



PERINATAL SERVICE SCENARIOS

The Future of Perinatal Counselling for the CRD, Island Health & BC

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AUTHORS

This paper is by Michael McGee, MA (EEC) in collaboration with Traci McGee, MA (ABS), RMFT, RCC-ACS, CCC, PMH-C. Additional background information about the authors is provided in the [Program Partners, Structure and Team](#) section of this paper.

ABOUT THE CRD PERINATAL COUNSELLING PROGRAM

At the time of writing, the [CRD Perinatal Counselling Program](#) is operated by Traci McGee as part of her private therapy and counselling practice, the [McGee Therapy Clinic](#),¹ which has a counselling office in downtown Victoria and an administration office in Saanich, British Columbia.

We want to acknowledge that program services received by local parents are the product of a large, collaborative effort of partners, associates, and contributors in the Greater Victoria area, also known as the Capital Regional District (CRD). These include:

- the local philanthropic group that generously provided the funding for the program to operate for five years,
- the South Island Primary Care Society, our charitable partner, that continues to champion and assist the program through fundraising and administrative support,
- the associate counsellors who support local parents with mental health care through their private practices, including current associates: Laurie Moniz, Theresa Gulliver, and Jody Lambert.

We also wish to acknowledge the intake work of Dayna McPhail who connects with each parent referred to the program to set up and prepare them for their first appointment—both for the current program (established in 2020) and its predecessor, the Post Partum Support Program. Dayna’s collaboration with Traci dates back to 2007.

More details about the program and its history are contained in [Part I](#) of this paper.

VERSION LOG

Version	Date	Notes
1.0	April 11, 2025	Original Final Version
1.1	April 17, 2025	Changes relating to perinatal psychiatry in Part III & Appendix A.

¹ The McGee Therapy Clinic is a registered trade name for McGee Therapy & Consulting Inc.

Perinatal Service Scenarios

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PERINATAL SERVICE SCENARIOS

The Future of Perinatal Counselling for the CRD, Island Health & BC

THE SITUATION

The CRD Perinatal Counselling Program is a mental health initiative that provides new and expecting parents across the Capital Regional District with funded counselling sessions when they need and can benefit from them. The program ensures access to specialized perinatal counselling for parents when they lack the resources to access private services.

Since its inception in 2020, the program has delivered perinatal mental health counselling to a thousand families across 13 municipalities in the CRD. With inadequate alternatives to keep delivering these services, the impending end of program funding in late June 2025² represents a significant loss and challenge for parents and their families in our community.

Despite ongoing efforts to secure replacement funding, attempts have so far been unsuccessful. We appreciate the commitment of our program partner, the South Island Primary Care Society, in continuing to seek new funding.

This paper aims to complement their efforts by making program information available and shareable for anyone who wants to help to ensure that perinatal mental health care remains accessible in the CRD—or that it becomes consistently accessible across British Columbia.

Part I (“About the Program”) introduces the CRD Perinatal Counselling Program, its purposes and its operational structure.

Part II (“Local Scenarios”) identifies a range of service level scenarios that are feasible depending on the level of new funding that can be secured. These scenarios are presented as a touchstone for prospective funding partners on what access can be achieved with either less, equal, or more funding.

Part III (“Future Scenarios For Island Health & BC”) presents the CRD Perinatal Counselling Program as a potential example and model for service delivery that can be adapted and adopted to provide access to perinatal counselling across a health region (i.e. Island Health) and the province. This broader perspective is relevant given the BC Legislature's unanimous support just weeks ago for the principle of universal access to perinatal mental health care.

The CRD program offers a unique private practice approach with capacity to scale if called upon. But without funding to continue this working program in the very near term, the community and province

² Although the delivery of program funded counselling sessions will stop on or about June 30, 2025, intake to the program will close earlier. In some cases, caps on counselling sessions provided have already been implemented in anticipation of the program closure.

stand to lose a potential bridge to a more healthy future for British Columbia families. For municipalities that make up the CRD, the loss is more immediate and stark. Parents are just a few months from a return to the 1980s when no program existed to support the mental health of parents in our local communities.

PART I: ABOUT THE PROGRAM

In this first Part, we introduce the CRD Perinatal Counselling Program, and we describe its services, purposes, structure and the context in which it operates.

The Mental Health Challenge

One in five women, and one in ten men may experience significant mental health disorders during pregnancy and within the first twelve months after birth. These include perinatal depression, anxiety and adjustment disorders. Left unaddressed, they can profoundly impact the long-term health and well-being of parents, children, and families.

Treatments like perinatal counselling are effective and widely available in our community. Yet for too many mothers and their partners across the CRD, services are not accessed on account of cost or other barriers.

For perinatal mental health care to become universally accessible, the linchpin is to ensure that perinatal counselling is available and accessible for all new and expecting parents.

Core Services

The program delivers the following funded counselling services for new and expecting parents who live in the Capital Regional District (CRD):

1. Perinatal Mental Health Counselling
 - Counselling treatments³ for depression, anxiety, or adjustment disorders during pregnancy (36% of patient referrals)⁴ or up to nine months postpartum (60%).
2. Perinatal Grief & Loss Counselling (4% of referrals)
 - Support after a pregnancy-related loss including stillbirth, infant death, and late-term miscarriage

³ All counselling is offered in person, and secure video counselling is provided at the request and convenience of patients.

⁴ Patient referral statistics are for the 2023/24 Program Year.

Program Objectives

With accountability to the following program objectives, the program operator has the autonomy to design and operate the program to:

1. Consistently deliver effective, timely counselling that improves the mental health and wellness of eligible patients.
2. Build and maintain the capacity of a specialized perinatal clinical team to deliver perinatal counselling that keeps up with the level of community need as it changes over time.
3. Develop the program as a sustainable source and resource for mental health resilience in the CRD.

Program Partners, Structure & Team

Funding & Administration

- 5 year funding commitment by a local private philanthropic group (2020 - 2025)
- Program administration and fundraising by the [South Island Primary Care Society](#) (since 2021)

Program Operator

- McGee Therapy Clinic (McGee Therapy & Consulting Inc.)

The McGee Therapy Clinic is the private practice of Traci McGee⁵ who is the principal and clinical director. Her husband, Michael McGee,⁶ assists as clinic support manager.

Team Composition (as of April 2025)

The program is operated by a team of five clinicians and two non clinicians.

- 1 clinical director / lead counsellor (Traci)
- 3 perinatal counsellors⁷ (contractors with independent professional practices)
- 1 perinatal student counsellor (intern)

⁵ In addition to her postpartum and perinatal program work, her career began in inpatient child and youth psychiatry, and it includes twelve years as a clinical member of a multi-disciplinary child and youth mental health team with MCFD, accreditation as a clinical supervisor, and accredited specializations in perinatal mental health and couples counselling. She has strong roots and connections in the Greater Victoria healthcare community, and her approach is well grounded in a biopsychosocial model. More about Traci's background is listed on her [credentials](#) webpage.

⁶ Michael McGee assists the operation of the McGee Therapy Clinic in a non-clinical role as Clinic Support Manager. He has an MA in environmental education and communication, and his background includes two decades as a policy and communications manager for a licensing tribunal responsible for the economic regulation of commercial passenger transportation companies in the province (BC Passenger Transportation Board).

⁷ At present, one "associate" perinatal counsellor is certified as a perinatal specialist (PMH-C), one completed the training, and all have been providing perinatal mental health (or loss) counselling for this population for years.

- 1 intake manager⁸ (employee)
- 1 program support manager⁹ (Michael)

Service Access & Delivery

- Patients are [referred](#) by local primary care providers¹⁰ using an [online form](#) with clear eligibility criteria.
- [Eligibility criteria](#) for program-funded counselling sessions include a family resource availability test: “extended health insurance is not available for the parent to receive counselling”¹¹ In short, services are for parents in the [Capital Regional District](#) who need and can benefit from the perinatal counselling but cannot afford the services.
- Timely, high-touch [intake service](#) is provided by phone (usually within one business day of a referral) to schedule each patient’s first appointment (first appointments are usually one to two weeks after they are scheduled) and check in on their ability to get to the appointment.
- When a referred patient does not respond to attempts to book a session, the [intake manager](#) informs the clinic or provider who made the referral.
- Fully funded perinatal counselling is delivered to patients¹² by a distributed [team of clinical counsellors](#) at the offices of their independent private practice.
- Program standards and team cohesion are fostered through individual consultations and team meetings led by the Clinical Director, among other mechanisms¹³

⁸ Intake is managed by an experienced medical office assistant who works remotely, connecting with each referred perinatal parent to verify eligibility, ensure appropriate supports are in place, schedule initial counselling sessions, provide appointment follow-up, and serve as an ongoing contact point in the event counsellor connections are a challenge. This direct, empathic engagement with referred parents constitutes a critical component of the program's service delivery. The intake manager and clinical director maintain regular communication for collaboration and clinical direction as needed on priority cases, complex service requirements, eligibility determinations, continuum of care matters, clinician assignments, team workload distribution, and operational protocols.

⁹ Working collaboratively with the clinical director, the program support manager oversees critical behind-the-scenes functions including program development, technological infrastructure, procedural systems, [website](#) administration, and external communications. This role compiles program statistics, maintains supporting documentation, prepares partner reports, administers HR processes, ensures privacy compliance, documents operational procedures, and provides administrative support.

¹⁰ In the 2023/24 program year, patients were referred to the program by midwives (40%), physicians (26%), PHNs (13%), psychiatrists (12%), nurse practitioners (5%) and clinical counsellors (4%).

¹¹ The Program is for parents without the family resources to pay for counselling. Our financial test is focussed on insurance benefits because it serves the intended purpose in most cases. In cases where it is apparent that a patient receiving service has the resources to access private pay counselling, our counsellors discuss this with the client and often reach an agreement to continue with counselling on a private pay basis.

¹² Counselling is provided for individuals (mothers as well as partners) and for couples.

¹³ Other standards setting and coordination mechanisms include independent clinician contracts, program policies, and ongoing communications with the Clinical Director and Intake Manager.

Team Size & Service Levels

To say more about how the program is operated, Table 1 below presents some annual statistics for the first four years.

TABLE 1: Key Statistics for the CRD Perinatal Counselling Program: First Four Years

Program Year ¹⁴	Counselling Team Size	Counselling Hours ¹⁵	Patient No Show / Late Cancellation ¹⁶	Families Served ¹⁷
20/21	2 to 3	527	5%	185
21/22	3	626.5	8%	207
22/23	3	552 ¹⁸	11%	184
23/24	4 to 5	699	12%	223

Historical Context

The CRD Perinatal Counselling Program emerged in 2020 as a direct response to a critical gap in mental health services that was created when the regional health authority cancelled public health funding for a similar program—the *original* Post Partum Support Program (PPSP)—that had been delivering counselling to mothers for three decades.

This original program was founded in March 1990 by Joan Wale, a Registered Social Worker and local therapist. This was through a partnership she established with the Queen Alexandra Centre for Children’s Health (QA) that provided funding through its charitable foundation.

In 1999, Joan invited [Traci McGee](#) to work with her as a second program counsellor. In 2004, Traci took over as lead counsellor when Joan began scaling back her practice. Together with QA, and then in 2014 with Island Health (and public health dollars), Traci operated the original program until Island Health cancelled funding as of March 2020.

The cancellation made the local news¹⁹, and upon hearing it, a local philanthropic group stepped forward with interest in seeing a continuation of counselling for new parents who otherwise cannot access it. With new private funding and a mandate to pursue the [three program objectives](#) listed previously, Traci

¹⁴ The Program Year starts July 1 and ends June 30 (except for Year 1 which began late June).

¹⁵ Counselling hours include both delivered counselling hours and billable no shows.

¹⁶ The program is designed to keep no show rates low so parents can access counselling when it will benefit them, and even when it can be a challenge for a parent to get to their appointment. Much of this work is undertaken by the program intake manager / client support manager.

¹⁷ A family served means a family that received one or more hours of individual or couple counselling

¹⁸ The 22/23 drop in counselling hours is due to a temporary contraction in counsellor availability.

¹⁹ See <https://www.cbc.ca/news/canada/british-columbia/postpartum-depression-island-health-1.5493221>

led the design and launched the new CRD Perinatal Counselling Program. By late June 2020, the enhanced program delivered its first perinatal mental health counselling sessions to local parents.

Soon after, the South Island Primary Care Society joined the partnership, taking responsibility for administering the funds and assisting with the [integration of the program](#) into the local healthcare system.

More details follow about the transition from the Post Partum Support Program to the redesigned and expanded CRD Perinatal Counselling Program. See Part III, [Future Scenarios for Island Health & BC](#).

Other Community Services

Without the CRD Perinatal Counselling Program, no existing local program or agency can adequately fill the resulting service gap. A “Scan of Perinatal Services” (in [Appendix A](#)) illustrates this reality by providing an overview of currently available perinatal resources. It identifies the limits of these services to make up for services that the counselling program now provides.

Resources for Perinatal Service Leaders

[Appendix B](#) (“Resources for Decision Makers”) compiles essential reports for leaders involved in designing, delivering, or overseeing perinatal mental health care services, programs, or systems throughout the CRD and BC. These resources provide valuable information for funders, advocates, policy developers, and perinatal service providers who are engaged in advancing maternal and perinatal mental health initiatives.

A Unique Community Counselling Program

It is well known that perinatal mental health programs are a patchwork across the province and country. Perinatal counselling services are available in some cities and towns outside the Greater Victoria area, although we are not aware of a program that closely resembles the CRD Perinatal Counselling Program.

PART II: LOCAL SCENARIOS

This section identifies near term scenarios that allow parents to keep accessing perinatal mental health counselling across the 13 municipalities of the Capital Regional District (CRD). Each scenario reflects different levels of funding, either for the CRD Perinatal Counselling Program or by making services available outside the program.

A. SERVICE SCENARIOS WITH NEW FUNDING

Scenario A1: Reduced Funding ‘Bridge’

At the suggestion of the Executive Director of the South Island Primary Care Society, we considered a

potential scenario where temporary, reduced funding is obtained in stepped fashion that serves as a kind of bridge while efforts continue to secure sustainable funding.

As we thought through this scenario, it became clear that bridge funding is workable only if the funding is enough to deliver 30 or more counselling hours per month for six months or longer. This is roughly half the current average.

Without the predictability of a minimum funding base like this, it is impractical and unethical to operate a mental health program that is open for referrals but unable to follow through with service for many of the patients, or unable to follow through with sufficient counselling sessions to provide benefits.

We think a minimum of 30 counselling hours per month for at least six months is low and would be challenging to operate. But if this minimum cannot be secured soon, we see no option but to close or keep the program closed.

Scenario A2: Status Quo Funding ‘Bridge’

This is a status quo scenario to secure funding that can maintain current funding levels, or recent services levels that slightly exceed funding levels. Referrals and counselling hours have generally been rising each year, so some increase in the hours allows the program to keep ‘treading water’ with the level of community need.

If continuation funding can be identified but is only temporary (e.g. one or two years only), this may provide time for the CRD Perinatal Counselling Program to be examined or developed further as a model that can be replicated or adapted to help advance a regional or provincial health strategy to make specialized perinatal mental health care universally accessible.

Scenario A3: Perinatal Program Intern Counselling

In late February, a grad student intern provided perinatal counselling treatments to program patients for the first time. The intern and her cases are supervised by Traci McGee, an Approved Clinical Supervisor (ACS²⁰) and a Certified Perinatal Mental Health professional (PMH-C²¹).

Fees for intern-delivered counselling hours are half the rate of a registered clinician, so it allows us to stretch program resources and increase counselling hours.

Grad students are selected with a background and interest in a perinatal specialization (which encompasses many mental health issues in the perinatal context), and the supervision is focussed on the foundation and development of this specialization. This is done through a formal private practice internship program the McGee Therapy Clinic recently set up for students near the end of their master’s level program for an MA, MC or MSW degree in counselling. This allows Traci to continue to use

²⁰ Professional accreditation as an ACS is provided by the BC Association of Clinical Counsellors (BCACC).

²¹ [Certification](#) as a Perinatal Mental Health professional (PMH-C) is provided by Postpartum Support International, the preeminent perinatal mental health association.

perinatal intern counselling for a small portion of the service hours that are delivered through the CRD perinatal program, for as long as it operates.

In the event that the perinatal program is operating in September, Traci will by then be supervising two interns with the background and skills to provide perinatal counselling. Based on current service hours, intern counselling could increase total counselling hours by 15% or more, or it can help maintain service hours with less funding.

Scenario A4: Expand & Improve Program Services

Thanks to generous philanthropic funding, the delivery of perinatal counselling was able to increase and improve in ways not imaginable when the health authority cut funding for the original postpartum counselling program in 2020.

Now in 2025, the program faces another ending. But the experience of redesigning the program and running it on a team basis allowed us to make a more reasonable estimate of the level of community need and how the program could meet that need.

In 2024 and 2023, the number of live births in the CRD averaged 2,760 per year. It is well established that a perinatal mental health disorder will inflict one in five mothers (estimated 552 per year in the CRD) and one in ten fathers / non-birthing partners (estimated 276 per year in the CRD).

We estimate that the number of needed service hours should grow to 2,000 per year, about three times the current level. The gap between this estimated target and funded levels over the past five years (>637 per year) is attributable to these factors:

- Referrals and service hours increased steadily over the past two years
- Average counseling hours per patient is low (4) and should increase (to about 8) to improve medium and longer term mental health benefits.
- The unintended geographical concentration of in-person counselling around downtown Victoria can and should be corrected by expanding the team to include counsellors with practices and offices in the Westshore and Saanich Peninsula.
- Perinatal indigenous parents are underserved by the Program and a strategy should be developed and implemented in partnership with (or by) indigenous community care providers.
- Fathers / non-birthing partners are underserved by our program and can be reached by promoting and providing more couples counselling plus perinatal counselling groups for partners.

Scenario A5: New FTE / Agency Funding

Here is another way to continue delivering perinatal counselling services: Obtain public health funding for one or two FTEs to hire specialized perinatal counsellors. In theory, this approach might allow a

public health agency to deliver perinatal mental health care within a budget that already exists or can be sustained over the long term, or both. Logistically, this approach might work in a number of ways:

- **Institutional Setting:** The FTEs and most services (e.g. finance, office facilities, systems, HR) are provided by a single agency (e.g. Island Health’s Perinatal Psychiatry Program at VGH)
- **Medical Clinic Network Setting:** The home for funded FTEs are in a medical clinic or network with office facilities, systems, HR, etc. and may be integrated within a primary care network that does not presently specialize in perinatal mental health care (e.g. medical clinics of the South Island Primary Care Society or clinics that are part of the Victoria Primary Care Network).

These settings and models differ from the CRD Perinatal Counselling Program which is set up as a standalone program that delivers services through the private practice offices of clinical counsellors who have a perinatal mental health specialization. If the perinatal services are to be delivered as a functioning and recognized program, decisions would be needed on who will provide other specialized elements of the program. These elements may include:

- Clinical training, supervision or consultation of counsellors
- Specialized perinatal patient intake
- Service provider and public communications services that may include the crdperinatal.ca program website

Another agency could provide these services, or the McGee Therapy Clinic could under contract.

B. SERVICE SCENARIOS WITHOUT NEW FUNDING

Scenario B1: Allow the Program to End

Given the absence of funding for program services beyond June 2025, this is the default option we are planning for, and already starting to implement.

In the event that new funding is secured after the program ends, we have systems, facilities and people in place for a rapid restart of community referrals and services for eligible parents.

For as long as CRD Perinatal Counselling Program ceases to operate, the impact on community access to essential perinatal mental health counselling will be significant. It is true that alternative services are in place that some parents can and are accessing now. These are noted in the “B” scenarios that follow.

Keep in mind that there are limitations in the scope or capacity of the service alternatives that fall far short of serving the number of eligible parents who are now being served by the CRD Perinatal Counselling Program.

Scenario B2: Private Pay Low Cost Perinatal Intern Counselling

The McGee Therapy Clinic is beginning to offer (as of April 2025) a low cost private pay counselling option for perinatal parents. As described in a [previous section on program funded intern counselling](#), an intern provides the counselling under Traci's supervision with a focus on perinatal clients and the issues they present. But as a low cost private pay service, the counselling is provided without program funds, and also without the full cost of private pay counselling that is prohibitive for many parents.²² It adds a perinatal service option that sits between free program counselling and high-cost private counselling.

Low cost counselling does not work for all parents. The suitability of low cost intern counselling depends on the presenting issues of a parent, and also on where the interns are in their development as a counsellor with a perinatal focus.

At present, the number of intern counselling hours in a month is very small compared to the number of parents who may access and benefit from this service. But it adds to the mix of counselling options that improves access, and it relieves or avoids pressure on resources (when available) for program-funded counselling.

Scenario B3: Limited MSP Coverage for Perinatal Counselling

On March 10 of this year, 91 MLAs debated and voted to give rare, unanimous support for a private member's bill that proposes universal access to perinatal mental health care for new and expecting parents.²³ The bill's sponsor, Jody Toor, summarized the aspirations behind the bill:

“It's about making sure prenatal and postnatal mental health is integrated in health care. This bill is about supporting mothers, fathers, partners and families and the entire community. It's about the mother who struggles in silence because she doesn't know where to turn and where to get the help she needs when she needs it. It's about the father who feels overwhelmed and unsupported in his new role. It's about the families who suffer because prenatal mental health isn't taken seriously enough.”

*~ Jody Toor, MLA Langley-Willowbrook
March 10, 2025²⁴*

For 75 minutes, a total of eleven MLAs for three parties (Conservative, NDP, Green) rose in the Legislature to share perspectives and personal perinatal experiences that point to the importance and need for perinatal mental health care.

²² In most cases, intern counselling is not covered by extended health insurance plans. The service is a potential access solution for parents of a so-called middle class family that does not have extended health care benefits.

²³ The Canadian Press. (2025, Mar. 12). *CBC News*. BC bill on perinatal, postnatal mental health care receives rare unanimous support. Retrieved from:

<https://www.cbc.ca/news/canada/british-columbia/perinatal-postnatal-mental-health-1.7482205>

²⁴ Hansard Blues for March 10, 2025 (morning) retrieved from the Legislative Assembly of British Columbia website: <https://www.leg.bc.ca/hansard-content/Debates/43rd1st/20250310am-House-Blues.htm>

Among the stories that were shared, MLA Darlene Rotchford (Esquimalt-Colwood) spoke of her traumatic birth experience. She shared the panic it triggered, the feelings she struggled with, and how counselling allowed her to process it all, and to learn how to cope. In recounting that experience, she spoke to the way she was able to access perinatal mental health counselling.

“Through Rosehip Midwifery, I was connected with a postpartum midwife named Rebecca. She truly was an angel. When she came to my home to check on me, I broke down, admitting for the first time that I was struggling. She informed me about a counsellor affiliated with her services. Because it was covered under MSP, I was able to access the support I desperately needed now.”

*~ Darlene Rotchford, MLA Esquimalt-Colwood
March 10, 2025*

As a new mom, Darlene Rotchford received the perinatal counselling she needed at the right time, thanks not just to the professionals, but to coverage under the Medical Services Plan (MSP). In most cases; however, MSP coverage excludes the services of counsellors and psychologists. So, two questions come to mind.

First: When or how is perinatal counselling covered by MSP?

A registered midwife²⁵ who is also a mental health counsellor has the ability to, in certain circumstances, provide and bill under MSP for clinical counselling services to the mother during pregnancy, and up to six weeks postpartum. Services are capped at a total of seven hours: three during pregnancy, and four in the postpartum period.

The MSP billing schedule for midwives²⁶ provides codes that cover consultative care in the prepartum and postpartum periods. For a midwife counsellor to sustain the ability to bill to MSP over the longer term, an [alternate practice arrangement](#) (APA) may need to be established through the BC College of Nurses and Midwives. To obtain APA approval, the service must “improve access to perinatal care,” contribute to “a high quality of perinatal care” and provide other benefits.²⁷

Second: Does MSP-covered perinatal counselling replace counselling the CRD program provides?

No. It complements the services of the program without replacing them. Several limitations and constraints keep MSP-funded counselling from being an option for many local parents in their perinatal period.

These include:

- **A shorter perinatal period.** The perinatal service period under MSP coverage (pregnant to six weeks postpartum) is short compared to the program service period (pregnant to twelve months

²⁵ Midwives are registered by the BC College of Nurses and Midwives.

²⁶ MSP information for midwives, including billing codes, is accessible through the [MSP webpage for midwives](https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/midwives).. <https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/midwives>

²⁷ Selected criteria from an [APA application](#) are quoted.

postpartum²⁸). Most parents are referred to the program after the birth of their baby (60% or more) and are likely unable to complete their perinatal counselling sessions within the constrained timelines for MSP-covered services.

- **Limits on session allocations.** The caps on sessions is not an issue for some moms, but it precludes access to sufficient counselling care for others. Service providers should have treatment plan flexibility to allocate total service hours that differ from one parent to another depending on the nature and level of mental health counselling that is needed. .
- **Rarity of Midwife Counsellors.** It is rare for a midwife to also have professional accreditation as a counselling therapist. For example, an RM who is also a registered social worker, registered clinical counsellor, or psychologist. This makes access to MSP-covered counselling dependent on the luck of having a midwife counsellor who is available to provide this service in one's vicinity.

The MSP-covered services of a midwife counsellor helps remove the financial barrier to counselling for some but not all parents who lack the family resources to get the needed help. But in a community like the CRD, the scale and scope of this alternative counselling source falls short of the level of need in the community. Access is more constant and certain with an anchor program and multiple perinatal specialists that are working to ensure that parents are able to get the perinatal mental health counselling that they need, when they need it.

Continuing this discussion of MSP coverage, we shift direction to approach it as a public policy matter. It may offer a new solution, and it deserves attention.

MSP coverage of midwife-led counselling has given recognition to specialized perinatal mental health counselling as *medically necessary*, a core prerequisite for MSP coverage. But this type of counselling is not the exclusive domain of midwife counsellors. Arguably, the service is medically necessary and effective even when it is provided by a registered counsellor and therapist (e.g. RSWs, RMFTs, RCCs, psychologists) who is certified²⁹ or at least recognizable as a specialist in perinatal mental health.

This presents a way for the provincial government to make perinatal counselling universally accessible to British Columbian in a quick and simple way: It could extend MSP coverage to *specialized perinatal counselling*. Or, it could allow *specialized perinatal counsellors* to get MSP approval to provide these services.³⁰

As a less comprehensive and less costly option, the provincial government could introduce a dedicated code for midwives who also have a professional counselling designation to allow MSP billing for more perinatal counselling sessions than three during pregnancy and four postpartum—and that includes a postpartum period of up to twelve months. This will go a long way to ensure that the system is not keeping professionals from delivering the services their patients need.

²⁸ Referrals must be received within nine months of the baby's birth.

²⁹ [Certification](#) can be obtained from Postpartum Support International as a perinatal mental health professional (PMH-C) which is recognized as the leading certification for this specialization.

³⁰ To think through the potential steps for covering perinatal counselling under MSP, [MSP fee schedule for midwives](#) may serve as a starting place. A similar but simpler schedule could be set up for perinatal counsellors approved by the MSP.

Scenario B4: Pacific Perinatal Loss Counselling

The Pacific Perinatal Foundation³¹ is a registered non-profit that offers partial and fully funded services for parents facing infertility or perinatal loss. This non-profit offers [up to five counselling sessions](#) and six week [mindfulness classes](#). Parents can apply for full or partial funding to cover private counselling through the Pacific Perinatal website. Services are offered to anyone in the region that is served by [Island Health](#).

Loss counselling through Pacific Perinatal overlaps with the grief and loss counselling of the CRD Perinatal Counselling Program. But the overlap is small relative to the need for perinatal counselling. Grief and loss is not as prevalent as perinatal depression, anxiety and adjustment disorders, and as [noted previously](#), just 4% of referrals by primary care providers to the CRD Perinatal program are for grief and loss.³² Depending on the resourcing of the Pacific Perinatal program, just a few who would be eligible for CRD Perinatal funded counselling may access service through this alternate local channel.

Scenario B5: Private Perinatal Counselling

Although it has been said previously, the Program does not provide counselling to parents who have the means to afford private mental health counselling. Some families have the income to afford the high cost of private counselling and therapy, but in most cases, we use the availability of extended health insurance benefits in the family as the main criterion for means to access private services. It is a test we are able to apply efficiently and as an effective way to identify who has means to get service with their own resources. At times; however, a client with means will receive a first session (which is covered by the program) at which time, they have the option of becoming a private client and continuing service with the perinatal counsellor.

PART III: FUTURE SCENARIOS FOR ISLAND HEALTH & BC

In this section, we scale up our thinking from local CRD municipalities to consider how the program might be an example or model for public health agencies to adapt and adopt across a health region (like Island Health) or the entire province.

Such thinking was inspired by the rare, unanimous passage earlier this month for second reading of a private members bill: the [Perinatal and Postnatal Mental Health Strategy Act \(Bill 204\)](#). This bill calls on the government to develop and implement a strategy to make perinatal mental health care universal. Whether or not the bill ultimately passes, the all-party endorsement suggests support in principle on the need and benefit of universal access to perinatal mental health care across the province.

³¹ The CRD Perinatal Counselling Program does not receive funding from the Pacific Perinatal Foundation.

³² Generally, the CRD Perinatal Counselling Program does not use its resources to provide counselling for grief and loss stemming from an IVF journey.

So, what is universal perinatal mental health, exactly?

A 2013 *Bulletin of the World Health Organization*³³ states that “universal health coverage is the goal that all people obtain the health services they need without risking financial hardship from unaffordable out-of-pocket payments.”

Turning to access and coverage for *perinatal* mental health care, consider these key service elements:

- screening and identification³⁴
- information access via clear communication with care providers and through online sources
- treatments that often involve mental health counselling and medication, or just one of these.

Assuming that access to perinatal mental health care entails the provision of many (and sometimes all) of these service elements, consider whether one or two elements stand out as both important and difficult to get.

For many (not all) who need medication for a perinatal mental health disorder, this form of treatment is important. Some medications can be expensive, and access to care providers who diagnose and write prescriptions can present issues and blockers.

For example, the Island Health perinatal psychiatry program³⁵ does not accept referrals from midwives. For parents in need of psychiatric services, this adds a structural, health system hurdle if they opted to access their healthcare from a midwife instead of a physician in their perinatal period.³⁶

This problematic issue aside, the provincial health system is generally set up to give British Columbians access to the prescription medications they need, and to keep them affordable, even when financial circumstances differ widely. It's set up in a way that is supposed to do that.

But the same cannot be said for perinatal mental health *counselling*. As with medications, counselling costs are high.³⁷ But unlike medications, the health care system is not set up to dispense effective, perinatal mental health counselling treatments in a way that is generally affordable and accessible for BC parents of different circumstances.

³³ See Evans, D.B., Hsu, J., Boerma, T. (2013, Aug. 1). Universal health coverage and universal access. *Bulletin of the World Health Organization*. Retrieved from <https://doi.org/10.2471/BLT.13.125450>

³⁴ In 2021, work to improve perinatal screening and facilitate earlier interventions was undertaken through the SharedCare *Partners for Patients* initiative. See [Help and hope for moms: Earlier mental health screening and support](#).

³⁵ This perinatal psychiatry program is described in [Appendix A](#).

³⁶ This problem has been compounded by the family doctor shortage that perpetuated medical care access shortfalls (despite the progress made in the past year or two to strengthen the functioning of the primary care system in the province). To ensure that parents have timely access to perinatal psychiatry services when needed, regardless of who the primary maternity care provider is, we suggest that Island Health or the perinatal psychiatry program review the referral requirements with primary care providers (including midwives) and identify improvements.

³⁷ Cost is often the main barrier to access, but other factors can be significant, including stigma, misinformation or misunderstanding.

Counselling is important because it is an effective and highly prevalent treatment, but access is difficult, insufficient, or impossible for a significant portion of perinatal parents. We suggest that counselling access is the main linchpin for achieving anything that resembles universal access to perinatal mental care.

So then, how can access become available and sufficient when needed?

Three possible directions are suggested as general options:

1. MSP coverage for specialized perinatal counselling (as discussed in [Scenario B3](#))³⁸
2. Direct delivery of specialized perinatal counselling through a public health agency³⁹
3. Direct delivery of specialized perinatal counselling through a funded program like the CRD Perinatal Counselling Program

This paper is focussed on service delivery by private counselling therapists in the community. This is simply because it is the approach we know and view as feasible.

In 2015, Island Health asked Traci how the Post Partum Support Program might be replicated across the regional health authority. This was the former program that she was operating at the time.

In hindsight, the simple answer is that we did not really know. At the time, the experience of delivering funded counselling was limited to a single-provider contract with the public health agency. Key design elements of the program, such as patient eligibility, were essentially handed to Traci by an Island Health administrator as terms of an annual contract.

We suspect that the Island Health decision in 2020 to cut funding after three decades of operation⁴⁰ was related to the question of replicability. If the program cannot deliver comparable services north of the Malahat, how is it fair and equitable to spend public health dollars that only benefit Island Health residents who are south of the Malahat?

It's a good question, and in 2025, we can now offer an answer. This is because of what happened in 2020: after the old program was cut and just before Traci launched the replacement program. It was not expected, but new funders stepped forward with a different question: *What would it take for the counselling for parents in the CRD to be quickly re-instated, enhanced and sustainable over the longer term?*

This invitation and question was inspirational, and the financial support that came after was fortuitous and generous. It prompted a recognition of the need to scale up from a solo clinician approach. The answer at

³⁸ MSP coverage offers a potentially quick way to make perinatal mental health counselling accessible, and with advance work needed to qualify approved specialists and allow service levels to differ based on individual needs.

³⁹ Service providers and counselling delivery could be integrated into medical clinics through the multidisciplinary care model used by South Island Primary Care Society to operate its clinics, or through the Primary Care Networks as part of BC's primary care system. This approach should be explored if leaders in the BC primary care system see a good place and fit for integrating specialized perinatal counselling into this system.

⁴⁰ The lead agency from 1990 to 2014 was the Queen Alexandra Centre for Children's Health, and from 2014 to 2020, it was Island Health.

the time was to develop as a coordinated team of clinicians providing counselling through their independent private practices.

Specialized intake had been in place well before 2020, and this provided a foundation for a clinical team to form and keep developing. Providing service as a team is very different, but the experience and advances in the past five years has resulted in a very different kind of program, one that looks like the stepping stone that is needed to scale services to the level of Island Health, or across another health authority.

A side goal of this paper is to share the experience, perspective and lessons that have come from operating funded counselling programs over the past two decades, the past five years especially. Even if the program disappears or we are not centrally involved in future initiatives, we know that a lot of people care about perinatal mental health care, and that some of what we have done and tried should be of use.

Another goal is to illustrate that there is a feasible way to achieve the aspirational aim of universal access to perinatal mental health care, counselling included. Based on the perspectives gained from running the CRD Perinatal Counselling Program, we envision a larger program in [Appendix C: A Scaled-Up Scenario](#).

There, we describe how the program could be structured to scale and operate across the regional health authority. It is not suggested as a pilot program with a question mark hanging over its future, but as an intentional stepping stone and next step to provincial accessibility.

If universal access is a real goal, the obvious, immediate priority is to preserve the leading access program that is already in operation: *the CRD Perinatal Counselling Program*.

CONCLUSION

For many, this paper provides a first time introduction to an innovative community counselling program that is built on 35 years of clinical service, protecting and improving the mental health and general well being of local parents, children and families. The impending loss of the program's specialized services will be a significant setback in perinatal mental health care for the second largest population centre of the province.

The paper first describes how the CRD Perinatal Counselling Program is set up to achieve its purposes: to deliver effective perinatal counselling, build clinical capacity, and sustain the program as a community source of wellness and resilience.

Second, it steps through a number of local service scenarios based on different funding levels and approaches. This part of the paper communicates our ability to keep providing services in the CRD whether funding can be secured that is less (subject to service level minimums), similar, or more. Regardless of the future scenario that comes to be, it shares how intern services allow us to stretch resources further than before while building capacity in the community for service delivery.

Lastly, the paper suggests that getting perinatal counselling is the main barrier to universal access for perinatal mental health care, and that this is the biggest issue to address in the mental health system.

Also, it suggests different approaches to address the issue, ideally as a progression of steps:

1. Quickly secure funding to continue the services of the CRD Perinatal Counselling Program
2. Scale the program to build a 'team of teams' to run community programs in cities and towns across the Island Health region
3. Then further scale the community programs to establish a provincial network.

Regardless of what the future brings, it is heartening that MLAs agree in principle on a goal of universal access to perinatal mental health care. But access to critical counselling services across the CRD is precarious, so now is the time to make access solid. It is time to be thinking about the best way to do that: by taking steps with intention to ensure that parents have secure access to perinatal counselling when it's needed in the CRD, and also, when it's needed by parents in cities and towns that are north of the Malahat and east of the Salish Sea.

The hope is that leaders in our community, region and province will soon step forward and begin working together to convert aspiration into funded services, some way, somehow. The goal is to improve the health and wellbeing of parents and their families in the short, medium and long term. Because that is what perinatal mental health counselling does.

APPENDIX A: SCAN OF LOCAL PERINATAL SERVICES

This environmental scan identifies the range of mental health and related care options available to new and expecting parents in the CRD. It shows that no other program or agency exists to give CRD residents access to specialized perinatal mental health counselling when they need it but do not have the family resources or insurance to access specialized private pay counselling.

Perinatal Psychiatry Program. This [Island Health program](#) is based at the Victoria General Hospital (VGH), and it comprises a multi-disciplinary team led by psychiatrists. It provides specialized perinatal psychiatric assessment and mental health counselling with referrals from physicians.⁴¹ Its services are for perinatal patients with more complex mental health diagnosis, particularly when they are not improving, or when patient medications require review. The perinatal counselling program has a long history of receiving referrals from the psychiatry program, and of consulting with its psychiatrists on shared patients.

Victoria PCN. This is a local network of health and community clinics and organizations that engage in team based planning and delivery of primary care services. We know through direct contact with the [Victoria Primary Care Network](#) (Victoria PCN) that its allied mental health care providers (including social workers) provide counselling to parents in their perinatal period. As the PCN does not offer specialized perinatal mental health services, administrators and providers have been urged to refer perinatal parents to the CRD Perinatal Counselling Program.

Midwife-led Perinatal Counselling with MSP Coverage. [Scenario B3](#) discusses the option for some parents to access specialized perinatal counselling with MSP coverage. Given the limits of this MSP covered counselling, it is not sufficient or scaleable to the level of community need that exists across the Capital Regional District.

PHN Perinatal Support Groups. The predecessor to the CRD Perinatal Counselling Program (Post Partum Support Program) provided group postpartum counselling to moms until PHNs at Island Health started postpartum counselling groups. Today, [PHNs at Island Health](#) offer postpartum depression screening for all new mothers and weekly postpartum depression support groups (with partner information sessions as required). We receive referrals from PHNs for individual perinatal counselling.

VGH NICU. The multidisciplinary team at the [Victoria General Hospital's NICU](#) provides care for babies and support for the families. Approximately 7% of referrals to the CRD Perinatal Counselling Program are made by a social worker at the VGH NICU. These referrals often relate to a birth trauma or loss that can strain or trigger mental health issues for parents.

Pacific Perinatal Foundation. As discussed in [Scenario B4](#), this foundation offers perinatal loss counselling that may be fully funded or subsidized, depending on funding availability. This service overlaps with the perinatal grief and loss counselling that can be accessed through the CRD Perinatal Counselling Program, representing 4% of program referrals. Potentially, Pacific Perinatal may fill some of the gap that opens up if the CRD Perinatal Counselling Program can no longer operate. We also note

⁴¹ In [Part III](#) we suggest that restrictions on who may refer to the psychiatry program blocks access for some parents in need of perinatal psychiatry services.

that Pacific Perinatal offers services to address loss during an IVF journey, and that CRD Perinatal does not offer funded counselling sessions to this population.

Adult Mental Health. Adult Mental Health & Substance Use Services provides diagnosis and short term treatment of severe and complex mental illness. Specialized perinatal mental health counselling is not provided. Historically and at present, Adult Mental Health is a referral source for perinatal counselling. (See [Victoria Mental Health Centre](#).)

FNHA Mental Health Services. First Nations people have access to culturally safe counselling through the First Nations Health Authority. These services are provided by psychologists, social workers, and clinical counsellors who are registered both with the FNHA and their professional regulatory body or college. The number of sessions accessible through the FNHA exceeds the number the perinatal program can provide. Referrals of First Nations people to the perinatal program are rare.

Her Way Home. Island Health's [Her Way Home](#) (HWH) program starts working with women from pregnancy to six months postpartum when they have a history of substance abuse and may also be facing mental health issues, violence or trauma. Once connected, the program can provide services until the youngest child is three years old. The broad menu of services they offer include perinatal health information, primary health care, and drug and alcohol counselling. The HWH services complement the work of the CRD Perinatal Counselling Program with little overlap.

Family Support Programs A number of non-mental health programs are available in our community that provide a range of support services to parents and families. Important as they are, they are not a substitute for the services of the CRD Perinatal Counselling Program for those parents who need access to specialized perinatal mental health care.

These non mental health services include:

- Perinatal parent education and support
- Parenting education
- Family outreach and support

Such programs are offered by [Esquimalt Neighbourhood House](#), [Fernwood NRG \(Best Babies\)](#), [James Bay Community Project](#), [Saanich Neighbourhood Place](#), and the [South Vancouver Island Boys and Girls Club](#).

Also, the [Parent Support Services Society of BC](#) offers CRD parents a number of online services (in English and other languages) through [parenting support groups](#), [parenting workshops](#), and the attachment-focussed [Circle of Security Parenting Program](#) (for families with children between four months and twelve years). Please note that [Circle of Security Programs](#) can be accessed through a number of agencies.

Resources in Metro Vancouver. Resources are accessible to CRD residents from the [Pacific Postpartum Support Society](#) and the [Reproductive Mental Health Program](#) at the BC Women's Hospital. Of particular

note, the BC Women's Hospital allows British Columbians to receive service through [virtual perinatal counselling appointments](#). However, we are not aware of anyone in the Capital Regional District who has received service from BC Women's in Vancouver.

International Resources. Resources are also accessible by parents and mental health care providers from [Postpartum Support International](#) (PSI) which is headquartered in Oregon. Two counsellors at the CRD Perinatal Counselling Program have professional certifications (PMH-C) from PSI.

Private Pay Counselling. Parents can be referred by a primary care provider (or by themselves) to a private counsellor of their choosing. This is always an option, and the cost of private pay counselling is often a barrier. We do not have statistics for perinatal patients in the CRD who access perinatal counselling through a private pay counsellor. However, counsellors who do work for the perinatal program all see some perinatal parents who pay privately.

APPENDIX B: RESOURCES FOR DECISION MAKERS

The reports and articles assembled here are for use by anyone who is contemplating or leading an effort to deliver specialized perinatal mental health services in the Capital Regional District or on a larger scale in British Columbia. References are organized by publication date.

2024 Clinical Practice Guideline for Management of Perinatal Mood, Anxiety & Related Disorders

This clinical practice guideline by the Canadian Network for Mood and Anxiety Treatments was published in the *Canadian Journal of Psychiatry* in 2025. The detailed, evidence-based recommendations give clinicians key information to promote the delivery of effective and safe perinatal mental healthcare. It aims to serve as a valuable tool for clinicians in Canada and around the world to help optimize clinical outcomes in the area of perinatal mental health.

Of relevance to service delivery options, see the section titled, “Question 2: What is recommended for the organization and delivery of healthcare services?” on pp. 12-14. [[Full Access](#)]

SOGC Guideline 454: Identification & Treatment of Perinatal Mood and Anxiety Disorders (2024)

Based on a literature review published in the *Journal of Obstetrics and Gynaecology Canada* (JOGC), this new guideline from the Society of Obstetricians and Gynaecologists of Canada (SOGC), is for perinatal health care providers to identify and assist pregnant and postpartum patients with perinatal mental illness, specifically perinatal mood and anxiety disorders. Areas of focus include risk factors and identification, screening, treatment, and referral.

[[Abstract](#) + [Abstract with Excerpts](#) + [JOGC Editorial](#) + [SOGC Slides](#)]

Mental Health for All: Building a Comprehensive System of Care in BC (2024)

CMHA BC Policy and Advocacy Roadmap 2024: “At CMHA BC, we believe that mental health should be treated with the same urgency and importance as physical health. **Our vision is a province where everyone can access quality mental health care promptly and with dignity.** That’s why we’ve developed a comprehensive roadmap ahead of the 2024 Provincial Election, outlining 31 actionable recommendations for creating a voluntary, integrated, and holistic system of care in BC. This roadmap is designed to guide policymakers, strengthen the mandate of the Ministry of Mental Health and Addictions, and ensure that mental health and substance use care is accessible, equitable, and effective for all individuals living in British Columbia.” [[CMHA Web](#) + [Download PDF](#)]

A global perspective: Access to mental health care for perinatal populations (2024)

Abstract: Perinatal mental health care differs around the world. We provide a global perspective on the current status of service provision, barriers and facilitators to access, and strategies to improve access in high-income and low- and middle-income countries across five continents (Asia, Africa, Europe, North America and South America). Many of the countries considered do not have universal healthcare coverage. This poses a challenge to perinatal mental health care access. However, there are other social and structural barriers to access, including stigma and other sources of marginalization and

discrimination. Yet there are opportunities discussed herein to learn more about what perinatal mental health services work for what populations* and in what circumstances, by adopting a global lens to examine innovative solutions utilized across geographical settings. [[Full Access](#)]

Reimagining Perinatal Mental Health Services: Toward an integrated model of care (2023)

This report by St. Paul's Hospital Reproductive Mental Health Program and partners including the UBC School of Nursing, presents an evidence-based, user-informed model of perinatal mental health care focused on improving access, coordination, and quality of perinatal mental health services in British Columbia and beyond. [[Download PDF](#)]

Best Practice Guidelines for Mental Health Disorders in the Perinatal Period: Substance Use Disorders (2023)

This guidance by Perinatal Services BC and partners describes best practices for the care of birthing individuals with substance use disorders in the perinatal period (before pregnancy to after birth). [[Download PDF](#)]

Time for Action: Why Canada Needs a National Perinatal Mental Health Strategy (2021)

The CPMHC created a first-of-its-kind national online survey to understand the state of perinatal mental health care in Canada. It looked at screening and treatment practices, seeking to identify gaps and what's working in different jurisdictions. Findings include:

- 95.8% of healthcare practitioners see perinatal mental health services as insufficient in Canada.
- 87% of health care practitioners in Canada do not have mandated screening for perinatal mental illness at their workplace.
- When people are screened and have symptoms indicative of needing intervention, 27% of health care practitioners indicated that patients were able to access their referral within a month, 31% waited between 1-2 months, while 42% had to wait for >2 months for access.
- Perinatal mental health services differ across health regions. More than half of health care practitioners surveyed (57.3%) reported that they have not received specialized training in PMADs or were unsure if they received specialized training.
- 87% of practitioners believe people from diverse backgrounds encounter barriers to accessing perinatal services. These include language, cultural, and cost barriers. [[Download PDF](#)]

Assessing the Costs and Benefits of Insuring Psychological Services as Part of Medicare for Depression in Canada (2017)

The study modeled the evolution of depression among patients over a 40-year period to assess the long term cost-effectiveness of increasing publicly funded access to psychotherapy in Canada, compared with the status quo. It concludes that every \$1 invested in covering psychological services would yield \$2.00

(\$1.78 to \$3.15) in savings to society, and that covering psychological services as part of Medicare for individuals with an unmet need for mental health care would pay for itself. [[Psychiatry Online - Full Access](#)]

Best Practice Guidelines for Mental Health Disorders in the Perinatal Period (2014)

This guidance by Perinatal Services BC and partners describes best practices for the care of birthing individuals with depression, anxiety disorders, bipolar disorder and psychotic disorders, including postpartum psychosis, in the perinatal period. [[Download PDF](#)]

Addressing Perinatal Depression: A Framework for BC Health Authorities (2006)

This framework will help guide the development of a regionally appropriate strategy for addressing perinatal depression at the local level. [[Download PDF](#)]

APPENDIX C: A SCALED UP SCENARIO

This appendix envisions what a perinatal counselling program for the Island Health region (or all of British Columbia) can look like if the CRD Perinatal Counselling Program is scaled up. It illustrates the feasibility of achieving the aspirational goal of universal access to specialized perinatal counselling. By suggesting how it can be done, we hope to inspire thinking and action that gets us to the goal, even if the ultimate solution differs from what is presented here.

This scaled up program has two main parts that work together: a network of community based programs that deliver the services, and a resource hub that supports the programs.

Network of Community Programs

Community Program Boundaries. Community programs are defined by the geographic area where services are provided. Health Service Delivery Areas (HSDAs) are suggested as the default program area to start with. Within Island Health, there are four HSDAs. Across the province, there are 16. In some cases, it may make sense for a program to cover a regional district (which can be half the size of an HSDA).

Lead Counsellors Each community program has a lead counsellor with community program roles that include:

- **Local Mental Health Services Integration.** Maintaining an active presence and ongoing communication with health care providers in the area (in order to know the main referrals sources and service providers for the perinatal population, and to be known by key members of the local healthcare community).
- **Liaison.** Ongoing coordination of local team and patient matters with local program counsellors (if any) and the central program team (intake, program leadership).
- **Local Resources Info:** Continual tracking and updates of local perinatal mental health services and resources for use by local program clinicians, the intake team, and in some cases, the public.
- **Local Team Building:** Lead the selection, development, and capacity building of the local clinical team.
- **Program Networking:** Periodic engagement with other Lead Counsellors and other program team members to exchange knowledge and resources that reside in the program team and network.

Perinatal Counsellors. Each community program has one or more perinatal counsellors (including the Lead Counsellor) who provide both in-office and virtual counselling for parents in the community program area. Primary points of contact are the Lead Counsellor, intake team members, and a clinical supervisor who provides individual or group clinical consultation. Perinatal counsellors include registered professionals with a minimum level of training and experience in perinatal mental health care. Counsellor registrations may include registered clinical counsellors, registered social workers and registered psychologists.

Central Resource Hub

The program also has a centralized hub of internal program resources and administrative support that is essential for coordinating multiple community program operations through a distributed but coordinated network of service providers across urban and rural areas.

Leadership. These key leadership roles are envisioned for the program:

- Clinical Director
- Administrative Operations
- Systems Operations
- Program Sustainability & Continual Improvement

Goal and Standards Setting. In collaboration with policy experts and decision makers, set program objectives and standards on issues that are key for program success and accountability (e.g. specialization qualification of perinatal counsellors and service level tiers⁴²).

Program Network Services. The program combines points of contact to the program through internal and online connections for use by parents who receive (or may receive) counselling, primary care providers who refer to the program, and perinatal service providers who work as part of both a community team and the larger program team. The program hub team provides services across the network which include:

- **Program infrastructure and systems** for secure communications, record keeping, HR, operational and clinical processes, service reports and billing.
- Public information on a **dedicated program website**⁴³ with local community pages for perinatal parents and the primary care providers who refer to the program
- A **dedicated program intake team** acquires local knowledge of providers and services for each community to provide direct and personal communication with:
 - referred parents
 - primary care providers (respecting referrals and follow ups on continuum of care matters)
 - lead counsellors (respecting special referral or parent mental health matters) to
- **Lead counsellor support** through coaching, guidance, resources, networking and ongoing communication
- **Counsellor support & tem engagement** through program resources and clinical consultation services by an accredited clinical supervisor (individually and through co 2 nsultation groups), and as a member of both a community and program team.

⁴² When a parent needs and can benefit from perinatal counselling, the number of sessions to meet that need will vary from one parent to another. Ultimately this is a determination for the clinician to make in their professional judgement. To help ensure that program resources are allocated appropriately and with reasonable consistency, we suggest the establishment of tiered session allocation ranges based on clinical presenting issues. To illustrate the concept: Initial session / consultation = 1 session; Tier 1 = 2 to 6 sessions; Tier 2 = 7 to 12 sessions; Tier 3 = 13 - 22 sessions.

⁴³ The website for the [program in the CRD](#) illustrates the sort of information that may be provided on a new website for a regional or provincial program.

- **External Clinician Consultations** Some parents will opt to receive mental health counselling from a counsellor who is neither a perinatal specialist nor a perinatal program counsellor (i.e. outside the program). To ensure access to specialist counselling in these circumstances, the program should advertise and provide specialist perinatal consultations to counsellors outside the program.

Ancillary Services. In addition to the core services that relate to the delivery of specialized perinatal counselling services, the program also has potential to serve as a vehicle for related perinatal mental health services and resources such as:

- Public awareness promotion
- Public education resources
- Training for clinicians
- Liaison with representatives of other agencies and programs with complementary services, programs and interests (e.g. Perinatal Services BC, Pacific Post Partum Society, and other organizations noted in [Appendix A](#)).

Note on the Availability of Perinatal Counsellors

As an additional note, the availability of perinatal counsellors in private practice is not a limiting factor for operating an expanded program. Rather, the availability of counsellors is a reason this envisioned, scaled-up program should be seen as a feasible approach.

To illustrate private counsellor availability, a search on *Psychology Today* for counsellors in “Victoria BC” with a specialty in “pregnancy, prenatal, postpartum” counselling lists [163 counsellors](#). Also, a search for perinatal mental health providers in “Victoria BC” on the directory at Postpartum Support International lists [eight local counsellors](#).⁴⁴ Many more perinatal counsellors can be found across Vancouver Island and the province.

Challenges are expected in some locales with the identification of professionals suitable and able to deliver (or learn to deliver) specialized counselling (i.e. counsellors who may be invited to deliver counselling through their practices). Where gaps or limitations exist, incentives and strategies can be put in place to encourage and build capacity in more and more communities across Island Health or the province.

⁴⁴ These online searches were conducted March 21, 2025. The CRD Perinatal Counselling Program presently operates with a total of [four perinatal counsellors](#) and one perinatal intern.