I. RECOGNITION OF THE PERSON'S INFORMATION AND SUPPORT NEEDS

Begin the screening process with a general discussion about the person's mental health and well-being. This discussion can be part of an initial visit, according to the judgment of the nurse or member of the interprofessional team (56).

Fully explain the purpose of the screening tool so that the person has been informed of the nature and intention of the tool to support consent and acceptance (57, 59). Ensure that the person understands that an elevated score above the threshold is not diagnostic nor an indication for treatment; instead, it is an indication for further assessment (11).

Take measures to support the person's comfort and privacy during the administration of the screening tool. This includes having an open dialogue about any concerns the person may have about the screening process or remaining flexible regarding the timing and use of the screen (59).

Recognize that screening for perinatal depression can be perceived as intrusive (57). The style, approach, and displayed trustworthiness by the health-care provider are critical to ensuring that the person feels empowered and supported to seek help where indicated (57).

A demonstration of a caring and empathic attitude, an unrushed environment, and a displayed interest in the person and their screening score can facilitate support and minimize any shame or stigma that the person may feel when discussing concerns about their mental health (59).

As part of a relational practice that applies a person-centred, holistic approach, seek to contextualize the person's lived experience and health care needs. Incorporate an understanding of personal, interpersonal, and social factors by recognizing any inequities and social structures that may influence the process of screening and screening outcomes (59 - 60).

II. RECOGNITION OF THE PERSON'S READINESS TO BE SCREENED

Communicate to the person that the completion of the screening process is voluntary and requires their consent (57). The person maintains the right to refuse or decline to answer any (or all) of the components of the screening tool.

To provide consent, persons must be made fully aware of how the screening tool will be used during the plan of care, including possible follow-up (57).

A person's consent to complete a screening process does not imply consent for any further follow-up. This is true regardless of the score and screening assessment, except in cases of an identified urgent risk of self-harm, suicide, infanticide, or harm to others (57).

When consent has not been given, inquire about any changes in mood or the presence of any depression symptoms can be made in lieu of a formal screening process. The offer for formal screening should be made at a follow-up visit if the person gives consent (57, 59).

III. INTEGRATION OF THE PERSON'S CULTURAL BACKGROUND AND PRACTICES

Nurses and the interprofessional team must recognize and integrate cultural awareness[G] and sensitivity throughout the screening process. Pregnant and postpartum persons may experience and express depression signs and symptoms differently, depending on their culture (61).

To engage in culturally sensitive care, the following components are integral:

- Recognize that persons who are less proficient in the language where they are residing or who are recent immigrants are at increased risk of perinatal depression (48).
- Seek to establish a therapeutic relationship by overcoming language difficulties by establishing trust and making a connection with the person as the quality of the relationship is central to effective screening, assessment, and possible intervention. By demonstrating compassion and genuine interest in getting to know the individual's culture, life circumstances, and way of parenting, the person can be empowered. Being available, receptive, and responsive is also important (48).
- Interpreters may be helpful, but the nurse or member of the interprofessional team needs to pay attention at each encounter to any verbal or non-verbal signs of perinatal depression. Observe for signs such as the person appearing tired or having a stiff facial expression or blankness in the eyes. The person may appear to have a lack of interest in their infant or be slow to respond to their cues. Behaviours suggestive of perinatal depression include being quiet, not asking any questions or offering only brief answers, seeming hurried at visits, or, conversely, having many questions and worries and constantly seeking help or reassurance (48).
- If a screening tool is used with a cultural interpreter, the validity of the tool may be threatened. Additional explanation and clarification may be needed (48). The selection of the screening tool must consider available languages and the validity of the translated tool (61). See **Appendices E** and **G** for further details on perinatal depression screening tools.
- A screen with a total score of zero would suggest absolutely no risk of perinatal depression. However, the score may instead reflect, in some cultures, a shame and guilt associated with having a mental illness. In such cases, observance of signs and symptoms of perinatal depression and the establishment of a therapeutic relationship is essential to be able to talk to the person regarding their mental health. Use of tacit knowledge based on a health-care providers' practice and experience may also be beneficial to the interpretation of mood (48).
- For some persons, being given practical advice and direction by a health-care provider regarding their plan of care was perceived as helpful (48).

See **Appendix D** (Diversity among Persons with Perinatal Depression) and the 'Supporting Resources' section for further details on cultural considerations in mental health services and supports in perinatal depression.