

**No Need to Despair:
Evaluation of the Middlesex-London Health Unit
Postpartum Depression Program**



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Members of the Young Families and Infant and Family Development Teams

Team members participated in the development of tools and resources, participated in focus groups, and more importantly support postpartum women and their families in their everyday work.

Members of the Mother Reach Coalition

Coalition members participated in the development of tools and resources, service provider training and focus groups, and like those mentioned above, provide service postpartum women and their families in their everyday work. (Organizations affiliated with Mother Reach are listed on p. 25.)

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Media Resources

Special acknowledgement to *Surge Communications* of London, Ontario for developing resources for the mass media campaign, including posters, brochures, and a web site on a *pro bono* basis.

Abbreviations Used in this Report

CAS	Children’s Aid Society
ECD	Early Childhood Development
HBHC	Healthy Babies Healthy Children
ISCIS	Information Services for Children Information System
IFDT	Infant and Family Development Team
MLHU	Middlesex-London Health Unit
OEYC	Ontario Early Years Centre
PHN	Public Health Nurse
PPD	Postpartum Depression
RNAO	Registered Nurses Association of Ontario
RRFSS	Rapid Risk Factor Surveillance System
YFT	Young Families Team

Executive Summary

Introduction

This document is a summative evaluation of the Middlesex-London Health Unit (MLHU) Postpartum Depression Program. The program was conducted from April 2002 through December 2006. Key findings are presented below in terms of three program components: *service provider training and development, education and skill building, and community capacity building.*

Service Provider Training and Development

Evaluation Question: What was the impact of training and development on service providers' knowledge, skill and practice with respect to PPD screening, assessment, early intervention, treatment and community resources available?

Program activities included: identification, review and development of tools and resources for screening, assessment and intervention; development and distribution of resource kits for professionals; development and delivery of training sessions to Public Health Nurses (PHNs) and other service providers in the community; and development of standard protocols for assessment and decision-making around intervention.

Between 2003 and 2006, a total of 46 documented training sessions were held; 17 were for MLHU staff, 29 were for outside service providers. There were 1003 attendees at these sessions.

Internal (MLHU) Training

- Increase in explicit screening. Training sessions and provision of new tools and resources brought PPD to the forefront of the awareness of “triage nurses”¹, and made explicit screening for PPD a more routine

practice. Between May 2004 and June 2005, the percentage of contacts during which PHNs explicitly asked women at the 48-hour call if they were experiencing symptoms of PPD increased from 73% to 90%. The increase during home visits was from 84% to 94%. Triage nurses became more likely to use the recommended screening questions to assess a woman's risk status, although the questions were still asked in only about 20% of documented postpartum contacts.

- No standard practice. There was no standard approach taken by PHNs with screening and more formal assessment. PHN practice tended to vary by years of nursing experience and type of visit (one-time or ongoing). More experienced nurses tended to rely on intuitive nursing judgement more than a screening or assessment tool. Those PHNs conducting one-time visits tended not to formally screen, but rather to inform women about what to do if PPD symptoms should arise.
- Recognition of need for judicious approach due to stigmatization. Similar to dealing with issues of woman abuse, there was wide recognition of a need to be sensitive and judicious in approaching any mental health-related issue with women at risk for PPD. PHNs felt that depression is stigmatized and that women may fear being labeled and/or “losing their child” to the Children's Aid Society. PHNs felt that in some cultures depression is especially stigmatized, which may result in women masking symptoms.
- Need to better engage family physicians around PPD. PHNs found the response of some family physicians to women's concerns around PPD ranged from non-receptive to dismissive. Some physicians responded well to data derived from the Beck and/or Edinburgh PPD assessment tools.
- Assessment skills improved; need more resources for intervention and treatment. PHNs identified a shortage of intervention and treatment resources in the community. Some PHNs wanted additional training to provide appropriate counselling as well as permission to follow and support women for longer periods of time. Feedback given by

¹ Those PHNs who conduct routine postpartum contact through the 48-Hour Call and Home Visit, as part of the Healthy Babies Health Children Program.

PHNs during focus groups led to the development of additional tools and resources to guide screening, assessment and intervention.

External Training

- Mother Reach as a conduit for training. Training was extended to the community largely through the 23 different organizations represented on a coalition of PPD-related service providers in the health, social service, and education sectors, as well as community representatives, called *Mother Reach*.
- Direct and indirect training. Training was delivered directly to coalition members at regularly scheduled coalition meetings. Some of the sessions were conducted with a “train-the-trainer” intent, whereby participants were encouraged to share knowledge gained and tools and resources with their co-workers. Several coalition members acknowledged conducting repeated training sessions at their agencies.
- Special training and adaptation of organizational processes. In several instances, specifically tailored training sessions were delivered to agencies including the Children’s Aid Society and an Ontario Early Years Centre to address service needs relevant to their particular mandates. This training led to adapting organizational processes and or procedures in order to respond more effectively or appropriately to women suffering with or at risk of PPD.
- Additional training desired. Mother Reach coalition members largely agreed that their knowledge and skill, particularly with respect to screening and assessment had increased substantially through various training opportunities. Several members, particularly some PHNs and others affiliated with mental health service provider agencies, identified a need for additional training in specific interventions that have been found to be effective with women suffering with PPD.

Education and Personal Skills Development

Evaluation Question: What was the impact of the program on the target population, in terms of awareness and knowledge of PPD, PPD risk factors, signs and symptoms of PPD, and resources that are available in the community to support women at risk of or suffering with PPD?

Program activities included: the development of educational resources for distribution to members of the target population through various public health and other community-based channels including Prenatal Health Fairs, Well Baby Clinics and the *Let’s Grow* newsletter; the conducting of a mass media campaign; the enhancement the Prenatal Classes curriculum; and teaching by PHNs at the 48-Hour Call and Home Visits (routine postpartum contacts.)

Knowledge and Awareness of PPD Among Users of MLHU Perinatal Programs

Surveys of attendees of MLHU Prenatal Health Fairs, Well Baby Clinics and Prenatal Classes held early in the program (prior to concerted efforts were made to raise awareness) suggest that about 90% of the target population already had some awareness of PPD.

- Impact of the mass media campaign. There was no evidence that a mass media campaign conducted in October 2004 increased awareness or knowledge about PPD per se, however there was evidence that the campaign was *noticed* at the target-population level. About 52% of Well Baby Clinic clients that were surveyed reported observing information about PPD in mass media sources before the campaign, compared with 82% after the campaign. Nor was there a measurable impact on level of awareness and knowledge about PPD in the *general population* resulting from a second wave of radio and television spots that aired during the summer and fall of 2005, according to data collected through the Rapid Risk Factor Surveillance System (RRFSS). However, “visit” statistics from the Mother Reach web site suggest there was steadily increasing awareness about PPD throughout the course of the program. Therefore, if viewed as part of a broader

campaign to raise awareness and knowledge through a variety of channels and programs, mass media campaigns may still be considered valuable. The efficacy of an isolated media campaign, especially in terms of increasing *knowledge*, should not be overestimated.

- Impact of Prenatal Classes on awareness and knowledge of PPD risk factors and symptoms. All those who attended MLHU Prenatal Classes during a four-month period (July through November 2004) were asked to complete pre- and post-course questionnaires pertaining to knowledge and awareness of PPD and PPD resources. Based on questions that asked attendees to rate their level of awareness in general terms, the Prenatal Classes were effective at increasing awareness about PPD symptoms and risk factors. For example, the percentage that indicated they were “quite aware” or “very aware” of PPD symptoms increased from 9.5% to 38.6%. In terms of awareness of risk factors, the percentage increased from 6.8% to 43.8%. Similarly, the percentage that said they knew the difference between PPD and “the baby blues” increased from 55.8% to 94.1%. However, when asked to indicate, for example, what percent of new mother they believed suffer from PPD, almost the same proportion of attendees (about 30%) were able to identify the correct answer before as after completing the series of classes. Similarly, fewer than 40% of attendees knew how long a woman should wait before seeking help if the baby blues persisted, with no difference in ability to identify the correct answer before versus after completing classes. It may be concluded that Prenatal Classes were more effective at increasing awareness of PPD than specific knowledge about PPD risk factors and symptoms.
- Impact of Prenatal Classes on awareness of supportive resources. Prenatal Classes substantially increased attendees’ awareness of various supportive resources such as Public Health Nurse support, informational resources and counseling services. The percentage of attendees that said they were aware of a given resource increased by anywhere from 8.3% to 35.9%. However, with the exception of Public Health Nurse support, fewer than half of those completing the post-class questionnaire

indicated they were aware of the other resources. For example, only 21.8% indicated they were aware of available counseling services.

Awareness and Knowledge of PPD in the General Population

Data on awareness and knowledge of PPD among adults 18 years and older in Middlesex-London was collected through RRFSS throughout 2005 (N=1213). These findings present a “snapshot” of the level of awareness and knowledge about PPD in the general population as it stood during the third year of the program. Key RRFSS findings on PPD, which are considered generalizable to the population as a whole, are presented below and, where relevant, compared to findings from surveys of Prenatal Class attendees and Well Baby Clinic clients.

- Differences in awareness of PPD based on gender, age and language. Consistent with the baseline data gathered from aforementioned MLHU services, 89.9% ($\pm 1.7\%$) indicated they had heard the phrase “postpartum depression”. There were statistically significant differences based on gender, age and language, but none based on whether the respondent had children, household income, education, or urban versus rural place of residence. Women were more likely to be aware of PPD than men (95.2% compared with 83%). Younger adults (ages 18 to 24 years) at 73.9%, and to lesser degree older adults (65 years and older) at 85.9%, were less likely to be aware of PPD than those in the three intervening age categories (spanning ages 25 to 64 years) at 93% to 96%. People who speak English at home were more likely to be aware of PPD than those who speak another language at home (93% compared with 59.3%).
- Knowledge of PPD symptoms. Just over half of RRFSS respondents (54.1%) were able to name two or more symptoms of PPD. This was similar to the percent of Well Baby Clinic clients (50.1%) that were able to name two or more PPD symptoms. The ability to name two or more symptoms of PPD varied significantly by gender, age, household income, education and whether or not

respondents had children. Men, younger adults (18-24 years) and older adults (65 years and older), persons with household incomes under \$40,000, those with less schooling (especially those who had not completed high school), and those with no children, were somewhat less likely to be able to name two or more symptoms of PPD.

- Awareness of “the baby blues”. About 59% of RRFSS respondents indicated they were aware of (i.e., had heard the phrase) “baby blues”. By comparison, 55.6% of those who were just starting MLHU Prenatal Classes were aware there was a distinction of the baby blues and PPD. A substantially higher percentage of MLHU Well Baby Clinic clients (86.1%) and those who had completed the Prenatal Classes (94.1%) were aware of the baby blues.
- Knowledge of when to seek help for baby blues. Among those RRFSS respondents who had heard of the baby blues, 13.9% were able to correctly identify that a woman should seek help if symptoms persist more than two weeks after giving birth. Well Baby Clinic clients (31.3%) and Prenatal Class attendees (36.4%) were considerably more likely to know that a woman should seek help if symptoms persist more than two weeks after giving birth compared with RRFSS respondents.
- Teaching by PHNs of postpartum women about PPD at 48-Hour Call and Home Visits. As discussed earlier, training sessions were conducted to increase the knowledge and skill of triage nurses in screening and assessment of PPD at postpartum contact. The training promoted increased teaching of postpartum women about PPD. To that end triage nurses were given tools and resources to facilitate teaching about PPD, the baby blues, risk factors, symptoms and available resources. Data recorded by triage nurses indicate that teaching during telephone contacts increased from 63% to 82% between May 2004 and June 2005. Nurses did some degree of explicit teaching during a substantial majority (80% to 90%) of their postpartum contacts. They were significantly more likely to discuss the idea that the baby blues is normal and the differences between baby blues and PPD (71% and 77% of cases respectively), than to discuss risk factors associated with PPD (28% of cases).

Community Capacity Building

The formation of a community coalition was one of the key strategies used in the MLHU PPD program. Its overall purpose was to improve the target population’s access to PPD-related services. MLHU program staff facilitated development of the coalition and has provided ongoing organizational support. Coalition members became involved in various aspects of the PPD program, including service provider training and community education efforts. The coalition provided direction and support in developing tools and resources, creating the mass media campaign, creating a web site and telephone hotline, and the development of a PPD drop-in centre. The coalition also attempted to measure demand for PPD services throughout the network of service providers, assess the degree to which the network is able to meet demand for services, and identify ongoing gaps in service. In terms of capacity building component of the PPD program, this evaluation was restricted to consideration of the following questions.

Evaluation questions: 1) What was the result of the coalition’s efforts to assess and improve the capacity of the network of PPD-related service providers to meet demand for PPD services? 2) What gaps in service remain?

- Tracking demand for service. Despite considerable effort, an attempt to measure past and current demand for PPD-related service by distributing and training coalition members in the use of a single, custom-made tracking tool was unsuccessful. It would appear that accurate tracking of demand for and provision of services among such a disparate and loosely affiliated group of professionals is very difficult to accomplish. To do so successfully may require more direct involvement of top administrators, perhaps more formal agreements, and a simple and easy-to-use mechanism for recording data such as an electronic database that would be accessible to all relevant parties.
- Qualitative evidence on the capacity to meet demand. Based on a focus group with 17 members of the Mother Reach coalition, it is clear that the work of the coalition has substantially increased and strengthened

community capacity to respond to PPD. Prior to the coalition, there was no regular communication with respect to coordination or development of PPD services. The PPD program greatly increased coalition members' knowledge and skill with respect to assessment and early identification of women with PPD. Front-line workers in coalition member agencies now feel well equipped to provide initial screening, assessment and information to clients about PPD resources. The development of the drop-in centre, web site, telephone hot-line, and a clear referral mechanism for women with acute symptoms of PPD to a local psychiatrist specializing in PPD were considered important new resources in the community.

- Gaps in service. There was a clear consensus that at least three significant gaps in service exist. First is a need for better access to appropriate, *affordable*, ongoing counseling support for women with PPD. The issue seems to be partly a matter of women with limited resources being unable to afford those services that are available, as well as a shortage of appropriately trained providers. Second, coalition members found that some family physicians tend to be unresponsive to their patients' needs or concerns around PPD. They identified a need to sensitize and enlist the support of family physicians in the proper support and treatment of patients who may be at risk of or showing symptoms of PPD. Finally, coalition members made a strong argument for the creation of a multi-disciplinary, women-centred, primary health care service for this region, that would have the capacity to address concerns such as PPD in the context of the a fuller range of health determinants.

Recommendations

Based on these findings, the following recommendations are offered by the Program Evaluator for the consideration of program managers, program staff and others that may be engaged in developing services to address the needs of women at risk of or suffering from PPD.

- Service provider training around best practices for PPD screening, assessment and

intervention should be offered on a periodic basis to both MLHU staff and external service providers, including training in specific interventions to support or treat women suffering with PPD.

- Further study should be undertaken to determine the extent to which formal early postpartum screening, assessment and teaching should become more standardized, in order to optimize early identification of women at risk of or suffering from PPD.
- Strategies should be considered to increase awareness about PPD among men, adults less than 24 years of age, new immigrants, and people with lower levels of education and income.
- Strategies should be considered to increase the assimilation of knowledge about PPD signs and symptoms risk factors, available community resources, and when to seek help, among those participating in programs such as MLHU Prenatal Classes and other prenatal education activities.
- Strategies should be developed to increase knowledge of family physicians and obstetricians about PPD, about women's experiences, needs and concerns around PPD, and about intervention and treatment options. More cooperative relationships between physicians and other PPD-related service providers should be forged.
- Strategies should be developed to mobilize resources needed to more systematically assess and redress the shortage of intervention and treatment resources for women suffering with PPD.
- The feasibility of establishing a specifically woman-centred, primary health care service in southwestern Ontario based on a model such as community health centre or family health team should be explored.

Introduction

This document is a summative evaluation of the Middlesex-London Health Unit (MLHU) Postpartum Depression Program. The program was conducted from April 2002 through December 2006.

Postpartum depression (PPD) is a potentially devastating condition that affects approximately 10-15% of women following the birth of child. Cheryl Beck, one of the foremost scholars working in the field of PPD assessment and treatment described postpartum depression as “a thief that steals motherhood.”² Postpartum depression may have serious negative consequences for mothers, their developing children, and their family and marital wellbeing. One of the most significant problems highlighted by Beck is that PPD is often suffered covertly, with perhaps up to 50% of cases going undetected. According to data collected through the Healthy Babies Healthy Children program, there were 4397 live births in Middlesex-London in 2003. Based on figures cited above, the incidence of PPD among postpartum women in Middlesex-London in 2003 will have been between 439 and 660 cases.

Purpose of the Evaluation

The MLHU Postpartum Depression Program was extensive. More work was undertaken over the course of the program than could be fully considered for this evaluation. This evaluation has been framed primarily in terms of three program components: *service provider training and development, education and skill building, and community capacity building*. The program’s impact on increasing women’s access to *clinical services* has been considered to a limited extent. The purpose of this evaluation is to provide an account of key activities associated with the program components, and to answer the following questions.

Evaluation Questions:

- What was the impact of training and development on service providers’ knowledge and skill with respect to PPD screening, assessment, early intervention, treatment and community resources available?
- What was the impact of the training and development on service providers’ practice with respect to screening and early identification of women who are at risk of or suffering from PPD?
- What was the impact of educational activities on the target population’s awareness and knowledge of PPD risk factors, signs and symptoms, and community supports and resources available to women and their families and/or support networks?
- What was the impact of the Mother Reach coalition on developing the capacity of the network of service providers to provide needed services?

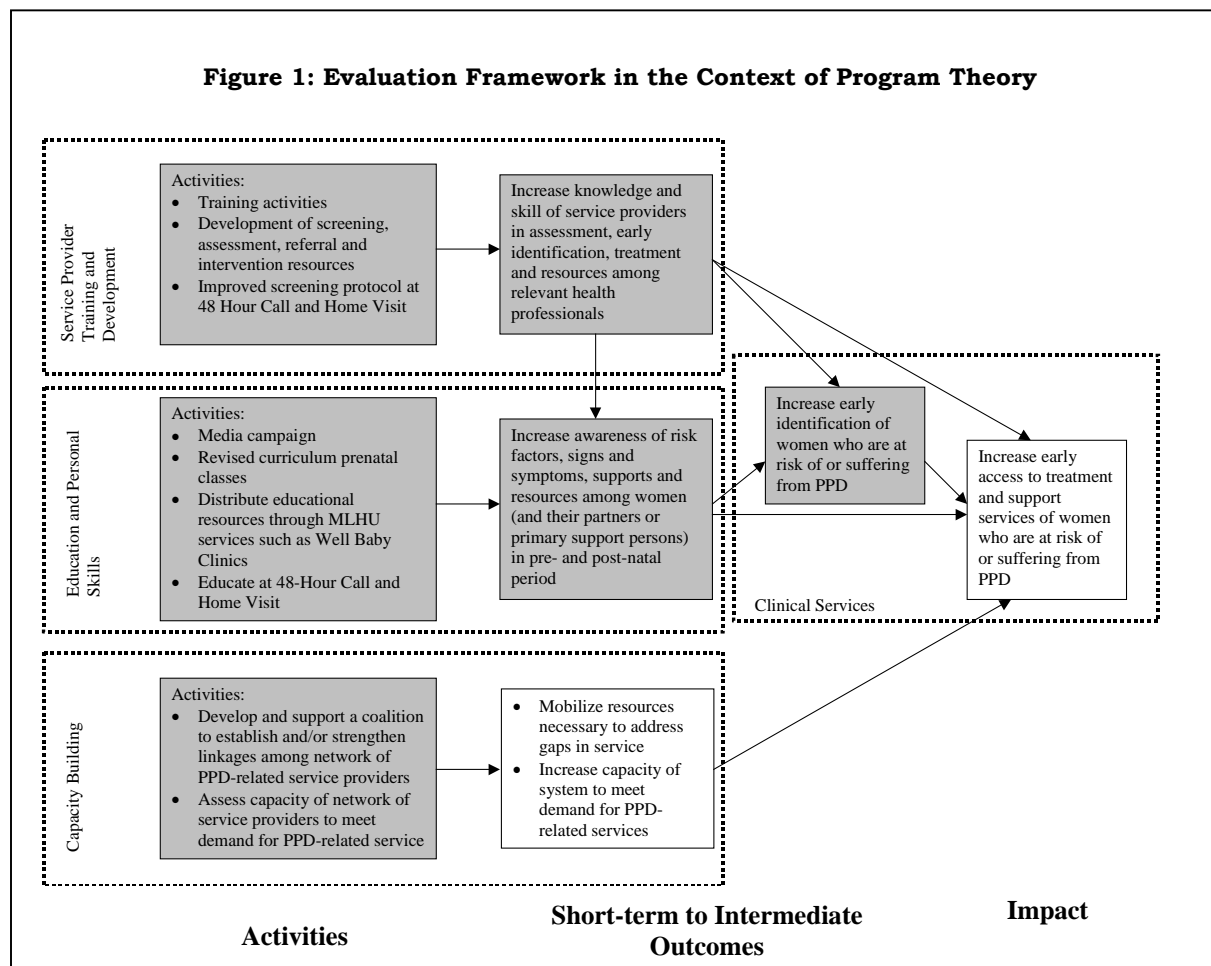
Program Theory

Figure 1 presents the PPD *program theory*. The program theory is a graphic depiction of how the program is expected to produce its intended outcomes. The program’s *components* are represented by the dotted rectangles. The first column of shaded boxes represent the *activities* associated with each component. The second column of boxes represents the shorter-term *outcomes* that are expected to be produced by each set of activities. The arrows represent the hypothesized causal linkage between activities and outcomes. The two boxes at the right hand side of the diagram represent an *intermediate outcome* and a longer-term *impact* of the program. As indicated, impact of the program is to increase early access to treatment and support services for women who are at risk of, or are suffering from PPD.

² Beck, C. T. (2002). Revision of the postpartum depression predictors inventory. *Journal of Obstetric, Gynecologic, and Neonatal Nursing : JOGNN / NAACOG*, 31(4), 394-402.

The shaded boxes represent the aspects of the program that have been considered in this evaluation. Thus, while there is little that can be said about the extent to which the program has produced the longer-term intended impact, there is some evidence to support evaluative statements about program activities and the shorter-term outcomes.

Before providing a brief description of the methods used for this evaluation, a description of the program’s background and early development will be provided.



Program Background

Provincial Early Childhood Development Initiative

The Postpartum Depression program is one of several *Early Childhood Development* projects that were undertaken at the Middlesex-London Health Unit over the last four years. In December 2001, the Ministry of Health and Long-term Care announced funding for the development of *Early Childhood Development* projects through Ontario's public health units. This program stemmed from an agreement reached by Canada's First Ministers in September 2000 to fund early years initiatives. In response to the First Ministers' agreement, Ontario had already developed an *Early Years Plan* based on thinking outlined in the *Early Years Study* co-chaired by Dr. Fraser Mustard and the Honourable Margaret McCain. The development of Ontario's Early Years Centres also emerged from the Early Years Plan. Funding was provided for three initiatives:

- Injury and Family Abuse Prevention
- Promotion of Healthy Pregnancy and Child Development
- Perinatal and Child Health Survey Strategies.

The Postpartum Depression Program was funded as part of the second initiative listed above. Funding covered the period from January 1, 2002 through March 31, 2006. The government's plan called for the initiative to be implemented in two phases.

Phase 1 was funded for \$52,000, and took place from April 1, 2002 through March 31, 2003. Phase 1 required the following deliverables: establishing partnerships, completing a community inventory, conducting a needs assessment, and developing a comprehensive 4-year plan to address one or more of the following areas: healthy pregnancy, child growth and development, and/or parenting capacity. The terms of reference also stipulated that the project must employ a *comprehensive population health promotion approach*.

The results of the planning process carried out by MLHU for Phase 1 were reported in a document entitled *Promote Healthy Pregnancy and Child Development Initiative, Project Status Report* (May 2002). An inventory of community services identified over 900 services and supports in London and Middlesex County for families with young children. A review of four previously conducted needs assessments identified a common theme: "*Parents in London and Middlesex County have difficulty accessing needed information.*" Three consultations were conducted with key community contacts and stakeholders to discuss and make recommendations with respect to priority areas. The outcome of the consultation process identified the following priority areas for programming:

- Increasing parent accessibility to available programs
- Postpartum depression
- Preconception health.

Initial Program Plan

Ministry guidelines stipulated that projects should be implemented according to "a combination of the following evidence-based strategies":

- Enhancing awareness, education, and/or personal skills;
- Strengthening community capacity;
- Creating safe and supportive environments; and
- Advocating for policy change or enforcement.

Based on these guidelines, the four components of the program as first conceptualized were *direct service, service provider training, media campaign/marketing plan, and policy/partnerships*. As the program evolved, it came to be reframed in terms of the four components presented in the program theory discussed earlier.

Overview of Program Development

Initial Review of Practices, Tools and Resources

In March 2002, the health unit's Community Nurse Specialist was assigned the role Program Coordinator for the project. She initiated a process of reviewing existing education resources in consultation with health unit and other local and regional colleagues.

Consultations were conducted with MLHU Public Health Nurses (PHNs) to begin activities such as the reviewing and updating prenatal classes curriculum and standards for home visiting practice, and examining ways to enhance education, assessment and intervention.

These initial activities led to the defining of priorities for enhancing ongoing nursing practice in MLHU Family Health Services. These included: 1) development of a screening tool; 2) expansion of educational resources for families; 3) development of intervention skills for PHN practice; and 4) establishing specific, defined linkages with community partners to ensure appropriate follow-up and support for clients.

Program Management and Staffing

Program management and staffing went through some changes over the course of the four years of the program. The project was managed by the Manager of the Young Families Team. As stated above, the health unit's Community Nurse Specialist was the initial Project Lead. Personnel changes at the health unit resulted in the program coordination function being shared by two public health nurses each in the role of Project Lead. Two different individuals served in the role of Program Manager and four different individuals served as Project Leads during the course of the project.

Formation of Mother Reach – A Community Coalition Dedicated to PPD

One of the first tasks was to facilitate the development of a community coalition devoted

to community capacity building around the needs of the target population with respect to PPD. In September of 2002 approximately 25 community members met to begin discussions around identification of needs, coordination of services and raising of public awareness around PPD. In September of 2003, the Mother Reach coalition was officially formed. The vision and mission statements adopted by the coalition were as follows:

Vision: Mother Reach London-Middlesex promotes a caring community to educate, treat and support women and their families who are at risk for, or coping with postpartum depression.

Mission: A team of community members and professionals in London and Middlesex County whose purpose is to provide:

- *Public/professional awareness of postpartum depression,*
- *Improved access to services, and*
- *Dissemination of information/resources for all postpartum women, their families and caregivers.*

Among the activities undertaken through the Mother Reach coalition were the creation of a booklet entitled *Postpartum Depression: Inventory of Programs and Services in London and Middlesex*, and the development of the Mother Reach website (www.helpformom.ca) and the Mother Reach hotline (672-HOPE). The coalition was also a crucial vehicle the delivery of training activities and resources to service providers, and the coordination of services.

Forming of the MLHU Internal PPD Working Group

Initial review and revision of practices, tools and resources was initially undertaken on an ad hoc basis in the early stages of the project. In September of 2003 an MLHU "Internal PPD Working Group" was formed to review, revise, and create needed educational and training resources and develop protocol for nursing practice related to PPD on an ongoing basis. The work of this group was primarily supported by one of the PHNs designated as Project Lead.

Project Leads also served as the link between the Internal PPD Working Group and the Mother Reach Community Coalition.

Working in close cooperation, one of the Project Leads assumed primary responsibility for supporting the Mother Reach community coalition, and the other assumed primary responsibility for supporting the MLHU Internal PPD Working Group. Project Leads undertook tasks such as researching, drafting documents, networking and attending conferences, assembling and disseminating tools and resources, conducting training, and planning and organizing meetings.

One of the PHNs who served as Project Lead during the last three years of the project described the role of the internal working group as “absolutely key”. Meeting monthly beginning in January 2004, the working group consisted of seven to eight PHNs who work with the population of expectant and young mothers. Initially drawn from the Young Families Team (YFT), membership was expanded to include representation from the Infant and Family Development Team (IFDT).³ Representatives from IFDT and YFT served as liaison to their respective teams, assessing what team members needed to be able to provide PPD-related services, and eliciting and channeling feedback from their teams to the working group for development of additional resources.

Overview of Tools and Resources Developed

In addition to the two Project Leads, there were at least two other PHNs that were members of both the community coalition and the internal working group. This enabled the two groups to work in close collaboration in developing a variety of resources, including:

- Resources to guide nursing practice, such as a protocol for “Dealing with a Client with Postpartum Depression”, screening procedures, a risk assessment decision tree, and intervention resources.

³ The team within Family Health Services that works with the high-risk population, including responsibility including the home visiting under for the Healthy Babies, Healthy Children Program.

- Professional training and skill development resources, including presentations for training both internal and external staff, and resource kits.
- Educational and intervention resources for the target population, development and launch of a mass media campaign, development of a web site⁴ and a PPD hotline, revisions to the curriculum for prenatal classes, the creation of informational pamphlets, and lists of available treatment and support services and resources.

These resources were developed gradually over the course of the program. The array of resources that was eventually developed for professional skill development and practice is listed below. The final version of the PowerPoint presentation that was developed for professional training is included as Appendix A.

⁴ The media campaign and web site were considered products of the Mother Reach coalition. Professional media consultation services for the development of these two products were provided in-kind by *Surge Communications*.

Lists of Tools and Resources

Table 1: Assessment Tools

Edinburgh Assessment Tool

4 Screening Tools

- 4 Key (PASS-CAN) Questions
- Other Risk Factors
- Suicidal Ideation
- Infanticidal Ideation

Mother Reach Reference Card “Postpartum Depression...It’s Real” (includes risk factors, symptoms, 4 PASS-CAN questions, intervention suggestions, community resources)

Pre/Post Mental Health Assessment Flow Chart

Authorization to obtain and release information

Suicidal/Infanticidal Children’s Aid Society Referral Flow Chart (“Decision Tree”)

Summary of Risk Factors of PPD

“Dealing with a client with PPD” (Protocol)

“Red Flags”—for Postpartum Mood Disorders

Doctor referral letter

Table 2: Intervention Tools

Cheryl Beck (PDSS) Postpartum Depression Screening Scale

Postpartum Depression--Inventory of Programs and Services in London and Middlesex

Nursing Information:

- The Nurse Program
- A Multi-Dimensional Explanation of Postpartum Depression
- Strategies That Work: How to Help a Woman Survive Postpartum Depression
- Postpartum Depression—Most Commonly Used Medications

Brochures:

- Baby Blues—When they won’t go away (available in several languages)
 - Why is Everyone Happy But Me?
 - Dad, They Both Need Your Help
 - 10+1 Tips for Fathers Through Postpartum Depression
 - Mother Reach PPD pamphlet
 - Breaking the Silence (booklet)
 - Grandparents Guide to Helping Mom With Depression
 - Mental Health Crisis Service
 - Anxiety and Affective Disorders Service (London Health Sciences Centre)
-

Methods

A variety of methods were employed in conducting the evaluation including, analysis of administrative records, administrative tracking, secondary data analysis, and conducting of surveys, focus groups and informal interviews with program staff. Table 3 provides an overview of primary methods used in this evaluation. It describes the various data

sources and methods used for evaluating the various program components. The information listed under the column with the heading “Purpose” corresponds to the evaluation questions specified earlier in the introduction. Where needed, more detail is provided about specific methods along with the presentation of findings throughout the body of the report.

Table 3: Overview of Primary Methods

Component Evaluated	Purpose	Data Source	Population	Method and Sampling Procedure	Data Collection Period and Sample Size
Service Provider Training and Development Education and Personal Skill Development	To assess impact of training activities on nursing practice (especially screening, assessment and education), and to seek input regarding additional training	Public Health Nurses that Conduct 48-Hour Call and Home Visits	Front-line providers of screening, assessment and education about PPD to postpartum women	Two focus groups. All PHNs from Infant and Family Development Team and Young Families Team were invited	April 26, 2004 • N=11 April 29, 2004 • N=11
Service Provider Training and Development	To assess nursing practice with respect to initial screening and teaching about PPD, and nurses’ assessment of client’s awareness of PPD and their risk status	48 Hour Call/ Home Visit (universal postpartum screening)	All women who have recently given birth in Middlesex-London	PHN requested to fill out tracking form after conducting each 48 hour call and/or Home Visit during study periods	First Round: April 1-May 31, 2004 • N=240 Second Round: April 1-June 30, 2005 • N=482
Service Provider Training and Development Community Capacity Building	To assess impact of training activities on skill and knowledge of service providers and to assess gaps in service	Mother Reach Community Coalition	Providers of health, social and educational services to perinatal population	One focus group conducted during regularly scheduled coalition meeting.	November 13, 2006 • N=17
Education and Personal Skill Development	To assess the degree of awareness/knowledge gained at the Prenatal Health Fair, and previous knowledge about PPD and related supportive community resources	Prenatal Health Fairs	People planning pregnancies, expectant parents, spouses/ support persons	Self-administered evaluation form offered to all attendees when exiting fair	Sep. 2003 - Feb. 2005 • N=1909 from eight fairs
Education and Personal Skill Development	To compare awareness/ knowledge of PPD, PPD risk factors symptoms, and supportive community resources among target population before and after mass media campaign	Well Baby Clinics	Families with young children, particularly women and their children up to four years old	Self-administered questionnaires offered to all clients of clinics conducted during survey period	Pre-media campaign: Feb. 23-Mar. 6, 2004 • N=215 from 35 clinic sessions Post-media campaign: Nov. 22-Dec. 3, 2004 • N=150 from 17 clinic sessions
Education and Personal Skill Development	To compare awareness/ knowledge of PPD, PPD risk factors, symptoms, and supportive community resources before and after taking prenatal classes	Prenatal Classes (Series)	Expectant parents	Self-administered questionnaire administered at all 35 series of Prenatal Classes offered during survey period. Data collected from each participant pre- and post-series	July 13 - Nov. 17, 2004 • Pre-course: N=522 • Post-course: N=413
Education and Personal Skill Development	To assess level of awareness/knowledge of PPD, PPD symptoms, and available supportive community resources	Rapid Risk Factor Surveillance System (RRFSS), PPD Module	General population in Middlesex-London, 18 years and older	Random sample, telephone survey administered by York University, Institute for Social Research	Monthly throughout 2005. • N=1213

Overview of the Report

The first section of the report entitled *Service Provider Training and Development* examines the impact of the program on knowledge and skill of both MLHU and other community service providers, with respect to screening, assessment, early identification, treatment, and available resources to assist or support women suffering with or at risk of PPD. It describes the development of the training component, the extent of training among PPD-related service providers, and the training activities that were delivered. Areas of substantially improved knowledge and skill, as well as suggestions for additional training are identified.

The second section of the report entitled *Education and Personal Skill Development* examines the extent to which the program increased awareness and knowledge among the population of childbearing women and their family and/or support persons, about risk factors and symptoms associated with PPD, and supportive resources available in the community. It provides a description of awareness raising and educational strategies employed, including a mass media campaign and revisions to the MLHU prenatal curriculum. Data pertaining to the impact of these strategies on users of various MLHU services is reviewed. Data from a survey of the general population of adults 18 years and older in Middlesex-London is reviewed to determine the level of awareness and knowledge about PPD in the general population and in various demographic subgroups. Subgroups with relatively low levels of awareness about PPD are identified.

The third section of the report entitled, *Community Capacity Building* examines the capacity of the network of service providers to meet demand for PPD-related services. A number of gaps in service are identified.

The final section of the report presents conclusions and recommendations based on the evaluation findings.

Service Provider Training and Development

The purpose of *Service Provider Training and Development* was to increase the knowledge and skill of service providers with respect to screening, assessment, early identification, treatment and available resources. This training was intended to lead to increased and/or improved screening and assessment of postpartum women by service providers. Before considering the extent to which these objectives were met an overview of program activities and description of the development of the training component will be provided.

Overview of Activities

The activities undertaken as part of this program component included:

- Initial identification and review of resources for screening, assessment, referral and intervention
- Development of a PowerPoint presentation for training health unit PHNs and other service providers in the community
- Development and distribution of resource kits for professionals
- Presentations and training sessions conducted with PHNs and outside service providers
- Development of standard protocol for assessment and decision-making around when and how to intervene.

Development of Training Component

The impetus to develop resources and training materials for professional skill building slightly predated the establishment of the ECD-funded PPD program, according to one of the Public Health Nurses who was involved from the earliest stages.⁵ In the spring of 2002, the family of an MLHU employee was touched by a PPD-related suicide. The family made a donation to the health unit for the development of a PPD “reach and teach kit”. Two PHNs began researching and assembling available

resources. They found that available educational and community support resources were very limited and inadequate. The PHNs began training other MLHU PHNs on an informal basis.

When ECD funding became available in April 2002, a base upon which to further develop a program had already been established. As briefly described in the introduction, a more formal review of practices, tools and resources followed shortly thereafter. This initial review led to the adaptation of health education materials (i.e., pamphlet, display board, an inventory of community resources) which had been earlier produced by the Mother Reach community coalition in Oxford County, a handout pertaining to medications for PPD, and the identification of a PPD screening tool developed by Cheryl Beck.

Initial training efforts undertaken in the fall of 2002 were exclusively internal; they were aimed at MLHU nursing staff, particularly the Young Families Team and Infant and Family Development Team. The training consisted of orientation to the use of the Beck Tool, and being available for one-to-one consultations for PHNs who were doing postnatal home visits. An important theme covered was the special sensitivity required in approaching this concern with clients. As with woman abuse, there is often a great deal of stigma and therefore “masking” of symptoms associated with PPD.

Subsequent to these preliminary efforts, a package of tools and educational resources for training and skill development of service providers was gradually developed, with input from both the internal working group and the Mother Reach coalition. The package was developed through an iterative process of needs assessment, tool development, trial, feedback and refinement. Likewise, a PowerPoint training presentation entitled *Postpartum Mood Disorders...It's Real!* was developed and refined based on learner feedback, for use in conjunction with the package of resources during training sessions. (See Appendix A for the most recent version of the training presentation.)

⁵ This account of the earliest stage of program development based on an informal interview with Mitzi Pohanka, PHN.

Table 1.1: Reach of Training Activities to Professionals Providing Health-Related Services to Perinatal Population

Year	Agency, Organization or Group	Type of Professionals	# of Participants	
2003	Interagency Coalition on Parent Education	Coalition of parent educators, (e.g., social workers, ECEs, counsellors)	38	
	Community Coalition for Healthy Pregnancy	Coalition of prenatal educators (e.g., midwives, doulas, PHN, ECEs)	10	
	Heartspace	Women's mental health service providers	9	
	Telehealth Staff (regional office)	Registered nurses providing telehealth services	14	
	London Health Sciences Centre	Maternal/newborn nurses, hospital setting	18	
	Children's Aid Society	Child protection and mental health service providers (social workers)	20	
	Strathroy General Hospital	Emergency room staff	20	
	Southwest Ontario Aboriginal Health Access Centre	Multidisciplinary health team working with aboriginal perinatal population	20	
	MLHU Young Families and Infant and Family Development Teams	PHNs working with perinatal population	25	
	MLHU Young Adult Team	PHNs working with perinatal population	9	
	Maternal/Newborn Nurses, SW Ontario (videoconference)	Maternal/newborn nurses, hospital setting	19	
	Maternal/Newborn Nurses, Elliott Lake (videoconference)	Maternal/newborn nurses, hospital setting	5	
	Maternal/Newborn Nurses, Manitoulin Island (videoconference)	Maternal/newborn nurses, hospital setting	14	
	Number of Professionals Reached for 2003			221
	2004	MLHU Neighborhood Health Care Staff	Multidisciplinary health team working with perinatal population	5
MLHU Infantline Staff		PHNs working with perinatal population	5	
Canadian Mental Health Association Staff		Mental health service providers	19	
Merrymount Children's Centre		Providers of various children and family services (e.g., social workers, ECEs)	22	
MLHU Young Adult Team		PHNs working with perinatal population	6	
MLHU Casual Nurse Orientation		PHNs working with perinatal population	10	
MLHU Public Health Nurses, Various Teams		PHNs working with perinatal population	37	
Service Provider Training		Women's mental health service providers	74	
Thames Valley Midwives and Womencare Midwives		Midwives	11	
Mother Reach Postpartum Depression Coalition		Coalition of perinatal service providers (e.g., nurses, ECEs, social workers, midwives, doulas)	20	
St. Joseph's Health Care Centre		Maternal/newborn nurses, hospital setting	14	
Number of Professionals Reached for 2004			223	
2005		MLHU Prenatal Teachers	PHNs working with perinatal population	10
		MLHU Infant and Family Development Team	PHNs working with perinatal population	14
		MLHU Family Home Visitors (Healthy Babies Healthy Children Program)	Postnatal home visiting program, high risk population	17
	MLHU Young Families Team	PHNs working with perinatal population	18	
	St. Clair Children & Youth Services and other Lambton county agencies	Providers of various children and family services (e.g., social workers, ECEs)	8	
	London Health Sciences Centre Pediatric Emergency Nurses/Physicians	Emergency room staff	12	
	St. Joseph's Health Care Centre	Maternal/newborn nurses, hospital setting	15	
	St. Joseph's Health Care Centre	Maternal/newborn nurses, hospital setting	15	
	MLHU Young Families and Infant and Family Development Teams	PHNs working with perinatal population	6	
	London Health Sciences Centre	Maternal/newborn nurses, hospital setting	13	
Number of Professionals Reached for 2005			128	
2006	St. Joseph's Health Care Centre	Maternal/newborn nurses, hospital setting	14	
	Childreach (Ontario Early Years Centre)	Providers of various children and family services (e.g., social workers, ECEs)	19	
	Provincial Best Start Annual Conference	Health service providers working with perinatal population, various disciplines	50	
	Children's Aid Society	Child protection and mental health service providers (intake workers)	3	
	Workshop Targeting All Perinatal Service Providers (by CAMH)	Health service providers working with perinatal population, various disciplines	56	
	Children's Psychiatric Research Institute	Providers of various children and family services (e.g., social workers, ECEs)	180	
	MLHU Public Health Nurses, Various Teams	PHNs working with perinatal population	20	
	MLHU Public Health Nurses, Various Teams	PHNs working with perinatal population	17	
	MLHU Public Health Nurses, Various Teams	PHNs working with perinatal population	20	
	MLHU Public Health Nurses and Family Home Visitors (Presentation by Dr. Sharma, Psychiatrist)	PHNs and Family Home Visitors working with perinatal population	20	
	Children's Aid Society	Child protection and mental health service providers	15	
	MLHU Public Health Nurses and Family Home Visitors (Presentation by Diane Prato, Counsellor)	PHNs and Family Home Visitors working with perinatal population	17	
	Number of Professionals Reached for 2006			431
	Total Number of Professionals Reached 2003-2006			1003

For the remainder of the program, service provider training followed two tracks—internal (MLHU) training and training of external service providers. Much of the external training was conducted through the Mother Reach network. Table 1.1 presents a list of both internal and external service provider training sessions that were conducted from 2003 through 2006. Individuals may have attended more than one session, therefore the subtotals and total should be understood to represent the number of attendees.

Description of Internal Training Activities

Internal training was aimed at various teams within Family Health Services that have regular contact with the perinatal population (see Table 1.2.) Among these teams, the primary target groups for training were the Infant and Family Development Team (IFDT) and the Young Families Team (YFT). Together, these two teams have direct contact with a substantial majority who have recently given birth as part of the Healthy Babies Healthy Children (HBHC) Program.

Under the HBHC, every woman giving birth in Ontario in a hospital or at home with a midwife is screened with the Parkyn tool, “a universal tool that successfully screens (with family consent) all newborns for risk.... The results of the postpartum screen are forwarded to the Public Health Unit for follow-up with the family, including, when indicated, the introduction of early and appropriate interventions and other services to reduce risk.”⁶

At MLHU, it is the IFDT and YFT that follow-up on the initial hospital screen (if new mother gives consent) by means of a 48-hour call and Home Visit. The IFDT works with “high-risk” mothers (defined as a Parkyn score of greater than 9) while the YFT works with “low-risk” mothers. During initial follow-up contact with low risk clients, the YFT conducts a “Brief Assessment”, which evaluates baby’s health, mother’s health, mother’s mental health, social support, and other stressors such as economic, recent death, etc.) In most instances low risk mothers receive only one home visit from a member of the YFT, during which support, education and information is offered to help with “normal” postpartum adjustment. If concerns are identified during the brief assessment, the client is referred to the IFDT for more intensive follow-up visiting and possible enrolment in the HBHC Home Visiting program. This process is sometimes referred to as *triage*.

Table 1.2. MLHU Teams That Have Regular Contact with Perinatal Population

MLHU Team	Function	Population Served
Infant and Family Development Team	PHNs conduct 48 hour call and home visits as part of the Healthy Babies Healthy Children Program	Women identified as high risk (Parkyn >9)
Young Families Team	PHNs conduct 48 hour call and home visits as part of the Healthy Babies Healthy Children Program	Women identified as low risk (Parkyn <9)
Infant Line	Casual PHNs provide after hours telephone counselling	General perinatal population
Family Home Visitors	“Lay visitors” work closely with IFDT; conduct home visits.	Women identified as high risk (Parkyn >9)
Young Adult Team	PHNs work in high schools	Teen pregnancies, and higher risk younger population
Prenatal Classes	Casual PHNs conduct prenatal classes	General perinatal population

⁶ Healthy Babies Healthy Children Policy Statement on Universal Screening and Assessment for Healthy Child Development Prenatal to School-Age. Retrieved on January 18, 2007 from www.health.gov.on.ca/english/providers/pub/child/hbabies/policy_statement.html

At least one member from both the IFDT and YFT participated in the early review and development of practices, tools and resources. Even before formal training sessions began in 2003, members of these two teams were briefed, shared information and resources and held discussions about their practice with respect to PPD at regular team meetings. As well, the YFT had long held case conferences about their high-risk clients as a regular part of their practice. These activities are not recorded in Table 1.1 as part of the formal training activities, but should be recognized as part of a culture of training around PPD that began to permeate relevant teams within Family Health Services as a result of the PPD program.

As discussed above, the main training tools (PowerPoint presentation and the package of tools and resources) were developed over time. Initially the package of resources included fairly basic information, a quick screening tool referred to as the four PASS-CAN⁷ questions, the Beck tool (which was the first screening tool to be adopted and promoted by program staff), and an inventory of community resources. Additional resources were developed and added to the package around the time of the PPD program “launch” in October 2004 in response to needs identified by both internal and external service providers. These included a protocol for dealing with a client with PPD, an assessment flow chart, a “decision tree” to guide assessment and intervention in instances of perceived danger to woman or child. A mass media campaign also coincided with the launch.

The content covered in the training presentation eventually came to include the following areas: background information including descriptions of and incidence PPD and related mood disorders; causes, risk factors and symptoms; effects of PPD, recommended screening and assessment protocols, the decision tree, information about available services, and case studies.

Each training session covered much of the same basic information, but the emphasis and focus was tailored to fit the professional needs of the particular team. For example, it was crucial for the IFDT and YFT to have an in-depth understanding of screening, assessment and intervention protocols. The training for the Infant Line team focused on being able to conduct initial telephone screening and refer to appropriate community resources.

Impact of Internal Training Activities on Knowledge and Skill

What impact did training activities have on MLHU service providers’ knowledge and skill with respect to PPD assessment, early intervention, treatment and resources?

Data Sources

To answer that question two main sources of information will be considered. First, data from two focus groups conducted largely with members of the IFDT and YFT in April 2004 will be considered. Second, data collected during the triage process (48-Hour Call/Home Visit) at two different points in time will be considered.

In the context of the question being considered here, the focus groups served two purposes: 1) assessment of nursing practice with respect to initial screening of PPD in light of training activities that had taken place to that point, and 2) obtaining feedback about use of the Beck and Edinburgh screening tools⁸ and input as to other tools or resources needed by PHNs. Eleven PHNs participated in each of the two focus groups. In total there were 13 from the Young Families Team, eight from the Infant and Family Development Team, one from the Young Adult Team, and one from the Health Promotion Team.

⁷ PASS-CAN is an acronym for Postpartum Adjustment Support Services-Canada, a non-profit, national clearinghouse for postpartum depression information and referrals, which apparently closed due to lack of funding in November 2002.

⁸ At the time of the focus group, the Beck tool was being advocated by program coordinators as the preferred tool. Sometime after this point, the Edinburgh was adopted as the preferred tool in accord with Registered Nurses Association of Ontario (RNAO) Best Practice Guidelines.

The Program Evaluator analyzed transcripts derived from the focus group, to identify themes, which are presented below.

PPD Brought to the Forefront, Screening Becomes More Routine

There was a strong concurrence among participants in both focus groups that the training associated with the program brought PPD to the forefront of their awareness, provided new screening and assessment tools, and made it more likely for PHNs to explicitly assess a mother's PPD risk status as a routine part of their practice. This was the case even though many PHNs stated that assessment of a mother's emotional or mental health has long been one of the matters PHNs attended to during postpartum contacts.

For example, when participants in the first focus group were asked to what extent PHNs think about and watch for signs of PPD during contacts, the following exchange ensued.

Participant 1: It's definitely part of the even basic assessment, just asking them at first, "How are you feeling emotionally?" just to start things off. And explaining to them, we always talk to moms about postpartum depression, whether she shows signs of postpartum depression or not. It's just become, especially since things have really come to the forefront in the last couple of years, just part of my basic assessment for everybody. With the work of the coalition, with the training that we've had. I mean I was doing that before, but (I am) really conscious of it, really conscious of it now.

Participant 2: I'd have to agree... I think it's always been part of my practice, but I think more so now, especially in the last couple of weeks, because of the blue tool⁹. I think that you have to fill it out, it's there in the record. It really makes

me do a lot more teaching as well, on the phone or at the home visit.

Participant 3: I don't think that this is totally new to our practice...it's always been a part of our (practice) because we always looked at the whole individual in our assessments.

Moderator: So it's not totally new. Is there a difference? Is there a change?

Participant 1: I think with each tool we get I think it heightens our awareness. But it's also just a great educational thing for the clients, when we have this in front of us. You do tend to address it probably a lot earlier than you would. And, no, they're probably not suffering from depression at that time, but you can do the education.

In the following exchange that transpired during the second focus group, PHNs make explicit reference to using the Beck tool, and a quick screening tool alternatively referred to as the PASS-CAN or the four questions.

Participant 1: Even just in the last couple of years, more of the in-services, and talks about cases and things like that. It's more to me I guess that I'm thinking more and more of it.

Moderator: In the relatively recent past? Are there things that have brought it more to your awareness?

Participant 1: Well just the little different tools that we are able to use. The Beck thing is great, I like that now. And I don't know, just over the last (while)... there's just been more in-service I guess.

Participant 2: I think the other thing that I've done that's different because of the workshops is... before I used to focus more on the physical. How they were feeling. Were they getting enough sleep? Were they eating? Did they have any

⁹ Referring to the 48-Hour/Home Visit tracking tool, described below. See Appendix B.

supports? But now (I get) into more of their thought processes, if they have any scary thoughts, those specific questions, and just ask them as routine. It's amazing what has come back when and if I ask that specific one. I just recently had one on the 48-hour call. And I directed her to the hospital and they admitted her for three days.... There was nothing there that would have indicated to me that she was at risk for postpartum depression or psychosis or anything like that. It was just going through all the baby questions and then focusing on the mom, and then at the very end when I asked about those scary thoughts, "Do you have any scary thoughts" which is one of the (PASS-CAN) questions. There was hesitation, this long pause, so I tried to get more information. And it was very real.

No Standard Practice: Nursing Judgement versus Formal Screening and Assessment

Another clear finding was that at this point in the program, there was no standard approach taken by PHNs in terms of the initial screening and more formal assessment. Some PHNs acknowledged using the PASS-CAN questions, the Beck and/or Edinburgh tools, however several indicated they had not.

Two factors seem to affect how PHNs approached screening and assessment: 1) years of nursing experience and 2) whether they were part of the IFDT and therefore involved in longer-term visiting, or part of the YFT and therefore likely only visiting once. It appears that younger and/or less experienced PHNs were more likely to use the PASS-CAN questions and Beck assessment tool than the more experienced PHNs. More experienced PHNs seemed to be prefer to trust their gut instinct or intuitive nursing judgement. Members of the YFT said the fact that they usually visit only once with a client often presents barriers that inhibited explicit screening for PPD using a screening tool, included lack of apparent symptoms, lack of privacy and other more pressing concerns such as breastfeeding. Members of the IFDT were much more likely to have used the Beck tool. A number of PHNs

noted strategies they take with one-time visits in lieu of explicit screening or assessment, including educating clients about symptoms of PPD, emphasizing the importance of watching for symptoms in the coming months, and informing them about available supportive community resources. (See findings about educating clients during postpartum contacts on p. 36.)

Need for Judicious Approach

Moreover, members of both teams emphasized the importance of needing to be sensitive and judicious in how they approach mental health-related issues with clients. This was one of the strongest points of concurrence in the two focus groups that was discussed in terms of the question of under what circumstances a formal assessment should be conducted. PHNs made comments along the following lines. Depression is stigmatized. Clients may fear being labeled. High risk and teen moms may fear their losing their child to the Children's Aid Society. PHNs spoke in terms of the importance of building rapport, establishing a relationship, normalizing clients' feelings, easing into a discussion about PPD, discussing depression in general terms, using phrasing such as "Some moms might feel this way." This may be especially important, it was suggested by one PHN, before undertaking a formal assessment using a tool such as the Beck tool.

The stigma and, in some cases, cultural taboos associated with admitting depression may motivate mothers to mask symptoms of PPD. One PHN shared how in one case the Beck tool helped her identify a woman as being at risk who had no apparent symptoms of PPD, while in another case helped alleviate concerns about a woman who she had felt was at higher risk than warranted.

Need to Better Engage Physicians Around PPD

Another very important point raised in both focus groups was that some PHNs found some family physicians to be dismissive of clients' concerns around postpartum mood concerns, or at least not very receptive or helpful in treating or supporting clients who complained of

depression symptoms. (This finding was later strongly echoed in a focus group conducted with the Mother Reach coalition at the end of the program in November 2006, as reported in Section 4 of this report.) While this may reflect time pressures due to the shortage of physicians, it also seems to reflect to some degree a lack of knowledge on the part of some family physicians about the nature, extent and seriousness of PPD.

One PHN stated that the data generated by the Beck tool validated their clients' concerns, helped them see their feelings as legitimate, and thus empowered them to go to their physician for treatment. PHNs mentioned that sending results from the Beck to physicians on behalf of clients increased physicians' attentiveness and sensitivity to clients' needs.

Assessment Skills Good; Need More Resources for Intervention and Treatment

One of the most strongly emphasized themes around which there was a clear consensus in both focus groups, was that while PHNs felt confident in their skills around screening and assessment, there were not enough resources in place for intervention and treatment.

This point is illustrated by the following exchange between two PHNs. These comments were in response to the question, "What is the most important thing we've discussed today?"

Participant 1: (T)hat really stuck out, hearing from everyone in the group that... we're doing a much better job of identifying and using the tools and our comfort level has gone way up. But where do they go then?

Participant 2: Same thing. We can identify until we're blue in the face but if we don't have anywhere to go, once we've identified, then what?

PHNs spoke of a need for more resources in two different senses. First, PHNs felt there was a shortage of mental health treatment resources available in the community.

Secondly, some felt that they needed to be allowed more time to keep, follow and support families at risk, rather than discharge families as soon as possible. This may mean for example, holding onto a record and following up two or three months postpartum.

Changes to PPD Program That Resulted From Focus Group Feedback

A number of suggestions were made during these focus groups that subsequently resulted in adjustments/changes to the program including:

- The development of additional tools for assessment and intervention including, 1) a standard protocol outlining steps for "Dealing With A Client With Postpartum Depression", and 2) an intervention tool called "A Decision Tree For Assessment And Intervention Of Women With Thoughts Of Harming Themselves and/or Their Children".
- Piloting of a *PPD Drop-In Centre* for women and their families, staffed by a PHN and a peer support worker.
- Instituting a series of lunch and learn sessions for nursing staff, featuring updates, case scenarios and possible intervention strategies.

Impact on Screening and Assessment Practice

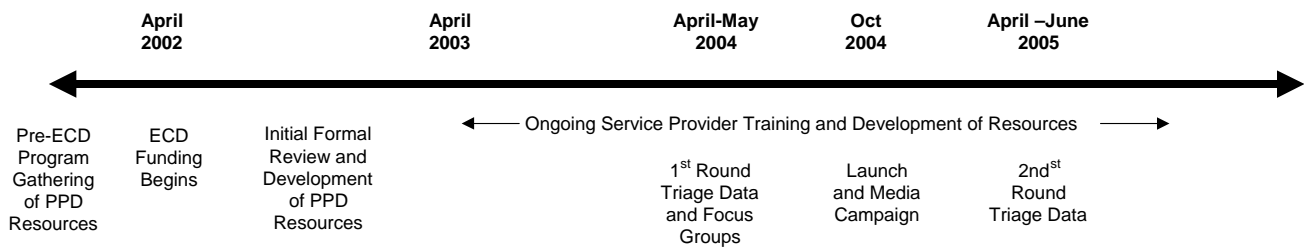
What was the impact of the training and development on service providers' practice with respect to screening and early identification of women who are at risk of or suffering from PPD?

Increase in Explicit Asking About PPD Symptoms During Triage

Data collected during the triage process using the 48-Hour/Home Visit tracking tool validates many of the PHNs' comments cited above. These data demonstrate a notable increase in the frequency with which PHNs systematically screened their clients for PPD in the 11 months that elapsed between data collection periods.

It may be helpful to contextualize the following analysis by providing a time frame in terms of when these data were collected, with respect to both the focus group cited above as well as previous and subsequent training activities. (See Figure 1.1.)

Figure 1.1: Timeframe for Collection of “Triage” Tracking and Focus Group Data

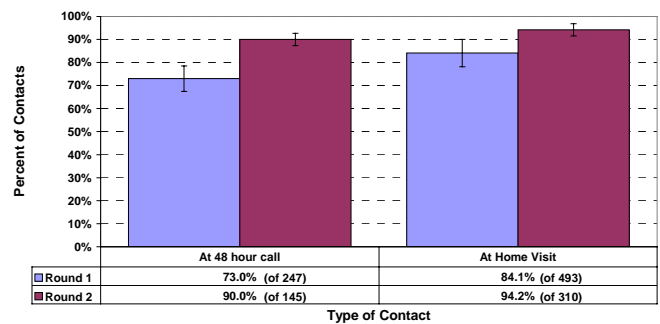


The first round of data collection occurred in April and May 2004. (This roughly coincided with the focus groups cited above.) The second round occurred from April through June 2005. PHNs were asked to complete the tracking tool for all contacts during the two data collection periods. For about two years prior to the first round of data collection, a gradual and informal increase in exposure of PHNs to PPD-related information had been occurring. Formal training had begun the previous fall. A scripted service provider training session, as well as formal screening and assessment protocol would later be established (in between the first and second round of data collection) based in part on feedback from the focus groups cited above. In October 2004 the formal program launch occurred. Additional training sessions for MLHU staff were held in the fall of 2004 and spring of 2005.

As shown in Figure 1.2, there was an increase of 17% in the number of instances in which PHNs explicitly asked clients if they were experiencing any PPD symptoms during the 48-Hour Call. There was an increase of 10% in explicit asking about PPD symptoms by PHNs at

Home Visits. The differences are statistically significant.¹⁰

Figure 1.2: Explicit Asking About PPD Symptoms at Postpartum Contact
Change from April 04 to April 05



¹⁰ Methodological note: The percentages reported are estimates based on a sample of contacts. The “I” shaped lines at the top of each large bar are called “error bars”. They represent the 95% confidence interval, or the range in which there is a 95% probability that the actual percentage would lie, if every member of the group had been surveyed. If the range of the error bars overlap, it means there is more than a 5% chance that the any difference observed between sampled subgroups does not exist in the whole group. If the error bars do *not* overlap, the result is said to be statistically significant. This type of analysis recurs many times in the rest of this report.

Increase in the Use of the PASS-CAN Quick Screen

Tables 1.3 and 1.4 display data about PHNs' assessment of PPD risk status at the 48-Hour Call and Home Visit respectively. The following analysis should be interpreted with caution because of small sample sizes. The differences reported are not statistically significant.

In both sets of tables, the first table indicates PHNs' assessment of clients' PPD risk status, while the second table reports how PHNs determined risk status, *only for those clients they had deemed to be at risk of PPD*. It should be noted that PHNs were not asked whether they used the Beck or Edinburgh tool for more in-depth assessment at this time.

As indicated in Table 1.3.1, after the second round of data collection PHNs were found to be less likely to indicate they were unable to assess risk of PPD at the 48-Hour Call. This suggests that they had obtained more information and were more confident of their ability to make an informed judgement. They were also less likely to have judged the client to be at risk for PPD. The figure of 12.8% is closer to the generally accepted estimates of incidence of PPD in the population. These conclusions are further supported by the data presented in Table 1.32. These data generally indicate that by the second round of data collection, PHNs were more likely to use various sources of data to make judgements about clients' risk of PPD, including the PASS-CAN quick screening tool.

The picture presented with respect to assessment of PPD risk status at Home Visits (Table 1.3.1 and 1.3.2) is ambiguous. It should be kept in mind that many of the same individual clients are being reported on *within* each round of data collection; first for the 48-Hour Call contact (Table 1.3), and then for the Home Visit contact (Table 1.4). For virtually all of those who received a Home Visit, the PHN would have had an opportunity to make a preliminary assessment of PPD risk status at the 48-Hour Call, and then do further assessment at the Home Visit. This might explain the notably lower percentage of cases in which PHNs indicated they were unable to

assess risk at Home Visits compared with at 48-Hour Calls. For the second round, Home Visit data is available for only 64% of those for whom 48-Hour Call data is available. Presumably, many of the other 36% did not consent to a Home Visit because they did not feel the need. Accordingly it makes some sense that a higher proportion of Home Visit records for both rounds would indicate a higher percentage *at risk*, given that lower risk mothers screened at the 48-Hour Call may have opted out of a Home Visit.

With respect to determining risk status during home visits, the only method for which an increase in frequency between the first and second round of data collection was noted, was in the use of the PASS-CAN questions. There was nearly a 12% increase. It is difficult to explain the notable decrease in the frequency with which PHNs said they determined at risk status through client self-disclosure, professional nursing judgement and clients' past history.

Table 1.3.1: Nurse’s Assessment of Client’s PPD Risk Status at 48-Hour Call

	1st Round (N=240)	2nd Round (N=480)
Unable to Assess	19.6%	15.4%
Not at Risk	60.8%	69.6%
At Risk	19.6%	12.8%

Table 1.3.2: How Nurse Determined “At Risk” at 48-Hour Call

	(N=47)	(N=63)
Parkyn	17.0%	28.6%
PassCan Questions	0.0%	22.2%
Client Self-Disclosure	25.5%	50.8%
Professional Nursing Judgement	44.7%	85.7%
Client’s Past History	36.2%	61.9%
Other Indicators	29.8%	15.9%

Note: Columns total to more than 100% due to multiple response options.

Table 1.4.1: Nurse's Assessment of Client's PPD Risk Status at Home Visit

	1st Round (N=140)	2nd Round (N=308)
Unable to Assess	5.7%	5.2%
Not at Risk	65.0%	74.4%
At Risk	29.3%	20.5%

Table 1.4.2: How Nurse Determined "At Risk" Status at Home Visit

	(N=41)	(N=63)
Parkyn	12.2%	11.1%
PassCan Questions	7.3%	19.0%
Client Self-disclosure	29.3%	19.0%
Professional Nursing Judgement	51.2%	30.2%
Client's Past History	56.1%	57.1%
Other Indications	29.3%	22.2%

Note: Columns total to more than 100% due to multiple response options.

There are various limitations with this data set, such as small sample sizes and an inability to compare records based on whether the PHN was interacting with a high risk or low risk client, that make it difficult to refine this analysis. Even based on this basic analysis however, it can be concluded that PHNs felt they had become much better informed and equipped to help women with PPD as a result of the PPD program. They approached PPD screening and assessment more systematically and explicitly after the introduction of the training and new PPD tools and resources than before. Moreover, focus group participants pointed out the need

for additional resources including a standard assessment and intervention protocol and a decision tree to assist in determining whether or not to intervene in situations of possible harm to a mother or child. These resources were subsequently added to the service providers tool kit.

Impact of External Training Activities

What impact did training activities have on external service providers’ skill and knowledge of PPD assessment, early intervention, treatment and resources?

The Mother Reach coalition was the primary vehicle through training was delivered to providers of PPD-related health and social services. Initiated through a series of meetings of Southwestern Regional Health Units from April through September 2002, a group of PPD-related service providers began meeting monthly starting in September of that year. Mother Reach was officially formed in September of 2003.

Representation on Mother Reach Coalition

As of January 2007 there were 33 active members of the coalition, representing 23 different organizations, and 21 different types of service providers. Three unaffiliated community members who serve as volunteer peer support workers and represent consumers of PPD-related services are also active members. Five other organizations were represented at one time on the coalition, but discontinued before formal training sessions began. The types and affiliations of coalition member who received training are presented in Tables 1.5 and 1.6.

Table 1.5: Types of Service Providers on Mother Reach Coalition

	N
Public Health Nurse	4
Child and family social services	3
Community mental health services	3
Counselling and mental health services	2
Doula services	2
Midwife services	2
Nursing education	2
Peer support	2
Psychiatric services	2
Addiction and mental health services for perinatal women	1
Child protection and mental health services	1
Continuing education to perinatal hospital departments	1
Group home for pregnant/parenting adolescents	1
Health information telephone service	1
Hospital services	1
Income support, public	1
Nursing education, Public Health Family Health Services	1
Psychologist	1
Public Health Family Health Services; Family practice nurses	1
Social work education	1

Table 1.6: Affiliation of Service Providers on Mother Reach Coalition

	N
Community member	3
Canadian Mental Health Association	2
Faculty of Nursing, UWO	2
Babeeze in Arms Doula Centre	1
Bethesda Centre	1
Birth Positive	1
Childreach – Ontario Early Years Centre	1
Children’s Aid Society	1
City of London, Ontario Works	1
Family Services Thames Valley	1
Heartspace	1
London Health Sciences Centre, Director of Perinatal and Gynecology	1
London Interfaith Counselling Centre	1
London Mental Health Crisis Service	1
Madame Vanier Children’s Services	1
Mental Health Program and Home Visiting Program for Infants, Child and Parent Resource Institute	1
Merrymount Children’s Centre	1
Middlesex-London Health Unit	1
Middlesex-London Health Unit, Child Health Team, London and Area Family Practice Nurses Group	1
Middlesex-London Health Unit, Family Health Promotion Team	1
Middlesex-London Health Unit, Manager, Family Health Promotion Team	1
Middlesex-London Health Unit, University of Western Ontario	1
Middlesex-London Health Unit, Young Families Team	1
Regional Mental Health Care	1
Regional Perinatal Outreach Program, St. Joseph Health Care	1
Research Coordinator, Regional Mental Health Centre	1
Telehealth Ontario	1
Thames Valley Midwives	1
Womancare Midwives	1

A focus group was held with 17 members of the Mother Reach coalition in November 2006. Participants were asked to recall what PPD-related training activities they had participated in and discuss the impact of training on their ability to provide service, as well as additional needs for training and resources. Their comments were tape recorded, transcribed, and analyzed by the Program Evaluator. Key themes are presented below.

Direct and Indirect Training, Distribution of Tools and Resources

Training to external service providers¹¹ was delivered in several ways. First, PHNs, coalition members, and in some instances invited outside experts conducted occasional training sessions during the coalition's regular monthly meetings. This directly increased the knowledge and skill of coalition members. Some sessions were conducted with the intent of "training the trainer", that is, coalition members were encouraged to take information, tools and resources back to their respective organizations to conduct training with their colleagues or staff. Second, specifically tailored training sessions were conducted for staff at agencies such as the Children's Aid Society (CAS) and Ontario Early Years Centres (OEYCs). Finally, in order to reach beyond those represented in the coalition, updated information and resource kits were mailed out in November 2004 and December 2006 to physicians, pharmacies, churches, and others that had some connection with services for postpartum women.

Comments made by several participants illustrate how training was disseminated from the coalition members to staff at their respective agencies. One participant recalled,

My understanding was to take the training kit and pass it out to our front-line people as well. That's what I did. I passed it out and we did a little training within — I think I'd probably do it again with our newer staff.

Several other participants indicated taking similar steps. One of the participants who works in children's mental health stated,

I think that...because of my presence here, I've been able to raise the awareness to my colleagues and do some in-house training. There's lots of turnover where I work, so that requires me to do lots of in-house training and I'm always trying to keep the awareness

there...it just constantly needs that ongoing training...

Another participant indicated she had repeated training in her agency three times.

Adapting Organizational Procedures and Processes

Among the impacts of this training was the adapting of organizational procedures and/or processes to respond to needs of clients around PPD. For example, reluctance of women to reveal symptoms or concerns around PPD for fear that their children might be apprehended by the CAS was identified as a barrier to early identification. As a result of their participation in the Mother Reach-based training, the CAS identified specific caseworkers to receive additional training and serve as resource persons for their colleagues. The CAS worked with health unit PPD program staff to increase sensitivity among caseworkers to the fear/stigma associated with this issue, and develop strategies for building trust among clients and helping them access CAS and other services for support. One participant described how her community mental health agency created a separate "referral office" to specifically respond to the concerns of pregnant and postpartum women. A representative from an OEYC described how, in keeping with their mandate, they recognized a need to go beyond training their own staff of Early Years Resource Consultants.

...[W]e recognized that there was another group that we serve which were people that may be missing [the training]...the informal care providers, and child care staff. So working with [MLHU program staff] and some of the others around the table, there was a workshop developed and co-facilitated to offer to care providers to look for signs [of PPD] in the families that they were seeing.

Additional Training Needs

Based on comments such as these, it is clear that the knowledge base of service providers

¹¹Refer to Table 1.1 for list of documented external training sessions conducted by MLHU program staff.

linked to the Mother Reach coalition – particularly in terms of knowledge of screening and assessment tools and available community resources – was increased substantially through the PPD program. A few focus group participants identified areas where they felt they needed additional training.

One participant, employed by a community mental health agency felt that her agency had “capacity to provide treatment and ongoing counselling,” but needed more training around assessment. She also expressed a desire for more training to work collaboratively with other community agencies, particularly in cases of women whose PPD is complicated by trauma and/or addictions.

Another participant expressed a need for training in specific interventions that have been found to be effective, namely Cognitive Behaviour Therapy and Interpersonal Therapy. She said, “So now I’m aware that those are the approaches that are most effective but I think I could really benefit and my colleagues could really benefit around specifically how do we do that.”

Reflecting on the fact that PHNs may follow a women for up to six years, one PHN expressed a need for more education and training in “non-directive counselling” noting that although it is “not full therapy”, it is “something that a nurse could be trained to do... (and) has been identified to be something that can be very helpful for women with PPD.”

Gaps in Service

Along these lines, one of the most important findings from Mother Reach coalition focus group was the identification of significant gaps in service. These are discussed in the section of this report entitled Community Capacity Building.

Education and Personal Skills

This section reports on the extent to which the PPD program increased awareness and knowledge among the target population of PPD, PPD risk factors, signs and symptoms of PPD, and resources that are available in the community to support women at risk of or suffering with PPD and their families.

Overview of Activities

The activities undertaken as part of this program component included:

- The development of informational and educational resources that could be distributed and/or presented through a variety of community settings and public health channels, including Prenatal Health Fairs (held five times a year), ongoing Well Baby Clinics and the periodically distributed *Let's Grow* parent education mail out package.
- The conducting of a mass media campaign, including the production and distribution of posters and informational pamphlets, the development of a web site, the development of content for distribution to and publication in local print media, and the airing of radio and television spots.
- The enhancement of the PPD education component of MLHU's Prenatal Classes and *Just Beginnings* parenting program.
- Educating new mothers about PPD at 48-Hour Call and Home Visits.

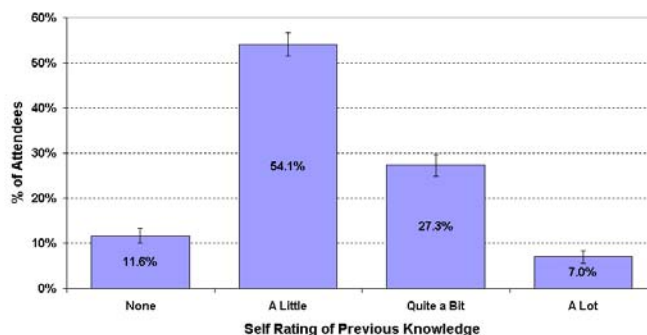
Baseline Measures

It was not possible to establish a "pure" baseline level of awareness about PPD among the target population before the program, as some modest efforts to increase the level of awareness and knowledge about PPD among the target population had been taking place before MLHU's ECD-funded program was developed. As well, health education activities in the first two years of the program developed gradually and were initially quite limited. They consisted of, for example, limited distribution of some pamphlets and newsletters, and the staffing of a

display at Prenatal Health Fairs. However, data was collected on general awareness and knowledge about PPD relatively early in the program, before a major mass media campaign was launched in October of 2004.

Figure 2.1 is based on evaluation data from five Prenatal Health Fairs from September 2003 through September 2004 (before the initial mass media campaign). Data was collected as attendees exited the fair. Approximately 50% of attendees completed evaluation questionnaires.

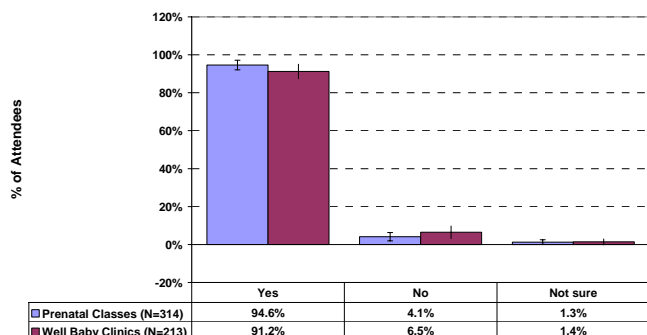
Figure 2.1: Previous Knowledge About PPD
Prenatal Health Fair Attendees-Sept 03 through Sep04
(N=1348)



Attendees were asked "How much knowledge did you have about Postpartum Depression before you came to the Prenatal Health Fair?" Figure 2.1 shows that about 88% of Prenatal Health Fair attendees indicated they had at least a little previous knowledge about PPD.

Similarly, questions were asked of Prenatal Class attendees and clients using Well Baby Clinics to assess their general awareness of PPD before the media campaign. Figure 2.2 compares the awareness level of these two groups. In the case of Prenatal Class attendees, the data reported was collected at the beginning of the series, that is, before they had received any instruction about PPD. In both instances, the same question was asked: "Have you ever heard of Postpartum Depression before?" As indicated in Figure 2.2, about 91% of clients attending Well Baby Clinics, and 95% of Prenatal Class attendees reported having heard of PPD.

Figure 2.2: Ever Heard of PPD Before?
Prenatal Classes and Well Baby Clinic Attendees Before Media Campaign (Oct04)



Based on data collected at Prenatal Health Fairs, Well Baby Clinics and Prenatal Classes before the mass media campaign in October 2004, it may be concluded that approximately 90% of the target population had some at least some awareness of PPD, prior to concerted efforts were undertaken to raise awareness.

Impact of the October 2004 Mass Media Campaign

A mass media campaign was conducted in October 2004. The campaign was targeted to professionals, families and the general public. A public launch was organized by the Mother Reach coalition, with approximately 75 community partners in attendance. A local communications firm, *Surge Communications* supported the media campaign pro bono. Posters, pamphlets and media spots were created. A major purpose of the media campaign was to publicize a telephone hotline (672-HOPE) dedicated to supporting women at risk of or experiencing PPD. Operating 24 hours/day, 7 days/week, the hotline was a joint effort of the Canadian Mental Health Association (London), the London Mental Health Crisis Service, Middlesex-London Health Unit, and Merrymount Children’s Centre. Also launched at this time was a web site (www.helpformom.ca).

The data displayed in Table 2.1. was reported in the ECD Annual Project Report submitted to the Ministry in June of 2005. They indicate the extent and estimated reach of the campaign.

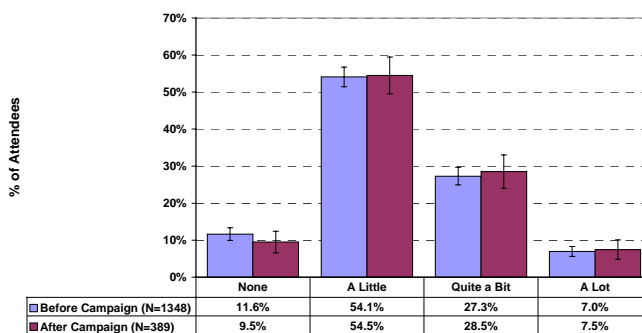
Table 2.1. Extent and Reach of Mass Media Campaign, October 2004

Type of Media	Nos.	Estimated Audience	Estimated Reach
Radio Appearance	1	201,600	201,600
Television Appearance	3	810,000	2,430,000
Newspaper Articles/ads	6	4,016	24,096
Display (Prenatal Health Fair)	1	200	200
Website (unique visitors)	1	123	123
Posters	1	4,500	4,500
Pamphlets	1	4,500	4,500
Radio PSA	1	144,488	144,488

Impact of Mass Media Campaign on General Awareness of PPD

As illustrated in Figure 2.3, there was no statistically significant difference in the level of self-reported “previous knowledge” about PPD among Prenatal Health Fair attendees before and after the mass media campaign.

Figure 2.3: Previous Knowledge About PPD – Prenatal Health Fair Attendees Before and After Mass Media Campaign

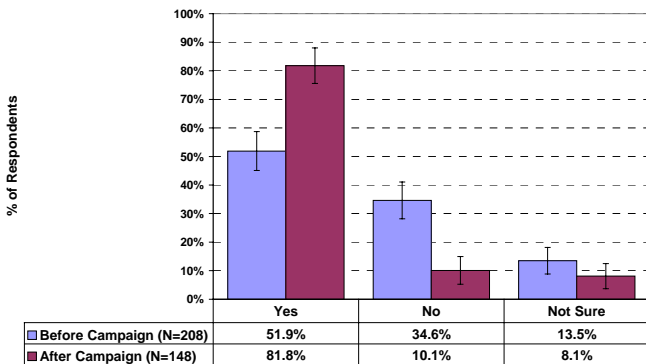


A similar analysis was conducted with data collected from Well Baby Clinics clients. This analysis also showed almost no difference in the number of clients who said they had heard of PPD *before* (91% of 213 clients) and immediately *after* (93% of 147 clients) the mass media campaign.

Notwithstanding these findings, as shown in Figure 2.4 there was evidence that the mass media campaign was at least *noticed*, even if it did not measurably increase general awareness or knowledge about PPD. Among clients of Well Baby Clinics, about 52% of respondents who

attended clinics *before* the campaign reported hearing or seeing information about PPD in mass media sources, compared with about 82% *after* the campaign. This difference was statistically significant.

Figure 2.4: Ever Seen PPD Info in Mass Media Sources?
Well Baby Clinics: Feb-March and Nov-Dec 2004



The foregoing suggests that there was already a high level of general awareness about PPD in the population before the mass media campaign. There was no evidence that the mass media campaign increased awareness about PPD per se, however there was evidence that the campaign did “register” in the population.

The indicators just discussed should be considered measures of general awareness about PPD. As will be reported later, an attempt was also made to measure whether the mass media campaign had any impact on knowledge about PPD.

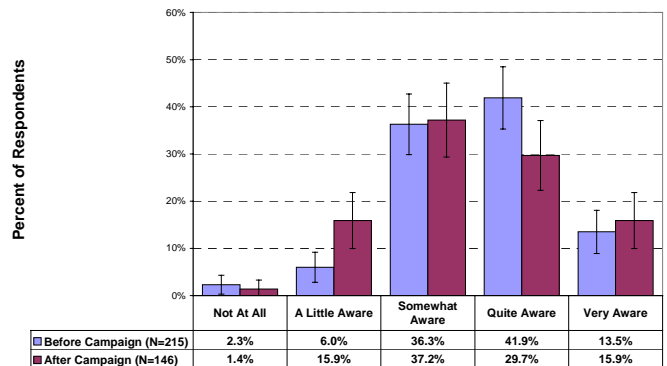
Impact of Mass Media Campaign on Knowledge of Risk Factors and Signs and Symptoms of PPD

As suggested by our program theory, early identification and intervention will be more likely if women at risk of or suffering with PPD are *knowledgeable* about risk factors and signs and symptoms of PPD.

Clients at Well Baby Clinics were asked to rate their level of awareness of PPD signs and symptoms. As shown in Figure 2.5 there was little difference in self-ratings of awareness of PPD signs and symptoms between clients who came to Well Baby Clinics in the months just

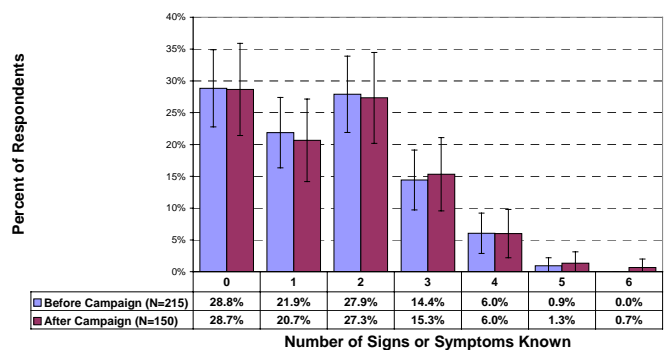
prior to and just after the mass media campaign. That is, the only statistically significant difference was a slight increase in the percentage of clients (from 6% to 15.9%) that said they were a little aware of PPD signs and symptoms after the campaign. This was offset by a decline in the percentage that said they were quite aware (from 41.9% to 29.7%).

Figure 2.5: Extent Aware of PPD Signs & Symptoms
Well Baby Clinic Clients – Before and After Mass Media Campaign



Well Baby Clinic clients were also asked to write down from memory any signs and symptoms of PPD that they knew. Respondents’ answers to that question were analyzed and categorized by two PHNs working with the PPD program. Figure 2.6 reports the number of recognized PPD signs and symptoms Well Baby Clinic respondents were able to correctly list. It shows that a substantial majority of Well Baby Clinic clients knew at least one symptom of PPD, but just less than half of the respondents knew two or more signs and symptoms. There was virtually no difference detected in measures taken before and after the campaign.

Figure 2.6: Number of PPD Signs & Symptoms Known
Well Baby Clinic Clients – Before and After Mass Media Campaign



Together, Figures 2.5 and 2.6 suggests that *when assessed as an isolated, time-limited event*, the mass media campaign, in and of itself, had no measurable impact on knowledge of PPD signs and symptoms.

Impact of Second Round of TV and Radio PPD Public Service Announcements

Some additional PPD public service announcements were aired on local television and radio stations in 2005, as described in Table 2.2.

Table 2.2: Public Service Announcements on Local TV and Radio (2005)

Date	Media	Count
June 20 th – July 3 rd	CFPL television	62 times
Sept. 5 th – Sept. 25 th	CFPL television	92 times
One week in August	Radio spots on 4 local radio stations	unknown

Analysis of data obtained through the Rapid Risk Factor Surveillance System (RRFSS)¹² indicates that there was no statistically significant increase in levels of awareness and knowledge about PPD in the general population of adults over the age of 18 in Middlesex-London related to the timing of these public service announcements.

Conclusions About the Impact of the Mass Media Campaign

What can be concluded from the apparently negligible impact of the mass media campaign on awareness and knowledge about PPD among the segments of the target population that were surveyed?

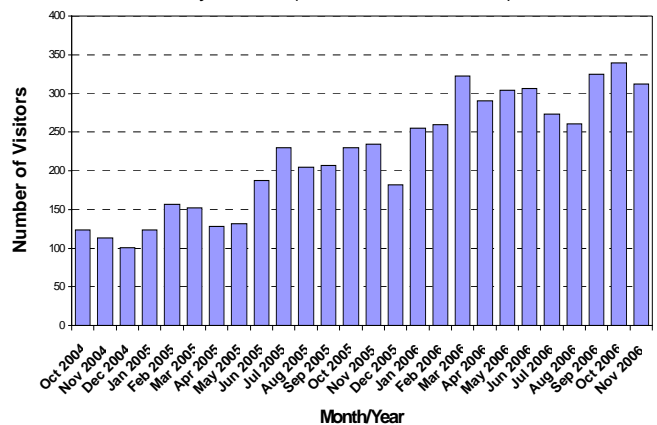
These data indicate that there was a high level of general awareness in the population about PPD before the mass media campaigns were conducted. There has been a lot of publicity over the last several years related to PPD. Increased public interest and awareness of PPD

in southern Ontario seems to have stemmed from incident that occurred in August 2000, when a physician from London, Ontario killed herself and her baby by jumping in front of a Toronto subway train.

It is not realistic to think of a “one-off” mass media campaign as a sufficient strategy for increasing *knowledge*. It should be noted that the MLHU mass media campaign was not really a “one-off” event. Though some of the mass media aspects of the MLHU program (i.e., television and radio spots) were conducted in relatively discreet waves, they were part of a broader campaign carried on through a variety of channels, including coalition meetings, face-to-face interactions, mailings, and the Mother Reach web site. Seen as part of a comprehensive strategy to increase awareness and knowledge in the population, a mass media campaign may still be useful and effective.

Generally, the indicators that were developed were not sensitive enough to measure the impact of the mass media strategy as a component in a broader educational campaign.

Figure 2.7: Unique Visitors to Mother Reach Website By Month (Oct 2004-Nov 2006)



One exception is the indicator displayed in Figure 2.7. This figure displays visit statistics from the Mother Reach web site from the point of the first mass media campaign, though to the end of the program. It reports the number of “unique visitors”¹³ to the web site by month. It suggests a trend of generally increasing awareness over the course of the program.

¹² RRFSS data is used extensively in analyses reported later in this section of the report. For a description of this data set, see p .

¹³ A person using the same computer is counted only once in any given month, no matter how many times they visit the site in that month.

One conclusion that may be drawn from these data is that the efficacy of an isolated mass media campaign, especially in terms of increasing knowledge, should not be overestimated.

Impact of Enhanced PPD Education at MLHU Prenatal Classes

As discussed briefly, one of the first activities undertaken as part of the PPD program, was to review and update the curricula of both the MLHU Prenatal Classes and Just Beginnings¹⁴ program. A pre/post survey of all Prenatal Class participants that attended classes from July 14th through November 17th 2004. Prenatal Classes consist of a series of five classes, for both expectant mothers and their partner or support person. The prenatal series covers a wide range of topics, including PPD. The questionnaires posed the same questions before and after the series, in order to detect any changes in awareness and knowledge that might be attributable to the course.

All participants (including spouses/partners or support persons) in each of the 35 series of Prenatal Classes that were conducted during this period were asked to complete pre and post-series questionnaires. The responses of individuals to the pre and post questionnaires were linked, in order to make it possible to directly compare their pre and post series responses. A total of 512 individuals completed the pre-series questionnaire, while 413 completed the post-series questionnaire. For the following analysis, only the 400 individuals who completed both pre and post questionnaires are included.¹⁵

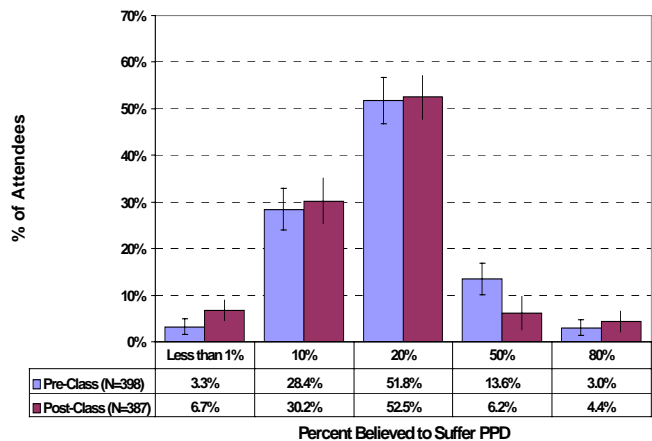
A series of questions were asked to determine the impact of the Prenatal Class curriculum on attendees' awareness and knowledge about PPD, PPD risk factors, signs and symptoms of PPD, and available resources. Figures 2.8 through 2.13 report attendees' self-reported

level of knowledge or awareness in terms of a number of basic indicators.

Impact on Basic Knowledge and Awareness of PPD Risk Factors, Signs and Symptoms

Respondents were asked to select from a list of response options what percentage of women they believe suffer from PPD after giving birth. As shown in Figure 2.8, a nearly identical proportion of respondents at pre-test and post-test --28% and 30% respectively--correctly identified that about ten percent of women suffer from PPD after giving birth. Respondents tended to over-estimate the incidence of PPD, which is perhaps better than underestimating it.

Figure 2.8: What Percent of New Moms Believed to Suffer PPD? Prenatal Class Attendees



Figures 2.9 indicates that 60.2% of respondents reported having no or little awareness of PPD signs and symptoms before their PPD classes began. At the end of the series, only 17.2% indicated having no or little awareness of PPD signs and symptoms. This is a change of 43%. The largest portion of this change was an increase from about 10% to almost 39% in the number of respondents who indicated they were quite or very aware of PPD signs and symptoms. Figure 2.10 reveals a very similar picture in terms of respondents' awareness of PPD risk factors.

¹⁴ A four week series of classes for new moms with babies up to six months of age, offered through MLHU and Ontario Early Years Centres. Due to resource limitations, a decision was made not to survey Just Beginnings participants.

¹⁵ A small number of respondents may not have answered any given item, hence the number of respondents on any given may be less than 400.

Figure 2.9: Awareness of PPD Symptoms
Prenatal Class Attendees

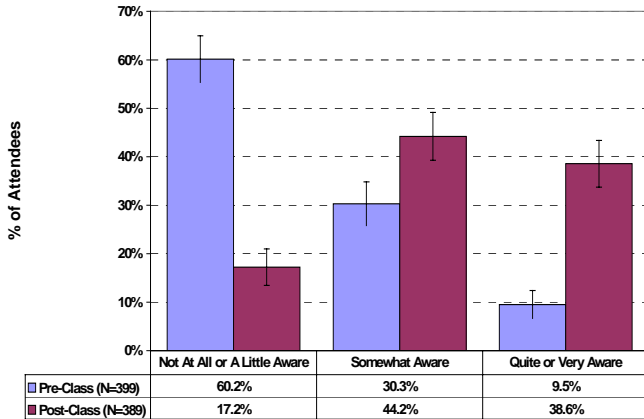


Figure 2.10: Awareness of PPD Risk Factors
Prenatal Class Attendees

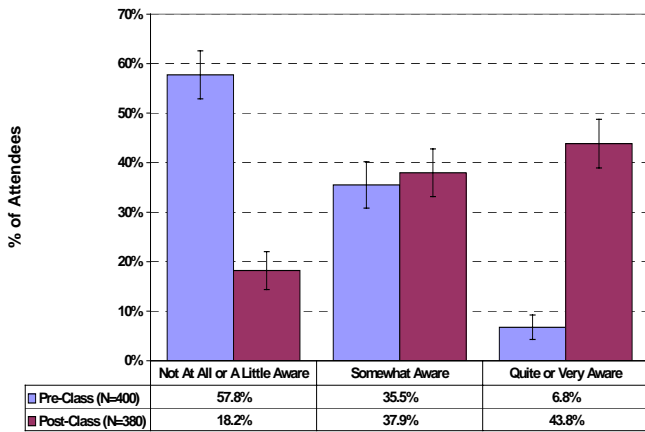
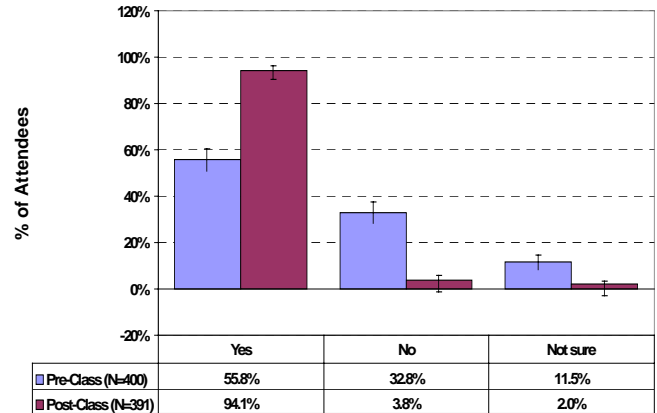


Figure 2.11 reports on respondents' knowledge that there is a difference between PPD and the baby blues. It indicates that whereas before classes began about 56% reported knowing there was a difference, at the end of the series over 94% reported knowing there was a difference. Thus when respondents were asked, as in these last two indicators, to indicate in *general terms* their level of awareness or knowledge about basic aspects of PPD, the Prenatal Classes appeared to be quite successful in increasing levels of awareness and knowledge. This appears to somewhat at odds with the finding reported in Figure 2.8.

Figure 2.11: Know Difference Between PPD and Baby Blues?
Prenatal Class Attendees



To probe a little more deeply into respondent's knowledge about PPD, they were asked them to indicate from a list of choices, "At what point would you say the "baby blues" becomes something a woman should seek help for?" According to the literature, women should seek help if the blues do not go away after about two weeks. That is one of the key messages conveyed by the Prenatal Class curriculum, as well as through the mass media campaign. This may be taken therefore as one indicator of increased knowledge about PPD signs and symptoms. Figure 2.12 compares the responses from the pre-series questionnaire with the responses from the post-series questionnaires.

A modest percentage of respondents answered the question "correctly" on the pre and post-series questionnaire (about 37% and 39% respectively). From this analysis it appears that the Prenatal Series was not very successful in increasing participants' knowledge in terms of this key message.

What cannot be discerned however from this analysis, is how the responses of the same individuals may have changed from pre to post-series. In other words, to what extent did those that *did not know* the correct answer before classes answer correctly at the end of the series? Conversely, to what extent did those that *did* answer correctly the first time, answer incorrectly on the post-series questionnaire? To answer this question respondents' answers to the question on the pre-class questionnaire were categorized as correct or incorrect, and compared to the responses of the same

individuals on the post-series questionnaire. The result of this analysis is displayed in Figure 2.13.

Figure 2.12: When to Seek Help for Baby Blues?
Prenatal Class Attendees

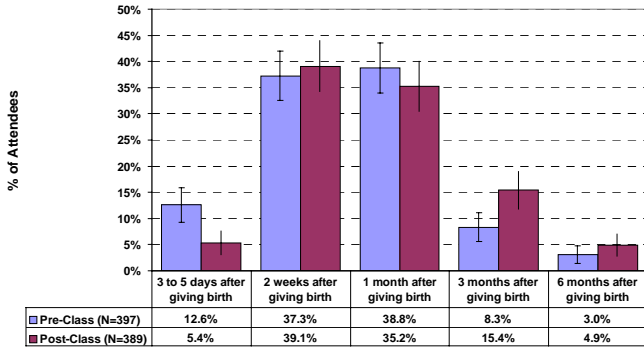
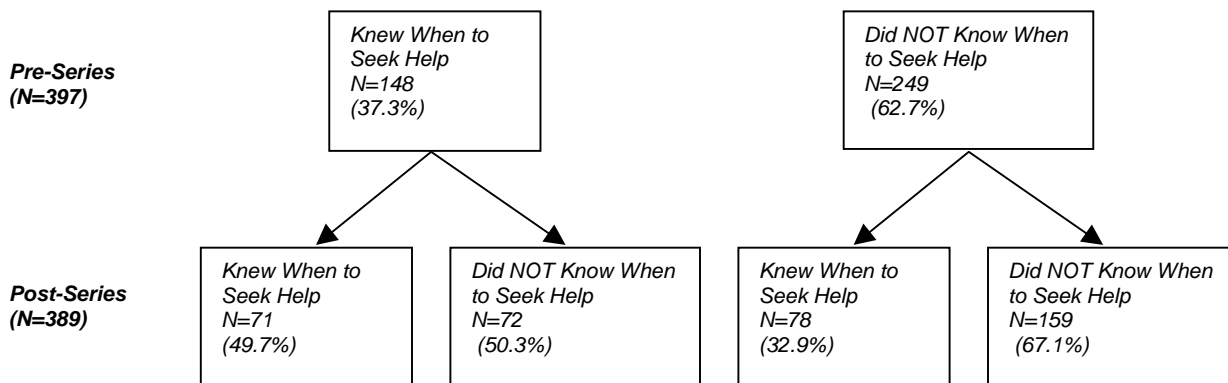


Figure 2.13: Comparison of Individuals’ Responses to “When to Seek Help” on Pre and Post Series Questionnaires



This analysis reveals that a substantial percentage (67.1%) of those who *did not know* before they began their prenatal series that a woman should seek help if the blues don't go away two weeks after giving birth, answered correctly on the post-series questionnaire. However, it also reveals that about half of those who answered correctly on the pre-test, answered incorrectly on the post-test. There was no difference when this analysis was performed considering only the responses of the mothers-to-be.

One must conclude that in terms of this particular key message, the prenatal series was, at best, only somewhat successful in increasing

the attendees’ knowledge about at what point after giving birth a woman should seek help for symptoms of PPD.

Impact on Awareness of Educational and Supportive Resources to Help with PPD

To get a sense of attendees’ pre-series and post-series awareness of various educational and supportive resources, respondents were asked to indicate on a list of 10 resources whether or not they were *already aware* (prior to the day of the survey) of each of the resources listed. In order to facilitate the most valid possible responses, a display board with samples and/or pictures of the various informational resources

posted on it was set up in the classroom. In this way, respondents could see the actual resource and hopefully recall more accurately whether they were already aware of the resource.

Analysis of pre and post-series responses is shown in Table 2.3. The list of resources is presented below in rank order, according to the percentage of respondents that indicated they were aware of the resource at post-test. It indicates that prior to the prenatal classes, just over 30% of respondents were aware of the availability of public health nurses for support, but less than 10% were aware of the various other resources. It also indicates notable increases in the percentage of respondents that were aware of these resources after their series of prenatal classes. While the Prenatal Series substantially increased attendees' awareness of various supportive resources that are available, less than half of the respondents indicated they were aware of the various resources at the end of the prenatal series, with the exception of *public health nurse support*.

Educating About PPD at 48-Hour Call and Home Visit

A final activity within the Education and Personal Skill component of the PPD program to be considered, is teaching about PPD done by

nurses at the 48-Hour Call (telephone contact) and Home Visits. As part of the Healthy Babies Healthy Children (HBHC) Program, the 48-Hour Call and Home Visit provide an opportunity to contact a large proportion of women who give birth in the immediate postpartum period. The intent is to come as close as possible to being a point of universal screening for perinatal prevention and health promotion (screening, assessment, education, and early intervention.)

Earlier in this report a description was provided about the training that the nurses who conduct the 48-Hour Calls and Home Visits received, to increase their knowledge and skill in PPD assessment and early identification, as well as their awareness of available resources for intervention. As noted, in the wake of that training nurses were asked to track and document aspects of their contacts with clients during two "rounds" of data collection; April through May of 2004, and April through June of 2005. Among the activities they were asked to document was the extent of teaching with clients about PPD during their telephone contacts and home visits.

Table 2.3: Awareness of PPD Resources Before and After Prenatal Classes

Description of Resource	Pre-Series		Post-Series		% Increase
	Total Responded	% Aware of Resource	Total Responded	% Aware of Resource	
Public Health Nurse Support	389	30.8%	369	56.6%	25.8%
Baby Blues: When They Won't Go Away (Pamphlet)	393	9.2%	368	45.1%	35.9%
PPD...More Than Just the Baby Blues (Pamphlet)	389	8.5%	366	37.2%	28.7%
10+1 Tips to Father Through PPD (Pamphlet)	390	4.6%	365	32.1%	27.4%
PPD Display	386	7.0%	359	25.1%	18.1%
Counselling Service	371	7.5%	331	21.8%	14.2%
PPD Support Group	387	5.4%	352	20.5%	15.0%
Grandparent's Guide to PPD (Pamphlet)	387	3.4%	363	19.3%	15.9%
Mothering & Depression Class	383	5.5%	355	15.2%	9.7%
Inventory of PPD Programs & Services	385	2.3%	356	10.7%	8.3%

Data on the number of births and postpartum contacts for the health unit area are reported and monitored through a provincially administered database known as the *Information Services for Children Information System (ISCIS)*. By comparing data from ISCIS with data collected for this evaluation at the 48-Hour Call and Home Visit, we can estimate¹⁶ the extent to which the population of women who gave birth were educated about PPD during the 48-Hour Call and Home Visits.

As displayed in Table 2.4, there were 784 families with a live birth in the Middlesex-London Health Unit area during the first round of data collection. Of these, 474 or 60% received a postpartum telephone contact according to the ISCIS monitoring report for the period. Of those who received a telephone contact, nurses recorded contact information for 238 individuals (or 50%). Nurses recorded contact information for 141 individuals (or 20%) of those who received a home visit.

Nurses continued making postpartum contacts between rounds of data collection as a matter of course. In order to increase the percentage of

postpartum contacts documented during the second round, the Program Evaluator conducted an “orientation session” with nurses. The session included giving feedback from what was learned from analysis of data collected during the first round, and reviewing the purpose of and recommended procedures for documenting contacts during Round 2. As shown in Table 2.4, we have contact information from Round 2 for 71% of those who received a telephone contact, and 61% of those who received home visits.

Table 2.5 displays the extent of teaching done during postpartum contacts by PHNs during both rounds of data collection. The first row of this table reports on the percentage of contacts during which the nurse did some kind of teaching with the mother about PPD. It indicates that the percentage of telephone contacts during which PPD teaching occurred increased from 63% ($\pm 6.1\%$) in Round 1, to 82% ($\pm 3.4\%$) in Round 2. This difference is statistically significant. The percentage of contacts during which PPD teaching occurred at home visits was nearly identical for both rounds.

Table 2.4: Sample Information, 48-Hour Call/Home Visit Data Collection Period

	Round 1	Round 2
	April 1 - May 31	April 1 - June 30,
	2004	2005
Number of resident families with a live birth*	784	950
Number (percent) of families with a live birth who received a telephone postpartum contact*	474 (60%)	676 (71%)
Number (percent) of families contacted by telephone included for whom data is available	238 (50%)	482 (71%)
Number (percent) of families with live birth who received a postpartum home visit*	347 (44%)	505 (53%)
Number (percent) of families who received home visit for whom data is available	141 (41%)	309 (61%)

*Source: ISCIS Monitoring Reports. There were some inconsistencies detected in the data reported, so these figures should be taken as estimates.

¹⁶ The two data sets do not correspond in time exactly. The ISCIS system reports on births and postpartum contacts that occurred precisely within the specified time periods. However, there is necessarily some lag time between the date of birth and the point in time a nurse is able to make telephone contact or conduct a home visit. Therefore, mothers contacted by nurses in the first or last few days of the data collection period most likely gave birth in the preceding or subsequent time period. Overall, the net effect of this source of error on both ends of the data collection period should be more or less neutral.

It should be noted that the “orientation session” held with nurses just prior to the second round of data collection probably had an impact on the findings reported in Table 2.5. Comments made during that session suggests two important points. First, feedback to the nurses of findings from the first round, and stressing the importance of completing the data collection forms thoroughly for each contact in Round 2 had the effect of increasing the proportion of contacts for which we have data. Second, the very act of asking nurses to document their practice using the tracking sheet (see Appendix B) had an impact on their practice. That is, according to their own accounts given in a focus group reported on earlier in this document, nurses were more likely to explicitly screen for and educate clients about PPD when having to document their practice on the tracking form, than they would otherwise have been. As such, differences between the extent of teaching indicated for Rounds 1 and 2 may be indicative of the difference in nurses’ practice that might be expected under conditions of more or less training reinforcement.

The data in Table 2.5 suggest that nurses do some degree of explicit PPD teaching during a substantial majority of their postpartum contacts—in up to approximately 80% of telephone contacts, and nearly 90% of home visits. Thus, though they indicated that they

taught about PPD in a majority of telephone contacts, they were more likely to have taught at home visits, especially during the first round. (In the second round the difference was slight [82% ±3.4% versus 89% ±3.5%] but still statistically significant.) The data further indicate that nurses were much more likely to discuss the idea that the baby blues is normal, and the differences between baby blues and PPD, than to discuss risk factors associated with PPD. Interestingly, nurses were more likely to have given clients information on where to go for help at home visits coinciding with Round 2 of data collection (31% ±5.2%) than with home visits during Round 1 (16% ±6.1%). This may reflect the fact that the package of resources and information available to nurses for teaching continued to be improved and developed between rounds of data collection. Nurses sent or distributed a package of information about PPD to clients in relatively few of the telephone contacts during either round. The percentage of clients to whom they gave information packages at home visits declined from 17% (±6.2%) in Round 1 to 5% (±2.4%) in Round 2. It is unknown why this would be the case.

Table 2.5: Extent and Content of Teaching About PPD at 48-Hour Call and Home Visits

	Round 1				Round 2			
	48-Hour Call (N=238)		Home Visit (N=141)		48-Hour Call (N=482)		Home Visit (N=309)	
	N	%	N	%	N	%	N	%
Nurse Did PPD Teaching With Mother	151	63%	17	88%	86	82%	276	89%
Nurse Did NOT Do PPD Teach With Mother	87	37%	124	12%	396	18%	33	11%
Discussed the idea that baby blues is normal	124	52%	100	71%	310	64%	218	71%
Discussed difference between baby blues and PPD (signs & symptoms of PPD)	98	41%	103	73%	291	60%	238	77%
Gave client info on where to go for help for PPD	27	11%	22	16%	47	10%	97	31%
Discussed various "risk factors" associated with PPD	25	11%	33	23%	66	14%	87	28%
Sent package of information to client	20	8%	24	17%	31	6%	16	5%

Awareness/Knowledge About PPD in General Population (RRFSS Data)

The data reported so far in this section of the report have come from surveys of users of various MLHU services or programs that serve the population of women in the perinatal period. The following analysis is based on data gathered through the Rapid Risk Factor Surveillance System (RRFSS).

RRFSS is an on-going telephone survey conducted on behalf of public health units across Ontario. On a monthly basis, a random sample of 60 to 100 adults aged 18 years and older is interviewed regarding risk behaviours, knowledge, attitudes and awareness about health related topics of importance to public health. The survey is conducted by the Institute for Social Research (ISR) at York University, on behalf of all RRFSS-participating health units.

During 2005, among the questions asked was a series of questions designed to determine aspects of awareness of and knowledge about PPD. Valid data on these questions was obtained for 1213 individuals from Middlesex-London for the year 2005.

General Awareness of PPD

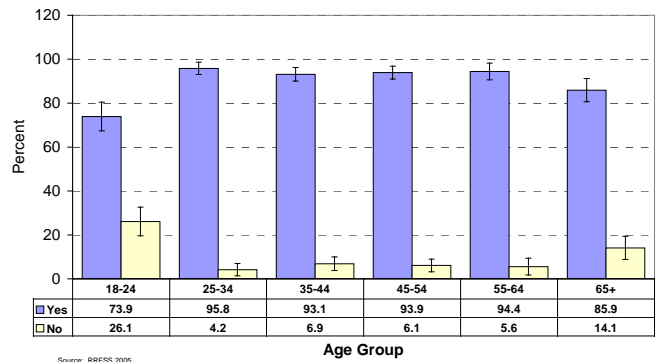
In 2005, 89.9% ($\pm 1.7\%$) of all respondents indicated they had heard the phrase “postpartum depression”. There were statistically significant differences based on gender, age, and language. There were no statistically significant differences based on whether or not respondent had children, income, education, or urban versus rural place of residence.

Gender. In terms of gender, 95.2% ($\pm 1.6\%$) of women compared with 83% ($\pm 3.2\%$) of men indicated they had heard the phrase “postpartum depression”.

Age. As shown in Figure 2.14, younger adults (18-24 years) and to a lesser degree, older adults (over age 65) were less likely to have

heard of PPD. Among 18 to 24 year olds, 73.9% ($\pm 6.5\%$) had heard of PPD, and 85.9% ($\pm 1.7\%$) of adults aged 65 years and older had heard of PPD, compared to between approximately 93% and 96% of respondents in the other age categories. One might have expected to find a difference in awareness of PPD between adults in their prime childbearing years compared to other adults. It is noteworthy that there were no statistically significant differences in awareness of PPD between adults in the four age groupings that included adults between the ages of 25 and 64 years old.

Figure 2.14: Awareness of PPD by Age
General Population



Language. Among persons who indicated that the language spoken most often in their home was English, 93% ($\pm 1.5\%$) indicated they had heard of PPD, while only 59.3% ($\pm 9.1\%$) of those who indicated that a language other than English was spoken most often at home had heard of PPD.

Knowledge of PPD Symptoms

RRFSS respondents were prompted with the question, “What are some symptoms of postpartum depression?” The interviewer did not read a list of symptoms to the respondent. Rather, the interviewer recorded how many symptoms respondents were able to name on their own, in terms of the following categories of symptoms: sadness/crying, anxiety/fears, sleep/appetite/energy changes, guilt feelings, and other.

Just over half (54.1% $\pm 3\%$) of the respondents were able to name two or more symptoms of

PPD. This was not significantly different than the 50.1% ($\pm 5.1\%$) of respondents to the two Well Baby Clinic surveys conducted in 2004 (N=365) that were able to name two or more symptoms of PPD (see p. 31).

The ability to name two or more symptoms of PPD varied significantly by gender, age, income, education, and whether or not respondents had children. It is noteworthy that among those that had heard of PPD, there was no statistically significant difference in the ability to name two or more symptoms between those that did and those that did not speak English at home. There was no statistically significant difference between those living in a rural versus urban place.

Gender. 61.7% of women ($\pm 3.7\%$) compared with 42.7% ($\pm 4.6\%$) of men were able to name two or more symptoms of PPD.

Age. 43.8% ($\pm 8.5\%$) of those age 18-24 years and 32.6% ($\pm 7.7\%$) of those 65 years and older could name two or more symptoms of PPD, compared with 60.3% ($\pm 4.6\%$) of 25-44 year olds and 58.6% ($\pm 4.9\%$) of 45 to 64 year olds.

Household Income. 45.2% ($\pm 6.3\%$) of those with household incomes under \$40,000 could name two or more symptoms of PPD, compared with 58.9% ($\pm 6\%$) in the \$40,000 to \$69,999 income bracket, 64.3% ($\pm 7\%$) in the \$70,000 to \$99,999 income bracket, and 62.9% ($\pm 6.9\%$) in the \$100,000 plus income bracket.

Education. 33% ($\pm 9.7\%$) of those who had not completed high school were able to name two or more symptoms of PPD, compared with 64% ($\pm 3.9\%$) of those who had graduated from a post-secondary school program. Of those who had some schooling past high school, but had not graduated from a program, 45% ($\pm 4.8\%$) were able to name two or more symptoms of PPD. (The difference between those with less than high school and those with some post secondary schooling was not statistically significant.)

Children. Among those who had no children 48.8% ($\pm 3.7\%$) could name two or more

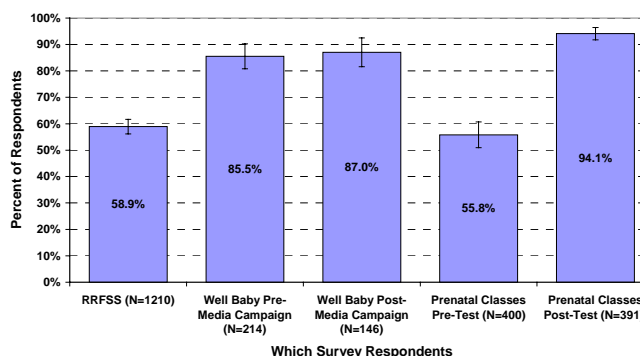
symptoms of PPD, compared with 65.5% ($\pm 7.7\%$) of those with children ages 0 to 6 years, and 61.5% ($\pm 6\%$) of those with children 7 years or older. (The statistically significant difference is between those with no children and the other two groups.)

Awareness of the Baby Blues and Knowledge of When to Seek Help

In terms of general awareness about the difference between PPD and “the baby blues”, 58.9% ($\pm 2.8\%$) of RRFSS respondents indicated they had heard the phrase “baby blues”. Of those who said they had heard the phrase “baby blues”, 13.9% ($\pm 2.5\%$) were able to correctly identify that a woman should seek help after two weeks if symptoms persisted.

To put these findings in some perspective, a comparative analysis can be conducted with data from the Well Baby Clinics and Prenatal Classes on two similar indicators, as displayed in Figures 2.15 and 2.16. The indicator for general awareness was similar¹⁷. The indicator for knowledge of when to seek help was almost identical.

Figure 2.15: General Awareness of Baby Blues
(Heard of/Knew Was Different than PPD)



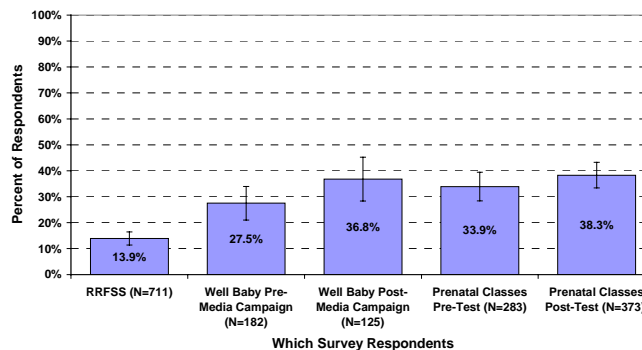
¹⁷ The Well Baby Clinic and Prenatal Class surveys asked: “Did you know that there is a difference between “the baby blues” (a normal period of temporary sadness immediately after birth) and Postpartum Depression (a very real illness which may require help)?”

As shown in Figure 2.15, the level of awareness about the baby blues was very similar among those in the general population (58.9% ±2.8%) and those who were just about to begin Prenatal Classes (55.8% ±4.9%). Well Baby Clinic clients (pre and post-media campaign combined¹⁸, 86.1% ±3.6%) and those who completed Prenatal Classes (94.1% ±2.3%) had greater levels of general awareness about the baby blues than the general population. This was true even when taking into account the fact that the indicator of general awareness for RRFSS is less discriminating (i.e., would err on the side of over-estimating the level of awareness of the general population.)

In other words, those who were definitely exposed to MLHU programs and services (Well Baby Clinics and Prenatal Classes) had a higher level of general awareness about the baby blues than the general population and/or those who were about to take the Prenatal Classes.

Figure 2.16 reports on whether respondents knew when to seek help, for those who had indicated they had some awareness about the baby blues (i.e., had indicated they had heard of the baby blues (RRFSS) or knew the difference between the baby blues and PPD (Well Baby and Prenatal Classes). It suggests that a considerably higher percentage of Well Baby Clinic clients (27.5% ±6.5% and 36.8% ±8.5%) and Prenatal Class attendees (33.9% ±5.5% and 38.3% ±4.9%) knew a woman should seek help if symptoms persist beyond two weeks after giving birth, compared to the general population (13.9% ±2.5%). As well, there appears to be a slight increase in knowledge about when to seek help among post-media campaign Well Baby Clinic clients and post-series Prenatal Class attendees, but these differences were small and not statistically significant.

Figure 2.16: Knew to Seek Help If Symptoms Continue 2 Weeks After Birth



¹⁸ There was no statistically significant difference in awareness of baby blues between pre-media campaign and post-media campaign Well Baby Clinic clients, therefore these data were combined in reporting this particular finding.

Community Capacity Building

As described in the introduction to this report, community capacity building was one of the key strategies employed in the PPD program. The purpose of this component of the program was initially framed in terms of establishing specific, defined linkages with community partners to ensure appropriate follow-up and support for clients. To achieve this MLHU staff initiated the formation of the Mother Reach coalition. The process of creating the coalition and its vision and mission statements are briefly described on page 10. The extent of membership as of January 2007 is presented on page 25.

The vision and mission that came to be adopted by participants was somewhat broader than the purpose originally defined by program initiators. The coalition's work became related to each of the components of the PPD program. Coalition members participated in increasing public awareness about PPD, training service providers, disseminating educational and information resources to the target population, as well as working to *improve access to services* as suggested by the original objective stated above.

Some of the outcomes of these activities are discussed in previous sections of this report. This section will focus on evaluating a fairly narrow aspect of the coalition's work, that is, the *assessment of the capacity of the network of service providers to meet demand for PPD-related services*.

Attempting to Track Demand for Service

The Program Evaluator worked with a subcommittee of coalition members to develop an evaluation plan that would assist in achieving their key objective. In order to improve access to services, committee members decided to assess the capacity of the network of service providers to meet demand and identify any gaps in service. This information would be used to mobilize resources needed to meet demand for PPD-related services.

A plan was made to develop a tracking tool that would be capable of measuring both current

system capacity and gaps in service. The tool would be filled out by appropriate personnel at all service providing agencies.

There were many challenges faced in trying to implement this plan including: identification of all relevant service providers, creation of a tool that would be able to appropriately measure relevant dimensions of the full range of services provided, securing the willingness and cooperation of all relevant personnel to collect and record needed information, and training relevant personnel in filling out the form so as to ensure that the data collected would be valid.

The tracking tool went through several drafts. The tool and procedures for data collection were presented to the coalition as a whole. Feedback was received and revisions were made. Concerns were raised at the coalition about the extent to which reliable and consistent completion of the tracking could be realistically expected. Nonetheless, coalition members decided to go ahead with and promote the tracking plan within their organizations. Data collection was to take place for the six months; November 2005 through April 2006. A series of training sessions were held by the Program Evaluator and the Public Health Nurse who was responsible for supporting the work of the coalition, to ensure proper completion of the tracking forms.

The primary result of this effort was the realization that the plan to track demand for service and actual service provision by this method, across such a disparate variety of loosely affiliated service providers (in terms of types of professional roles and organizations) was not feasible.

Service providers from 51 different health, social service and educational organizations were asked to complete the tracking forms. In the end there were records of service obtained for 464 individuals. However, MLHU generated 72.4% of the records. One of the hospitals generated another 10.8% of the records. One of the Ontario Early Years Centres generated 5% of the records. Three other community-based agencies provided the balance of the records

(less than 5%). The majority of the records were collected for the month of November 2005.

It is impossible to draw any conclusions about the demand on the system, the capacity of the system to meet demand, or gaps in available service from this data.

Qualitative Evidence on Capacity to Meet Demand and Gaps in Service

The best information we have as to the extent to which the network of service providers is able to meet demand for service and gaps in service comes from the focus group that was conducted with Mother Reach coalition members in November 2006.

Participants were asked to comment on the capacity of the network of service providers to provide adequate assessment, early identification and treatment for PPD before the program began four years earlier.

There was strong concurrence that the PPD program, including the work of the coalition has clearly increased and strengthened community capacity to respond to PPD. Participants recalled that in terms of PPD-specific resources, there had been only one peer support group for women with PPD. There was no regular communication or connection between agencies with respect to coordination or development of PPD services. As one participant noted, there was “no knowledge of what other agencies were doing”. Another participant commented that “in the area of children’s mental health services, awareness was minimal to non-existent.”

As reported earlier, the PPD program greatly increased service providers’ knowledge and skill respect to assessment and early identification of women with PPD. Front-line workers in coalition member agencies now feel well able to provide initial screening, assessment, information about PPD.

In terms of new resources, it was commonly agreed that the PPD Drop-In Centre (pilot project) housed at the *Babeez in Arms Doula Services* is an important available resource that clients can be referred to for a combination of

peer support and counseling from a Public Health Nurse.

In terms of being able to refer women with acute symptoms of PPD, all coalition members were well aware of the work of the psychiatrist Dr. Verinder Sharma. Dr. Sharma has emerged as a critically important and highly utilized resource for assessment of women with acute symptoms of PPD.

There was a clear consensus that the significant gaps in service remain in two key areas:

- The need for appropriate, *affordable*, ongoing counseling support for women with PPD.
- The need to sensitize, train and enlist the support of family physicians to properly support and treat their patients with PPD.

In terms of the first of these two points, the following comments from focus groups participants are illustrative.

Well I think the ability to refer for acute assessment of an individual with postpartum depression to Dr. Sharma has made that an easier referral mechanism for anybody working in the community. But I think the long-term is where the gap in service is. I mean he can do that initial and see the client, be able to put into play some therapy, whatever he sees is necessary, but he doesn’t have the capacity to do that long-term. And it’s what do you do with those patients or clients after that? So I see that as being a real concern. I think we have peer support groups, we have the drop-in centre operating now that we can give clients that information to be able to access those resources. But if you’re needing something else that’s a routine follow-up with someone who knows your case, that you can speak to them one-on-one, and if that is a physician-oriented or a counselor or a psychiatrist, psychologist even. But it comes down to accessibility and affordability for many clients.

In response, participants strongly echoed and reinforced the concern around the affordability

of ongoing counselling support for women with PPD, especially those with limited resources.

As pertains to the second point, another participant made the following observation.

...(W)e see that at the drop-in a lot, that family physicians is a huge, huge gap. And the people that do bring it up the family physician, unfortunately a lot of doors are slammed.... (I)t's mainly Public Health and (other community) agencies, and it's either the grandmother, or their mother or a family friend or the husband...(that currently provide support, and) they're just at their wits' end and they're bringing them (to the drop-in.) And I don't know if it's because they're not going to the physician and actually opening up because at that point they may be six, seven, eight months postpartum and they're just not seeing their physician. I don't know if it's because of that or if it's because they really aren't getting any help when they're at their physicians.

In response another participant commented,

Or are they given the opportunity to really explore it? I think that is part of the issue...And so an individual may come in and think if they're not given the opening to say "Now that you ask me, yes, I am not sleeping well, I am having this sense." But the opening isn't always being provided.... We've heard some horrible stories at the drop-in. Women saying...the questions weren't asked, and [they said] 'When I did bring it up, they [family physicians] didn't know what to do with me.'

In terms of potential solutions to the existing gap, a passionate and extensive discussion took place around the desirability of creating a specifically woman-centred primary health care service possibly based on a model such as community health centre or family health team. Such a model would have elements of the drop-in centre that was piloted as part of the PPD program. As one participant reminded the group,

When we first got around the table and looked at what we would envision as

being a service for women with postpartum depression, it still came back to the one-stop, being able to refer those women to a non-threatening environment where they would have peer support, professional counseling, any of those services that they felt would benefit. But it was in one spot. And we have them in the community in certain ways but certainly not to the capacity that we need it.

A strong argument was made to push hard for the creation of such a woman-centred community health centre, particularly in light of the current health system restructuring. One participant argued that in light of the evidence around the consequences of PPD, including the costs to individual, families and communities that arise from failure to provide adequate support services, the creation of such a service should be seen as a moral imperative.

I think really what it comes down to is...not having a Women's Centre in this region, and that's where the big gap is. There really isn't the resources in that way and it's not coordinated and we don't have that Women's Centre and that's maybe what we need to put the energy into... Something that is part of the hospital, or part of the mainstream so that women who need any kind of mental health services don't have to go to a separate spot. Because the needs for these women are complicated and layered... They need the support of a handful of people in order to recover...with that the recovery rate is good. So it's a worthwhile investment to have a more integrated service for these women. They need medication, they need support, they need support from counselors, from peers, they need psychiatrists, they need dieticians....Their children need support. So you know, you can't just refer to one person and that's going to do the trick, it needs to be integrated... I think what we need to focus on is decreased duration...end result savings by investing in something like that... So if we can prove that there's cost savings by putting money into something like that, then that's where we are going to get more.

Conclusions and Recommendations

The MLHU Postpartum Depression Program achieved number of its intended outcomes.

A comprehensive set of up-to-date tools and resources for professionals for screening, assessment and referral was developed and distributed to a wide range of service providers. The knowledge and skill of service providers in assessment and early identification of women suffering with or at risk of PPD was significantly increased through many training sessions. There is a significant staff turnover in some agencies that provide PPD-related services, which suggests that service provider training should be offered on an ongoing basis. Front-line service providers identified a need for more training in specific interventions which have proven to be effective in treating or supporting women with PPD.

PPD was moved to the forefront of PHNs' awareness, and explicit asking about PPD symptoms became more routine during postpartum contacts (48-Hour Call and Home Visits) by PHNs. Use of a recommended screening tool increased substantially, however many nurses continued to rely on intuitive nursing judgement when deciding whether to formally assess a woman for PPD. The very act of tracking PPD-related practice probably increased the degree to which PHNs routinely screened for and educated women at postpartum contact about PPD.

Direct evidence about whether or not early identification of women suffering with or at risk of PPD increased as a result of the program was not obtained. However, there was evidence that the percentage of routine postpartum contacts for which PHNs *were unable to assess risk* decreased slightly.

The vast majority of the population of childbearing women, as well as the population of all adults over age 18 were generally aware of postpartum depression. High levels of awareness of PPD preceded the conducting of MLHU's PPD program. There are segments of the general population that were on average, relatively less aware of PPD, including men,

adults under age 24 or over age 64, people who speak a language other than English at home, and people without children. A mass media campaign was noticed, but did not have a measurable impact on levels of awareness and knowledge of PPD. However, visits to a newly created PPD web site with information and links to resources rose steadily throughout the course of the program.

While general awareness of PPD was very high, *knowledge* of more specific aspects of PPD, including symptoms and risk factors was lower. For example, while a substantial majority of Prenatal Class attendees reported their knowledge about PPD symptoms and risk factors had increased, only 30% to 40% were able to demonstrate increased knowledge. However, Well Baby Clinic clients and Prenatal Class attendees exhibited greater awareness and knowledge about the difference between PPD and "the baby blues" than members of the general population. In other words, those using MLHU perinatal services appear to have higher levels of awareness and knowledge about PPD than the general population of adults 18 years and older.

A broadly representative coalition of PPD-related service providers was formed and continues to be very active. Members participated in development of tools and resources, in giving and receiving professional training, and in the development of community education resources. The formation of the coalition resulted in improved access to service through more sharing of information and expertise, and the creation of new support resources and referral mechanisms. Coalition members identified ongoing gaps in service including a shortage of appropriate, affordable and accessible treatment services, and a lack of integration or engagement of family physicians in the network of PPD-related service providers. They also identified the lack of a specifically woman-centred, multidisciplinary primary health care service in the southwestern Ontario that would be capable of addressing the various determinants of PPD.

Recommendations

The following recommendations are offered by the Program Evaluator for the consideration of program managers, program staff and others that may be engaged in developing services to address the needs of women at risk of, or suffering from PPD:

- Service provider training around best practices for PPD screening, assessment and intervention should be offered on a periodic basis to both MLHU staff and external service providers, including training in specific interventions to support or treat women suffering with PPD.
- Further study should be undertaken to determine the extent to which formal early postpartum screening, assessment and teaching should become more standardized in order to optimize early identification of women at risk of, or suffering from PPD.
- Strategies should be considered to increase awareness about PPD among men, adults less than 24 years of age, new immigrants, and people with lower levels of education and income.
- Strategies should be considered to increase the assimilation of knowledge about PPD signs and symptoms, risk factors, available community resources, and when to seek help among those participating in programs such as MLHU Prenatal Classes and other prenatal education activities.
- Strategies should be developed to increase knowledge of family physicians and obstetricians about PPD, about women's experiences, needs and concerns around PPD, and about intervention and treatment options. More cooperative relationships between physicians and other PPD-related service providers should be forged.
- Strategies should be developed to mobilize resources needed to more systematically assess and redress the shortage of intervention and treatment resources for women suffering with PPD.
- The feasibility of establishing a specifically woman-centered, primary health care service in southwestern Ontario based on a model such as a community health centre or family health team should be explored.

Appendix A: Service Provider Training Presentation

Postpartum Mood Disorders

...It's Real!



Ontario

Postpartum Mood Disorders

- Occurs during pregnancy, and/or anytime up to one year after a miscarriage, adoption, or birth of a baby
- Most common complication of pregnancy
- if untreated - can lead to chronic depression, attachment problems in children and family dysfunction
- in extreme cases
 - Maternal Suicide
 - Infanticide

Ontario

Myths of Motherhood

- Because of the many myths surrounding motherhood, women may be reluctant to talk about their feelings of unhappiness
- guilt and shame occur when reality doesn't match what society and/or the woman expects
- Important to talk about feelings in order to cope -- need to know what's normal

Ontario

Normal Postpartum Adjustment

- Establishing a new family unit with changed roles, relationships, and communication patterns
- Realizing that having a new baby may not be what was expected

Ontario

Normal Postpartum Adjustment

- Grieving the loss of the pregnancy, the loss of her "old self", the change in relationships with partner, friends and family
- adjusting to the responsibility of caring for an infant, which can be overwhelming for a new mother

Ontario

Postpartum Mood Disorders (PPMD)

- ◆ Postpartum blues: up to 75%
- ◆ Postpartum depression: 10-15%
- ◆ Postpartum anxiety: 4-15%
- ◆ Puerperal psychosis: 0.1-0.2%

From Ross, Lori et al (2005). Postpartum Depression: A guide for front-line health and social service providers. Toronto: Centre for Addiction and Mental Health.

Ontario

Postpartum Blues

- Up to 80% of new moms experience postpartum blues
- usually starts on day 3 or 4
- can last for up to 2 weeks

Symptoms of Postpartum Blues

- Sadness
- fatigue
- mood swings
- tearfulness
- appetite changes
- sleep problems
- anxiety

Possible Causes of Blues

- Hormonal changes after delivery
- fatigue and sleep deprivation
- physical discomforts
- emotional letdown after pregnancy and birth
- anxiety about new role
- challenges of breastfeeding

Postpartum Depression

- Symptoms of blues that last longer than 2 weeks after the birth of the baby
- feelings of anxiety, loneliness, inadequacy
- feeling overwhelmed
- hopelessness, sadness, emptiness
- extreme fatigue/exhaustion
- changes in appetite
- thoughts of harming self or the baby

Strong Risk Factors

- Depression/anxiety during pregnancy
- Stressful recent life events
- Lack of social support(perceived or received)
- Previous history of depression

Aggravating Factors

- Sleep deprivation
- isolation
- breastfeeding difficulties
- demands of baby
- lack of supports

Personality Factors

- Anxious
- perfectionist
- unrealistic expectations
- strong, in-charge person
- pessimistic outlook

Factors With No Effect on PPMD

- Ethnicity
- Maternal Age
- Level of Education
- Parity
- Gender of Child(within Western Societies)

Risk Factors for Adolescents

- higher rates of depression:
 - under 18 yrs: >23%
 - 20 - 24 yrs: 13%
- higher rates of anxiety:
 - under 18 yrs: 45%
 - 20 - 24 yrs: 30%

Risk Factors for Adolescents

- poor prenatal care
- unrealistic expectations
- alcohol and drug abuse
- socioeconomic status
- cultural issues - rejection by family
- stressful events : peer pressure
dropping out of school

Postpartum Psychosis

- Rarest but most serious form of PPMD
- Occurs in 1 or 2 per 1000 mothers
- onset is usually 3 days postpartum or in the early weeks
- occasionally may be later related to new stressors or as a link with abrupt weaning

Postpartum Psychosis

- Symptoms:
 - out of touch with reality - key finding
 - hallucinations - visual or auditory
 - delusions
 - decreased need for sleep
 - psychomotor agitation
 - confusion/paranoia

Postpartum Psychosis

- THIS IS AN EMERGENCY SITUATION
- hospitalization is necessary
- medication and counselling for mother and family
- ensure safe care of infant

Risk Factors

- Personal or family history of psychosis, bipolar disorder or schizophrenia
- previous postpartum psychotic or bipolar episode
- unclear if postpartum psychosis is a distinct illness or part of an underlying condition such as bipolar disorder or schizophrenia

Effects of Untreated PPMD

- ◆ Impaired mother-infant attachment
- ◆ Interference with cognitive & behavioural development
- ◆ Relationship Stresses
- ◆ Potential mental health sequelae for women

Effects of Maternal Mood Disorders on Infants/Children

- 2/3 of infants of depressed mothers develop insecure attachments(higher incidence with no partner)- Murray and Cooper, 1992
- depression lasting longer than 6 months may result in growth and developmental delays

Effects of Maternal Mood Disorders on Infants/Children

Infants:

- difficulties with self-regulation
- sleeping disorders
- problems with sleep-wake and eating routines
- behaviour & social difficulties (socially withdrawn, anxious behaviors)
- Severe temper tantrums by 18 months

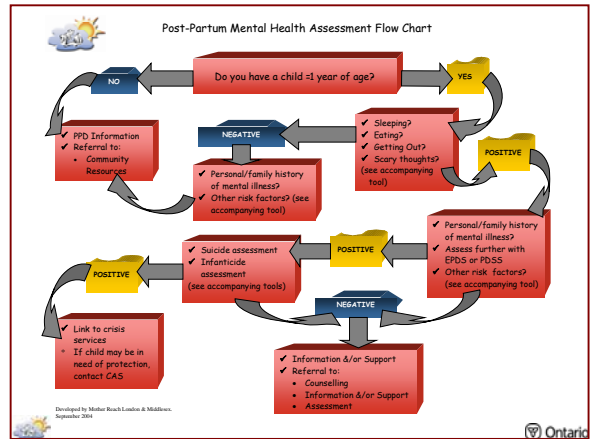
Effects of Maternal Depression on Older Children

- Cognitive delays
- speech and language delays
- social withdrawal
- depression
- substance abuse
- school problems

Mother Reach PARTICIPANTS

Babeez in Arms Doula Centre
Bethesda Centre
Birth Positive
Canadian Mental Health Association
Children's Aid Society of London & Middlesex
Family Services Thames Valley
heartspace
London Health Sciences Centre
London Mental Health Crisis Service
Madame Vanier Children's Services

Merrymount Children's Centre
Middlesex-London Health Unit
Ontario Early Years Centres
Regional Mental Health Care
St. Joseph's Health Care
Telehealth Ontario
Thames Valley Midwives
UWO - Health Zone
Womancare Midwives
Community members



Developed by Mother Reach London & Middlesex, September 2014



Edinburgh Postnatal Depression Scale (EPDS) Cox et al 1987

- 10 item self report scale
- translated into 20 languages
- can be used prenatally
- incorporated into the RAO BPG
- score needs to be used in conjunction with clinical judgement



Postpartum Depression Screening Scale (PDSS) Beck and Gable 2002

- 35 item scale with 7 symptom areas
- uses a 5 point response scale where mothers agree or disagree with each statement
- administered after 2 weeks or before 1 year
- copyrighted



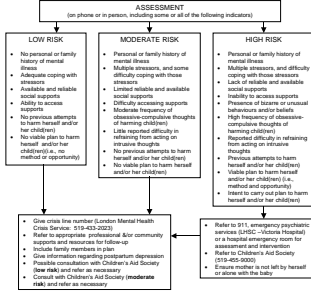
Available Services

- 519-672-HOPE
- www.helpformom.ca
- Postpartum Drop-In (Thursday 1 - 3 p.m.)
- Postpartum Adjustment Group @ Childreach (contact Anne Mckay @ 519-434-3644)
- Mental Health Crisis Service
- Inventory of Services



Decision Tree for Assessment & Intervention of Women with Thoughts of Hurting Themselves or Their Children

This decision tree is a guideline that can inform your practice with postpartum women. Your professional judgement is a critical element in its use. You may identify one or two 'red flag' signs/symptoms and may directly move to intervention without completing the entire assessment, or you may identify factors of concern that are not included below. **IF AT ANY TIME YOU ARE UNCERTAIN OF A WOMAN'S LEVEL OF RISK, CONSULT WITH A CHILDREN'S AID SOCIETY INAKE SOCIAL WORKER WITH EXPERTISE REGARDING POSTPARTUM DEPRESSION (519-455-9000)**



Revised Reference by Health Canada



Messages to Moms

- “You are not alone.”
- “It’s not your fault.”
- “You can get better.”
- “There is help.”



Case Studies

Questions to Consider

- Is there a role for CAS?
- If yes, what role?
- What other information do you need?
- What would be your initial steps for intervention?
- What interventions would be appropriate for this client? Short term?/long term?
- What other referrals would be appropriate?

Case Study #1

- Caller (PHN) reports that Susan has a 3 week old baby
- Lives with her parents (very supportive)
- Susan’s mother has a hx of postpartum psychosis and was hospitalized after Susan’s birth
- Susan has a hx of depression/sees a psychiatrist
- baby is thriving
- Susan is looking forward to her next psychiatrist appointment to discuss thoughts that she’s been having - when baby cries continually, Susan says she has thoughts of throwing him down - when she feels this way, says that she puts baby down and walks away
- recently has been prescribed Prozac
- receptive to CAS involvement

Case Study #2

- Caller (Police officer)
- Kelly is a 23 year old who is engaged to be married
- has a 5 month old daughter
- police attended the home a few days earlier in response to a call for a paramedic to take Kelly to hospital
- Kelly was feeling depressed
- Kelly stated that she was feeling overwhelmed with the baby’s care, and feeling isolated because fiancé was living out of town
- expressing no thoughts of harming herself
- professionals felt that Kelly may be experiencing PPD
- Kelly was receptive to CAS referral

Case Study #3

- Referral from London Mental Health Crisis Service
- Shannon is a single mother of 3 children: 7yr old son, 5 year old son, and 6 month old daughter
- Moved 1 1/2 years ago and has few supports in London
- Mother Reach referred her to the Crisis Service with concerns re: depression
- admitted to frequent hallucinations that she will harm the children
- when baby is crying, Shannon says she sees herself throwing her against the wall
- has had hallucinations of drowning children
- struggling to get out of bed in the am

Case Study #3 (cont’d)

- frequent suicidal ideation
- scored 24/30 on the EPDS
- unable to make a safety plan for self and children struggling to get out of bed in the am
- frequent suicidal ideation
- scored 24/30 on the EPDS
- unable to make a safety plan for self and children
- children staying with a competent, trustworthy friend
- CAS worker received a call from hospital RN saying that Shannon has been placed on a form1, and will be admitted
- Shannon worried because baby is breastfed(refuses a bottle)
- maternal grandmother is depressed and may not be able to care for children at this time

Case Study #4

- Cathy is a mother of a 2 1/2 month old
- she has been attending Smart Start for Babies
- at a meeting yesterday, she expressed frustration with the baby’s feeding
- shared with the group that the other night while breastfeeding, she was tired and frustrated, and pulled the baby’s face in to her breast; the baby was trying to move away to breathe
- baby appeared well at SSFB
- PHN and Family Doctor Involved
- Client is agreeable to CAS involvement

Appendix B: 48 Hour/Home Visit Tracking Tool

48 Hour Call--Postpartum Depression Data Collection Sheet

Client's Postal Code:

Date of Contact: Month: _____ Day: _____ Year: _____

Who Contacted: Mother Partner Other (specify) _____

Plan for Follow-up: Discharge Follow-up Telephone Call Home Visit

If "Partner" or "Other", DO NOT attempt to complete this side of form. Reverse may be completed at home visit.

1. Did you explicitly ask client if they have had specific symptoms of Postpartum Depression?

No → Which ONE of the following is closest to the reason you did not ask?
 Other more immediate concerns (e.g., breastfeeding)
 Mom seemed closed or defensive
 Other reason (specify): _____
Check ONE Only

Yes → Which ONE of the following best characterizes your assessment of client's response?
 Symptoms not apparent
 Not wanting to discuss because of stigma or denial
 Admitted experiencing slight symptoms
 Admitted experiencing pronounced symptoms
Check ONE Only

2. Did you ask client if she had prior awareness of Postpartum Depression?

No
 Yes → How would you rate client's prior awareness about Postpartum Depression?
 Not at all aware
 Somewhat aware
 Aware
 Very aware
Check ONE Only

3. Did you do any teaching with the client about Postpartum Depression?

No → Which of the following is closest to the reason you did not do PPD teaching?
 Other more immediate concerns (e.g., breastfeeding)
 Mom seemed closed or defensive
 Other reason (specify): _____
Check ONE Only

Yes → How would you characterize the extent of the teaching?
 Discussed the idea that Baby Blues is normal
 Discussed difference between Baby Blues and PPD (signs & symptoms of PPD)
 Discussed various "risk factors" associated with PPD
 Sent package of information to client
 Gave client info on where to go for help for PPD
Check As Many As Apply

4. Would you identify the client as "at risk" for Postpartum Depression?

Unable to Assess
 No
 Yes → How did you determine "at risk" status?
 Parkyn tool
 PassCan Questions
 Client Self-disclosure
 Your professional nursing judgement
 Client's past history
 Other reason (specify): _____
Check As Many As Apply

Home Visit--Postpartum Depression Data Collection Sheet

Client's Postal Code:

Date of Contact: Month: _____ Day: _____ Year: _____

Plan for Follow-up: Discharge Follow-up Telephone Call Home Visit

1. Did you explicitly ask client if they have had specific symptoms of Postpartum Depression?

No → Which ONE of the following is closest to the reason you did not ask?

- Already asked and documented at 48 hour call
- Other more immediate concerns (e.g., breastfeeding)
- Your judgement that mom feels quite well
- Mom seemed closed or defensive
- Other reason (specify): _____

Check ONE Only

Yes → Which ONE of the following best characterizes your assessment of client's response?

- Symptoms not apparent
- Not wanting to discuss because of stigma or denial
- Admitted experiencing slight symptoms
- Admitted experiencing pronounced symptoms

Check ONE Only

2. Did you ask client if she had prior awareness of Postpartum Depression?

No → Which ONE of the following is closest to the reason you did not ask?

- Already assessed and documented awareness at 48 hour call
- Other reason (specify): _____

Yes → How would you rate client's prior awareness about Postpartum Depression?

- Not at all aware
- Somewhat aware
- Aware
- Very aware

Check ONE Only

3. Did you do any teaching with the client about Postpartum Depression?

No → Which of the following is closest to the reason you did not do PPD teaching?

- Other more immediate concerns (e.g., breastfeeding)
- Your judgement that mom feels quite well
- Mom seemed closed or defensive
- Other reason (specify): _____

Check ONE Only

Yes → How would you characterize the extent of the teaching?

- Discussed the idea that Baby Blues is normal
- Discussed difference between Baby Blues and PPD (signs & symptoms of PPD)
- Discussed various "risk factors" associated with PPD
- Sent package of information to client
- Gave client info on where to go for help for PPD

Check As Many As Apply

4. Would you identify the client as "at risk" for Postpartum Depression?

Unable to Assess

No

Yes → How did you determine "at risk" status?

- Parkyn tool
- PassCan Questions
- Client Self-disclosure
- Your professional nursing judgement
- Client's past history
- Other reason (specify): _____

Check As Many As Apply