NORTHEASTERN ONTARIO
POSTPARTUM MOOD DISORDER PROJECT

FULL REPORT
(PHASE I)

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EXECUTIVE SUMMARY

Within the province of Ontario, there is no coordinated comprehensive strategy for families suffering with postpartum mood disorders (PPMD). Families are experiencing a "postal code lottery" where their place of residence determines their access to services.
Our project, through the creation of a Northeastern Ontario Postpartum Mood Disorder Strategy, begins to address this lottery for families in Northeastern Ontario that is resulting in too many suffering unnecessarily.

The implications for a lack of awareness, diagnosis and treatment for PPMD can have profound effects on mothers, fathers, infants, partners and the entire family. Furthermore, PPMD carries with it the burden of shame, stigma and silence that further complicates the already complex.
Due to the complexity of the issue, which engages multiple domains including the physical and mental health of the parents, child health, child development and child welfare, it necessitates a strategic comprehensive response.
PPMD impact one in five mothers, one in ten fathers, and over one in four adoptive parents. Over **2700 families in our Northeastern Ontario districts are impacted annually by this illness**. The economic and social burden of PPMD is immense. Globally, initiatives are beginning to emerge that are attempting to address the complexities of PPMD.
*all photos are part of the Northeastern Ontario Photovoice Project. "Reflected Truth", Michelle Roberts; "Monument", Kathleen Jodouin; "The Gaps", Michelle Roberts.

Through a grant from the Ontario Trillium Foundation, six communities in Northeastern Ontario including Nipissing, Muskoka/Parry Sound, Sudbury, Sault Ste. Marie, Timmins and Temiskaming, came together over the past year and created this strategy.

This strategy is the combined voices of working groups in each community (comprised of professionals, community members and women with lived experience), a regional photovoice project, individual interviews and the best practice literature.

Through this community project, a strategy to address PPMD for Northeastern Ontario emerged. Our communities strongly recommend that PPMD becomes a priority for Northeastern Ontario and that,

1. A holistic, timely, comprehensive sustainable continuum of care, based on best practices, providing a menu of services for the entire family is created through an inter-ministerial partnership.
2. Upon the creation of the system of care, we enact a coordinated system of competency building within our communities.
3. Upon facilitation of competency building, we engage in a systematic and creative community awareness and education campaign.

There are currently too many gaps for families experiencing PPMD to fall through. Though the adoption of these recommendations we can end the suffering of families experiencing PPMD in Northeastern Ontario.

CHAPTER ONE

Background and Analysis

RATIONALE

Postpartum Mood Disorder (PPMD) is a multifaceted, gendered, political, and global issue. The etiology of PPMD varies according to the theoretical and ideological orientation of the reference source. The rhetoric remains blurred within both the literature and the medical and social welfare discourses. These factors have impacted the diagnosis and treatment of this mental health issue within Ontario and results in families becoming victims of a postal code lottery in which their access to services is dependent upon their luck in residency.

The implications for a lack of awareness, diagnosis and treatment for this disorder can have profound effects on mothers, fathers, infants, partners and the entire family. Furthermore, PPMD carries with it the burden of shame, stigma and silence that impede access to services. Due to the complexity of the issue, which engages multiple domains including the physical and mental health of the parents, child health, child development and child welfare, it necessitates a strategic comprehensive response.

RATES AND TEMPORAL BOUNDARIES

Rates of PPMD have been reported to affect one in five women (Marcus, Flynn, Blow, & Barry, 2003) and are described as one of the "most disabling disorders for women in their childbearing years" (O'Hara, 2009, p. 1258). In addition, this illness affects one in ten fathers (Paulson & Bazemor, 2010) and 28% of adoptive parents (Payne, Fields, Meuchel, Jaffe & Jha., 2010).The illness can occur during pregnancy and

up to the first year post partum (Breese McCoy, 2011; O'Hara, 2009). The severity of PPMD symptoms can range from mild to severe.

Postpartum blues occurs after the birth of a child and can affect up to 75% of mothers. It normally lasts for 10 days and mothers tend to exhibit symptoms such as crying, fatigue, irritability and anxiety, but, unlike other forms of PPMD, postpartum blues does not typically require formal intervention (Beck, 2006).

PPMD often involves co-morbid presentation of anxiety and depression. Symptoms of PPMD include mood lability, irritability, insomnia or hypersomnia, obsessive thoughts, changes in appetite, tearfulness, anxiety, feelings of worthlessness, poor concentration, interpersonal hypersensitivity and loss of interest or pleasure (Beck, 2006; Breeze McCoy, 2011; O'Hara, 2009; Phillips, Sharpe, Matthey, & Charles, 2009).

Postpartum post-traumatic stress disorder (PPTSD) has recently begun to receive attention within the literature. However, due to variances in concepts and methodology, accurate rates of impact are difficult to authenticate. A recent Canadian study of PPTSD has reported it affecting 7.6% to 16.6% (Verreault et al., 2012) of mothers.

Postpartum psychosis, which affects approximately 1 in 1000 births (Kendell, 1987), is inclusive of symptom clusters that includes hallucinations, delusions, and extreme agitation and can also include thoughts of harm to self and to others.

INTERGENERATIONAL TRANSMISSION

Perinatal mental health concerns have severe implications not only for mothers and fathers but for the children of mothers who experience mood changes during pregnancy (Kingston, Tough, & Whitfield, 2012). During pregnancy, the fetus of mothers with mood disorders experience disturbed fetal activity and growth rates (Field, 2011). Subsequently, pre-term delivery, low weights for gestational age, low birth weights and increased admission to neonatal intensive care units are reported for infants of mothers experiencing mood disorders (O'Brien, Laporte, & Koren, 2009; Muzik & Borovska, 2010). Of key consequence is that low birth weight is associated with higher rates of mortality and morbidity for infants (Public Health Agency of Canada, 1999). Pregnant women who are depressed are reported as less likely to follow prenatal health directives and are more likely to use alcohol and/or drugs (O'Brien et al., 2009).

Furthermore, children of mothers with PPMD are less likely to attend well baby checkups and follow immunization schedules. These children have increased emergency room utilization (Minkovitz et al., 2005) as well as significantly increased infant hospitalization rates than children of non affected mothers (Guttman, Dick, & To, 2004; Holland et al., 2010; Minkovitz et al., 2005). Recently, even greater catastrophic implications for PPMD have been reported by international researchers, stating that infants, toddlers and preschoolers, up to the age of five, of mothers with PPMD are at increased risk of mortality (Chen, Tsai, & Lin, 2011).

The literature demonstrates a strong link between PPMD and adverse effects not only on children's physical wellbeing but also on their social and psychological well being. This is shown by the "distortions

of the communication regulatory system in the mother-infant dyad [that] lead to an intergenerational transfer of both depression and a negative affective state from mothers to their infants" (Tronick & Reck, 2009, p. 148).

For example, postpartum mood disordered infant mother dyads have fewer vocal and physical interactions, less visual communication, disturbed sleep and appetite, and increased crying (Righetti-Veltema , Bousquet, & Manzano, 2003). Children of mothers who have experienced PPMD have higher levels of anxiety, hyperactivity and aggression, and poorer pro-social behaviors than children of non-depressed mothers (Letourneau et al., 2006). These children show delays in cognitive development at four years of age (Righetti-Veltema et al., 2003) and are two to five times more likely to develop long term behavioral problems (Letouneau et al., 2006). A recent systematic review of perinatal mental health and infant development by Canadian researchers Kingston, Tough and Whitfield (2012) clearly indicates that perinatal distress has adverse effects on the cognitive, behavioural, psychomotor, cognitive and socio-emotional development of children. In addition, children of mothers who experience maternal depressive symptoms have a decreased utilization of preventative services, including age appropriate well child visits, which may have provided an opportunity for early intervention of treatment for developmental concerns (Minkovitz, et al., 2005). Early intervention and treatment of PPMD can help to prevent the adverse effects on mothers, children and families, and help to minimize the chances of intergenerational transmission (Kingston et al., 2012).

Furthermore, recent research has demonstrated the importance of a systematic response to perinatal mental health and its impact on child development. Interventions should focus on developing partnerships between adult and pediatric providers (Letourneau et al., 2012), and should also focus on the parents, the infant and the parent child dyad while concurrently addressing the triadic nature of the issue (Kingston, Tough, & Whitfield (2012); Letourneau et al., 2012; Tronick & Reck, 2009). Looking toward global trends, New Zealand's Ministry of Health (2011) has promoted this triadic model of care within its' *Health Beginnings* guidelines and is advocating for a concurrent model because a "child's development should be viewed within the context of the system of relationships that form their environment" (p.6).

NORTHEASTERN ONTARIO FAMILIES

In 2009-2010, there were 9092 babies born in Northeastern Ontario (BORN, 2011). Based on this number and on the research stating that 20% of mothers and 10% of fathers are affected by PPMD (O'Hara, 2009; Paulson & Bazemor, 2010), over **2700 families in our districts are impacted annually by this illness**. As "untreated maternal mental health problems have serious emotional, social, physical, and economic impact on entire families" (MotherFirst, 2010), action needs to be taken now to address this significant community health issue.

ECONOMIC COSTS

The economic and social burden of PPMD is immense. Canada currently spends less on mental health services than other developed countries; 7.2% compared to the recommended 10% (Jacob et al., 2010). The bulk of these funds are invested in acute care that "has not resulted in measureable improvement in mental health" (Jacob et al., 2010). The MOHLTC Advisory Group for the 2010 Mental Health and Addiction Strategy has advised that in order to provide the needed supports and services, more investments need to be made in community-based services (Respect, Recovery and Resilience, 2010).
It is vital to understand the economic and social costs of PPMD and the ways it contributes to the overburdening of the social and health care systems in Ontario. Conservative estimates, which only measured the direct health care costs of untreated mood disorders in pregnancy alone, identify the figure to be about $20.5 million (O'Brien, Laporte & Koren, 2009). As only half of all PPMDs are recognized (Gjerdingen, Katon & Rich, 2008) by health care providers, this estimated cost is no way reflective of the true cost of this illness.
Furthermore, The Post and Antenatal Depression Association of Australia (2012) recently released *The Cost of Perinatal Depression in Australia FINAL REPORT* and reported that loss of productivity due to PPMD is estimated at $310 million annually.

CURRENT BARRIERS

In order for parents to access mental health services in Ontario they are required to meet the criteria for a serious mental illness. This criterion is inclusive of three dimensions: (a) disability, (b) anticipated duration/current duration, and (c) diagnosis (Ministry of Health and Long Term Care, 1999). Parents must be able to demonstrate difficulties that interfere with or severely limit daily functioning. This level of disability is often difficult to demonstrate for those with PPMD because parents typically continue to take care of their children no matter how much they are suffering. The second criterion, the duration of difficulties, has recently shifted in its definitional properties and is now measured by service usage. However, this measure excludes most parents with PPMD as they are not able to access services nor have they done so in the past. The final criterion, having a current or pending diagnosis, closes the door for many parents attempting to access services. The DSM-IV does not recognize postpartum depression as a separate diagnosis; rather, patients with a diagnosis of postpartum depression must meet the criteria for major depressive episode within 4 weeks of giving birth. (American Psychiatric Association, 2000). This inclusionary criterion does not address the temporal or symptomoligical boundaries of women's experience with PPMD (Boland-Prom & MacMullen, 2012).
Furthermore, the current separation of adult mental health services (Ministry of Health and Long Term Care) and child development services (Ministry of Children and Youth Services) requires parents to navigate a complex service system in order to meet their needs and the needs of their children which create significant barriers for families attempting to access services.

GLOBAL INITIATIVES

Globally, we are seeing initiatives beginning to emerge that are attempting to address the complexities of PPMD (Table 1). Each initiative is addressing the issues of PPMD in unique ways. However, each strategy demonstrates a commitment to addressing the issues facing families and communities that are struggling with PPMD, as well as demonstrating the importance of a systematic response to PPMD.

TABLE 1
GLOBAL PERINATAL MENTAL HEALTH INITIATIVES

Title of Initiative	Mother First	Perinatal Mental Health National Action Plan	Health Beginnings	**The organization of perinatal mental health services in Ontario - ECHO**
Country of Origin	Canada (Saskatchewan)	Australia	New Zealand	Canada (Ontario)
Year of Publication	2010	2008-2010	2011	2012
Action	Recommendations	Strategies	Guidelines	Recommendations
1.	Education	Training & Workforce Development	Triadic Services	Service
2.	Screening	Universal Routine Psychosocial Assessment	Triad requires access to comprehensive and integrated services	Education and Training
3.	Treatment	Pathways to Care	Developmental approach to assessment and treatment	Policy
4.	Sustainability & Accountability		Tailored interventions that are the least restrictive and most normative	Research
5.			Early identification and intervention	
6.			Family/Service provider collaboration	
7.			Culturally Appropriate	
8.			Services need to be evidence based, goal focused, accountable, acceptable and accessible	

COMMUNITY HEALTH PROFILE

Northeastern Ontario covers 400, 000 square kilometers, and is home to approximately 550, 000 people. Approximately 23% of the population is Francophone, 10% are Aboriginal, First Nations and Métis, and 6.2% are New Comers to Canada (North East LHIN, 2012). Northeastern Ontario faces significant challenges related to health and wellbeing. Statistics Canada (2013) reports that those living in Northeastern Ontario experience lower levels of functional health, lower access to a medical doctor and lessened life expectancy. In addition they experience higher levels of mood disorders, significantly higher mental illness hospitalization rates as well as repeat hospitalization rates for mental illness. Furthermore, Northeastern Ontario's children face additional challenges with higher than average low birth weights as well as higher than average infant mortality rates (North East LHIN, 2012).

At this time, within the province of Ontario, there is no coordinated comprehensive service delivery model for families suffering with PPMD. Due to the complexity of the issue, which engages multiple domains including the physical and mental health of the parents, child health, child development and child welfare, it necessitates a strategic comprehensive response, rather than the postal code lottery were the families place of residence determines their access to services. Our project, through the creation of a Northeastern Ontario Postpartum Mood Disorder Strategy, will address this inequality that is resulting in too many families suffering unnecessarily.

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CHAPTER TWO

The Northeastern Ontario Project Process

The Northeastern Ontario Postpartum Mood Disorder Strategy was produced from a review of the literature and global PPMD initiatives (see Chapter 1), as well as from the expertise and guidance from a number of sources within our communities. The project recognized that policy recommendations resulting from local expertise and lived experience would more effectively contribute to a successful strategy to address PPMD than those that emerge solely from the literature. These additional sources of expertise included working groups within each of the six communities involved in the project, and families

who had experienced PPMD. We believe this type of community engagement and involvement is a highly effective means to address the complexity of PPMD.

WORKING GROUPS

The call for participation with the Northeastern Ontario Postpartum Mood Disorder Project working groups was facilitated primarily through presentations to key stakeholder groups throughout Northeastern Ontario as well as through telephone and email requests. Members volunteered to join the working groups and committed to one year of involvement with the project. The Working Groups had two primary responsibilities: (1) to inform and guide the development of the Northeastern Ontario Postpartum Mood Disorder Strategy; and (2) to assist in the recruitment of women and families with lived experience of PPMD to participate in the photovoice project.

Working Groups in each of the six districts were formed and consisted of three to ten members, representing a variety of community organizations and community members with an interest (either professional or personal) in PPMD. Membership included,

- Aboriginal health providers
- Addiction service providers
- Adult mental health providers
- Best Start Network representatives
- Child care providers
- Children's mental health providers
- Community health providers
- Early Years Centres
- Health Units
- Interested community members
- Nurse Practitioners, G.P.'s
- Women with lived experience

Over the course of the project each working group completed a service map of PPMD for their area, discussed the challenges and strengths with reference to PPMD in their communities and made recommendations to address the challenges they face. For a complete list of working groups see appendix A.

LIVED EXPERIENCE EXPERTISE
PHOTOVOICE PROJECT

A vital component of the Strategy development involved improving our understanding of families lived experience with PPMD. One of the ways we accomplished this was through the use of photovoice. Photovoice is a process for people to identify and represent their experiences and bring about positive changes in their community through the use of photography. Photovoice has three goals: (1) to document a community's strengths and challenges; (2) to promote critical dialogue; and (3) to build public awareness and influence policy developers (Wang, 1999).
Photovoice, through the use of photos and written narratives, provides participants and the community an opportunity to understand lived experience in a highly impactful way. The "visual images and accompanying captions bring to the public arena the voices of those who are most affected by public policy, but have little, if any, input into its creation" (Duffy, 2010, p. 788). Photovoice's efficacy has been proven throughout the literature as a tool to educate, to influence and to create change (Duffy, 2011; Hergenrather, Rhodes, Cowan, Bardhashij & Pula, 2009; Lorenz & Kolb, 2009; Strack, Lovelace, Davis Jordan, & Holmes; Wang, 1999; Wang and Pies, 2004).

Twelve women from throughout Northeastern Ontario who had experienced PPMD volunteered to participate in the photovoice project. These women came together electronically, using Adobe Connect, over the course of six weeks to share their experiences with PPMD. They were provided cameras (generously provided by the North Bay Regional Health Centre) and asked to take pictures that represented their experiences with PPMD and to give voice, through images.
The women were then asked to select three photos that they felt best represented their experience or represented a message they would like to share with others in the community regarding PPMD. These three photos were then framed and an exhibit of 36 beautiful and at times heart wrenching photos was created (see Appendix A). This exhibit was hosted by each of the six communities during mental health week, an annual event held during the first week of may and was open to the public. The exhibit continues to be displayed in our communities as a way to educate and inform. For a complete list of photovoice participants, please see Appendix B.

INDIVIDUAL DISCUSSIONS

In addition to the photovoice participants, numerous other women and families participated in discussions regarding their experiences with PPMD and the challenges they faced in accessing appropriate and timely services. Their voices are also part of this Strategy.

"We need to step out from behind the stigma, the shame, the stereotypes, and the fear that is perpetuated about Postpartum Mood Disorders. We need to speak up loud and clear without shame and say "I survived, this is what I needed." Only then can we be a positive example of the outcomes of proper

care for Postpartum Mood Disorders - not only for others suffering from this serious illness, but also for our communities and the service providers that are in a place to develop and implement programs that will fill the wide gap in service for women's mental health particularly the spectrum of Postpartum Mood Disorders. An individual who beats cancer proudly tells the world "I have beat my illness", women who have overcome the illness of Postpartum Mood Disorders need to do the same. We need to take that stand and usher in change. Then those caught in the shadows of this illness, the fear and shame that come along with it can be encouraged, they can have hope that it will get better and most important that they are not alone. Hopefully because of our stand they will have place to go to get the help they need free from stigma, stereotypes, shame and fear!" Michelle Roberts

"People with lived experience of mental illness or addictions, and their families; bring their strength, wisdom, resilience to their care. They must have a voice as essential partners in system design, policy development, and program and service provision, and the opportunity to make informed decisions about their personal care and support."
(Ministry of Health and Long-Term Care, (2011). Open Minds, Healthy Minds)

"Dreary, gray and lonely. For me, this picture represents my journey to wellness. There was no clear path to get there. I could only try to keep afloat until I hit solid ground. It seemed impossible to pick my way through the ever-changing maze while slowly sinking, allowing myself to melt into the cold silence. Each step forward was an unsteady leap. We need to give women and families affected by PPMD a clear path to follow. They need help to navigate their way to solid ground. We need to support them on their journeys to wellness." Stephanie

"This photo is mean to depict how it felt to be in the middle of my illness. If the other side of the lake were to represent wellness, it is very far away. This woman is sitting alone and the tone is very cold and ominous, similar to my experience in that this was something I felt, and perhaps still do that no one could really understand the guilt, loneliness and embarrassment for not coping well. Trying to navigate the mental health services and identify what recovery was for myself was a very overwhelming task, exacerbated by lack of sleep and confusion, hidden to everyone except a close few. I would hope that the message people can take from this photo is that it is a very scary, unsure journey for a women to make and even if options are presented, it is a confusing time to assess what is needed and when to reach out." Kaarina Ranta

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CHAPTER THREE

Northeastern Ontario Postpartum Mood Disorder Strategy Recommendations

RECOMMENDATION #1: INVESTMENT IN FAMILIES

A holistic, culturally safe, timely, comprehensive, sustainable continuum of care, based on best practices, providing a menu of services for the entire family is created through an inter-ministerial partnership.

RECOMMENDATION #2: COMPETENCY BUILDING WITHIN OUR COMMUNITIES

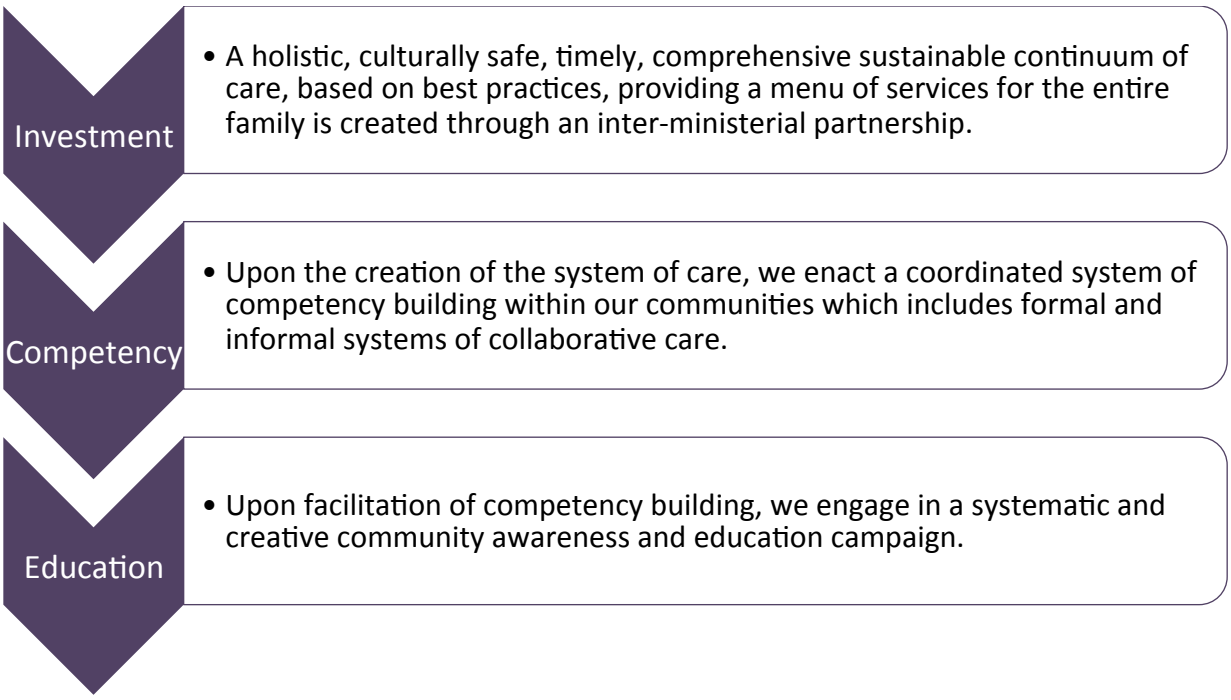
Upon the creation of the system of care, we enact a coordinated system of competency building within our communities which includes formal and informal systems of collaborative care.

RECOMMENDATION #3: EDUCATION CAMPAIGN FOR OUR COMMUNITIES

Upon facilitation of competency building, we engage in a systematic and creative community awareness and education campaign.

PROCESS MODEL

Figure 1 Northeastern Ontario Postpartum Mood Disorder Strategy Stepped Recommendations



RECOMMENDATION #1: INVESTMENT IN FAMILIES

A holistic, culturally safe, timely, comprehensive, sustainable continuum of care, based on best practices, providing a menu of services for the entire family is created through an inter-ministerial partnership.

Addressing PPMD requires an investment in families. As PPMD impacts the entire family a partnership between the Ministry of Health and Long Term Care and the Ministry of Children and Youth Services is required. This invested collaborative partnership will provide a comprehensive continuum of care to families. This continuum of care will provide a menu of services for families and will utilize a variety of models of service delivery including electronic options that recognize the geographic challenges faced by those in the North. This model of care would be delivered in a person-centered, inclusive, holistic manner and would recognize the cultural diversity of the North and the diversity of familial connections. Services will be provided in a timely manner utilizing an expanded understanding of PPMD and will utilize inclusionary criteria rather than exclusionary criteria for admission.

RECOMMENDATION #2: COMPETENCY BUILDING

Upon the creation of the system of care, we enact a coordinated system of competency building within our communities which includes formal and informal systems of collaborative care.

Provision of a system of care will require a coordinated system of competency building within our communities. This competency building should occur within all sectors that are involved with the provision of service and care to families and would respect the scope of practice of each sector. Systems of care include but are not limited to physicians, nurses, peer providers, social workers, early childhood educators, mental health and addiction workers, child protection workers, lay home visitors, psychotherapists, etc. Competency building would utilize best practice evidence related to PPMD in addition to the expertise of Northern communities of practice and Northern families with lived experience of PPMD.

RECOMMENDATION #3: EDUCATION CAMPAIGN

Upon facilitation of competency building, we engage in a systematic and creative community awareness and education campaign.

PPMD is an often an illness of secrecy, silence and shame. Upon the creation of a system of care and the enactment of a coordinated system of competency building we engage in a public education and awareness campaign. This campaign will utilize both traditional and non-traditional communication methods to provide accurate information on PPMD, pathways to care, and systems of support. This education will be provided in accessible and normalized language.

APPENDIX A

Northeastern Ontario Postpartum Mood Disorder Project Working Groups

MUSKOKA PARRY SOUND

Carol Corriveau-Truchon	BA	Muskoka Family Focus & Children's Place
Dawn Dawson		Community Member
Doris Chartrand	RN, BScN	North Bay Parry Sound District Health Unit
Laurie Regan	RN, BScN, CPMHN(c)	Muskoka-Parry Sound Community Mental Health Services
Meghan Gyorffy	RN, BScN	Simcoe Muskoka District Health Unit
Peggy Govers	RN, MScN	Simcoe Muskoka District Health Unit
Sarah MacKinnon	MD, CCFP	Sundridge and District Medical Centre
Sue Lessard		HANDS

NIPISSING

Diana Hamilton	BSW, RSW	North Bay Nurse Practitioner-Led Clinic
Karen Cobb	BA	The Learning Partnership
Kat Jodouin	BA Hons	AIDS Committee of North Bay and Area
Kerri McGuire-Trahan	NP	AIDS Committee of North Bay and Area
Margi Clarke	B.A.	Canadian Mental Health Association Nipissing Regional Branch
Maureen Lebeau	Support Services Counsellor	True Self - Debwewendizwin Employment and Training
Nicky Restoule	Housing and Transition Support	Nipissing Transition House
Rosella Kinoshameg	R.N., BSc.N	Lawrence Commanda Health Centre
Sue Lebeau	PHCNP, MScN, CHE	Community Member
Terry Smith	RN, BScN	North Bay Parry Sound District Health Unit

SAULT STE. MARIE

Annette Ratz	RN(EC),	Algoma Public Health
Diana Taranto	R.E.C.E., ECE.C	Child Care Algoma
Iola Needs	M.S.W., RSW	Algoma Family Services
Karen Conforzi	RN, BScN, CPMHN(c)	Sault Area Hospital
Marilyn Fratesi	RN, BScN	Algoma Public Health
Michelle Brown	RN, BScN	Algoma Public Health

Michelle Borrelli	BA, RSSW	Canadian Mental Health Association Sault Ste. Marie-Algoma Branch
Sarah Schryer	RSW	Nurse Practitioner Lead Clinic
Sharon Vanderburg	RN, BScN	Algoma Public Health
Shawna Baron		Canadian Mental Health Association Sault Ste Marie Algoma Branch
Stephanie Whalen	RN	Sault Area Hospital/Community Member
Veronica Arthurs	RN, CPMHN©	Sault Area Hospital

SUDBURY

Cathy Manuel	CYW	Child and Community Resources
Courtney Sakaluk	B.A, Dip MHAW	Pregnancy/Parenting Outreach Program – Iris Addiction Recovery for Women
Jannah Berney	Student	Student Cambrian College
Johanne Thompson	Program Manager	Better Beginnings/ Better Futures Sudbury
Kaarina Ranta	RSSW	Northern Initiative For Social Action
Rebecca Sabourin		Sudbury and District Health Unit
Sonja Lamothe	Parent Resource Worker	Our Children, Our Future/Nos enfants, notre avenir
Stephanie Brazeau	Manager of Program Services	Our Children, Our Future/Nos enfants, notre avenir

TEMISKAMING

Dani Grenier-Ducharme	Children's Services Manager	District of Timiskaming Social Services Administration Board
Edith Plouffe	BSW	North Eastern Ontario Family and Children's Services
Laurel Beardmore	Hons B.A. (psych.) R.S.W.	Addiction/Mental Health Program Timiskaming Health Unit

TIMMINS

Alison Dubien	RN, BScN	Porcupine Health Unit
Anne Vincent	M.H.A.	Balance on Purpose Consulting & Coaching
Rachèlle Pelletier	ECE, BA	North Eastern Ontario Family and Children's Services/Ontario Early Years Centre

APPENDIX B

Photovoice Members

Twelve women, from throughout Northeastern Ontario who had experienced Postpartum Mood Disorders, came together electronically over the course of six weeks to share their experiences with postpartum mood disorders. They were provided cameras and asked to take pictures that represented their experiences, to give voice through images.

- Annie
- Bonnie Dart
- Christine Mackie
- Janice Ireland
- Julie
- Kaarina Ranta
- Kathleen Jodouin
- Mandy
- Michelle
- Michelle Roberts
- Sonia
- Stephanie