Time for Action: Why Canada Needs A National Perinatal Mental Health Strategy Now More Than Ever

Canadian Perinatal Mental Health Collaborative National Report

May 2021
Acknowledgements

We gratefully acknowledge Edmonton-Strathcona MP, Heather McPherson, for championing this important cause and encouraging dialogue across party lines. We owe much gratitude to our National Committee and Social Media Ambassadors, a strong, dedicated group of researchers, health care providers, people with lived experience and those who support them; we are humbled by their dedication to this important cause. In particular, we wish to extend a thank you to Christina Deroche, PhD, Anita Ewan, PhD, Laurel Hicks, PhD, Amanda Hooykaas, PhD, Christine Ou, PhD, Lesley Tarasoff, PhD, and Jodi Pawluski, PhD, all of whom worked tirelessly to analyze the survey data and contribute to this report. Thank you to Lianne Tomfohr-Madsen, PhD, for overseeing our national survey. Dr. Tomfohr-Madsen's scholarly work is supported by the Alberta Children's Hospital Research Institute (ACHRI) and the Alberta Children's Hospital Foundation. Our thanks to the ACHRI team for help with design and dissemination of this report.

Written by: Amanda L. Hooykaas, PhD (Geog.), MPhil, MSW, BES
Edited by: Jaime Charlebois, RN, BScN, PNC(C), MScN, PMH-C & Patricia Tomasi, BJ

Correspondence: Patricia Tomasi, Barrie, ON; Tel: 705-715-3151; Email: Canpmhc@gmail.com

Statement of Inclusion

Some people who experience pregnancy, birth, and parenting, and some who seek perinatal care, including mental health care, do not identify as a mom or mother; some people who experience pregnancy and birth do not identify as cisgender women or use the pronouns she and her. Recognizing the diversity of gender identities and expressions, we commit to making improvements in the use of gender-neutral or gender-inclusive language. At the same time we acknowledge that “mother” and “women” are terms used when referencing studies that involved mothers and women as participants or when directly quoting survey participants or people with lived experience who have themselves used those terms. In addition, many dads and partners are suffering in silence, largely due to stigma, and not accessing needed treatments – this is a problem that also needs to be addressed.

It is vital that in our efforts to improve perinatal mental health across Canada, we are inclusive with regard to sexual and gender identity, and to those who experience marginalization and oppression, such as persons with disabilities, Black, Indigenous, and People of Colour (BIPOC).
Perinatal Mental Health Care in Canada

Perinatal Mental Illness/Perinatal Mood and Anxiety Disorders (PMADs) can occur from conception to one year postpartum.

PMADs
- Depression
- Obsessive-Compulsive Disorder
- Post-Traumatic Stress Disorder
- Anxiety
- Panic Disorder
- Bipolar Disorder
- Psychosis

PMADs are the #1 medical complication during pregnancy & postpartum.

#TimeForAction

- 20% of women experience PMADs
- 10% of men experience PMADs

BIPOC, people with disabilities, sexual, & gender minority populations experience higher rates of perinatal mental illness.

What do Canadian health care providers report?

- 95.8% believe that perinatal mental health services in Canada are insufficient.
- 87% report that they do not have mandated screening for perinatal mental illness at their workplace.
- 57.3% report that they don’t have specialized training in perinatal mental illness.
- 87% report that persons from diverse backgrounds encounter language, cultural & cost barriers to perinatal services.
- 69% report that COVID-19 complicated access to care.

*Rates of PMADs have increased during the pandemic.

Canadian Perinatal Mental Health Collaborative/UCalgary 2021 Health Care Practitioner Survey.
What we know:

- Perinatal mental health services, screening & wait times are disparate across all health regions in the country.
- Untreated PMADs can affect the long term mental & physical wellbeing of parents and their children.
- Suicide is the 4th leading cause of maternal death in Canada.

31% waited 1-2 months
42% waited > 2 months

Treating PMADs saves money!

Perinatal depression, anxiety and psychosis carry a total long-term cost to society of about

£8.1 Billion

$13.9 Billion CAD for each one-year cohort of births in the UK

In Canada, 1 case of PMADs is estimated to exceed:

$150,000 CAD / mother-child dyad

With screening & treatment, this could be reduced to: $5,000


Tens of thousands of Canadians struggle with perinatal mental illness

Canada needs a National Perinatal Mental Health Strategy with universal screening & access to Timely, Culturally sensitive, Evidence-informed treatment.
Executive Summary

In Canada, 20% of women and 10% of men suffer from perinatal mental illness; rates during the COVID-19 global pandemic have doubled. Unlike the United Kingdom, Australia, and many parts of the United States, Canada does not have a comprehensive national strategy, mandate, or directive to guide how health care practitioners should assess, diagnosis, treat, or provide follow-up to individuals suffering from perinatal mood and anxiety disorders (PMADs) – a spectrum of mental health disorders that can affect an individual from conception to 12 months after birth. The adverse outcomes, both acute and long-term, of PMADs for parents, their children, and families is well known. Consequences of untreated postpartum mood disturbances can include prolonged maternal depression, paternal depression, partner relationship dissatisfaction and conflict, impaired parental-infant interactions and attachment, risk for impaired cognitive or psychosocial development for the child, and in extreme situations, maternal suicide or infanticide. Programs and policies have not kept up with best practices, research, or the overarching science. Services currently available to those experiencing PMADs in Canada are largely inadequate and issues have been magnified during COVID-19. Addressing the psychosocial needs of families to enhance ongoing mental, maternal/child health disparities is a major public health issue.

For these reasons, we, the Canadian Perinatal Mental Health Collaborative (CPMHC), an advocacy organization, are calling on the federal government to enact a national perinatal mental health strategy that includes mandated universal perinatal mental health screening and timely access to treatment among the recommendations listed in this report. The CPMHC is comprised of two founders, over 40 National Committee members (health care practitioners, researchers, and individuals with lived experience) representing all provinces and territories, and Social Media Ambassadors who disseminate campaigns and messages to the Canadian public.

We formed the CPMHC in 2019 and our work gained momentum in January 2020 with the commencement of the #ThisIsMyStory campaign in conjunction with Bell Let’s Talk Day. Followers were asked to submit personal stories surrounding their struggles with mental illness in the perinatal period. Next on the agenda for the CPMHC was the #NowMoreThanEver campaign for World Maternal Mental Health Day (celebrated the first Wednesday in May each year). Individuals with lived experience, dignitaries, politicians, mayors, celebrities and agencies submitted videos of why they felt a national perinatal mental health strategy was needed now more than ever. A compilation video lives on our website (www.cpmhc.ca). This campaign was followed by the submission of an e-petition to the House of Commons for the creation of a national strategy, sponsored and tabled by MP Heather McPherson of Edmonton-Strathcona.

The CPMHC is persisting with our efforts to co-create a national strategy for perinatal mental health care. With a goal to learn about screening and treatment practices across Canada to identify gaps as well as what’s working in different jurisdictions, the CPMHC created a first-of-its-kind national online survey (reviewed and approved by the Conjoint Faculties Research Ethics Board [CFREB] at the University of Calgary) to understand the state of perinatal mental health care in Canada. Four hundred and thirty-five health care practitioners participated. Top findings and the voices of those surveyed are included throughout this report. Critical findings include:

- 95.8% of health care practitioners believe that perinatal mental health services are insufficient in Canada.
• 87% of health care practitioners in Canada do not have mandated screening for perinatal mental illness at their workplace.
• When people are screened and have symptoms indicative of needing intervention, 27% of health care practitioners indicated that patients were able to access their referral within a month, 31% waited between 1-2 months, while 42% had to wait for >2 months for access.
• Perinatal mental health services differ across health regions. More than half of health care practitioners surveyed (57.3%) reported that they have not received specialized training in PMADs or were unsure if they received specialized training.
• 87% of practitioners believe people from diverse backgrounds encounter barriers to accessing perinatal services. These include language, cultural, and cost barriers.
• 69% of practitioners reported that COVID-19 has complicated access to care, including reduced in-person visits and overall services.

The survey findings underscore a critical need for a national perinatal mental health strategy to address gaps in screening and treatment and are the basis of recommendations in this report. All recommendations have been structured around four pillars of the socio-ecological health care model:

   1. Policy
   2. Screening
   3. Treatment
   4. Follow-up

Health care practitioners should integrate screening for perinatal mental illness into routine practice while structural changes are required to ensure accessible and culturally safe treatment of people experiencing perinatal mental illness across Canada.

The CPMHC is requesting a meeting with Minister of Health, the Honourable Patty Hajdu, to discuss our recommendations and how we can work together to create a national perinatal mental health strategy that leaves no one behind.

Enough talk. It’s time for action!

Sincerely,

Jaime Charlebois, RN, BScN, PNC(C), MScN, PMH-C
Co founder & Research Director, CPMHC

Patricia Tomasi, BJ
Co founder & Communications Director, CPMHC
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The current problem in Canada

1.1 Definition of PMADs/perinatal mental illness

Perinatal mood and anxiety disorders (PMADs) are serious, largely underdiagnosed mental health conditions. These include prenatal and postpartum depression, anxiety, panic disorder, post-traumatic stress disorder, obsessive compulsive disorder, bipolar disorder, and psychosis. PMADs can significantly impact an individual’s experience of pregnancy and parenting and are associated with increased risks of obstetric and neonatal complications, with the potential of profoundly affecting a person’s ability to bond with the baby, and the infant’s psychological adaptation over the longer term [1]. Despite the frequency of PMADs within Canada (with a pre-pandemic rate of 1 in 4 mothers [2]), there is currently no national perinatal mental health strategy. This has resulted in the underdiagnosis of PMADs and grossly uneven access to resources and evidence-based treatment (See Appendix A: “Perinatal mental health in the news”).

“In the pandemic, I was never asked by a health care provider directly how I was doing mentally. I feel frustrated and let down, like my health doesn’t matter.”
– Ali Kosloski from Cupar, SK

In 2019, Statistics Canada released an infographic with results from its Survey on Maternal Health, which showed that 23% of mothers in Canada reported feelings consistent with postpartum depression or an anxiety disorder. What were the actionable items from this survey or was it just a collection of data the academic community was already aware of? Or, was this the first step in the Government of Canada’s commitment to addressing perinatal
mental health care? We can only hope it is the latter. As well, the Government of Canada updated its Family-Centred Maternity and Newborn Care National Guidelines. The last time the guidelines were updated was in 2000. On the surface, it looks like Canada has finally created perinatal mental health guidelines and is taking the issue seriously; however, upon further inspection, the fundamental elements of universal screening and timely access to treatment are not part of the recommendations. In Section 4.1, Postpartum Mental Health, guidelines call for a “multifaceted, family-centred approach” with treatments potentially requiring referral to a mental health professional, without mentioning the problem of wait times. It goes on to recommend that health care practitioners be the ones to “identify women at risk of developing postpartum emotional disorders”. However, without mandated screening, adequate clinical training, and sufficient numbers of health care practitioners to respond to the demand, women are not being properly assessed, diagnosed and treated to remission.

The U.S. Preventive Services Task Force and the American College of Obstetricians and Gynecologists came out with recommendations supporting routine screening for perinatal depression several years ago. In contrast, the Canadian Task Force on Preventative Health Care has advised against universal screening for depression in adults, and issued only a "weak recommendation" for screening only when symptoms are apparent. No provision was made for pregnancy, the postpartum period, or the lasting consequences of parental depression or other mental health disorders on the newborn. A nation-wide, working group of perinatal mental health experts with provincial
representation was created in 2017 by the Society of Obstetricians and Gynecologists of Canada and Canadian Psychiatric Association but has yet to release a joint statement. Finally, the Family Physicians of Canada have endorsed Australian perinatal mental health care guidelines instead of redacting their own. In sum, there is fragmentation and a lack of cohesion regarding perinatal mental health recommendations in Canada.

"Thoughts of not being here anymore creep up and some days I don’t have the energy to fight them. I am terrified. Who can help me?"
– Candice Thomas from Barrie, ON

While the Government of Canada officially recognizes that perinatal mental illness is a debilitating issue for a large percentage of people, in practice there has been no nation-wide concerted efforts across the country to change screening and clinical practice for people suffering from PMADs. As a result, the gaps within the current health care system remain and many families are suffering. At the time this report was written, the CPMHC reached out to the Mental Health Commission of Canada (MHCC) to discuss working together on advocating for a national perinatal mental health strategy. During a meeting with the MHCC in March 2021, the CPMHC learned that the MHCC is citing the work done by CPMHC and including support for the CPMHC’s call for a national perinatal mental health strategy as part of its recommendations to the federal government in its upcoming Policy Brief, “COVID-19, Early Years and Mental Health: Fostering Systems Change and Resilience”. The MHCC report states:

Amidst intensified calls for a national perinatal mental health strategy, advocates, service users, researchers and systems planners should look to areas of disrupted perinatal mental health services and supports that lapsed during the COVID-19 pandemic as a foci for standardization, system and quality improvement initiatives (Canadian Perinatal Mental Health Collaborative, 2020).
Recommendation: Conduct a sex and gender-based analysis of gaps in perinatal mental health, health and social services, ensuring long-term follow-up, virtual service and in-person service coverage that works and is culturally appropriate.

Recommendation: Utilize gaps in perinatal mental health coverage as a basis for action, systems and quality improvement on the impending national perinatal mental health strategy.

We look forward to working with our national partners and the federal government to implement the MHCC’s recommendations as well as those in our report.

1.2 Prevalence of PMADs

While pregnancy, childbirth, and parenting are often seen as times of excitement, this period from conception to one year postpartum is also associated with increased risk for onset and relapse of mental health conditions for women – higher than at most other times in a woman’s life [1]. During this time, the focus tends to be on the act of caring for the baby. Detection of maternal mental health conditions is unlikely. Without routine standardized screening, three-quarters of women meeting Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) criteria for depressive and anxiety disorders are not identified [3] and just 10% of those requiring mental health care receives it [4]. Perhaps more concerning is that even if diagnosed,
only 15% of women receive evidence-based treatment [4]. And now more than ever, during the COVID-19 pandemic, the mental health of pregnant Canadians is of concern, with recent studies by Groulx, et al., 2021 reporting up to three-fold increases in perinatal mental health problems [5]. (See Appendix B: What persons with lived experience are telling us).

“I needed medical help and ended up going to the emergency room a total of three times to try and find it. I felt like I had to justify why I was feeling the way that I was.”
– Carleigh Weldon from Windsor, ON

1.3 Implications of untreated PMADs on the individual

Proper treatment of PMADs is critical; suicide is a leading cause of death during the perinatal period and accounts for 5-20% of maternal deaths [6]. In one cross-sectional study of childbearing individuals in the United States, the prevalence of suicidal ideation and intentional self-harm occurring in the year preceding or following birth (hereby identified as the perinatal period), increased substantially over a 12-year period:

- **Diagnoses of suicidality with comorbid depression or anxiety doubled from 2006 to 2017 (increased from 1.2% in 2006 to 2.6% in 2017).**
- **Diagnoses of suicidality with comorbid bipolar or psychotic disorders more than doubled from 2006 to 2017 (increased from 6.9% in 2006 to 16.9% in 2017)** [7].

Marginalized individuals experienced larger increases in suicidality over the study period [7]. In a 2017 study of perinatal suicide in Ontario, most suicides occurred during the final quarter of the first postpartum year, with highest rates in rural and remote regions. In addition, only 39.2% of those individuals had mental health contact
within 30 days before death [6]. This highlights the urgent and emergent need for universal suicidality screening and appropriate treatment for pregnant and postpartum individuals.

1.4 Implications of untreated PMADs on the entire family

PMADs are associated with impaired functioning in the parent, making parenting more challenging. PMADs are also linked to poorer infant social, cognitive, and behavioural development, as well as increased risk for later child psychopathology [8]. Untreated PMADs impact the whole family and have been linked to higher parenting stress and transmission of depression to partners [9]. Treatment for PMADS result in better parental-child attachment and mental health, and child development outcomes [8]. It is therefore imperative that individuals (and their families) experiencing PMADs are identified early in order to receive the timely support and care they need.

“I know particularly as a Black teenage mother, I was uncomfortable calling the police or emergency services to help me through the negative thoughts.”
– Dr. Anita Ewan from Toronto, ON
2.0 #Survey4Change national survey for health care practitioners

2.1 Overview of survey

Prenatal stress, anxiety and depression have been linked to a number of adverse outcomes for the expectant person (e.g. postpartum depression) and the fetus (e.g. preterm birth). There is now a strong body of research linking evidence-based interventions for mental health problems that improve maternal and paternal mental health outcomes; however, these are inconsistently delivered within the Canadian health care system. Moreover, there are significant inconsistencies in how health care practitioners (even within the same area) respond to PMADs.

![Image of survey results]

2.2 Methods/approaches

For this first-of-its-kind, national survey CPMHC recruited health care practitioners (N=435) via social media (Facebook, Twitter, etc.) and snowball sampling and asked them to complete a questionnaire about the state of perinatal mental health care in Canada. This was the first survey to ask health care practitioners qualitative and
quantitative questions about perinatal mental health screening and treatment in Canada. The results contribute to our understanding of the gaps in services for perinatal mental health problems of pregnant and postpartum Canadians and their families. This research received ethics approval from the University of Calgary Conjoint Research Ethics Board.

2.3 Findings

As expected, survey respondents were passionate and committed health care practitioners. Said one survey respondent: “It is a deep honour to support people through perinatal mental health challenges. It is past time for a universal perinatal [mental health] strategy in this country. There are too many people slipping through the cracks and not receiving the treatment they need which is worsening their condition. Screening must be mandatory across Canada and treatment readily available and accessible.” The following are key findings.

“"There is so much suffering at the individual and family level. I feel helpless when I see clients and have no place to refer them to that will meet their needs. The 'one size fits all' online supports and programs governments have available now do NOT meet the needs of expecting and postpartum parents. We need specialized care and specially trained professionals to support and address the illnesses experienced by this population. I feel very frustrated and abandoned when we have no place to turn to for timely and sensitive support.” ~ Survey Respondent

2.3.1 Current perinatal mental health services are inadequate

95.8% of health care practitioners believe that perinatal mental health services are insufficient in Canada. Within this group, 60.6% of survey respondents believe that current perinatal mental health services partially fail, mostly fail, or do not meet current needs of health care practitioners and their patients, while another 35.2% of health care practitioners say that these services only partially meet needs.
2.3.2 Inconsistent screening and treatment

Screening for PMADs is inconsistent and 87% of health care providers do not have mandated screening. If and how a client is screened for PMADs is largely dependent not only on postal code but also on the training/awareness of a patient’s first point of contact. If that health care practitioner is not trained in perinatal mental health (and relatively few are), they may not screen for PMADs. Health care providers cannot treat the problem when it is not being detected; the response, therefore, may be insufficient, inadequate, and potentially deadly. Furthermore, treatment for mild to moderate PMADs depends on extra health insurance benefits for private therapists and private psychologists. Twenty-seven per cent of health care providers indicate that patients are able to access their referral within a month, 31% wait between 1-2 months, while 42% wait for >2 months for access to their referral. Even in our nation’s capital, the situation is dire: “In Ottawa, the wait times for publicly funded perinatal mental health one-on-one support are extremely lengthy (6 months - 1 year). Clients who have insurance and are able to pay privately can access care, but those who do not have those means are being failed by the health care system when it comes to their mental health.”

“I was not screened. I had postpartum depression with my previous baby so I thought it would be on my file somewhere that I struggled.”
– Lindsay Gareau from Regina, SK
When one is able to access treatment, it may not be adequate: “I believe many women or parents fall through the cracks because there are no (or virtually no) specific services for PMADs in our province.” The current system is often reactionary and patients are often not admitted to services until they are seriously ill or needing urgent intervention (e.g. admission to psychiatric facility). Preventative policies would help practitioners provide supports at an earlier time point in the community, thus contributing to improving outcomes and decreasing costs associated with urgent acute care.

"The doctor placed me on a four month wait list to see a general psychiatrist. I was crushed."
– Sarah Cunningham from Bowmanville, ON

What we know:
Perinatal mental health services, screening & wait times are disparate across all health regions in the country

31% waited 1-2 months
42% waited > 2 months

Untreated PMADs can affect the long term mental & physical wellbeing of parents and their children

Suicide is the 4th leading cause of maternal death in Canada
Mental health services provided are disparate across health regions. More than half (57.3%) of practitioners reported they have not received specialized training in perinatal mental illness or were unsure if they received specialized training. Eighty-seven per cent of providers believe people from diverse backgrounds encounter barriers to accessing perinatal mental health services. These include language, cultural, and cost barriers.

2.3.3 Marginalized populations need better access to care

The most vulnerable individuals - those with multiple mental health and social issues including trauma histories, substance use disorders, severe mental health histories, poverty, youth, transgendered people, race or immigration-based marginalization - have decreased access to care.

Indigenous mothers are 20% more likely to suffer from prenatal and postpartum depression than white, Caucasian mothers in Canada [10]. The findings parallel the Government of Canada's 2008 Maternity Experiences Survey that found Indigenous women have a higher prevalence of postpartum depression than non-Indigenous women [11].

Pregnant Indigenous women and service providers were interviewed for a 2015 Voices and PHACES study in Calgary, Alberta. The study found chronic life stress and trauma to be key causes of prenatal depression in Indigenous women. Almost all of the pregnant Indigenous women interviewed for the study reported being deeply and negatively impacted by having someone in their life — a parent, an aunt or uncle, a grandparent, an older sibling — who survived the Residential School system [12].

Currently there is very little data on the health disparities Black parents face when it comes to perinatal health support and services in Canada. However, there are statistics in the United States that are relevant to Canada since they reveal how systemic racism plays a role in the inequities Black parents experience. Some key findings by the UPMC Western Behavioural Health (2020) in the U.S. include: 40% of Black mothers will suffer from postpartum depression, which is double the rate for the general population; and Black mothers are four times more at risk of maternal morality than white mothers. [13]
One survey respondent suggests, “existing supports are geared at wealthy, often white, educated women who have mild anxiety or depression”.

2.3.4 Informal care providers are integral in addressing PMADs in the community

In our survey, many individuals mentioned informal care providers (family, friends, doulas, lactation consultants, massage therapists) as essential. One example of this is the need for breastfeeding/chestfeeding support: “Canada needs to support pregnant and birthing people as well as provide support for lactation. We know ~90+% of people want to breastfeed/chestfeed yet the access to services to support them within the public system is almost nonexistent. Lack of education of our health professionals has significant impact on perinatal mental health.” Another respondent said: “Doulas are seeing what doctors are not. We are with clients for extended periods of time, in their homes, at all hours of the day and night. We see new parents in their most intimate moments, often unguarded moments, and many are struggling.” It is clear that community support roles need to be incorporated into community health care planning and, as such, their roles need to be funded and valued by the appropriate provincial/territorial government.

2.3.5 Need for a national strategy

A national strategy is necessary and urgent to better support health care practitioners and families.

“Mental health is incredibly undervalued and underfunded in general. Perinatal mental health especially so, with outcomes and consequences that affect not only the birthing person/partners but generations to come. This is a service that is very badly needed. And we need sensitive and appropriate care for diverse backgrounds.” ~ Survey Respondent
3.0 Current provincial/territorial mandates

3.1 Summary of findings and highlights

Resources are disparate across Canada. Because the timing of onset, degree of severity, and outcomes vary widely, there are challenges to recognizing PMADs in people. Recent perinatal research suggests that integrated interventions following assessment are essential for managing PMADs. Currently in Canada, the majority of people cannot receive mental health care in the location where they see their primary care provider for postpartum
physical care; however, perinatal specialized providers are integral to address often stigmatized topics. For example, in clinical practice, perinatal individuals with mental disorders and multiple comorbid problems may need to be referred to separate services. This results in poor care for both the mother/birthing person and the baby.

In Canada, there are large gaps in services and supports available to those with perinatal mental health challenges. Over four months, we attempted to connect with government officials from each province/territory via email and phone with varying levels of success. We learned that there is tremendous variability in supports for parents experiencing PMADs in each province/territory.

While some regions/catchment areas have guidelines to follow, screening and suitable follow-up care (if required) for patients and families are largely left to chance. In British Columbia (BC), for example, there are guidelines for perinatal mental health care but no mandates - there is nothing “enforceable” about the guidelines. There are multiple prompts on BC’s standard antenatal forms (used on every pregnant woman in BC) to screen for mental health - usually at the first visit and via an Edinburgh Postnatal Depression Scale (EPDS) screen at around 27 weeks; again, this is completed at varying levels and is not the standard for all provinces and territories.

The following table highlights our findings:

<table>
<thead>
<tr>
<th>Province/Territory</th>
<th>Is there a government mandate for perinatal mental health screening?</th>
<th>Is there a guideline?</th>
<th>Is screening recommended on the antenatal/perinatal record?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newfoundland &amp; Labrador</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>No</td>
<td>&quot;New parents are invited to participate in screening for perinatal depression and anxiety using the Edinburgh Postnatal Depression Scale (EPDS) screening tool at their child’s 2 month child health clinic visit. If you are concerned about how you are feeling, your Public Health Nurse can assist you to complete the Edinburgh Postnatal Depression Scale (EPDS) screening tool before your child’s appointment. Contact your local Public Health Nursing office and ask to speak to a nurse.” (Health PEI website, June 9, 2020): <a href="https://www.princeedwardisland.ca/en/information/health-pei/pregnancy-">https://www.princeedwardisland.ca/en/information/health-pei/pregnancy-</a></td>
<td>No</td>
</tr>
<tr>
<td>Province</td>
<td>Screening Program</td>
<td>Notes</td>
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<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>New Brunswick</td>
<td>No</td>
<td>Yes - Public Health Healthy Families, Healthy Babies program services that assess and support maternal mental health include: A targeted intensive home visiting program to first-time high risk prenatal clients: Nurses specifically screen client’s mental health as part of their prenatal assessments and both dietitians or nurses can refer clients to mental health services. The Edinburgh Postnatal Depression Scale is completed at the 36 week visit. A targeted intensive home visiting program for first-time high risk postnatal clients: Maternal mental health is assessed using the Edinburgh Postnatal Depression Scale at 2 month, 6 months and 18 months. Referrals are made as applicable. A universal postnatal assessment program: Public Health hospital liaison nurses visit with all parent(s) of newborns in NB to complete this assessment. If the family is discharged before the nurse visits, they will receive a phone call to do the assessment. This assessment includes mental health screening questions. Referrals are made for services such as mental health if applicable. Some parents/newborns will also be eligible for the Public Health intensive prenatal visiting program (above). The universal Healthy Toddler Assessment: This is offered to all NB parents of toddlers at 18 months of age. The Edinburgh Postnatal Depression Scale will occur during each trimester of pregnancy and at the 6-week postpartum appointment. Currently, the Healthy Beginnings Program run by Public Health Nurses includes a mental health screen. This questionnaire is administered to every new birth parent shortly after birth. (Health Promotion/Mental Health &amp; Addictions and Acute Care: Department of Health and Wellness)</td>
<td></td>
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<tr>
<td></td>
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<td>On the new antenatal record (due to be launched in 2021), the Edinburgh Postnatal Depression Screen will occur during each trimester of pregnancy and at the 6-week postpartum appointment.</td>
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<tr>
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<td>The antenatal record indicates screening is required for women between 28-32 weeks of pregnancy and again at 6-8 weeks during postpartum using the EPDS.</td>
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<tr>
<td>Location</td>
<td>Screened at Risk</td>
<td>Recommendations</td>
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</tr>
<tr>
<td>Manitoba</td>
<td>No</td>
<td>Postpartum Mental Health Toolkit created by the Winnipeg Regional Health Authority in 2014 which recommends screening via public health with no specific timelines.</td>
<td></td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>No</td>
<td>Maternal Mental Health Toolkit (2015): Perinatal mental health screening recommended within the first two weeks postpartum, at six weeks, and during the baby’s immunization appointment at eight weeks postpartum.</td>
<td></td>
</tr>
<tr>
<td>Province</td>
<td>Screening Policy</td>
<td>Policy Details</td>
<td>Government-Mandated Standards</td>
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<td>--------------------------------</td>
</tr>
<tr>
<td>Yukon</td>
<td>No</td>
<td>Prenatal Audit Tool: <a href="https://www.hss.gov.nt.ca/professionals/fr/node/148">https://www.hss.gov.nt.ca/professionals/fr/node/148</a></td>
<td></td>
</tr>
<tr>
<td>Nunavut</td>
<td>No</td>
<td>The Nunavut Perinatal Record contains discussion points for perinatal mental health, the EPDS, and a place to chart the score with a date in section 22 between 28 and 32 weeks of pregnancy. <a href="https://www.uvic.ca/medsci/assets/docs/arbour/Nunavut%20POMIC%20Prenatal%20Records%20-FINALMar%202010.pdf">https://www.uvic.ca/medsci/assets/docs/arbour/Nunavut%20POMIC%20Prenatal%20Records%20-FINALMar%202010.pdf</a></td>
<td></td>
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</table>

The information (or lack thereof) indicates that while several provinces/territories may have guidelines in place, they are not government-mandated standards and therefore families continue to miss out on evidence-based screening and treatment during this challenging time of life. There have been advocacy-driven initiatives across the
country to help those who live within specific geographic regions – these rely on health care practitioners who are aware of PMADs and who are trained in perinatal mental health care.

“\textit{I am speaking out now for all the moms who don’t know that it is not their fault. They’re being told every day that they are failing when in reality, the system is failing us.}”
– \textit{Heather Marcoux from Red Deer, AB}

3.2 Noteworthy Canadian initiatives

- \textbf{Pacific Post Partum Support Society} (PPPSS, 1971-present), a non-profit organization, has been supporting families experiencing perinatal distress for almost 50 years. With a small staff, ample volunteers and provincial partners, PPPSS provides telephone support, weekly women's support groups, partner education sessions, community trainings and resource materials.

- MotherFirst Project (2009), a multi-stakeholder working group, was created by advocates in Saskatchewan to address gaps and lack of policy for the prevention, identification, and treatment of maternal mental health problems. Out of that came participation from the Ministry of Health, First Nations groups, and women with lived experience. This group created \textit{MotherFirst: Developing a Maternal Mental Health Strategy in Saskatchewan} (2010), comprehensive policy strategy that was presented to the Saskatchewan government as well as Prime Minister Justin Trudeau. As a result of these efforts, the Saskatchewan Ministry of Health (which funds the Saskatchewan Health Authority) now provides a perinatal mental health hotline and screening tools. However, gaps still exist, especially during the pandemic, and people are still falling through the cracks. See
Perinatal Mental Health Alliance of Newfoundland & Labrador is an organization created by community-university partners of agencies, educators, health and social care professionals, and government leaders who want to address the gaps in programs, supports and services for mothers, infants and families.

Northern Ontario Postpartum Mood Disorder Project (Phase I: 2012-2013; Phase II: 2014-2015), was a community collaboration which resulted in a postpartum mood disorder strategy for Northern Ontario. The project was made possible through an Ontario Trillium Foundation grant and the support of the North East Local Health Integration Network (North East LHIN).
4.0 How other countries are supporting perinatal mental health

While there are several innovative programs across the world, none have received as much attention as those implemented by Australia and the United Kingdom. Both countries feature strengths that can be applied to a national perinatal mental health strategy in Canada.

4.1 Australia

In Australia, there have been significant investments in specialist outpatient, community, and inpatient perinatal mental health services [15]. The most notable program has been the National Action Plan on Perinatal Depression, which was funded from 2009–2015 by the federal and state governments on an equal cost-sharing basis, as the National Perinatal Depression Initiative [15]. This initiative had several arms: introducing screening for depression and psychosocial problems antenatally via general practitioners and midwives, and postnatally via maternal and child health nurses, funding for pathways to care when problems were identified, development of clinical practice guidelines, and public awareness campaigns undertaken by Beyond Blue [16]. In addition, there are now Mother-Baby units (MBUs). These units provide inpatient mental health treatment across the spectrum of mental disorders to women and their infants up to one year of age and avoid unnecessary and potentially lengthy separations while a person accesses inpatient mental health treatment. MBUs not only provide inpatient mental health treatment for individuals but also care for infants and ideally also offer skill development in parenting [17]. The federal government ceased funding this initiative after six of the first promised eight years and most states and territories also withdrew funding.

This initiative has evolved into COPE: Centre of Perinatal Excellence was commissioned by the Commonwealth Government of Australia to review and update the National Perinatal Mental Health Guideline. Visit https://www.cope.org.au/health-professionals/health-professionals-3/review-of-new-perinatal-mental-health-guidelines/. A 2016 study suggests that screening antenatally has been successfully instituted in most public obstetric settings around Australia, thus approximately 70% of individuals are screened antenatally by midwives to
help identify depression, anxiety and psychosocial problems. Around 90% of Australia’s birthing people are now screened postnatally by maternal child health nurses [18].

**Focusing on the whole family has been shown not only to alleviate human cost but to provide more effective intergenerational interruption of problems and also great economic benefit with cost-savings in trauma, physical and mental health, unemployment and incarceration [18].** It is estimated that for each AUS$1 invested in the first three years of life, AUS$10 may be saved by the time that infant reaches adolescence [19]. This figure may not be far from the cost-benefit citizens might realize in Canada, given the right resources.

### 4.2 UK/Northern Ireland focus

In 2016, the UK Prime Minister announced a strategic >£290 million investment into new specialist perinatal mental health services [20]. In the years following, the UK government has promised additional funds, with the aim of ensuring that individuals in all parts of the UK have access to appropriate community services and psychiatric inpatient mother and baby units, as well as extended service provision up to two years postpartum. These plans align with the Antenatal and Postnatal Mental Health Guidelines produced by NICE: National Institute for Health and Care Excellence [21]. As a result of this investment, forward-thinking advocates have driven the following non-partisan approaches:

- An infant mental health initiative, 1001 Critical Days (from conception to the infant’s second birthday), has highlighted the crucial need for better problem identification, followed by interventions for mother and infant. Advocacy has successfully improved funding and services are rapidly developing. See [https://parentinfantfoundation.org.uk/1001-days/](https://parentinfantfoundation.org.uk/1001-days/).
- The Maternal Mental Health Alliance has worked by joining together the many relevant UK organisations working in perinatal infant mental health, and mapping out which regions are well-serviced for mentally ill individuals and their infants, and those which are not. See [http://maternalmentalhealthalliance.org](http://maternalmentalhealthalliance.org). Centrally the government has better ensured this service development with extensive new investment. The Maternal Mental Health Alliance commissioned an independent report to document the economic costs of perinatal mental illness for the UK. It shows that perinatal depression, anxiety and psychosis carry a total long-term cost
to society of about £8.1 billion for each one-year cohort of births in the UK. In Canada, Dr. Ryan Van Lieshout suggests that the cost of one case of PMADs is estimated to exceed $150,000 [22].

In Canada, 1 case of PMADs is estimated to exceed:

$150,000 CAD

/mother-child dyad

Perinatal depression, anxiety and psychosis carry a total long-term cost to society of about

$13.9 Billion CAD

for each one-year cohort of births in the UK

In Canada, $150,000 CAD

With screening & treatment, this could be reduced to:

$5,000

In addition, Northern Ireland has recently made significant changes in its perinatal mental health provisions and as of January 2021, funding has been approved to establish a new specialist perinatal mental health community service model. This initiative will provide new multidisciplinary community perinatal mental health teams in each of the five Health and Social Care Trusts and will include a new stepped care model to ensure regional consistency. As such, perinatal mental health community teams will provide wraparound maternity and mental health care to women in the perinatal period who may be struggling with perinatal mental health challenges. See https://www.health-ni.gov.uk/news/swann-approves-funding-new-perinatal-mental-health-delivery-model.

4.3 United States

The United States Congress has recently noted that:

- The U.S. suffers from one of the highest maternal death rates in the developed world.
- Suicide and overdose have been identified as the leading causes of death during the first year postpartum.
The US has recently (December 20, 2020) provided $3 million to establish and maintain a maternal mental health hotline to be staffed by qualified counselors, 24 hours a day. Funding may also be used for outreach to raise awareness about maternal mental health issues and the hotline. The cost of the hotline is less than 75 cents per new mother. In addition, they have approved $5 million for an ongoing program that provides grants to states to address maternal mental health which reauthorizes the 2015-2016 Bringing Postpartum Depression Out of the Shadows Act. This program was launched in 2018 and provides funding for five years to seven states: Florida, Kansas, Louisiana, Montana, North Carolina, Rhode Island, and Vermont. These changes took place after the U.S. Preventive Services Task Force and the American College of Obstetricians and Gynecologists made recommendations for routine screening for perinatal depression. Each state is working to:

1. Educate frontline providers, such as obstetricians and pediatricians, about maternal mental health conditions so they can screen and treat their patients.

2. Provide real-time psychiatric consultation to the frontline providers for more complex cases.

3. Provide resources and referrals for affected women and families.

Finally, Congress requested the Department of Health and Human Services (HHS) to produce a report detailing how HHS agencies are addressing gaps in maternal mental health.

If not for the policy work enacted in New Jersey in 2006, much of this would not have been possible. That state successfully enacted a law that provides direction and education for all perinatal care providers to screen all new birthing people for PMADs prior to discharge from hospital and at the first few postpartum check-up visits. New Jersey is one of three states (along with Illinois and West Virginia) that requires screening for PMADs.

This summary is a snapshot and current developments are updated on the following website:

https://www.2020mom.org/federal-policy

5.0 Our Recommendations for system change in Canada

It is clear that Canada requires a robust national perinatal mental health strategy. It’s time for action. Using the socio-ecological health care model as a framework, we have highlighted four key areas of focus
in our recommendations – policy, screening, treatment, and follow-up. The Canadian Perinatal Mental Health Collaborative is calling on the Government of Canada to implement the following:

1. Legislation that provides clear guidelines for clinicians through a national perinatal mental health strategy that prioritizes equitable health care across all Canadian jurisdictions.
2. Targeted perinatal mental health care funding allocated to each province and territory to administer perinatal mental health programs.
3. Mandated universal perinatal mental health screening at regular intervals from preconception to one year postpartum and beyond as well as timely access to treatment.
4. The implementation of a comprehensive perinatal mental health curriculum directly into medical syllabuses (in schools of medicine, nursing, and allied health) and ongoing training for front line health care practitioners.
5. The investment in culturally sensitive, accessible and patient-oriented treatment solutions.
6. The acknowledgement and active incorporation of the specific and related Calls to Action as specified in the Truth and Reconciliation Commission of Canada (TRC), with emphasis on core principles 18 to 24, named in the TRC health section.
7. Emphasis on a holistic approach to perinatal mental health which recognizes a systematic and community approach to healing and wellness, based on Indigenous principles. This may include investment in peer-to-peer supports and mentors from the community trained in culturally appropriate prevention and treatment methods.
8. Prenatal childbirth education for people and families, which includes a comprehensive overview of the psychosocial changes and mental health challenges inherent in the transition to parenthood.
9. The creation of “Mother and Baby Units” modelled after MBUs in the UK, for people with severe perinatal mental illness that allows for continuous infant contact instead of treating parents in general psychiatric wards and separating person from baby.
10. Home care for people with PMADs that are affecting their ability to function within their parenting role as well as delivery of integrated and continued model of care from acute psychiatric treatment to symptom remission.
11. Specialized perinatal mental health care practitioners and programs accessible within all Canadian jurisdictions, not just in urban centres.
12. A 24-hour national perinatal mental health crisis hotline staffed by trained perinatal mental health professionals.
13. Increased funding for perinatal mental health research in Canada.
14. Funding for increased perinatal mental health awareness in Canada.

15. The creation of a collaborative Perinatal Mental Health Strategy Team to ensure these recommendations are being implemented.
6.0 Moving forward

Our request for a robust national perinatal health policy and appropriate funding is aligned with previous recent federal investments provided for, but not limited to:

- **Autism-Intellectual-Developmental Disabilities National Resource and Exchange Network (AIDE Canada) (2018)** led by the Pacific Autism Family Network (Richmond, British Columbia) and the Miriam Foundation, Montréal, Quebec): $20 million in federal funding will be provided over five years to new initiatives aimed at helping families affected by autism spectrum disorder. This will be achieved through supporting families with children diagnosed with autism spectrum disorder and helping educate the public about autism spectrum disorder, thereby reducing stigma.

- **The creation of a pan-Canadian suicide prevention service (2021):** $21 million invested over five years, to help develop a national crisis support service with access to trained responders, in the official language of the client’s choice, 24 hours a day, seven days a week. By standardizing services currently offered unevenly across the country, more lives will be saved as interventions via phone, text or chat allow people to choose their preferred method of communication.

These programs highlight how specific needs are being addressed through the reduction of barriers (e.g. financial, geographical, language, stigma). We strongly believe that by creating and funding a comprehensive national perinatal mental health strategy, we too can make significant gains in providing evidence-based support to Canadians no matter where they reside. A Canadian health care practitioner reflected on the challenges facing this field and suggested:

“The evidence is clear that in order for individuals, families, and communities to maintain health, this important public health issue needs to be addressed and prioritized in health care. Families are too often suffering in silence and victims of the “postal code lottery” of having access to some (or any) treatment options. It's absolutely astonishing that in this day and age we cannot see the value of investing in parents, children for a healthier tomorrow.”
The Canadian Perinatal Mental Health Collaborative remains committed to engaging in the important dialogue of improving the mental health of people, parents, children, and families. By focusing on improving the mental health of people with mandated screening and rapid access to care we can reduce the burden of mental illness for families, children, and society. We know that a reduction in perinatal mental illness will help improve health outcomes for people throughout the rest of their lives as well as improve child outcomes in cognitive, social and health domains. Thus, by improving the mental health of people, we will automatically be contributing to improving the mental health of subsequent generations. **Now more than ever, we need to give people in Canada the support that they deserve as they usher in the next generation.**
Appendix A: Perinatal mental health in the news

“New parents shouldn’t have to worry about perinatal mood and anxiety disorders while taking care of their newborns and growing families. An NDP government will work with our provincial, territorial and Indigenous partners, as well as families with lived experiences to develop a national perinatal strategy for Canada.” NDP Leader Jagmeet Singh, https://www.huffingtonpost.ca/entry/jagmeet-singh

"In Canada, we are not yet doing anything. No politician is comfortable disclosing that they have been directly impacted by perinatal issues and like many mental health and women's issues, they are not broadly publicized or demanding of political attention.” Dr. Ariel Dalfen, https://www.huffingtonpost.ca/2018/05/01/maternal-mental-health-canada_a_23424672/

"There is a lack of awareness among caregivers that disorders other than depression are also common after childbirth. There is a lack of routine screening for anxiety disorders, obsessive-compulsive disorder and particularly bipolar disorder. Accessibility of timely care and follow-up is a huge issue. There is no period in a woman's life when the saying that 'there is no health without mental health' is more true than the perinatal period.” Dr. Verinder Sharma, https://www.huffingtonpost.ca/2018/05/01/maternal-mental-health-canada_a_23424672/

"I was involved in a similar initiative when I was based in the U.K. and now I feel it is high time we get it started here (Canada).” Dr. Kieran O'Donnell, https://www.huffingtonpost.ca/2018/05/01/maternal-mental-health-canada_a_23424672/

"It's a very sorry state of affairs in perinatal mental health in Canada. If a woman needs psychiatric admission in Canada, generally she is separated from her baby. It's awful, whereas in Australia, New Zealand, and the U.K., they admit both mother and baby together and each have their own nurse to look after them." Dr. Vivian Polak, https://www.huffingtonpost.ca/2018/05/01/maternal-mental-health-canada_a_23424672/
"I'm shocked that no one is screening moms or dads for their mental health in Canada. It causes relationships to end, substance abuse, the poor development of children and sadly, suicide." Mark Williams, 
https://www.huffingtonpost.ca/2019/01/30/depression-dads-postpartum-perinatal_a_23655472/

"The new U.K. guideline is an excellent start to identifying and addressing the mental health needs in men. It would be great if Canada or the provinces and territories implemented screening for both women and men for common conditions such as depression during the transition to parenthood in order to initiate appropriate support and minimize the impact of mental illness on their relationship with their children and their child's development.” Dr. Andrew Howlett, https://www.huffingtonpost.ca/2019/01/30/depression-dads-postpartum-perinatal_a_23655472/

"By not screening we keep our head in the sand and pretend it isn't a problem, which it is.” Dr. Angela Bowen, https://www.huffingtonpost.ca/2018/01/22/postpartum-depression-screening_a_23337997/

“Sometimes I feel that women are just incubators. It’s a shame the government does not see the value in investing in perinatal mental health, especially during the pandemic when rates of postpartum depression are increasing.” Dr. Jodi Pawluski, https://cpmhc.ca/2020/07/30/moms-disappointed-with-government-of-canadas-response-to-postpartum-depression-petition/

“When I had my second son, I had postpartum depression and anxiety and it was incredibly challenging…now we’re all in these isolated places, new moms, moms-to-be, and I just want to express maternal mental health matters now more than ever…We’re in this together.” Juno Rinaldi, https://cpmhc.ca/2020/04/22/covid-19-why-maternal-mental-health-matters-nowmorethannever/

“The last time I remember feeling this isolated is when I was a new mom and I first brought my babies home…I’m thinking of perinatal mental health and how important that is because when you add this isolation on top of the new responsibility, it’s a lot to bear so just wanted to give a shout out and remind new moms you are not alone. It probably feels like it but it does get better. And there’s always carbs to help us through it.” Jessica Holmes, https://cpmhc.ca/2020/04/22/covid-19-why-maternal-mental-health-matters-nowmorethannever/
“Parenting has always been tough and now it’s even tougher. Now more than ever we need a national perinatal mental health strategy and the investment to back that. It’s time.” - Ann Douglas, https://cpmhc.ca/2020/04/22/covid-19-why-maternal-mental-health-matters-nowmorethenever/

“I’m thinking of the many new moms and moms-to-be who are caring for or who are bringing new life into this world in the midst of pandemic. Now more than ever we need to shine a light on this issue. We need a strategy for maternal mental health. It cannot be overlooked.” - Ontario MPP Bhutila Karpoche, Parkdale-High Park, Critic, Mental Health and Addictions, https://cpmhc.ca/2020/04/22/covid-19-why-maternal-mental-health-matters-nowmorethenever/

“I’m the mom of two children so I know a little bit about how challenging, exhausting and frankly isolating new parenthood can be. Now more than ever, we need a national strategy for perinatal mental health care. I was proud to sponsor the petition calling on the government to implement universal testing and treatment for all moms and dads during the pregnancy and perinatal period.” MP Heather McPherson, Edmonton-Strathcona, NDP Deputy House Leader, https://cpmhc.ca/2020/04/22/covid-19-why-maternal-mental-health-matters-nowmorethenever/

“As a mother to three wonderful daughters, I know how important it is to have support from family and friends during the postpartum period. Right now, social distancing is critical in the fight against COVID-19 but this can be tremendously difficult for postpartum moms, dads and parents altogether. Your support means everything to new moms. During this period of isolation, even a check-in via phone or video chat can go a long way. Now more than ever, postpartum moms need your support. We will get through this together.” Ontario MPP Jill Dunlop Simcoe North, Associate Minister of Children and Women’s Issues, https://cpmhc.ca/2020/04/22/covid-19-why-maternal-mental-health-matters-nowmorethenever/
Appendix B: What persons with lived experience are telling us

“I was an educated, informed parent and I still fell through the cracks. When I finally did start reaching out for help, I couldn’t find it. The way we address perinatal health focuses so thoroughly on the baby that the mother gets lost in the shuffle. We need to do better.” Morag Wehrle, North Vancouver, BC

“I have personally never felt so alone and depressed as I was during hospitalization. It was by far the worst experience I have ever had to go through and I strongly believe my experience in recovery would have been so much better with my baby by my side and my daughter being able to visit. We all have rights and every mother who is suffering should never have to be separated from her baby for any length of time. If recovery is the goal in mind there should be nurses and doctors encouraging more time to bond and care for their babies. That kind of support needs to be available to mothers and families who are struggling with mental illness.” Sandra Jessop, Sault Ste Marie, ON

“Make going to get help a lot more accessible and an easier process. Don’t make a mom go through the emergency room to end up in a psychiatric ward. Have a ward in the hospital for moms that are having breakdowns from perinatal mental illness a quiet, calm space to get the help they need. Educate moms leaving the hospital more. Give them the resources and information. The only resources and information I was given at the hospital was breastfeeding being shoved down my throat and some pamphlets on where to go if it wasn’t going right. Have the nurse that visits you at home screen mom and give her tools to identify any perinatal mood disorders. There is so much focus on the newborn and the moms are being forgotten. We too are being born as new moms and we need support and help too. We need a national perinatal mental health strategy. Too many moms are suffering with some even losing their lives over this. We are all in this together. We can change the system!” Nicole Devlin, Calgary, AB

“I told my family doctor I was feeling rage, hopelessness, and exhaustion, all of which were severely uncharacteristic me. I told my family doctor I couldn’t go on feeling the way I did. The doctor placed me on a four month wait list to see a general psychiatrist. I was crushed. I couldn’t wait four months. The only way that I finally got the help I needed was by seeking out private therapy on my own which was both costly and time-consuming.” Sarah Cunningham, Bowmanville, ON
“I was not screened for perinatal mental illness by either my family doctor or my obstetrician during pregnancy. I was never asked how I was doing mentally or emotionally. Both of my care providers knew what my nursing job was and felt confident that I would be fine. I really believe they just felt that I would speak up if something was off. But I was so embarrassed to admit that I was struggling. And I wasn’t even sure it was abnormal at the time. I can say now that I certainly had some of the risk factors, but I found it difficult to recognize and accept that the symptoms of anxiety and then eventually depression, were actually happening to me.” Kiersta Hazlett, Barrie, ON

“When it was time for my six week checkup with my obstetrician, after my first born, I mentioned that I was sad, perhaps more than I should have been. He didn’t seem concerned and just mentioned medication if I ‘needed a little something to help’. My checkup was about a minute long and I remember thinking, ‘I waited six weeks for that!’ I felt alone. Trying to navigate the health care system was especially very frustrating and time consuming after the birth of my second child so I had to take matters into my own hands. My friends, family and coworkers came over to help in shifts so I was never left alone. But I needed medical help and ended up going to the emergency room a total of three times to try and find it. I felt like I had to justify why I was feeling the way that I was.” Carleigh Weldon, Windsor, ON

“This year was nothing like we had planned. Being pregnant was hard enough without having to live through an unprecedented pandemic. We are in lockdown. Again. In the middle of winter. And it’s just so damn hard. I have found my anxiety and depression slowly increasing since the pandemic started. Since I shut down my business and became a stay at home, working mom, it all feels so overwhelming with no end in sight. COVID-19 has changed the way I cope because often going out to visit family and friends was part of my routine to decompress. Now, even though I can see them virtually, it is not the same. The connection just isn’t the same. I’ve had days where I don’t get out of bed. I cry for a few hours and sometimes just putting my coat on to go outside for a walk seems like too much for me. I have to be strong for my daughters, but as the days go by, it’s getting harder and harder. Sometimes people will say, you can do it, it’ll pass, but that just makes me feel like I’m in a world of my own, like they don’t see or feel what I’m feeling, like a car is running me over but they don’t see the car, they just see me lying down and want me to just get up. As if it’s that easy. I so wish it were. My anxiety grows. It keeps me up at night. Suffering from perinatal mental illness during a pandemic is a literal nightmare. Most days feel
impossible to get through. Most days I just want to stay asleep. It’s lonely but I have a newborn and a toddler to care for. It’s so hard. The sadness is all consuming. The anxiety makes me feel like I am constantly drowsy and gasping for air. I don’t know if this is a battle I can win. I feel like giving up, but I am scared to leave my baby. She needs me. Thoughts of not being here anymore creep up and some days I don’t have the energy to fight them. I am terrified. Who can help me?”  
Candice Thomas, Barrie, ON

“The pandemic changed life as we knew it. I was pregnant and trying to work full-time from home while caring for a preschooler and worried the whole time about the prospect of giving birth without my husband present or worse, contracting COVID-19 at the hospital. Because of my history of anxiety and depression, and the significant life stress I was experiencing, I knew I was at risk of postpartum depression and I asked my obstetrician for a referral to the regional perinatal mental health program. As my exhaustion increased and anxiety worsened, I made an appointment with my family doctor to talk about my mental health and was referred to a guided self-help program. Although the program’s website suggested I would hear from someone within five days, it took about two months to receive an initial call to schedule an intake appointment a month later. When I had my intake appointment for the self-help program, I was told I needed more intensive support and referred to another service provider. I was given an estimate of around four weeks to hear back, but told it could take longer due to COVID-19. After already waiting so long for counselling through our healthcare system, it seemed like paying out of pocket might be the only way to get help in a timely way. I was finally able to access support nearly a year after reaching out for help. My experience trying to obtain perinatal mental health care during COVID-19 has been both frustrating and disappointing. Mothers are told to speak up when they are struggling, but can still fall through the cracks when they do. Concerns might not be taken seriously or help might not be available when it is most needed. I’ve learned self-advocacy is important, but so too is advocating for systemic improvements. Now, more than ever, perinatal mental health needs to be taken more seriously by both practitioners and politicians and I’ll keep talking about it until they do.”  
Tanya Nayler, Ottawa, ON

“I was physically fine and emotionally spent. I just wanted to stay in my blankets and imagine what a great life this baby would have without me. Imagine the woman my husband could find after my inevitable death. I did reach out for help when I was pregnant. I told my doctor, I cry every day. I can’t stop. She laughed and said, that’s just part of being pregnant. I tried to track down the email of the nurse the primary care network had given me—the one who told me to reach out if I ever needed someone—but
no one answering the phone knew who I was talking about and I’d lost her card. Thankfully, in the third trimester, my mood improved drastically. I was able to get up and move and nest and was so looking forward to meeting my baby. And when I did it was incredible. When the health nurse came to check on my family two days after we came home from the hospital, she remarked on how great I looked, that most moms weren’t able to get dressed and do their hair this early. I even had makeup on. I rode that new mom high for months. I was great at this. I was back to walking my dogs just days after giving birth. I was a superhero. And so I passed the mental health assessment at my child’s first health unit appointment. I was fine. But then the darkness came back. I was tired, so incredibly tired, and I began to think sad thoughts. Complex thoughts. Thoughts like I need to find new homes for my dogs because if my husband’s a widower and a single dad he won’t be able to handle them. Maybe he can keep the cat. The day before my baby’s second health unit appointment I got so excited. They’re gonna do the mental health screen again, I thought. She’ll see I need help. But when we got to the appointment they didn’t do the screening. I’d passed the last time, so I guess that counted forever. Except everything had changed for me. And no one knew. I went on like this for a long time, too long. Finally, I went to the walk-in clinic and asked the doctor for help. They suggested I try a book on Amazon before antidepressants. I ordered the book. It had the word happy in the title but it didn’t make me happier (perhaps because I put it in the breadbox instead of reading it). I went back to the clinic and demanded antidepressants. I found a therapist through my husband’s employee assistance plan. I got better, but this doesn’t feel like a story about a mother finding support when she needed it. It feels like the story of a woman who white-knuckled her way into survival. I am disappointed in our society. I am not disappointed in myself. This—none of it, not the depression, not my baby’s diagnosis, not the system failures—is my fault. But I am speaking out now for all the moms who don’t know that it is not their fault. They’re being told every day that they are failing when in reality, the system is failing us.”  

Heather Marcoux, Red Deer, AB

“My story is not unique. Many Indigenous women suffer from postpartum mood and anxiety disorders. But in our communities, there is a greater stigma towards mental illness. I was once told by a Grandmother in the middle of my perinatal presentation that she didn’t have time to be depressed back in her day. My mom was a product of the foster care system. Her father went to a Residential School outside of Brantford, Ontario. Residential Schools were government-supported religious schools developed to assimilate Indigenous children into Euro-Canadian culture. She was kind of like a “Sixties Scoop” child. We have been a people surviving through dysfunction. There are families who have depression but will not name it. We feel silenced. We feel we don’t have worth. We look for ways to heal but sometimes, it feels easier to stay in a situation where, even though we know it is unhealthy, we stay so we won’t be
alone. We are told family is everything. Some of us are told that the man makes the rules. We chose (even if it wasn’t a choice) to have our baby with him so we need to make it work. As the woman, it is our responsibility to make him happy. That dysfunction has been passed down from generation to generation.” Stephanie George, Jarvis, ON

“It’s hard for me to think back to the night I was having challenges with my daughter. And it’s even harder to think about what would have happened if I did not have my aunty to reach out to during that time. But it’s important for me to reflect on that night and share my story to provide the realities of postpartum psychosis and how dangerous it can be if left untreated. I also wanted to highlight the lack of resources some mothers have during this time. I know particularly as a Black teenage mother, I was uncomfortable calling the police or emergency services to help me through the negative thoughts. I knew that children’s services would be involved, an organization I distrust. I would have rather died (or at the time, killed my baby) than have my baby torn away from me and be stripped of my maternal rights. I now wonder what it would have been like if there was an organization I trusted to reach out to when I was in distress. How great and reassuring would it have been to have someone come and stay with me and help me get through the rest of the night. I thank God each day for my aunty and mommy. They say it takes a village to raise a child, it also took one to save our lives.” Dr. Anita Ewan, Toronto, ON
References


