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**Reproductive Mental Health Guideline 2**

**MENTAL ILLNESS DURING THE PERINATAL PERIOD:  
DISCHARGE PLANNING AND COMMUNITY FOLLOW-UP GUIDE**

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***INTRODUCTION***

Discharge planning and community follow-up should be given the highest priority when counseling women with mental illness in the perinatal period. Women with reproductive mental illness present a unique challenge for health care practitioners. Health care providers must be attentive not only to the woman's medical/clinical symptoms, but also to her status as mother or expectant mother, and the complex life context in which her condition developed. The discharge of these women from hospital, and follow-up in the community requires a comprehensive, well-coordinated plan based on assessment parameters that effectively take into account the multidimensional aspect (biological, psychological, social and spiritual) of mental illness in the perinatal period.

The purpose of this guideline is to provide guidance to physicians, obstetricians, midwives, hospital nurses, psychiatrists, hospital social workers, community health nurses, mental health counselors and other professionals involved in developing an effective discharge plan with community follow-up strategies for women with mental illness in the perinatal period. It is vital for health professionals to strive for continuity of care for women, their infants and families throughout this period.

***PARAMETERS FOR DISCHARGE PLANNING***

It is recommended that discharge planning follow the process components of *Integrated Case Management* as outlined by the Ministry for Children and Family Development (MCFD-[www.mcf.gov.bc.ca](http://www.mcf.gov.bc.ca))<sup>1</sup>. Assignment of a case manager is necessary to provide coordinated and consistent care during the discharge planning process. It is also recommended that the mother, her partner/spouse or any other support persons, as well as any key community resource representatives be included and consulted in the discharge planning process. Involving family members and other informal network members in the discharge planning increases the likelihood of success.

Integrated Case Management and Family-Centred Case Management are discussed in a recent provincial publication entitled, "Supporting Families with Parental Mental Illness".<sup>2</sup> This document enables service providers to assist women with severe recurrent symptoms of mental illness to make plans for the care of their children in case they suffer a relapse.

***MEMBERS OF THE INTERDISCIPLINARY DISCHARGE PLANNING TEAM***

The discharge planning team members will include the mother (family) and may include: general practitioners; family physicians; obstetricians; geneticists; endocrinologists; hospital social workers; psychiatrists; hospital nurses; midwives; community health nurses; MCFD child protection workers; mental health counselors; Pregnancy Outreach Program workers and other relevant professionals or community support people (refer to Appendix A: The Roles and

Responsibilities of Service Providers) that may compose a discharge planning team. Any key community resource workers or professionals who have been involved with the mother during her pregnancy and/or who will be having ongoing contact with the mother infant dyad after discharge should be included in the discharge planning team.

### ***INTEGRATED CASE MANAGEMENT***

The Integrated Case Management Tool developed by MCFD supports the efforts to achieve better outcomes for women experiencing mental illness in the perinatal period. When a hospitalized postpartum woman is diagnosed with a mental illness a case manager must be assigned. This person could be any member of the interdisciplinary team.

#### **I. PROCESS COMPONENTS OF INTEGRATED CASE MANAGEMENT**

- Emphasizes a holistic approach and client-centered service e.g. woman-family centered approach
- Builds on a woman's strengths
- Recognizes women's diverse needs, background and abilities
- Demands optimal collaboration from various service providers
- Builds on mutual respect for the client
- Provides continuity, plans for transitions and promotes the least intrusive interventions.

#### **II. GENERAL TASKS ASSOCIATED WITH INTEGRATED CASE MANAGEMENT**

- Assignment of a case manager
- Multi-disciplinary case conferences
- Proactive assessment, planning, review and implementation of case plans
- Follow-through/follow-up

#### **III. SPECIFIC TASKS OF THE CASE MANAGER RELATED TO THE DISCHARGE PLAN**

- Coordinates family and team meetings
- Ensures the Discharge Plan is done in collaboration with multi-disciplinary team members including appropriate representation from the community, (refer to Appendix B: Discharge Planning Guide).
- Ensures members of the discharge planning team have made referrals for medical, social and mental health follow-up.
- Ensures that discharge planning team members have identified the process for planning and effective ongoing communication. This includes:
  - An Integrated Case Management Discharge meeting which includes the woman and family supports.
  - Plans for community follow-up, including dates of follow-up and by whom (e.g. hospital nurse, outreach nurse or social worker, psychiatrist, psychiatric nurse, mental health team, Friendship Center, Ministry for Children & Family Development, etc.) are in Appendix B: Discharge Planning Guide.

- Plans for community follow-up are clearly documented on the Community Liaison Record in the hospital and are recorded in the appropriate notes by the hospital nurse, social worker, and/or community health nurse.
- The Discharge Planning Guide and its list of recommendations are placed in the hospital chart and given to the case manager, community health nurse and the mother.

## **DISCHARGE PLANNING**

### **I. DISCHARGE PLAN FOR THE MOTHER**

A member of the interdisciplinary discharge team should complete the comprehensive mental health assessment (refer to Guideline 3 Appendix C: The General Perinatal Mental Health Assessment Tool) and arrange for follow-up with a mental health professional e.g. a psychiatrist, mental health worker, psychiatric nurse, etc. after discharge. Record the mental health worker's name and telephone number in the Discharge Planning Guide (Appendix B). The Discharge Plan for the mother should consist of the following components:

#### **A. Physical Assessment**

- Contraception counseling for the woman and her partner may be warranted. Accidental pregnancies should be prevented in the aftermath of a postpartum mental illness diagnosis and during recovery. The kinds of contraceptives recommended should be given careful consideration. Hormonal contraception may not be the best first choice for some women as the hormones can trigger and/or aggravate depressive and anxiety symptoms.

#### **B. Mental Health Assessment**

- A woman's general mental health should be obtained upon admission, during pregnancy, labour and delivery, in the postpartum period and upon discharge (refer to Guideline 3, Appendix D: General Perinatal Mental Health Assessment Tool). The community health nurse should assess the mother in the home and record her findings on the British Columbia Reproductive Care Program Community Maternal Assessment Checklist (HLTH 1596) Perinatal Forms Guideline 13 (see [www.rcp.gov.bc.ca](http://www.rcp.gov.bc.ca)).
- The prenatal period is an important time to identify women with mental health issues. There are a number of prenatal providers that may have contact with prenatal clients including: general practitioners, obstetricians, social workers, nurses, doulas, childbirth educators, midwives, mental health workers and Pregnancy Outreach workers. It is important for each of these providers to have some knowledge regarding illness in the perinatal period (refer to Guidelines 4, 5, and 6).
- A pre-crisis plan should be developed in conjunction with the woman and her support network to avert possible crisis or emergencies once she is out in the community. This can be achieved by teaching the woman's support people how to recognize the warning signs and what steps to take. The pre-crisis plan should include advance-planning strategies for the care of children in the event that the mother suffers a relapse and/or has to be hospitalized. As a preventative measure, it is important to ensure that women receive

ongoing support even if they “appear well”. Refer to the document “Supporting Families with Parental Mental Illness”.<sup>2</sup>

- The importance of timely follow-up and effective monitoring of the woman’s condition once she is discharged to the community cannot be underestimated. A woman’s mental condition can deteriorate rapidly and suicidal ideation acted upon. The well being of the baby may be at risk. Regular mental health assessment must be carried out.
- Suicidal risk and potential for harm to the infant must be evaluated as part of the regular mental health assessment, and if necessary, a safety plan or precautions must be developed in conjunction with the woman and her family. Ministry for Children and Family Development involvement may be necessary if there is a perceived risk to the infant. However, the emphasis should be on incorporating supportive services into the home to provide the best possible chances for the mother-infant attachment process to develop. Health care providers have to be willing to advocate strongly for these services on behalf of women and their families. The safety of the infant and the mother is of paramount consideration. Therefore the discharge plan must include provisions for the implementation of an ongoing evaluation of suicidal risk and potential for harm to the infant (refer to Guideline 3. Appendix E. Perinatal Suicidal Assessment Questionnaire, & Appendix F. Infanticide Ideation Assessment Questionnaire).

### **C. Psychosocial Assessment of the Mother**

- A family-centered approach which validates the impact of the mother’s illness on the family members and vice-versa is essential for successful intervention. For a brief summary of individual, family, marital and support/ therapy group modalities, refer to Guidelines 4, 5, and 6.
- A mother suffering from a mental illness is likely to need help looking after her newborn infant and/or her older children. She may require assistance with household management tasks such as meal preparation, housecleaning, and grocery shopping. Alternatively, she may need the presence of another adult in the home to keep her safe and monitor the mother-infant interaction. Assisting the woman and her partner to develop a support network is critical. This may involve recruiting friends and family members, or accessing community services to help meet the family’s needs. The first step to assessing a woman’s relationships and supports is to conduct a psychosocial assessment and ascertain her social support network (refer to Appendix C: Psychosocial Assessment of Women with a Mental Illness in the Perinatal Period, and Appendix D: Social Support Networking for Women with a Mental Illness in the Perinatal Period).
- The psychosocial assessment is particularly important to assist health care providers in identifying areas of need or concern which have a direct impact on the woman’s mental health condition and recovery. This includes an evaluation of family dynamics and partner relationship. **Screening for intimate partner violence is critical** (refer to BCRCP Obstetric Guideline 13: Intimate Partner Violence during the Perinatal Period, [www.rcp.gov.bc.ca](http://www.rcp.gov.bc.ca)). In this assessment, it is important to recognize the woman’s strengths and to be sensitive to cultural and spiritual issues. While completing the

psychosocial assessment, it is vital to reassure the woman (and her family) that her illness does not make her an inadequate mother, nor is it her fault. (Refer to Appendix C: Psychosocial Assessment of Women with a Mental Illness in the Perinatal Period).

**Note:**

Discharge on weekends (Friday-Sunday) or holidays should be strongly discouraged for mother-infant dyads flagged as requiring immediate follow-up in the community. This is due to the generally decreased availability of community health services during these times.

Completion of discharge planning that incorporates all aspects of the mother and infant's transition back to the community, including support for the partner and family members involved, is needed (refer to Appendix B: Discharge Planning Guide).

**D. Breastfeeding**

- Women generally should be encouraged to breast feed their infants. The baby's weight gain should be monitored routinely to ensure that the mother's milk supply is adequate.
- If a woman is suffering from a mental illness in the postpartum period and her abilities to cope with this illness make breastfeeding an additional source of stress, breastfeeding should be reassessed. Should the decision be made that the mother not breastfeed, this decision should be supported.

**E. Community Follow-up**

- 1) Ensure medical follow-up within 48-72 hours of discharge, and ensure ongoing communication thereafter. Continuity of care is critical.
- 2) Ensure psychiatric follow-up within 48-72 hours of discharge, and ensure ongoing communication thereafter. Continuity of care is critical.
- 3) Ensure prompt and complete referral to the local community health unit. This is especially critical when the mother does not deliver her baby in her home community. Every attempt should be made so that a home-visit/telephone contact from the Community Health Nurse is made within 24-48 hours of discharge. Follow-up visits/contacts should be made as needed by the family based on all the other resources and services involved.
- 4) Ensure social supports within the community, refer to
  - Appendix D: Social Support Networking for Women with a Mental Illness in the Perinatal Period
  - Appendix E: Community Resources
  - The document "Supporting Families with Parental Mental Illness"<sup>2</sup> also provides strategies for supporting parents in the home and in the community

- 5) Ensure that issues and/or concerns arising from psychosocial assessment are addressed and that community strategies are in place. This may involve referrals for family counseling, battered women support services, etc. (refer to BCRCP Obstetric Guideline 13: Intimate Partner Violence during the Perinatal Period [www.rcp.gov.bc.ca](http://www.rcp.gov.bc.ca)).

## **II. DISCHARGE PLAN FOR THE INFANT**

Infants born to women being treated for mental illness during pregnancy or immediately after delivery may require special medical and social attention. Start by completing the standard provincial form – Newborn Record, Part 2: Sections 13, 14, 15, and 16.

### **A. Assessment of Infant: Physical, Neurological, and Behavioral Assessment and Documentation**

- 1) Newborn growth parameters:
  - plot height, weight, and head circumference on standard growth charts and insure normal parameters.
- 2) Newborn feeding:
  - insure newborn period weight gain. When bottle-feeding, the infant has at least two normal feedings, of 30cc/feed. When breastfeeding the infant demonstrates latching-on behavior for 2 feedings prior to discharge.
- 3) Prenatal medication exposure: If medication is used by a woman prenatally for depression, anxiety etc., consider the following key questions:
  - Is the infant demonstrating symptoms of withdrawal from the medication e.g. altered neurological/behavioral states (sleeping, eating, crying, settling, and handling)
  - Consider other causes of abnormal behavioral status: e.g. unstable CNS status which includes: sepsis/meningitis, hypoglycemia, hypocalcemia, CNS haemorrhage (initiate laboratory and radiology investigations as clinically indicated). Assess HIV, HCV, HBV status/risk as a part of any general health approach. Follow established British Columbia Reproductive Care Program for Guidelines for Perinatal Care of Substance Using Women and their Infants (November, 1999) for testing of serology obtained early in pregnancy and high risk behaviors.

### **B. Assessment of the Mother-Infant Dyad**

Close attention must be paid to the mother-infant dyad. A mother's attention to her child can be impaired in the presence of maternal depression and anxiety. This may have immediate and long-term consequences for the mother–infant relationship and for infant development in general. The following areas need to be assessed:

- 1) Parenting needs, refer to Appendix C: Psychosocial Assessment of Women with a Mental Illness in the Perinatal Period

- 2) Impact of parental mental illness on the infant: 0-8 months; 9 months –2 years; 3-5 years etc are discussed in the Supporting Families with Parental Mental Illness document<sup>2</sup>
- 3) Bonding and Attachment

Several mother-infant interaction tools are found in the literature as follows:

- a) The **Birmingham Interview for Maternal Mental Health** (3<sup>rd</sup> Edition) consists of 40 questions/clinical observations about: infant characteristics, mother's emotional response to her infant, and defines 3 bonding disorders:
  - Delay in, or loss of maternal emotional response
  - Pathological anger towards infant
  - Rejection of infant

From the Birmingham Interview Brockington developed a 6-point Likert scale of 25 items entitled the "Postpartum Bonding Instrument"<sup>3</sup>. Both the Birmingham Interview and the Postpartum Bonding Instrument would need to be administered by clinicians who could not only gather the mental health data but interpret the findings and provide appropriate follow-up of the mother-infant dyad.

- b) **Pregnancy Intervention Tracking Form** (Nursing Child Assessment Satellite Training, NCAST) published a book entitled, "Promoting Maternal Mental Health during Pregnancy: Theory, practice and intervention" through Nursing Child Assessment Satellite Training program in Seattle Washington.<sup>4</sup> One of the units in her corresponding 'Pregnancy Intervention Tracking Form' is entitled attachment. The items deal with a woman's preparatory actions during pregnancy which exemplify a mother-fetus relationship. The health care provider subjectively scores the woman's involvement on a scale of 1 to 10. This NCAST program will publish qualitative data on this tool in the future.
- c) **Parent Child Early Relationship Assessment Scale (PCERA)** developed by Clark<sup>5</sup> was recently, used by Reebye, Morison, Panikkar et al<sup>6</sup> to assess the quality of the mother-infant relationship. The mother-infant relationship was assessed during feeding and play and positive maternal affect, maternal sensitivity and negativity and infant affect both positive and negative were noted. This study found that mothers treated with antidepressant medication were more intuitive at handling their infants positive affective states. When mothers were both depressed and anxious the mother-infant dyad seemed to be more vulnerable. These mothers had difficulty responding to their infant's positive and negative moods, which they seemed to do in an inconsistent fashion.

Although, mothers who experience mental illness in the perinatal period will not show consistently positive affective behaviors towards their infants, it is beyond the scope of these guidelines to recommend mother-infant bonding assessment tools, treatment, and follow-up of these mother-infant dyads. We however, have encouraged those in the

infant attachment area to pursue funding and development of such guidelines. We also have several recommendations, if you are concerned about interactions between a mother- infant dyad:

- Document your observations
- Consult local, regional and provincial sources about your findings
- Refer the woman to the appropriate regional resources e.g. Psychiatrist, Community Health Nurse, Hospital Social Worker or Psychologist, Mental Health worker and/or appropriate community resources (refer to Appendix E: Community Resources)
- Refer to the Ministry for Children and Family Development when there is concern about lack of attachment and possible neglect or harm to the infant
- Refer to Provincial Programs: Child and Family Clinic at BC Women's and Children's Hospital, Infant Psychiatric Clinic Tel: 604-875-2424 local 2010.

### **C. Community Follow-up**

Refer to the above Section II: Discharge Plan for the Mother, Section E: Community Follow up (page 5).

### **D. Child Protection Issues**

Every adult has the responsibility to report infants considered at risk to the MCFD in a timely and comprehensive manner. It is the mandate of the MCFD child protection worker to assess and where appropriate, to investigate reports where a child may need protection. The result of the investigation may be either:

- the mother needs supports to enable her to safely care for her infant upon discharge
- the infant is in need of protection and is removed from the mother's care

**Note:** Children are only removed from their parents when they are in immediate danger and there is no alternative, less disruptive way to protect them.

The social worker must conduct a comprehensive risk assessment for every child who may be in need of protection, and develop a plan to reduce the highest risk factors. The plan will include specific steps to be taken and services to be provided to family members. The process of decision making for children at risk is a complex one and benefits from a team approach. The removal of an infant is one of the most difficult experiences for women and their partners. MCFD social workers can work with the hospital social workers and health care providers to incorporate supportive services into the plan for the family. Considerable support is needed for the woman and an ongoing support plan needs to be developed on a case by case basis.

**REFERENCES**

1. Ministry for Children and Families (November, 1999). Integrated Case Management: A User's Guide.
2. British Columbia Ministry of Health. (2001). Supporting Families with Parental Mental Illness: A community Education and Development Workshop. A Training Tool for Communities to Organize Services to Support Families. [www.bcsm.org](http://www.bcsm.org)
3. Brockington, I. F., Oates, J., George, S., Turner, D., Vostanis, P., Sullivan, M., Loh, C., & Murdock, C. (2001). A Screening questionnaire for mother-infant disorders. Arch. Women's Mental Health (3), 133-140.
4. Solchany, J. E. (2000). Promoting Maternal Mental Health during Pregnancy: Theory, practice & Intervention. NCAST Publications Seattle.
5. Clark, R. (1985). The Parent-Child Early Relational Assessment. Madison: Department of Psychiatry, University of Wisconsin Medical School.
6. Reebye, P. N., Morison, S. J., Panikkar, H., Misri, S., & Grunau, R. E. (2002). Affect expression in prenatally psychotropic exposed and non-exposed mother-infant dyads. Infant Mental Health Journal (23), NO. 4, 403-416.

## **APPENDIX A**

### **ROLES AND RESPONSIBILITIES OF THE SERVICE PROVIDERS**

#### **I. COMMUNITY HEALTH NURSE**

The role of the Community Health Nurse is:

- to assess the health of mother and newborn
- to provide information about breastfeeding, baby's health and infant care as well as maternal health care.
- to give breastfeeding assistance and support as needed
- to assess woman's social support system and help her and her family identify needs as well as plan ahead. In the event of crisis, explore options for temporary resources in the home.
- to link women and families to individuals and agencies in the community who can help meet the family's needs.
- to coordinate services received by a woman.
- to assess home environment

Other services, which may be available through community services, include:

- Newborn Hotline
- Moms & Baby Drop Ins
- Breastfeeding support groups
- Prenatal Classes
- Prenatal Home Visits/Telephone contact
- Pregnancy Outreach Programs
- Postpartum Support Groups
- Home-making services (antepartum and postpartum)

The types of community health prenatal and postpartum services available to women with mental illness may vary considerably throughout the communities of British Columbia. Please check with your local Public Health office for more information.

#### **II. PHYSICIAN**

Physicians are often one of the first professionals to witness women experiencing the signs of mental illness in pregnancy and the postpartum period. They are in an optimum position to ask pertinent questions and when possible to utilize early identification tools. When unsure of community services available contact the community health nurse and the mental health manager for the region and request a list of community resources. With the woman's permission refer her to the appropriate community services. Encourage a dialogue between referring agencies to: share significant changes in the woman's mental status; extend criteria to include women in existing community services and when appropriate advocate for added services or health professionals in the community.

### **III. HOSPITAL/COMMUNITY SOCIAL WORKER**

Social workers can assist women in the perinatal period to examine their social networks and understand how members of these networks are part of their support system. Refer to Appendix D: Social Support Networking Guide for Women with a Mental Illness in the Perinatal Period for background information on assisting women to establish, ameliorate and/or strengthen their social support network.

- 1) Completes the Psychosocial Assessment of Women with a Mental Illness in the Perinatal Period Appendix C. The assessment explores the following areas:
  - Relationships and support, family functioning
  - Cultural and/or spiritual issue
  - Lifestyle
  - Mothering
  - Parenting needs
  - Housing
  - Finances
  - Transportation and
  - Legal issues
- 2) Map a woman's social supports within her network and identify if they are practical/emotional support and formal/ informal.
- 3) Counsel women regarding her strategies to increase a woman's support networking in the perinatal period, refer to Appendix D.
- 4) Discharge Planning
  - Makes recommendations regarding the woman's readiness for discharge.
  - Refers advocates and liaisons with a wide range of appropriate community agencies from community health nursing, reproductive mental health, social workers, mental health teams, multicultural groups / agencies, and community support programs as required.
  - May facilitate case management conference as appropriate with both community and hospital caregivers.
  - Ensures coordinated proactive post-discharge plan has been communicated to the mother and all caregivers prior to discharge.

### **IV. MIDWIFE**

Midwives are in a position to:

- educate women and their partners about mood disorders in the perinatal period
- utilize early identification tools
- monitor women with major and minor risk factors for developing symptoms
- observe women for early signs and symptoms
- refer women whom they have concerns to their physician

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- link women with community health nurse and appropriate community agencies for follow-up and support

### **V. COMMUNITY MENTAL HEALTH**

Community Mental Health Programs provide treatment, rehabilitation and specialized services to people with a serious mental illness and may provide any combination of the following services:

- psychiatric assessment and diagnosis
- medication and follow-up
- individual, group and family therapy
- Short-term treatment groups for a number of interrelated mental health issues such as personality disorders, survivors of abuse, and eating disorders among others
- Specialized services \* (e.g. Parent-Infant Program in Vancouver/Richmond area)
- Emergency services

\* The kind of specialized services available to women with mental illness during pregnancy and in the postpartum period may vary considerably throughout the communities of BC. Please check with your local Mental Health office for more information.

### **VI. MINISTRY FOR CHILDREN AND FAMILY DEVELOPMENT**

The role of MCFD in the discharge planning and community follow-up of women with mental illness in pregnancy and the postpartum period is to:

- Ensure that appropriate support services are available for the needs of mother and infant.\*
- Assess child protection issues
- Conduct an investigation if appropriate.
- Conduct a risk assessment in consultation with discharge planning team and/or any key service providers in the community who are involved in the care of the mother.
- Arranges alternative care/respice care if necessary

\* The supportive services available to mothers through MCFD will vary between communities. This may include homemaking, doula care, childcare subsidies, etc. Check with the Office near you.

**APPENDIX B  
DISCHARGE PLANNING GUIDE  
FOR WOMEN WITH A MENTAL ILLNESS AND  
THEIR NEWBORNS IN THE POSTPARTUM PERIOD**

1. Case conference for Discharge Plan complete: Date \_\_\_\_\_

2. Assigned case manager for:

Community Follow-up: Name: \_\_\_\_\_ #: \_\_\_\_\_

Psychiatric Follow-up: Name: \_\_\_\_\_ #: \_\_\_\_\_

\*Indicate if this is a G.P. Psychiatrist mental health worker

\*Indicate if a referral to Reproductive Mental Health has been made. Yes \_\_\_ No \_\_\_

3. Follow-up visits have been booked for:

a. Woman's psychiatric needs: Yes \_\_\_ No \_\_\_  
Physician name: \_\_\_\_\_ #: \_\_\_\_\_ 1<sup>st</sup> appt: \_\_\_\_\_

b. Woman's medical needs: Yes \_\_\_ No \_\_\_  
Physician name: \_\_\_\_\_ #: \_\_\_\_\_ 1<sup>st</sup> appt: \_\_\_\_\_

c. Infant's medical needs: Yes \_\_\_ No \_\_\_  
Physician name: \_\_\_\_\_ #: \_\_\_\_\_ 1<sup>st</sup> appt: \_\_\_\_\_

4. Have the woman's following needs been addressed?

- |   |         |        |         |
|---|---------|--------|---------|
| a. Received information about diagnosis                                     | Yes ___ | No ___ | N/A ___ |
| b. Concerns about medication  | Yes ___ | No ___ | N/A ___ |
| c. Has been observed feeding,   | Yes ___ | No ___ | N/A ___ |
| • Bathing the infant  | Yes ___ | No ___ | N/A ___ |
| • Changing the infant   | Yes ___ | No ___ | N/A ___ |
| d. Concerns about caring for their infant                                   | Yes ___ | No ___ | N/A ___ |
| e. Received information about community resources                           |         |        |         |
| • Pacific Postpartum Support Society Pamphlet                               | Yes ___ | No ___ | N/A ___ |
| • Mother and baby groups in their area                                      | Yes ___ | No ___ | N/A ___ |
| f. Received information about mental health teams                           | Yes ___ | No ___ | N/A ___ |
| g. Received information about Ministry for Children<br>& Family Development | Yes ___ | No ___ | N/A ___ |

5. Ministry for Children & Family Development Social worker's name and number, if appropriate: \_\_\_\_\_

6. Follow-up 6 week conference: Date: \_\_\_\_\_  
Place: \_\_\_\_\_

Case Manager: \_\_\_\_\_

Date: \_\_\_\_\_

*Copies to appropriate referring agencies: e.g.*

Community Liaison	MCFD Social Worker	Paediatrician
Family Physician	Hospital Social Worker	Mental Health Team
Midwives	Reproductive Mental Health	

**APPENDIX C  
PSYCHOSOCIAL ASSESSMENT OF WOMEN  
WITH A MENTAL ILLNESS IN THE PERINATAL PERIOD**

Under each of the following topic headings are things to consider and/or suggested questions to ask to effectively assess life areas of the woman.

**I. RELATIONSHIPS AND SUPPORTS**

- Does the woman have a partner? What is her relationship with this partner? Does she feel supported within this relationship? Specify, is marital counseling an alternative?
- Does the woman feel safe within this relationship?

**NOTE:** Up to 25% of the women seen at the Reproductive Mental Health Programs at the BC Women's Hospital are the victims of abuse during their childhood, adolescence, or during the perinatal period. Screening for abuse should be done with every woman. (Refer to Appendix A and to BCRCP Obstetric Guideline 13: Intimate Partner Violence during the Perinatal Period) [www.rcp.gov.bc.ca](http://www.rcp.gov.bc.ca)

- Does the woman perceive her family, extended family and in-laws as supportive? Specify; expand on frequency and quality of contact etc.
- Does the woman have any friends? Specify; work related, neighborhood, church etc. Does the woman perceive any of these friends as supportive?
- Would the woman like to be linked with:
  - Community Health Nursing
  - Pregnancy Outreach Programs
  - Building Blocks Programs
  - Mental Health Worker
  - Ministry of Children and Families e.g. child protection or support services
  - Alcohol and drug treatment programs or services
  - Psychotherapy counseling
  - Marital counseling
  - Postpartum Support Agencies- Pacific Post Partum Support Services

**II. CULTURAL AND/OR SPIRITUAL**

- Does the woman have any beliefs or practices (e.g. cultural affiliations or spiritual beliefs) about mental illness, pregnancy or birth that she would like taken into account during her assessment and treatment for mental illness during pregnancy and/or the postpartum period?
- If so, what are these beliefs and practices?
- How does she believe they will influence her pregnancy, delivery, hospital stay and care of the baby in the postpartum period?

### III. LIFESTYLE

Speaks to the balance in life and a woman's perceived contentedness with the balance she has achieved. Such as a woman's balance between:

- |   |    |  |
|---|----|--|
| • taking care of others<br>e.g. cooking, cleaning | vs | taking care of herself<br>e.g. taking a bath, listening to music                     |
| • nurturing her body<br>e.g. eating healthy foods | vs | nurturing her inner self<br>e.g. taking a walk, reading a book                       |
| • activities<br>e.g. doing errands                | vs | rest & relaxation<br>e.g. lying down and reading a book, watching a favorite TV show |

### IV. MOTHERING NEEDS

- A woman with mental illness can mother a child with support, treatment and community follow-up.
- Foster opportunities for interaction between the mother with mental illness and her child to promote maternal-infant-attachment.
- The woman will need assistance to deal with her feelings of guilt for the time lost interacting with her child while she was ill.
- A woman's child is her greatest incentive to recover from her mental illness.
- Practices that support the woman with mental illness interacting with her child will have the greatest success.

Some questions that should be addressed include:

- Does the woman have specific issues regarding mother/baby attachment?
- Has she had previous experiences with other pregnancies/children? If so, what are they?
- Has she experienced previous losses of children due to child protection issues, custody, or death? Does she have any residual fears from these losses?

### V. PARENTING NEEDS

- Close attention must be paid to the **mother-infant unit**. A woman who is cognitively and affectivity impaired cannot interact with her infant in the usual attentive way and may need significant help in this area. Her parenting capacity should be assessed. Counseling or therapy may be warranted to address attachment difficulties stemming from past trauma or unresolved childhood issues. The baby's development should also be monitored for signs of developmental deficits which have been noted in children whose mothers were depressed in the first year of life.

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Ask the woman if she has any concerns about her parenting. Some typical questions to ask are:

- How is she coping with caring for her infant (and other children) while she is recovering from (insert diagnosis)? If some difficulty is expressed, does she have a family or relative that could come and support you during this time? If not, what activities would she have someone help with if someone were available?
- Would she like the number to contact the Ministry for Children and Family Development? They do provide homemaker services in some of these circumstances.  
**Note:** Advise the woman that in *most* not all cases a protection file will have to be opened in order for the woman to access services. Service providers should be aware of the Ministry for Children and Family Development's policy in regard to accessing supportive services in their region.
- What kinds of things does she do to cope with your child when he/she has had a fussy day?
- When she has limited sleep how does she cope the next morning?
- Does she have anyone to share parenting ideas with? If so whom? Does she share similar values in parenting?
- Is she happy with her coping and parenting skills? If not, would she like to be linked with parenting services within your community?

### **VI. HOUSING**

- Is the woman satisfied with her housing arrangement?
- Is housing safe, affordable and adequate?
- Is temporary housing needed?

### **VII. FINANCES**

- Are the woman's finances adequate to meet her needs and the future needs of the child? E.g. Housing, clothing, food, crib and other necessities
- Does she qualify for Ministry supports? Has she applied for social assistance? Does she have support in this process?

### **VIII. TRANSPORTATION**

- Form of access to on-going transportation e.g. bus pass, access to a vehicle, etc.
- Transportation to psychiatric and medical appointments?

### **IX. LEGAL ISSUES**

- Does the woman have any legal concerns e.g. restraining orders, refugee issues, child protection issues, custody issues, immigration etc

**APPENDIX D**  
**SOCIAL SUPPORT NETWORKING FOR WOMEN**  
**WITH A MENTAL ILLNESS IN THE PERINATAL PERIOD**

Women in the perinatal period interact with different people throughout their day, e.g. their partners, family members, work acquaintances, old school friends, pregnant women and their partners at prenatal classes etc. These different people form her social network. Mitchell<sup>1</sup> defines *social network* as a specific set of linkages among a defined set of persons, with the characteristic of these linkages as a whole affecting the social behavior of the person involved.

Support networks appear in clusters, such as the *religious cluster* around church activities and groups, the *work cluster* around work associates; *school clusters* e.g. your older children's friends' parents in high school, your younger child's friend's parents in elementary school. These cluster form a '*social orbit*' around a woman.<sup>2</sup>

People with no mental illness have networks of about 40 people, while those with schizophrenia have 4-5 people- usually family.<sup>3</sup> The social networks of persons with severe mental illness are smaller in size and more tenuous.<sup>4,5,6</sup> Therefore over the course of an illness they are left with an even more restricted network which is not capable of providing the degree and type of support for maintenance in the community.<sup>4</sup>

**To map a woman's social network, refer to Table 1.** Not all members of a woman's social network will be supportive. Cobb<sup>7</sup> defines social support as information leading individuals to believe they are cared for and loved, esteemed and valued and belong to a network of communication and mutual obligation. According to Alloway and Bebbington<sup>8</sup> there are two types of social support. These supports include practical or instrumental (homemaking, baby-sitting) and emotional support (such as partners, mothers, girlfriends). These two types of supports can also be formal or informal in context,<sup>4</sup> such as formal practical support being a paid homemaker, and an informal practical support being a mother-in-law making meals and cleaning the house.

Availability of a confiding person acts, as a buffer against stress and a lack of support in the event of a life stressor could be detrimental to mental health.<sup>3</sup> There is a strong association between women's social supports and psychological symptoms.<sup>2</sup> Depressed women were found to have fewer support in the form of a confidant.<sup>2</sup> Depressed women also acted as confidants to fewer people.<sup>2</sup>

The chronically mentally ill women have fewer social networks, therefore fewer clusters and more formal social networks than women in the normal population.<sup>3</sup> Patients with more symptoms have fewer networks and are less likely to seek support in a crisis. This group may need particularly active monitoring and outreach. A social worker could focus on skills required to elicit social support. Women are more likely to receive support if they give support<sup>2</sup> which is also known as reciprocity. Therefore women may need help in learning how to give support to others.

Women who experience mental illness in the perinatal period perceive: minimal support from their partners,<sup>9</sup> fewer supports from the community, and isolation due to recent moves, immigration, or language barriers. Lack of social support is correlated with increased risk for postpartum depression,<sup>10</sup> increased demand for mental health services, more frequent relapse, and more negative influence on the parenting role and subsequent consequences on the child.<sup>11</sup> There is a relationship between a woman's social network, her mental health and her infant/child's behavior. Mothers who receive emotional support are less aggressive and rejecting of their children.<sup>12</sup> **Map a woman's social supports within her network and identify if they are practical/emotional support and formal/ informal refer to Table 1.**

Two other strategies suggested by Morin and Seidman<sup>13</sup> to increase a person's social network is increasing the flexibility of networks, and increasing the stable networks. A flexible network is one that shows acceptance and supports both when symptoms are experienced and when they are not.<sup>13</sup> This can be accomplished by increasing both network clusters and individual member, as well as increasing the multiplexity of relationships. A multiplex relationship is one in which a network member serves or fulfills more than one role or provides several types of exchanges.<sup>13</sup> The network must have the flexibility and the stability to remain the same, to retain the same membership over time, even if the person is temporarily removed because of hospitalization.<sup>13</sup> Some of the strategies to increase stability in the network are to generate connections between unconnected persons and to generate connections between clusters with similar functions.<sup>13</sup> Refer to Table 2 for practical strategies to increase a woman's social network in the perinatal period.

Intervention strategies to improve social networking, according to Biegel, Tracy, Song<sup>4</sup> can be implemented at the systems level, the community level, the client and family level and the case manager level. On the systems level, the barriers that prevent case managers from engaging in social network interventions need to be removed.<sup>4</sup> On the community level, case managers with the assistance of persons with community organization skills need to identify and engage individuals and organizations in community development.<sup>4</sup> *On the client and family level,* supportive services in the community need to be both present and accessible.<sup>4</sup> Finally, on the case manager level, case managers need to be educated on how to mobilize support systems for clients.<sup>4</sup>

**Table 1. Social Networks to Social Support Networks to Support Systems**

<b>Network Clusters</b>	<b>Supportive Members of Clusters</b>	<b>Support System</b>
<ul style="list-style-type: none"> <li>• Formal Clusters e.g. community health nurse, mental health worker, hospital social worker, community social worker, midwife, doula, psychiatrist, psychiatric nurse, psychologist, case manager if appropriate etc.</li> </ul>	<p>Identify which members of the different clusters the woman perceives as being supportive.</p> <ul style="list-style-type: none"> <li>• e.g. community health nurse who provides emotional support</li> </ul>	<p>System Level Case Manager</p>
<ul style="list-style-type: none"> <li>• Partner- common-law-husband</li> <li>• Family members-e.g. sister, mother, mother-in-law, brother, cousin, uncle or aunt etc.</li> </ul>	<ul style="list-style-type: none"> <li>• e.g. Common-law-partner is provides emotional and practical support</li> <li>• e.g. Sister lives 2 blocks away &amp; provides emotional and practical support e.g. homemaking and looking after the oldest child.</li> </ul>	<p>Client &amp; Family Level</p>
<ul style="list-style-type: none"> <li>• Work friends e.g. 5 work colleagues</li> <li>• High school friend e.g. 3 women that have kept in contact for 2 decades</li> <li>• Elementary school mothers where youngest child attend e.g. 4 friends trade childcare</li> <li>• Church friends e.g. the pastor and 2 women with children attending Sunday school</li> <li>• LaLeche League mothers e.g. 2 mothers that meet 1X per month for coffee</li> <li>• Support Group mothers e.g. 3 women who belonged to a depression group that talk on average several times a month</li> <li>• Prenatal class friends e.g. 2 women that have kept in touch for the last 5 years</li> </ul>	<ul style="list-style-type: none"> <li>• e.g. 4 mothers from her oldest child’s elementary school provide practical support, trading babysitting. One mother also provides emotional support.</li> <li>• e.g. a woman from the depression group calls her daily gives her emotional support</li> <li>• e.g. a woman from the prenatal class gives her emotional and practical support, they walk and talk 2 X/week with their infants</li> </ul>	<p>Community Level</p>

**Table 2. Strategies to Improve the Social Support Networks for Women with Mental Health Illness in the Perinatal Period**

<b>Strategies to Improve Women's Social Network</b>	<b>Activities</b>
1. Map women's social network clusters.	<ul style="list-style-type: none"> <li>• Identify all individuals and clusters in the woman's social network, refer to Table 1. For examples of some of the possible clusters.</li> </ul>
2. Identify which of the woman's social networks are supportive.	<ul style="list-style-type: none"> <li>• Identify which individuals in the women perceives are supportive from her social network clusters.</li> <li>• Those who provide emotional support, e.g. those people she would talk to and confide in.</li> <li>• Those who provide practical support, e.g. cooking, cleaning, childcare.</li> </ul>
3. Modify attitudes of network members to maximize their effect.	<ul style="list-style-type: none"> <li>• Educate network members about mental illness in the perinatal period E.g. meet with members; offer information night's etc.</li> </ul>
4. Increase social network size	<ul style="list-style-type: none"> <li>• Explore other possible network clusters with women e.g. religious clusters, recreational clusters- WMCA, social clusters-mom and tots groups, pregnancy outreach program, friendship center groups, special interest group clusters- prenatal class, La Leche League etc.</li> <li>• Provide the woman with information about the network cluster e.g. pamphlets etc.</li> <li>• Some women may be reluctant to contact the group unless they know someone who attends the group e.g. ask the woman if she would like to be contacted by another group member.</li> <li>• Increasing a woman's social network size increases the likelihood of some of these networks developing into social supportive relationships (Cresswell, Kuipers, Power, 1992).</li> </ul>
5. Increase the multiplexity of social network	<ul style="list-style-type: none"> <li>• Encourage and assist members to provide additional types of assistance e.g. mother to cook instead of care for the baby, friend to take the older child to the park instead of coming over for coffee with her 2 year old, a work friend to order a pizza instead of calling for 1 hour in the evening when you are trying to settle your oldest child.</li> </ul>
6. Encourage the woman to generate spans	<ul style="list-style-type: none"> <li>• Between clusters with similar functions</li> <li>• Between clusters in conflict</li> </ul>
7. Encourage the woman to generate spans	<ul style="list-style-type: none"> <li>• Between clusters with similar functions</li> <li>• Between clusters in conflict</li> </ul>

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## **APPENDIX E COMMUNITY RESOURCES**

In this appendix several possible community resources are defined. Understandably community resources will vary from community to community. It may be beneficial to list the names and phone numbers of resources available in your own community for reference purposes.

### **British Columbia Reproductive Care Program (BCRCP)**

F5 – 4500 Oak Street  
Vancouver, BC V6H 3N1

Tel: (604) 875-3737

Website: <http://www.rcp.gov.bc.ca>

### **Aboriginal Organizations and Services in British Columbia**

The Ministry of Aboriginal Affairs published a document entitled, “A Guide to Aboriginal Organizations and Services in British Columbia” in 1999. It can be accessed through their website at [www.gov.bc.ca](http://www.gov.bc.ca) (under Reports & Publications)

This guide provides information about First Nations Bands, tribal councils/affiliations and treaty offices and services such as communications, education, employment, Friendship Centres, Health and family services, housing, treatment centres and women’s organizations. Refer to this guide for information about aboriginal services relating to perinatal women in your community.

### **Affiliation of Multicultural Societies & Service Agencies of BC (AMSSA)**

AMSSA provides leadership in advocacy and education in British Columbia for anti-racism, human rights, and social justice. AMSSA supports its members in serving immigrants, refugees and culturally diverse communities. You can access a list of AMSSA agencies in BC via their membership directory on their web site [www.amssa.org](http://www.amssa.org) or e-mail: [amssa@amssa.org](mailto:amssa@amssa.org)

### **Aurora Center (BC Women’s Health Program)**

Aurora Center is provincial program that provides residential and day treatment for women with addictions problems. They also provide parenting groups for their clients and wellness groups for children whose parents are using or in recovery. A consultant also acts as a provincial resource for alcohol and drug programs in the province. For more information you can contact them at Tel: (604) 875-2032.

### **BC Housing**

A provincial agency responsible for the management of public housing and the development and administration of housing for people with low incomes, including families, and people with mental or physical disabilities. For Vancouver and Lower Mainland program and information line call 1-800-257-7756 or 604-433-2218.

### **Crisis Pregnancy Centers**

The Centers provide options counseling for women with unplanned or problem pregnancies and/or their partners. Crisis Pregnancy Centers are non-profit community agencies, which are available in many cities throughout BC. All services are free and confidential.

### **Crisis Intervention and Suicide Prevention Center for Greater Vancouver**

The Vancouver Crisis Center provides 24- hour telephone crisis counseling by trained volunteers. Crisis intervention services are also available to the hearing and speech impaired through a TTY machine. For more information on the Vancouver Crisis services you can e-mail [info@crisiscentre.bc.ca](mailto:info@crisiscentre.bc.ca) or contact their website: [www.crisiscentre.bc.ca](http://www.crisiscentre.bc.ca) Access your local hospital or community directory for a crisis line in your community.

### **Domestic Violence Helpline**

Abused persons who come to the Vancouver General Hospital emergency department for treatment are identified, assessed, cared for, referred and followed up by a multidisciplinary staff. The program also has a strong outreach education component. For more information you can contact them at Tel: (604) 875-4924.

### **Doula Services Association (BC)**

Not-for-profit provincial organization which provide a network of doulas available throughout BC. A doula is a woman experienced in childbirth who helps other women. A doula provides continuous care from the prenatal through to the postpartum period. Her role is to provide emotional support and information. All doulas in the Association are trained and follow the Doulas of North America Standards of Practice and code of ethics. There are fees involved. Call the Doula Association for a list of doulas in your area or check their website at <http://doula.com/bcdoulas> or call their information line at (604) 515-5588.

\* The Ministry of Children and Family Development can fund Doula services under certain criteria. Possible qualifying criteria are: child protection, social isolation, lack of emotional support, limited parenting skills, health issues and/or concerns for the care of older children. Check with the MCFD office near you.

### **Drug and Alcohol Meeting Support for Women (DAMS)**

DAMS provides 1 to 1 and group support, advocacy, referrals, outreach and life skills workshops for women around harm reduction related to alcohol and drug use. This program focuses on prevention rather than a crisis intervention. For more information you can contact them at Tel: (604) 687-5454.

### **Eating Disorders Program**

Provincial program for adults with anorexia nervosa, bulimia nervosa, and related eating disorders. Service includes multidisciplinary assessment, psychosocial evaluation and a variety of treatments. Provides education for parents/families in collaboration with the Greater Vancouver Mental Health Services Tel. (604) 806-8347. Contact their web site at [www.eatingdisorders-sph.org](http://www.eatingdisorders-sph.org)

### **Eating Disorders Resources Centre of BC**

A nonprofit information, referral and educational service that works to address the problems of people with eating disorders and their families, friends, and concerned health professionals. Has a resource library and a toll free number 1- 800- 665-1822 and a web site [www.anorexianervosa.org](http://www.anorexianervosa.org)

### **Health Connections- You and Your Baby**

This Family Services of Greater Vancouver Program assists pregnant women to work through trauma-related issues that can interfere with their ability to parent their children. For more information you can contact them at Tel: (604) 874-2938.

### **Infant Development Program**

The Infant Development Program is a home-based program designed to assist families to encourage their child's development. The program serves families of children between the age of birth and three years who have a developmental delay, a suspected delay or a diagnosed disability.

There are more than forty such programs throughout British Columbia. They are funded by the Ministry of Social Services. All services are provided free of charge. Families can self-refer. Check with your community for an Infant Development Program near you. Two examples of such programs in Vancouver are:

1. The Alan Cashmore Centre Tel: (604)-454-1676 Fax: (604)-454-0959  
The centre offers treatment services to families with children age's birth to six years, who have significant emotional and behavioural problems. Some of the programs offered are:
  - the Parent-Infant Project; infants from birth to 2 ½ years
  - the Outpatient Program; children from 2 ½ to 5 years
  - the Day Program; children from 2 ½ to 6 years
2. The Parent-Infant Program utilizes as therapeutic intervention, which focuses on relationship issues.

### **NeighbourLink**

NeighbourLink is a local extension of World Vision Canada, a network of churches, and those links volunteers to people in need in their own community. These volunteers can provide a number of services free of charge such as cooking, cleaning, child care, home visiting, etc. NeighborLink services are presently available in a number of communities throughout BC.

For a complete listing of Neighbourlink services or to see if there is one available in your area, check the World Vision Canada website under Neighbourlink Network listings at [www.worldvision.ca](http://www.worldvision.ca)

## **Mental Health Associations**

### **Canadian Mental Health Association (CMHA)**

A nation-wide organization with branches throughout BC which works to promote mental health. They provide various community based education programs for people with mental illness:

- public education initiatives to reduce the stigma attached to having a mental illness
- resource libraries with information about mental illness
- provides information and referrals
- some branches provide:
  - support groups and educational programs others link to existing community services
  - community recreational activities for persons with a mental illness
  - Supported or Transitional Employment Services
  - Consumer Development Programs

For more information about local branches and the services they offer e-mail:

[cmhanat@interlog.com](mailto:cmhanat@interlog.com) or website: [www.cmha.ca](http://www.cmha.ca) or [www.cmha-bc.org](http://www.cmha-bc.org) or contact the BC branch at Tel: 1 800- 555-8222 Fax: (604)-688-3236.

### **Schizophrenia Association of BC**

Offers support, public awareness education, information and advocacy for people with schizophrenia and their family and friends. Holds regular meetings. Over 30 branches throughout BC. Contact their web site at [www.bcsc.org](http://www.bcsc.org)

### **Schizophrenia Society of Canada**

The national schizophrenia association which can be accessed through their web site at [www.schizophrenia.ca](http://www.schizophrenia.ca)

### **Mental Patients Association**

Offers a wide range of support services to adult ex-psychiatric patients, including a community resource center, activity program, research, financial and legal advocacy services. Contact through e-mail at [vanmpa@direct.ca](mailto:vanmpa@direct.ca)

### **Kidder Place (Vancouver)**

A safe, subsidized, supported housing option for mentally ill mothers and their children. An apartment building for single mentally ill mothers who are either pregnant or have a child under two years of age. Visit Mental Patient's Association's web site @ [www.vmpa.org](http://www.vmpa.org). Check with your local housing authority for housing options available in your area.

### **Midwives Association of BC (MABC)**

A midwife is a trained professional who provides comprehensive care and support during pregnancy, labour, and birth and up to six weeks postpartum to healthy women and their newborns. Midwifery is fully funded by the BC Ministry of Health. Midwives are registered with the College of Midwives of BC. The College of Midwives of B.C. is the regulatory body for the

profession of midwifery in the province of B.C. The College provides a list of registered midwives. Contact their web site at [mabc@telus.net](mailto:mabc@telus.net)

### **Mood Disorders Association of BC**

Offers support groups to those with bipolar and unipolar mood disorders and their families and friends. Access their web site @ [www.mdabc.ca](http://www.mdabc.ca)

### **Pacific Post Partum Support Society**

The Pacific Post Partum Support Society (P.P.P.S.S.) provides a support program for women experiencing postpartum depression. They offer a telephone help-line, volunteer telephone support, facilitator-led support groups, partners' information sessions, and literature for individuals and professionals at no cost. The Society also provide Community Training's on postpartum depression and group facilitation skills.

The Society publishes a book entitled " Postpartum Depression and Anxiety: A Self-Help Guide for Mothers". This guide is useful for mothers, families and anyone who is involved in caring for a woman experiencing postpartum depression. It is available through the Society at a reasonable cost. The telephone help-line can be accessed by anyone needing information, support or referrals, or wanting to order books or information packages. The P.P.P.S.S. also have the following resources: their pamphlet in English, Punjabi and soon to be published Cantonese; facilitators manuals on conducting postpartum support groups and soon to be published Telephone Support Manual (fall of 2002). Call 604-255-7999 or Fax 604-255-7588, Website: [www.postpartum.org](http://www.postpartum.org) note that long-distance charges have to be assumed by callers.

### **Postpartum Depression Support Programs**

There are a number of postpartum depression support programs modeled after the Pacific Post Partum Support Society program which are available in various communities throughout BC. Some of these programs offer support groups while others provide telephone support. For a list of current postpartum depression support programs in BC, or check out their website at [www.postpartum.org](http://www.postpartum.org)

### **Pregnancy Outreach Programs**

May also be found in the Red Book under

- Options: Services to Community Society ( under women services)
- Community Action Programs for Children
- Canadian Prenatal Nutrition Program.

These programs provide services such as assessment, individual health counseling, and referral. Peer support, nutritional education and food supplements for high-risk pregnant women. Contact you regional health center for the pregnancy outreach programs in your area.

### **Reproductive Mental Health, BC Women's Health Centre and St. Paul's Hospital**

The Reproductive Mental Health Program serves women with psychiatric disorders specifically related to their reproductive cycle, such as psychiatric difficulties in pregnancy, postpartum depression and anxiety, premenstrual syndrome, infertility and pregnancy loss. The Program consists of psychiatrists, nurse clinicians, a dietitian and psychologists.

The Program provides:

- One-to-one consultations with a psychiatrist, nurse clinician, or psychologists
- Psychotherapy groups for women with serious postpartum depression
- Family therapy
- Hospital visits
- Referral and consultations with other professionals.

A doctor's referral is required for a woman to access the service. Call the receptionist at 604-875-2025 for a faxed copy of the referral form.

In January of 1999 the Reproductive Mental Health hired an outreach program coordinator to improve the capacity of regions across BC to respond to issues related to reproductive mental health. If your community needs education or resource building contact the outreach coordinator at (604) 875-2424 local 6469.

### **Sexual Assault Program (BC Women's Health Program)**

The Sexual Assault Service (SAS) works in partnership with Vancouver General Hospital to provide sensitive and comprehensive emergency medical care to sexual assault survivors. Care is provided on a 24-hour on-call basis by specially trained female physicians, nurses and nurse examiners. SAS also has a mandate to work with communities around the province to support the development of sustainable hospital-based care for sexual assault survivors. For more information call Tel: (604) 875-2881.

### **Sheway Project**

Offers practical support, prenatal care and counseling for high-risk pregnant women who live or access the Downtown Vancouver eastside area. Issues covered include prenatal health, nutrition, alcohol, and drug dependencies, women's health, parent support and infant development. A multi-agency project funded and directed by the Ministry of Health for Children and Families, YWCA of Vancouver, Vancouver Native Health Society and the Vancouver/Richmond Health Boards Tel (604) 658-1200.

### **Transition Housing**

Emergency accommodation for physically, emotionally or sexually battered women and their children. Offers temporary accommodation, support, and counseling. Advocacy, information and referrals to community resources. Access your region for the names of the transition houses in your area.

### **University Psychology Department Counseling**

Counseling services are often available through University Psychology Departments. Psychology students provide counseling to clients and families. There is usually a fee attached to this service. For example the Simon Fraser University Clinical Psychology Clinic has a fee payment that is based on a sliding scale (tel: 1-604-291-4720). If you have a university campus in your community inquire as to the counseling services they may provide.

**Vancouver Richmond Health Board**

Helping Overcome Early Psychosis website a resource for Psychosis, Schizophrenia, mood disorders and Mental Health at [www.hope.vancouver.bc.ca](http://www.hope.vancouver.bc.ca)

**Resources Specific to Your Community**

**Name**

**Phone**

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