# Best Practice Guidelines for the Treatment of Major Depression in the Perinatal Period

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# Learning Objectives:

- Introduction to B.C.'s Best Practice Guidelines for Mental Health Disorders in the Perinatal Period
- To become familiar with recommendations specific to Major Depressive Disorder in the Perinatal period
- Medication Tables and the Importance of Informed Consent

# Partners:

- **B.C. Reproductive Mental Health Program**
- **Perinatal Services B.C.**

  (Both are agencies of the Provincial Health Services Authority in BC)

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# Background:

- Time for Update - Last Best Practice Guidelines written in 2003
- Ongoing requests from health care providers and women for information about safety of psychotropic medications in pregnancy and breastfeeding
- Ongoing requests from health care providers and women for advice about different treatment options to address mental health disorders in pregnancy and postpartum.

# Disorders Reviewed in the Guideline:

- Major Depressive Disorder
- Anxiety Disorders
- Bipolar Disorder
- Psychotic Disorders, including Schizophrenia and Postpartum Psychosis

- Special Section on Suicide and Infanticide

# What's New in "Mental Health Disorders in the Perinatal Period (2013)"

- More information about the clinical presentations of all the disorders
- Each Disorder has a **Key Points and Recommendations Section**
- More detail about Non- Pharmacological treatment options.
- More medications covered in the Medication Tables, and more information addressing common concerns about exposure of the fetus/infant to medications
- Suggested Questions to ask when there are concerns about suicide risk or infanticide risk and **Developing a Safety Plan**.
- More in-depth discussion about Screening

# Prevalence of Major Depressive Disorder in the Perinatal Period

Major Depressive Disorder (MDD)

- Estimates suggest that between 5% - 16% of women will experience MDD at some point during their pregnancy.
- Estimates suggest that between 4.2% - 9.6% will experience a major depressive disorder between birth and 3 months postpartum
- Estimates vary between 9.3% and 31% for the first year postpartum.
- **No evidence that there is a difference in prevalence between perinatal women and women of childbearing age.**

# PND or MDD in the Perinatal Period

- The DSM-V criteria for diagnosis of “depression with peripartum onset” indicates that the onset of the depressive episode must occur during pregnancy or within four weeks after childbirth

- Clinical experience in BC has shown that symptoms can appear anytime up to one year postpartum.

# PND or MDD in the Perinatal Period

The **DSM-V criteria for a Major Depressive Disorder** include:

At least one of the following must be present for at least a 2-week time period:

- Depressed mood or Anhedonia (loss of interest or pleasure).

At least five or more of the following must be present over the same 2-week time period:

- Feeling sad most of the time, nearly every day.
- Decrease in pleasure or interest in all, or almost all, daily activities, nearly every day.
- Changes in appetite (with marked weight gain or loss).
- Sleep disturbance (insomnia, hypersomnia), nearly every day.
- Psychomotor retardation or agitation nearly every day (observable by others).
- Lack of energy or fatigue nearly every day.
- Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
- Difficulty concentrating, or making decisions, nearly every day.
- Frequently occurring thoughts of death, suicide or suicidal plan.
- Symptoms must cause significant impairment or distress in social, occupational or other important daily living functions.

# Risk Factors :

**Major Risk Factors:**

- **Personal history of depression.** This is the strongest risk factor for depression during pregnancy and a strong predictor of postpartum depression.
- Up to 50% of women who have a history of depression before conception and during pregnancy will experience depression during the postpartum period.
- **History of postpartum depression with a previous pregnancy**. More than 40% of women who experience postpartum depression will experience a recurrent episode after a subsequent pregnancy.
- **Family history of depression.** Up to 50% of women experiencing postpartum depression have a family history of psychiatric illness.

# Risk Factors:

Contributing risk factors include:

- Excessive anxiety during pregnancy or postpartum
- Poor social support – social isolation, recent move, poverty, cultural or language issues.
- Poor partner relationship/conflict.
- Recent adverse life events (e.g., loss of close relative or friend).
- Life/financial stress.
- Domestic violence.
- Unintended pregnancy/ambivalence towards pregnancy.
- Infants with health problems or perceived difficult temperaments.
- Chronic/acute maternal health problems.

# Impact of Untreated mental health disorders in the Perinatal Period

## ***Potential impacts on women:***

- Negative attitude toward motherhood & themselves as mothers.
- See their baby's behaviour as "difficult".
- May not recognize their baby's cues & respond appropriately, with potential of negative consequences to baby's development.
- May breastfeed for shorter period of time.
- May use alcohol, cigarettes or other substances.
- Increased risk of future episodes of depression and other mental health issues.
- Risk of suicide (rare but does occur, especially in cases of untreated postpartum psychosis).

# Impact of Untreated mental health disorders in the Perinatal Period

## ***Potential impacts on babies:***

- Behaviour disturbances:
  - Quicker to cry & cry louder & longer.
  - Spend less time in the ‘quiet & alert’ state when they learn the most about their environment.
- Development delays:
  - May walk & talk later than others.
- Social issues:
  - May have more difficulty establishing secure relationships.
  - May be socially withdrawn.
- Risk of infanticide (rare but does occur, especially in cases of untreated postpartum psychosis).

# Impact of Untreated mental health disorders in the Perinatal Period

## ***Potential impacts on partners/families:***

- Relationship disruption (increased risk of separation/divorce).
- Partners may also be depressed and may need treatment.
- A meta-analysis of depression rates in men in the perinatal period reported:

  Depression rates of about 10% (studies ranged from 1.2% - 25.5%).

  Rates were highest in the 3 – 6 month postpartum period.
- A moderate positive correlation between paternal and maternal depression.
- Partner depression in the perinatal period has been shown to have many of the same negative impacts on relationships, family and the baby as maternal depression.

# Screening for Perinatal Depression Using the Edinburgh Postnatal Depression Scale (EPDS)

Perinatal Services BC
An agency of the Provincial Health Services Authority

**Edinburgh Perinatal/Postnatal Depression Scale (EPDS)**

For use between **28–32 weeks** in **all** pregnancies and **6–8 weeks** postpartum

Name: _____ Date: _____ Gestation in Weeks: _____

As you are having a baby, we would like to know how you are feeling. Please mark "X" in the box next to the answer which comes closest to how you have felt in the **past 7 days**–not just how you feel today.

***In the past 7 days:***

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

Total Score ☐

*Talk about your answers to the above questions with your health care provider.*

*Translations for care-provider use available on PSBC website: perinatalservicesbc.ca.*

# Screening for Perinatal Depression Using the EPDS:

- Assuming care pathways are established, **screen all women for perinatal depression.**
- Screen using the Edinburgh Postnatal Depression Scale or EPDS at least once during pregnancy and once in the postpartum period. Suggested timeframes for administering the EPDS are: **28 to 32 weeks gestation** (although the tool is valid anytime during pregnancy), **6 to 16 weeks postpartum** and anytime concerns are identified.

**EPDS Scores: Interpretation and Actions:**

**Score Less than 8:**

- Depression not likely
- Continue support

**Score 9 – 11:**

- Depression possible
- Support, re-screen in 2-4 weeks. Consider referral to primary care provider (PCP)

**Score 12 – 13:**

- Fairly high possibility of depression
- Monitor, support and offer education. Refer to PCP.

# Screening for Perinatal Depression Using the EPDS:

**EPDS Score 14 and higher (positive screen)**

- Probable depression
- Diagnostic assessment and treatment by PCP and/or specialist.

**Positive score (1, 2 or 3) on question 10**

- (suicidality risk)
- Immediate discussion required.

Refer to PCP +/- mental health specialist or emergency resource for further assessment and intervention as appropriate. Urgency of referral will depend on several factors including: whether the suicidal ideation is accompanied by a plan, whether there has been a history of suicide attempts, whether symptoms of a psychotic disorder are present and/or there is concern about harm to the baby.

# Screening for Perinatal Depression: Controversial!!

- On May 13, 2013, The Canadian Task Force on Preventive Health Care recommended NOT ROUTINELY SCREENING for Depression, even in the perinatal period:

  "Due to a lack of high quality evidence on the benefits and harms of screening, the new guideline recommends not routinely screening adults who show no apparent symptoms of depression."

- A Forum has been called for Jan 17th, 2014 to address the issue of universal screening for depression in pregnancy and postpartum

# Recommendations for all mental health disorders in the perinatal period:

**Encourage women with a history or family history of a mental health disorder to plan their pregnancy**, ideally timed when their mood (and physical condition) is as stable as possible.

- For women with a chronic mental health disorder:
  - Work with the woman and other healthcare providers pre- and during pregnancy to develop **an individualized treatment plan** which optimizes the woman's mental health during the perinatal period.
  - Consider referring the woman to a psychiatrist pre- or during pregnancy to assist with treatment planning and ongoing monitoring of the woman's mental health status during the perinatal period.
  - If a woman decides to stop taking her medications prior to or upon discovery of her pregnancy without consulting a healthcare professional, pay particular attention to her mental status throughout the pregnancy and especially in the postpartum period (high risk of relapse).

# Treatment of Mental Health Disorders in the Perinatal Period:

**Mild to Moderate Symptoms:**

- Psychoeducation
- Self-Care: The NEST-S Program

  Mind- Body Modalities e.g. Meditation, Mindfulness
- Psychotherapies
  - Cognitive Behavioural Therapy (CBT) or MCBT
  - Interpersonal therapy (IPT)
  - Psychodynamic therapy (PDT)
  - Group Therapy (therapist and/or peer led)
  - Parent-Infant psychotherapy
  - Couples and Family therapy
- Bright Light Therapy

# NESTS Program:

Each letter in **NEST-S** stands for one area of **self-care**:

- **N**utrition: Eating nutritious foods throughout the day.
- **E**xercise: Getting regular exercise. There is considerable research on the benefits of exercise for improving depression.[77]
- **S**leep & rest: Sleep is very important for both physical and mental health. Getting enough in the perinatal period can be challenging.
- **T**ime for self: Taking self-time is an area that new mothers often neglect. This is a particular concern in women who are depressed and/or experiencing other mental health disorders.
- **S**upport: Social support plays an important role in helping new mothers adjust to the life changes that go along with being a mother. Healthy relationships are a protective factor against depression and other mental health disorders and are an important factor in recovery.

# Recommendations for all Mental Health Disorders in the Perinatal Period:

- **For women with moderate to severe symptoms requiring psychotropic medications in the perinatal period:**
  - Support **informed decision-making** by **discussing the risks and benefits** of the medications with the woman as well as the risks of not treating her symptoms. Involve the woman's partner and other family members whenever possible and where appropriate.
  - **Risks of Medication exposure in pregnancy may include:**

    Spontaneous Abortion/ obstetrical complications
    Major Congenital Malformation
    Neonatal Adaptation Syndrome
    Persistent Pulmonary Hypertension of the Newborn
    Possible longterm developmental Effects

  - **Risks of Not Treating her Symptoms may include:**

    increased risk of obstetrical complications
    self-medication or substance use
    compromised mother/infant interactions
    cognitive, emotional and behavioural impairments in the developing child
    maternal suicide and infanticide.

# Recommendations for all Mental Health Disorders in the Perinatal Period:

- **Where possible, encourage breastfeeding** (psychotropic medications are not usually a contraindication to breastfeeding):
  - **Maximize the breastfeeding support** provided to women to increase the probability of success (e.g., refer to a lactation consultant and/or public health nurse).
  - In situations where exclusive breastfeeding is not possible (e.g., medical reasons for the mother/baby or there are challenges with breastfeeding, including significant psychological stress for the mother), **support infant feeding options that promote optimal nutrition for the baby and consider the health and wellbeing of the mother**. This may include use of the mother's own expressed breast milk, pasteurized donor milk and supplementation with formula and/or formula feeding.
  - Encourage women wanting to breastfeed but whose babies are premature or have significant health problems to discuss their psychotropic medications with their baby's pediatrician.

# Recommendations for all Mental Health Disorders in the Perinatal Period:

- **For women requiring psychotropic medications in the perinatal period:**
  - Use the minimum number of psychotropic medications at the lowest effective dose.
  - When breastfeeding whilst taking psychotropic medications, monitor the baby for any adverse effects.

- Encourage women with severe mental health disorders that require multiple psychotropic medications to deliver in a hospital (versus a home birth). This will facilitate closer monitoring of the mother and baby.

# Recommendations for all Mental Health Disorders in the Perinatal Period:

- Educate partners and family members about recognizing the symptoms of mental health disorders and ways to support women during pregnancy and after the birth.

- Support should include ways to maximize the woman's opportunity for adequate sleep.

# Recommendations Specific to Perinatal Depression:

For Women with mild to moderate MDD who have been clinically stable for 4-6 Months and Risk of Relapse is Low:

- Focus on Psychoeducation, Self-Care and/or Psychotherapies
- If taking a medication, consider gradually discontinuing the medication prior to pregnancy.
- If evidence of postpartum relapse, consider recommencing an SSRI medication, if non-pharmacological treatments are not fully effective in treating the women's symptoms.

# Recommendations Specific to Perinatal Depression:

For Patients with Moderate to Severe MDD who are symptomatic or Risk of Relapse is High:

- Medications are frequently requiresd, in addition to Psychoeducation, Self-Care and/or Psychotherapy
- If taking an antidepressant, continue with the current medication, if effective.
- If not taking an antidepressant and one is required during pregnancy, consider an SSRI (1st option) or SNRI (2nd. Option). If possible, avoid paroxetine
- At birth, maintain therapeutic dose of antidepressant to reduce the risk of postpartum relapse.
- Dose adjustments may be necessary postpartum. Treat for 6-12 months .

# Appendix 5: Psychotropic Medications Used in the Perinatal Period
# SSRIs: Citalopram

| Drug Class | Dosage Range | FDA Pregnancy Risk Category ♦ | Fetal Risks | Hale Lactation Risk Category Δ | Breastfeeding |
|---|---|---|---|---|---|
| ***Antidepressants*** | | | | | |
| SSRIs | | | | | |
| Citalopram (Celexa®) | 10 - 40 mg per day.[276] | C[277] | SSRIs in general: Small increased risk of SAB (OR 1.8)[278], prematurity (aOR 1.4)[279] and LBW (aOR 1.2)[278-280] For SSRIs the risk of teratogenicity is not large, with an expectation that most exposed infants would be born without a MCM.[278,280,281] SSRIs have been associated with a very slight risk of cardiac defects.[279,280-282] For citalopram: possible small increase in the risk of septal heart defects (incidence 1.1%, expected 0.5%, also reported for other SSRIs).[278,279,284,282-287] NAS has been reported in up to 30% of infants.[280,287,288-307] Small risk of PPHN for all SSRIs (incidence 0.3%; expected 0.1 - 0.2%), approximately double the background risk.[308] | L2 | M:P ratio up to 3. Infant serum levels up to 17% of maternal levels. Sedation reported.[305,309-314] Monitor baby. |

# Appendix 6: Suggested Actions/Monitoring for Women on Psychotropic Medications in the Perinatal Period

| Psychotropic Medication | Pregnancy | At Birth | Breastfeeding |
|---|---|---|---|
| **Antidepressants** | | | |
| SSRIs (except Paroxetine)<br><br>SNRIs | Folic acid (0.4-1.0 mg daily).<br><br>Detailed ultrasound 18-20 weeks. | Monitor for Neonatal Adaptation Syndrome (NAS). Take baby's vital signs post-delivery q4 hr x 24 hr. If possible, measure $O_2$ sat using pulse oximeter 1 hr post-delivery & q4 hr with vital signs x 24 hrs. If $O_2$ sat low, consult with pediatrician (to rule out rare congenital heart defects or PPHN). | Considered safe; however:<br>• Monitor baby for adverse effects (e.g., sedation, poor feeding & irritability).<br>• If concerns, check baby's serum drug level (if possible). |

# Suicide

Pregnancy-related maternal mortality is rare.

However, of the causes, **suicide is the most common cause of death during pregnancy and in the first postpartum year**. BC data from 2001 to 2010 presented to the Maternal Mortality Review Committee of Perinatal Service BC (unpublished, 2013) showed that of women in the perinatal period, there were:

- 10 documented suicides (3 during pregnancy and 7 during the first year postpartum).
- 3 accidental poisonings "suggestive" of suicide.
- 1 "traumatic" death.
- 3 deaths involving trauma and/or drugs where suicide could not be ruled out.

- In BC in 2008, the estimated pregnancy-related mortality rate was 7.6 per 100,000 births (BC Maternity Mortality Review Committee, 2008; www.perinatalservicesbc.ca). If suicides and deaths suspicious for suicide were to be included, this rate could increase to as high as 11.6 per 100,000.

# Suicide and Infanticide:

- Suicide is four times more likely to occur in the nine months after childbirth than during pregnancy.
- Psychiatric illness leading to suicide was a significant factor in at least 28% of maternal deaths in the United Kingdom.
- Women who have had a postpartum psychiatric admission have a 70 times greater risk of suicide in their first postpartum year.
- Violent suicides appear more common in childbearing women who commit suicide than in the population generally.

- It is important that women who are depressed and have suicidal thoughts in the perinatal period be assessed for suicide risk and, if present, appropriate actions taken.

# Appendix 3: Perinatal Suicide Risk Questions

Begin the discussion with: "Sometimes when women are depressed, they have thoughts about harming themselves". Then proceed to the following questions:

1. **Have you had any thoughts of harming yourself?**

   If yes:

   - Can you describe your thoughts of harming yourself?
   - How frequent and persistent are these thoughts?
   - Do you have a definite plan to harm yourself?
   - Do you have a definite plan to end your life?
   - Do you have the means to carry out your plan?
   - How close have you come to acting on this plan?
   - What stopped you from acting on this plan?

   If no:

   - Do you ever wish that you were dead?
   - Do you ever wish that you could escape or disappear or not wake up in the morning?

2. **Have you attempted to harm yourself in the past?**

   If yes:

   - Can you tell me about it?
   - Did you want to die at that time?
   - Were you drinking alcohol or using drugs at that time?
   - Were you admitted to hospital?
   - How did you feel after the attempt?

3. **Is there a family history of suicide?**

   If yes:

   - Can you tell me about it?

If you are concerned that the patient is a suicide risk, develop a safety plan and refer immediately for psychiatric care (see section 7.0 for a discussion of suicide and infanticide).

# Suicide and Infanticide:

***Concern about harm to the baby***

- The baby's safety is paramount. Ask who will be responsible for the care of the baby or supervision of the mother's care of the baby and, if appropriate, make contact with the partner or other family member(s).
- A Social Worker at the Ministry of Child and Family Development should also be contacted (phone: 310-1234, no area code required) for their assessment of the suitability of alternative carers or supervisors and the home circumstances. Good communication between all agencies is vital to the safety of the baby as well as the mother.

***Developing a safety plan***

- A healthcare provider should develop a safety plan in collaboration with the woman and a responsible family member or friend.
- A safety plan is a prioritized list of coping strategies and sources of support that women can use when they experience suicidal thoughts.

# General Responses to Identified Suicide Risk

Table 12: General Responses to Identified Suicide Risk

| Ask<br>• Suicidal thoughts • Plan • Lethality • Means<br>Consider risk to the infant at all times | | |
|---|---|---|
| ↓ | ↓ | ↓ |
| Suicidal ideation or thoughts only, without a plan | Suicidal ideation with a plan or history of suicide attempt, without immediate intent | Suicidal ideation with an imminent plan |
| ↓ | ↓ | ↓ |
| Low Risk | Medium Risk | High Risk |
| • Refer to primary care provider (PCP) as soon as possible for further assessment &/or mental health referral | • Contact PCP to discuss need for urgent mental health assessment | • Refer immediately to local Emergency Room |
| • Provide information about crisis/urgent telephone lines e.g., 1 800-SUICIDE (1-800-784- 2433) | • Provide information about crisis/urgent telephone lines | • If family unable to take woman to ER, call 911 (or other immediate response such as 'car 87' in Vancouver) |
| • Develop a Safety Plan with the woman (see section on Developing a Safety Plan) | • Develop a Safety Plan with the woman (see section on Developing a Safety Plan) | |

# Components of a Safety Plan

Table 13: Components of a Safety Plan

**Safety Plan:**

1. Warning signs of the risk of imminent suicide (e.g., feeling trapped, worthless, hopeless, talking about death, writing a will, hoarding medications).
2. Coping strategies that decrease the woman's level of risk (activities that calm or comfort the woman such as deep breathing, meditation, taking a bath, a walk, etc).
3. People within the woman's network who can assist in times of need (friends/family).
4. Health professionals, agencies and crisis lines that can be contacted for help.

*Safety plans need to be frequently revisited and modified as needed.*

Table 14: Sample Safety Plan

**Example of a safety plan:**

Mary told her public health nurse that she was having thoughts that *'she would be better off dead'*. She had no definite plan and no immediate intention to end her life. Through discussion and identifying the issues for her, the public health nurse helped Mary to draw up her safety plan.

**Mary's Safety Plan**

1. Warning signs to look out for: *Hoarding my antidepressants. Feeling like a failure.*
2. Coping strategies: *Going for a walk with neighbour, Ann. Practising mindfulness meditation.*
3. Phone numbers of friends who can be called on: *Ann: XXX-XXX-XXXX. Joan: XXX-XXX-XXXX.*
4. Supportive Health Professionals: *Family Physician: Dr A, XXX XXX XXXX. Crisis Line: 1-800-784-2433. Emergency: 911.*

# Coping and Support Networks

- **Community Resources for Moms**
- Family Physician/Midwife/Nurse Practitioner
- Local Public Health Nurse
- Local Mental Health Team
- Emergency Room
- HealthLink BC at 811 (24/7). Provides non-emergency health information. www.healthlinkbc.ca
- Mental Health Support/Crisis Line at 310-6789 (no area code) (24/7). Provides mental health support, information and resources
- Suicide Line at 1-800-784-2433 or 1-800-SUICIDE (24/7). Provides skilled suicide assessment and intervention. www.crisiscentre.bc.ca

- **Self-Care Guides for Moms**
- Coping with Depression during Pregnancy & Following the Birth: A Cognitive Behaviour Therapy-based Self-Management Guide for Women. Download from www.bcmhas.ca
- Coping with Anxiety during Pregnancy and Following the Birth: A Cognitive Behaviour Therapy-based Resource and Self-Management Guide for Women and Healthcare Providers, 2013. www.bcmhas.ca
- PPD & anxiety: a self-help guide for mothers (small cost). Order from www.postpartum.org

# Coping and Support Networks

**Resources for BC Physicians:**

- Psychiatrist from BC Reproductive Mental Health available M-F 09:00-16:30 @ 604-875-2025
- Reproductive Mental Health Programs:
- BC Reproductive MH (BC Women's): 604-875-2025; www.bcmhas.ca
- St Paul's: 604-806-8589
- Richmond: 604-244-5488
- Royal Columbian: 604-520 4662
- Surrey Memorial: 604-582-4558
- Victoria General: 250-737-4529
- Kamloops Perinatal Support Services: 250-377-6500
- Motherisk (information for physicians and patients regarding medication safety in pregnancy and while breastfeeding from the Hospital for Sick Children in Ontario). www.motherisk.org
- BC Psychosis Program (UBC Hospital): Inpatient services to patients with psychotic illness (referral required). www.vch.ca
- Edinburgh Postnatal Depression Scale (PEDS) is available in multiple languages at www.perinatalservicesbc.ca
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# Mental Health Disorders in the Perinatal Period

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