Guidance Document

Perinatal Mental Health

Guidance for the identification and management of mental health in pregnant or postpartum individuals

July 2021

Provincial Council *for* Maternal *and* Child Health

building a brighter future

Contents

Introduction

Mental health is an important part of one's overall well-being and involves effective functioning with activities of daily living. This includes supportive activities (e.g., caregiving), healthy relationships (e.g., family bonding), and the ability to cope and adapt to change and challenging life events [1]. It is clear that the impact of untreated mental health problems in pregnant and postpartum individuals may result in negative outcomes for the parent, child and family. For children, there can be substantial impact to parent-child attachment, and to child growth, development and socioemotional well-being, which can lead to intergenerational effects with long-term implications for developmental trajectories [2].

To assist healthcare providers (HCPs) in delivering high-quality standardized care to pregnant and postpartum individuals, there was a recognized need to develop an Ontario-specific care pathway focused on perinatal mental health. The *Care Pathway for the Management of Perinatal Mental Health* (the care pathway) is designed to support HCP understanding about how to identify those who are pregnant or postpartum who may be experiencing difficulties with their mental health, assess the severity of their symptoms, determine an appropriate care or treatment that corresponds to need, and follow individuals through their care journey to ensure that their mental healthcare needs are being met.

The objective of the care pathway is to build HCP understanding and awareness of the delivery of mental healthcare for pregnant and postpartum individuals across Ontario, including how to:

(1) **Identify** individuals who may require care.

(2) **Direct** them to the care pathway most likely to be effective for them, depending on their level of need and treatment preferences.

(3) **Monitor** via follow-up to ensure individuals are engaging with care pathway services and are directed to additional resources when appropriate.

The scope of this work is focused on a care pathway supported by current evidence on best practices, and on existing Ontario-based resources for mental health support and treatment. This includes a tool sheet (page two of the care pathway) that follows a stepped-care approach that begins with identification and ends at treatment and/or follow-up. This guidance document should be used in conjunction with the care pathway tool (Appendix A) to support its appropriate application.

The scope of this work does not include guidance on specific mental disorder(s) and/or substance use. In addition, specific details about recommended pharmacological (drug) treatments or their potential benefits and harms when used in pregnancy and/or lactation are not included in this report. Instead, links to evidence-based up-to-date information are provided in the treatment pathway.

Acronyms, Abbreviations, and Definitions

APA	American Psychiatric Association
BORN	Better Outcomes & Registry Network Ontario
CPA	Canadian Psychiatric Association
DSM-5	Diagnostic and Statistical Manual of Mental Disorders (5th Edition) is the standard classification of mental disorders used by mental health professionals in the United States and is applied broadly within Canada.
HCPs	Healthcare providers such as physicians, midwives, nurses, or other regulated healthcare providers (often in a primary care setting) that may support pregnant or postpartum individuals.
Mental Health	Mental health involves the effective function of activities of daily living (such as work, school, caregiving or maintaining relationships, ability to adapt to change and cope with adversity).
Mental Illness	Mental illnesses are health conditions involving changes in emotion, thinking or behaviour (or a combination of these).
PCMCH	Provincial Council for Maternal and Child Health
GAD	Generalized Anxiety Disorder
OCD	Obsessive Compulsive Disorder
PTSD	Post-Traumatic Stress Disorder
EPDS	Edinburgh Perinatal/Postnatal Depression Scale
PHO	Public Health Ontario
PHAC	Public Health Agency of Canada
NICE	National Institute for Health and Care Excellence
SOGC	Society of Obstetricians and Gynaecologists of Canada
RNAO	Registered Nurses' Association of Ontario
WHO	World Health Organization

Intended Use

The care pathway outlines five steps that can be considered in the management of perinatal mental health: ask, advise, assess, assist, and arrange. This report describes these steps and is paired with an implementation care pathway tool where these steps are described briefly. The pathway provides direction for HCPs to guide pregnant and postpartum individuals to the most appropriate type of care, while remaining flexible in its application to a wide range of diverse population groups. HCPs must tailor the treatment approach to meet individuals' unique needs in all their diversity. HCPs must perform an individualized assessment and apply clinical judgment to ensure a safe and effective plan of care. This document does not take the place of national or provincial medical guidelines.

The resources hyperlinked in the care pathway and guidance document are current and consistent with the intended purpose of this work, as of the date of publication.

Background

The World Health Organization (WHO) indicates mental health issues that occur around the time of pregnancy are a major public health concern [3]. Perinatal mental illness can impact the quality of life and well-being of parents and, when untreated, may increase their risk of chronic mental illness. While rare, suicide is a leading cause of maternal death [4, 5, 6, 7]. Mental illness in pregnancy and postpartum has also been linked to problems with children's growth and development, including preterm birth, low birth weight and delayed development (cognitive, behavioural and emotional). It may also put the child at increased risk for developing mental health issues later in life themselves [4, 5, 7, 8, 9].

Any type of mental health issue can affect pregnant and postpartum individuals [4, 7]. This includes common conditions such as depression, anxiety, obsessive-compulsive disorder, and trauma and stressor-related illnesses. Less common, but often more severe, illnesses such as bipolar and psychotic disorders could also develop. Alcohol and substance use disorders may also be present in the perinatal period, either on their own, or accompanying other mental health issues. According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), the diagnostic criteria for mental health concerns occurring around the time of pregnancy are the same as when these conditions arise in the general (non-pregnant or postpartum) population [10]. However, there are specific considerations that are important to their management in the perinatal period, including how psychological treatments may need to be adapted, and how to make decisions around the safety of medication use during pregnancy and lactation. As a result, the DSM-5 allows for a diagnostic specifier to be attached to some diagnoses, such as depressive disorders, when the onset of illness occurs during pregnancy or within the first four weeks postpartum. For practical purposes, most clinical and research experts consider symptoms arising within the first year postpartum as

"perinatal", given that many of the issues in the transition to parenthood remain relevant through this time [11]. To support HCP practice, a perinatal mental healthcare pathway provides a recommended approach for the identification, assessment and monitoring of mental health issues for pregnant and postpartum people in Ontario. The care pathway does not replace individualized assessment, and clinical judgment is required to ensure safe, effective, equitable and inclusive treatment.

Clinical Conditions and Presentation

Transient Mental Health Concerns

Some pregnant and postpartum individuals present with symptoms of common mental health concerns in the context of the transition to parenthood that do not result in substantial impairment. Such symptoms often resolve with support and resolution of initial stressors (e.g., sleep deprivation, difficulty breastfeeding). These are known as adjustment disorders, which are defined as emotional or behavioural symptoms (such as low mood or anxiety) in response to a specific stressor or another event that exceeds what would normally be expected [7]. These disorders typically occur within three months from the time of the stressor, resolve within six months, and may require supportive care but not formal therapies or medication [7]. In postpartum specifically, as many as 60 to 80 per cent of individuals who have given birth experience emotional symptoms due to hormone changes that tend to resolve on their own without intervention in the weeks after delivery. This phenomenon, commonly referred to as "baby blues", is most often characterized by sadness, tearfulness and sometimes irritability that comes and goes throughout the day. It does not persist, nor become so severe that day-to-day life is affected [12].

Mental Health Issues Requiring Additional Clinical Attention

While some mental health issues resolve over time and on their own (or with support and improved sleep, for example) others may be more persistent and develop into a clinical mental disorder requiring more than supportive interventions. Described below are common mental illnesses seen in the perinatal period, including depression, anxiety and related disorders, and less prevalent but often more severe presentations of illness. To see the full list of required symptoms or criteria for all mental disorders, including those out of scope for this guidance document, please consult the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5) [13].

Depression

To be diagnosed with depression in pregnancy or postnatally, the DSM-5 indicates that a person must experience prolonged (at least two weeks of) low mood or loss of interest in activities that would have previously been enjoyable, as well as a total of five symptoms that include at least one of these two key symptoms.

Depression *cont'd*	Disruptions in sleep, appetite or concentration, excessive feelings of guilt/low self-worth, feeling keyed up or slowed down, and suicidal thoughts or intent may be other indicators [13].Symptoms of anxiety are common in individuals experiencing depression around the time of pregnancy, and attacks of panic (shortness of breath, chest pain, claustrophobia, dizziness, heart palpitations, and numbness or tingling in the extremities) can be present even in the absence of an anxiety disorder. Depressive episodes can range from mild symptomatology to more severe symptoms and impairment. At the most severe end of the spectrum, individuals may develop suicidal ideation and plans and/or psychotic symptoms [14]. Individuals presenting with depressive symptoms should be assessed for a history of mania or hypomania to rule out bipolar disorder (later discussed under *bipolar and psychotic disorders*), as a diagnosis of bipolar disorder might have implications for the treatment plan.
Anxiety and Related Disorders	Common anxiety and related disorders presenting perinatally include Generalized Anxiety Disorder (GAD), Panic Disorder, Obsessive Compulsive Disorder (OCD) and Post-Traumatic Stress Disorder (PTSD). Similar to depression, these disorders present along a spectrum of severity, depending on the level of symptoms and degree of impact on quality of life. GAD presents with excessive worry that is difficult to control, impacting energy, concentration and sleep. Panic disorder occurs when attacks of anxiety occur out of the blue and leave individuals nervous about having recurring attacks [15]. OCD symptoms include obsessional thoughts (recurrent, intrusive thoughts or images that lead to substantial distress), sometimes accompanied by behaviours or repeated mental rituals ("compulsions") that temporarily reduce the distress (e.g., a postpartum person has recurrent intrusive thoughts that their child will die while sleeping so repeatedly checks on the child throughout the night) [4]. PTSD symptoms occur in relation to traumatic events – sometimes following a traumatic childbirth experience. Affected individuals may re-experience events in nightmares, flashbacks and re-living of events, and feel the need to avoid feelings, people or places associated with the event [4, 14].
Bipolar and Psychotic Disorders	Bipolar and psychotic disorders – rarer than depression, anxiety and related disorders – can have serious health outcomes and impact the quality of life for the parent, child and surrounding family. Bipolar disorders are characterized by episodes of elevated or irritable mood (mania), as well as depressive episodes [5]. Individuals with bipolar disorder are at high risk for relapse, particularly in the first few weeks postpartum, with depression as the most common relapse presentation and mania also occurring [4].

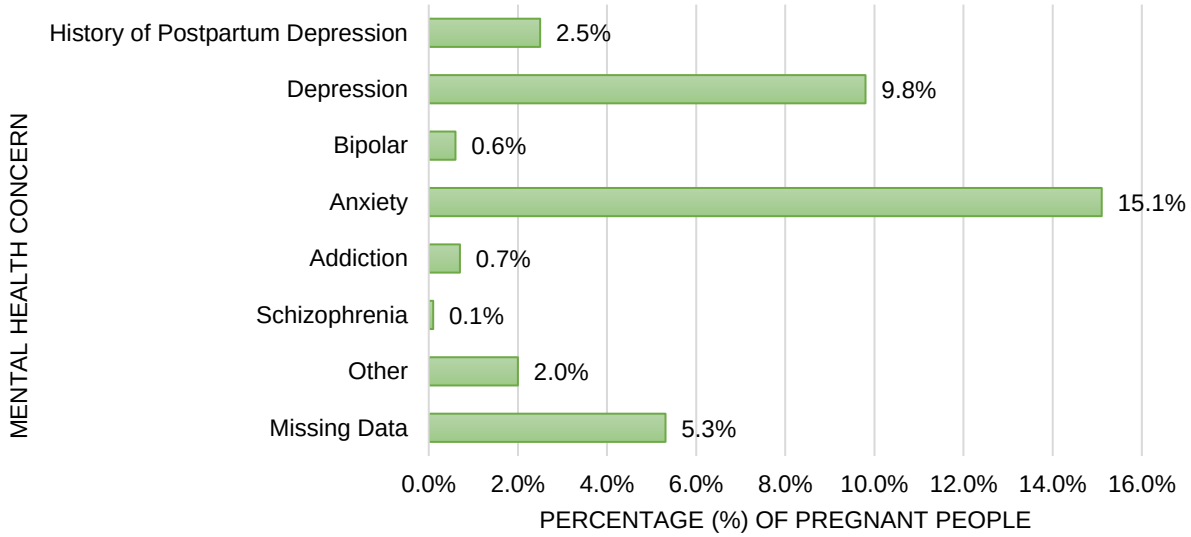
Bipolar and Psychotic Disorders *cont'd*	Individuals with bipolar disorder are also at particularly high risk for postpartum (also known as puerperal) psychosis (see below), especially in the setting of sleep deprivation or other stressors. Psychotic disorders, like schizophrenia, are characterized by symptoms such as delusions, hallucinations, disorganized thinking/speech, grossly disorganized or abnormal motor behaviour (including catatonia) and negative symptoms (e.g., apathy, inability to show emotions, withdrawal from social situations) [13]. Many individuals with schizophrenia have successful parenting experiences with appropriate support; however, there is an increased risk for pregnancy complications and infant health effects in this population, as well as risk of destabilization of illness in pregnancy and the postpartum period [4]. Individuals affected by both bipolar disorder and schizophrenia often require ongoing medication treatment to avoid relapse, including during pregnancy and lactation, which may require specialized care and advice.
Postpartum Psychosis	Postpartum psychosis occurs in 0.1 to 0.5 per cent of individuals [7]. It most often arises within the first two to four weeks after childbirth, and may include symptoms of mania, severe depression, delusions and/or hallucinations, and disorganized speech, thoughts or behaviours. Individuals with a previous history of postpartum psychosis are at very high risk of recurrence, as are individuals with bipolar and psychotic disorders (see above) [5]. Postpartum psychosis is considered a psychiatric emergency and is a risk factor for self-harm, suicide, and harm to the infant or other children, including infanticide [8]. If there is postpartum psychosis, or active intent or plan for harm to self or others, the client will require urgent care and hospitalization for immediate treatment.
Differential Diagnosis and Co-occurring Conditions	For a mental health condition to be diagnosed, the symptoms must not be better explained by either a medical condition or by a substance or substance use disorder. Several common medical conditions such as anemia, thyroid abnormalities, Vitamin B12 deficiency, or untreated alcohol or substance use disorders, can mimic or worsen mental health conditions. These conditions should always be considered as alternate diagnoses or issues that may be perpetuating mental health symptomatology.

Prevalence

It is estimated that up to 20 per cent of pregnant and postpartum people struggle with their mental health [16]. Major risk factors for perinatal mental illness are personal or family history of mental illness, low levels of social support, and current life stressors such as partner discord, financial problems and child health [17]. Perinatal mental

illness rates appear to be highest in low-income countries, and in individuals facing socioeconomic disadvantage and marginalization [8]. In Ontario, a diagnosed and/or self-reported mental health concern in pregnancy (pre-existing, diagnosed during the pregnancy or active during the pregnancy) was recorded for about 20 per cent of the 139,488 pregnant people in fiscal year (FY) 2019-2020 (Table 1). The most commonly reported concerns were anxiety (15.1 per cent) and depression (9.8 per cent).

Table 1: Percentage of pregnant people reporting mental health concerns in Ontario (FY 2019-2020)



Data from Better Outcomes Registry and Network (BORN) Ontario. Years Provided: (2019 to 2020). Resource Type: Tabulated data. Data Provided on March 11, 2021. All inferences, opinions, and conclusions drawn in this publication are those of the authors, and do not necessarily reflect the opinions or policies of BORN Ontario. Note: Mental health concerns are a multiple-selection data element in the BORN Information System which means that an individual can select more than one mental health condition. The total number of individuals (all pregnancies that resulted in a live or stillbirth) in fiscal year 2019/2020 among pregnant individuals who are residents of Ontario totalled 139,488. About 79 per cent of these had no mental health concern reported.

Perinatal mental health concerns of pregnant people in Ontario have increased as a result of the COVID-19 pandemic [18, 19]. In the first nine months of the pandemic, there were increased rates of diagnoses of anxiety, depressive, alcohol or substance use disorders among pregnant and postnatal people, particularly within the first 90 days after birth as compared to the remainder of the first year after birth [19]. Therefore, the early postnatal period represents a vulnerable time for families. This is consistent with findings from national studies: Canadian mothers are reporting significantly higher levels of depressive and anxiety symptoms [20, 21]. Pregnant people who reported higher levels of social support and physical activity during the COVID-19 pandemic had significantly lower anxiety symptoms. [21] Access to care has been complicated due to

the pandemic [22], thus further emphasizing the importance of identifying individuals in need of support, care and intervention. Healthcare providers report that COVID-19 has complicated access to care, including reduced in-person visits and overall services [23]. Many social determinants of health, including socioeconomic status, geographic location and race, influence a person's risk of facing mental health issues and the probability that the individual will have access to treatment. Systemic health inequities have been magnified in vulnerable populations as well as Indigenous communities and Nations across Ontario during the COVID-19 pandemic [24].

Method

Literature Review

The development of the care pathway and guidance document was informed by evidence identified in a literature review. Research databases searched included: Ovid, PubMed, MEDLINE, Cochrane Library and select journals, including *Journal of Obstetrics and Gynaecology Canada*, *Canadian Medical Association Journal, British Medical Journal* and *Journal of the American Medical Association* (JAMA). Search terms included: care pathway; perinatal; mental health; depression; anxiety; baby-blues; pregnancy; postpartum. Articles referencing mental health issues, such as substance abuse or addictions, were excluded as they did not meet the scope criteria outlined in this document. Thirty-one articles were identified related to this topic and its inclusion criteria.

National and international clinical practice guidelines were also reviewed (Appendix B). These included guidelines from Public Health Ontario, Registered Nurses Association of Ontario, Society of Obstetricians and Gynaecologists of Canada, Public Health Agency of Canada and the National Institute for Health and Care Excellence. General and diagnostic information was derived from the DSM-5 published by the American Psychiatric Association (APA) where appropriate [13].

Stakeholder Consultation

The care pathway was developed in consultation with subject matter experts who helped apply evidence-based practice recommendations from clinical guidelines to a local Ontario context. Two focus group sessions were held with diverse clinical stakeholders to review and share feedback on the application of the care pathway from their perspective and/or from use in their clinical practice.

Data

Data were requested from the Better Outcomes Registry and Network (BORN) Ontario to provide background on the prevalence of multiple self-reported mental health concerns.

Application of the Care Pathway

To assist HCPs in ensuring that pregnant and postpartum individuals receive high quality evidence-based care, the care pathway (Appendix A) was developed as a resource to support the identification and management of individuals who require intervention for mental health during the perinatal period.

A stepped-care approach to manage mental health problems was adopted as a useful mechanism to follow care guidelines, being recognized by institutions such as the *National Institute for Health and Care Excellence* [25]. This stepped approach will help Ontario HCPs navigate the diverse treatment options and improve service access when addressing perinatal mental health concerns. While the pathway provides a standardized approach for perinatal mental healthcare, clinical judgment is required to ensure that care plans are tailored to meet the diverse needs and contexts of an individual. A person can enter at any step in the care pathway and move up or down it based on severity of illness and response to prior interventions. Treatments can build upon interventions available in the lower steps. Ongoing monitoring is required regardless of the treatment step being applied

Pre-conception planning

While not covered by the care pathway, optimizing management prior to pregnancy for individuals with pre-existing mental illness or risk factors for an episode in the perinatal period is ideal. Management includes preventative strategies such as: optimizing health behaviours, including nutrition, physical activity and sleep patterns; promoting a supportive environment; reviewing current or previously used psychological and pharmacological interventions; and engaging treatment to reduce risk for relapse perinatally. Plans for pharmacological management during pregnancy and breastfeeding should be made with a shared decision-making approach to balance benefits and risks of medication use in pregnancy and lactation for the pregnant person and infant [5, 17, 26].

Care pathway steps

The care pathway for pregnancy and postpartum includes five steps, described in more detail below.

Step 1: ASK

Ask about the well-being of the pregnant or postpartum person at every visit to identify a need for mental health support and treatment.

The first step is to identify early if a pregnant or postpartum person may be struggling with their mental health. Early identification can create an opportunity for the healthcare team to improve short-term maternal, infant and family outcomes and provide supports to mitigate long-term adverse outcomes [4, 7, 17, 27, 28]. HCPs should be alert to risk factors for mental illness – especially those that can be addressed with appropriate social and/or community supports and services. Major risk factors for mental illness in the perinatal period include a personal or family history of mental illness, low social support and current life stressors, including partner discord, financial problems and child illness [17, 29].

At each visit, the HCP should attend to any signs or symptoms of mental health difficulty, including non-specific symptoms such as insomnia and fatigue, and difficulty in home, relationship or occupational functioning [5, 7, 17]. The HCP can *then ask* the pregnant or postpartum person about their mental health, sensitively inquiring about how a person is feeling and coping, or about specific symptoms. The dialogue should include a focus on a person's mental health within their own unique context and in all their diversity, with attention to a person's age, gender identity, race, ethnicity, ability and disability, and other relevant factors. HCPs should draw on available equity, diversity, and inclusion resources.

Healthy Babies Healthy Children (HBHC) Program and Interactions between Healthcare and Other Sectors in the Identification of Individuals in need of Perinatal Mental Healthcare

Pregnant and postpartum individuals requiring assistance with their mental health may also come to the attention of their HCPs through the individual's support system (e.g., family, partner) or via other community agencies with which the individual has been interacting, including social services, shelters and agencies assisting with supports for domestic violence.

HCPs should be aware that support for perinatal mental health issues is available through the Healthy Babies Healthy Children (HBHC) program, a free program delivered through Ontario's public health units in partnership with hospitals and other community partners [30]. The HBHC program uses screening and assessment to identify families at risk of compromised healthy child development, who may benefit from a home-visiting program so families can receive supports and services they need, including those that enhance maternal mental health, self-care and parenting capacity while in the community [31]. Referrals from HBHC may also be made to HCPs given that, while not specific to mental health screening, the HBHC screening tool can identify someone who may require mental health support. Screening is offered through HBHC to pregnant people and their families and to families with children from birth to their transition to school. Universal screening is offered at the postpartum stage. Visit the Ontario HBHC website for more information.

No specific tools are required to sensitively ask a pregnant or postpartum person about their mental health. However, to improve identification of issues and to help Ontario HCPs identify individuals struggling with their mental health, several validated depression and anxiety screening tools are contained in the Ontario Perinatal Record (OPR), previously known as the Antenatal Record 1 & 2. Since 1979, the OPR has been the standard tool for documenting perinatal care and provider visits [32]. In 2017, the OPR was updated to append specific screening tools to the record so providers would have easy access to evidence-based screening tools at each perinatal visit (Appendix C, page 4 of the OPR). The tools below are used internationally, have been translated into various languages and validated in diverse populations [33, 34, 35, 36].

- **Generalized Anxiety Disorder-2 (GAD-2)**
  GAD-2 is a validated two-item tool that screens for anxiety and can be used repeatedly with perinatal people at risk of anxiety or to confirm symptomatology. Studies indicate a sensitivity of 76 per cent and a specificity of 81 per cent with GAD-2 [37]. A total score of three or more warrants consideration of using the **GAD-7** (Appendix D) for further assessment or additional mental health follow-up. A study conducted for primary care patients with GAD-7 had a recorded Cronbach's alpha of 0.92, 89 per cent sensitivity and 82 per cent specificity [38].

- **Patient Health Questionnaire-2 (PHQ-2)**
  The PHQ-2 is a validated two-item tool to screen for depression that can be used repeatedly with perinatal people at high risk of depression or to confirm symptomatology [32].A total score of three or more warrants consideration of using the **PHQ-9** (Appendix E). Previous studies have indicated a PHQ-9 score of 10 or more signified a depressive disorder at an 88 per cent sensitivity and 88 per cent specificity [39]. Alternatively, to the PHQ-9, one could use the **Edinburgh Perinatal/Postnatal Depression Scale (EPDS) (**Appendix F**).**

- **Edinburgh Perinatal/Postnatal Depression Scale (EPDS) (**Appendix F)
  EPDS is an internationally recommended tool that can be used if the PHQ score indicates risk or can be administered on its own. Studies indicate that this tool demonstrates major depressive disorder with a sensitivity of >90 per cent and specificity of >80 per cent has a cut-off score of ≥10, and a sensitivity of >85 per cent and specificity of >80 per cent with a cut-off score of ≥13 [40].

Clinical Pearl — "Screening" vs "Diagnosis"

While these screening tools are helpful in identifying someone who is struggling with their mental health and **may** have a mental illness, they **do not** replace a clinical diagnostic interview [12]. Some individuals may not score above cut-offs on screening tools but do have significant mental health issues requiring care. Other individuals may screen "positive" on one of the scales but a clinical diagnostic interview may determine that there is another explanation for their symptoms, including a medical condition, alcohol or substance use disorder, or transient stressors where symptoms are likely to resolve with the stressor itself. These important considerations will guide treatment.

Step 2: ADVISE

Advise by providing education on perinatal mental health and arrange support to mitigate factors that are affecting mental health.

By starting conversations about the challenges of pregnancy and parenthood in Step 1 (ASK), HCPs can create a non-judgmental environment to discuss mental health. When possible and appropriate, family members can and should be included in education and treatment planning.

Education

Education about perinatal mental health should include information about prevalence, symptoms and risk factors for perinatal mental illness, as well as sensitive discussion of the potential impacts of untreated illness on both parental health and child health and development. The HCP can also educate about self-care strategies to promote mental health (such as getting adequate sleep, asking friends and family for support, eating healthy and getting exercise). Adequate time should be dedicated to discussing access to support services and psychosocial strategies to increase practical and emotional social support, improve night-time sleep, and encourage regular meals and physical activity.

Identifying and Addressing Psychosocial Risk Factors, Medical and Substance Use Comorbidities

HCPs should try to address modifiable precipitating and perpetuating factors for perinatal mental health issues (e.g., stress or anxiety related to the pregnancy or birthing experience, sleep deprivation or the feeling of being overwhelmed by caring for a newborn 24/7). As previously indicated, a medical work-up to address any easily treatable perpetuating conditions (i.e., anemia, thyroid dysfunction) is required. There may also be a need to discuss referrals to available community services, if appropriate [5, 17]. This might include accessing resources for individuals facing low social support, intimate partner violence and financial difficulties, and arranging treatment for active alcohol and/or substance use disorders.

Ontario Community Resources for Substance Use and Domestic Violence Support

Toronto Centre for Substance Use in Pregnancy (T-CUP) – Unity Health Toronto

Mothercraft – Early Intervention Programs

Barbara Schlifer Commemorative Clinic (legal, counselling and interpretation services)

Assaulted Women's Helpline – Toll Free: 1-866-863-0511 TTY Toll Free: 1-866-863-7868

Step 3: ASSESS

Assess the severity of the mental health concern.

As indicated, some mental health issues can resolve on their own with time and support, or with addressing the other risk factors or concerns identified above. However, other issues may be more persistent and develop into a clinical mental disorder requiring more than supportive interventions. For presentations that require clinical intervention, treatment planning is guided by the severity of the illness (mild, moderate, severe and urgent – see below), which is assessed by considering the number, nature and persistence of symptoms and the degree of impact on quality of life.

The general goal of the HCP assessment is to determine the level of severity as follows:

1. Mild	Few and mild symptoms but persistent with minimal impact on activities of daily living [13]. Mild severity of the common mental illness is defined as meeting the full DSM-5 criteria, but only with the minimum number of required symptoms and with minimal distress or functional impairment [5].
2. Moderate	Multiple symptoms, persistent, impacting day-to-day function and quality of life [13]. Moderate severity is a level of symptoms, distress and impairment that are more than mild but less than severe.
3. Severe	Many symptoms, persistent, significant impact on day-to-day function and quality of life [15]. A severe level of symptoms for a common mental illness can be defined as having far more of the DSM-5 criteria for the disorder than required for diagnosis, with a significant level of distress or functional impairment.
4. Urgent	Clinical concern about manic or psychotic symptoms, or active suicidal or aggressive ideation. While clinical judgment at the level of the HCPs scope of practice is required, the following general guidance can be provided to assess whether an individual has active suicidal or aggressive ideation. A person can be asked directly whether they have had any thoughts of harming themselves, their infants or anyone else. Active intent means the intent to cause harm to self or others, and/or the planning of possible ways to cause harm to self or others. [13].

Clinical Pearl — Intrusive Thoughts

It is important to recognize if the person is experiencing intrusive thoughts about harm but does not have any active intent or plan to act on these thoughts or images. Some individuals experience intrusive thoughts – also known as obsessional thoughts – that can sometimes be confused by HCPs as active suicidal or aggressive ideation. Intrusive thoughts are recurrent and persistent thoughts, urges or images experienced by the individual as invasive and inappropriate. These often cause marked anxiety and distress, and the individual has no intent to act on them [13].

If there is any uncertainty about whether a person is experiencing mania or psychosis, or if there are concerns about the safety of the individual and/or others, initiate plan to transfer patient for **emergency psychiatric assessment**.

For common mental health concerns such as depression, anxiety and related disorders, the recommended screening assessments tools can help guide severity assessment in combination with clinical assessment, as listed below:

1. **Mild:** PHQ-9 or GAD-7 score of 5-9, or EPDS score of 10 to 12.
2. **Moderate:** PHQ-9 or GAD-7 score of 10-14 or EPDS score of 13 to 18.
3. **Severe:** PHQ-9 or GAD-7 score greater than 15, EPDS score greater than 19 or question 10 has a score greater than zero.
4. **Urgent:** Active intent to harm self or others and/or suicidal ideation endorsed on any of the aforementioned questionnaires.

Step 4: ASSIST

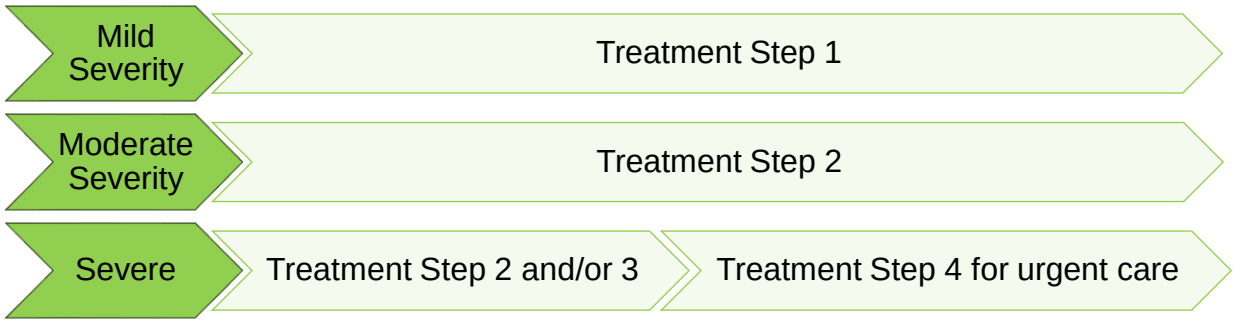
Assist by recommending or implementing a Treatment Step

Recommendations for treatment are made within the context of a stepped-care model, an evidence-based approach that ensures interventions are matched to patient need [41]. A stepped-care management plan may include a range of treatment options and interventions and is adaptable to a patient's changing needs and preferences. As stated previously, a pregnant or postpartum individual can enter the pathway at any step and move between steps based on severity of illness and in response to interventions.

At all steps in the management plan, the need for additional education, identification and addressing of psychosocial, medical and other risk factors must be continually assessed. Regardless of which "Step" is being considered, a discussion of infant and

childcare supports is essential in the care management plan. The HBHC program offers a home-visiting program so families can receive supports and services they need, including to enhance maternal mental health, self-care and parenting capacity while in the community [24]. HBHC and specific Public Health Units (PHUs) in Ontario offer a range of additional services and supports, including peer support groups, virtual parenting groups, and other psychosocial interventions that are helpful in the support of all treatment plans.

Ongoing assessment and monitoring are required to ensure that treatment is effective and adjustments are made where needed. The following approach outlines Treatment Steps based on the nature and severity of the person's symptoms, and the impact the symptoms are having on their functioning and well-being.



Each step is accompanied by suggested interventions that should be administered or recommended to patients. Whenever possible, personal preferences and circumstances of the individual and their family should be considered in decisions about treatment [4, 5, 7, 17]. With the patient's permission, a copy of the care plan should be shared with their support person [4, 5, 6].

The HCP and the individual should work together on creating a care plan with clearly identified roles to manage symptoms over the perinatal period. Other specialized staff can be invited to create a care team to support the diverse and complex needs of the individual on a case-by-case basis.

The care plan should include the following [4, 5, 6]:

- a description of the agreed-upon treatment goals and outcomes;
- a description of the agreed-upon system of monitoring and when follow-ups should occur; and
- the contact information of the care team and the roles and responsibilities for which each are accountable. This may include family and close relations should the individual allow it.

Treatment Step 1:
Psychosocial Interventions (Community Support)

Symptoms	Interventions by Type and Recommended Resources	
• Common mental health concerns such as depression or anxiety, where symptoms are mild or subclinical (may include patients for whom you are taking a watch-and-wait approach)	Self-help (perinatal-specific)	Self-directed workbooks for depression • Managing Depression • Coping with Depression during Pregnancy and Following the Birth Self-directed workbooks for anxiety • Coping with Anxiety during Pregnancy and Following the Birth • The Pregnancy and Postpartum Anxiety Workbook
	Guided self-help	e.g., internet- or paper-based self-guided intervention that may include assistance from a trained coach • Bounce Back Ontario postpartum-specific resources (online, self and physician referral accepted)
	Peer support and Supportive counselling	e.g., mother-to-mother support, and public health nurse telephone/home visits, facilitated support groups • Postpartum Support International (Ontario-specific resources) • Healthy Babies, Healthy Children (online/in-person, by region)

Focus of Intervention

Individuals with sub-syndromal or mild symptoms of common mental illnesses such as depression or anxiety may benefit from low-intensity psychological interventions [7, 5]. This first step of the pathway may also be appropriate for individuals who acknowledge their need for additional social support rather than clinical interventions.

Nature of Intervention

Low-intensity psychosocial or psychological interventions that are recommended for common perinatal mental disorders include guided self-help tools with the assistance of a coach, peer support and supportive counselling provided at home, over the phone or through support groups. Individuals can benefit at any time during pregnancy or the postpartum period from these interventions either alone or in combination.

Treatment Step 2:
Psychological Interventions and Antidepressant Medication

Symptoms	Interventions by Type and Recommended Resources	
• Common mental health concerns of mild severity that do not remit with Step 1 interventions *AND* • Common mental health concerns of moderate severity or greater.	Cognitive Behavioural Therapy (CBT) and Interpersonal Psychotherapy (IPT)	CBT and IPT are first-line treatments for perinatal depression and anxiety: • Guidance on Cognitive Behavioural Therapy • Guidance on Interpersonal Psychotherapy • Mother Matters: Online therapist-facilitated discussion board and therapy group for postpartum depression/anxiety (free in Ontario) • BEACON digital therapy, AbilitiCBT:Internet-based CBT(free in Ontario, therapist available with perinatal expertise) Additional Resources: • Postpartum Support International (for public and private services) • Local resources (e.g., Family Health Teams, Ontario Structured Psychotherapy program, private services) • 211Ontario (online Ontario community and social services database) • ConnexOntario (online and mobile access to mental health services)
	Medication (within scope of primary care provider)	Antidepressant can be used (and/or psychological intervention) when (1) psychological intervention alone is insufficient (2) symptoms are severe, or (3) preferred by the person Additional Resources: • Canadian Network for Mood and Anxiety Treatments • Information on antidepressants in pregnancy and lactation: MotherToBaby, LactMed

Focus of Intervention
Individuals with sub-syndromal or mild symptoms of common mental illnesses who do not achieve a response or remission with low-intensity psychological interventions, or those who present initially with a moderate or severe level of symptoms, may benefit

from higher-intensity non-pharmaceutical interventions and/or medications [5, 6]. Those who request medical interventions or high-intensity psychological interventions can also be considered in this step.

Nature of Intervention
In pregnant and postpartum individuals, psychological (non-pharmaceutical) interventions are recommended by most guidelines as the first line of treatment for those with moderately severe symptoms. Psychological interventions that may be effective for common mental illnesses in pregnancy and postpartum include cognitive behaviour therapy (CBT) for all types of common mental illnesses, and interpersonal therapy (IPT) for depression (links in Treatment Step 2 table above with more information). First-line psychological interventions such as CBT and IPT can be delivered by trained mental healthcare providers, including nurses, social workers, psychologists and physicians. In Ontario, government-funded psychological interventions are available at community health centres, from primary care, psychiatrists and various hospital-based programs, as well as online.

For those exhibiting more severe symptoms, HCPs can consider medications as the first line of treatment. Those who prefer medication treatment, or have difficulty accessing psychological treatment, may also be considered for medication treatment. The medication intervention for common mental illnesses in pregnancy and postpartum is antidepressant medications. Antidepressants can be prescribed in primary care for pregnant and breastfeeding people, and therapeutic recommendations can be found in the Canadian Network for Mood and Anxiety Treatments Guidelines for Health Professionals, as listed in the table above. HCPs should discuss the benefits and risks of antidepressants when they are being considered with up to date information on the potential impacts of antidepressant medication on the developing fetus or infant (if breastfeeding) before prescribing [26].

Treatment Step 3:
Additional Specialized Interventions

Symptoms	Interventions by Type and Recommended Resources	
• Mild or moderate mental health concerns that do not remit with Step 2 interventions *AND*	Medication	• Second and third-line medication options (see Canadian Network for Mood and Anxiety Treatments) • Provider to Psychiatrist E-consultation: Ontario Telemedicine Network • Patient consultation: Refer to psychiatrist at local institution or network or to specialized perinatal program (Check lists at Public Health Units in Ontario)

• Severe mental health concerns (severe depression or other severe mental illnesses such as bipolar disorder or schizophrenia).	Other	• Refer to local acute care centre with specialty psychiatric services. May include:
		  ○ Specialized psychotherapy
		  ○ Pharmacological follow-up
		  ○ Somatic treatment options; neurostimulation, electroconvulsive therapy.
		• Partial or full hospitalization

Focus of Intervention
This step is meant for individuals with a common mental illness that does not respond to interventions outlined in Step 1 and Step 2, or if there are concerns about diagnostic issues or rapidly increasing severity of illness (but without need for urgent care services). It is also meant for those who do not respond to initial antidepressant options or are experiencing severe symptoms (e.g., psychosis, suicidality) or who have a less-common mental illness that requires specialized care such as bipolar disorder or schizophrenia.

Nature of Interventions
Clinicians requiring additional information on second- and third-line medication options can review the guidelines listed in the table above. If more information or advice is needed, e-consultation networks can connect providers to psychiatrists across the province. If patients require consultations for their medication or treatment, they can be referred to a psychiatrist at a local institution or to a perinatal psychiatric program. These specialized services will support further diagnostic assessment, providing second- and third-line medication treatments (when primary care providers are not comfortable providing these) and considerations for other possible interventions. Other interventions may include neurostimulation, electroconvulsive therapy for severe depression, partial or full hospitalization. Intervening as early as possible when severe illness is identified, to minimize the risk of deterioration to urgent cases, is recommended [5, 6].

Treatment Step 4:
Urgent Care and Hospitalization

Symptoms	**Interventions by Type and Recommended Resources**	
• Suspected mania or psychosis • Discloses intention or plan for suicide,	Immediate Action	• Urgent risk assessment – Safety first. A person with possible mania, psychosis, thoughts of harming self or baby should NOT be left alone or with baby until an appropriate assessment is complete. Many pregnant and postpartum individuals do have “intrusive” thoughts of harm coming to their baby with no “active” intent. Each

self-harm or harm to fetus/infant		provider will have a different level of comfort with this assessment.
		• Provider is concerned about mania, psychosis or harm to self or others: Initiate plan to transfer patient for emergency psychiatric assessment.
		  ○ MDs can complete an Ontario application for extended assessment (Form 1 Mental Health Act)
		  ○ Call emergency services as needed to ensure safe transport for patient to the closest emergency department. Call local Family and Children's Services if concern about harm to child.
		• Provider assesses that there is no active intent or plan for harm to self or others, and that patient has appropriate support, as well as capacity to access crisis services if symptoms worsen acutely:
		  ○ Mobilize patient's support system
		  ○ Ensure the individual has contact information for crisis services.
		  ○ Maintain close follow-up, follow treatment Steps 2 and 3 as appropriate.
		  ○ Maintain and update plan of action with patient and patient's support system, including providers in patient's circle of care

Focus of Intervention

Urgent care is warranted when a clinician's assessment of the individual suggests concern about mania, psychosis or potential for harm to the individual or others. In this case, the HCP should not leave the pregnant or postpartum individual alone or with the baby until a risk assessment has been completed, as described. The HCP should also check to see if there are already existing safety plans in place for the individual or if previous safety plans were made that should be revisited [5].

Nature of Intervention

In the case of severe illness that includes psychosis or mania (including exacerbations in schizophrenia and/or bipolar disorder), or risk of harm to self or others, immediate action from the HCP to protect the safety of the individual and/or their infant and/or others is required. Postpartum psychosis or active suicidal or aggressive ideation must be considered a psychiatric emergency, often requiring hospitalization due to its rapidly changing course and the danger of suicide or harm to the infant [28].

Urgent and rapid risk assessment is to determine the level of risk that the pregnant or postpartum individual poses to themselves and to others [4, 5, 6, 7]. This can be done by a primary HCP or by a specialist. There are two courses of action considered in this

treatment pathway depending on HCP assessment and degree of concern (as listed in the table above):

(1) Provider **is concerned that the pregnant postpartum individual is experiencing** mania, psychosis or **active intent or plan for harm to self or others: A plan** to transfer patient for emergency psychiatric assessment should be initiated. In Ontario, a physician may make an application for extended assessment by completing a Form 1 - Mental Health Act (Appendix G). This will authorize admission of the person to hospital for psychiatric assessment. The physician must have personally examined the person seven days prior to completing the Form and must perform the examination themselves (not delegating to another staff). Emergency services (e.g., 911) can be called to ensure safe transport for the person to the closest emergency department.

Children's Aid Society/Family and Children's Services Involvement

If there is concern about ongoing risk of harm to a child, the individual should not be left alone with the child, and it may be appropriate to provide a report to the local Children's Aid Society/Family and Children's Services using clinical judgement in accordance with professional regulatory colleges and Ontario legislation. Refer to section 125 of the *Child, Youth and Family Services Act (CYFSA)* for more information about the duty to report a 'child in need of protection'.

(2) Provider is able to assess and conclude that there is **no active intent or plan** for harm to self or others, and is able to provide appropriate support and follow-up: Mobilize patient's support system and ensure the individual has contact information for crisis services. Maintain close follow-up and consider treatment Steps 2 and 3 as appropriate. It is valuable to share information and maintain communication with providers in the person's circle of care, as permitted. A plan of action should be created, updated, and maintained with the patient and their support system.

Step 5: ARRANGE

Arrange follow-ups to monitor recommended treatment plan. Make modifications or changes to treatment step as required.

Regardless of the treatment step, HCPs should actively monitor symptoms to determine if the pregnant or postpartum individual responds well to the prescribed intervention or whether changes are required. Follow-up is essential to address barriers to treatment uptake, review risk factors and discuss progress.

Frequency of initial follow-up should be at minimum two weeks during the active treatment phase (12 weeks). More frequent contact may be required if there is a higher

severity of illness or if medication is prescribed, and conversely less frequent as symptoms improve. It should be clear to the person which health professional is providing follow-up care and the expected timelines. Where applicable, HCPs can use the mental health assessment tools for anxiety and depression listed in this report and pathway to monitor symptoms and need for additional treatments, or to determine when an individual has reached remission. Remission can be defined as PHQ-9 or GAD-7 score that is less than five, or EPDS score less than 10, on at least two assessments that are at least two weeks apart [42, 43].

Individuals with common mental illnesses who are prescribed psychotropic medication should be followed for at least six months after remission to assess need for ongoing treatment. Those with more severe and persistent mental health issues will require longer-term treatment and follow-up and should be referred back to their primary HCP for ongoing care.

Summary

The mental health of a pregnant or postpartum individual is important for their overall well-being and for that of their fetus/newborn and surrounding family. The care pathway is a guide for HCPs who may care for pregnant or postpartum individuals to identify, assess and treat (or arrange treatment) for mental health concerns across a spectrum of severity. The care pathway (Appendix A) is a tool that can be used with other resources, including the Ontario-based resources listed in the pathway. HCPs looking for more specific information should refer to the DSM-5, which is intended as a guide to assist clinicians' diagnosis and treatment of mental disorders. HCPs are encouraged to work with local experts and services when further assessment and treatment may be warranted.

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Appendix A: Care Pathway Tool

(Access and download the PDF document: PCMCH-Care-Pathway-for-the-Management-of-Perinatal-Mental-Health_23July2021.pdf)

CARE PATHWAY FOR THE MANAGEMENT OF PERINATAL MENTAL HEALTH

This Care Pathway provides a recommended approach for the identification, assessment and monitoring of mental health issues for pregnant and postpartum people in Ontario. This tool **does not replace individualized assessment, and clinical judgment is required** to ensure safe, effective, equitable and inclusive treatment of your patient.

1. **ASK** ABOUT THE WELL-BEING OF THE PREGNANT OR POSTPARTUM PERSON AT EVERY VISIT TO IDENTIFY THE NEED FOR MENTAL HEALTH SUPPORT AND TREATMENT
   - Ask about mood and well-being of the pregnant or postpartum person at each visit and consider input from patient's circle of care. Assessment Tools can be used, including the Generalized Anxiety Disorder (GAD-7), Patient Health Questionnaire (PHQ-9) and Edinburgh Perinatal/Postnatal Depression Scale (EPDS) (see table below).
   - Initiate a dialogue to understand the context of the person's mental health within their own unique situation with a lens on equity, diversity and inclusion.
   - Identify factors that precipitate or exacerbate mental health symptoms (e.g., lack of support, financial difficulties, domestic violence, alcohol or substance use disorders, etc.).

2. **ADVISE** BY PROVIDING EDUCATION ON PERINATAL MENTAL HEALTH AND ARRANGE SUPPORT TO MITIGATE FACTORS THAT ARE AFFECTING MENTAL HEALTH
   - Provide information about mental health problems in pregnancy and postpartum, how common they are and that effective treatments are available.
   - Discuss strategies to increase practical and emotional social support, improve night-time sleep and incorporate regular meals and physical activity. These factors may improve mental health on their own for those with mild or subclinical symptoms and in conjunction with mental health treatments for those with problems that are more severe.
   - Link to community supports:
     - Across Ontario, the Healthy Babies Healthy Children (HBHC) program is a free program delivered through Ontario's public health units in partnership with hospitals and other community partners to help families receive supports and services to enhance mental health, self-care and parenting capacity in the community.
     - Arrange assistance in addressing precipitating and perpetuating factors, including resources available in the community to provide support (e.g., accessing financial, legal and domestic violence support, and accessing care for substance use disorders).

3. **ASSESS** THE SEVERITY OF THE MENTAL HEALTH CONCERN
4. **ASSIST** BY RECOMMENDING OR IMPLEMENTING A TREATMENT STEP (SEE DETAILS ON PAGE 2)

	MILD	MODERATE	SEVERE	URGENT
ASSESS Severity and Symptom Level	Mild or few, but persistent symptoms, minimal impact on day-to-day function	Multiple symptoms, persistent, impacting day-to-day function and quality of life	Many symptoms, persistent, significant impact on day-to-day function and quality of life	Psychosis, mania, or risk of harm to self or others
Assessment Tools (Depression & Anxiety ONLY)*				
GAD-7 (Anxiety)	Score = 5-9	Score = 10-14	Score = 15 or more	Not applicable
PHQ-9 (Depression)	Score = 5-9	Score = 10-14	Score = 15 or more or Q9 > 0	Intent or plan for suicide
EPDS (Depression and Anxiety)	Score = 10-12	Score = 13-18	Score = 19 or more or Q10 > 0	Intent or plan for suicide
ASSIST Initial Suggested Treatment Step	**Treatment Step 1** (If **very mild**, can monitor and reassess at 2-4 week intervals)	**Treatment Step 2**	**Treatment Step 2 or 3**	**Treatment Step 4**

*Patient Health Questionnaire (PHQ-9), Generalized Anxiety Disorder (GAD-7), Edinburgh Postnatal Depression Scale (EPDS) – Scores are a guide only, clinical assessment is required.

5. **ARRANGE** FOLLOW-UPS TO MONITOR RECOMMENDED TREATMENT PLAN. MAKE MODIFICATIONS OR CHANGES TO TREATMENT STEP AS REQUIRED
   - Address barriers to treatment uptake, review risk factors and discuss progress to determine whether new level of Treatment Step is required.
   - Frequency of initial follow-up should be at minimum every two weeks during active treatment phase (12 weeks). More frequent contact may be required if there is a higher severity of illness or medication is prescribed, and may be less frequent as symptoms improve. Be clear about which health professional is providing follow-up care.
   - Use the assessment tools to monitor symptoms. Scores on a GAD-7 <5, PHQ-9 <5 or EPDS <10 on at least two assessments that are at least two weeks apart suggest remission.
   - Follow patient to remission. Follow the individual on medication treatment for at least six months or longer after remission to assess need for ongoing treatment.

The pathway was modelled after the 5As Construct (Goldstein, Whitlock, & DePue, 2004). **Please refer to the guidance document for full list of references.** The *Care Pathway* is meant to be clinically applicable for a wide range of populations. Ontario has diverse pregnant and postpartum populations and this can greatly influence individual needs and mental health care expectations. When appropriate, health professionals should consult with specialized organizations dedicated to the support of specific populations when tailoring the *Care Pathway* to the person's unique needs.

Appendix A cont'd: Care Pathway Tool

TREATMENT STEPPED-CARE APPROACH

A person can enter at any step in the Care Pathway and move up or down based on severity of illness and response to prior interventions. Treatments can build upon interventions available in the lower steps. Regardless of the treatment step being applied, continuous monitoring is required. Note: both public and private fee service options are provided below for a full list of options.

TREATMENT STEP	FOCUS OF INTERVENTION	INTERVENTIONS BY TYPE AND RECOMMENDED RESOURCES

TREATMENT STEP 1
Psychosocial Interventions (Community Support)
	• Common mental health concerns such as depression or anxiety, where symptoms are **mild or subclinical** (may include patients for whom you are taking a watch-and-wait approach).	**Self-help (perinatal-specific)**
		• Self-directed workbooks for depression
		  • Managing Depression
		  • Coping with Depression during Pregnancy and Following the Birth
		• Self-directed workbooks for anxiety
		  • Coping with Anxiety during Pregnancy and Following the Birth
		  • The Pregnancy & Postpartum Anxiety Workbook
		Guided self-help (e.g., internet- or paper-based self-guided intervention that may include assistance from trained coach)
		• Bounce Back Ontario postpartum specific resources (online, self and physician referral accepted)
		Peer support (e.g., mother-to-mother support) and **Supportive Counselling** (e.g., public health nurse visits, facilitated support groups)
		• Postpartum Support International (Ontario-specific resources)
		• Healthy Babies, Healthy Children (online/in-person, by region)

TREATMENT STEP 2 Psychological Interventions (self or health care provider referral) and Antidepressant Medication	• Common mental health concerns of **mild severity that do not remit** with Step 1 interventions AND • Common mental health concerns of **moderate severity or greater.**	**Cognitive Behavioural Therapy (CBT) and Interpersonal Psychotherapy (IPT) are first-line treatments for perinatal depression and anxiety** • Mother Matters: Online therapist-facilitated discussion board and therapy group for postpartum depression/anxiety (free in Ontario) • BEACON digital therapy, AbilitiCBT: Internet-based CBT (free in Ontario, therapist available with perinatal expertise) **Additional Resources:** • Postpartum Support International (for public and private services) • Local resources (e.g., Family Health Teams, Ontario Structured Psychotherapy Program, private services) • 211Ontario (online Ontario database) • ConnexOntario (online mental health database) **Medication (within scope of primary care provider)** • Antidepressant can be used (and/or psychological intervention) when (1) psychological intervention alone is insufficient (2) symptoms are severe, or (3) preferred by the person **Additional Resources:** • Canadian Network for Mood and Anxiety Treatments • Information on antidepressants in pregnancy and lactation: MotherToBaby, LactMed
TREATMENT STEP 3 Additional Specialized Interventions	• **Mild or moderate mental health concerns that do not remit with Step 2** • **Severe mental health concerns** (e.g., severe depression, bipolar disorder or schizophrenia)	• Provider to Psychiatrist e-consultation for support around treatment recommendations: Ontario Telemedicine Network • Refer to specialized perinatal program for direct patient-provider consultation (Check lists at Public Health Units in Ontario) • Refer to local acute care institution for somatic treatment (neuro-stimulation, electroconvulsive therapy) or for partial (day program) or full hospitalization **Additional Resources:** • Additional medication options (see Canadian Network for Mood and Anxiety Treatments) • When specialized perinatal mental health care is unavailable, refer to local hospital specialty psychiatric services for specialized psychotherapy and pharmacological management and follow-up
TREATMENT STEP 4 Urgent Care and Hospitalization	• Suspected mania or psychosis • Discloses intention or plan for suicide, self-harm or harm to fetus/infant	• **Immediate Action: Urgent Risk assessment – Safety First.** A person with possible mania, psychosis and/or thoughts of harming self or baby should NOT be left alone or with baby until an appropriate assessment is complete. Many pregnant and postpartum individuals do have "intrusive" thoughts of harm coming to their baby with no "active" intent. Each provider will have a different level of comfort with this assessment. • Provider is concerned about mania, psychosis or harm to self or others: Initiate plan to transfer patient for emergency psychiatric assessment. MDs can complete an Ontario application for extended assessment (Form 1 Mental Health Act). Call emergency services as needed to ensure safe transport for patient to the closest emergency department. Call local Children's Aid Society/Family and Children's Services if concern about harm to child. • Provider assesses that there is no active intent or plan for harm to self or others, and that patient has appropriate support, as well as capacity to access crisis services if symptoms worsen acutely: Mobilize patient's support system; Ensure the individual has contact information for crisis services; Maintain close follow-up, follow treatment Steps 2 and 3 as appropriate. • Maintain and update plan of action with patient and patient's support system, including providers in patient's circle of care.

Your feedback is important! The Provincial Council for Maternal and Child Health is dedicated to improving the usability of this tool and the accompanying guidance document. We encourage healthcare providers using this tool to submit feedback via an online survey by scanning the QR code or clicking the link online here.

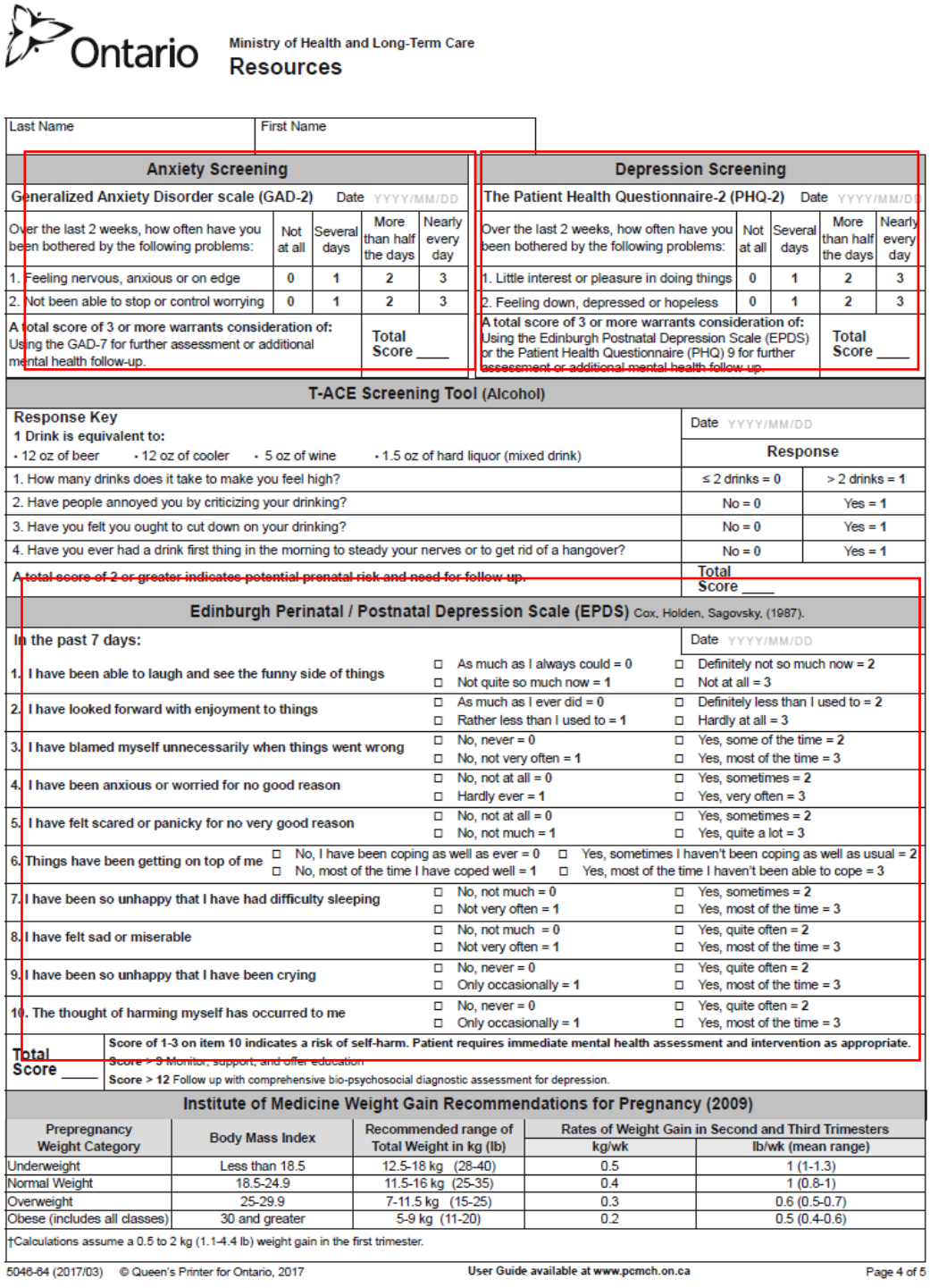
Page 2 of 2 (July 2021)

Appendix B: Table of Clinical Guidelines

Clinical Practice Guidelines

	Name (Publication Location and Year)	Resource Link
Canada	Family-Centred Maternity and Newborn Care: National Guidelines (Canada, 2019)	https://www.canada.ca/en/public-health/services/maternity-newborn-care-guidelines.html
	Assessment and Interventions for Perinatal Depression, Second Edition (Ontario, 2018)	https://rnao.ca/bpg/guidelines/assessment-and-interventions-perinatal-depression
	Perinatal Mental Health Toolkit for Ontario Public Health Units (Ontario, 2018)	https://www.publichealthontario.ca/en/health-topics/health-promotion/maternal-infant-health/hhdt
	Screening for Perinatal Depression (Ontario, 2018)	https://www.publichealthontario.ca/-/media/documents/R/2018/report-adapte-screening-perinatal-depression.pdf?la=en
International	Best Practice Guidelines for Mental Health Disorders in the Perinatal Period (British Columbia, 2014)	http://www.perinatalservicesbc.ca/Documents/Guidelines-Standards/Maternal/MentalHealthDisordersGuideline.pdf
	Antenatal and Postnatal Mental Health. The NICE Guideline on Clinical Management and Service Guidance (UK, 2018)	https://www.nice.org.uk/guidance/cg192
	Maternal Mental Health: The Knowledge Network. Free Registration (UK, 2015)	http://www.knowledge.scot.nhs.uk/maternalhealth/learning/maternal-mental-health.aspx
	Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline (Australia, 2017)	https://www.clinicalguidelines.gov.au/portal/2586/mental-health-care-perinatal-period-australian-clinical-practice-guideline
	Bettercare Maternal Mental Health Handbook (International, 2015)	https://www.mhinnovation.net/resources/bettercare-maternal-mental-health-book

Appendix C: Ontario Perinatal Record – Mental Health Screening Tools



Ontario
Ministry of Health and Long-Term Care
Resources

Last Name	First Name

Anxiety Screening

Generalized Anxiety Disorder scale (GAD-2) Date YYYY/MM/DD

Over the last 2 weeks, how often have you been bothered by the following problems:	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not been able to stop or control worrying	0	1	2	3

A total score of 3 or more warrants consideration of: Using the GAD-7 for further assessment or additional mental health follow-up. Total Score ____

Depression Screening

The Patient Health Questionnaire-2 (PHQ-2) Date YYYY/MM/DD

Over the last 2 weeks, how often have you been bothered by the following problems:	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

A total score of 3 or more warrants consideration of: Using the Edinburgh Postnatal Depression Scale (EPDS) or the Patient Health Questionnaire (PHQ) 9 for further assessment or additional mental health follow-up. Total Score ____

T-ACE Screening Tool (Alcohol)

Response Key
1 Drink is equivalent to:
• 12 oz of beer • 12 oz of cooler • 5 oz of wine • 1.5 oz of hard liquor (mixed drink)

Date YYYY/MM/DD

	Response	
1. How many drinks does it take to make you feel high?	≤ 2 drinks = 0	> 2 drinks = 1
2. Have people annoyed you by criticizing your drinking?	No = 0	Yes = 1
3. Have you felt you ought to cut down on your drinking?	No = 0	Yes = 1
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?	No = 0	Yes = 1

~~A total score of 2 or greater indicates potential prenatal risk and need for follow-up.~~ Total Score ____

Edinburgh Perinatal / Postnatal Depression Scale (EPDS) Cox, Holden, Sagovsky, (1987).

In the past 7 days: Date YYYY/MM/DD

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

Total Score ____

Score of 1-3 on item 10 indicates a risk of self-harm. Patient requires immediate mental health assessment and intervention as appropriate.
~~Score > 9 Monitor, support, and offer education~~
Score > 12 Follow up with comprehensive bio-psychosocial diagnostic assessment for depression.

Institute of Medicine Weight Gain Recommendations for Pregnancy (2009)

Prepregnancy Weight Category	Body Mass Index	Recommended range of Total Weight in kg (lb)	Rates of Weight Gain in Second and Third Trimesters	
			kg/wk	lb/wk (mean range)
Underweight	Less than 18.5	12.5-18 kg (28-40)	0.5	1 (1-1.3)
Normal Weight	18.5-24.9	11.5-16 kg (25-35)	0.4	1 (0.8-1)
Overweight	25-29.9	7-11.5 kg (15-25)	0.3	0.6 (0.5-0.7)
Obese (includes all classes)	30 and greater	5-9 kg (11-20)	0.2	0.5 (0.4-0.6)

†Calculations assume a 0.5 to 2 kg (1.1-4.4 lb) weight gain in the first trimester.

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[1]

[1] *GAD-2 and PHQ-2 referenced in the OPR cues a provider to utilize the full tool (GAD-7 or PHQ-9). It is the GAD-7 and PHQ-9 that are indicated in the care pathway.*

Appendix D: Generalized Anxiety Disorder-7 (GAD-7)

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

Appendix E: Patient Health Questionnaire (PHQ-9)

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ **DATE:**_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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A2663B 10-04-2005

Appendix F: Edinburgh Perinatal/Postnatal Depression Scale (EDPS)

Edinburgh Perinatal/Postnatal Depression Scale (EPDS)

SCORING GUIDE

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

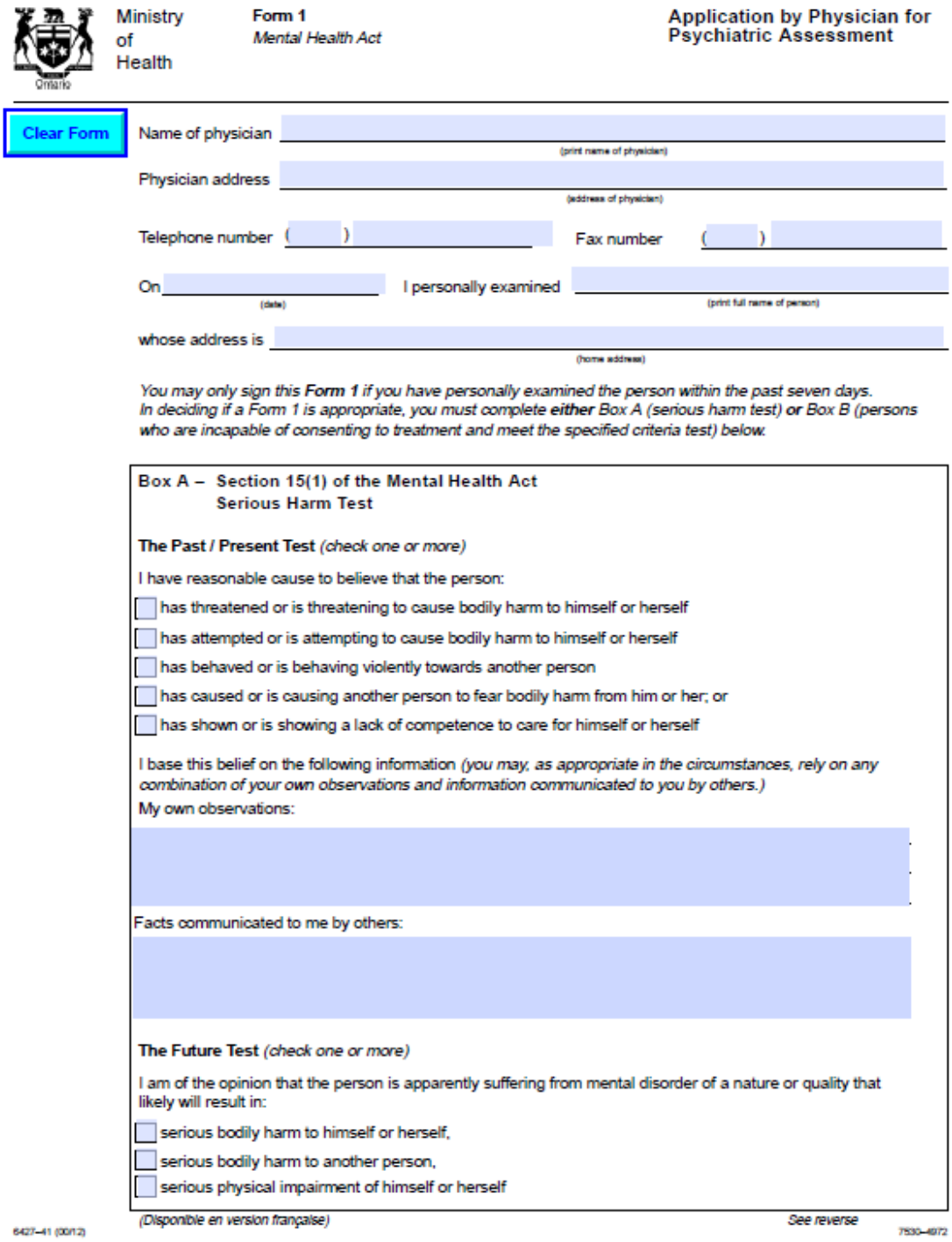
EPDS Score	Interpretation	Action

The British Journal of Psychiatry. 1987; 150(6):782-786.
BC Reproductive Mental Health Program and Perinatal Services BC. (2014), *Best Practice Guidelines for Mental Health Disorders in the Perinatal Period.* Available at: http://tiny.cc/MHGuidelines

Revised March 2015

Appendix G: Form 1 *Mental Health Act*

Below is a snapshot of page one of the form. The complete three-page form can be accessed online at the [Government of Ontario Central Forms Repository] (Form No. 014-6427-41).



Ministry of Health

Ontario

Form 1
Mental Health Act

Application by Physician for Psychiatric Assessment

Clear Form

Name of physician _____
(print name of physician)

Physician address _____
(address of physician)

Telephone number ( ) _____ Fax number ( ) _____

On _____ (date) I personally examined _____ (print full name of person)

whose address is _____ (home address)

*You may only sign this **Form 1** if you have personally examined the person within the past seven days.*
*In deciding if a Form 1 is appropriate, you must complete **either** Box A (serious harm test) **or** Box B (persons who are incapable of consenting to treatment and meet the specified criteria test) below.*

Box A – Section 15(1) of the Mental Health Act
Serious Harm Test

The Past / Present Test *(check one or more)*

I have reasonable cause to believe that the person:

- ☐ has threatened or is threatening to cause bodily harm to himself or herself
- ☐ has attempted or is attempting to cause bodily harm to himself or herself
- ☐ has behaved or is behaving violently towards another person
- ☐ has caused or is causing another person to fear bodily harm from him or her; or
- ☐ has shown or is showing a lack of competence to care for himself or herself

I base this belief on the following information *(you may, as appropriate in the circumstances, rely on any combination of your own observations and information communicated to you by others.)*

My own observations:

Facts communicated to me by others:

The Future Test *(check one or more)*

I am of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in:

- ☐ serious bodily harm to himself or herself,
- ☐ serious bodily harm to another person,
- ☐ serious physical impairment of himself or herself

6427–41 (00/12) *(Disponible en version française)* *See reverse* 7530–4972