraised by two Nursing Research Associates. In total, 16 studies from this update were included in the Guideline (see **Figure 5**). Studies of low quality were included only where the findings provided distinct and relevant examples. The included research articles continued to support the current recommendations within the Guideline and are incorporated within the pertinent discussions of evidence.

A detailed flow diagram of the inclusion and exclusion of articles for the updated systematic review, along with a complete bibliography of all the full-text articles screened for inclusion from the 2015, 2017 and 2018 searches, is available at <https://rnao.ca/bpg/guidelines/assessment-and-interventions-perinatal-depression>.



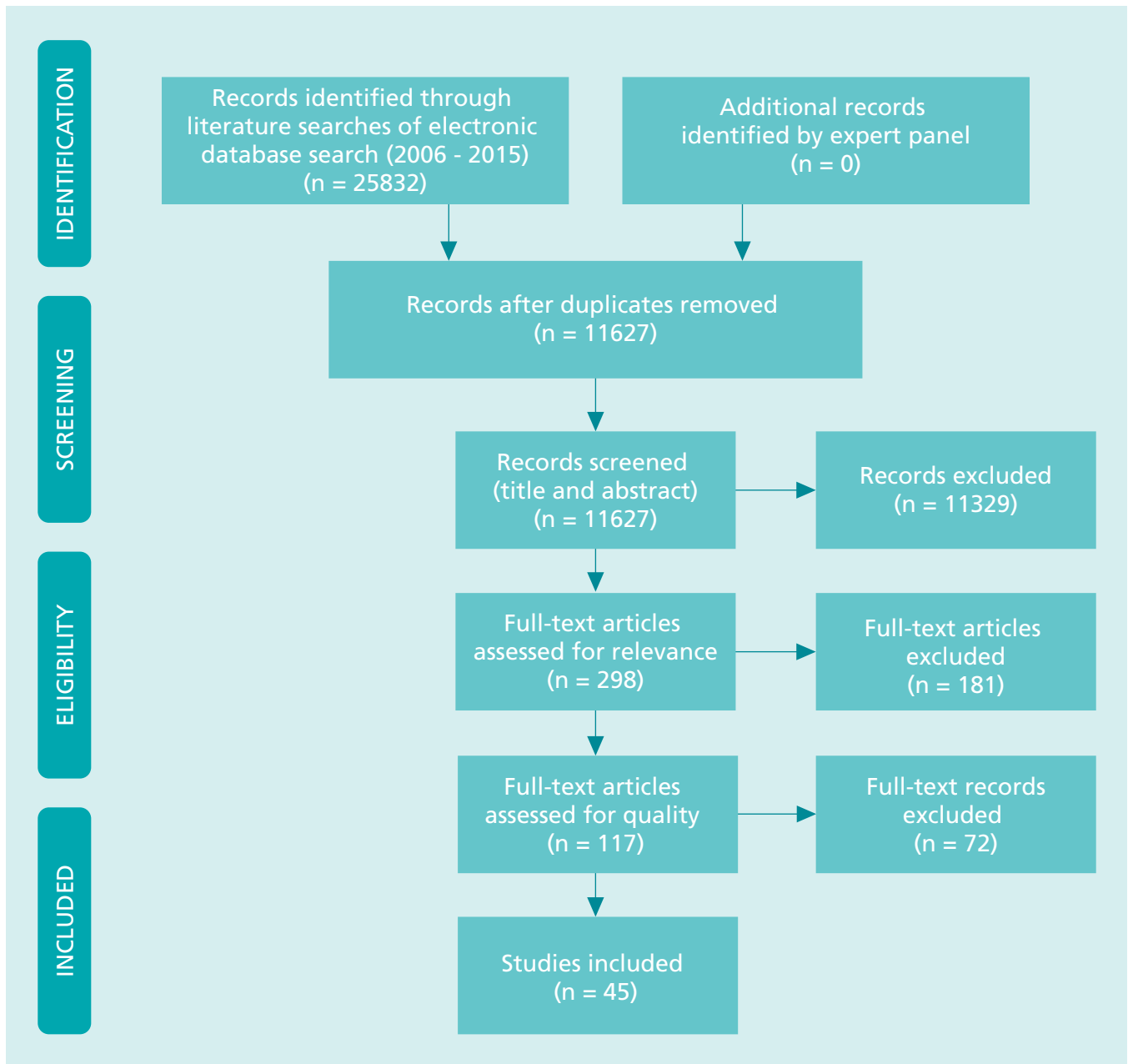
Figure 3: Guidelines Review Process Flow Diagram



Source: Adapted by the RNAO expert panel from: Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *BMJ*. 2009;339:b2535. doi: 10.1136/bmj.b2535

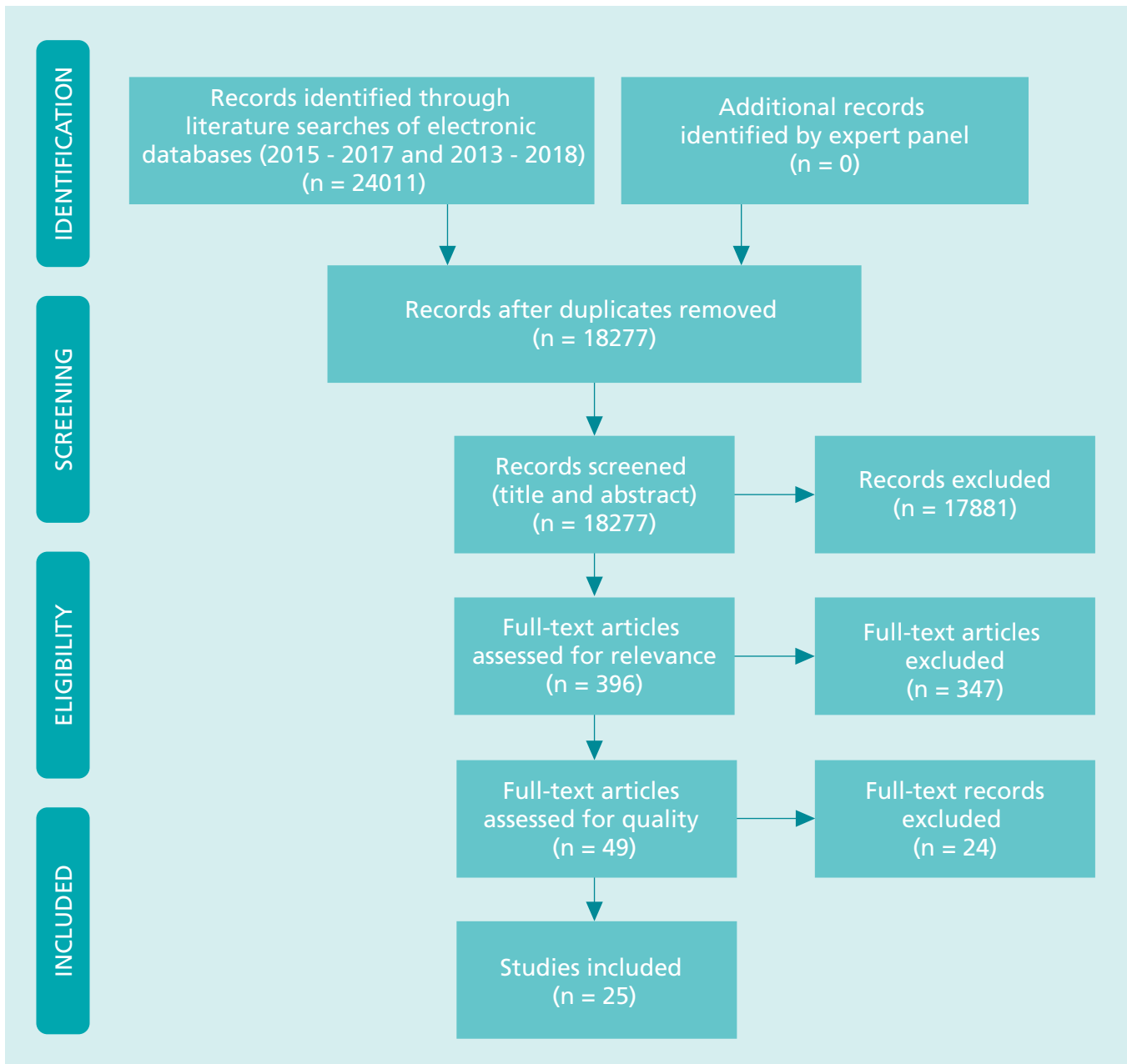
Included guidelines had an overall AGREE II score of five or more (out of seven).

Figure 4: Article Review Process Flow Diagram



Source: Adapted by the RNAO expert panel from: Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *BMJ*. 2009;339:b2535. doi: 10.1136/bmj.b2535

Figure 5: Article Review Process Flow Diagram



Source: Adapted by the RNAO expert panel from: Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *BMJ*. 2009;339:b2535. doi: 10.1136/bmj.b2535

Appendix D: Diversity among Persons with Perinatal Depression

When caring for persons with perinatal depression, consideration of unique circumstances and life contexts that may shape a person's need for services and supports are important. In this section, the diverse needs of pregnant and postpartum persons experiencing perinatal depression are highlighted. The following subgroups, listed alphabetically, include adolescents, adoptive parents, breastfeeding persons, immigrants, incarcerated persons, Indigenous peoples, lesbian and bisexual persons, persons with abuse histories, persons with disabilities, persons with histories of substance use, persons with low income, refugees, and transgender persons. Cultural considerations and perinatal depression in male partners are also highlighted.

Adolescents

There are limited studies on perinatal depression in adolescents as the majority of studies focus on adult populations (177). Nonetheless, it is quite common with a reported prevalence of 14 to 53 per cent (depending on the study population) (30, 177 - 178). The high rates of depression are associated with many risk factors, as listed in **Table 12**. The table also includes positive protective factors that reduce risk.

With a high prevalence and adverse consequences for the person and their infant, including a three-fold increased risk of suicide attempts in the postpartum period compared to during pregnancy (20 per cent versus 6.3 per cent), interventions are paramount (179). Screening for one year or longer is recommended as the peak onset for depression in adolescents is four months after childbirth (177). As the EPDS has not been found to be valid for adolescents, other simpler screening tools should be considered that rate feelings of hopelessness, sadness, or a lack of pleasure or interests on a daily basis (180).

Effective interventions from the evidence included 1) co-ordinated care in a home setting by members of the interprofessional team including psychotherapists, social workers, psychiatrists, and midwives (180); and 2) support in a school setting from a nurse and accommodations to attend medical appointments during the school day, as needed (181). Another study found weekly physical activity in the third trimester was associated with reduced depression symptoms in early postpartum (182).

For adolescents, a school nurse or nurse at a community centre (where available) can be invaluable for support and awareness of local perinatal depression resources, including peer support (30, 177 - 178, 183). The nurse also can support the young parent about the option to stay in school. Given the high prevalence of perinatal depression among adolescents, it is important that the nurse screen for and recognize any signs or symptoms of depression. For further details regarding the role of nurses and the required competencies for supporting adolescent mental health, refer to the RNAO's *Enhancing Health Adolescent Development*, available at <http://RNAO.ca/bpg/guidelines/enhancing-healthy-adolescent-development>

Table 12: Risk and Protective Factors for Perinatal Depression among Adolescents

RISK FACTORS	PROTECTIVE FACTORS
<ul style="list-style-type: none"> ■ Younger age at the time of pregnancy and birth* ■ Being on social assistance* ■ Dropping out of school* ■ Negative family support ■ Perceived lack of support from social network or isolation from peers ■ Low self-esteem ■ Body dissatisfaction ■ Lower socio-economic status ■ Conflict with the father of the baby, where applicable ■ Self-reports of being lonely or lacking confidence ■ High levels of personal stress ■ History of depression and/or anxiety pre-pregnancy or during pregnancy ■ Addiction and mental illnesses, including anxiety, or bipolar or eating disorders 	<ul style="list-style-type: none"> ■ Parental support ■ Support and involvement from the father of the baby, especially as the due date nears (where applicable) ■ Receiving care from a nurse or other supportive member of the interprofessional team ■ Awareness of local resources and available social supports ■ Screening for perinatal depression ■ Self-perceived parenting self-confidence

Sources: Banti S, Borri C, Camilleri V, et al. Perinatal mood and anxiety disorders. Clinical assessment and management. A review of current literature. *Ital J Psychopath.* 2009;15(4):351–366; Dinwiddie K, Schillerstrom T, Schillerstrom J. Postpartum depression in adolescent mothers. *J Psychosom Obstet Gynecol.* 2017;2:1-8; Reid V, Meadows-Oliver M. Postpartum depression in adolescent mothers: An integrative review of the literature. *J Pediatr Health Care.* 2007;21(5):289–298; and Yozwiak JA. Postpartum depression and adolescent mothers: A review of assessment and treatment approaches. *J Pediatr Adolesc Gynecol.* 2010;23(3):172–178.

* These risk factors have not conclusively been found to be predictive for perinatal depression in adolescents (177 – 178, 183).

Adoptive Parents

There are few studies examining the prevalence of postpartum depression among parents who have adopted. A quasi-experimental study surveyed mothers who had adopted a child (mean age of two years) within the past 12 months (184). The findings indicated that adoptive mothers have depression symptoms of comparable severity to those of biological mothers. The risk of postpartum depression among adoptive mothers can be heightened due to challenges with infertility, a past psychological disorder, and lower marital satisfaction (184). Postpartum depression screening is indicated for adoptive mothers to support earlier assessment and treatment, where needed.

Breastfeeding Persons

The evidence of associations between breastfeeding prevalence, duration, and postpartum depression is inconsistent (185 - 187). Some studies found persons with depression symptoms had decreased rates of breastfeeding prevalence, duration and initiation (185, 187 - 188). In contrast, another study found breastfeeding attempts and duration were not associated with postpartum depression, and that any previously reported associations between these variables may have been due to other risk factors (186). Additionally, breastfeeding may be protective against postpartum depression due to the calming effects of the lactation hormones prolactin and oxytocin and the reduction of cortisol, a stress hormone (188).

When supporting persons with moderate to severe depression symptoms who are contemplating a pharmacological treatment, the risks and benefits must be examined through an informed decision-making process. The decision regarding the use of pharmacologic approaches and whether to initiate or continue breastfeeding is influenced by many factors, including the person's feelings about breastfeeding and the severity of their depression symptoms (187). All possible options should be explored including i) exposure to medication through breast milk to treat postpartum depression, ii) exposure avoidance to medication through breast milk by not treating postpartum depression pharmacologically, or iii) exposure avoidance to medication through breast milk by ceasing breastfeeding (187). When weighing these options, a general reassurance can be made that many of the medications prescribed for postpartum depression are considered safe for breastfeeding because the infant dose via breast milk is less than 10 per cent of the maternal weight-adjusted dose, making infant exposure low to very low (189). Nonetheless, individual considerations must be addressed and respected in the decision-making process. While recognition is made of the mental health benefits and the positive parental-infant relationship associated with breastfeeding, all persons need to be supported in their choices regarding infant feeding, including partial or complete weaning (187 - 188).

For further details regarding breastfeeding and depression, refer to the RNAO's *Breastfeeding – Promoting and Supporting the Initiation, Exclusivity, and Continuation of Breastfeeding for Newborns, Infants, and Young Children* Best Practice Guideline, available at <https://rnao.ca/bpg/guidelines/breastfeeding-promoting-and-supporting-initiation-exclusivity-and-continuation-breast>.

Immigrants

A systematic review of immigrant women and postpartum depression found a prevalence of 20 per cent, which reflected a 1.5- to 2-fold increased likelihood compared to non-immigrant women (33). Immigrant women were at higher risk for depression under the following conditions: had immigrated fewer than ten years prior, had low local language literacy, had low socio-economic status, had low decision-making power within the household or experienced violence and abuse by an intimate partner. Other associated risk factors for postpartum depression among immigrants include experiences of stigma, conflict in family relationships, economic dependence, being a younger age and having a poor perception of one's health (185, 190).

Incarcerated Persons

Pregnant and postpartum persons who are incarcerated are at increased risk of perinatal depression; they often have also experienced social inequities such as homelessness, addiction, repeated violence in childhood or adulthood, or poverty (191). An estimated eight to ten per cent of incarcerated persons are pregnant and most have committed nonviolent crimes often motivated by addiction or poverty (191 - 192). One study found that 80 per cent of pregnant incarcerated persons had depression and were socially isolated with little to no support from family or friends (192).

Many persons in jails do not receive any accommodations to support a healthy pregnancy, such as additional food including fruit and vegetables, prenatal vitamins, an extra mattress, or access to childbirth classes (191). Persons may not be prepared emotionally or legally for losing temporary or permanent custody of their infant unless a parent-child unit is available within the institution (191). Policies to accommodate pregnant incarcerated persons may not be developed or enforced, leaving the person more vulnerable to depression (193).

Nurses who work in corrections can effectively provide care for pregnant incarcerated persons through strategies including:

- Screen for depression and associated risk factors as part of routine care.
- Facilitate referrals to prenatal health-care providers such as an obstetrician, midwife, nurse practitioner, family physician, dietician, lactation consultant, or a social worker.
- Advocate for and support protocols to minimize the use of restraints or shackles in labour to reduce the risk of depression and/or trauma (191).

In the postpartum period, the nurse can advocate for or provide the following strategies:

- Provide social support.
- Facilitate resources to support pumping of breast milk (where requested).
- Advocate to promote and protect the rights of incarcerated persons by acting on their behalf and champion social justice by providing or facilitating access to interventions for perinatal depression, where available (191).

Further discussion of best practices for mother-child units in Canadian correctional facilities is available at https://icclr.law.ubc.ca/wpcontent/uploads/2017/06/Guidelines_MCU_26AUG2015.pdf

Indigenous peoples

There is a lack of evidence on Indigenous peoples and perinatal depression (194). Data suggests that perinatal depression is common among Indigenous women in Canada; the prevalence is estimated at 17 to 47 per cent during pregnancy and 10 to 30 per cent during postpartum (194). The risk of depression is further increased as Indigenous women have 1.5 times more pregnancies than women in the general population.

It is important to contextualize perinatal depression for Indigenous women as a major public health problem (194 - 195). There are unique challenges faced by Indigenous peoples, with factors that are complex, intersecting, and multi-factorial (194 - 195). Some of these include systemic racism, sexism, marginalization, poverty, abuse, and the intergenerational effects of colonization (which lead to the eradication of traditional practices) (194 - 195). Some Indigenous peoples are forced to give birth outside of their home communities, leaving them disconnected from their socio-cultural and familial supports (194 - 195). This results in exclusion and isolation, and it contributes to a lack of access to services and resources that places them at higher risk of perinatal depression (194 - 195).

Although there are increased risk factors for perinatal depression among Indigenous peoples, there are also positive protective factors that support their strength and resiliency and can reduce risk (196). These include the following:

1. A healthy mind, body, and spirit including strategies to cope with stress, spirituality, and prayer.
2. Healthy relationships with intimate partners, family and community members, and service providers. This includes emotional and practical support.
3. Healthy environments including positive physical and social environments where persons felt safe and secure with easy access to resources.
4. Barrier-free, effective, and culturally safe services that meet the needs of persons where they feel empowered and respected.

Care of Indigenous women with perinatal depression requires nurses and the interprofessional team to have a strong awareness of social determinants of health, along with skills in **cultural humility**^G and **cultural safety**^G (158). This can be achieved through understanding and reflective practice, which will better ensure that health disparities can be addressed, power can be shared with the person, and care can be accessed (197). Indigenous populations tend, in research, to be collapsed into a single category of study participants, further understanding of the unique cultural needs of each subgroup is needed (194). A select list of perinatal depression resources for Indigenous women can be found in [Appendix L](#) (Additional Resources).

Lesbian and Bisexual Persons

There is emerging research on perinatal depression and its predictors among lesbian and bisexual persons (198 - 200). Some evidence suggests a higher prevalence of perinatal depression among lesbian and bisexual persons than among heterosexual persons and a need for mental health services and trained health-care professionals who can provide inclusive care that is affirmative of lesbian and bisexual persons (201). This includes the ability to recognize the unique risk factors arising from homophobia and biphobia and how lesbian and bisexual women have care needs that are both similar and different to heterosexual women. Other affirmative practice principles include the following:

- Not assuming that the person is heterosexual.
- Becoming knowledgeable about how lesbian and bisexual persons form relationships and become parents.
- Being aware of local and national resources that support lesbian and bisexual persons as parents.
- Seek to create an affirmative environment through steps such as modified forms that recognize same-sex partners and include sexual orientation and gender expression in an organization's mission statement and non-discrimination policy (201).

Persons with Abuse Histories

Despite a high prevalence in the general population, there are few studies that examine the relationship between persons with histories of abuse and perinatal depression and their findings are inconsistent (202). For example, a systematic review of the prevalence of postpartum depression and persons with abuse histories demonstrated a significant relationship (202). The types of abuse identified included physical, emotional, sexual, and intimate partner violence. Empowerment was found to be an effective strategy for decreasing prenatal depression symptoms in persons who had experienced emotional abuse (202). In contrast, a 2016 prospective study found no significant association between persons with histories of trauma and postpartum depression when symptoms were measured at 12 and 24 weeks postpartum (203). The researchers concluded that a history of depression prior to pregnancy or during pregnancy is an increased risk factor for postpartum depression.

Perinatal depression symptoms were strongly associated with a history of intimate partner violence, however, a causal (i.e., cause and effect) relationship could not be determined (204). Persons with probable depression (i.e., high levels of depression symptoms, as measured by EPDS scores) had a three- to five-fold increased odds of having a history of intimate partner violence during their adult years and during pregnancy. The researchers concluded that intimate partner violence, like postpartum depression, is a public health problem with risks to the person, their fetus, infant, and other children (where applicable). As such, it is necessary to identify persons at risk for, or experiencing, intimate partner violence and to respond appropriately.

Further information regarding woman abuse is available through RNAO's BPG *Woman Abuse: Screening, Identification and Initial Response* (2012) found at <http://RNAO.ca/bpg/guidelines/woman-abuse-screening-identification-and-initial-response>

Persons with Disabilities

There is very limited evidence focusing on postpartum depression for persons with self-reported physical, mental or emotional disabilities (205). Prevention, frequent screening, and timely follow-up interventions are recognized as important to the health and emotional well-being of these persons because of greater risk of depression symptoms (205 - 206). An American study examining the prevalence of depression among persons with and without disabilities found those with disabilities were at a significantly higher risk of postpartum depression (205). These persons also were more likely to have limited social support, incomes to the federal poverty level, experiences of physical violence during pregnancy, high levels of stress and medical complications.

Persons with Histories of Substance Use

Persons who currently use substances during the perinatal period—or who have a history of substance use—have an increased risk of both prenatal and postpartum depression (202). Similarly, pregnant persons who use alcohol have an elevated likelihood of postpartum depression, although there is a scarcity of research examining the relationship between substance use and depression (208).

Pregnancy can further worsen symptoms of mental illness, including prenatal depression, as persons may struggle to cope with challenges such as the physical discomforts of pregnancy, social stigma from using substances, and ambivalence regarding the pregnancy and the transition to becoming a parent (207). A systematic review focusing on postpartum persons who use substances consistently found high rates of depression symptoms (202).

For persons with co-morbidities of perinatal depression and addiction, there is a need for care that is coordinated and integrates mental health, substance use, and trauma issues (207 - 208). For pregnant or postpartum women with a history of substance use, it is important to assess and intervene for perinatal depression, as a lack of treatment will have adverse maternal and child health outcomes (207 - 208). Further information regarding crisis intervention using a trauma-informed approach is available through RNAO's BPG *Crisis Intervention for Adults Using a Trauma-informed Approach: Initial Four Weeks of Management* (2017) found at http://rnao.ca/sites/rnao-ca/files/bpg/Crisis_Intervention_FINAL_WEB_April6.pdf

Persons with Low Income

Persons with low income and/or living in poverty are at a disproportionately increased risk of perinatal depression due to social inequities as rates of prenatal depression are double that of middle-class persons (9 – 10, 90, 143). Additionally, persons who are socio-economically disadvantaged face multiple barriers in accessing treatments including the following: practical barriers (cost, lack of medical insurance, childcare, transportation, limited time, inaccessible clinic location, or competing priorities); cultural barriers (language, provider insensitivity to cultural values, coping styles (e.g., spirituality), and beliefs about depression); and psychological barriers (previous negative experiences using services or a sense of self-reliance or distrust of others due to histories of violence or abuse in childhood or as an adult) (143). As such, persons facing these barriers may be understandably reluctant to seek or continue treatment (143).

Low income and poverty are powerful predictors of depression (9). The adverse effects of perinatal depression for the person, their infant, and family are elevated due to stressors such as insufficient income for basic needs such as housing, food, and material goods. Additionally, persons may have other risk factors for depression (e.g., a history of trauma, intimate partner violence, or discrimination) which further increases their risk of depression symptoms, which, if actualized, leads to further health disparities (90).

For persons living with low income, perinatal depression can go undetected (9, 90). This may be due to missed prenatal or postpartum visits caused by related factors such as the financial costs of transportation or child care. For similar reasons, persons who screen positive for perinatal depression risk may not attend follow-up visits and receive treatment, if indicated. Additionally, they may fear discrimination or stigma if identified as having perinatal depression.

An important limitation of a screening tool for perinatal depression for persons with social inequities such as low income is the tool's focus on depression symptoms only (9). As such, screening tools do not incorporate other relevant factors, such as social inequities, in their determination of risk for depression. Instead, for those facing social inequities, an approach to screening may be indicated that includes recognition of intersecting risk factors and barriers, such as low income. Comprehensive care approaches for perinatal depression are needed that recognize the complex needs of the person; mental health services and supports that are multi-factorial and are offered proactively with input from consumer users can better ensure that persons' needs and barriers to care are addressed (9). For example, in addition to mental health services and supports for depression, a program might also provide food vouchers, bus tickets, on-site child care, advocacy, and support (9).

Refugees

Compared to Canadian-born women, refugees have a significantly increased risk of screening positive for postpartum depression (209). A prospective **cohort study**^G found a prevalence of 11 per cent for refugees with postpartum depression symptoms, second highest to asylum seekers (209). Refugees in the postpartum period had additional risk factors for depression including experiences of abuse or trauma, separation from family members or social inequities (e.g., abuse or trauma, lacking social supports due to family members left behind) or who experienced social inequities (e.g., food insecurity, discrimination, or reduced access to health care) (209 - 210). In response, nurses and the interprofessional team must routinely screen refugees for depression symptoms and advocate for increased access to health care (209). As social support and having a sense of belonging to a community are identified as positive protective factors against postpartum depression, encouraging psychosocial support may also be effective.

Transgender Persons

Transgender persons include those whose gender identity or expression does not align with their gender assignment at birth and who may identify as non-binary (i.e., neither masculine nor feminine) (4). Transgender persons can be at higher risk for perinatal depression due to their unique social context as individuals and as parents (4). Depression symptoms may worsen with persistent stigma, transphobia, discrimination, judgment, bullying, or other forms of oppression as a pregnant person or as a new parent (4, 211). These risk factors indicate a need for screening and treatment as indicated (4). Nurses and the interprofessional team must remain vigilant for an increased risk of depression and suicide for transgender persons due to factors such as lack of social supports, discrimination, assault, loneliness, and lack of trained health-care providers (211).

Cultural Considerations

An understanding of culture is important as perinatal depression is a global mental health concern (212). The prevalence of perinatal depression varies widely across cultures, from 0 to 60 per cent (213). Very low prevalence rates are cited in countries such as Malaysia, Malta, Austria, and Denmark (213); in contrast, a high prevalence of perinatal depression is reported in countries such as Brazil, Italy, Chile, Costa Rica, and South Africa (213). Overall, more knowledge is needed to better understand the prevalence, experience, and needs of pregnant and postpartum persons with perinatal depression globally.

Symptoms of depression are expressed differently across cultures, with the meaning given to depression by persons and their community varying (213). For instance, some cultures have no words for perinatal depression (214). In cultures that are reluctant to report symptoms, lower cut-off scores for screening tools may be used. It is essential that when a screening tool for perinatal depression is used, it is one that has been validated in the language spoken and read by the person (where applicable) (61, 213). For example, the EPDS has been translated in several languages (e.g., Chinese, Dutch, French, and Punjabi) (215). See [Appendix J](#) for the French translation of this screening tool.

Although perinatal depression has similar characteristics worldwide, there can be differences in perception and experiences of depression that are embedded in culture (208, 216). Culture can shape variables such as how roles, community supports, and rituals are defined and the status and importance given to mental health (216). This suggests an association between perinatal depression and cultural factors that can either mitigate, neutralize, or increase risk (212). For example, persons from developing countries, where psychological issues are often ignored, typically do not reach out for treatment (216).

In traditional cultures, as defined in the evidence as ones where reproduction is of utmost importance and becoming a parent gives a person status, there can be little acceptance of mental illness and perinatal depression and reported prevalence rates are low (217). Traditional cultures may buffer against perinatal depression symptoms due to strong religious practice and faith or clear and distinct social roles in families and communities (212, 216). Nonetheless, close ties among a family and community can also exacerbate depression symptoms in cases where persons experience shame, guilt, or incompetence in their role of parenting (212).

Western societies promote individualistic responsibility; as such, pregnant and postpartum persons may experience social isolation related to urbanization and fragmented families (216). This can predispose persons to an increased risk of depression (216). A shift in attention to the infant in the postpartum and less on the person can be another risk factor related to Western culture.

In response, it is important that nurses and the interprofessional team integrate a culturally sensitive approach and have an awareness of the person's culture and its effect on perinatal depression treatment and recovery (212). Persons, their families, and communities need to be aware of perinatal depression and how cultural factors may create challenges or opportunities for perinatal depression care. This awareness may help persons, especially those with low prevalence due to traditional cultures, feel supported to reach out and utilize perinatal depression services and supports, where needed (212). Education on depression symptoms can support the recognition of perinatal depression as a serious health concern (216).

Perinatal Depression in Male Partners

Male partners can also experience partner or paternal depression during the perinatal period (218). The estimated prevalence is 10 per cent, but is often underestimated; other sources report a prevalence of up to 25 per cent (218 - 219). The strongest predictor of paternal depression includes a partner experiencing perinatal depression or a personal history of depression or anxiety. Other risk factors identified in the evidence include unemployment, a lack of social support, older age, financial stressors, incongruence between parenting expectations and realities, and feelings of exclusion from infant bonding. The impact of paternal depression includes a negative relationship with the partner, infant, and other children, where applicable. Work performance also can be adversely affected (218 - 219).

The EPDS has been recognized as a suitable screening tool for paternal depression, but with a lower cut-off score, in comparison to maternal levels. This is due to gender differences in the expression of depression symptoms; in particular, tearfulness is not frequently reported by fathers, and, as such, reduces their total EPDS scores (218 - 219).

Signs and symptoms of paternal depression may include an increased likelihood to spank their child, use alcohol and/or drugs, express anger and cynicism, and experience somatic symptoms, including headaches, insomnia, or nausea (218 - 219).

Beyond screening, prevention and interventions are indicated from the evidence. Prevention strategies that have been found to be effective include education and attending support groups, particularly from a male facilitator. Interventions for paternal depression include CBT, group therapy, and peer support (218 - 219).

The evidence supports a need for recognition, assessment, education (including anticipatory guidance), prevention, treatment, and evaluation of paternal depression (218 - 219). Paid paternal leave and mental health services for paternal depression are also indicated to promote improved outcomes for the father and the family unit (218 - 219).

As a prevention strategy, a scoping review on promoting postpartum mental health in fathers using tailored, gender-specific includes the following recommendations:

- Organize or facilitate access to postpartum sessions geared to fathers during times that accommodate work schedules, where possible, to encourage attendance.
- Offer father-focused sessions to enhance their relationship and to provide an environment that promotes peer support.
- Offer educational sessions using less formal, more practical group formats as evidence suggests these are preferred by fathers as an environment for learning. Topics can include infant care, stress-reducing activities, and healthy lifestyle.
- Promote peer and online resources, especially to first-time fathers (220).

Appendix E: Examples of Perinatal Depression Screening Tools

The perinatal depression screening tools included in **Table 13** are some that have been identified from the evidence-based literature, but the list is not exhaustive. The table outlines a description of the components of each screen and whether it is specific to perinatal depression.

Components of screening tools for perinatal depression vary (56). Many screening tools incorporate a series of statements reflecting different signs or symptoms of depression and persons are asked to rank their symptoms. For example, the EPDS can be used to determine increased risk for depression and uses a self-rated listing of symptoms including feelings of guilt, hopelessness, sadness, lack of concentration, irritability, loss of interest in usual activities, thoughts of self-harm or suicide, as well as physical symptoms such as fatigue and changes in appetite (56). A synthesis of evidence on postpartum depression that included a value analysis found the use of the EPDS as beneficial resulting in improved mental health in comparison to standard care, although all of the studies did not demonstrate statistical significance (59).

Screening tools support nurses and the interprofessional team in obtaining specific clinical information about the person's possible depression symptoms. This, in turn, informs the next steps of assessment and development of the care plan in conjunction with the person. It is important to note that the screening tools listed are never diagnostic in nature. In cases where the nurse or member of the interprofessional team is unfamiliar with a tool, the expert panel recommends that the provider seeks out appropriate support from his or her organization or consult with an expert.

Table 13: Examples of Perinatal Depression Screening Tools

SCREENING TOOL	DESCRIPTION	SPECIFIC TO PERINATAL DEPRESSION?
<p><i>Edinburgh Postnatal Depression Scale (EPDS)</i> (Cox, Holden, & Sagovsky, 1987)</p>	<ul style="list-style-type: none"> ■ Widely recommended as a first stage screening instrument. ■ The most commonly used instrument for perinatal depression screening. ■ A 10-item scale asking persons to rate emotional depressive symptoms over past seven days. ■ Has been validated for use with both pregnant and postpartum persons up to one year following childbirth. ■ The total score reflects the probability of depression, but not the severity. ■ A total score of 9 – 10 has a positive predictive value (PPV) (i.e., the proportion of positive and negative results in statistics that are true positive and true negative results) of 9 – 64 per cent for major depression; a total score of 12 – 13 has a PPV of 17 – 100 per cent (SIGN, 2012, p. 13). ■ Available publicly at no cost. ■ Written for a grade three level of education. ■ Tested among various cultures to determine cut-off scores and associated sensitivity and specificity levels. ■ Translated into many languages. ■ Includes three items—(i.e., blame self unnecessarily, been anxious or worried for no good reason, and felt scared or panicky for no very good reason)—that have been validated as a subscale for anxiety (Birmingham et al., 2011). These same three items are found to perform as well as the full screen, with 100 per cent sensitivity as a modified and condensed screen based on findings of a cross-sectional study^G (54). ■ See Appendices I, J, and K for the EPDS tool, French translation and the administration and interpretation of the tool. 	<ul style="list-style-type: none"> ■ YES ■ Can be used to screen both prenatal and postpartum depression

SCREENING TOOL	DESCRIPTION	SPECIFIC TO PERINATAL DEPRESSION?
<i>Beck Depression Inventory (BDI)</i> (Beck, Steer, Brown, 1996)	<ul style="list-style-type: none"> ■ A self-reported screening tool with 21 items to rate symptoms and symptom severity over the previous two weeks. ■ Symptoms rated using categories of minimal/mild/moderate/severe to reflect intensity. ■ Well validated. ■ Features 100 percent sensitivity to capture all persons at increased risk. ■ Must be purchased to access. ■ Available in a variety of languages, including English, Chinese, German and Japanese 	<ul style="list-style-type: none"> ■ NO ■ Measures general symptoms of depression
<i>Centre for Epidemiological Studies–Depression Scale (CES-D)</i> (Radloff, 1977)	<ul style="list-style-type: none"> ■ A structured and self-administered questionnaire with 20 items and a Likert-type scale to measure the frequency of depression symptoms. ■ Commonly used during pregnancy. 	<ul style="list-style-type: none"> ■ NO ■ Measures general symptoms of depression
<i>Patient Health Questionnaire -9 (PHQ-9)</i> (Kroenke, Spitzer, Williams, 2001).	<ul style="list-style-type: none"> ■ A validated screening tool for depression with high sensitivity and specificity in pregnant and postpartum persons. ■ Tool measures depressive symptom severity as indicated by the total score with the following categories: minimal (score 1-4), mild (score 5-9), moderate (score 10 – 14), moderately severe (score 15 – 19) and severe (20 – 27). 	<ul style="list-style-type: none"> ■ NO ■ Measures depression symptom severity
<i>Postpartum Depression Screening Scale™</i> (Beck & Gable, 2002)	<ul style="list-style-type: none"> ■ A self-rated 35-item scale of 7 different domains (sleep and appetite, anxiety/insecurity, emotional lability, loss of self-esteem, cognitive impairment, guilt/shame, and suicidal thoughts). ■ An abbreviated 7-items scale is also available. ■ An effective screening tool to identify postpartum depression and the level of depression symptoms. ■ Includes introspective concerns (e.g., self-esteem, guilt, and shame) 	<ul style="list-style-type: none"> ■ YES, ■ Only for postpartum depression

SCREENING TOOL	DESCRIPTION	SPECIFIC TO PERINATAL DEPRESSION?
<p>Whooley Scale (Whooley, Avins, Miranda, & Brownder, 1997)</p>	<ul style="list-style-type: none"> ■ Used as a first stage to identify perinatal depression. ■ A two question binary (Yes / No) scale to screen for perinatal depression, with a follow-up question (Question 3) in the event that the person indicates ‘Yes’ to either of the first two questions. ■ Question 1: During the past month, have you often been bothered by feeling down, depressed, or hopeless? ■ Question 2: During the past month have you often been bothered by little interest or pleasure in doing things? <ul style="list-style-type: none"> □ In the event that the person answers “Yes” to either of these questions, a third question can be asked as follows: ■ Question 3: Is this something you feel you need or want help with? ■ Has consistent high sensitivity and moderate specificity. ■ Capable of ruling out depression for those who respond “No” to both questions. ■ Considered a positive screen for depression if the person answers yes to one or both of the first two questions. 	<ul style="list-style-type: none"> ■ NO ■ Measures general symptoms of depression

Sources: Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *Br J Psychiatry*. 1987; 150:782–786; Beck AT, Steer RA, Brown GK. Manual for the Beck Depression Inventory-II. San Antonio, TX: Psychological Corporation; 2009; Radloff LS. The CES-D Scale: A self-report depression scale for research in the general population. *Applied Psychol Measurement*. 1977;1(3):385–401; Kroenke K, Spitzer R, Williams J. The PHQ-9: validity of a brief depression severity measure. *J Gen Intern Med*. 2001;16:606-613; Beck C, Gable RK. Postpartum Depression Screening Scale™ (PDSS™). Torrance, CA: Western Psychological Services (WPS); 2002; Whooley MA, Avins AL, Miranda J, et al. Case-finding instruments for depression: Two questions are as good as many. *J Gen Intern Med*. 1997;12(7):439–445.

Appendix F: Examples of Perinatal Depression Assessment Tools

Examples of assessment tools for perinatal depression varied in the evidence (40, 56, 65). These tools were developed to assess pregnant persons for the presence of psychosocial risk factors associated with perinatal mental health disorders, including depression (65). However, there is insufficient evidence that supports or refutes the use of a psychosocial assessment tool in the assessment of perinatal depression (40). Examples of assessment tools are listed in **Table 14**.

Table 14: Examples of Perinatal Depression Assessment Tools

ASSESSMENT TOOL	DESCRIPTION	SPECIFIC TO PERINATAL DEPRESSION?
<i>Generalized Anxiety Disorder 7-item (GAD-7) Scale (Spitzer, Kroenke, Williams, Lowe, 2006).</i>	<ul style="list-style-type: none"> ■ Assesses symptoms and severity of anxiety over the past two weeks. ■ Anxiety may be a component of depression symptoms. Available from: https://patient.info/doctor/generalised-anxiety-disorder-assessment-gad-7 	<ul style="list-style-type: none"> ■ NO ■ Measures general symptoms of anxiety
<i>The Antenatal Psychosocial Health Assessment (ALPHA) (Reid, Biringer, Carroll, et al., 1998).</i>	<ul style="list-style-type: none"> ■ Assesses the following factors: <ol style="list-style-type: none"> 1. the person’s family, 2. their clinical history, 3. substance use, and 4. history of family violence. ■ Available from: http://www.cmaj.ca/content/cmaj/159/6/677.full.pdf and https://ocfp.on.ca/docs/default-source/cme/alpha_formfeac6c2a6831.pdf?sfvrsn=0 	<ul style="list-style-type: none"> ■ YES ■ Measures psychosocial risk factors for mental illness ■ To be used during the prenatal period

ASSESSMENT TOOL	DESCRIPTION	SPECIFIC TO PERINATAL DEPRESSION?
<p><i>The Antenatal Psychosocial Health Assessment (ALPHA) Self-report Questionnaire for Women (Reid, Biringner, Carroll, et al., 1998).</i></p>	<ul style="list-style-type: none"> ■ The ALPHA Self-report Questionnaire assesses the following factors: <ol style="list-style-type: none"> 1. the person’s family life (e.g., family factors, recent life stresses, and relationship with their partner), and 2. their own life (e.g., feelings about being pregnant, relationship with their partner and their parents, feelings about becoming a parent and raising a child, emotional health, and alcohol and drug use). ■ The ALPHA tool has a low sensitivity and is unable to predict depression in the majority of persons. However, it may facilitate communication with persons regarding personal matters and therefore, improve clinical care outcomes. Available from: https://pdfs.semanticscholar.org/11cd/5aa10ba7be0c03214c09ac451d79d5fa3ff9.pdf 	<ul style="list-style-type: none"> ■ YES ■ Measures psychosocial risk factors for mental illness ■ To be used during the prenatal period
<p><i>The Antenatal Risk Questionnaire (ANRQ) (Austin, Colton, Priest, et al., 2013).</i></p>	<ul style="list-style-type: none"> ■ A highly acceptable self-reported psychosocial tool which, when used in combination with a symptoms-based screening tool (e.g., EPDS), can be useful for early identification of risk of mental illness. Available from: https://www.ncbi.nlm.nih.gov/pubmed/21764399 	<ul style="list-style-type: none"> ■ YES ■ Valid for use during pregnancy, but not postpartum

Sources: Kroenke K, Spitzer RL, Williams JB. The PHQ-9: Validity of a brief depression severity measure. *J Gen Intern Med.* 2001;16(9):606-613; Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097; Reid AJ, Biringner JD, Carroll D, et al. Using the ALPHA form in practice to assess antenatal psychosocial health. *CMAJ.* 1998;159(6):677-684; Austin MP, Colton J, Priest S, et al. The Antenatal Risk Questionnaire (ANRQ): Acceptability and use for psychosocial risk assessment in the maternity setting. *Women Birth.* 2013;26:17-25.

- To support the diagnosis of perinatal depression as a major depressive disorder with a peripartum onset, the Structured Clinical Interview for DSM-5 (SCID-5) is administered by trained mental health professionals familiar with the DSM-5 diagnostic criteria (29). The SCID-5 is a semi-structured interview guide and is available for purchase through the American Psychiatric Association (29).

Appendix G: Additional Considerations for Perinatal Depression Screening

Health-care organizations need to determine which screening tool to use for perinatal depression in the practice setting so that they can identify and monitor symptoms consistently when screening. Examples of screening tools from the literature used in the detection of perinatal depression are listed in [Appendix E](#) (Examples of Perinatal Depression Screening Tools).

In order to screen effectively for perinatal depression, nurses and the interprofessional team must use screening tools that are recognized for their **reliability**^G and validity, and that have been tailored to detect depression symptoms during pregnancy or postpartum (53, 61, 221). Examples of screening tools frequently identified in the reviewed evidence are presented in [Appendix E](#); they reflect tools designed to be used either during the perinatal period or across the adult lifespan.

The following are key considerations when appraising the suitability of perinatal depression screening tools for an organization: scope, cut-off score, the timing of the screen, and feasibility and acceptability.

Scope

In general, many screening tool scores do not correlate with a degree of severity of illness, as this is beyond the scope of the tool. Instead, the total score—as it relates to the cut-off score—is a measure of the likelihood of depression, with higher scores suggesting an increased risk and need for further assessment or follow-up (214). **A screen is only a tool: it never replaces clinical judgment.**

Cut-off Score

All screening tools have a corresponding cut-off score that indicates a positive or negative result and whether further assessment is indicated (61). Users of screening tools need to be mindful of how the cut-off scores influence outcomes. In general, higher cut-off scores or thresholds generally demonstrate increased sensitivity, where persons who are at an increased risk were more likely to be identified. Conversely, screening tools with low cut-off scores have a tendency towards higher false positives, where persons who are not at an increased risk are more likely to screen above the cut-off score and are recommended for further assessment or treatment (61). Variances in the rates of sensitivity (i.e., true positives) and specificity (i.e., true negatives) for screening tools for perinatal depression reflect differences in methodology, cut-off thresholds, diagnostic criteria, and timing of the intervention (214). False positives are recognized as concerning for persons, nurses, and the interprofessional team. Persons may be erroneously identified as depressed, receive unnecessary treatments, and feel stigmatized. This results in added demands for mental health services and supports and subsequent longer wait times (61).

The Timing of the Screen

There is limited evidence examining the optimal frequency and timing of screening for perinatal depression and the findings are inconsistent as indicated by examples from the following organizations:

- The Canadian Pediatric Society (CPS) recommends that physicians remain alert to any signs of postpartum depression and encourage the parent to contact their primary care provider or mental health services and supports (225). This approach reflects the CPS' lack of consensus on screening criteria or screening tool and concerns regarding the potential burden of false positives, limited benefits of screening to only those who have access to treatment, and a lack of sustained benefits established in the evidence.
- The American Academy of Pediatricians (AAP) support screening routinely for risk and protective factors for postpartum depression (224). The AAP recognizes that pediatricians have a longitudinal relationship with families providing care over many years by providing them with multiple opportunities for screening to support the healthy development of the child (224).
- The American Congress of Obstetrics and Gynecology recommend routine screening for depression a minimum of once during the perinatal period using a standard validated tool (223).

Examples from the evidence also reflect diverse approaches regarding the timing and frequency of screening. These include:

- According to the SIGN guideline *Management of Perinatal Mood Disorders*, regular screening of postpartum depression symptoms is recommended at the first visit, at four to six weeks, and at three to four months (62). This allows for multiple screenings and opportunities for persons to disclose any concerns they have regarding changes in mood and to identify those developing depression symptoms during the postpartum period.
- A longitudinal study examining the prevalence of postpartum depression during the first twelve months found screening on a monthly basis to be beneficial (226). The highest rate of positive screens was between six to twelve months, with twelve months having the highest prevalence. Consistent with other studies, predictors of a positive screening for postpartum depression were low levels of income and education attainment.
- A study to determine the optimal time of screening for perinatal depression in order to facilitate timely referral and access to services and supports found that screening immediately post-birth, versus prenatally or at six weeks postpartum, was most effective as the study participants were still admitted to the acute care setting following birth and had not yet been discharged (53). In non-tertiary health-care facilities that lack on-site mental health services and supports, the researchers recommended developing a screening algorithm and implementing regular perinatal depression screening at 36 weeks, following delivery, and at two and six weeks postpartum, to optimize the detection of depression for those at risk.

Despite these findings, more empirical evidence is needed to determine best practices regarding the timing of screening for perinatal depression.

Feasibility and Acceptability of Perinatal Depression Screening

The feasibility of perinatal depression screening is well-documented in the evidence across a variety of clinical settings, including primary and acute care, community health centres, and public health units (59, 227 - 228). A person's home is another possible venue for screening, with services and supports provided using different formats such as in-person, by telephone, via the Internet, and through mailed questionnaires, assuming the available time, space, privacy, and appropriate follow-up are available, where indicated (58, 227 - 229). A person's place of residence may be preferred for screening versus a clinic that may be a rushed and less private environment, suggesting that location may influence acceptability (230).

Screening is deemed acceptable overall to most pregnant and postpartum persons, members of the interprofessional team, and the general public when conducted by trained and compassionate health-care providers and when valid screening tools are used (5, 227, 230). Universal screening is perceived as a strategy to reduce the stigma associated with mental illness following detection (227). Acceptance of screening recognizes perinatal depression as a mental illness that is treatable and that affects the person and their family. Other positive secondary outcomes of screening include increased awareness of perinatal depression, reduced stigma towards, and appreciation for the opportunity to talk about emotional responses to becoming a parent and role transitioning (230). However, others may prefer the option of flexible approaches to disclosing any concerns regarding emotional health (as opposed to having to complete a particular screening tool at a set time in care) as the approach of using only one screening tool may be seen as a barrier to accessing follow-up care and resources (227).

Acceptability of screening was also influenced by the approach taken by the health-care provider (230). The following approaches were found to be beneficial:

- Recognition that screening is not solely the administration of the tool but rather a mechanism for discussing more broadly perinatal depression.
- Health-care providers who are sensitive to the needs of the person completing the screen and are not intimidating or judgmental and ensure sufficient time allotted for discussion.
- Health-care providers who explain the rationale for screening.
- The person's screening results are explained and any indicated follow-up assessments and referrals are accessible and conducted in a timely manner.

Appendix H: Responding to an Identified Risk of Maternal Suicide

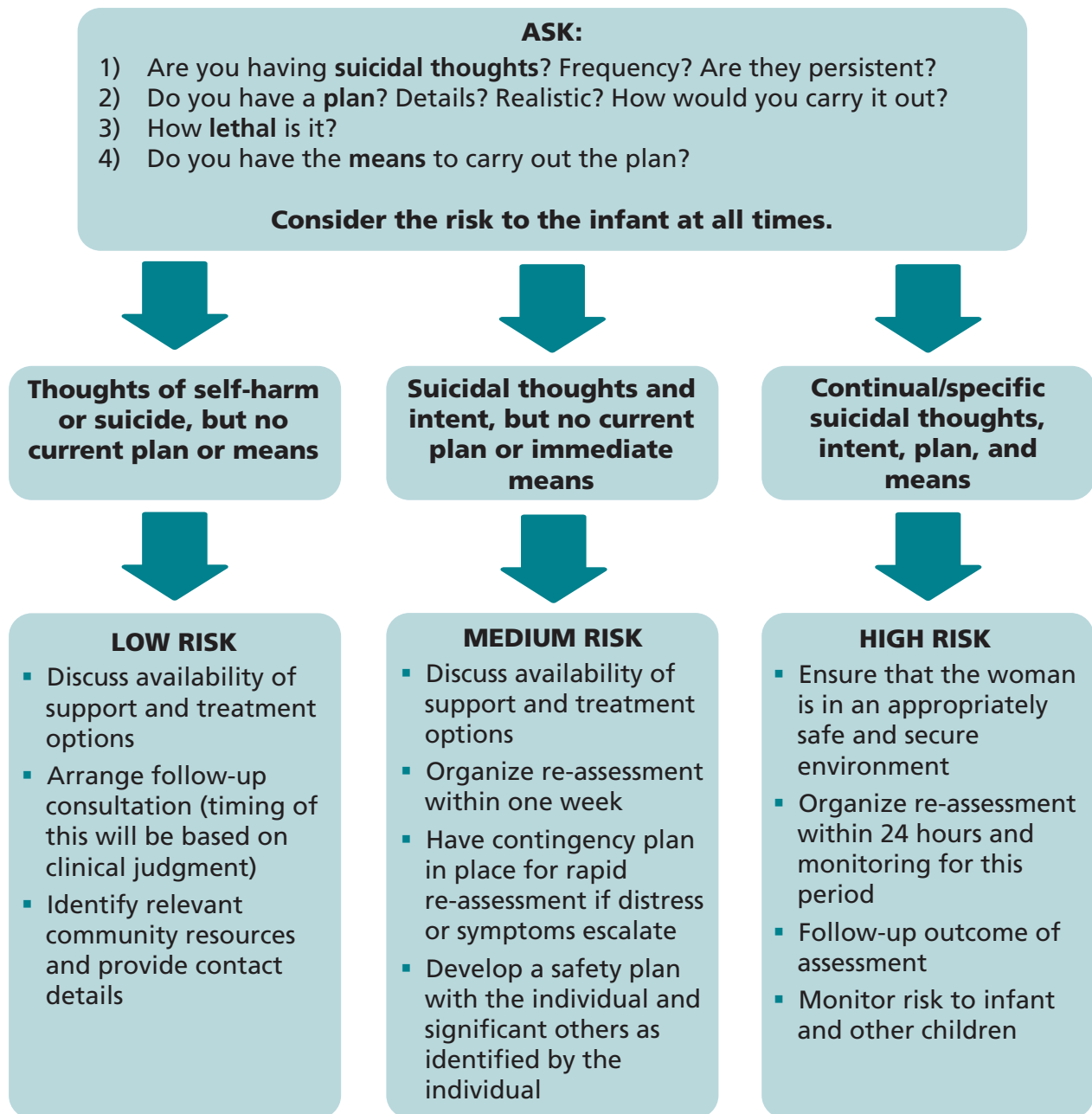
Suicidal ideation should be part of an assessment for perinatal depression. This includes any active suicidal thoughts (e.g., thoughts about hurting oneself) or passive ones (e.g., thoughts of going to sleep and not waking up). Homicidal ideation (i.e., thoughts, considerations or plans of killing another person) should also be explored. In the event that either suicidal or homicidal ideation is identified, emergency psychiatric evaluation is warranted (231). Death by suicide in the perinatal period is a more common cause of mortality than either postpartum hemorrhage or hypertensive disorders; up to 11 per 100,000 births (231).

Assessment of suicide risk may include the following components:

- Questions about the person's access to weapons.
- Current drug or alcohol use.
- Immediate plans to self-harm.
- History of person's suicide attempts (143).
- The results of a suicide assessment can determine the level of risk and indicate where urgent consultation with a mental health specialist is indicated. Protocols are needed for each level (143). In cases where a person reports suicide risk, they need to be reported immediately to the provider who completed the screen (if not the same individual) (143).

Figure 6 represents some general principles for responding to suicidal thoughts or ideation. Care and referral pathways must be adapted to individual circumstances and local resources and informed by clinical judgment. Additional resources and best practice recommendations can be found in the 2009 RNAO BPG *Assessment and Care of Adults at Risk for Suicidal Ideation and Behaviour*, available at <http://RNAO.ca/bpg/guidelines/assessment-and-care-adults-risk-suicidal-ideation-and-behaviour>

Figure 6: Responding to an Identified Risk of Maternal Suicide



Source: Adapted from Beyondblue. Clinical practice guidelines for depression and related disorders—anxiety, bipolar disorder and puerperal psychosis—in the perinatal period. A guideline for primary care health professionals. Melbourne (AU): Beyondblue; 2011, p. 32.

Appendix I: Edinburgh Postnatal Depression Scale

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed:

I have felt happy:

- Yes, all the time No, not very often
 Yes, most of the time No, not at all

This would mean “I have felt happy most of the time” during the past week. Please complete the other questions in the same way.

In the past 7 days:

- | | | |
|--|---|--|
| <p>1. I have been able to laugh and see the funny side of things:</p> <p><input type="checkbox"/> As much as I always could
 <input type="checkbox"/> Not quite so much now
 <input type="checkbox"/> Definitely not so much
 <input type="checkbox"/> Not at all</p> | <p>4. I have been anxious or worried for no good reason:</p> <p><input type="checkbox"/> No, not at all
 <input type="checkbox"/> Hardly ever
 <input type="checkbox"/> Yes, sometimes
 <input type="checkbox"/> Yes, very often</p> | <p>*7. I have been so unhappy that I have had difficulty sleeping:</p> <p><input type="checkbox"/> Yes, most of the time
 <input type="checkbox"/> Yes, sometimes
 <input type="checkbox"/> Not very often
 <input type="checkbox"/> No, not at all</p> |
| <p>2. I have looked forward with enjoyment to things:</p> <p><input type="checkbox"/> As much as I ever did
 <input type="checkbox"/> Rather less than I used to
 <input type="checkbox"/> Definitely less than I used to
 <input type="checkbox"/> Hardly at all</p> | <p>*5. I have felt scared or panicky for no very good reason:</p> <p><input type="checkbox"/> Yes, quite a lot
 <input type="checkbox"/> Yes, sometimes
 <input type="checkbox"/> No, not much
 <input type="checkbox"/> No, not at all</p> | <p>*8. I have felt sad or miserable:</p> <p><input type="checkbox"/> Yes, most of the time
 <input type="checkbox"/> Yes, quite often
 <input type="checkbox"/> Not very often
 <input type="checkbox"/> No, not at all</p> |
| <p>*3. I have blamed myself unnecessarily when things went wrong:</p> <p><input type="checkbox"/> Yes, most of the time
 <input type="checkbox"/> Yes, some of the time
 <input type="checkbox"/> Not very often
 <input type="checkbox"/> No, never</p> | <p>*6. Things have been getting on top of me:</p> <p><input type="checkbox"/> Yes, most of the time I haven't been able to cope at all
 <input type="checkbox"/> Yes, sometimes haven't been coping as well as usual
 <input type="checkbox"/> No, most of the time I have coped quite well
 <input type="checkbox"/> No, I have been coping as well as ever</p> | <p>*9. I have been so unhappy that I have been crying:</p> <p><input type="checkbox"/> Yes, most of the time
 <input type="checkbox"/> Yes, quite often
 <input type="checkbox"/> Only occasionally
 <input type="checkbox"/> No, never</p> |
| | | <p>*10. The thought of harming myself has occurred to me:</p> <p><input type="checkbox"/> Yes, quite a lot
 <input type="checkbox"/> Yes, sometimes
 <input type="checkbox"/> No, not much
 <input type="checkbox"/> No, not at all</p> |

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Appendix J: Échelle de dépression postpartum d'Edinburgh

Vous venez d'avoir un bébé. Nous aimerions savoir comment vous vous sentez. Nous vous demandons de bien vouloir remplir ce questionnaire en soulignant la réponse qui vous semble le mieux décrire comment vous vous êtes sentie durant la semaine (c'est-à-dire sur les 7 jours qui viennent de s'écouler) et pas seulement au jour d'aujourd'hui:

Voici un exemple:

Je me suis sentie heureuse:

- Oui, tout le temps Non, pas très souvent
 Oui, la plupart du temps Non, pas du tout.

Ceci signifiera "je me suis sentie heureuse la plupart du temps durant la semaine qui vient de s'écouler". Merci de bien vouloir répondre aux autres questions.

Pendant la semaine qui vient de s'écouler

1. J'ai pu rire et prendre les choses du bon côté:

- Aussi souvent que d'habitude
 Pas tout-à-fait autant
 Vraiment beaucoup moins souvent ces jours-ci
 Absolument pas

2. Je me suis sentie confiante et joyeuse, en pensant à l'avenir:

- Autant que d'habitude
 Plutôt moins que d'habitude
 Vraiment moins que d'habitude
 Pratiquement pas

*3. Je me suis reprochée, sans raisons, d'être responsable quand les choses allaient mal:

- Oui, la plupart du temps
 Oui, parfois
 Pas très souvent
 Non, jamais

4. Je me suis sentie inquiète ou soucieuse sans motifs:

- Non, pas du tout
 Presque jamais
 Oui, parfois
 Oui, très souvent

*5. Je me suis sentie effrayée ou paniquée sans vraiment de raisons:

- Oui, vraiment souvent
 Oui, parfois
 Non, pas très souvent
 Non, pas du tout

*6. J'ai eu tendance à me sentir dépassée par les événements:

- Oui, la plupart du temps, je me suis sentie incapable de faire face aux situations
 Oui, parfois, je ne me suis pas sentie aussi capable de faire face que d'habitude
 Non, j'ai pu faire face à la plupart des situations
 Non, je me suis sentie aussi efficace que d'habitude

*7. Je me suis sentie si malheureuse que j'ai eu des problèmes de sommeil:

- Oui, la plupart du temps
 Oui, parfois
 Pas très souvent
 Non, pas du tout

*8. Je me suis sentie triste ou peu heureuse:

- Oui, la plupart du temps
 Oui, très souvent
 Pas très souvent
 Non, pas du tout

*9. Je me suis sentie si malheureuse que j'en ai pleuré:

- Oui, la plupart du temps
 Oui, très souvent
 Seulement de temps en temps
 Non, jamais

*10. Il m'est arrivé de penser à me faire du mal:

- Oui, très souvent
 Parfois
 Presque jamais
 Jamais

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Appendix K: Administration and Interpretation of the Edinburgh Postnatal Depression Scale

The EPDS can be administered to women who are pregnant or have had a baby within the past year, and have been identified with depressive symptoms either subjectively or objectively.

Instructions for the administration of the EPDS:

1. The EPDS may be administered in person.
2. Efforts should be made to have the mother complete the scale by herself, where she feels she can answer the questions honestly.
3. Mothers may need assistance with the EPDS if they have limited reading skills or understanding of the English language.
4. All 10 items on the questionnaire must be completed.
5. The mother or health-care professional should check the box of the response that best describes the mother's feelings in the last week.
6. The EPDS can be administered anytime during pregnancy and within one year postpartum.

Sample lead-in statements

Please be as open and honest as possible when answering these questions. It is not easy being a new mother and it is OK to feel unhappy at times. As you have recently had a new baby, we would like to know how you are feeling. Please state the answer which comes closest to how you have felt during the past several days, not just how you are feeling today.

Scoring of the EPDS

Each response is scored 0, 1, 2 or 3 based on the increased severity of the symptoms. Calculate the total score by adding together each of the 10 items.

QUESTIONS 1,2, & 4 (without an *) are scored 0, 1, 2 or 3 with the top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5 - 10 (marked with an *) are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30

Always look at item 10 (suicidal thoughts)

Interpretation of the EPDS

1. The EPDS score must be considered in combination with the assessment of the health-care provider.
2. A score of 13 or greater indicates the probable presence of depressive symptoms.
3. A score of 10 or more indicates possible depression.
4. The score does not reflect the severity of the symptoms.
5. Use caution when interpreting the score of mothers who are non-English speaking and/or use English as an additional language or are multicultural.
6. If a mother scores positive (1, 2 or 3) on self-harm item number 10, further assessment should be done immediately for self-harm ideation. Refer to **Appendix H** (Responding to an Identified Risk of Maternal Suicide) for examples of interventions in response to identified suicide risk.
7. Items 3, 4, and 5—(i.e., blame self unnecessarily, been anxious or worried for no good reason, and felt scared or panicky for no very good reason)—are validated as a subscale for anxiety.
8. Follow agency/institution protocol regarding scores.
9. Remember that the EPDS is only a tool. If your clinical judgment indicates differently than the EPDS, continue with the follow up as the assessment indicates.

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Appendix L: Additional Resources

The following is not an exhaustive list of resources, but rather a selection of resources identified within the systematic review, AGREE II-appraised guidelines, and by the expert panel or external stakeholder feedback. Inclusion in this list does not constitute an endorsement by RNAO.

Links to websites that are external to the RNAO are provided for information purposes only and are current at the time of publication. The RNAO is not responsible for the quality, accuracy, reliability, or currency of the information provided through these sources. Further, the RNAO has not determined the extent to which these resources have been evaluated. Questions related to these resources should be directed to the source.

SOCIAL DETERMINANTS OF HEALTH	
Registered Nurses' Association of Ontario. Policy and political action. Social determinants of health. [Internet]. Toronto (ON): Registered Nurses' Association of Ontario; 2013.	www.rnao.ca/sdh
Centre for Effective Practice. Poverty: A clinical tool for primary care providers [Internet]. [place unknown]: Centre for Effective Practice; 2016.	https://thewellhealth.ca/poverty/
Canadian Centre on Substance Abuse. Trauma-informed care toolkit [Internet]. Ottawa (ON): Canadian Centre on Substance Abuse; 2014.	http://www.ccsa.ca/Resource%20Library/CCSA-Trauma-informed-Care-Toolkit-2014-en.pdf#search=trauma%20informed%20toolkit
INDIGENOUS CARE	
BC Reproductive Mental Health Program. Celebrating the circle of life: Coming back to balance and harmony [Internet]. Vancouver (BC): BC Reproductive Mental Health Program; 2011.	http://www.perinatalervicesbc.ca/Documents/Resources/Aboriginal/CircleOfLife/CircleOfLifeIntro.PDF
Aboriginal Health Initiative Committee. First Nations, Inuit, and Métis maternal health. In: Aboriginal Health Initiative Committee. Health professionals working with First Nations, Inuit, and Métis consensus guideline. J Obstet Gynecol Canada. 2013;6(35):S33-S36.	
https://sogc.org/files/HealthProfessionalsWorkingWithFirstNations,Inuit,andMetisConsensusGuideline2013.pdf	

INDIGENOUS CARE	
Southwest Ontario Aboriginal Health Access Centre. Ontario Indigenous Cultural Safety Program [Internet]. Owen Sound (ON): Southwest Ontario Aboriginal Health Access Centre; 2014.	http://soahac.on.ca/ICS-training/
CARING FOR NEWCOMERS TO CANADA	
Best Start Resource Centre. Giving birth in a new land: Strategies for service providers working with newcomers [Internet]. Toronto (ON): Best Start Resource Center; 2009.	https://www.beststart.org/resources/rep_health/Newcomer_%20Guide_Final.pdf
Best Start Resource Centre. Growing up in a new land. Strategies for working with newcomer families [Internet]. Toronto (ON): Best Start Resource Center; 2010.	https://www.beststart.org/resources/hlthy_chld_dev/pdf/Growing_up_new_land_FINAL.pdf
MULTI-LANGUAGE PERINATAL DEPRESSION PRINT RESOURCES (FREE DOWNLOADS)	
Toronto. Emotional help during pregnancy and after birth [Internet]. Toronto (ON): City of Toronto; 1998 – 2018.	https://www.toronto.ca/community-people/children-parenting/pregnancy-and-parenting/pregnancy/during-pregnancy/emotional-health/
Postpartum Support International. Multi-language resources [Internet]. Portland (OR): Postpartum Support International; undated.	http://www.postpartum.net/professionals/multi-language-resources/
Office on Women’s Health. Postpartum depression [Internet]. Washington (DC): US Department of Health & Human Services; 2018.	https://www.womenshealth.gov/mental-health/mental-health-conditions/postpartum-depression

PERINATAL DEPRESSION ADVOCACY AND AWARENESS

<p>Postpartum Mood Disorder Project. Northern Ontario Postpartum Mood Disorder Project [Internet]. Nipissing (ON): Postpartum Mood Disorder Project; 2012-2015.</p>	<p>http://postpartumresource.com/</p>
<p>Ontario Agency for Health Protection and Promotion (Public Health Ontario), Mensah G, Singh T. Evidence brief: Exploring interventions to address perinatal mental health in a public health context. Toronto (ON): Queen’s Printer for Ontario; 2016.</p>	<p>https://www.publichealthontario.ca/en/eRepository/Evidence_Brief_Perinatal_Mental_Health_2017.pdf</p>
<p>National Perinatal Association. NPA advocacy [Internet]. Lonedell (MO): National Perinatal Association; 2016.</p>	<p>http://www.nationalperinatal.org/advocacy</p>

Appendix M: Description of *Toolkit*

BPGs can only be successfully implemented if planning, resources, and organizational and administrative supports are adequate and there is appropriate facilitation. To encourage successful implementation, an RNAO expert panel of nurses, researchers, and administrators has developed the *Toolkit: Implementation of Best Practice Guidelines, Second Edition* (1). The *Toolkit* is based on available evidence, theoretical perspectives, and consensus. We recommend the *Toolkit* for guiding the implementation of any clinical practice guideline in a health-care organization.

The *Toolkit* provides step-by-step directions for the individuals and groups involved in planning, coordinating, and facilitating guideline implementation. These steps reflect a process that is dynamic and iterative rather than linear. Therefore, at each phase, preparation for the next phases and reflection on the previous phase is essential.

The *Toolkit* specifically addresses the following key steps, as illustrated in the Knowledge-to-Action framework (149):

1. Identify the problem, and identify, review, and select knowledge (the appropriate BPG);
2. Adapt knowledge to the local context:
 - assess barriers and facilitators to knowledge use; and
 - identify resources
3. Select, tailor, and implement interventions.
4. Monitor knowledge use.
5. Evaluate outcomes.
6. Sustain knowledge use.

Implementing guidelines to effect successful practice changes and positive clinical impact is a complex undertaking. The *Toolkit* is one key resource for managing this process. It can be downloaded at www.RNAO.ca/bpg/resources/toolkit-implementation-best-practice-guidelines-second-edition

Endorsements



Association of
Ontario Midwives
Delivering what matters.

October 31, 2016

Doris Grinspun RN, MSN, PhD, LLD(hon), O.ONT.
Chief Executive Officer
Registered Nurses' Association of Ontario (RNAO)
158 Pearl Street
Toronto, ON
M5H 1L3

Dear Doris,

On behalf of the Association of Ontario Midwives (AOM), I am pleased to convey AOM's endorsement of RNAO's timely, comprehensive Best Practice Guideline, *Assessment and Interventions for Perinatal Depression, Second Edition*. With its evidence-based focus on the importance of clinical care for persons at risk for, or developing perinatal depression, this guideline will benefit pregnant people and their families, nurses, other health-care providers, organizations, research, education, health-care policy and systems.

The AOM is the professional organization representing midwives and the practice of midwifery in the province of Ontario. There are more than 700 registered midwives in Ontario, serving communities in 100 clinics across the province. We work to promote the profession of midwifery and registered midwives as primary maternal care providers based on the principles of choice of birthplace, continuity of care, and informed choice. The RNAO BPG's evidence-based recommendations addressing perinatal depression in clinical practice is a knowledge translation document which will facilitate health care providers, their associations and advocacy groups, to work towards creating improved outcomes for those with perinatal depression. In this regard, we see this best practice guideline as an important contribution that will positively impact RNs and other health-care providers in delivering the highest quality of care to all clients/ patients.

We believe RNAO's Best Practice Guideline, *Assessment and Interventions for Perinatal Depression, Second Edition*, will assist us in improving the quality of care experienced by Canadians who use our health care services.

Best Regards,

Kelly Stadelbauer RN, BScN MBA
Executive Director, AOM

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April 6, 2017

Doris Grinspun, RN,MSN, PhD, LLD(hon), O.ONT
Chief Executive Officer
Registered Nurses' Association of Ontario
158 Pearl Street
Toronto, ON M5H 1L3

Letter of Endorsement - Perinatal Depression: Nursing Best Practice Guideline

Dear Dr. Grinspun,

The Canadian Association of Perinatal and Women's Health Nurses (CAPWHN) is pleased to offer our support for and endorsement of the Registered Nurses' Association of Ontario's (RNAO) newest edition of the guideline on perinatal depression. As you know, CAPWHN has a national mandate of promoting excellence in care to advance women's health, through leadership, education, advocacy, and collaboration. We believe *Assessment and Interventions for Perinatal Depression* is a high quality evidence-based guideline. It will be a helpful resource for nurses and other health-care providers in appropriately screening and assessing for perinatal depression, and providing the best possible care to pregnant and postpartum women and their families.

The overall themes and evidence-based recommendations in your best practice guideline are very much aligned with our own guiding principles. We commend RNAO on encouraging nurses and other health-care providers to advocate for informed choice and family-centred care for Canadian women, newborns, and families.

Sincerely,

Sharon Dore, RN PhD
President
Canadian Association of Perinatal and Women's Health Nurses

Canadian Association of Perinatal and Women's Health Nurses
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