

CRHR



Improved Support for Rural Perinatal Mental Health: A Framework for Peer Support



**Final Report to
Social Planning and
Research Council of BC**

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A Message from the SPARC Perinatal Peer Support Team

Part I - The Community Co-Lead Research Partner

I write to you today as a single, mentally ill mom on Disability; that is the first thing that comes to mind. However, as I reflect on my journey with this project I am reminded that I am more than a single mentally ill mom on Disability - I am a Co-Lead Researcher with Dr. Jude Kornelson and our amazing team, Audrey (gonna be a doctor one day) Cameron and Simrat (the soon to be Midwife) Dial... And of course all of you at SPARC who helped us get here.

Where is here? Well, it's an enriched place in my life, the lives of others in my community and the research team's lives. It's a supportive, diverse, informed, inclusive and utterly brilliant place. Our project took us on a journey through the minds and hearts of a vast array of lived experience. We went into this with an idea and a notion, but we were never glued to it. You know? We were more focused on, what will the people need? Will our idea meet their needs? How much change will we see from our original ideas?

You see, working in a meaningful, intentional and truly authentic way changes you, changes the perspective- but it doesn't challenge you in challenging ways if you know what I mean. You probably don't, so I'll explain it a bit further. Things are only challenging if you are trying to force something ya know- like an agenda or a preconceived notion that you already have it all figured out, and now, "How can we get the voices of the community to support that notion?"

Our methods for attaining information, creating program content and implementation was highly focused on a multi lens and community inclusion approach. Lots of programs say they are doing this, or have the goal of doing this, but what we found is they rarely "put their money where their mouth is." In our project, when we asked for input on content we created, the content was challenged, but instead of going, "Yeah, well whatever, we think it's fine." We said "Ok, let's do that then." Fluid movement through the process and the thoughts and ideas that were put forth allowed the "challenges" to be wonderful suggestions that (back to enriching) enriched our whole project.

I hope you enjoy our report. It was such a delight to work, create and collaborate with so many incredible voices.

Warmest Wishes,



April (the mentally ill AF) Hards

And the rest of my Research (Family) Team

Part II - The Academic Principal Investigator

In 2018, as part of a commissioned consultation of the state of maternity care in the community of Golden, BC, Jude Kornelsen facilitated a community forum to discuss the *desire* for local maternity care, *the consequences* of not having local access to care, and suggestions for *improving* local services. At the well-attended forum, a community member spoke clearly and articulately to the need for ancillary support for perinatal mental health. Although there were existing services within the community, the community member suggested that as someone with intersecting vulnerabilities (low-income, bisexual, Metis with existing mental illness), the stigmatization and barriers to care she experienced rendered the services unhelpful. The clear articulation of the compounded health disparities she faced directly called for the need to investigate further the lack of low-barrier mental health supports in the context of rural health services.

Through introductions by a mutual colleague and a face-to-face meeting after the community form, a quick partnership was formed around the shared objective to understand perinatal mental health services available in the community, their level of accessibility, and how to achieve a more expansive approach to care. We were successful in our application to the (then) Michael Smith Foundation for Health Research titled, “An evaluation of citizen-patient developed resources to support rural women in the post-partum period: A feasibility study of community engagement.”

The initial objectives of the research project were to assess the feasibility of engaging patient partners who have experienced perinatal mental health concerns in the development of a community-based approach to address such issues and evaluate the efficacy of the framework with key stakeholders. Initially, the project was aimed at piloting a perinatal mental health questionnaire that could be used between peers. However, as the study progressed, the research team recognized the urgent need to gain a better understanding of pre-existing

perinatal mental health resources in the community, in order to identify any gaps and understand where the peer support model might fit in.

In terms of the impacts of the study, participants did not share a sense of necessary changes to increase accessibility of mental health supports. Some, however, reflected the need for a framework for *peer support* to navigate challenges in the perinatal period while others – mostly care providers – did not feel peer support was necessary given existing resources available in the community. Service providers who did value the need for peer support, however, noted the difficulty of implementing such a program into the system infrastructure due to the aforementioned resistance. The findings, however, galvanized the collaborators, Jude Kornelsen and April Hards, to turn their attention towards understanding the *desirability*, *do-ability*, and *best approach* to peer support in this context. This led to our application to the Social Planning and Research Council of BC.

The strength of the collaboration between the project co-leads rests on the productive marriage of a rigorous academic approach to the research woven together with *the insights and expertise of a rural resident with lived and living experience of perinatal mental health challenges*. We have previously published on our process of working together to honor each perspective without censure or the need to find common ground (Hards, 2022): sometimes this did not exist due to diverse frames of reference, but importantly, we *both* were completely committed to the values proposition that each of us had, which was an acknowledgement of an equivalence of contribution. As our take-home message in the article noted:

Co-production highlights the value of lived experience in health research, sets it in conversation with scientific inquiry, and moves away from hierarchies of assumed knowledge often embedded in traditional health care research. Incorporating both academic researcher and community partner writing into our paper reflects a commitment to maintaining the integrity and authenticity of lived experience, an affirmation of its equal validity as a source of knowledge, and a rejection of qualifying patient voices.... We suggest co-productive research as a means of addressing the epistemic injustice that arises in health care research from the privileging of certain forms of knowledge, and the exclusion of others, namely that derived from patient experience (Hards, 2022).

Working through our collaborative relationship provided the spring-board to allow us to effectively envision and undertake the work for the current SPARC grant. As an added



advantage, our team also involved a research assistant who had been involved in the previous project and shared the same values proposition we operated from.

This report details what we learnt about establishing a peer-to-peer support model for perinatal mental health support in a low-resource rural community. We heard from interview participants that it usually takes up to two years to achieve critical mass for such groups; certainly, the growth in participation was slower than we anticipated. However, we were able to lay the groundwork for the group structure by co-developing supportive literature and documents with community members that are now freely available; we developed an informative, promotional website and we learnt from interviews with other social service agencies of the potential for productive synergies in purpose and intent. This was all accomplished within a relatively short time frame, and due to the generosity of SPARC funding.

Due to SPARC funding, we had the capacity to consider alternative, community-based solutions to the lack of resources for mental health support pan-provincially, and in rural communities in particular. The funding allowed us to explore solutions to the care provider shortage that currently plagues BC and other jurisdictions *through a diversity lens*. This meant we could take direction from those with lived and living experience to develop a model of care that meets the needs of those who do not feel safe, welcomed, or included in current programming. This modest approach is a tentative first step to creating further low-barrier programming; we are delighted to be able to share our accomplishments through this report.

Sincerely,

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Project Overview

This project was conceptualized to build on the gains made through an environmental scan of perinatal mental health resources in Golden, and considered through a low-barrier, diversity lens. This step-wise progression allowed us to build on foundational work that not only assessed existing resources, but considered their accessibility and how well they met the needs of marginalized populations who often do not have a voice in service planning. Based on previous work, we identified the need for a low-barrier service model to meet the needs of this community, and on review of existing evidence and in response to health and social human resource challenges, proposed a peer-to-peer support model. As the 12-Step model is globally recognized, provides an effective peer-support framework, and was well-known to the community researcher, we decided to adapt it to the task at hand. This decision, however, came with the commitment to adapt the model not only to the content area, but also consider it through a *decolonized lens*, and to address non-secular language that has the potential to be alienating for some. Ultimately, the adaptation was focused on application to a rural setting, where other resources may be limited, and geographic distance makes travel difficult.

To this end, we set out to collaboratively engage community partners with lived and living experience of perinatal mental health issues, recognizing that we do not want their “input” on a model we develop, but instead want to take direction from them, starting with their articulation of needs. We committed to do this based on the values proposition of honoring partner voices, with emphasis on Indigenous voices. That required cultural responsiveness to Indigenous teachings and communities as part of an authentic effort to actualize the call for Truth and Reconciliation. We integrated the philosophy of “Seven Generations” into the development of the materials by attending to what has worked – and not worked – in the past (three generations past), current gaps and barriers in the 12-step model (current state) and trends and aspirations of an inclusive and decolonized model (future generations).

The structural framework we used to actualize this vision included a community advisory committee and, to maintain the integrity of the 12-step model, a 12-step advisory board. We sought – and achieved – diversity of membership on the committees, which was reflected through the extensive feedback we received as we were developing the materials. These documents are the legacy of this work and will allow us to “scale and spread” the model to other communities.

Alignment with SPARC's Mission

Prior to searching for funding, we very clearly knew that we wanted to create a decolonized version of a perinatal peer-to-peer support program. We knew that it needed to be adaptable, and that the motto or slogan “one size does not fit all” would be key to appropriate program development. We needed a framework that had integrity and was applicable to various demographics and communities. It was kismet that our research and the creation of Postpartum Depression Anonymous (PDA) was established in partnership with SPARC. SPARC's mission aligned well with our project's focus on meeting the needs of rural communities. Given the 12-Step model's demonstrated adaptability, longevity, and scalability, we believed that a decolonization of this framework would help us achieve our goals. It is the SPARC commitment to social justice and inclusion, equality and equity, adaptability and integrity that sparked (pun intended) our origin.

The argument for rural health services is often framed by an ethic of *equivalence*: that is, resources should be allocated proportionally, based on population need (interpreted as density). A more helpful framing of the issue, however, is through *proportionate universalism*, or attributing resources based on need. A myriad of evidence from Canada and internationally has convincingly demonstrated the health disparities between urban and rural communities (please see the report on the SPARC-funded Gap Analysis for background). Beyond the vulnerabilities experienced by rural residents' health status, there are specific vulnerabilities for rural birthers.

Finally, this work aligns closely with SPARC's commitment to *equality*: analysis of the project data confirms that a commitment to increasing equality “builds social cohesion, improves health, increases safety... and contributes to sustainable and vibrant communities.”

Background and Context

This project built on both observations of rural deficits learned through previous research work by the team and existing literature on rural peer-to-peer support. Some of this literature is reviewed below, starting with setting the context for a focus on perinatal mental health issues.

In high income countries such as Canada, it is estimated that 1 in 10 birthers are affected by perinatal anxiety or depression (World Health Organization, 2022). As untreated depression is associated with significantly increased odds of preterm birth and low birth weight (Jarde et al., 2016), as well as long term adverse outcomes affecting the offspring behaviourally, socially, and cognitively (Gentile, 2017), treatment of perinatal depression is imperative for the health of the dyad. However, barriers may prevent individuals from seeking timely treatment, such as long

wait times to access reproductive mental health, cost of care, geographical distance, and stigma. An intervention suggested to bridge the gap in formal care provision is peer-to-peer support.

Perinatal peer to peer support generally refers to one-to-one or group support provided through various modalities (over telephone, online, or in person) to a pregnant or postpartum individual by peers that have experienced postpartum depression (PPD) themselves. It is built on the foundation that “people who have like experiences can better relate and consequently offer more authentic empathy and validation” (Mead & Macneil, 2004). The shared experiences cultivate trust, a sense of support and normalize the participants’ experiences, allowing them to feel more comfortable sharing their needs (Dennis, 2010; McKimmy et al., 2023; Prevatt et al., 2018). Participants express variations of the idea that “Talking to someone who’d gone through [postnatal depression] made me feel okay about divulging some of the things that I was thinking and feeling” (McLeish & Redshaw, 2017). In comparison, when seeking professional help, individuals may exercise self-censorship due to inadequate appointment times, fear of being reported to child protection services, or the absence of continuity of care (McLeish & Redshaw, 2017; Prevatt et al., 2018). Especially for immigrants in rural communities, perceiving a lack of empathy of genuine interest or judgment from the healthcare provider also contributes to a lack of trust in their provider (Higginbottom et al., 2016; McKimmy et al., 2023).

Despite this, a study evaluating telephone-based peer support in New Brunswick found 11% of mothers receiving peer support had a relapse in depressive symptoms (Letourneau et al., 2015). This finding acknowledges that some individuals may require pharmacotherapy or psychotherapy from a professional, which may be administered adjacent to peer support to effectively treat their PPD.

We note from the literature that there is variance in the definition of “peer support.” For our purposes, and in keeping with the mandate of “low barrier services” (both in regards to implementation and to access), we note the difference between professionally-facilitated peer-support and what we refer to as “peer-to-peer support,” the latter requiring no professional training or designation. This is an essential attribute of the model if it is to be applied in low-resource, rural settings where trained providers may not be available, be in great demand if they are available and charge for their services. The caveats are, our course, to ensure group and individual safety, thus a clear pathway to elevate concerns was one of the key documents in our work (see Appendix 1).

Rural Peer-Support Programs

In a national survey of rural hospitals across the US, at least half the communities of responding hospitals did not have postpartum peer support groups; in the most vulnerable counties, postpartum support groups were significantly less available (Basile Ibrahim et al., 2022).

In British Columbia, most birthers receive a follow up phone call with a public health nurse to check in on mood, which may include administering the Edinburgh Postnatal Depression Scale.¹ Depending on severity of a recognized mood disorder, birthers may wait more than two months for follow up (Hicks, 2022). There are, however, provincially-supported programs available.

The Pacific Post Partum Support Society is a non-profit and registered charity that offers support to parents across BC. Their services are made more accessible through offering a variety of different support options, having a toll-free number, and having a self-referral process. Support options offered include phone and/or text support as well as in-person or online peer support groups for parents with a baby under 18 months of age (Pacific Post Partum Support Society, 2024). The peer support groups meet weekly and are facilitated by a trained peer facilitator. Their website also has resources such as videos and a podcast that provides helpful tips in addition to experiences shared by other postpartum individuals, normalizing the postpartum experience.

Motherwise, like some other programs across the province, is a postpartum weekly support group. Motherwise serves the Kootenay region, including the communities of Grand Forks, Castlegar, Nelson, and Trail. For 8 weeks, birthing parents struggling with their mood postpartum can connect with other birthing parents and share their experience in one of two sessions held in each city (Kootenay Family Place, 2021). The group is professionally facilitated. In 2018, the group was looking for funding to continue their program after their funding provided by the Kootenay Boundary Division of Family practice expired (Kline, 2018).

More general postpartum groups exist in rural communities across the province, such as Bellies to Babies or Baby's Best Chance in communities such as Fort St. John, Fernie, Campbell River, and the Sunshine Coast. These programs do not focus specifically on postpartum mood, instead

¹The Edinburgh Postnatal Depression Scale (EPDS) is a set of 10 screening questions that can indicate whether a parent has symptoms that are common in women with depression and anxiety during pregnancy and in the year following the birth of a child" (Perinatal Services BC).

they provide a space for postpartum moms or birthers to receive breastfeeding or postnatal education and support. Some program length is dependent on the individual program, some are offered until 6 weeks postpartum, 6 months, 1 year, or 18 months postpartum. Transition to a “parenthood” program may be offered after children and parents age out of these “postpartum” programs, however this is not consistent across communities. For Indigenous people, these programs are typically offered by a local friendship centre society such as the North Okanagan Friendship Center Society. *Celebrating the Circle of Life* is also a guide created for Aboriginal Women and their families for emotional health throughout pregnancy and early motherhood.

As a part of situating our program in the context of existing social service programming, a list of relevant programs that support rural individuals in the perinatal period has been compiled into a Resources Matrix and is available as Appendix 2.

Outcomes and Experiences of Peer Support Programs

Many studies have evaluated participant satisfaction for peer support interventions, although a lack of rurally focused studies is noted. Although models of peer support vary greatly in modality and how the support is provided, the reported participant satisfaction is high, and many participants experience a decrease in depression symptoms. Findings from a study evaluating a free postpartum depression support group in an urban American city and another telephone-based postpartum peer- to-peer support group in Ontario reported approximately 80% of participants being highly satisfied with their experience in the program (Dennis, 2010; Prevatt et al., 2018). Peer support group participants have expressed that having peers validate their feelings and experiences built up their confidence; the normalization of their mood or experience positively impacted the confidence of depressed or anxious mothers that struggle with a sense of profound failure (McLeish & Redshaw, 2017). Birthers also expressed feeling valued by their peer supporters and empowered through the non-directive information provided by their groups.

Additional reported benefits of participation in a peer support group includes a reduction in depressive symptoms, lower Edinburgh Postnatal Depression Scale (EPDS) scores and improvement in social integration, (Dennis, 2010; Letourneau et al., 2015; Prevatt et al., 2018). The improvement in social integration seems to be related to sharing a common experience. One individual noted “Before this experience, I never thought that other people will be interested in the way I feel. It’s good to know that I’m not alone.” (Dennis, 2010). Peers in groups or volunteers are responsible for establishing this connectivity. Depending on the group, these individuals may be members that are also currently going through postpartum

depression. Alternatively, some programs have designated peer facilitators or mentors trained for the role. Typically, they have lived experience of postpartum depression and their personal experience allowed them to “offer some depth of understanding to others in similar positions” (Biggs et al., 2019).

Research reflects that being in a support role has a positive impact on facilitators as well (Leger & Letourneau, 2015). These peer supporters have reported “feeling like [they’ve] made a difference to someone” (Biggs et al., 2019). Their support prevents individuals from feeling like “[their] mental health is suffering because of missing connection[s] with other first-time moms” (Benoit et al., 2023). Overall, peer support has “an expansive capacity for healing that encompasses not only the [peers]... but also the larger community in which they live and work” (McKimmy et al., 2023).

Enablers and Modality

Despite similar rates of depressive symptoms and perceived social support between rural, semi-rural and urban participants (Ross et al., 2011), the lack of infrastructure in rural communities and inequities in formal services can create vulnerabilities for birthers that are affected by PPD. Furthermore, individuals may face difficulties in setting up informal services in these communities. For example, when taking initiative to set up a perinatal mental health peer support group in rural, northern England, the individual initiating the group was told “there was not enough need due to the sparsity of the population” (Jackson et al., 2020). Virtually administering a peer support program, through telephones or online, can be used to overcome limited need within sparse populations and increase accessibility and sustainability of PPD support (Lingley-Pottie & McGrath, 2007).

Additional benefits of remote administration include reduced cost to the participant and to the system (Singla et al., 2021). The reduction in cost of transportation and childcare can increase accessibility for people in rural communities, immigrants, refugees, or people that face difficulties with transportation when accessing social support or healthcare (Higginbottom et al., 2016). Accessing remote peer support has also been described to be less intimidating and more private which may allow participants to feel self-assured with increased autonomy (Lingley-Pottie & McGrath, 2007).

Some challenges and inequities exist with the use of remote peer support. Participants of a study conducted in Nova Scotia during the COVID-19 pandemic did not see virtual connections to be equivalent to in-person connection and support (Benoit et al., 2023). One participant

explained that “while text messages and phone calls help, it’s not the same.” In addition, although virtual administration increases accessibility for some individuals, due to it being contingent on access to stable internet connection or cell phone reception, it may not be a viable option for some rural and remote communities. In a narrative review of peer support interventions, findings suggested peer support should be targeted by taking into consideration personal factors such as age, culture, language and circumstances/needs (Leger & Letourneau, 2015).

When contemplating the needs of a participant, another challenge for peer programs is managing the end of the relationship. The perinatal period is a time of intense life transitions and the sudden loss of support, after they are deemed no longer “postpartum” may be difficult for the participants. During a study of support from volunteer doulas throughout the perinatal period, a third of the participants noted that the support ended too soon (Spiby et al., 2015).

While research has traditionally focused entirely on the effectiveness of peer support on reducing depression symptoms, there are also implications for influencing ongoing after-effects of depression. An ongoing trial in the Calgary health region is currently evaluating the effectiveness of peer support on increasing gestational age at delivery, which will provide insight on changes to incidence of preterm birth (Chaput et al., 2023).

Application of the 12-Step Framework to Perinatal Mental Health

Currently, there is a gap in the literature surrounding the evaluation of 12-Step programming as applied beyond substance use disorders. Although the program has been widely adapted to other contexts, most of the literature written about the 12-Step method has been centred around the largest 12-Step program, Alcoholics Anonymous. In recognizing the fundamental differences between substance use disorders and mood disorders such as postpartum depression, and the need for research which explores the application of 12-Step programming to social, emotional challenges, we hope that our thorough evaluation of this pilot project will contribute to closing this identified gap.

While many groups centre their work around compulsive behavior and addictions disorders, other 12-Step groups have been adapted to address mental and emotional wellbeing, such as Depression Anonymous, for individuals dealing with depression, Emotions Anonymous, for individuals seeking to better understand and control their emotions, and Al-Anon, a recovery group for the family and friends of alcoholics.

Peer support groups that use the 12-Step framework are based on authentic relationships between group members who share a similar experience and desire to solve their common challenge and help others recover as well (Alcoholics Anonymous World Services, 2017). Emphasis is put on serving other members of the group and helping fellow peers stick to their wellness journey through sponsorship, individual growth, and sharing stories about their experiences (Donovan et al., 2013). This is applicable to those struggling with perinatal mental health challenges, where being in community with others who have experienced and moved through mental health challenges is essential to coping (Kamalifard et al., 2013).

Postpartum depression and postpartum anxiety are neuro-physiological conditions, brought on by various causes including rapid hormone changes following birth, and require at their core, professional clinical and counseling support. Although the 12-Step framework provided an established guide for peer support, we acknowledge the difference in etiology of the conditions the 12-Step framework has historically addressed and those we have applied it to. However, in conjunction with standard treatment, peer support for individuals with postpartum depression and anxiety has been shown to have positive results, and we have clearly expressed the adjunctive nature of the peer-support group to potential participants, as demonstrated in the program evaluation.

Our previous research experience in Golden, BC, combined with the research evidence on both the vulnerability of and need for increased perinatal health resources, led us to focus on a rurally adapted, inclusive model of peer support. A description of our process and outcomes are presented below.



Project Objective

The convergence of the need for mental health services in rural communities, low-barrier care that meets the needs of vulnerable populations and recognition of the value of peer support as an adjunctive modality to professional health and social service care, we developed a plan to co-create a community-driven model for perinatal peer support. The process was equally - perhaps more - important as the outcome, as we sought to be responsive to a range of needs that were not currently being met through standardized programming. We needed an authentic and inclusive community-driven process to do this. We adapted a well-established peer-support framework, the 12-Step Program which, although grounded in supporting recovery from substance addictions, has been adapted to support people affected by mental health conditions including depression, thoughts of self-harm, and eating disorders, as well as support people affected by someone else's disease of addiction or compulsion.

Through collaborative work with key partners, we emphasized the need for a decolonizing, low-barrier lens with the objective of application in rural, low-resource settings. Co-creation of the model with those who have previously felt marginalized from mainstream programming was essential to maintain fidelity with the needs of this community. Soliciting their experience of both the program structure and their engagement with and by the research team was essential to maintain authenticity of goals and objectives and validate the intention of 'scale and spread' to other communities.

Project Goals Accomplished

We began this project with the hope of designing a program that was responsive to the pragmatic and community-identified needs of rural birthers. What resulted was a rigorously established framework and the development of comprehensive program literature and recruitment materials, including an active website and email list. Each of these outputs was thoughtfully created by the wider team, including input from the advisory committees and program attendees. The PDA universe has specifically been designed to be expandable and adaptable to diverse contexts, with minimal required resources.

A detailed discussion of project goal and objectives are broken down into three phases below: Community-Based Co-Creation of the Framework and Adaptation of the Peer-Support Literature, Pilot Application of the Postpartum Depression Anonymous 12-Step Program, and Evaluation of Peer Support Framework for Perinatal Mental Health.





Pre-Phase I: Project Planning

Project Initiation

As a part of launching the PDA project, our team underwent a process of applying for and receiving ethics approval for the research component of the project, from UBC's Behavioural Research Ethics Board. To submit for ethics, we prepared and compiled all outreach materials for the research project (recruitment posters for Community Advisors as well as program participants), letters of initial contact and a Terms of Reference agreement for the Advisory Committee, and interview guides for the project evaluation interviews. The public-facing presentation of the project was important to the team and the community researcher spent time developing the right "look" of promotional material. Ethics approval was granted on **May 26th, 2023**. We also underwent a process of requesting **Intellectual Property Approval** from the Alcoholics Anonymous World Service, to adapt the 12 Steps and program framework. Approval was obtained on **May 17th, 2023**.

Human Resources

The core project team was onboarded following ethics approval and the release of grant funding. Audrey Cameron was hired as the program Research Coordinator, April Hards as the Community Co-Lead Researcher, and Simrat Dial as a student Research Assistant through UBC's WorkLearn program. In December 2023, Payal Parti was contracted as a temporary Research Assistant to contribute to the Program Evaluation. All four members of the team held prior experience working at the Centre for Rural Health Research.



Phase I: Community-Based Co-Creation of the Framework and Adaptation of the Peer-Support Literature

Establishment of Advisory Committees: Interfacing NGOs and Health Systems Planning

The initial **PDA Community Advisory Committee** was established, as per our original grant proposal, to guide the direction of PDA framework adaptation and implementation through sustained citizen and community engagement. Involvement of community partner voices and Indigenous voices and practices was crucial to the success of not only our research, but the development of an effective and inclusive peer-to-peer support program. To this end, we recruited seven advisors with varied experiences of perinatal mental health challenges themselves, as well as representatives of existing local social service organizations. The intentionality and meaningful engagement of the advisors, representing a diverse array of lived and professional perspectives, was a critical source of the PDA program's success. Over the course of the project, we held 5 Advisory Committee meetings (June 14th, July 20th, August 17th, September 28th, and December 14th). Meetings were oriented around reviewing specific pieces of literature, with iterative adjustments made to meeting agendas as relevant conversations arose. On occasion, individual meetings were held with advisors when they were unable to attend a group meeting, to ensure equivalence of contribution. We were committed to fully engaging the minds, hearts, and wisdom of our community advisory committees and to taking immediate action to implement and actualize their feedback, ideas, and suggestions.

Specific contributions of the Community Advisory Committee included:

- In depth, content-based feedback on program literature (including the PDA Booklet and Workbook);
- Suggestions on augmenting program inclusion for neurodivergent birthers through the use of bionic text (bolding the most important parts of significant words to guide the eye and maintain attention), attention to plain language, and increased visual components;
- Reorienting literature to centre “we” and “our” statements rather than “I” or “you” language to increase a sense of community and shared experience;
- Making clear in recruitment materials that the group is open to all individuals who have experienced mental health challenges in the perinatal period, not just those within the “typical” window of up to 1-2 years postpartum. This opened the group to individuals who may not currently be *in* the perinatal period, yet are looking for individuals to process their experience with, and who can share lessons learned with peers who are at earlier stages;

- Identified a need for further program literature that expands on each of the 12 PDA steps.

12-Step Advisory Committee

Feedback relating to the need for further context on the PDA program *steps* led to the development of the PDA Workbook, which guides participants through each of the 12 Steps. We recognized the importance of including input from Advisors with lived experience of accessing and using 12-Step programming. Three 12-Step Advisors were recruited to this committee, with advisors holding a collectively four decades worth of experience in 12-Step programs and service positions. As such, each was well-versed in traditional 12-Step literature and well-positioned to speak to the Framework and literature's existing gaps. The 12-Step Advisory Committee met four times between August and November 2023. Advisors reviewed both the PDA Booklet and the Workbook and provided line-edits to both. Further, discussions from these meetings were crucial to the effective development of the PDA Guide to Spreadability and Services.

Specific feedback from this group led to the development of **Newcomer Info Sessions**. 12-Step Advisors shared that in their experiences, it can take up to 2 years to develop a consistent participant base when starting a new program. In order to increase the no-barrier nature of our meetings, we launched a weekly 15-minute Newcomer Info Session prior to the PDA meeting, where interested members of the public are welcome to come to learn more about the program. This is designed to create a low barrier space for newcomers where they can ask questions and get a feel for the program without feeling obligated to attend a full meeting. This is reflective of the PDA invitation to participants to engage with the program “in your own time and in your own way.”

12-Step Framework Adaptation and Development of Program Literature

The PDA Booklet

A core component of the 12-Step framework adaptation was the development of program literature, including the PDA Booklet. This booklet includes segments such as Welcome to PDA, Mission Statement, About Postpartum Depression, the 12 Steps of PDA, and introduced guidelines to keep meetings safe and healthy (Appendix 3). The Booklet went through several rounds of edits within the PDA project team, as well the Community Advisory Committee, and the 12-Step Advisory Committee. Based on their feedback, a Bionic Text version of the Booklet is also available online. The PDA Booklet is our most accessed piece of literature and is what guides weekly PDA meetings, along with the PDA Meeting Script. The Booklet, like all PDA literature, is freely available via the PDA website.

A key section of the Booklet is the **Intervention and Crisis Traditions**. These guidelines were developed following interviews with Social Service Sector partners interviewed during the Program Evaluation (see Phase III). Through these conversations, we as a research team recognized a need to develop clear and straightforward guidelines to addressing crises or instances of harm identified or discussed during PDA meetings. The Intervention and Crisis Traditions take a peer support approach to anonymously and respectfully addressing crises, including approaching the individual of concern first and working with them to reduce potential for harm, identifying needs, and responding with appropriate resources if needed.

PDA Meeting Script

The meeting script (Appendix 4) was created so that in each PDA meeting, the format remains consistent. Members come to know what to expect and newcomers gain a better understanding of what goes on in the meetings prior to attending. Additionally, the Script guides the topic for each week's meeting.

PDA Workbook

As noted above, feedback from advisors continued to be integrated into the PDA literature through the course of the project. The PDA Workbook (Appendix 5) was finalized in October 2023 and made available to PDA participants via the PDA website. As of January 2023, the Workbook will be used to start PDA's first Step Circle, where interested participants will work through the 12 Steps intentionally as a group. This piece of literature gives concrete guidance to participants who are working through the 12 Steps of PDA. A Bionic Text version of the Workbook, tailored for neurodiverse participants, is available on the website. The Workbook was heavily informed by the guidance of the 12-Step Advisory Committee.

PDA Guide to Scalability and Services

The Guide to Scalability and Services (in progress) is a forthcoming document that is being designed as a reference resource for PDA collective members. The Guide outlines how groups are run, how to host a meeting, and how to tailor meeting formats to individual communities. It also speaks to the future forward lens of the PDA collective. It is detailed, to ensure that all members and potential group hosts are hearing the same message and operating the same way. This document is designed to help unify the collective and ensure that as the program grows, all members are experiencing the same structure and values, no matter where they are attending a PDA meeting. As this document is still in draft form and has not yet been reviewed by the advisory committees, it is not public facing. It has been attached as an Appendix for reference (Appendix 6).

Program Branding

Along with program literature, a PDA Logo and recruitment posters were developed, focusing on branding consistency across handouts, the website, and the literature. Recruitment materials have been posted around the pilot community as large posters, distributed as postcard sized handouts, and shared online as virtual images (Appendix 7).

PDA Logo





Phase II: Pilot Application of the Postpartum Depression Anonymous 12-Step Program

Program Recruitment and Outreach

Recruitment and outreach processes straddled both physical and online environments. PDA posters have been hung in public areas in the pilot community, in the birthing suites and maternity recovery rooms in the local hospital, on community bulletin boards, and in local resource centres. Additionally, we partnered with “Books for Babies,” a program run by Columbia Basin Alliance for Literacy and accessed through the public health nurse in the pilot community, such that each new parent in the pilot community now receives a PDA postcard inside their Book for Babies packet.

Online recruitment was targeted towards rural communities in BC, through local community information and resource social media pages, as well as through Facebook pages that reach birthers and new parents specifically, such as Midwifery collectives, doula groups, and perinatal education pages. On public pages, we posted the content directly, and for private pages, we contacted page administrators to request they post the PDA social media posters and captions on our behalf. Though our targeted recruitment efforts focused on under-resourced, rural communities, PDA meetings remained open to all who were interested in participating, including those from urban settings.

PDA Website

In order to begin recruiting participants to the peer support group, we designed and launched a website in July of 2023 where individuals could sign up for a weekly Zoom meeting link, as well as download the PDA Booklet and Workbook and read more about the program. We developed an automated mailing list that participants could opt in to if they wish to remain connected to the program. As emphasized in our Mid-Project report, PDA is committed to delineating peer-to-peer support as an *adjunctive* mechanism of care. Our website reflects this commitment, with a text box encouraging individuals to seek emergency care if they are experiencing a mental health crisis. The text on our website is formatted using bionic text, as suggested by our Advisory Committee. **Since August 2023**, we’ve added several pages to our website, including information about our approaches to diversity and cultural appreciation and a Q&A page where interested community members can learn more about the program. The Q&A page was developed through responding to questions presented by individuals interested in PDA, as well as other programs in the province. Additionally, the website includes a guide to the 12 Steps of PDA, an info page for care providers who may be interested in referring patients to the program, a participant feedback page, and a tab dedicated to guiding interested leaders in starting their own PDA groups. Future groups will also be listed on the Meetings page.

Eventually, our hope is that new PDA participants will be able to choose from multiple meeting times, dates, locations, and modality (virtual, in-person or hybrid) and find one that best fits their needs.

■ Website Hyperlink: <https://www.pda-support.org/>

PDA Support Group Meetings Application

PDA Support group meetings were launched at the beginning of August 2023, and have run consistently for the last 5 months. Meetings are hosted by our Community Partner, April Hards, and chaired by a rotating PDA peer volunteer. Each meeting is guided by the PDA Meeting Script, has a focus area of the week, and is connected to a selected excerpt from the PDA Booklet. The majority of the meeting time is protected for participants to share how they are doing and to connect with one another. As laid out as an expectation in the PDA Framework, confidentiality and respect are cornerstones of the program. Participants have thus far been respectful and appreciative of the group safety and confidentiality policies outlined in the material and meetings. This is of specific importance to participants in small rural communities, who may know one another outside of meetings. As meetings continue to run into the future, we are committed to continuing to respond dynamically to suggestions and feedback surrounding inclusivity and accessibility.

Meetings continue to be open to participants who identify as having experienced mental health challenges in the perinatal period, no matter how long ago they were pregnant or had a child. This lack of an exclusionary timeframe is a quality that sets the PDA meetings apart from other programming.

PDA Meetings are held on Zoom on Wednesday nights, with the 15-minute Newcomer Info Session preceding the gathering. So far, there are four regular participants who attend meetings, and 14 people have subscribed to the PDA email list. While uptake has been slower and lower than we had originally anticipated, based on the need identified by community members in previous projects, recruitment is ongoing, and conversations with Advisors and social service sector partners interviewed during the Program Evaluation phase suggest that it may take up to two years to develop a robust participant base. In these early days, we have been reminded of the importance of consistency and reliability in holding weekly meetings, even if no participants were able to make it. This created space and opportunity for newcomers and was crucial to developing trust with participants.

Following the conclusion of SPARC funding on January 10th, 2023, the PDA Peer Support group will continue to run. The program has reached a self-sufficient stage and will continue to be

hosted by the Community Partner, April Hards. Future funding opportunities may enable the thorough scale and spread of the program.

Obstacles and Project Adaptations

Over the course of this nine-month project, adjustments have been made to iteratively adapt and respond to obstacles encountered, as well as community needs and advisor and partner feedback.

As noted, one challenge faced was overall slow rates of subscription to the PDA group. Given the relatively short timeline of the project, and the consequential need to establish the program in a truncated time frame, we responded by expanding our inclusion criteria and recruitment efforts beyond the pilot community to reach birthers from neighboring rural communities. Expanded recruitment efforts were also encouraged by advisors, who were interested in sharing the program with friends from other communities. Our recruitment strategy remained focused on reaching under-resourced birthers from rural communities, though groups were open to any participant that was interested. This expansion of recruitment and inclusion criteria was enabled by the virtual delivery of the PDA pilot program.

Given the small number of regular PDA participants, we decided to forgo the project-evaluation survey that had originally been planned. Instead, we added interviews with social service sector program leaders to the evaluation dataset and focused our program evaluation on interview data from participants and advisors as well as the social service sector partners (see Phase III below).

Adjustments were also made to the project staff team. While we had originally budgeted funds to have interview audio recordings transcribed by an external transcription agency, extending the contract of our student research assistant enabled us to negate expenses originally budgeted for transcription. Our research assistant was able to use Zoom auto-transcription software to create a draft of the interview transcripts, and then performed thorough quality assurance edits on each transcript. Additionally, she supported visual knowledge translation, led the project background literature review, and supported online recruitment efforts.

Secondly, we hired a second Research Assistant to support data analysis during the Program Evaluation phase (December 18th - January 10th, 2024). To augment efficiencies, we contracted a research assistant who had prior experience working with CRHR, and who was already familiar with the PDA project. This allowed her to dive into the work with minimal need for orientation and education.

Finally, as expanded on above, after identifying a need for the further inclusion of individuals with lived experience of 12-Step programming, we recruited three 12-Step expert advisors to a second advisory committee. This committee heavily informed the development of the PDA Workbook.



Phase III: Evaluation of Peer Support Framework for Perinatal Mental Health

The final phase of this project was the program evaluation, informed by program end-users and advisors. Findings from interviews with these participant groups were supplemented by interviews done with social service sector partners from various organizations across BC, working in similar mental health spaces. We saw this addition as an essential part of partner development in the social service space and a bridge to collaboration, both by providing ancillary resources to agencies taxed by client demand and by building relationships that would enhance common goals and objectives.

Methods

The evaluation was done through data from open-ended qualitative research interviews to understand the efficacy of the adaptation of the 12-Step framework to the perinatal period. This evaluation was conducted in accordance with the guidelines and regulations of the University of British Columbia's Behavioural Research Ethics Board (Ethics ID: H23-01645).

Setting and Participants

We sought to understand the perspectives of three essential groups: peer PDA participants, PDA advisors, and social service sector partners working in similar support contexts as the PDA program. All PDA participants and advisors were invited to participate in a research interview with the project evaluation team. We expanded our inclusion criteria to include social service sector partners working in perinatal mental health and peer support spaces across British Columbia as we recognized the importance of understanding the interface between peer support groups and existing services. This enabled us to situate the findings from the PDA participants and advisors within the larger context of peer support and perinatal mental health in British Columbia.

Data Collection:

Data was collected in October and November of 2023. Interviews were conducted virtually over Zoom. All interviews were co-led by the project team. Prior to the interview, participants were sent a consent form to review. Participants were given the opportunity to ask questions before the start of the interview, and then gave verbal informed consent to participate. Interviews where consent was granted for audio recording (11/13) were transcribed and underwent a thorough quality assurance process. Where permission for audio recording was declined, detailed notes were taken by the research coordinator (AC) for the process of data analysis.

Data analysis:

Data was analyzed separately by both an academic researcher and the community research partner. Methods of analysis diverged, as explained below. Nevertheless, themes generated through both processes and methodologies yielded a high level of congruency, pointing to their validity.

Academic Researcher Data Analysis Methodology

The academic researcher reviewed four transcripts that were representative of the different participant datasets. Once well-versed in the data, a hierarchical coding framework was developed. “Codes” were generated by disassembling the data into “discrete units” and then reassembling the units into meaningful groupings, following the process of thematic analysis described by Castleberry and Nolan (2018). The codes in the codebook were grouped by high level ideas, or *themes*, allowing the academic research team to interpret and capture patterns in participants’ experience (Castleberry and Nolen, 2018).

This codebook and the identified themes were reviewed by the team and adjustments were made until consensus was reached. The codebook was then uniformly applied by the academic researcher across the dataset.

Community Research Partner Data Analysis Methodology

The community research partner took a different approach, by reading and marking up hard copies of interview transcripts and taking notes in a journal of things that stood out to her. Through this process, common themes became obvious. From this point, she allowed the formation findings to form into solid thoughts and began writing. As she is a member of the community of interest, there were often times where free flowing conversations occurred outside of interviews and advisory meetings, so using her notes as a guide ensured she did not miss or include anything that wasn’t in the transcripts.

As a team, we recognize that the differences in our processes of data analysis embody the essence of the diverse perspectives represented on our blended community-academic research team. As such, these differences are a strength of our interpretive process (Hards, 2022). Despite diverging analytic methodologies, there was close alignment in the themes generated by both researchers, for each of the participant group datasets. These themes are explicated below.



Findings

Through the course of the PDA Project Evaluation, two PDA peer participants, four PDA advisors, and seven social service sector partners were interviewed. The findings from each of the three sets of interviews are presented below.

Findings from Participant Dataset

In analyzing the *PDA participant interviews*, the research team identified two major themes: factors that attracted peers to PDA and PDA group experiences. Within PDA Group experiences, salient subthemes included a) experiences of connection and safety, b) 12-Step framework efficacy, c) peer facilitation, and d) accessibility of virtual meeting delivery/modality.

Attracting Factors

In discussing what drew them to the PDA program, participants identified “peer support” as having the potential to fill a gap in the care and support they experienced in the postpartum period. This was seen as particularly important for participants in rural communities, where distribution across complex geography and low population density can exacerbate feelings of isolation. One participant shared, “Maybe it takes half an hour just to drive into town. And when you have a newborn, that's a lot of effort that maybe...it's too much to do.” This resulted in an increased sense of aloneness during an already difficult time. Peer-to-peer support was identified as one strategy of combating feelings of isolation, through connecting with peers who have similar lived experiences.

One participant recognized their need for more support after speaking with a friend and acknowledging that they had been exhausted for two years as a parent. This realization led to joining the PDA program to access additional supports and to connect with others experiencing the same challenges.

Another participant contrasted their experiences in the different rural communities they had had their children in, and the varying levels of support they'd felt from the healthcare systems and resources available in each town.

“In [community where I had my first baby], the health nurse walked me to the mental health unit and got me signed up, whereas [in second community] they gave me paperwork to fill out. And I never did.”

Having a second child in a community with fewer resources and less capacity for wrap-around care resulted in a significant difference in postpartum experience and wellbeing for this participant, and ultimately led to a desire to seek out peer-to-peer support.

Group Experiences

Participants discussed their experiences of the PDA group itself, touching on the sense of connection they experienced, their perception of group safety, the structure of the group, and its format as an online program.

Sense of Connection and Safety

When speaking about the impact PDA had on their mental health, peers highlighted the feeling of connection they experienced after attending PDA meetings. They reported that listening to other participants share their stories, being reminded that they are not alone, and contributing to supporting others resulted in significant benefits to their own mental wellbeing.

One participant shared, “It’s definitely really nice to share and be seen and know I’m not alone. So yeah, even after attending the first meeting I felt way better. It was wonderful.” Another expressed,

It has had positive effects for sure. I think it has helped me to form that supportive community. And it has given me an outlet to take a moment to pause and to not only just to show up for myself, but to show up for the other humans that are in the meeting.

Being able to support other parents themselves, even if they were still struggling, also had positive effects on participants’ own wellbeing. “It feels good to be able to support other people too. I think that’s been big for my mental health. To know that even if I’m going through something, I can still be there for somebody else.” As peers, offering support resulted in feelings of enhanced self-efficacy and positive self-regard.

Participants also touched on the importance of *safety* in peer-to-peer support settings and expressed feelings of comfortability and security within PDA meetings. Despite being piloted in a small rural community, with diminished likelihood of anonymity, participants reported feeling comfortable sharing what they needed from the group, and that they trusted the expectation of confidentiality laid out by the PDA framework. One participant explained, “I feel like privacy is very much honored in that space. It feels like it’s almost like a sacred thing. Like you, you don’t mess with that.” For both participants, the values explicated in the PDA framework and reiterated in meetings created a context of safety and security, bolstering their comfortability with sharing their experiences and not holding back with the group.

Participants did associate some of their confidence in the group's confidentiality with it being a *small* group, and wondered if they'd feel differently as the group continued to expand. That being said, participants also were invested in the idea of a larger group, sharing, "I also understand that having more people is more supportive in some ways."

12-Step Framework Efficacy

Speaking directly to the adaptation and use of the 12-Step framework, participants expressed interest and curiosity around the selection of the model, and an overall positive perception of how the framework has structured the program. When asked if the 12-Step framework created any hesitation, one participant replied, "It actually kind of did the opposite. I was more intrigued by it...I found it interesting, the comparison, what my knowledge of what a 12-Step program is and what postpartum is. It felt intriguing."

PDA participants shared they understood there could be stigma associated with the 12-Step Framework, but that they weren't sure how this would impact someone's desire to participate or learn more about the program. Taking a different perspective, one participant noted that though a 12-Step framework might carry some stigma, the fact that it is associated mainly with substance use disorders in fact added some weight to the difficult experience of postpartum depression and anxiety. They noted,

"I think it's also kind of validating too...addictions feels like a huge thing that you need the support of a 12-Step program. So, to say that for postpartum depression...you should have access to a 12-Step program, is kind of like, oh yeah, cause it is a huge thing. And it is significant in how it affects your life."

For this participant, the adaptation and use of the 12-Step framework contributed credibility and gravity to the public perception of perinatal mood disorders and related mental health challenges in a meaningful way.

Participants did note a few changes to the program structure they'd be curious to explore, including integrating more of a talk back and discussion time following other participants' shares. Nevertheless, participants reported that they had the opportunity to share everything they wanted at meetings. Slow uptake in peers stepping into participation roles was noted and associated this with the newness of the program and a hesitancy among peers of overcommitting during a tumultuous stage of life.

Comfortability with PDA Literature

Participants shared that PDA literature was effective at validating their experiences and helping them feel recognized and understood. The literature was described as “beneficial,” “affirming,” and “accessible.”

One participant noted that though she had an idea that she might be experiencing postpartum depression, reading through the PDA website helped to validate her experience. She explained, “There was a paragraph about, ‘I recognize that... things in my life have blown out of control,’ and a few things and I was like, oh yes, every statement, yes, yes, yes, okay, this feels like me.” For this participant, reading through the literature helped to remind her that while her experience may not be “normal,” they are common, and that she was not alone.

Regarding the accessibility of the literature, one participant shared that looking at the literature did initially feel overwhelming, and that “there was a lot to go through,” but that other than that, it was “pretty straightforward.” Another participant shared that she’d like to engage with the literature further herself. She explained, “I feel like I haven’t really delved into it as much as I would like. So maybe having it as a book study or a circle or something like that would get me more invested into the literature.” Participants suggested that a bit more structure in working through the 12 Steps would be helpful and might provide an opportunity to measure their progress and growth.

Overall, participants enjoyed reading through the PDA materials and referenced specific readings such as “In This Moment,” as particularly helpful. Finally, participants noted that having the PDA literature and structuring group meetings around the written materials helped to set the flow and intention of the meetings in a beneficial way.

“It creates that ritual at the beginning of a meeting. Like when you start talking, it’s not just a gab, we’re here for a purpose. So having the literature at each meeting reminds me of that.”

Peer Facilitation

Participants also discussed the structure of PDA as a peer-to-peer support group, facilitated by peers rather than professionals. Participants acknowledged strengths in each approach, but ultimately reported they’d chosen a peer-to-peer group intentionally, finding the format to be less prescriptive and more relatable. Peers valued knowing that everyone in the room came to the collective with shared lived experience.

Relying on peer facilitation also led to increased participant buy-in and engagement. As one participant explained, “I feel like peer-to-peer, as a participant, it gives you more ownership.

Because you have to show up for you, not for somebody else. It's kind of amazing to be heard and supported by people who are going through a similar process as you."

For one participant, the peer-to-peer structure more closely reflected an experience of being supported by "sisters or friends in the community," or by individuals who know their personal and family context, rather than a professional who is less familiar with participants on a personal level. Peer-to-peer support was described as "you showing up for you" rather than to meet the expectations of a professional.

Regarding the level of support offered by peers, one participant shared, "I'm quite comfortable that it's just peers. I have enough respect for the peers, of like their experiences in life and their professions that if I feel like counseling was needed, that would be something else, not the peer-to-peer group."

Despite preferences for peer-to-peer support, participants acknowledged the value of professionally facilitated and clinical support when it is needed and recognized that the two models have different levels and scopes of care. Neither participant found that one form of support must replace or exclude the other.

Meeting Modality

Participants provided helpful feedback on the roll-out of PDA meetings online, agreeing that virtual meetings allowed for more flexibility and convenience, especially for participants with young children. Nevertheless, participants also expressed a real desire to meet with peers in person. "I would probably prefer in person," one participant shared, "but the convenience of having it available online is huge, when you have kids and a job."

While connecting in-person was seen as most conducive to building relationships, participants worried that weekly in-person meetings would be logistically "unrealistic." As such, a hybrid or mixed model approach was suggested as an ideal format, with both virtual and online options available.

Finally, participants touched on their hope for the program moving forward, including options for more meeting times in general, to reduce availability conflicts and enable more participants to attend. Ultimately, participants shared they would love to see the group grow, though recognized the challenges specifically with recruiting people who are dealing with mental health challenges. As one shared,

“I think the hardest part is just getting people to come. Like even if they are available, I feel like there's that initial big hesitation for many reasons. Yeah, as much as I can say ‘you should come to this,’ you know, I can't make them.”

Findings from Advisor Dataset

In the second participant cohort, four *advisors* were interviewed, representing both of the PDA advisory committees. Advisors spoke to both their experiences of working on their respective committees, as well as shared overarching feedback on the PDA program as a whole. Findings from these interviews are broken into four major themes: significance of peer-to-peer support, advisor experiences, perception of PDA, and PDA scale and spread.

Importance of Peer Support

Across the advisors interviewed, each expressed respect and admiration for the power of peer-to-peer support in providing authentic, empathetic, and trustworthy support. For many, this was due to the way that peer support “models community” and helps to combat isolation. Advisors noted that reassurance can come from even just going to sit in peer-to-peer support spaces, when one does not have the capacity to talk or actively participate.

“Nothing beats that peer support model where you can fully be honest and completely truthful with that peer. And they can understand you because they're literally going through probably the same thing.”

Another advisor stressed the value of connection and the power of normalizing one's experiences, sharing,

“People who are struggling need that connection. They need the community and need to know that it's normal. And that what you're going through happens a lot and you're not alone. And I mean, your doctor can tell you that, your therapist can tell you that, but to actually go and talk to other [people] that are also struggling is a totally, totally different thing.”

Within the advisory group, advisors spoke of the importance of a peer-to-peer support group in filling a gap in their own communities. One participant explained,

“There are posters and the phone numbers you can call if you're feeling sad or you're suffering from postpartum. But there's never been anything strategically vocalized in the

community. I had two babies here, and essentially the only thing that was ever brought forward to me was ‘make sure you come for immunizations.’”

Advisor Experiences

With regards to their *own* experiences, advisor interviews revealed three subthemes: attention to impact on project development, personal learnings and growth, and satisfaction with the group process.

Impact on Project

Advisors reported feeling encouraged and empowered by how their suggestions for program adjustments were received, appreciated, and incorporated into the project. As one shared:

“It was a real honour to be a part of this process. I feel like it was very forward thinking and the way that many programs should be developed. I love the shifts in language that have been brought forward and accepted. The ability to speak candidly and freely without judgment is very unique to this group. As much as other [programs] say they do that, it's not always the real way it works. I really liked the diversity of [people] that were involved in the process, having the lived experience.”

Advisors noted appreciation for the way that all voices were equally heard and respected on the advisory committee, no matter the background of the advisor. This was seen as also unique to the PDA Advisory Committee process, with one advisor explaining, “Sometimes folks who don’t have a “professional” [quote unquote] role in life can get brushed under the rug as ‘just one person's opinion,’ but here that ‘just one person's opinion’ was valued and utilized.”

Personal Learnings

Advisors reported that their involvement on the PDA advisory committee and their engagement with the literature and materials, even as an advisor, had increased their own self-knowledge and had personal effects on their life. One advisor shared,

“For me in particular, there were some real moments of realization...that perhaps I too have struggled with the postpartum pieces and that the system isn't, you know, up to snuff. And that was really interesting for me and took me on a bit of a journey myself in terms of my own mental health and wellbeing.”

Another participant shared a similar comment, expressing gratitude for the program and her advisor role, sharing of their own postpartum experience, “Thank you for bringing us [advisors] to the PDA space too. Because I could have used it 50 years ago.”

In other instances, advisors noted that their work on the PDA committee had influenced them in other spheres of their life, reinvigorating their attention to inclusivity and accessibility.

Satisfaction with Group Process

Advisors also had positive comments about the Advisor group *process*, reporting that the committee represented a diversity of perspectives, with vast lived and professional experiences, which brought value to the project. One advisor contrasted her experience on the PDA Advisory Committee with past experiences of feeling like a “token” representative, rather than a true collaborator in social program development. As such, her experience on the PDA Advisory Committee felt like true “actualization” of an inclusive and diverse advisory board:

“To actualize it is what we did. To not, and say you did, is to sort of invite people to the table and then hear what they say, but not listen to what they say. And not take their perspectives seriously and continue to move forward on the trajectory that you essentially have in the first place. I find that often there’s that token gesture of ‘Oh, let’s have lived experience at the table, but we’re gonna carry on and just do what we’re doing anyway... We can tell everybody that we have lived experience at the table and we can pat ourselves on the back about it.’ And that’s really frustrating for me when that happens.”

Others expressed that they felt the committee itself created a sense of community and that the conversations held within the context of program development left them feeling heard and valued.

“It was an absolute honour, and it was my first experience on an advisory council. So, I’m like, ‘Oh god, if they, I hope they’re all like this if I get asked again.’ So, thank you for making my first experience through a process like this so enjoyable and eye opening. It was wonderful.”

Another shared of their experience: “I enjoyed being able to partake in it and hear people’s opinions and also share my opinions. I feel like we did take giant steps forward with it and it’s gonna help a lot of people.”

Perception of PDA Accessibility and Inclusivity

In discussing the PDA program specifically, advisors discussed several factors they saw as contributing to group inclusivity. These factors fell into four thematic categories: accessible

language, broad inclusion criteria, attention to cultural safety, and equitable outreach and recruitment efforts.

Accessible Language

Speaking to PDA literature, advisors voiced appreciation for a strategy of taking what works from the 12-Step framework and leaving the rest behind. Particular changes that were highlighted included changing singular language in program literature (“I”) to group language (“we”), in order to reinforce and honour the collective experience of participants and to actively combat the isolation and stigma often associated with perinatal mental health challenges. One advisor explained, “The lack of judgment that’s built in...I think is going to work really well.”

Others highlighted the importance of PDA literature that is tailored to neurodiverse birthers, a suggestion originated by an advisor who is neurodiverse themselves. This was also seen as a strength of the PDA group process, given that advisors viewed many programs as not created with low-level literacy or plain language in mind.

Inclusion Criteria

Advisors also touched on the broad inclusion criteria of PDA, noting specifically the value of a program designed to welcome birthers at any point in their perinatal journey, not limited to immediately after birth or the early years of a child’s life. As one advisor noted, “I was just talking the other day about the ability for people to access this program down the line... that it can continue well into your entire life as a mother...I think it’s just remarkable.”

Others voiced appreciation for the openness of the program and the lack of specific inclusion requirements, such as being a cis-woman, having a living child, or being a biological parent. One advisor noted, “I think [PDA] could be useful for everyone.”

Another expressed appreciation of PDA, and for efforts made by the PDA team and advisory groups to not “leave anyone behind.” The openness, and the consequential safety created through that flexibility was identified as an element missing in other social service program groups that are well intended, but not as comprehensive.

Attention to Cultural Safety

Although the PDA framework was overarchingly perceived by advisors as a positive and inclusive structure, they reiterated the importance of cultural safety, and the necessity of “walking the walk for a while before people really believe your words.” Advisors emphasized that peer-to-peer support spaces must be designed to be “culturally aware and psychologically safe,” not only for Indigenous participants, but for any participants with experience of past

harm or hurt. One advisor, with lived experience in Indigenous programming, expressed the importance of having a “charter” and values, in the form of policy and protocols to lay out what the group believes in, and what the group is committing to in a shared space. It was important that peer-to-peer support spaces be diverse and include a cross section of cultures and experiences.

Suggestions for further enhancing PDA cultural safety included compensating a safe Indigenous person for their involvement in the group, such as a knowledge holder or an elder. This would be someone “to help ground that piece, who is strong enough to say, ‘that’s not an ok comment to make,’ or ‘we’re going to let this person share this experience.’” It was important to advisors that PDA participants who are visible minorities would be able to see and ask, “Who are my people here, who can I relate to?” This in turn helps to create a context of safety.

Outreach and Recruitment

In discussing effective peer support programs, advisors also noted the importance of striving to develop outreach mechanisms that reach all birthers, including those who may have unstable internet or phone connection, unreliable forms of transportation, or who live far from town centres. This helps to ensure that birthers from diverse backgrounds receive invitations to the programs, rather than only birthers who are already connected to existing supports.

PDA recruitment efforts, such as distribution of PDA postcards through public health, was seen as an effective mechanism, as it ensured that each birther received the information, minimized the stigma often associated with perinatal mental health challenges, and routinized discussions of perinatal mood disorders. One participant shared, “I don’t know how you could find better outreach, cause you’re reaching the whole community. It’s not stigmatizing, and they’re getting it automatically.”

Further suggestions included listing PDA information at schools, in grocery stores, and through early childhood education programming, to further broaden the pool of potential participants who are reached.

Adaptation of the 12-Step Framework

Advisors also touched on the use of 12-Step framework as the PDA model, and discussed ways to mitigate any potential barriers that arise due to use of the framework.

One advisor, with lived experience of 12-Step programming, spoke specifically to the language changes made to decolonize and refresh the program. They shared, “I think it’s really

an important process that there's decolonization in all of our approaches, all of our therapies, all of our institutions... In the 12-Steps space, I think it's really needed." The opportunity to develop and adapt the program from the ground up was a welcome change to the obstacles this participant had faced in working to update the classic 12-Step program.

Advisors had positive perceptions of the changes made to the framework, describing them as "deliberate," and "bringing the past to the current." One advisor specifically touched on the political climate currently surrounding 12-Step groups, explaining, "...within the 12-Step universe, people are struggling with reframing, rewording, articulating...a more universal approach. So, I think that having things coming...from the outside and other traditional programs, it's also a good time." There was satisfaction with the PDA Advisory Group process of combining lived experience with academic, professional approaches to adapting the 12-Step framework to the perinatal period, finding that a blending of these perspectives lent credibility to ongoing efforts to create change and progress within the broader 12-Step community.

Participants did in a few instances express some initial hesitation with the selection of the 12-Step framework as the model of adaptation. One participant explained that her initial hesitations stemmed from her understanding of the historical colonial and patriarchal foundations of 12-Step programming. As a visible minority, this was concerning to her, yet found that as she read through the literature and reviewed the adaptation choices made in the PDA framework, her concerns were alleviated. She shared, "I was pleased to see there was so much intentional thought into...making it as no-barrier as possible."

Suggestions for addressing potential negative perceptions of the 12-Step framework included intentional marketing that highlights the adaptive choices made to decolonization the framework and enhance its inclusivity. Though advisors noted that ultimately the efficacy of the 12-Step framework adaptation would be up to PDA participants to determine, each reported that by the end of the project, they were comfortable with the selection of the 12-Step framework as the PDA model.

Limitations or Potential Barriers to Engagement

Finally, advisors touched on potential barriers they identified with peer-to-peer support groups in general, including challenges with slow program uptake and potentially complex language in program literature. Challenges with slow program uptake stemmed from concern with participants feeling a disproportionate pressure to participate in small groups. Having a "base" of at least 5 to 6 participants was deemed preferable, as it "allows for a person to be absent" or to show up and not feel like the "spotlight" is on them. Participants suggested that this potential barrier was less intense in online spaces, but still important to note. To mitigate this

challenge in the PDA context, advisors suggested offering “newcomer meetings” centred around an educational presentation and then a talk back time, as well as reducing the sharing time at meetings with only a few participants.

Program Scale and Spread

Advisors were eager to hear more about future plans for expanding the PDA program to other communities and provinces.

“I was home this summer and I was talking about this committee and the work that was being done with some of my aunts...one of my aunts is a neonatal nurse, and they’ve all had children. They were all just sort of blown away by it...they were like, “This is amazing. We don’t have this in our province.”

In discussing the scale and spread of PDA, program flexibility was prioritized over a “cookie cutter” approach, but the importance of having solid, consistent, and well-communicated values was emphasized. Advisors described the “most effective” support groups as specific about their scope and resistant to becoming “catchall” groups.

Advisors also touched on the timing and cultural landscape surrounding discussions of healthcare in Canada, identifying a growing normalization of mental health challenges in the public eye. This was seen as both a positive change for wellbeing in Canada, as well as a beneficial opportunity for PDA to expand and meet a growing need.

“I did have the opportunity to participate in a couple things in my life that turned out to change the world a little bit, and the timing is important. A lot of people can be working on something and then it’ll come together in a way that it really helps grow it. And I think your [program] has a great potential for that.”

Linkages with Community Partners

While some advisors suggested that partnerships with clinical and professional organizations may be helpful in growing the PDA peer-to-peer program, others reiterated the importance of being independent. As one noted, “Ideally in a perfect world, [public health] would be a great space for it--but I also feel like there's just so much red tape and bureaucracy held in that space that it can't be as organic as you want it to be...” Instead, advisors noted the value of engaging peers in individual communities to determine the needs, interests, and priorities of their communities, as well as to act as trusted conduits in recruiting interested participants to the groups.

Virtual Program Delivery

Advisors, like peer participants, discussed both positives and negatives associated with the online delivery of PDA. Benefits they cited included reducing the need for transportation and associated weather and road related challenges to accessing in-person groups, enabling parents to be home with children, and increasing the flexibility of the group. With the exception of technological barriers, virtual meetings were seen as being more accessible than groups delivered exclusively in-person. Challenges to virtual program delivery were associated with the requirement of reliable internet and access to a computer and to a safe and quiet space for peers to join the online call. Advisors agreed that as the capacity of PDA grows, the ideal solution would be to offer groups that meet virtually, in-person, and as a hybrid of the two, so that each participant can decide what modality works best for them. The 12-Step format of “chapters” was suggested as a helpful working model for PDA scale and spread and for offering groups of different modalities.

The value of orienting virtual groups around geographical communities was discussed as another potential approach. Some advisors suggested that this may help to create a “grounded feeling” even in virtual PDA groups, as participants would have shared experiences of their community.

Findings from Social Service Sector Partner Dataset

To gain insight into potential interfaces between the 12-Step PDA program and existing postpartum peer support infrastructure in BC, interviews were conducted with a third cohort, leaders of *social service organizations* offering perinatal and postpartum support programming. Programs mainly ran through regional resource centres, though also included provincial wide programs. Most interview partners were paid facilitators with some degree of professional training. Some interviewees were peers themselves, who had received facilitation training to lead groups. These conversations revealed common themes about the need for peer support and provided insight into aspects of existing peer support programs, including group structure, facilitators experiences, program barriers, and goals for scale and spread.

Need for Peer Support Programs:

Filling a Gap

Across the board, social service sector interview participants agreed that peer support is a valuable mechanism of care that fills gaps in existing systems. Some participants shared specific anecdotes about how their respective support groups were developed in response to observation of a community need or inspired by lived experience of facing gaps in support. One respondent described that in their community, even a decade ago, postpartum depression was

not commonly discussed, as “spaces were not safe to do that.” However, when the topic was introduced in peer support spaces, “the volume of conversation and the feedback and the engagement was so big and so rich.” Peer support spaces were found to be often at the forefront of addressing historically stigmatized topics.

The importance of peer support was also frequently discussed in the context of filling clinical care gaps. Some participants saw peer support as a method of addressing aspects of the postpartum experience that clinical professionals may not be able to effectively attend to due to lack of experience. In these instances, the testimony and support of peers with similar shared experiences was seen as an invaluable resource for supporting individuals going through difficult postpartum experiences. This was especially significant for individuals of marginalized communities, such as queer and trans birthers, for whom clinical healthcare environments have not been, and are not always, safe spaces.

Participants noted a growing awareness within healthcare contexts of the utility of peer support, as both a timely intermediate support to individuals waiting to access clinical services as well as a legitimate and useful stand-alone mechanism of support:

“When we first started it was, there was definitely a struggle to be respected as something that was worthwhile. We’ve really found that has shifted. We find that public health, reproductive mental health are often relying on these peer support groups as a bit of a stopgap when other supports aren’t available...[they] are really seeing the value now in peer support as a way of working with perinatal mood disorders.”

Value of Peer Support

Many participants reported that their affiliated programs had gone through significant growth since inception, suggesting a still growing need for peer support programming in the perinatal mental health space. Several reported high uptake of their programming, illustrated by groups being “always full,” and many having substantial waitlists. For one organization, perinatal peer support programming was described as “wildly popular and successful,” despite barriers to accessing groups. Given the clear needs, many participants expressed desire to increase the number of available groups running through their program and to increase the frequency of existing programming. As one participant noted,

“I would have [program] running probably four days a week if I could. I think it would be attended every single one of those days, five days maybe even...It’s really difficult to close the door because nobody wants to go. So, I think we need more time.”

Participants resoundingly described peer support as valuable mechanism of care, more specifically, “invaluable”, a “requirement” and “absolutely everything.” According to one participant, members of their organization’s support group reported that peer support was “lifesaving.” Central to the reported value of peer support were the concepts of community, connection, and safety. As one participant noted:

“Even when you're listening and supporting and not providing anything at all, the other person's ability to sense that you have a parallel experience... something that a struggling person can feel not alone, I think is a very key part of the healing that happens when we are sharing our story. That sense that the other person can mirror our story in some way. ”

Another described peer engagement in peer support spaces as “building their village,” a practice that is “transformative for a lot of families.” Participants felt that the shared lived experience inherent to peer support groups could also provide peers with a source of hope: “What I really love is the tenant of self-determination, and this idea that hope and recovery is possible because you are sitting alongside someone who has done it before.”

Participants felt that peer support facilitated deep levels of mutual understanding and trust among group members. This mutual understanding in many ways eliminated the need for group members to “explain themselves” or provide justification for their experiences. Referencing common sentiments expressed in their own support group, one respondent gave the example:

“I get to come here, and I don't have to explain myself. I don't have to do queer and trans 101. I don't have to tell you how my family was created. Nobody is going to ask me that question. And if I offer that up, people are already gonna have like this deep understanding of what that is like.”

In these instances, participants felt that peers were able to be their true, authentic selves in peer spaces, and fully express their vulnerability without fear of judgment or consequence, leading to an enhanced sense of safety. Comparing peer support with support delivered by clinical professionals, one participant explained,

“This is a place that feels much safer. And much more friendly and it feels much more like sitting down group of close friends to talk about the experiences rather than trying to fix anything; rather than worrying about what you say is going to flag something for

somebody, somewhere... When they're in a room with us, it's a place that they can really talk about much more difficult things, in a hopefully really safe way."

This comment highlighted how safety in peer support groups is cultivated, in part, through respectful processes around listening and responding to shared experiences.

Beyond connection and safety, another participant commented that peer support was also essential for "prevention" of other potential downstream health impacts and for "the overall wellbeing of families": "It's the prevention piece is so powerful. We don't need to be treating so many people for so many things. We need to hold them before that happens and during those journeys."

Need for Multiple and Diverse Peer Programs

The notion that peer support programs are not "one-size fits all" was regularly acknowledged by participants from the social sector, with many emphasizing that their services were a "complement to clinical supports," and that "you can never get all the support you need from one person or one organization." Many also mentioned that their support groups were "missing people," highlighting the gaps in existing peer support spaces, and the need for many different programs to meet diverse community needs.

For another participant, the importance of having multiple peer support programs was rooted in concerns about ensuring efficacy of programming for diverse populations.

"You might need a second program for people with perinatal loss, also people who have lost their children due to child apprehension, also people who parent their children in their home. They may not want to commingle."

Individual supports, such as telephone and chat-based peer support resources, were also identified as valuable resources for peers to access in-between group sessions, or if they would like more regular and flexible support.

Cautions and Hesitations

While participants agreed on the value of peer support groups, discussions revealed various concerns about external exploitation or endangerment of peer support programs as "sacred" spaces.

"This is something that we really have felt pressure in the past. To be opening our space... because we collect this population and health authorities in particular, they have

certain mandates they need to meet and numbers they need to get. And so there's this this pressure on me to let them have access to this population, right?... I've really resisted that to be honest. I feel a little bit like I'm like keeping people safe..."

Other participants emphasized the importance of implementing context-specific support programming. This was emphasized by one participant in the context of shared locational ties, such as specific supports to address the unique perinatal experiences of rural residents:

"Although you're virtual, and you've got the majority of people from the lower mainland, they're probably not going to relate to the challenges that rural birthers go through...it's a very different experience of raising a baby in those communities. So, we'll bring them in because then simply at least it's some support. But we know it's not ideal."

Existing Peer Support Group Structures

Inclusion Criteria and Group Demographics

When asked about who their peer support programs were intended to serve, participants reported different inclusion criteria in terms of perinatal and postpartum timelines. Many programs supported mothers and infants until 18 months or two years postpartum. Underlying this approach was the understanding that different stages may call for different support requirements. Additionally, there was a perception that the needs of parents after the 2-year mark were less about the postpartum period and more about parenting. As one participant stated, "If somebody's calling in and their baby is about 3 years old, we may start sending them to other places such as...more parenting focused groups...we did tend to find at about 18 months, you're moving into toddlerhood and parenting more than postpartum."

A few participants voiced interest in and appreciation for the PDA model of keeping groups open to participants at any point after the perinatal period. They saw value in having people from "different stages" of the postpartum experience be in the same group in order for members to see "what that broader journey looks like." Another participant commented,

"If your kids have grown and left home and you're still feeling 'in it' and you want to be part of a postpartum depression and anxiety group, you're gonna get a lot out of it, I imagine, but you're also gonna offer the other participants that perspective that your children do grow up. For the moms that have babies in their first months of life, it often feels like you're going to be there forever. You just feel like it's never gonna end. So, there's just so much to be offered by different generations and ages together."

Discussions about program characteristics also revealed insights into the demographic makeup of peer support groups. A desire for enhanced outreach and an increase in diversity of participants was a common theme, with some participants reporting that their respective support groups were serving more gender diverse and Indigenous community members. Nevertheless, one participant described their group as being predominantly composed of “cis women with babies.” This raised concern for how cultural biases may arise and influence the level of safety of the group for participants with different backgrounds.

“There’s cultural bias embedded in the way that we converse...the assumptions that a group of largely white, Canadian women make that kind of set a tone in the room that is just, it doesn’t intend to be exclusive to anybody, but what happens is it’s just not the same feeling.”

Referrals and Community Partnerships

Many participants reported ongoing referral relationships between their peer support programs and other clinically oriented and community resources. Participants identified effective and valuable referral patterns going both ways between healthcare organizations and peer support programs. Many emphasized that these community partnerships were essential for helping group members receive comprehensive care at the right level. Commenting on the productive interface between peer support and clinical resources, one participant noted

“These relationships are fundamental to health and wellness. I think the peer-to-peer, it serves a really specific need. And we also need people who can offer medication and who have sort of the power within these systems that we have to help us navigate it...”

Participants did not have hesitations about referring peers to other types of peer support programming if they thought a different group would better meet the peer’s need.

Group Leadership and Facilitation Styles

In terms of the style of peer support offered, several participants were involved with professionally co-facilitated groups, where a peer leader would be supported by a professional mental health support worker. This model was valued by several participants for expanding the capacity of the group to address immediate health and safety concerns. Participants recalled instances where the expertise of the professional “really saved us” in situations that fell beyond the limits of a peer facilitator’s scope or comfort. One participant explained:

“The load is so significant, right? Like to, we just can’t shoulder this on our own and what I find is, say I have a suicidal client. I can sit with them in that deep pain in a much better

way if I know that their counselor knows, or if I know that their doctor knows... As soon as I know that they have somebody else on their care team, I can just sit in the emotional turmoil in a way that I couldn't if I was the only person that knows. That's an example of how we work well together."

On the other hand, some participants felt that certain aspects of the safety of a support space may be *compromised* in the presence of a professional co-facilitator. Concerns included participants not feeling safe enough to be fully vulnerable, given fears of their words being "flagged" or reported, and clinical staff not necessarily having personal lived experience, which may alienate participants.

Ultimately, one participant, who stressed the value of a professional co-facilitator, concluded, "I will always pick peer support over my concerns, right? I'll expand peer support over my concerns. But my concerns are always based in safety and responsibility." For them, despite their commitment to ensuring a safe professional be involved in their peer support programming, they still saw the value of the peer-to-peer nature of these groups as the most essential component to be preserved.

Insights on virtual modalities

Several partners interviewed had experience with conducting virtual versions of their peer support groups. Many participants expressed appreciation for certain aspects of virtual programs, despite facing some challenges. Increased program reach was identified as a key advantage, with several participants highlighting how this format had permitted "access [to] communities that we've not usually had a presence in." This included rural communities. In one case, the ability to deliver a province-wide support group online allowed for increased group size, and therefore, increased "anonymity," within the group, perceived by some as creating a safer space for sharing personal experiences. As one respondent described,

"One of the things I've noticed is parents really enjoy being able to do this in their own homes. Not having to get dressed, not having to worry about paying for the bus to get there, not having to worry about trekking through the snow, to be able to just do this."

Another shared,

"I've got folks that will [join] it in a darkened bedroom while their baby is napping on them. We- we don't really care how they show up. Just show up. And so folks I think have enjoyed that and we've still managed to keep a really close group atmosphere online."

Nevertheless, challenges relating to virtual program delivery were equally discussed. Several participants found the occlusion of visual cues such as body language to be a significant shortcoming of virtual groups, leading to diminished experiences of “connection” and “interpersonal contact.” One participant described how facilitating a group through a screen, instead of in-person, attenuated their capacity to be aware of emotional shifts occurring among the group.

Acknowledging potential resource constraints, the same participant suggested having two facilitators online instead of one, to “split that duty [such] that one of us is doing the bulk of the interaction and the other one has an eye on the room.” Concern for psychological and emotional safety was echoed by another participant, who expressed worry relating to “people leaving raw” from virtual spaces, due to the reduced level of connection and emotional awareness. As such, conscious group discussions of alternative resources and after hour supports was of particular importance.

While virtual formats showed potential to increase accessibility to support programs, participants acknowledged that this benefit is only seen by those who have access to technology. Poor internet connection and access to a computer were brought up as potential barriers for accessing virtual support groups.

Experiences of Facilitators

In most groups, facilitators brought both personal lived experience and professional training to their role. Referring to their professional training and knowledge, one participant noted that their own lived experience was their greatest asset as a peer group facilitator, and that their professional education is “just a great foundation for the type of presence maybe you can provide.” One participant described the notion of calling themselves a professional as a “gray area” given their mix of personal and professional experience.

Among many participants, there was a strong desire for further learning, either for themselves or for other facilitators within their organization, in order to better support peer participants. Overwhelmingly, participants discussed feeling “privilege[d]” and “grateful” to be a part of the “sacred spaces” that make up their peer support groups and had immense respect for their group members. A few did also acknowledge the significant emotional and psychological toll that facilitators often incur and identified a need for additional supports and resources to prevent facilitator burnout.

The training required for peer facilitators across different groups varied, but most integrated some degree of shadowing or class training for peers to participate in group facilitation.

Barriers to Accessing Groups

While participants highlighted high levels of need for perinatal and postpartum supports, responses also indicated various barriers that members of the community may face in accessing these resources. These included physical, psychological, and safety-related, infrastructure/program level, and broader systemic barriers.

Transportation Challenges and Geographic Isolation

A few participants discussed the geographical spread in certain regions of BC that make it difficult for remote birthers to access in-person support groups. Local public transportation, or lack thereof, in rural and remote communities was a key issue.

“You gotta be able to drive to get [to the meeting], right? Unless you live right downtown, even then it's not a very walkable city. You either need to have kind of a nice stroller or a car. So, by the time you get here, you've already got a lot of privilege in place.”

Given these challenges, some participants pointed to the potential suitability of virtual programming to enable alternative access options.

Psychological and Social Safety

Many participants also alluded to the absence or insufficiency of psychological safety as a barrier to accessing groups. Specifically, confidentiality was identified as a primary factor contributing to the safety of a space and group members' comfort with sharing freely. Respondents noted that the concern around confidentiality were relevant for groups running in smaller communities:

“One of the challenges I've noticed in smaller communities is that piece of confidentiality. The need is there, but people are reluctant to attend something, particularly in-person, because they know everyone in the room, and they do not want to be sharing pieces of their story with people that they went to high school with.”

Some participants noted that despite their best attempts, it was not always possible to foster safe spaces for everyone and the unique experiences they carried with them: “There are still people that will not walk into our space. And so being humble enough to know that no matter how hard you work at making a space safe, somebody still feels judged and somebody still feels like it's not a safe space.”

Some participants mentioned how a group format of support was not the most appropriate option for all peers, due to varying comfort levels in group environments, and the potential for “triggering” situations.

Infrastructure and Program Level Barriers:

Some participants discussed how specific inclusion criteria for joining support groups could be restrictive, leading to limited or no resource options for certain individuals in need of support. As one participant described, “They talk about ‘no barriers’ but you have to be able to get to the [meeting location] ...You have to have birthed the baby. The baby has to be alive. The baby has to be under 18 months.”

Other comments alluded to the logistical barriers of program timing, with certain days and times of peer support group operation not aligning with work schedules and transit operation schedules, for instance. Emphasizing the importance of considering socioeconomic factors, one respondent noted, “We actually moved our groups to evenings. So, we’re reaching definitely working poor, right? People who are working Monday to Friday who aren’t able to access in-person services at community organizations for free.”

A few participants also mentioned program waitlists, highlighting how increased demand may pose a challenge for accessing timely support.

Higher-Level Discussion of Barriers

Participants consistently acknowledged that despite their best efforts, their programs inevitably contained barriers, and that no one group would meet every peer’s need. One participant pointed to the inevitability of barriers:

“I think the thing we need to be cautious about when we say “no barrier” is that we’re making assumptions...about participants that I really don’t have a right to make... Because my barriers would be different than yours, would be different than theirs. Like someone’s barrier might be, “my husband doesn’t let me engage with other people.” So, we can’t actually be no barrier...[Online services are] low barrier, but you still need the internet, a computer, and a reliable connection, and whatever else going on in your life to allow you to show up.”

Systemic barriers such as “historical negative relationships with adult mental health [services]” created additional levels of barriers, especially for marginalized communities. One participant also acknowledged the social stigma associated with needing help may deter people from accessing resources.

Challenges with Program Funding

A commonly voiced frustration relating to program execution was inadequate funding, described by social service sector partner participants as “limited,” “minimal,” and “tenuous.” One participant stated, “To be honest with you, I don't find a lot of challenges other than money. We don't have enough money. We never have enough funding.”

As another noted, precarity was a result of having to apply for grants on an annual basis. Financial challenges were expressed both in the context of maintaining existing programs but also for achieving goals for program expansion, such as creating groups to serve specific, high needs demographics, providing multiple programs of support, increasing frequency of group sessions, and training facilitators. One participant expressed frustration towards lack of action from leadership:

“Everyone's kind of in a place where it's like we know what we want to do or what we need to do. It is that we don't have the money to do it, right? So many leaders get frustrated now that we're going to keep talking. We know what the problem is. We went to a housing round table a month ago where they were like, ‘It's a problem.’ We're like, ‘Yeah, it is a problem.’ Like, we don't need money to talk about that it's a problem. We just need money to make the housing, right?... The same solutions have existed for 20 years, but there's no money being put into it.”

Perceptions of PDA

Several participants voiced appreciation for aspects of the PDA group structure, including the program's virtual modality, “routine of a regular time-per-week model,” broad inclusion criteria, and continuity of support in-between group sessions. Acknowledging how “everybody's support pieces ha[ve] limitations,” many expressed interest in recommending the PDA program to their group participants for the program's potential to meet diverse needs that may not be met by their programs alone.

“One of the things we are always struggling with is where to send our parents when they're graduating from one of our groups. ... They're sort of past the initial postpartum experience, but they may still be struggling with parenting with general sort of mood disorders... From what you're describing, [PDA] sounds like a wonderful place to send parents who are ready to leave this quite intense support... I think that's where I would see the work that you're doing sort of complementing ours.”

One participant asked thoughtful questions about how the PDA program may address group participant safety concerns. Highlighting the potential increased incidences of “child welfare and wellness concerns” among PDA group participants as individuals self-identifying as having mental health challenges, this participant stressed the need for clear procedures surrounding management of “emergent situations, especially online.”

12-Step Framework

When asked about their perceptions of the language around the adaptation of the 12-Step program to the perinatal context, some participants identified association with religion as a potential limitation. However, one participant explained that while this may be a limitation particularly for newcomers, they felt that stigma associated with 12-Step programming may not be an issue due to increased awareness of the idea of supporting birthers using substances among the wider community:

“Language and stigma and all sorts of things are changing in that area already. I believe in the community they might be curious around 12-Step. Like structuring something like that around a 12-Step [model]...I think with explanation and with curiosity and asking questions, I think it would be really well received.”

Goals and Wishes for Existing Programs

Drawing on observations of strong community need, many participants reported interest in scaling up their programs if they had the resources. This included increasing the number and types of support groups, as well as increasing the frequency of existing support sessions. When asked about how groups promoted increases in participant numbers, some participants mentioned word of mouth, referrals from healthcare organizations, and outreach via social media as sources of program growth.

Some participants described goals that related to enhancing group experience and efficacy of programming. Other participants envisioned implementation of additional support resources such as childcare and transportation services to make peer support programming more accessible. Other goals included development of “a good evaluation model,” having a clinical professional on the staff team, broadening inclusion criteria, gathering more community input, and having support resources for facilitators to help manage emotional stress.

Discussion of Findings

Audience Served

As noted through our reporting, the intent of the program framework was to meet the needs of rural populations who are not well-served by current perinatal mental health programming. While the community researcher had lived experiences of marginalization which motivated her action, a guiding motivation for the academic researcher was recollection of an early encounter between the two project leads where the community lead described walking to the location of a 'Moms and Tots' playgroup, early on in her postpartum period. She recounted that as she neared the location of the group, she noticed a row of Chariots (expensive baby strollers) outside, now referred to as "Chariot Row," and knew that the group would not be welcoming to her. To her, the expense of the strollers signified group participants who were able to "get their nails done and go skiing on the local ski hill," activities that were out of the range of possibility for a single mother living below the poverty line. Being woken up to the structural biases against those who were not economically, culturally, or socially normative reignited a commitment to reducing health and social disparities and promoting equity for the academic lead.

To this end, our commitment to inclusion and diversity underscored our activities and allowed us to remain open to "what we don't know that we don't know." It allowed us to adjust our programming and materials to those who are neurodivergent, dyslexic, a surrogate parent, in the early, middle or late postpartum period (or outside of the normative definition of 'postpartum' but still struggling with issues arising from birthing), had experienced pregnancy loss, abortion, addiction, mental illness, and cultural marginalization.

Quite literally, the list goes on. We took the perspectives of all of them and allowed it to not only inform us, but shape the very essence and structure of everything we did and created. Everything you will see on the [PDA-support.org](https://pda-support.org) website sparked from conversations we had with "those" lenses. We held ourselves accountable to their voices so that they wouldn't have to hold us accountable to our commitments. Too often, these "lenses" are completely left out and if they happen to be included, are they *really* included? Are they authentically included? I (April) have myself had to beg organizations to be accountable to my varying lived experiences, with doors continuously being slammed in my face. Or groups totally disbanding, because they just wanted to see things their way and with their ideas. I was adamant that this did not occur and thankfully the rest of the team was also adamant about this.


In addition to all of that, there were so many random conversations in the streets when I (April) was putting up posters around town. People were so curious and interested that they would

ask for some of our small postcard size flyers. These random conversations were so full of gratitude towards our project.

The people that we interviewed for the research wanted to learn more about the PDA program afterwards. So, meetings were set up to discuss and people were mind blown at how non gatekeepery (new word) our program was. It shocked *me*, how shocked people were. But then when I sat and pondered it and thought of my own experiences outside of PDA, they were right to be shocked. Programs hold onto their content for dear life and if they can't make a buck off it, then they certainly don't want you to be able to access it easily.

What was Learned

Jude



In academia, the social sector, healthcare, policy and decision-making alongside other sectors, there is a growing awareness of the importance of work *with* patients, residents, and communities to improve the responsivity of research, programing, and policy development. In some sectors, this awareness has translated into a mandate, but without a change in culture.

Lacking this essential antecedent runs the risk of performative actions ('check-box' exercises), not the democratization of decision making and planning that we are hoping to achieve.

Participating in a project that truly views the lived and living experiences of others not just as a benefit but *as a necessary foundation for true learning* yields outputs in understanding that could not be gained without the collaboration. For me, this underscored the content learning that we achieved, learning that illustrated the importance of accessible programming without arbitrary exclusion criteria (limited to <18 months after the birth of a child) and that welcomes diversity by creating a safe space. We learnt of the importance of 'de-professionalized' peer support, adjunctive to professional clinical and social support, and the efficacy of the 12-Step model itself. Ultimately, we learnt of the value of a community based on shared experience in addressing not only mental health issues but providing a group-up solution to our current health human resource challenges.

April

This experience has taught us many things and one of the big takeaways was the value it added to lives of those we included. Because we actually did include them. It's not enough to just ask people and then pat ourselves on the back and call it a day. We had to go the distance with this. We learned that going the distance was more like the extra mile. During our interviews with the community advisory committee, we received an overwhelmingly positive response to the way in which we conducted our meetings, but also to the way we listened, responded, and implemented their comments and concerns. When we highlighted the social expectation of inclusivity and through accommodating diversity, advisors reflected that a lot of organizations

don't actualize it in the context of their programming. But it shouldn't be that way. Asking the opinions of others is not enough. Asking opinions through one lens is not enough. That is, unfortunately, barely the norm. We have proven that the more lenses equally invited to the table, the richer the experience, the richer the content, and the richer the value. And it is that richness that allowed us to exceed our project expectations.

Audrey

This project allowed for a meaningful opportunity to develop, design, adjust, and implement, in collaboration with a diverse group of community advisors, a service we believe can help fill established gaps in rural comprehensive mental health services. Interviews with social service sector partners, PDA participants, and PDA advisors showed that the 12-Step framework has the potential, with clear communication of unique program values, to be a useful framework for addressing perinatal mental health challenges. We learned that in some cases, participants found the use of the 12-Step framework to add credibility to the significance of their experiences with postpartum depression. Peer-to-peer support as a model was again and again cited as “sacred,” “lifesaving,” and “remarkable,” demonstrating its value as a model. Participants understand the differences in scope between professional and peer support mechanisms, and the importance of both as complementary forms of care. Finally, we learned about the importance of diverse program delivery models. Following the COVID-19 pandemic, use of virtual modalities for program delivery have increased. This both augments program accessibility, particularly for new parents with children at home, but also creates new barriers, such as a need for reliable internet, a device, and a quiet space at home, to join online programs. The PDA program evaluation demonstrated the importance of a mixed program delivery model that enables participants to select the format that works best for them.

Recommendations

The following recommendations are derived directly from the primary data we gathered with key partners. They are broken down into three categories: process recommendations, program recommendations and aspirational activities. Each are presented, below, following the underlying assumptions.

Underlying Assumption

1. The health and social service needs of equity-seeking populations are often not included in health planning, despite the fact that creating healthcare services to meet these needs ensures all needs will be met;
2. The 12-Step model of peer-to-peer support is a well-subscribed framework and has application to all social needs;

3. An urban-derived approach to perinatal peer support may not be applicable in rural settings and may require contextual adjustment.

Process Recommendations

1. Decolonize all 12-Step programs to meet the needs of equity-seeking populations who may feel excluded due to language that does not represent their living experience nor sexual or religious orientation;
2. Honour the needs for perinatal mental healthcare of equity-seeking populations by stratifying the larger population to provide services based on common demographics and life experiences (e.g., participants who use substances). This will create a safe environment for those who regularly experience stigma.

PDA Program Recommendations

3. Create accessible program literature to meet diverse needs (ie. ASL, braille, text for neuro-divergent participants);
4. Recognize and accommodate the importance of removing physical barriers to participation such as the need for childcare and transportation to in-person meetings;
5. To better accommodate the reality of the perinatal period where infant and children's schedules are often unpredictable and birthers contend with significant fatigue, offer the opportunity for virtual as well as in-person attendance at meetings;
6. Appreciate and facilitate solutions to lack of internet connections for rural and remote birthers;
7. Be mindful of the need to accommodate new perspectives, even if they challenge entrenched ways of running meetings;
8. Approach group facilitation through a trauma-informed lens, prioritizing creating the conditions for participant safety;
9. Ensure that programming is approached through an equity lens with attention to who might *not* be served.

Aspirational Recommendations

10. Based on small-scale, local successes, spread and scale the PDA program to other like settings by sharing successes and ensuring all program materials are open-access;
11. Maintain a commitment to the Indigenous "Seven Generations" approach to correct and adjust what has happened in the past, acknowledge the lived and living experience of the present and plan for a sustainable future.



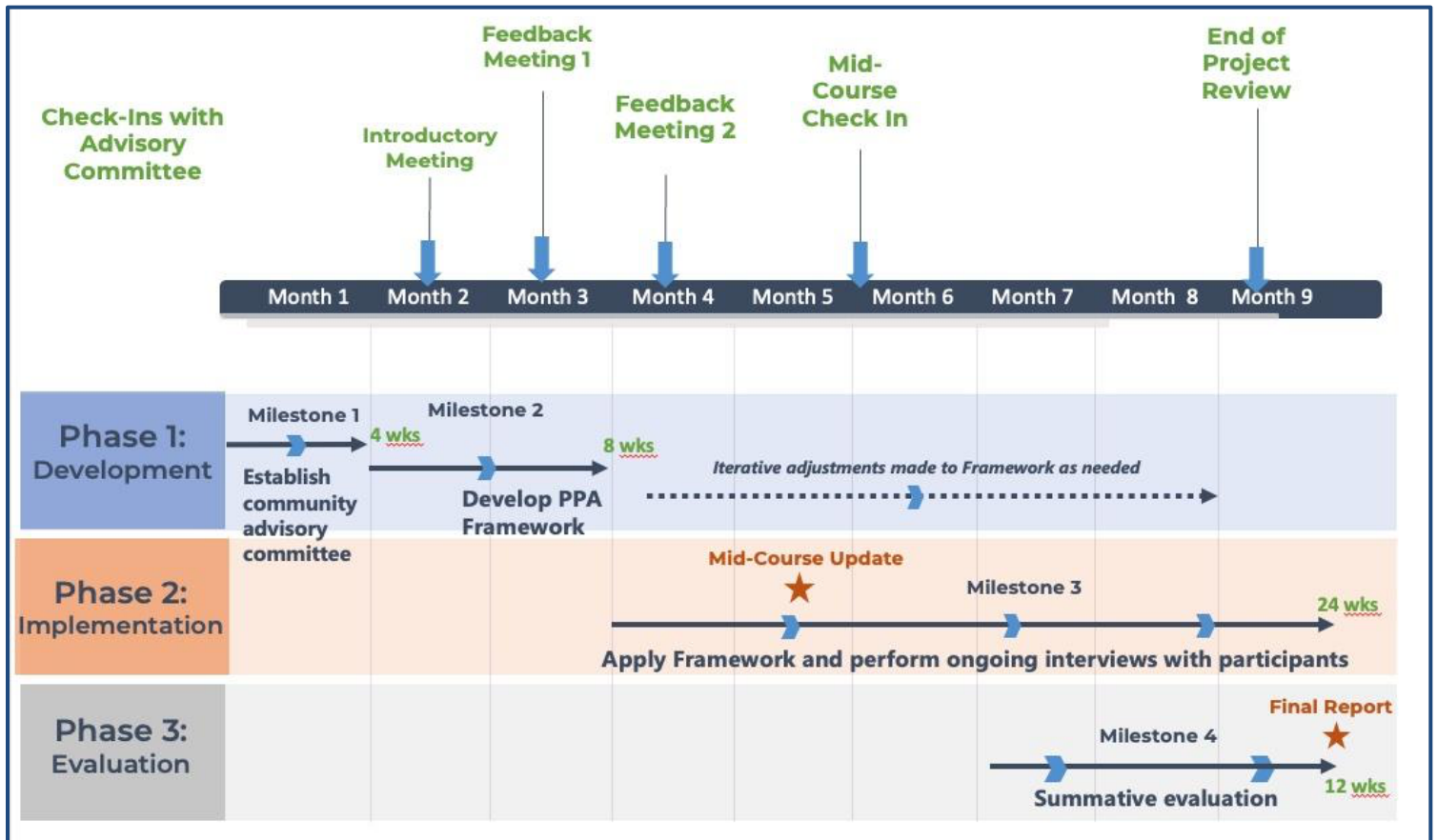
Financial Report*

A. Human Resources	Amount Requested	Original Justification	Actual Amount Spent	Rationale
Patient Co-Lead	\$9,750	Re-imbursement for research and project coordination	\$9,599	
Student Research Assistant	\$3,550	Subsidized Work Learn RA will help with admin tasks and project development	\$7,589.00	As per our mid-term report, we extended the contract of our subsidized UBC Work Learn Student to the end of the project (extension: Sept 1-Jan 10, 2024). To account for this additional cost, we redistributed the budget line item relating to open access journal publication fees and will rely on journals that have subsidized publication fee agreements with UBC if we decide to pursue a peer-reviewed publication.
Research Assistant	\$0		\$1,182.00	To support data transcription and analysis, a second RA was hired on a short term contract in December (40 hours). We redistributed funds from the Transcription Service line item to cover this expense, as the RA was able to assist in performing the transcription.
Research Coordinator	\$55,695	RC (1.0FTW with benefits) will perform administrative duties, assist in project development, and lead analysis of transcribed data	\$57,395.00	As a result of the UBC Association of Professional Staff union agreement, ratified in August 2023, salary for the Research Coordinator increased 6.75%. The increase was effective July 1, 2023. As such, the RC worked 0.91 FTE to account for the majority of the additional salary expense.
Total Human Resources	\$68,995		75,765.00	
B. Honorariums	Amount Requested	Original Justification	Actual Amount Spent	Rationale
Community research participants	\$750	Honorariums (\$50) will be provided to focus group and interview participants	\$470	After the first interview, participant honorariums were adjusted to \$35 dollars for cost savings. A total of 13 interviews were performed.
Patient Co-Lead	\$7,000	An honourarium will be provided to the patient co-lead for their work on project and program development	\$7,000	
Community Advisory Committee	\$3,150	Honorariums (\$50) will be gifted to members of the community advisory committee per meeting	\$1,388	Advisors were reimbursed \$45 per meeting attended, and \$75 for work performed outside of group meetings. 10 advisors were involved in the project, though not all attended every meeting.
Total Honorariums	\$10,900		8858	
C. Publication Costs	Amount Requested	Original Justification	Actual Amount Spent	Rationale
Open source journal publication fee	\$4,000	Journal levied article processing charge for open source publication	\$1,800	
Total Publication Costs	\$4,000		1800	
D. Services and Supplies	Amount Requested	Original Justification	Actual Amount Spent	Rationale
Scriptastic Transcription Service	\$1,900	Service to transcribe interview audio recordings. Amount derived from Scriptastic Transcription Company	0	We were able to negate this line item through the transcription and quality checking support of the two research assistants. Funds were then directed to the salaries of the RAs.
Meeting supplies	\$1,000	Paper resources for recruiting group members, handouts provided for focus groups and peer program participants	\$307	
Total Services and Supplies Costs	\$2,900		307	
Total Requested:	\$86,795		86,730	
Total Difference between Anticipated and Actual Costs			\$65	

*With final salary expenses and actual expenses finalized, February 2024.



Final Project Timeline



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Appendices

- Appendix 1 - Mental Health Resource Sheet
- Appendix 2 - Matrix of Perinatal Supports Services
- Appendix 3 - Postpartum Depression Anonymous Booklet
- Appendix 4 - Meeting Script
- Appendix 5 - Postpartum Depression Anonymous Workbook
- Appendix 6 - Guide to Scalability and Services
- Appendix 7 - Program Branding and Outreach Materials

Appendix 1



MENTAL HEALTH & COUNSELLING RESOURCES

If you or someone you know is in immediate danger, please call 9-1-1 or go to your nearest hospital. If you need emotional support, help is available.

It's important to get help if you or someone you know is going through a crisis or thinking about suicide. Help is available. Learn about the resources available to you.

Help is available if you need to talk and you:

- are not feeling yourself
- are experiencing a crisis
- have emotional pain
- have thoughts of suicide
- know someone who needs help

EMERGENCY NUMBERS

The following numbers are available for **24 hour emergency assistance**:

RCMP, Ambulance, Fire	911	
East Kootenay Crisis Line	1-888-353-2273 (1-888-353-CARE)	
Golden Safe Homes	(250) 344-2101 (a service for women)	www.goldenwomenscentre.ca
Golden Hospital	(250) 344-5271	
Golden Medical Clinic (day-time only)	(250) 344-2211	
Suicide Help Line	1-800-784-2433 (1-800-SUICIDE)	www.crisiscentre.bc.ca
	Online Chat Service for Youth	www.YouthInBC.com
	Online Chat Service for Adults	www.CrisisCentreChat.ca
VictimLink	1-800-563-0808	
Concerns about child abuse	310-1234 (no area code needed)	
MCDF after-hours	310-1234 (no area code needed)	
Alcohol & Drug Information and Referral	1-800-663-1441	
KUU-US Crisis Services First Nations	1-800-KUU-US-17 (1-800-588-8717)	http://www.kuu-uscrisisline.ca

Golden Specific Resources

Golden Mental Health & Substance Use

- Provides a range of mental health and substance use services for all ages
- Phone number: **250-344-3015(main)**
- Website: <https://www.interiorhealth.ca/locations/golden-mental-health-substance-use>
- Address: 835 - 9th Avenue South, Golden BC V0A 1H0

Golden Family Center

- The Golden Family Center provides affordable, confidential counselling and support services to individuals and families who live in Golden and the surrounding area. Women have access to all the general services we offer. We also offer a few programs specifically geared to women.
- Phone number: **(250) 344-2000**
- Address: 421 9 Ave N, Golden, BC V0A 1H0



- Services:
 - [Parenting & Family Support](#)
 - [Counselling for Families, Couples and Individuals](#)
 - [Abuse recovery – Stopping the Violence](#)
 - [Substance Use and Addictions Services](#)
 - [Drop-in Counselling Clinic](#)

The Golden Women's Resource Centre (GWRC)

- The GWRC provides information, support, advocacy, educational workshops, free internet access and most importantly a safe, non-judgmental, welcoming environment for women to gather, relax, share ideas and get support.
- Phone Number: **250-344-2817**
- Women's centres and services: 250 344 5317
- Women's Shelter Crisis Line: 250 344 2101

General Provincial Resources

Crisis Centre BC:

- **Help is available!** We are here to listen, here to help – 24 hours a day, 7 days a week.
- If you or someone you know is having thoughts of suicide, call 1-800-784-2433 (1-800-SUICIDE), or call your local crisis centre.
- **Language Service:** Both of the 310-6789 and 1-800-SUICIDE phone lines are available in over 140 languages using a language service. Let us know which language you require, and we will try and provide an interpreter.
- **Contact Us:**
- **Anywhere in BC 1-800-SUICIDE: [1-800-784-2433](tel:1-800-784-2433)**
- **Mental Health Support Line: [310-6789](tel:310-6789)**
- **Vancouver Coastal Regional Distress Line: [604-872-3311](tel:604-872-3311)**
- **Sunshine Coast/Sea to Sky: [1-866-661-3311](tel:1-866-661-3311)**
- **Seniors Distress Line: [604-872-1234](tel:604-872-1234)**
- **Online Chat Service for Youth: www.YouthInBC.com** (Noon to 1am)
- **Online Chat Service for Adults: www.CrisisCentreChat.ca** (Noon to 1am)

Reproductive Mental Health Program at BC Women's Hospital

- Call BC Women's Hospital at 1-888-300-3088 ext. 2025 (toll-free in BC) or call 604-875-2025 (in Greater Vancouver) to find out how to see a specialist in postpartum depression or anxiety.
- You can also visit www.bcmhas.ca/ProgramsServices/ChildYouthMentalHealth/ProgramsServices/Reprodu



ctive+Mental+Health. You must have a referral to the Reproductive Mental Health Program from your doctor. To get referral forms, doctors may call the numbers above.

- o In addition to issues related to pregnancy, this program can also be helpful for other times in a woman's reproductive cycle where mental health problems can happen such as the pre-menstrual period, menopause, after a miscarriage, or while experiencing infertility.

HealthLink BC

- Call 811 or visit www.healthlinkbc.ca to access free, non-emergency health information for anyone in your family, including mental health information. Through 811, you can also speak to a registered nurse about symptoms you're worried about, or talk with a pharmacist about medication questions.

Mental Health and Wellness Counselling in BC

- You may be eligible for Health Benefits coverage. Many providers are registered to bill Health Benefits directly for services so clients do not have to pay out of pocket. Before booking an appointment with a counsellor, call 1-855-550-5454 or visit fnha.ca/benefits to check if they are registered and if the service is eligible for coverage.

Canada Wide Resources

Canada Suicide Prevention Service

- If you or someone you know is thinking about suicide, call the [Canada Suicide Prevention Service](http://CanadaSuicidePreventionService.ca) at 1-833-456-4566 (24/7).
- For residents of Québec, call 1 866 APPELLE (1.866.277.3553).
- Visit Crisis Services Canada for the [distress centres and crisis organizations](#) nearest you.

Kids Help Phone

- Call 1-800-668-6868 (toll-free) or text CONNECT to 686868.
- Available 24 hours a day to Canadians aged 5 to 29 who want confidential and anonymous care from trained responders.
- To access support through Facebook Messenger see the [Kids Help Phone website](#).

Hope for Wellness Help Line

- Call 1-855-242-3310 (toll-free) or connect to the [online Hope for Wellness chat](#).
- Available to all Indigenous peoples across Canada who need immediate crisis intervention. Experienced and culturally sensitive help line counsellors can help if you want to talk or are distressed.
- Telephone and online counselling are available in English and French. On request, telephone counselling is also available in Cree, Ojibway and Inuktitut.



Victim Services

- The Victim Services Directory (VSD) has been created by the Policy Centre for Victim Issues of the Department of Justice Canada to help service providers, victims and individuals locate services for victims of crime across Canada
- Website: <https://www.justice.gc.ca/eng/cj-ip/victims-victimes/vsd-rsv/index.html>

Additional Resources for Indigenous People

Indian Residential School Crisis Line

- A national service for anyone experiencing pain or distress as a result of their residential school experience. Call toll-free 1-866-925-4419.

Kuu-Us Crisis Line Society

- Provides crisis services for Indigenous people across BC. Adults/Elders line 250-723-4050; youth line 250-723-2040. Or call toll free 1-800-588-8717. Learn more at www.kuu-uscrisisline.com.

Métis Crisis Line

- A service of Métis Nation British Columbia. Call 1-833-MétisBC (1-833-638-4722).

First Nations Virtual Doctor of the Day

- Provides virtual health care and referral support for people who do not have a doctor or are unable to get an appointment. It is for all First Nations people living in BC and their family members, including family members who are not Indigenous. Doctors are available by video or phone from 8:30 a.m. to 4:30 p.m. every day. Call 1-855-344-3800 to book an appointment. Learn more at fnha.ca/virtualdoctor.

Tsow-Tun Le Lum Society

- Provides confidential outreach services such as counselling, cultural supports and personal wellness programs. Call toll-free 1-888-403-3123 or visit www.tsowtunlelum.org.

Virtual Substance Use & Psychiatry Service

- <https://www.fnha.ca/what-we-do/ehealth/virtual-substance-use-and-psychiatry-service> is an FNHA service providing virtual specialist support in addictions medicine and psychiatry. This service requires a referral from a health and wellness provider who can support the individual on their journey. First Nations Virtual Doctor of the Day can provide referral support for anyone who does not have a provider who can refer them to the program. The FNHA and other organizations provide culturally safe and trauma-informed cultural, emotional, and mental health services to Indigenous people in BC.

Mental Health and Wellness Counselling in BC





- You may be eligible for Health Benefits coverage. Many providers are registered to bill Health Benefits directly for services so clients do not have to pay out of pocket. Before booking an appointment with a counsellor, call 1-855-550-5454 or visit fnha.ca/benefits to check if they are registered and if the service is eligible for coverage.

Missing and Murdered Indigenous Women and Girls Health Support Services

- A national program administered in BC by First Nations Health Benefits. Services are available to survivors, family members and others who have been affected. Call Health Benefits toll-free 1-855-550-5454 for more information.





Appendix 2

Name	Contextual Information	Contact Information	Location (Pan-Provincial)
Reproductive Mental Health at BC Women's	Clinic offers many different types of group therapy already (must be referred by provider) - Mindfulness-based cognitive therapy (over zoom), postpartum depression and anxiety therapy group (in-person), emotional regulation and anger management group - perinatal focus (online) and adjustment to motherhood with self-compassion (online)	(604) - 875- 2025	Box 164, 4500 Oak st, Vancouver, BC V6H 1N4
First Nations Virtual Substance Use and Psychiatry Service (FNvSUPS)	Addictions and psychiatry care for first nations people AND their family members (within BC) even if those family members are non-status. Referral based, no cost for clients or their family. Delivered through zoom or phone appts for those without easy access to conferencing. Must attend appt with referring provider.	1 - (833) - 456 - 7655 (for healthcare providers referring) OR 1 - (855) - 943 - 3354 FNVSUPS@fnha.ca	pan-provincial
Maternity and Babies Advice Line (MaBAL) https://rccbc.ca/initiatives/rvts/mabal/	Advice line open 24 hours a day, seven days a week via Zoom; no appointment wait times. Healthcare provider must set up the appointment for you. Provides services and urgent or non-urgent advice to expectant mothers and new parents/guardians/caregivers in rural and remote First Nation communities in BC. Team includes family physicians and midwives. Partnered with RccBC. Podcast link with more information: https://soundcloud.com/firstnationshealthauthority/maternity-and-babies-advice-line	(236) - 305 - 7364 CALL ZOOM ACCOUNT: mabal@rccbc.ca --> do not email.	pan-provincial
The Cridge Young Parent Outreach program https://youngparentoutreach.com/	Provide free support for young parents and teen moms in Victoria. Mental health, education and housing.	(250) - 384 - 8058 https://youngparentoutreach.com/contact/	1307 Hillside Avenue, Victoria, B.C. Canada V8T 0A2
Victoria Native Friendship Centre (VNFC) Early Childhood Development https://vnfc.ca/ecd/#slaheena-prenatal	Drop-in support group for all parents with young children (up to the age of 6). Public health nurse, dietitian and female Elder for available for guidance and support. Breastfeeding support by lactation consultant Slaheena Prenatal Support Program: supporting pregnant mothers to have healthiest babies possible. Public health nurse teaches prenatal classes, dietician provides nutritional info and dental hygienist.	Tel: (250) 384-3211 Fax: (250) 384-1586 Rebecca Mabee, AEENP Coordinator Email: r.mabee@vnfc.ca	231 Regina Avenue Victoria, BC V8Z 1J6
Right from the Start	Support for pregnant people and new parents by public health nurses that are available via phone or in person at island health public health units across the region. Offer physical and emotional support to new parents and babies	1 - (855) - 544 - 2403 RFTS@islandhealth.ca	
WESTSHORE: Primary Care Society / Capital Regional District (CRD) Perinatal Counselling Program	Operated privately and sustained with charitable dollars of donors. Mental health support during the perinatal period and offers perinatal grief and loss counselling. Must be referred by primary care provider.	(250) - 885 - 6760 perinatal@tracimcgee.ca FAX: (250) - 472 - 6762	1516 Winchester Road, Victoria, BC V8N 2B5

Name	Contextual Information	Contact Information	Location (Pan-Provincial)
<p>Perinatal Counselling Services - Interior Health Locations</p> <p>LOCATION Mental Health & Substance Use</p>	<p>For pregnant women or new mothers experiencing or at risk of mental health or substance use concerns. Services may include screening & diagnosis, individual & group counselling and referrals to other community services & support networks</p>	<p>CRANBROOK: (250) - 420 - 2210</p> <p>CRESTON: (250) - 428 - 8734</p> <p>GOLDEN: (250) - 344 - 3015</p> <p>INVERMERE: (250) - 342 - 2363</p> <p>KAMLOOPS: (250) - 377 - 6500</p> <p>KELOWNA: (250) - 469 - 7070</p> <p>KIMBERLEY: (250) - 427 - 2215</p> <p>SPARWOOD: (250) - 425 - 2064</p>	<p>"20 - 23rd Avenue South Cranbrook BC V1C 5V1</p> <p>243 - 16 Avenue North Creston BC V0B 1G0</p> <p>835 - 9th Avenue South Golden BC V0A 1H0</p> <p>1100 10th Street Invermere BC V0A 1A0</p> <p>200-235 Lansdowne Street Kamloops BC V2C 1X8</p> <p>505 Doyle Avenue Kelowna BC V1Y 0C5</p> <p>260 - 4th Avenue Kimberley BC V1A 2R6</p> <p>570 Pine Avenue Sparwood BC V0B 2G0"</p>
SheWay	Provides comprehensive care to individuals that are pregnant or postnatal, but also provides primary care.	<p>Telephone: (604) - 216 - 1699</p> <p>Fax: (604) - 216 - 1698 Email sheway.sheway@vch.ca</p>	533 East Hastings Street Vancouver, BC V6A 1P9
Haven Pregnancy Support Clinic	CHRISTIANITY AFFILIATED but open to helping individuals of all races, religion and sexuality. Provide support after abortion or infant loss, offer prenatal, childbirth and parenting classes. FREE SUPPORT.	<p>(250) - 380 - 6883</p> <p>info@havenpsc.ca</p>	112 - 826 North Park Street Victoria, BC V8W 3B4
MOTHERWISE	Support group for Moms, childcare provided	<p>Kirsty Kuromi (250) - 442 - 2267 ext 40258</p> <p>Lauren Andres (778) - 460 - 5103</p>	1200 Central Ave, Grand Forks, Kootenay Family Place
PUBLIC HEALTH NURSES for postpartum help:	Postpartum telephone support, home visits & education	<p>Grand Forks: (250) - 443 - 3150</p> <p>West Boundary: (250) - 449 - 2887</p> <p>Castlegar: (250) - 365 - 7711</p> <p>Salmo: (250) - 357 - 9511</p> <p>Trail: (250) - 364 - 6219</p> <p>Nelson: (250) - 505 - 7200</p> <p>Kaslo: (250) - 353 - 2291</p> <p>New Denver: (250) - 358 - 7911</p> <p>Nakusp: (250) - 265 - 3608</p>	

Name	Contextual Information	Contact Information	Location (Pan-Provincial)
Kootenay Family Place	Offers various such as motherwise (for postpartum moms) such as MotherWise - weekly support group for postpartum moms struggling with mood. Breastfeeding support group led by Public health nurse. Beautiful Beginnings program	(250) - 365 -8448 (250) - 365 - 5792 info@kootenaryfamilyplace.org	Mailing: Box 3144, Castlegar, BC, V1N 3H4 Physical: 767 11 Ave, Castlegar, BC, V1N 1J7
Boundary family Services	Baby's Best Chance program (free) provides pregnant individuals with nutrition, lifestyle, emotional support and other educational and fun groups for pregnant individuals. Also have an Aboriginal family support program. ALSO HAVE BREASTFEEDING CAFÉ	(250) - 442 - 2267 Baby's Best Chance Kristy Kuromi 250-442-2267 ext 40258 kristy.kuromi@bfiss.org Cynthia Garnett 250-442-2267 ext 40223 cynthia.garnett@bfiss.org	MAILING Box 2498 Grand Forks, BC V0H 1H0 PHYSICAL 1200 Central Ave., Glanville Centre Grand Forks, BC V0H 1H0
Apple tree Maternity	Midwifery clinic that can opt to have group prenatal sessions starting halfway through the pregnancy until 37 weeks and have a group reunion during the postpartum period. Run for about 2 hours in the evenings once every 2 weeks and meeting facilitated by maternity care provider and childbirth educator.	(250) - 354 - 3884 appletreematernity@gmail.com	518 Lake st, Nelson, BC V1L 4C6
Bellies to Babies offered by Community Connections Society of Southeast BC (CCSSEBC)	Pregnancy and postpartum education and support (up until infant is 1 years old), supporting people of Cranbrook/Kimberley	(250) - 489 - 5011 B2B.coordinator@ccssebc.com	22 12th Avenue North, Cranbrook BC
Bellies to Babies: Sunshine Coast Community Services	2 weekly hot lunches, support for breastfeeding, postnatal support, resource sharing, infant massage and prenatal breastfeeding. Free and confidential	Shirley: (604) - 865 - 1108 sfrench@ssccss.ca https://www.facebook.com/groups/284374478286625	Gibsons & Area Community Centre, 700 Park Road The Family Place, 5520 Trail Avenue, Sechelt Pender Harbour: We also offer a once monthly group at the Lions Park Hall, Madeira Park
Bellies to Babies: Fernie Women's Resource Centre	prenatal education, referrals and support. Opportunities for parent connection	(250) - 423 - 4687 belliestobabies@outlook.com	1592 10th Avenue. PO Box 2054, Fernie BC, V0B 1M0
Aboriginal Prenatal Nutrition Program	Serves Aboriginal/ Metis/ Inuit people. Pre and post-natal support and education. Food security assistance, food and vitamin vouchers.	(250) - 394 - 7020 Fax: (250) - 394 - 7028 emails: blulua@eniyudhealth.ca beelulua@yahoo.ca	?Eniyud Health Services Box # 51. Williams Lake, BRITISH COLUMBIA, V0L1X0
Pregnancy Outreach Program offered by Cariboo Friendship Society	Nutrition, counselling, education and support to pregnant individuals. Offers free weekly lunch with drop in guest speakers and guest activities.	(250) - 392 - 3583 FAX: (250) - 398 - 6115 admin@cfswl.ca	99 3rd Avenue S, Williams Lake, BC V2G 1J1 202 4th Avenue N, Williams Lake, BC V2G 2E1

Name	Contextual Information	Contact Information	Location (Pan-Provincial)
Babies Open New Doors (BOND)	Ongoing perinatal support (till 6 months pp). Weekly group meetings which include healthy snack as well as food vouchers and vitamin supplements. Registered nurse, dietitian, peer outreach worker and volunteers make up the team. Staff assess your eligibility.	(604) - 485 - 2604 FAX: (604) - 485 - 9244 Email: bondprogram@prepsociety.org	PREP Society 103-4511 Marine Avenue, Powell River, BC V8A 2K5 New address (?) : Lift Community Services, 218-6975 Alberni Street, Powell River, BC V8A 2B8
Baby's Best Chance FSJ	Prenatal education, transportation support, weekly drop with lunch. Free! Support until 6 months pp. Services provided by program coordinator, pregnancy outreach workers and registered dietician/nutritionist.	(250) - 785 - 6021 ext 251 INFO@communitybridge.ca OR Kezia Menzies BBCCoord@communitybridge.ca	Community Bridge, 10142 - 101st Avenue, Fort St. John, BC
Campbell River Family Services Society (Baby's Best Chance - CR)	Individual and group health counselling offered to vulnerable or high risk pregnancy individuals. Separate groups for prenatal and postnatal, both offered health lunch and options of peer support or one-on-one support. Various other pregnant and new parent programs offered at Campbell River Family Services Society.	(250) - 287 - 2421	487 - 10th Avenue Campbell River, BC Canada V9W 4E4
Elizabeth Fry Society - Baby's New Beginnings - PG	Education and support groups for prenatal and postnatal support. Prenatal vitamins and food vouchers also offered.	(250) - 563 - 1113 Fax: (250) - 563 - 8765 Katrina McGraw (family programs manager) --> katrina@pgefry.bc.ca	Prince George - Elizabeth Fry. 1575 - 5th Avenue. Prince George, BC V2L 3L9
Best for Babies	South-asian specific online group to support immigrants by providing culturally sensitive care. Group support offered, weekly professional visits from community partners, education and support on infant care. Resources and referrals.(Care up until 6 months pp.) Free but limited numbers so need to contact to register.	(604) - 859 - 7681 ext. 288 BestforBabies@archway.ca	33780 Laurel Street. Abbotsford, BC V2S 1X4
Encompass Support Services Society - Best Babies of Langley	Lunch clubs (drop in sessions to expecting and postpartum individuals (up to 1 year pp). Lunch and childminding provided during group activities, opportunity to socialize with others. Most prgrams are free or have small subsidized cost.	(778) - 808 - 1478	Family Place (located in a portable behind Shortreed Elementary), 27330 28 Ave, Aldergrove. The Willows Family Life Centre - 5735 203 Street #103
Ladysmith Resources Centre Association Born Healthy	Community-based support and education program for pregnant or pp (up to 9 months) individuals. Conversations/education/meals offered	Jessica Raymond, Born Healthy Coordinator 250-245-3079 jraymond@lrca.ca Beverly Boese, Born Healthy Outreach Worker 250-245-3079 beverly@lrca.ca	PHYSICIAN: 630 2nd Avenue, Ladysmith, BC MAILING: P.O. Box 1653 Ladysmith, BC, V9G 1B2
Trail Fair (Building Beautiful Babies)	Support, resources and information for expecting or pp moms (up to 1 year pp). Weekly group with guest speakers, lunch and outreach visits.	(250) - 364 - 2326 Hello@trailfair.ca https://www.trailfair.ca/program-listing/	FAIR centre: 2079 Columbia Ave. Trail BC V1R 1K7

Name	Contextual Information	Contact Information	Location (Pan-Provincial)
Tillicum Lelum: Aboriginal Friendship Centre (Building Better Babies)	Pregnant or pp (up to 6 months pp) individuals. Prenatal classes, doula support and moms, dads and babies group for families and group drop in for everyone in program.	(250) - 753 - 6578	927 Haliburton Street Nanaimo, BC V9R 6N4
Terrace Child Development Centre (Building Healthier Babies Group)	Perinatal and postpartum (up to 12 months pp) weekly drop in. Option to have one-to-one support or group.	(250) - 635 - 1830	4665 Park Avenue. Terrace BC V8G 1V9
Pregnancy outreach program prenatal and Baby & Me (postnatal) program	Weekly support groups (separate for prenatal and postnatal) for individuals experiencing challenges (pp infants 0-6 months). Registration required but is free and no referral required.	(250) - 659 - 2225	OLIVET CHURCH, 613 QUEENS AVENUE, NEW WESTMINSTER EDMONDS RESOURCE CENTRE, ROOM 104, 7355 CANADA WAY, BURNABY
Dease Lake Pregnancy Outreach program at Dze L K'ant Friendship Centre Society	Perinatal info and resources for postpartum (up to children aged to 6), groups, drop in sessions and one-to-one support offered and food vouchers and lending library.	(250) - 771 - 3147	71 Stikine. PO Box 328, Dease Lake, BC. VOC 1L0
Dze L K'ant Friendship Centre Society (Pregnancy In Reach program)	Assisting pregnant individuals using substances navigate harm reduction and also connecting the family to community supports or BCAPOP programs	(250) - 877 - 1175 lnreach@dzekant.com	1188 Main Street. P.O. Box 2920. Smithers, BC. VOJ 2N0
AECD Pregnancy Outreach program	Drop in programming offered, home visit support and provides practical necessity (such as vitamins, cleansing wipes and other resources).	(250) - 845 - 2131 houston.pop@dzekant.com	3383 11 St. Houston, BC. VOJ 1Z0
Pregnancy Outreach Program Shushwap Healthiest Babies Possible	Private office or home visits, drop in group (tummies 2 Tots) for expectant and new moms, 22 week nutrition and fitness group (postnatal).	250 - 832 - 2170	681 Marine Park Drive NE, Salmon Arm, BC, Canada, British Columbia
Healthy Babies offered by Kitimat CDC	Weekly drop-in groups at Roy Wilcox for pregnant and postpartum (up to 1 yr) and private one-to-one support. Public health nurse twice a month and guest speakers.	(778) - 631 - 2071 ext. 2006	7 CARLSON ST. KITIMAT, BC V8C 1A9
Healthy Babies - Canada Prenatal Nutrition Program (CPNP)	Supports families through their pregnancy and first year of baby's life, increases access to health and social support for prenatal and recently pp families. Group support and/or one-to-one support.	Manager: (250) - 871 - 7577 250-338-7575 info@cvfso.org	1507 C McPhee Avenue Courtenay, BC. V9N 3A6
Healthiest Babies Possible & Early Years offered by House of Friendship Society	Nutrition counselling, prenatal education and one-to-one support or group sessions (including transportation, childcare and lunch). Once weekly.	(250) - 748 - 2242 Ajack@hofduncan.org	Hiiye'yu Lelum Society MAILING: P.O. Box 1015 PHYSICAL: #106 - 5462 Trans Canada Hwy. Duncan, B.C. V9L 3Y2
Health moms, Happy babies	Prenatal/postnatal information and support for people of Fort Nelson	Telephone: (250) 233-8920 Fax: (250) 233-8921 Email: pop.nraws@northwestel. net	Northern Rockies Aboriginal Women's Society 5019-52 Avenue. Fort Nelson, BRITISH COLUMBIA. VOC 1R0

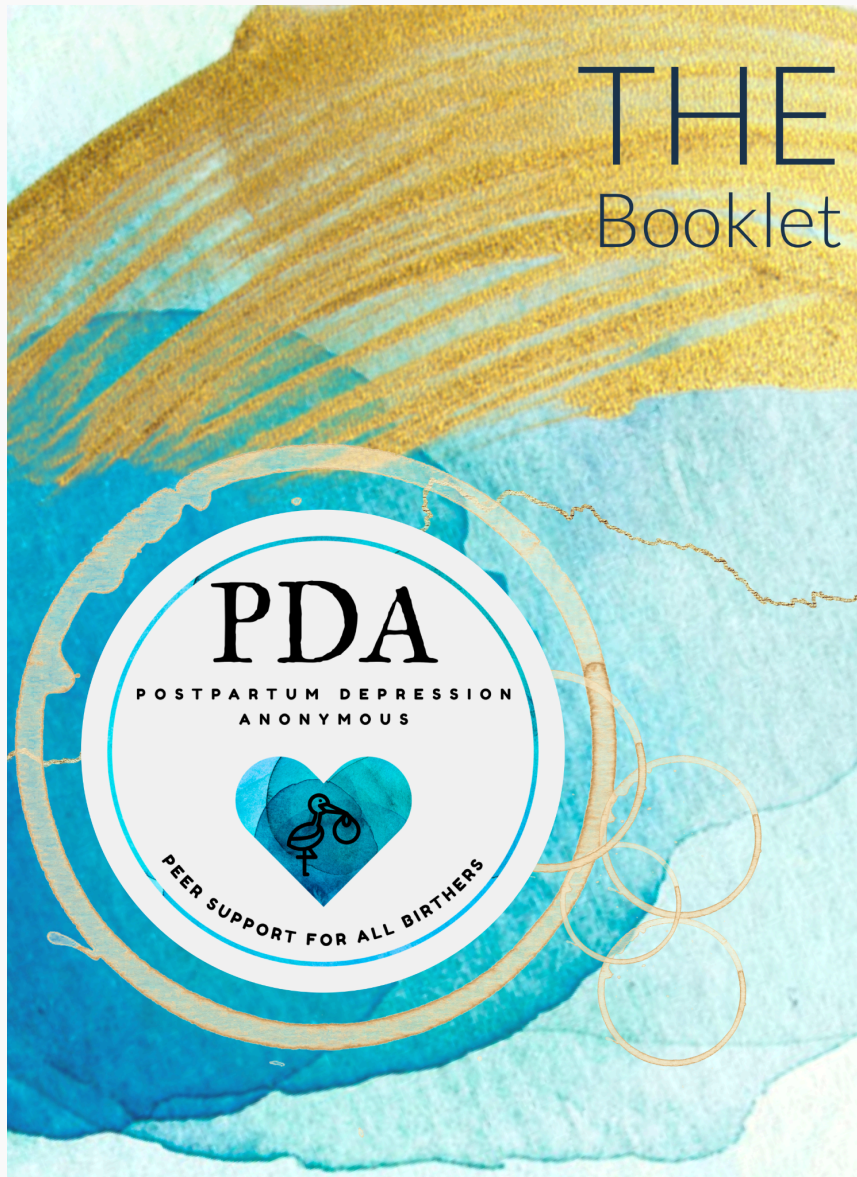
Name	Contextual Information	Contact Information	Location (Pan-Provincial)
Healthy Pregnancy Outreach Program (Squamish & Pemberton)	Pre and post-natal individuals weekly drop-in discussion group, cooking club and one-on-one support. Program is for women who are pregnant / have child 6 months old or less. Funded by Government of Canada (GoC).	Squamish: Ruby Bhangoo - (604) - 815 - 3808 Email: ruby.bhangoo@sscs.ca Pemberton: Lorelee Seitz: (604) - 894 - 6101 Email: lorelee.seitz@sscs.ca	Sea to Sky Community Services. 38024 Fourth Ave. Box 949. Squamish, BC V8B 0A7 Pemberton location is weather dependent.
Pregnancy in-reach Worker as part of pilot project	As a part of the Healthy Care Pregnancy Program Pilot Project, 10 different sites were provided funding to hire an in-reach worker. This worker supports pregnant and pp (0-7months) individuals by talking to them about their needs, offering services, people and resources the client can access and attend appts with you.	https://www.bcapop.ca/resources/Documents/HCPP%20Portal%20Documents/HCPP%20Poster%20%20(6).pdf	https://www.bcapop.ca/Pilot-Project
Merritt Moms and families	Pregnancy and pp (0-6 months) & families with children 0-6 years old. Offer various forms of support, prenatal classes, nutritional counselling, bodyfeeding support, outreach, infant massage and one to one support. Can support Aboriginal folks to learn more about culture and meet Elders.	Rhonda Munro Family Development Coordinator Email: mfc@conayt.com Call: 778-661-1016 Steffanie Michel Prenatal Coordinator Email: psw@conayt.com Call: 778-661-1010 Shelley Bara Prenatal Outreach Worker Email: prenataloutreach@conayt.com Call: 778-661-1000	Conayt Friendship Society. 2164 Quilchena Avenue. PO Box 1989. Merritt, BC V1K 1B8
Pregnancy Outreach Program at North Okanagan Friendship Center Society	Free and confidential support during pregnancy and up until baby is 6 months. Offer weekly group sessions. Nutritional education and coupons, prenatal/birth classess, breastfeeding support, monthly cooking classes and offer support from nutritionists, nurses (work with public health nurses in Armstrong, Cherryville, Falkland and Lumby) and outreach workers. North Okanagan Friendship Center Society is an Indigenous non-profit affiliated but also offers services in Punjabi and Hindi. Also have branches of program such as postpartum depression peer support group and for mothers for recovery.	(250) - 542 - 5448 ext. 108; text (250) - 306 - 9954 For Services in Punjabi or Hindi : Contact Baljinder (250) - 558 - 9432 prenatal@fnfc.ca	North okanagan Friendship Center Society 2904 29 Ave, Vernon, BC V1T 1Y8
Postpartum Depression & Anxiety peer support group at Boys & Girls Club of Vernon	Referral required from RN, midwife or doctor required due to limited space.	Resource-Nurse@nofcs.ca	Boys and Girls Club of Vernon, 3300 27th Ave, Vernon, BC
North Island Community Services Society (NICSS) Promising Babies	Funded by Canada Prenatal Nutrition Program by PHAC. Particular focus on providing support to prenatal and postpartum (up to 1 year) individuals facing high risk such as isolation, family violence, use of substances, food security, teen pregnancy etc.	Program Coordinator: Shannon Llewellyn (250) - 230 - 3763 OR (250) - 956 - 4484 Email: s.llewellyn@nicommunityservices.ca OR reception@nicommunityservices.ca	North Island Community Services Society. PO Box 1028. Port McNeill, BRITISH COLUMBIA. V0N 2R0

Name	Contextual Information	Contact Information	Location (Pan-Provincial)
Quesnel Pregnancy Outreach Program	Individual and group services including educational information about nutritional health, access to prenatal care, counselling and caring for babies after birth. Referral required but can fill out self-referral	Phone: (250) - 992 - 2481 Fax: (250) - 992 - 3439 Email: heidik@quesnelcdc.com	Quesnel & District Child Development Centre 300 - 488 McLean St. Quesnel, BC V2J 2P2
Starting Smart Pregnancy Outreach Program	Prenatal to 6 months pp, provide lunch and services are open to whole community free of charge. Offer birth preparation classes and one-on-one outreach services.	Phone: (250) - 842 - 4516 Email: cnpnstar@gmail.com	2452 B Hwy 62, Hazelton, BC, Canada, British Columbia
Healthy Start	Offer weekly classes to focus on topics to improve health and social development of pregnant women and their children.	Southside: (250) - 692 - 6063 Burns Lake: (250) - 251 - 8222 Email: OFFICE@THELINK-LD.CA	125 - FIRST AVENUE, BURNS LAKE, BC
Carrier Sekani Family Services Prenatal Nutrition Program	Provide various different resources and referrals to different programs that support prenatal and pp health (up to when children 6 years of age, although more focus on child as getting older). Program did not have active page, may not be currently offered.	https://www.csfs.org/contact-us/contact-information	Lots of different offices...
Family Place	Peer support groups, parenting support & education and playgroups. Also offer at home support after birth (need referral but can self-refer). All services free and most offer snack or meal. Childminding for children 1-5 years.	(250) - 352 - 6678, ext. 1	Family Place. 312 Silica Street, Nelson BC V1L 4M5

Name	Contextual Information	Contact Information	Location (Pan-Provincial)
Canadian Mental Health Association https://cmha.bc.ca/documents/postpartum-depression-3/#cure	Has resource page for postpartum depression	(604) - 688 - 3234 1 - (800) - 555 - 8222 info@cmha.bc.ca	Suite 905 - 1130 West Pender Street Vancouver
Parent Support Services Society of BC	Offers province wide and regional support groups for free, regardless of immigration status and some offered in different languages. Volunteer facilitators.	office@parentsupportbc.ca	
Aboriginal Mother Centre Society https://www.aboriginalmothercentre.ca/programs	Provide housing for Aboriginal mothers and kids that are at risk of or facing homelessness and/or that have or are at risk of having their children apprehended. Open to having organizations reach out to collaborate or offer programs or resources that might be suitable for family wellness programs.	Sarah Anne Mitchell (604) - 558 - 2627 x 7011 programs@aboriginalmothercentre.ca	
Centre for addictions and Mental Health (CAMH)	SUMMIT study - more than 1100 perinatal women across north america involved in behavioural activation therapy. Support mental health broadly but currently unable to offer perinatal services.		

Name	Contextual Information	Contact Information	Location (Pan-Provincial)
(CARES) Central Access & Rapid Engagement Services	Mental health & substance use services for clients, family members and pcps.	(250) - 519 - 3485	1119 pembroke st, Victoria
Right from the Start	Support for pregnant people and new parents by public health nurses that are available via phone or in person at island health public health units across the region. Offer ohysical and emotional support to new parents and babies	1 - (855) - 544 - 2403 RFTS@islandhealth.ca	
BounceBack	Free skill-building program designed to help adults and youth 13+ manage low mood, mild to moderate depression, anxiety, stress or worry. Coaching delivered online or over the phone, available in many different languages - english, french, cantonese, mandarin and punjabi.	1 - 866 - 639 - 0522 bounceback@cmha.bc.ca	across the province
Cognitive Behaviour Therapy (CBT) Skills group: participant information. Victoria Division of Family Practice https://divisionsbc.ca/sites/default/files/users/user55807/Patient-Information.pdf	MSP -covered physician led CBT skills program. Upfront cost of \$75, \$40 returned if you attend 7 or more sessions and the remaining \$35 covers the cost of the workbook.	(778) - 746 - 1705	
Salmo Community Services	Organize various programs to support community members. Lorraine Kreuzer (250) - 357 - 2277 ext 203	250 - 357 - 2277	
SmartMom	Sends educational text messages every week which include links to websites, phone numbers and videos on various gestational age related topics	"contact@smartmomcanada.ca 1 - (800) - 871 - 2229"	

Appendix 3



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Preamble

Postpartum Depression Anonymous is dedicated to helping people through the time before and after birth, often described as the pre- and postpartum period. We do this by connecting and sharing with others in a peer to peer support setting. Our collective is based on the 12 Step peer support framework. The 12 Step program, in the context of our collective, is one of inclusion, secular serenity and neutrality.

Mission Statement

Our mission is to offer a safe space to access inclusive support for all birthers experiencing mental health challenges through the perinatal period.

The Logo

Our logo – STORK is HEART: "Sharing truthful, organic, relatable knowledge is helpful, effective, anonymous, rewarding tranquillity." In Short "KNOWLEDGE is TRANQUILLITY."™

™

PDA Mantra

Together may we find the mental wellbeing to accept the things we cannot change, the courage to change the things we can and gain the wisdom to know the difference.

About Postpartum Depression

Postpartum depression does not discriminate and any birther may be affected by the temporary experience.

Postpartum depression (PD) looks different for everyone, but common lived experiences may include difficulty connecting to loved ones, overwhelming exhaustion causing you to sleep too much or not at all, loss of interest in activities that used to bring joy, loss of energy, excessive repetitive behaviours, anxiety, and/or feelings of worthlessness. Many of us may be living in denial - afraid to admit what we are feeling out of fear, shame and even guilt. We may find ourselves asking, "What's wrong with me?". In fact, there is nothing wrong with us. Many factors may play a role in the development of illness. These factors include physical, psychological, genetic, social, and emotional factors, as well as rapid hormonal changes during the perinatal period. It's not our fault. We are not alone. There is help available.

While peer support is an important tool of care during the perinatal period, it is not a replacement for professional treatment. Only a health care professional can diagnose someone with depression or other mental health disorders. If you think you may be experiencing depression, it is important to seek safe, professional care, and advocate for your feelings. You deserve to get the best care possible, and all the help your community has to offer.

Welcome to PDA

Welcome to PDA. This may be your first meeting or perhaps you've been coming for a while now. Regardless of where you are on your journey, we always begin somewhere. Some of us might be first time moms, surrogates, trans men, birthers of multiple babies, or birthers of babies that, heartbreakingly, did not survive outside the womb. Maybe you are trying to conceive or maybe you have many experiences of pregnancy loss, abortions and/or your children are not able to live with you at this time.

One thing that joins us, is our common lived experience surrounding our mental health in the period surrounding birth. And although our journeys to this point may have been different, we have arrived here. Together. You are in a safe space here. We aim to be a beacon of light to one another - in the depths of our despair - to acknowledge each other and validate our feelings and experience.

We encourage you to attend as many meetings as possible and even after this temporary mental health challenge has passed, we encourage you to continue on this path of healing. The reason we ask you to stick around is so that you may show others that it is possible to heal and that things will get better.

When we use the 12 Steps of Postpartum Depression Anonymous we may see growth that we never knew we needed or was possible. We become ready to live the best versions of ourselves, for ourselves. The 12 Steps of PDA encourage us on a journey we refer to as STORK is HEART: "Sharing truthful, organic, relatable knowledge is helpful, effective, anonymous, rewarding tranquillity." In Short "KNOWLEDGE is TRANQUILLITY."

Feel your feelings! We are here for it, honey!

Introduction to the 12 Steps of PDA

The 12 Steps are a tool for helping us realise the best version of ourselves and guide us to actualize that authentic self. When we actualize the best version of ourselves, we become better human beings, and that will naturally translate to all our relationships and life experiences. This is important in the postpartum period when we need to nourish ourselves. The 12 Steps of PDA are merely suggested. The program is something we each choose to do, in our own time and in our own way. Each step prepares us for the next step. We can take as much time as we need with each step. There is no time limit or time frame one needs to work through them. We're mindful not to place expectations of hurry on ourselves.

The 12 Steps of Postpartum Depression Anonymous

1. We admit our lives have become unmanageable and we are feeling powerless over our mental wellbeing.
2. We are beginning to believe that it is possible to restore our personal peace of mind.
3. We are making a decision to turn our current experience over to a power outside of ourselves.
4. We are making a commitment to see ourselves honestly, compassionately and without self-criticism.
5. We admit to ourselves, a power outside of ourselves and to another human the commonalities in our positive and negative patterns.
6. We **ARE WILLING** to release the negative to a power outside of ourselves and amplify the positive.
7. We **WILL ACTIVELY** release the negative to a power outside of ourselves and amplify the positive.
8. We will make a list of people we believe we need to make amends or gratitude offerings to and be willing to make them.
9. We will make amends or gratitude offerings to such people, except when doing so would cause harm to ourselves or others.
10. We will continue to search within ourselves daily and when negative, correct it, and when positive, give gratitude.
11. Through the support of our peers, tools of the program, self-reflection, the act of letting go, and including ourselves in our boundaries, we continue to improve our lives.
12. Having a conscious personal awakening as a result of these steps, we practise these principles in all our interactions.

The Health and Safety of our Collective

To keep our PDA meetings healthy and safe, to serve our members in a meaningful way and protect the unity of our collective we follow these basic rules.

1. We leave our religion, politics and titles at the door and do not discuss them at our meetings.
2. Postpartum Depression does not discriminate, so neither do we.
3. Gender has many forms, identities, and names. PDA welcomes all birthers, from all walks of life, with all types of birthing experiences.
4. We do not tolerate any expressions of bigotry, racism, transphobia, anti-semitism, and the like.
5. We allow members time to share, uninterrupted. We do not cross talk, including using in-app chats when applicable and silence our devices.
6. We do not give advice, we merely share how we may have solved similar problems.
7. NO gossip. Period.
8. We hold in confidence what we hear in meetings and do not repeat what others share with us.

In This Moment

- In this moment we allow ourselves to feel joy.
- In this moment we will take three deep breaths.
- In this moment we forgive ourselves for one thing.
- In this moment we allow ourselves to let go of resentments.
- In this moment we acknowledge something positive.
- In this moment we remind ourselves that we are capable of healing.
- In this moment we allow ourselves to grieve.
- In this moment we allow our feelings to move within and through us.
- In this moment we cease any hate that we feel.
- In this moment we give ourselves grace.
- In this moment we respect ourselves.
- In this moment we think of something kind about ourselves.
- In this moment we free ourselves from other people's responsibilities.
- In this moment we do not judge ourselves.
- In this moment we see ourselves with compassion.
- In this moment we have empathy for our struggles.

One Day at a Time

Postpartum Depression and anxiety can seem endless. To aid in our journeys of healing from this temporary mental health challenge, we practise the motto of one day at a time. Some days we might need to break it down to one hour or even one minute at a time.

With the mindset of taking life one day at a time, we free our minds from things like worrying about the future. Taking one day at a time offers us the strength to make it through the day and attend to the things that only this day requires of us.

One day at a time allows space for us to focus on the present moment, reducing the scope of problems life can throw at us.

How important is it?

How important is it to fold the laundry, do the dishes or sweep the floor? Is any harm going to come to me if I don't get to those things today? Would resting and digesting be more beneficial to my well being?

It can be any number of things that we are stressing over today. But is it really important? Do we need to be stressing or beating ourselves up over it? Every day tasks can seem super overwhelming when our mental health is struggling and it is easy to feel bad for not being able to keep up with everyday tasks. The next time you are being too hard on yourself, remember the question "How important is it?"

The Twelve Intervention and Crisis Traditions of Postpartum Depression Anonymous

It is with utmost respect and importance that we adhere to these Traditions of the PDA Collective.

Purpose:

- These are a mandatory set of structured rules to follow that maintain anonymity of our members;
- They protect the safety of our members and their loved ones in the event we become alarmed by an interaction within the meetings;
- To foster harm reduction;
- To prevent a crisis;
- To intervene in a healthy, compassionate and meaningful way.
- To ensure respect for self advocacy.

The 12 Intervention and Crisis Traditions of PDA

To keep our members, and when applicable, their children and families safe, we follow these Twelve Intervention and Crisis Traditions. No one member has the authority to take action and all must adhere to these traditions. Membership of the group may be revoked as a result of not following these processes.

1. Compassion, empathy, kindness, love and transparency are and will always be the guiding force of these traditions.
2. If a situation arises where any member(s) of the group becomes extremely concerned with the personal wellbeing of a member and/or their family, or identifies a severe crisis, the concern will be privately expressed to the host of the meeting as soon as possible.

3. It is the host and the concerned member's responsibility to reach out to the person of concern. Together they will work towards resolution.
4. If the member of concern is unable to accept the concerns of the host and member, and/or a resolution can not be identified, the issue will be presented to the group as a whole with compassion, empathy, kindness, love and transparency.
5. It is the duty of the group to have transparent discussion, while still following the guidelines of no cross talk and no discrimination.
6. After discussion is had, the group will decide together, by way of consensus decision making, if further steps and/or actions need to be taken.
7. The group will come up with an action plan. If the member in question is not part of this discussion, the action plan will be made known to them prior to action.
8. The group will allow the member of concern agency and self advocacy if they feel the action will further harm them. It is important to understand why and alter the action plan if necessary.
9. No matter the instance or action plan, the anonymity of the members' shares will be respected. This includes when needing to report to an agency outside of the PDA collective. The agency does need to know why a report is being made, they just need to know what to do.
10. If reporting to an agency outside of the PDA fellowship, a wellness check will be requested for the member.

11. A single point of contact and responsibility to report will be defined by the group. Reporting must be anonymous to protect the anonymity of the collective and its members.
12. Be very aware and evaluate all avenues for support before coming to a decision. Extra support from the members might be the best thing, but always bear in mind we are not a replacement for professional help and care.

Disclaimer

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Appendix 4



PDA Meeting Script (2024)

OPENING THE MEETING:

Hello everyone, and a special welcome to any newcomers. I'm _____, I'll be chairing our meeting.

- We do request that we have our video on for the duration of this meeting.
- This creates a better connection to each other and shows our support to everyone.
- We do understand that sometimes we may need to have our screen off for personal reasons - please do our best to limit this whenever possible.

Though we may be calling in from different regions, we'd like to acknowledge that many of us reside on the traditional territories of Indigenous peoples, on land that was stolen.

- We acknowledge the ancestral stewards of the land, and thank them for their stewardship, past, present and ongoing.

Postpartum Depression Anonymous (PDA) is a peer to peer support group for those of us who have been, or still are, affected by mental health challenges in the pre- and postpartum period.

- We offer our help by sharing our lived experience with these mental health challenges.
- Together we can hold one another up.
- In these meetings, we don't give advice or tell each other what to do, we simply suggest how we solved similar problems.
- We share about our own journey.



We hope that when we attend our meetings, we are able to move through our situations with meaningful support from each other and know that we are not alone on this journey.

- We practice the Twelve Steps of PDA as an optional tool to aid in healing ourselves emotionally and mentally.
- We respect each other's anonymity.
- This program is a suggested way of improving our mental well being, in our own time and in our own way.

Let us open the meeting by taking three mindful deep breaths.

As we begin, remember that we do not ask questions or comment on what others say, as this would be considered crosstalk. This includes using chat during the sharing.

All the emotions are welcome in this meeting.

- We are invited to feel them freely.
- One of our slogans is, "If we are feeling it- express it".
- In this meeting we get to share whatever we feel we need to.
- Crying, anger, laughter and everything in between.
- We are in a safe place. We've all been there before.

The following readings come from "The Booklet"

- We can access it for free on our website at [PDA-support.org](https://pda-support.org).

READINGS (assign each reading to someone different):

1. Welcome to PDA
2. The Health and Safety of our collective
3. The 12 Steps



PICK TWO READINGS (assign each reading to someone different):

4. In This Moment
5. About Postpartum Depression
6. How Important is it?
7. One Day at a Time

Alright let's open the meeting for sharing.

VIRTUAL MEETING-

- Please stay muted when we are not sharing.
- Please do not use the chat during sharing.
- It is common to say "Thanks for listening" when we finish.
- Everyone is welcome to respond with "Thanks for sharing" or whatever positive phrase we feel like saying!

IN PERSON MEETING

- Please silence your phone and/or devices for the duration of the meeting.
- No talking at all when we are not sharing.
- It is common to say "Thanks for listening" when we finish.
- Everyone is welcome to respond with "Thanks for sharing" or whatever positive phrase we feel like saying!

Who would like to share first?

CLOSING THE MEETING:

Thank you to everyone for being here. We invite ourselves to keep coming back, even after our mental wellness has returned.



- We gain strength, wisdom and peace of mind from other members.
- It's important that we return to be that beacon of light for the newcomers.

PDA offers a sponsor for the week so that members have someone to reach out to, if needed, during the week.

- It's only a one week commitment.
- We just have to listen, suggest how we solved similar problems and/or read some PDA literature.
- It's a great way to be of service and to gain personal confidence.

Is there anyone here tonight who is willing to act as a sponsor for one week?

- Wait for Volunteer to come forward

VIRTUAL MEETING

- Please share your preferred method of contact to everyone via the chat and thank you for volunteering.

IN PERSON MEETING

- Thank you for being of service, if anyone would like their information please stick around after the meeting.

Would anyone like to volunteer to chair next week's meeting?

- It is super easy.
- There is a first time for everything.
- I've been following our Group Script that our host sends out and every one has free access to The Booklet readings online.
- Wait for Volunteer to come forward
- Thank you for volunteering to be of service.

To help guide our meetings in a meaningful way, tonight's Chair will choose the topic for next week's meeting.



- Acceptance
- Rest is Best
- Self-care
- Awareness
- Compassion
- Empathy
- Denial
- forgiveness
- Respect
- Courage
- Nourish
- Anxiety
- Fear
- Futerizing
- Control
- Boundaries
- Unmanageable
- Focus on ourselves
- The Power of a meeting
- Service work
- Clarity
- Responsibilities
- Sharing
- Changing our minds
- Belonging



- One at a day
- In this time
- moment
- How important is it
- Changes
- Growth
- Working the Steps
- Step ____ (fill in the blank)
- Limits
- No longer alone
- Progress not perfection
- Letting go
- Guilt
- Just for today
- Greif
- Nothing changes, if nothing changes
- Slow Down
- Facing Reality
- Overcoming
- Patience
- Desperation
- Humility
- Wisdom



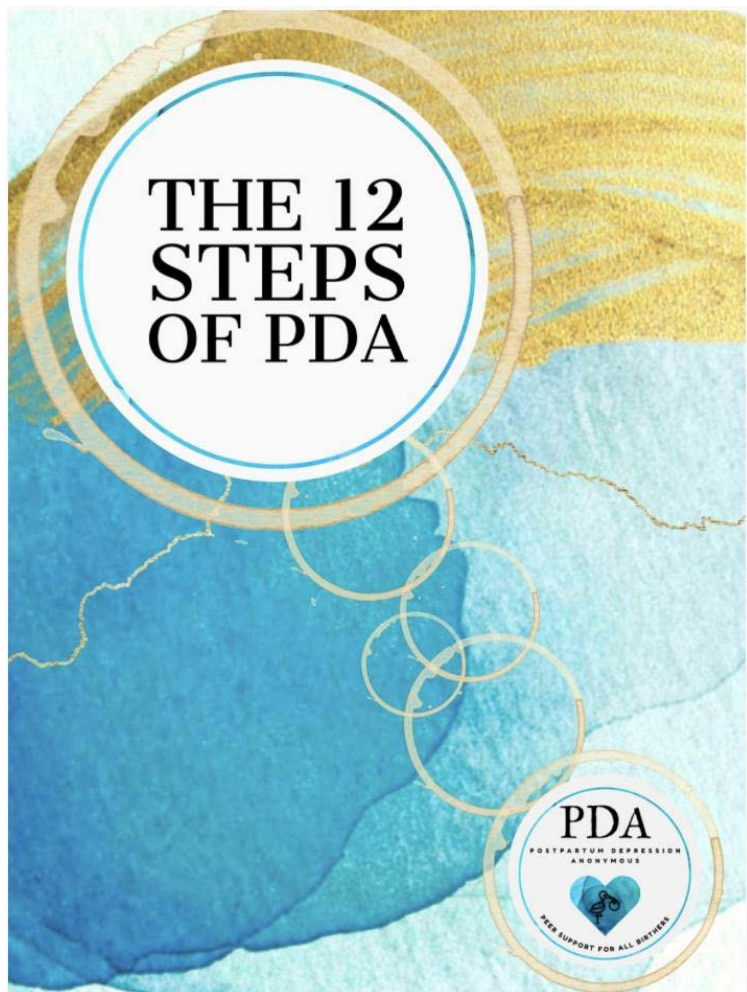
As this is an anonymous program, we remind everyone to respect our anonymity.

- When we leave our meeting, we take home with us those thoughts that have been most helpful and leave the rest
- Please keep coming back
- We will now close the meeting by reciting the PDA Mantra and closing.
- I will say it and everyone else is asked to say it with their mute on.
- Let's say it like we mean it.

"Together may we find the mental wellbeing to accept the things we cannot change, the courage to change the things we can and gain the wisdom to know the difference. - Keep coming back. It works if we work it, so work it because we are worth it!"



Appendix 5



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Preamble

Postpartum Depression Anonymous is dedicated to helping people through the time before and after birth, often described as the pre- and postpartum period. We do this by connecting and sharing with others in a peer to peer support setting. Our collective is based on the 12 Step peer support framework. The 12 Step program, in the context of our group, is one of inclusion, secular serenity and neutrality.

Introduction to the 12 Steps of PDA

The 12 Steps are a tool for helping you realise the best version of yourself and guide you to actualize that version. When we actualize the best version of ourselves, we become better human beings, and that will naturally translate to all our relationships and life experiences. This is important in the postpartum period when we need to nourish ourselves. The 12 Steps of PDA are merely suggested. The program is something you choose to do, in your own time and in your own way. Each step prepares us for the next step. We can take as much time as we need with each step. There is no time limit or time frame one needs to work through them. We're mindful not to place expectations of hurry on ourselves.

Intention of the 12 Steps

The 12 Steps are grouped into four phases:

1. Letting Go
2. Accountability
3. Self-Forgiveness

4. Transformation

Steps 1-3

The first three steps help us develop awareness and language to describe our experiences and current state of mind, and to build the foundation for positive change to occur. This phase is referred to as the "letting go" phase. It allows us to realise that even when we feel our worst, there is hope for mental wellness. It teaches us how to have full, transparent honesty with ourselves. When we are honest with ourselves in this way, we become open to the idea of letting go of what we cannot control, and reclaiming what we can. We learn to let go of our fears and allow ourselves the permission to turn them over to a power outside of self.

Steps 4-6

This phase is referred to as the "accountability" phase. Working through these steps provides us with courage to fearlessly acknowledge what we can and cannot control. We do this by acknowledging what is positive and negative within ourselves. This includes patterns in our reactions, actions, communication and behaviours. The first phase helps us ensure we have a solid foundation of self-awareness which we can build upon. It prepares us to be honest and transparent and teaches us how to release what we cannot control. With this foundation, we are now able to attain the willingness for change, growth and accountability to occur. Working together, with another person, or with a group on Steps 4, 5 & 6 is a supportive approach.

Steps 7-9

This phase is referred to as the “self-forgiveness” phase. This phase encourages us to have empathy towards ourselves and illuminates our ability to transform ourselves in meaningful and long lasting ways. Because the previous phases provided us a foundation to be honest with ourselves, and ignited a new level of courageousness and willingness for growth and change to occur, we now find the change to be tangible within ourselves, often experienced as self-compassion.

Steps 10-12

The final phase is referred to as the “transformation” phase. If we look at our journey through the Steps as building a new home because we have outgrown our old one, we can see that phase one gave us a foundation, phase two gave us the framing, phase three gave us the roof and walls to create the solid structure of the new home we created and phase four is about settling into and enjoying our new home.

The honesty, integrity and grace we have been working on is now like breathing. This change in us is now second nature and no longer something we are working towards, but something we are living and practising. We no longer view this program as only something to be applied to help us through our perinatal mental health challenges, which brought us together into these meeting rooms, but as a new healthier way of life. We are now presenting the best version of ourselves to the world and to ourselves, in our relationships, interactions, community and literally all our affairs.

We get here step by step, one day, one moment at a time, and we do it all in our own way and in our own time. No one told us how to “do it”, *when* to do it, or what to do or not do. We just continue to come to meetings. We use the suggested tools of the program such as sharing, journaling and meditation. We arrive at meetings ready to listen for the sake of listening and allow ourselves to learn from other people sharing about their similar life experiences and how they approach problems similar to ours. In turn, we share our personal journeys with others so that others can hear about our approach to solving similar lived experiences.

The 12 Steps of Postpartum Depression Anonymous

1. We admit our lives have become unmanageable and we are feeling powerless over our mental wellbeing.
2. We are beginning to believe that it is possible to restore our personal peace of mind.
3. We are making a decision to turn our current experience over to a power outside of ourselves.
4. We are making a commitment to see ourselves honestly, compassionately and without self-criticism.
5. We admit to ourselves, a power outside of ourselves and to another human the commonalities in our positive and negative patterns.
6. We **ARE WILLING** to release the negative to a power outside of ourselves and amplify the positive.
7. We **WILL ACTIVELY** release the negative to a power outside of ourselves and amplify the positive.



8. We will make a list of people we believe we need to make amends or gratitude offerings to and be willing to make them.
9. We will make amends or gratitude offerings to such people, except when doing so would cause harm to ourselves or others.
10. We will continue to search within ourselves daily and when negative, correct it, and when positive, give gratitude.
11. Through the support of our peers, tools of the program, self-reflection, the act of letting go, and including ourselves in our boundaries, we continue to improve our lives.
12. Having a conscious personal awakening as a result of these steps, we practise these principles in all our interactions.

Step 1

We admit our lives have become unmanageable and we are feeling powerless over our mental wellbeing.

Denial is mental health challenges best friend! However they don't have to be best friends forever. Step 1 encourages us to break free by simply admitting that things are feeling overwhelming, or maybe that we are not quite connecting to those around us. Perhaps we find ourselves feeling alone or isolated. We may be experiencing some obsessive compulsive* thinking or actions (*when a person feels compelled to repeatedly perform certain actions or thoughts to alleviate persistent fears or intrusive thoughts). The obsessive thinking and actions may be an attempt to control things that are simply out of our control. In Step 1, we admit our life's unmanageability and our powerlessness over it.

When we admit and accept what we can not control, we are then able to free ourselves from fear and/or compulsions. We become grounded, or more grounded than we were. We can breathe a little easier, especially when we hear others share similar things. Our lives may feel unmanageable and overwhelming but we are no longer alone.

Step 1 is the first step in shifting our focus onto ourselves rather than those around us. It's the beginning of the journey of putting ourselves first. It's the beginning of realising that our needs matter, it is ok to have needs and we ourselves can meet those needs, without the expectation that others meet them for us.

A huge part of this step is first identifying our worries and fears so that in future steps we can process and let go of anything that is holding us back from living our best life and finding the best versions of ourselves.

Some questions to consider and answer that aid us in working through Step 1 (in our own time and in our own way).

1. Do I experience difficulty expressing my needs?
2. Am I able to talk openly and honestly about my fears?
3. Do I believe my fears to be rational? Why?
4. Can I admit I have no control over the onset of my perinatal mental health challenges?
5. Am I isolating myself from my community, friends and family? Please elaborate.



6. Do I try to cover up my anxiety and mental health challenges when talking about how I am doing with others? If yes, why?
7. Do I have a fear of change? If yes, why?
8. Do I feel like I will never get past this mental health experience?
9. What in my life do I not have control over?
10. What in my life is not mine to control?
11. What can I control in life?
12. What is mine to control in my life?

At first it might be easier to answer these and the rest of the Step questions inward, through thought. It may be helpful to seek answers through journaling or writing, creating art, singing or dancing the answers. Journaling may look different for each of us, depending on our preferences and abilities. We express our answers in whatever ways work best for us, in our own time and in our own way.

Step 2

We are beginning to believe that it is possible to restore our personal peace of mind.

Step 1 allows us to admit and accept our reality for what it is. We now start to realise that our mental state in Step 1 was one that we did not create.

In working Step 2, we start to see a light where all had been dark. We recognize that our current mental health experience can be temporary, and begin to have hope that, in time, our mental wellbeing can be restored.

How do we attain this hope? We accept that we alone can not efficiently get it back. We recognize we need to allow ourselves to accept help. 12 Step programs suggest that we find a power outside of ourselves to turn things over to, specifically, the things that are out of our control. We as individuals have the right to make up, create, acknowledge whatever power works for us, whatever we want that to be. For some of us, it might be science and facts that get us there. It might be the meeting itself, an object in your home, a journal. It might be a supernatural concept. It may be nature. It does not matter what this power beyond ourselves is, it can be multiple things and ever changing. It's just a pathway that allows us to visualise letting go of something that is not working and mentally giving it to something outside of ourselves to take care of it.

When we do this, we give ourselves the opportunity for freedom from self-imposed burdens, fears, mistaken senses of responsibility, resentments and so on.

Step 2 is not an action step, just a shift in thought. It's just asking us to think of the possibility of peace of mind.

Here are some questions to consider and answer that aid us in working through Step 2, in our own time and in our own way.

1. Thinking of the words 'believe', 'hope' and 'willingness', what do I think those words mean?

2. Thinking of the concept of a power outside of myself, is there anything preventing me from forming the idea of one? If so, what is it?
3. Do I believe that turning something over to a power outside of myself will benefit my mental well being?
4. How can turning things over to a power outside of myself help restore my personal peace of mind?
5. Can I see the importance of letting go? Please elaborate.
6. Will letting go of things that are not mine to hold on to free up my energy and time to focus on things that matter?
7. What is/are my idea(s)/visualisation(s) of a power outside of myself?
8. Do I find myself accessing and turning things over? If yes, how do I feel after? If not, why?
9. What does restoring my personal peace of mind look like?
10. Do I feel hopeful? If not, what could I feel hopeful about?
11. Can I allow myself permission to explore the idea of what this step is suggesting could happen? With this acceptance of possibility, can I take another step in this journey?
12. If I am able to accept a power outside of myself to be a useful tool in letting go, in what ways do I see it restoring my personal peace of mind?

Step 3

We are making a decision to turn our current experience over to a power outside of ourselves.

In Step 2 we have been working towards accepting that there is a possibility of restored peace of mind and taking the time to discover and/or define a personal concept of a power outside of ourselves. Step 3 asks us to actively make a choice to turn over our experiences with postpartum depression to this personal power outside of self.

Unlike Step 2, Step 3 is an action step. We need to choose to consciously turn over our experience of postpartum depression to something outside of ourselves. Step 2 created the idea of letting go, now we must actually let go so that the change that is taking place can continue. It is not necessary to accomplish turning over as this first action, it is only necessary to make a choice to do so. Decision is the action in this Step. Turning over, for many, is accomplished.

Working through Step 3 brings us to the completion of the first phase and into the next. Transformation is occurring. Think of Step 3 as a *decluttering process*. We need to release some of the mental clutter to make room for that transformation. Step 4 can be challenging, but liberating, so it is important to begin Step 4 with as much free mental and emotional space as possible.

Some questions to consider and answer that will aid us in working through Step 3 (in our own time and in our own way.)

1. Am I feeling like this process is going to be easy or difficult? Please explain.
2. Am I able to trust the process?



3. Am I fearful of what will happen if I truly let go of what is not mine to carry? Please elaborate.
4. Do I believe that making this decision will create opportunity for positive growth to occur? Please elaborate.
5. Am I someone who usually struggles with making decisions on my own? Or do I make decisions quickly to avoid the struggle? Can I set those past experiences aside?
6. Do I feel safe and secure with this Step process? What could help me feel safer or more secure?
7. Do I believe that I will gain strength through this decision to turn over and let go? Please elaborate.
8. Using the analogy of "my plate is full," am I able to identify items I now have on my plate? What are they? Do they all belong to me? Are any of them secrets?
9. What items on that plate may I be willing to let go of?
10. What are some things to work on letting go of as I continue to work the steps? Please elaborate.
11. Am I beginning to see how trying to handle other people's choices may be unnecessarily contributing to the mental instability I am experiencing?
12. A way to look at it is "chuck it in the bucket". What can I do that will help me "chuck it in the bucket"?

Step 4

We are making a commitment to see ourselves honestly, compassionately and without self-criticism.

As we begin Step 4, remember our logo, STORK is HEART. Think about its meaning: Knowledge is Tranquillity. We will be emotional on many different levels. When we need support, it's safe to reach out for it since our anonymity will be respected. In this step we learn how to be truthful, honest and open to seeing our positive and negative traits and patterns. We treat ourselves with respect and self-compassion. The whole journey of this step opens up so much knowledge about ourselves. We get to choose whether to let go of the things that no longer serve us.

This step is about seeing ourselves and our life today - what works and what doesn't. Remembering our past is required, however some people, experiences and times may not be safe for all of us to return to. If it doesn't feel safe, we leave it be. We remember as far back as it feels comfortable for us. If it feels overwhelming, we can slow down and allow ourselves grace and time to process before continuing.

We start thinking about amends and/or gratitude offerings - but that's it, just start thinking about them. So we can breathe easy knowing that this part is just about identifying patterns in our lives and how they may have come to be.

Above all we take as much time as we need and we do it only if it feels safe.

How do we do this process? We think of significant people, experiences or times that have left a lasting impression on us or memory with us; whether it is positive or negative. We use the twelve



part tool below to aid us in this process. Each part has a series of questions - this is where a journal may come in handy.

1. Preparing

- a. What does seeing myself *honestly* and with *compassion* mean to me?
- b. Am I critical of myself? If yes, what can I do to change that?
- c. Do I believe I am worthy of self-compassion?
- d. Are there things I am not yet ready to be honest about? Can I accept that it is ok to not be ready to be honest about them at this time?
- e. What are some signs that might indicate I am feeling overwhelmed?

2. Visualising

- a. Can I see myself opening up to myself in an honest way?
- b. Can I see myself treating me with respect and compassion?
- c. Can I see myself letting go of self-criticism and judgement?
- d. Can I see myself recognizing that I might be overwhelmed?

3. Willingness

- a. Am I willing to actualize these visuals?
- b. Am I willing to commit myself to treating me with compassion and without self-criticism?
- c. Am I willing to be as honest as I feel comfortable with?
- d. Am I willing to take a break, no matter how long it might be, if I am feeling overwhelmed?

4. Reminders

- a. May I remind myself that I get to do this step in my own time and in my own way?

- b. May I remind myself to allow for compassion?
- c. May I remind myself that I only allow for things that feel safe?
- d. May I remind myself that when things are feeling overwhelming, I can take a break?
- e. May I remind myself that there is no timeframe for this and my break can be as long as it needs to be?
- f. May I remind myself not to force this process?

5. The Person, Experience or Time

One at a time, answer as many of these questions as you can. Use short answers.

- a. Has this person harmed me? Was this experience detrimental?
- b. Have I harmed them?
- c. Do I resent this person? Do I have uncomfortable or negative feelings for this person?
- d. Does this person bring me joy?
- e. Did I bring joy into this person's life?
- f. Do I foresee a need to make amends or a gratitude offering to this person?

6. The Cause

- a. What particular experience with this person stands out as either harming and/or joyful?

7. The Effect

- a. What effect has this experience had on my life?





- b. Has it created a pattern that I repeat in my life?
- c. Is it a positive or negative pattern?

8. Damage

- a. Was there damage to my mental well being by this experience?
- b. What was the nature of the damage?
- c. Have I let go of this damage or am I still holding on to it?

9. Improvement

- a. Did this experience improve my life and/or mental well being?
- b. How did it improve it?
- c. Can I utilise this improvement to counter negative patterns? How?

10. My Part

- a. Is there anything in this experience that requires me to take accountability and/or responsibility? If yes, what?
- b. Is my accountability in this experience from a positive or negative lens?

11. Looking Back

- a. Looking at all my answers, can I identify a pattern within the answers?
- b. How many of these experiences were positive and how many were negative?

- c. Am I able to pinpoint things that might be more of a pattern or character trait?
- d. What are these pattern/character traits, both positive and negative?

12. Three choices

- a. Does this require me to make amends?
- b. Should I make a gratitude offering to this person?
- c. There is always a third option of doing nothing. Not everything will need addressing, it will simply be.

Now that we have identified positive and negative patterns/traits, we make a short list of the common ones for both sides. This will be used in Step 5.

Please congratulate yourself! Step 4 may be the hardest one and it's officially behind us in this initial journey working the steps. Enjoy the rest of this journey and keep in mind it is "progress not perfection." We don't need to accomplish all of the changes in our lives all at once. Here we take care of what's working or not working right now.

Step 5

We admit to ourselves, a power outside of ourselves and to another human the commonalities in our positive and negative patterns.

Step 4 uncovers a lot about ourselves and it will be a different experience for all of us. However, our challenges are often challenges

faced by others, and sharing with others reminds us that we are not alone. Step 4 gives us the opportunity to move forward with a clearer mind.

At the end of Step 4 you were asked to make a short list of common patterns/traits. Step 5 asks us to admit to these patterns ourselves, to a power outside of ourselves and to another human being. Use this list to do so. It is as simple as that.

Some questions to consider and answer that aid us in working through Step 5 (in our own time and in our own way).

1. Am I ready to share my list from Step 4 with myself, a power outside of self and to another human being?
2. What will I look for in the person(s) I choose to share these deeply personal patterns with?
3. What method of sharing/communicating will feel the most comfortable for me?
4. Do I believe there will be healthy benefits from honest and open communication about my negative and positive patterns? Please explain.
5. Have I noticed any positive changes in my self esteem and/or confidence? Please explain.
6. Am I less fearful? Please explain.
7. What are my current relationships with fear and opinions of myself? Have I admitted what my opinion of myself is?
8. Am I willing and able to let go of the negative patterns and traits? Please explain.
9. Am I able to embrace the positive patterns and traits identified in Step 4? Please explain.

10. What about trust? Has this process opened up a new level of trust in myself? Of trust in this process? Please explain.

11. How might the process of communicating these patterns with another human being increase my self awareness and prevent me from falling back into the patterns that I am working towards releasing?

12. Am I embarrassed by or ashamed of any negative patterns/traits? Please explain. Am I actively remembering to be kind and compassionate to myself?

Step 6

We are willing to release the negative to a power outside of ourselves and amplify the positive.

Step 4 was the beginning of the accountability Step 4-5-6 phase. And we see it wrapping up in Step 6 as we become willing to release our negative patterns and embrace the positive. It does not mean we have to do it now. Step 6 just asks us for willingness to start thinking about it.

Some questions to consider and answer that will aid you in working through Step 6 (in your own time and in your own way).

1. Think about the phrase, 'willing to release', what does it mean to me?





2. When I think of all the things on my list - am I willing to release them all? Please elaborate.
3. Do I have any resentments towards my negative patterns? If yes, what are they, and why?
4. Am I giving myself enough *credit* for all the work I have done so far in these Steps?
5. If I think about the words 'resentment', 'releasing', 'love' and 'amplifying', what comes to mind?
6. Am I willing to amplify my positive traits and willing to be a better version of myself?
7. Do I think that it is possible to be a better version of myself?
8. In order to amplify my positive traits I must embrace them. How will embracing my positive patterns affect me?
9. How will letting go of my negative patterns affect my relationships with my near and dear loved ones, friends, family and community?
10. How will embracing my positive patterns affect my relationships with my near and dear loved ones, friends, family and community?
11. Are there current relationships that hold me back from living my best life and embracing a better way to live?
12. Am I ready to release what no longer serves me? Can I release it with love?

Step 7

We will actively release the negative to a power outside of ourselves and amplify the positive.

Step 7 is the beginning of the self-forgiveness phase and we do so with love, gratitude and kindness. In the previous step, we have allowed ourselves the grace and time needed to process the deep inner-workings of ourselves. We've found courage and our own understanding of the willingness to change. Now we get to actively and consciously make those changes. We do that in any ways that feel appropriate to us individually. Some use journaling, mediation, prayer and/or ceremony. Some may utilise art, dance, song or commune with nature or a supernatural force. Remember, no one has the right to define our power and/or process outside of our individual selves. When we become willing in Step 6, we allow ourselves the time and opportunity for the process to naturally present itself.

Some questions to consider and answer that can aid us in working through Step 7 (in your own time and in your own way).

1. What does it mean to me to actively release negative patterns?
2. How will I amplify my positive traits?
3. Am I able to accept that this Step is a fluid, continuous part of working my program? What does it mean to me?
4. Do I see change taking place? Please elaborate.
5. What will my process be?
6. Would journaling be a useful tool to aid me in this step? Please elaborate.
7. What has the process of this program taught me so far about myself?
8. Am I learning a better way to live? Please elaborate.

9. Do I find myself presenting a better version of myself to the world?
10. Do I notice myself being kinder to myself and to others?
11. Am I giving myself the grace and time to digest all the knowledge I am learning about myself?
12. Do I feel prepared for the next steps? Is there anything standing in my way?

Step 8

We will make a list of people we believe we need to make amends or gratitude offerings to and be willing to make them.

If we go back to our questions in Step 4, we will see the list present itself. Step 8 is asking us to have the willingness to make amends and/or gratitude offerings when needed. Sometimes feelings such as shame, guilt and fear try to come up in the working of this step. We might want to rekindle our friendship with Denial. However, reflecting on our journey through this program will remind us we have the ability, the strength and the courage to do this.

In this Step, we let go of the fear and become willing to do the work of Step 9. Step 8 and 9 both talk about amends and gratitude offerings. There are many ways in which we can do these:

1. Direct amends and/or gratitude offerings;
 - a. Directly, in person, make the amend and/or gratitude offering.

- b. We do not make direct amends and/or gratitude offerings if it will cause harm to ourselves or to others.
 - c. If making a direct amends and or gratitude offering could cause harm, we need to look at the others ways of making them.
2. Written amends and/or gratitude offerings;
 - a. This type of amends and/or gratitude offering is useful if meeting someone in person is not possible.
 - b. It is useful if we are not able to verbally make an amends or gratitude offering.
 - c. If making a direct amends and/or gratitude offering will cause harm, consider writing the amend or offering out on a piece of paper and mailing it to yourself or burn it. Do both if you like. You can do whatever you need to do with it to let it go and turn it over.
3. Verbal amends and/or gratitude offering;
 - a. This type of amends and/or gratitude offering is useful when the amends or offering could cause harm.
 - b. It's useful if we are unable to write.
 - c. You can verbalise to yourself in a mirror, to a fellow member or trusted confidant.
4. Living versus death amends and/or gratitude offerings;
 - a. A living amends and/or gratitude offering means the person subject to them is still alive.
 - b. A death amends and or gratitude offering means the person subject to them is no longer living.





- c. If the person has passed away consider a written or verbal amends and/or gratitude offering.

Some questions to consider and answer that will aid you in working through Step 8 (in your own time and in your own way).

1. Am I afraid of or nervous about making amends and/or gratitude offerings? If I am, what will help me feel better while taking these actions?
2. How will making amends allow me to forgive myself?
3. How will making gratitude offerings allow me to celebrate myself?
4. When I think of making amends, what does that look like to me for the various kinds of amends?
5. When I think about making a gratitude offering, what does that look like to me?
6. Thinking about the words 'amends' and 'gratitude', what comes to mind?
7. Am I willing to make these amends and offerings?
8. What does 'becoming willing to make' them mean to me?
9. Do I see a benefit to my personal peace of mind if I make amends or gratitude offerings?
10. Would making direct amends or gratitude offerings to certain people on my list be harmful to myself or others? Please elaborate.
11. If I am unable to make direct amends, how might I be willing to make them?
12. Am ready to let go and turn my amends and gratitude offering over to a power outside of self?

Step 9

We will make amends or gratitude offerings to such people, except when doing so would cause harm to ourselves or others.

Forgiveness and celebration of oneself! Who doesn't like the sounds of that? Step 9 is definitely an action step. We need to start making amends and or gratitude offerings.

In Step 8 we asked ourselves to become willing. In doing so, we can now allow opportunities to present themselves. Making amends and/or gratitude offerings isn't so much about immediately searching out people on your list and making amends or offering. It's about being prepared and ready for the opportunities. Sometimes we might feel we need to search the person out and other times we might just run into them in the street or at an event and if we allow our willingness from Step 8 to guide us these situations will occur with ease.

With each one we make, our personal peace of mind flourishes, our confidence expands and we become better listeners, people and the best version of ourselves will be actively presenting itself.

Remember making amends and/or gratitude offerings is a journey not a destination.

Some questions to consider and answer that will aid you in working through Step 9 (in your own time and in your own way).

1. Am I concerned with how my amends or gratitude offering will be received?
2. Do I find myself imagining the responses of the person(s)? If yes, is this a necessary use of my time? Am I creating expectations that might result in disappointments?
3. Am I futurizing thoughts and creating fears based on these thoughts? Please elaborate.
4. Would letting this process go and turning over to a power outside of myself make this step easier? Please explain.
5. Do I feel prepared to make amends and/or a gratitude offering when the opportunity presents itself?
6. Are there some amends and/or gratitude offerings I have to seek out opportunities to make? Please elaborate?
7. Do thoughts of making certain amends and/or gratitude offerings to certain people(s) on the list make me feel sick or create unhealthy anxiety? If so, should I reconsider my choice to make the amends or offering?
8. Are people coming to mind that did not show up in Step 4 or Step 8? Do you want/need to add them to your list?
9. When thinking of the phrase "a journey not a destination", what does that mean to you?
10. What positive changes or growth can I now identify in me that I didn't see before?
11. Am I happy or pleased with my journey so far?
12. Do I see myself equipped for success in the final phase of the Steps?

Step 10

We will continue to search within ourselves daily and when negative, correct it, and when positive, give gratitude.

We did it! We got through the first three phases - letting go, accountability, self-forgiveness and are now well into our transformations. The transformation phase is about maintaining the positive growth and change we now see within ourselves.

Step 10 asks us to make a conscious effort to acknowledge our actions and patterns daily. When we do this we are able to promptly address them, whether they are positive or negative. It is important to remember and remind ourselves to always put equal measure on our positive and negative experiences.

Being prompt with our accountability and/or gratitude allows us to live in the present moment with the best versions of ourselves.

Some questions to consider and answer that will aid you in working through Step 10 (in your own time and in your own way).

1. When I think about checking in with myself daily, what does that look like to me?
2. Would daily journaling be useful in this Step? Please elaborate.
3. Would a daily mindful meditation practice be a useful tool in working this Step? Please elaborate?



4. When thinking of equal emphasis on both negative and positive, what comes to mind?
5. What are the biggest changes I see in myself since beginning at Step 1 compared to where I am now on my journey?
6. Is part of me still holding on to negative patterns or traits from my past? If yes, am I willing to include them in my daily reflections in hopes of eventually letting them go? Please elaborate.
7. What does the saying "attitude of gratitude" mean to me?
8. Do I see myself as courageous? Please elaborate.
9. Am I happy that I decided to take this journey?
10. What benefits will come from taking an honest daily look at myself?
11. Am I willing to forgive and thank myself daily?
12. Do I feel confident in moving on to Step 11? If not, what is standing in my way and how do I remove that barrier?

Step 11

Through the support of our peers, tools of the program, self-reflection, the act of letting go, and including ourselves in our boundaries, we continue to improve our lives.

Step 11 introduces us to a new word, in the context of PDA, BOUNDARIES. What are boundaries and how can they be a useful tool in being the best version of myself? A boundary, in this context, is a limit we recognize, self-actualize and present to people around us through communication. A boundary is not something we use to control or hurt someone, it is a tool in protecting our personal peace

of mind. A key word in all of this is communicating. If we do not effectively communicate our boundaries to the people we need to have them with, ourselves included, then we open ourselves up to resentment, anger and frustration.

Boundaries can change over time. They are not necessarily concrete or black and white, but again, we must find ways to effectively communicate these changes.

Boundaries are only useful if we maintain them and don't allow people to cross the line of our boundary. People will try to step over our boundaries all the time. It is up to us to enforce them by using reinforcing communication.

Step 11 asks us to draw on all the tools we have learned to use and implement them in our daily lives. Through reflection on the previous steps, we will learn what our boundaries are. Step 11 is another maintenance step.

Some questions to consider and answer that will aid us in working through Step 11 (in your own time and in your own way).

1. Do I understand the definition of boundaries? Please elaborate.
2. Am I able to identify some of my boundaries? Please elaborate.
3. Do I have the confidence to communicate and enforce these boundaries? Please elaborate.
4. Are these boundaries about self preservation, mental wellbeing and my personal peace of mind?

5. Am I using my boundaries to punish someone?
6. When thinking about boundaries, how does it make me feel?
7. Am I only willing to consider boundaries or am I ready to set boundaries? Please elaborate.
8. If I am only willing, what is standing in my way? How do I move past it?
9. How has the support of my PDA peers helped improve my mental well being and my journey of personal growth?
10. Looking back on Step and Phase 1, how has my opinion of letting go transformed?
11. Has journaling and meditating been a useful tool in this process? Please elaborate.
12. How has my attitude towards self reflection changed?

Step 12

Having a conscious personal awakening as a result of these steps, we practise these principles in all our interactions.

The final Step. When we started coming to this meeting and reading the 12 Steps, this one may have been a little tricky to understand. By now you probably have it figured out. Step 12 asks us to not only apply this program to the context of PDA, but to use the tools and new skill set in our day to day life. For example, in the meetings, we do not engage in cross talk, rather, we listen to listen. How are we applying that to our experiences with people outside of the meetings?

Leading by example. A large part of our program and completing these steps is the meetings themselves. We share our knowledge based on our own lived experience and we listen to others share theirs. Through this process we share our journey and as we change, so do our shares in the meetings. Perhaps we showed up crying, mad, silent, nervous, scared - but now we share with confidence, not to be confused with ego. We are reflecting rather than dwelling. And although we may very much still be experiencing the mental health challenge, we are ready, willing and hopeful for the balance and peace of mind to return.

We are helping ourselves control what we can, letting go of what we can not and learning the difference between the two. This notion is widely spread through all 12 Step programs. It is based on a quote by Reinhold Niebuhr "...grant me the serenity to accept the things I cannot change, the courage to change the things I can."

In PDA we have our own version- The PDA Mantra:

"Together may we find the mental wellbeing to accept the things we cannot change, the courage to change the things we can and gain the wisdom to know the difference."

Some questions to consider and answer that will aid you in working through Step 12 (in your own time and in your own way).

1. When thinking about my journey working these Steps, what comes to mind?



2. Have I witnessed a transformation in myself? Please elaborate.
3. Do I find I am a better listener?
4. When thinking about compassion and empathy, what comes to mind?
5. Do I see myself as someone who is compassionate and empathetic? Please elaborate.
6. Am I filled with hope? Please elaborate.
7. Do I have a better understanding of who I am? Please elaborate.
8. How full is my mental plate? Is everything on it mine?
9. What is the biggest takeaway for me from working these Steps?
10. What would be the benefit of me continuing to come to these meetings and working the Steps even after my mental well being is restored from the perinatal mental health challenge?
11. Would continuing to come to meetings and sharing my experiences help me carry the message to newcomers attending the PDA meetings?
12. Was there anyone in the meetings that gave me hope? In what ways could I pass that hope on to others?

You've successfully completed your first set of Steps. (Some people do them multiple times.) Be proud of yourself! This is now another tool in your basket. Thank you for starting the journey. May it continue to ever flow and allow you to bring the best version of yourself to all situations.

Disclaimer

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Appendix 6

Postpartum Depression Anonymous Guide to Scalability & Services

Cultural Appreciation and Acknowledgment:

PDA fully acknowledges the use of Indigenous teachings to guide the creation of our documents and literature. We use the Seventh Generation Principle and Seven Grandfather Teachings.

The Seventh Generation approach is used in two ways. The first being to reflect on three generations prior, to evaluate what has and has not worked within the 12 step model. The next is to evaluate the current generation as a guide to hypothesize if current practices will take us in a relevant direction in the next three generations. We also use them traditionally by looking seven generations ahead to help us ask important questions about relevancy, safety, inclusion and the continuous modernization of society.

The Seven Grandfather Teachings are our past, present and future. We will forever be guided by truth, humility, respect, love, courage, honesty and wisdom. As PDA grows and shifts and evolves, we will always reflect on these teachings to ensure we are transforming, changing and planning in a meaningful way.



Diversity Statement:

Diversity. What does this mean to the PDA Collective as a whole?

- It means that now and forever more, we will continuously welcome all communities of birthers.
- We will respond with humility, respect and action when our ideas of diversity and inclusion are challenged by acknowledging that scrutiny from others allows for growth.
- We will take to heart the needs of the people that are accessing and would like to access PDA.
- We understand that the needs of people are always changing, so we must allow our PDA collective to change with it.
- We will continuously look for barriers to accessing the PDA program, so that we can remove any roadblocks with great speed.
- We will act with compassion and empathy, never assuming we know the lived experience of communities other than our own.
- When making changes that will affect communities other than our own, we will be guided, solely, by that community.

Mission Statement:

Our mission is to offer a safe space to access inclusive support for all birthers experiencing mental health challenges, through the perinatal period.

Preamble:

Postpartum Depression Anonymous is dedicated to helping people through the time before and after birth, often described as the pre- and postpartum period. We do this by connecting and sharing with others in a peer to peer support setting. Our collective is based on the 12 Step peer support framework. The 12 Step program, in the context of our collective, is one of inclusion, secular serenity and neutrality.

Vision Statement:

To help Birthers around the world regain their mental wellness throughout the varying stages of the pre and postpartum period, no matter how long after birth that might be.

We will do this by:

- Connecting through our peer support meetings.
- Practicing "The Twelves" of PDA.
- Creating a community of unity within our collective.
- Being inclusive.
- Listening to people that feel excluded and taking immediate action to reduce exclusion..
- Making PDA literature accessible to all.
- Maintaining transparency at all levels of service.
- Communicating with compassion, empathy and kindness.
- Outreaching to communities through attraction in our actions and promotion by way of posters, media, literature, etcetera.

Introduction:

This Guide takes an in-depth look at how to scale the PDA Collective to a wider audience in a way that is efficient, consistent, healthy and safe for PDA as a whole. It also acknowledges that each group and region might have individual needs that differ slightly from the PDA collective as a whole and addresses how to respond to those unique needs.

- Breakdown of our "Twelves", why we have them, the importance of having them and the value they add to our program and lives.
- Messaging- How do we be consistent in our messaging? Why is it important to be consistent in our messaging?
- Provides information you will need to start and register a group both virtual and in person. Which is best for your demographic?
- Provides information you will need to start and register a Region both virtual and in person.
- Effective communication and our role in it.
- How to reach birthers in your communities. What are the pathways? Are there partnership opportunities? Questions to consider when reaching out to our individual communities?
- Acknowledging barriers. How to stay current and relevant, identify barriers at the Group, Region and World level.
- How to be of service, and what service opportunities there are from the group to the world level.
- World Collective Committees- What are they? Who runs them? Why do we have them?
- Literature- Why do we have it? How is it created? Processes for editing, translating, printing, literature. How do we publish print, electronic and/or virtual literature? What is the literature review and approval process?

- Events- How and why do we host and/or organize conventions and conferences? What is the difference? How to host and/or organize get togethers, retreats, etcetera.
- What does our non profit status mean? How does it work?
- Board of directors- the type of board, expectations, responsibilities, terms of our board. How many members can be on the board at one time and what is our minimum? How does someone apply to be on the board? What are the requirements? How do we elect and welcome members to the board?
- Our organization's bylaws- What are they? Why do we have them and how are they created?
- What our financial practices are, including grant funding, donations and outside lenders. You will learn how to manage finances at the group and world level.
- Research and our Collective. What is the purpose? What does that look like?

Index of abbreviations and contact emails.

First things First - "The Twelves"

Why do we have them?

- To ensure members are hearing the same message no matter where or how they are attending a meeting.
- So that we are all working together, in a common way, to regain and maintain our mental well being.
- To have consistent unity throughout the collective as a whole and as individual groups.
- To have consistent procedures for service structures, crisis and intervention and policies.

What is the importance of having them?

- Having them helps us create a safe and consistent space for members attending.
- They keep diversion from the PDA Collectives primary purpose, helping birthers of all demographics regain and maintain their mental well being.
- They prevent misunderstandings.
- They create common ground.
- They protect the foundation of PDA.
- They inform us on how to solve problems, welcome diversity, and manage crisis situations within PDA.
- They maintain the integrity of the program.

What is the value they add?

- They help the spread and scalability of the PDA collective.
- They give people the confidence to start their own groups and regions.
- They provide structure, guidance and routine to the PDA collective as a whole.

The 12 Steps of Postpartum Depression Anonymous

Purpose:

- An optional tool we use to help us regain and maintain our mental wellbeing, encourage personal growth and guide us in our PDA journeys.

The 12 Steps of PDA

1. We admit our lives have become unmanageable and we are feeling powerless over our mental wellbeing.
2. We are beginning to believe that it is possible to restore our personal peace of mind.
3. We are making a decision to turn our current experience over to a power outside of ourselves.
4. We are making a commitment to see ourselves honestly, compassionately and without self-criticism.
5. We admit to ourselves, a power outside of ourselves and to another human the commonalities in our positive and negative patterns.
6. We **ARE WILLING** to release the negative to a power outside of ourselves and amplify the positive.
7. We **WILL ACTIVELY** release the negative to a power outside of ourselves and amplify the positive.
8. We will make a list of people we believe we need to make amends or gratitude offerings to and be willing to make them.
9. We will make amends or gratitude offerings to such people, except when doing so would cause harm to ourselves or others.
10. We will continue to search within ourselves daily and when negative, correct it, and when positive, give gratitude.

11. Through the support of our peers, tools of the program, self-reflection, the act of letting go, and including ourselves in our boundaries, we continue to improve our lives.
12. Having a conscious personal awakening as a result of these steps, we practice these principles in all our interactions.

The Twelve Health and Safety Traditions of Postpartum Depression Anonymous.

It is with utmost respect and importance that we adhere to these Traditions of the PDA Collective.

Purpose:

- A tool for creating a safe and inclusive space.
- A set of structured rules to follow no matter where or when you attend a meeting to keep our collective unified, from the group to the world level.

The 12 Health and Safety Traditions of PDA

To keep our PDA meetings healthy and safe, to serve our members in a meaningful way and protect the unity of our collective we follow these twelve Traditions.

1. The health, safety and unity of PDA and its members comes first. Therefore we leave our religion, politics, titles and opinions on outside issues at the door and do not discuss them at our meetings.
2. For all intents and purposes there is no one authority. We make decisions based on group consensus. We do not govern.
3. The PDA collective does not discriminate; our only requirement for attendance is lived and/or living experience with mental health challenges for birthers in the pre- and postpartum period. This includes, but is not limited to, all birthers from all walks of life, with all types of pregnancy experiences, gender identities and expressions of love.
4. Each group will be autonomous except in matters affecting other groups and Postpartum Depression anonymous as a whole.

5. PDA has one purpose; to help birthing people restore and maintain their mental well being. We do this by practicing the 12 steps of our program, comforting and encouraging each other on our journeys.
6. PDA groups and/or individual members will not endorse, finance or lend our name to outside enterprises for personal gain. Our public relations policy is based on attraction and promotion. It must always protect the personal anonymity of our members.
7. Mutual respect is part of the PDA foundation. Therefore PDA does not tolerate any expressions of bigotry, racism, transphobia, anti-semitism, or other prejudicial behavior.
8. We allow members time to share, uninterrupted. We do not cross talk, including using in-app chats. We do not give advice, we merely share how we may have solved similar problems.
9. Anonymity is held in the highest regard. We hold in confidence what we hear in meetings and do not repeat what others share with us. We practice principles above personalities.
10. Individual groups will be self-supporting, thriving on donations from their members, but have the autonomy to apply for grants applicable to their needs. Postpartum Depression Anonymous as a whole will never take loans from banks or credit card companies.
11. Postpartum Depression Anonymous should remain forever non-professional, but our service centers may employ special workers. If useful and applicable, available grants may be applied for to support the operations of PDA as a whole.
12. Postpartum Depression Anonymous groups should be well organized, create special service boards or committees directly responsible to those they serve and these positions and

committees will be transparent and open to any member who wishes to join or observe.

The Twelve Intervention and Crisis Traditions of Postpartum Depression Anonymous

It is with utmost respect and importance that we adhere to these Traditions of the PDA Collective.

Purpose:

- These are a mandatory set of structured rules to follow that maintain anonymity of our members;
- They protect the safety of our members and their loved ones in the event we become alarmed by an interaction within the meetings;
- To foster harm reduction;
- To prevent a crisis;
- To intervene in a healthy, compassionate and meaningful way.
- To ensure respect for self advocacy.

The 12 Intervention and Crisis Traditions of PDA

To keep our members, and when applicable, their children and families safe, we follow these Twelve Intervention and Crisis Traditions. No one member has the authority to take action and all must adhere to these traditions. Membership of the group may be revoked as a result of not following these processes.

1. Compassion, empathy, kindness, love and transparency are and will always be the guiding force of these traditions.
2. If a situation arises where any member(s) of the group becomes extremely concerned with the personal wellbeing of a member and/or their family, or identifies a severe crisis, the concern will be privately expressed to the host of the meeting as soon as possible.
3. It is the host and the concerned member's responsibility to reach out to the person of concern. Together they will work towards resolution.

4. If the member of concern is unable to accept the concerns of the host and member, and/or a resolution can not be identified, the issue will be presented to the group as a whole with compassion, empathy, kindness, love and transparency.
5. It is the duty of the group to have transparent discussion, while still following the guidelines of no cross talk and no discrimination.
6. After discussion is had, the group will decide together, by way of consensus decision making, if further steps and/or actions need to be taken.
7. The group will come up with an action plan. If the member in question is not part of this discussion, the action plan will be made known to them prior to action.
8. The group will allow the member of concern agency and self advocacy if they feel the action will further harm them. It is important to understand why and alter the action plan if necessary.
9. No matter the instance or action plan, the anonymity of the members' shares will be respected. This includes when needing to report to an agency outside of the PDA collective. The agency does need to know why a report is being made, they just need to know what to do.
10. If reporting to an agency outside of the PDA fellowship, a wellness check will be requested for the member.
11. A single point of contact and responsibility to report will be defined by the group. Reporting must be anonymous to protect the anonymity of the collective and its members.
12. Be very aware and evaluate all avenues for support before coming to a decision. Extra support from the members might be the best thing, but always bear in mind we are not a replacement for professional help and care.

PDA Messaging

Consistent messaging throughout every PDA meeting is the key to our success. We must ensure that every member is hearing the same message no matter where they attend a meeting. Staying consistently on brand with our promotional tools makes us stand out in a memorable way. Therefore:

- We read only from advisory approved custom PDA content.
- We use only the PDA logo and other trademark images.
- We use the PDA poster background when creating posters, specific to our individual groups' needs.
- We never read literature from outside entities.
- We use the suggested PDA script as a template to structure and present meetings, although encourage each group to adapt it as needed, to suit the needs of the group.
- We must always practice "The Twelves"

How to Start a PDA Group

Questions to ask yourself: (Humans only - No AI allowed)

- Am I prepared to commit to consistently hosting a meeting?
- Should I look for someone else in my community to co-host a meeting with me?
- Do I need to host a virtual, in person or hybrid meeting?
 - If the need is **virtual**-
 - PDA uses Zoom as a platform for hosting meetings.
 - Consistent use of the same technology is vital in the success of our collective and member attendance.
 - Do you have a Zoom Account?
 - Do you know how to use Zoom? (if not PDA as a whole will assist you in learning)
 - How will you pay for Zoom? (personally, donations, grants)
 - Do you have Wifi?
 - Is it unlimited or do you have to pay per GB?
 - Will you need funding for the internet and how will you pay for that? (personally, donations, grants)
 - If in **person**-
 - Where will you host the meeting?
 - Is there a free space that you can access?
 - If you have to rent a space, do you need insurance?
 - How will you cover the cost of the rental space and/or insurance? (personally, donations, grants)
 - Are there community grants available, will you ask for donations from members?
 - Will you fund it yourself until you have established a group?
 - Do you need to reach out to PDA the collective for assistance?
 - If the need is **hybrid**-
 - Does space have the technology equipment you need?
 - Will you provide the equipment?

- If you need to purchase the equipment, how will you fund that? (personally, donations, grants)
- Does the space have internet access?
- Is that access included in the use of the space?

Once we have answered all of those questions we need to now consider what demographic are we serving?

- Is the meeting going to be open to all birthers, or just a specific lived and living experience?
 - For example, perhaps you just want to serve people struggling with trying to conceive, or addiction, or pregnancy loss and so on.
 - It is important to consider if being exclusive is the best way for me to be inclusive to the needs of the community I wish to serve?

Now it is time to pick a name for your group.

- It would be useful to pick one that easily identifies the group's goals and/ or demographic.
 - For example, Birthers in Recovery, Unity among Birthers, Conception and Beyond, Hope After Loss, Steps to Mental Well Being, and so on.

Deciding on contact information.

- Do you want to use your personal email and/or phone number or create a new email specific to your group?
- Do you want to use a phone number generating app?
- Do you want to communicate using Whatsapp?

What do you want and need to include in your registration?

- You must include your group name and how to access the meeting, date and time of meeting and location.
- How does a person get the meeting invite and/or meeting reminder email?
 - PDA suggests using a Mailchimp landing page. This allows members to subscribe and unsubscribe at their own will.

- Additionally, having a Mailchimp "Audience" can be useful when needing to send out information other than a meeting invite.
- If Virtual, do you want the direct link to the meeting posted on the website?
- Do you want to post your email or phone number?

Now that you have all the questions answered, head to PDA-support.org to register your group. It's easy and there is a guided form to fill out. Once you are registered, your meeting will be listed on the PDA website. You will receive a free electronic information package to guide you in promoting your meeting and how PDA consistently operates meetings.

- Remember to update your information if there are any changes.
- Please let PDA know if your group is no longer operational.

Fill service positions:

- Host
 - Host meetings and sends out the meeting invites and informative emails.
 - Sends out the monthly financial report provided by the treasurer.
- Group Service Representative
 - Represents the groups voice at the Regional Level
- Secretary
 - Keeps track of the attendance numbers per meeting.
 - Keeps track of each meeting's duration.
 - Keeps track of the number of shares per meeting
- Treasurer
 - Manages the funds.
 - Looks for grant and/or funding to further the groups primary purpose, that is to reach and help as many birthers regain and maintain their mental well being.
 - Provides a monthly transparent report to the host of the group finances.
- Literature Coordinator

- When applicable manages "professional" printing of literature and getting it out to newcomers (see more about this in the literature section).

How to Start a PDA Region

Starting a region requires a minimum of three groups to work together in forming their region. (Humans only - No AI allowed)

- Each group must designate a human Group Service Representative (GSR). The role of the GSR is to liaise between their group and the region.
- Choose a name for your Region.
- Who is the single point of contact for your Region? Usually this would be the Chairperson, however, if you do not have that decided yet, you can pick someone to be a stand-in contact.

A region can be a geographical parameter and/or a cluster of virtual groups. There is no limit to how many groups can be in a Region, but PDA does suggest no more than 20.

Regions host quarterly assemblies, to discuss business matters, share information from the PDA Collective as a whole and for groups to share their concerns within their groups and/or the PDA Collective as whole.

Any Member of the region can request transparent financial reports at any time.

Each region is responsible for filling the service structure, including but not limited to, these positions:

- Chairperson
- Vice-Chairperson
- Treasure
- Secretary
 - Secondary Secretary (in the event the regular has to miss a meeting)
- Delegate
- Alternate Delegate

Not all of these positions have to be filled off the hop of starting a region.

The roles and responsibilities of each position are:

Chairperson

- The chairperson is expected to organize and send Zoom invitations out for the quarterly assemblies and any other meetings necessary to fulfill the region's responsibility to the groups and the PDA collective as a whole.
- They act in the best interest of the PDA Collective as a whole and their respective Region.
- They are responsible for informing the PDA Collective as whole, of any changes in their service structure, contact and/or active status.
- Each term is suggested to be 2 years, serving no more than 2 consecutive terms. In reality, life happens, things come up so it is unreasonable to force someone to adhere to these terms.

Vice-Chairperson

- Assumes the position of Chairperson, when the Chairpersons term has ended.
- Fulfills all the duties of the Chairperson if the Chairperson is unable to for whatever reason.
- Shadows the Chairperson to prepare for their term(s) as Chairperson.
- Each term is suggested to be 2 years, serving no more than 2 consecutive terms. In reality life happens, things come up so it is unreasonable to force someone to adhere to these terms.

Treasure

- Responsibly manages any and all funds of the region.
- Searches and applies for grants that support the needs of their region and/or have potential to grow the PDA Collective as a whole.
- To provide a quarterly, transparent statement of accounts, at the regional assembly.
- The statement must be sent out to the regional collective a few days prior to the quarterly assembly.
- Must provide a transparent statement of accounts anytime it is requested outside of the quarterly assembly.

- Each term is suggested to be 2 years, serving no more than 2 consecutive terms. In reality life happens, things come up so it is unreasonable to force someone to adhere to these terms.

Secretary

- Takes minutes, when minutes are required, at any regional meeting or assembly.
- Share any minutes with the region service structure and GSRs in a timely fashion.
- The Secretary can take minutes in whatever way feels best for them. However, the secretary should send them out in a structured fashion. (Suggested templates can be found in the Appendix)
- Each term is suggested to be 2 years, serving no more than 2 consecutive terms. In reality life happens, things come up so it is unreasonable to force someone to adhere to these terms.

Secondary Secretary

- This position is only in the event that the secretary has a conflicting schedule.
- They will take the minutes and forward them to the secretary to properly format and send out.
- There is no suggested term for this position.

Delegate

- Works for the good of the PDA Collective as a whole, by representing the voice of their region.
- The voice of the region is decided by using the information provided by the GSR and any vote, polls or surveys that are used for gathering information.
- Attend all regular meetings of their Region.
- When applicable attend all events that require representation of the PDA regions.
- Keep the regions informed about The PDA Collective as a whole.
- Each term is suggested to be 2 years, serving no more than 2 consecutive terms. In reality life happens, things come up so it is unreasonable to force someone to adhere to these terms.

Alternate Delegate

- Assumes the position of Delegate, when the Delegates term has ended.
- Fulfills all the duties of the Delegate if the Delegate is unable to for whatever reason.
- Shadows the Delegate to prepare for their term(s) as Delegate.
- Each term is suggested to be 2 years, serving no more than 2 consecutive terms. In reality life happens, things come up so it is unreasonable to force someone to adhere to these terms.

Effective Communication

Effective communication is vital. If ever our communications are causing us anxiety and/or stress we must be mindful to stop and evaluate our situation. Being mindful not place blame, but to take accountability even if only inward- the change can be reflected in our actions. If we are trying to reach the regions, or groups, or a specific demographic and are finding low response, it is up to us to effect change and try a different pathway.

Reaching Birthers in Your Community and Beyond

Community outreach is an important factor in reaching birthers in your area. Look for pathways already established. A pathway is an organization, service and/or person that has access to the birthers in your community.

Are pathways already established in your community?

- Community health nurses
- Family Centers
- Women's Centers
- Hospitals
- Clinics
- Maternity wards
- Ultrasound Clinics or departments
- Child and family services
- Postpartum Societies
- Doulas
- Midwives
- Maternity care clinics
- Parents and Tots
- Strong Start
- Pre schools
- Daycares
- Early Years Centers
- NICU
- Prisons with Birthers
- Treatment Centres focused on serving Birthers
- Psychiatric care facilities
- Food Banks
- Immigration Services

These are all just examples and each community and/or area will have their own pre established pathways.

Reach out to these places and ask them:

- Is there a gap in their services?
- What is the gap?
- Are you and/or your group filling that gap?
- Are you catching people that may be falling through the cracks?
- Is there opportunity to collaborate through use of a space they may offer?
- Are they willing to put PDA posters up (on site and/or virtual)?
- Ask if they are willing to promote the meetings? If the answer is no, try to get an understanding of why? (please email info@PDA-support.org if you come across this and the reasoning so that we may find better ways to function)
- Ask if you can come into the establishment and give a talk about PDA?

Put posters up in places that are visible and/or places frequented by birthers. Postcard size flyers are handy to put in places that are easily accessible and eye-catching.

Remember that we only use PDA approved content- to keep consistent in our messaging. Posters for print and social media can be accessed for free on PDA-support.org.

- Media relationships are valuable if used and accessed in the right way.
- We never ever break the anonymity of members ever.
- We never share what other members have shared.
- If we as individuals decide that we are ok with people knowing that we are in PDA, that is totally fine and a personal choice.
- When discussing PDA in the public eye you must always maintain the integrity, health and safety of the PDA Collective.
- It is a good idea to read the Health and safety of the Collective and the 12 health and safety and safety traditions of PDA, prior to public appearances.
- As always in PDA, your title, politics, creed and religion are left out of the conversation.
- We highly suggest never sharing your personal contact info when in situations involving mass media.

Grassroots initiatives could include things like having a booth at your local farmers market with flyers and information. Or perhaps your community has craftfaires that you could set a booth up at. Remember that when we are doing these in person community outreach programs that we never break the anonymity of our members- to be more clear, if you see another member out the community event never identify them as someone you know through PDA.

If you have ideas that are not listed here, but would like them included, please reach out to us at info@PDA-support.org.

How to Stay Current and Relevant

How do we stay relevant? We practice the three A's Awareness, Acceptance and Action.

- We stay current and relevant by always welcoming change, suggestions, comments and critiques.
- We pay attention to the world around us and what are the growing needs of that population.
- We seek out and acknowledge barriers.
- We seek out challenges.
- We seek out accessibility standards.

Practicing the three A's at the:

Group:

- Be mindful
- Listen to the concerns of members
- Become aware of them
- Accept them and accept that if it is an issue for one member it is probably an issue to another member
- Take action either by group discussion, survey and/or poll.
- Is there opportunity to resolve this at the group level or does it need to go further.
- Either way, always report the concerns and unmet needs of the group to the PDA collective as a whole by emailing info@PDA-support.org. So that the Collective as a whole has a pulse on the groups

Region:

- Be mindful
- Listen to the concerns of the GSR's
- Become aware of them, have discussion about them.
- Ask the GSR's to take the issue back to the group and ask if the issue is present in their groups.
- GSR's will identify if it is prevalent in other groups in the Region.
- Take action either by group discussion, survey and/or poll.

- Is there an opportunity to resolve this at the region level or does it need to go further.
- Either way, always report the concerns and unmet needs of the Region to the PDA collective as a whole by emailing info@PDA-support.org. So that

World:

- Always allow for open healthy communication between members, groups, regions and the PDA Collective as a whole.
- We do not support gatekeeping.
- Change is inevitable. We must accept that.
- We pay attention to the news of the world. We fact check.
- We always include the voices of the lived and living experience when making changes to policies and procedures and/or creating services that will directly affect them.
- We do not assume that we know their needs.
- Stay up to date on current events, technological advancements and social media platforms.

Every second of the day, at lightning speed the world is changing. We must stay relevant and current to maintain the success, spread and scalability of PDA. Most importantly to continuously strive to reach as many birthers as possible.

Every year the PDA Collective will take a tally of all issues and concerns that were brought to the PDA collective as a whole and we work to make those changes if they are in the best interest of PDA as whole and if they keep in line with the 12's. See events section for more information.

Service Work

How to be of service, and what service opportunities there are from the group to the world level? The sooner we become of service the more likely we are to continue in the collective. Any member can be of service at any level, wherever they feel like they would be a good fit.

There is no minimum requirement of time in the PDA Collective to be of service. You just get to be if you want to be. The suggested term of service is 2 years, serving no more than 2 consecutive terms. In reality life happens, things come up so it is unreasonable to force someone to adhere to these terms.

Sometimes we may find ourselves short of members in service so that may extend us past the suggestion. Oh well, such is life.

As an incentive to be of service, each service structure and/or committee will hold a draw at least once a year, although quarterly is suggested, for a gift card of the winners choosing. Each service structure and or committee has the responsibility to choose the amount. The draw must be held fairly and in front of as many of the members in the draw as possible.

Group:

- Volunteer to Chair a meeting (there is a first time for everything)
- Volunteer to be the sponsor of the week.
- Make donations to the group.
- Share during the meetings.
- Take on a service position.
- Volunteer to organize special get togethers.
- Become a GSR
- Regularly attend the meetings

Region:

- Take on a service position.
- Participate as a GSR.
- Make donations to the region.
- Attend the meetings

World:

- Take on a service position
- Chair a committee
- Volunteer to be of service in Committees
- Take on a service position within a Committee

World Collective Committees

Each committee has a special role. World Collective committees are a group of members, who have a special skill set valuable to the committee they serve, that have volunteered to be of service. Any committee is allowed to create working collectives that branch out of the main committee. The working collectives are responsible for reporting to their committee. The World Collective Committees are responsible for reporting to the Board, the ED and the PDA Collective as a whole in whatever way they see fit. Communications are transparent.

Who can serve on them?

- Any member of the PDA collective can volunteer to be of service.

Why do we have them?

- To assign special duties and responsibilities that aid in the growth, relevance, spread and scalability of the PDA Collective as a whole.

What are the different committees?

- LitCom
 - Responsibilities: (including but not limited to)
 - create new literature content.
 - edit documents and existing literature.
 - update existing literature.
 - Poll the regions for suggested literature needed.
 - Liaise with non english speaking demographic to create literature in other languages.
 - Constantly make literature accessible in areas that it is not. For example, brail, sign language video and audio books.
- TechCom
 - Responsibilities: (including but not limited to)

- Staying up to date on current technical developments.
 - Advising the PDA collective as a whole on the current trends of social media and best practices for accessing that.
 - What are the best services available for spread and scalability.
- WebCom
 - Responsibilities: (including but not limited to)
 - Managing the website
 - Updating the website
 - Managing meeting and region listings
 - Managing email subscription lists
- EventsCom
 - Responsibilities: (including but not limited to)
 - Developing structures for PDA World Collective Conferences.
 - Rules of Order for PDA WCC
 - Developing Agendas for PDA WCC
 - Delegating other PDA World Collective events to working working collectives
 - (see events for more information)
- FinanceCom
 - Responsibilities: (including but not limited to)
 - Reviews the Budget presented by the ED and the board.
 - Approves the Budget
 - Looks for grant funding opportunities to fulfill the operations of the PDA collective as a whole.
 - Reviews the financial Statements presented by the ED and the Board
 - Sends the Financial statements out to the Regions.
 - Shares a presentation at the PDA Annual General Meeting. (see events for more information)

- AccessCom
 - Responsibilities: (including but not limited to)
 - Identifies ways that the PDA Collective as whole is not accessible.
 - Work towards removing any identified barriers.
 - Handles all requested accessibility needs of the PDA Collective.
 - Updates, quarterly, the PDA Collective as a whole.
 - Formal asks the regions and groups of the PDA Collective as a whole if they are experiencing accessibility challenges.
 - Come up with ways to support the regions and groups to be more accessible.

Literature

Any member of the collective can submit literature suggestions, to info@PDA-support.org, provided they sign a release of ownership giving all rights to the PDA collective as a whole.

I give my permission to Postpartum Depression Anonymous, as a whole, to use my writing in any book or publication that may be produced.

The title of my document is:

The words in my document are:

My signature warrants that the words I submit for consideration are my own and have not previously been published or copyrighted. I have not plagiarized, copied or otherwise violated copyright protection of any other person or publication. Any quotes referred to have been properly and legally cited and attributed.

I relinquish all claims to any royalties or revenues that may be collected through the production of any book or other publication now or in the future. I understand my writing will become the sole intellectual property of Postpartum Depression Anonymous, as a whole, to be held for the benefit of the PDA collective. This release allows my writing to be edited for publication.

All writings will be printed anonymously.

I agree to hold Postpartum Depression Anonymous, as a whole and individually, completely and forever harmless from any liability whatsoever in connection with any use, by Postpartum Depression Anonymous, of my writing.

_____(Signature)

_____(Print Name Legibly)

_____(Date)

_____(Parental Consent if author under the age of 18)

_____(Print Name Legibly)

_____(Date)

~ This release form must be included with your submission. Consideration for publication cannot be given without such written authorization.

Our preference is that writings be in a Google document and sent via email to PDA at info@PDA-support.org

Any suggested new literature and edits to current literature, excluding the meeting script, must go through an Advisory Committee (AC). The advisory committee must be created equally and include:

- One part PDA members
- One part non PDA members
- One part lived/living experience of the demographic its purpose will serve
- With no more than 9 people
- The executive director will serve as Chair of the advisory committee.
- All voices will be heard and all input will be valued and implemented, unless deemed to go against any of "The Twelves"
- The original author of the content will have a seat in this committee and be responsible for making the necessary edits and bringing it back to the lit AC for review.
- It suggested that there be three opportunities to edit and suggest before the AC approves the literature.
- Once approved it now becomes Advisory Approved Literature (AAL)
- The AAL is then sent to the LitCom for processing into the appropriate format and to make any grammatical edits needed.
- All literature must be made accessible to whatever demographic finds it inaccessible, within three months of being notified of the lack of access.
- Whenever possible we provide honorariums to the Literature Advisory Committee.

PDA Events

PDA encourages creating community outside of the meetings, by organizing events, get togethers, retreats, etcetera. If the event is using the PDA name, logos, trademarks or copyright content all members in attendance are expected to act in a way that reflects "The Twelves". Do not drag The PDA Collective, its groups, regions or members into any public controversy.

PDA World Collective Conference (PDAWCC) is an annual virtual conference that brings the delegates and alternate delegates together to "take a pulse of the world". We do this by utilizing the "three A's" (awareness, acceptance and action) and practicing "The Twelves".

The eventsCom is responsible for organizing this event. (see World Collective Committees for more information).

The PDA Annual General Meeting (PDA AGM) is a yearly business meeting that presents and approves the Annual financial reports and Budgets.

- Any member is welcome to attend.
- The FinanceCom must attend.
- The Board must attend.
- It is organized by the ED.
- Although the PDA world treasurer and FinaceCom will keep track of the book keeping, the reports will be prepared by an outside accounting business that has no affiliation with PDA.

Non- Profit Status

What does our non profit status mean? How does it work?

These are questions we would like to be able to answer. Currently we do not have non-profit status, although we are working towards having it.

If you are familiar with the process of becoming a registered non-profit and would like to be of service in helping PDA get there; please reach out to us at info@PDA-support.org.

Board of Directors

Board of directors- the type of board, expectations, responsibilities, terms of our board. How many members can be on the board at one time and what is our minimum? How does someone apply to be on the board? What are the requirements? How do we elect and welcome members to the board?

On our journey to becoming a registered non-profit, these will be questions PDA as whole need to consider and answer. If you have experience in this area and would like to be of service please; please reach out to PDA at info@PDA-support.org

PDA Bylaws

Our organization's bylaws- What are they?. Why do we have them and how are they created?

We will not be able answer these questions until we are ready to become a registered non-profit. Some of the answers will be dictated by non-profit law and some we will be able to create with the help of the PDA collective as a whole.

Financial Practices

The PDA Collective as a whole, WCs, Regions and/or groups will never take loans and or incur debt.

- Always look for grants first.
- Donations second.
- Donations can be made by any member.
- The PDA collective does not take money from organizations that practice principles that break the principals and intent of "The Twelves.
- We must carefully vet outside donors.
- Funds Must be managed responsibly.

Group:

- Manages the funds.
- Looks for grant and/or funding to further the groups primary purpose, that is to reach and help as many birthers regain and maintain their mental well being.
- Provides a monthly transparent report, to the host, of the group finances.
- Makes donations to the region.
- Manages honorarium draws for service positions at the group level. (see service work for more information)

Region:

- Responsibly manages any and all funds of the region.
- Searches and applies for grants that support the needs of their region and/or have potential to grow the PDA Collective as a whole.
- Provides quarterly, transparent statement of accounts, at the regional assembly.
- The statement must be sent out to the regional collective a few days prior to the quarterly assembly.
- Must provide a transparent statement of accounts anytime it is requested outside of the quarterly assembly.
- Makes donations to the world.

- Manages honorarium draws for service positions at the regional level. (see service work for more information)

World:

- Responsibly manages any and all funds at the world level.
- All funds are to be clearly earmarked and put in the appropriate accounts.
- Search and apply for grants that support the needs of the PDA Collective as a whole.
- Provides monthly, transparent statements of accounts to the PDA world service structures and the regions.
- Creates a yearly financial budget that must be approved by the board and regions by way of the AGM. (see PDA Events for more information)
- Must provide a transparent, current statement of accounts anytime it is requested.
- Manages honorarium draws for service positions at the world level. (see service work for more information)

Research and the PDA Collective

Forthcoming...



Appendix 7

POSTPARTUM

ARE YOU FEELING
OVERWHELMED?
COULD YOU USE PEER
SUPPORT?

JOIN OUR
ANONYMOUS,
VIRTUAL
PEER TO PEER
SUPPORT GROUP.

FOR QUESTIONS EMAIL:
INFO@PDA-SUPPORT.ORG

