

An Evidence-Based Protocol for Optimal Screening and Treatment of Antenatal Depression:

A Best Practice Approach

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TABLE OF CONTENTS

I. Abstract.....4

II. Chapter 1 – Introduction.....5

 A. Statement of Purpose.....5

 B. Significance of Problem.....5

 C. Antenatal Depression.....6

 D. The Clinical Problem: Barriers to Treatment.....7

 E. Summary.....8

III. Chapter 2 – Review of Literature.....9

 A. Edinburgh Postnatal Depression Scale.....9

 B. Therapy in a Home-Based Setting.....10

 C. Involvement of the Partner.....12

 D. Summary.....15

IV. Chapter 3 - Best Practice Protocol: Nursing Care for Pregnant Women with
Antenatal Depression.....16

 A. Screening.....16

 B. Home-Based Treatment.....17

 C. Involving the Partner During Treatment.....19

 D. Summary.....20

V.	Chapter 4 – Implementation and Evaluation.....	21
	A. Knowledge.....	21
	B. Persuasion.....	22
	C. Decision.....	23
	D. Implementation.....	24
	E. Confirmation.....	25
	F. Strengths/Limitations and Recommendations for Future Research.....	26
	G. Summary.....	27
VI.	References.....	29
VII.	Appendix.....	32

ABSTRACT

The purpose of this thesis was to develop a best practice protocol for the nursing care of pregnant women with antenatal depression. Approximately 11% of obstetrical clients experience antenatal depression at some point during their pregnancy (Banti et al., 2011). The periods associated with the highest incidence of depressive symptoms are the first and third trimesters (Bowen, Bowen, Butt, Rahman, & Muhajarine, 2012). In spite of the high occurrence of antenatal depression, many women go undiagnosed (Banti et al., 2011). Many of the pregnant women confirmed to be depressed do not receive treatment (Segre, McCabe, Stasik, O'Hara, & Arndt, 2012). This is in large part due to various barriers such as cost and lack of accessibility, an issue that nurses can help to overcome (Segre et al., 2012; Segre, Stasik, O'Hara, Arndt, 2010). Evidence-based interventions were proposed in the paper and include: depression screening among pregnant women in addition to treatment through home visits and partner involvement will provide an accessible form of nursing care. A proposed plan for implementation and evaluation were also discussed.

CHAPTER 1

Introduction

Statement of Purpose

The purpose of this thesis is to create a best protocol practice for the nursing care of women experiencing depression during the antenatal period. This protocol addresses the evidence-based interventions of screening for depression in addition to home visits and partner involvement during treatment. Within this first chapter, information regarding the significance of the problem and the barriers to receiving treatment are discussed. From this information, the general background of antenatal depression is established, laying the foundation for further discussion on how best to approach nursing care for this health care issue.

Significance of Problem

The prevalence of antenatal depression is estimated to be as high as 11% among general obstetric clients and possibly higher among disadvantaged populations (Banti et al., 2011). However, this percentage tends to vary among studies depending on the definition and method of assessment used (Segre, Stasik, O'Hara, & Arndt, 2010). Yet, despite this relatively significant number of women affected by antenatal depression, the majority of cases go undetected by healthcare providers (Breedlove & Fryzelka, 2011). Without the proper attention and treatment, this depressive disorder can lead to adverse outcomes for the mother, child, and family (Bowen et al., 2012; Rowan, Greisinger, Brehm, Smith, & McReynolds, 2012).

Antenatal depression is associated with numerous issues for both the mother and her family. One common side effect of depression is emotional withdrawal and disengagement from normal functions (Bowen et al., 2012). This places the mother at a greater risk for the deterioration of her relationships, which may further aggravate her symptoms due to reduced

social support. Interestingly, research has shown that the partners of women diagnosed with postpartum depression are at risk for developing depressive symptoms as well (Bowen et al., 2012).

The children of these women are also directly susceptible to the effects of antenatal depression. Women with antenatal depression have an increased risk for developing preeclampsia or having a miscarriage (Bowen et al., 2012). Additional complications for these infants include an increased risk for intrauterine growth restriction, preterm birth, low birth weight, admission to the neonatal intensive care unit, and decreased duration of breastfeeding (Bowen et al., 2012 & Breedlove & Fryzelka, 2011). If left untreated, the symptoms of depression during pregnancy may affect women after childbirth as well by developing into postpartum depression (Staneva, Bogossian, & Wittkowski, 2015). Mother-baby attachment is often hindered by postpartum depression due to the symptoms the mother experiences such as fatigue, loss of interest and motivation, and cognitive impairment (Segre et al., 2010). In addition, depressed mothers are less likely to adhere to the recommended healthcare for their babies including immunizations and well-baby check-ups (Rowan et al., 2012).

While the impaired ability of a mother to provide appropriate and loving care for her infant immediately following birth is of great significance, the effects of inadequate care has been shown to affect the child long-term. The occurrence of psychological challenges increases among children and teenagers who experienced insecure attachment as infants (Bowen et al., 2012).

Antenatal Depression

Antenatal depression affects more women than intimate partner violence, yet it is more commonly undiagnosed than the latter (Breedlove & Fryzelka, 2011). This is in large part due to

the overlap between depressive and pregnancy symptoms (Banti et al., 2011). Another challenging factor is that antenatal depression is poorly defined, with the definition varying between clinicians, practices, and studies (Banti et al., 2011). Additionally, the etiology of this depressive disorder currently remains uncertain (Banti et al., 2011). However, despite the many “unknowns” of perinatal depression, several trends have been identified.

Of the women diagnosed with perinatal depression, the majority tend to experience episodes during the first trimester, improve over the course of the pregnancy, and then peak again just before or after birth (Bowen et al, 2012). During the first year postpartum, the period associated with the highest rates of depression is within the first three months (Bowen et al., 2012). Factors that may contribute to postpartum depression include a discrepancy between the perceived experience of motherhood and the actual experience, feelings of inadequacy and inability to meet the demands of motherhood, perception of inadequate partner or social support, and struggle with holding on to previous identity (Highet et al., 2014).

Recent attention has focused on the issue of postpartum depression, yet antenatal depression is still frequently neglected (Breedlove & Fryzelka, 2011). However, despite this imbalance of attention, the literature has shown that the occurrence and severity of depression are equal both during pregnancy and after childbirth (Banti et al., 2011). In fact, one of the most significant risk factors for postpartum depression is antenatal depression, which is now being considered a predictor for a mother’s mood following delivery (Banti et al., 2011; Highet et al., 2014). Both antenatal and postpartum depression appears to be connected for many women. Effective treatment for either of these types of depression will require that this link be acknowledged and understood.

The Clinical Problem: Barriers to Treatment

The majority of women experiencing antenatal depression are not receiving care for this issue (Segre et al., 2012). Barriers appear to serve a large role in preventing many of these women from accessing the care that they need. Examples of the barriers women with perinatal depression experience include a preference for peer support over mental health care, desire to avoid pharmacotherapy, and lack of knowledge regarding or access to services (Rowan et al., 2012). Discomfort with disclosure and wariness of the stigma associated with depression are additional barriers (Breedlove & Fryzelka, 2011; Segre et al., 2012).

Researchers have noted that many of these barriers relate back to mental health professionals (Segre et al., 2012). Some of these barriers include patients' distrust of mental health providers, lack of access to and expense of treatment services, and inconvenient office hours (Segre et al., 2012). A recent study examined the possibility and benefit of including public health nurses in the treatment of these women (Segre et al., 2010). By including nurses in the outreach towards women with perinatal depression, many of the barriers preventing treatment may be overcome.

Summary

Antenatal depression is a major health concern among women of childbearing age. Unfortunately, many women do not receive the appropriate care that they need. In order to provide appropriate care to women experiencing perinatal depression, it is imperative that midwives understand the barriers that these women face. A larger portion of the barriers women face relate to a lack of knowledge, resources, and trust. By incorporating nurses into the treatment plan, care for women with perinatal depression may become more readily available.

CHAPTER 2

Review of Literature

This chapter provides a review of the literature of recent studies addressing screening tools and treatments for antenatal depression. The search engines used to find these articles include the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Ovid MEDLINE, and Google Scholar. Only articles between the years of 2010 and 2015 were incorporated into this literature review. The key terms used during the search included: pregnant women, pregnancy, depression, antenatal depression, perinatal depression, midwives, assessment, home interventions, listening visits, partner support, and partner involvement.

Edinburgh Postnatal Depression Scale

Depression screening has been a topic of controversy as researchers have debated the benefits, or lack thereof, for health outcomes during pregnancy and the postpartum (Thombs et al., 2014). However, in spite of these conflicting views, the American College of Nurse-Midwives (ACNM) has retained its statement that all certified nurse-midwives (CNMs) and certified midwives (CMs) “should integrate prevention, universal screening, and/or referral for depression into the care they provide for women” (American College of Nurse-Midwives, 2013). Many tools are available for the screening of depression however, the Edinburgh Postnatal Depression Scale (EPDS) is recommended for the screening of depression during pregnancy as it has proven to be the most reliable in terms of specificity and sensitivity for depression in prenatal research (Breedlove & Fryzelka, 2011).

Cox, Holden, & Sagovsky (1987) first developed the EPDS in response to the increased awareness of postpartum depression and the lack of an accurate screening tool among childbearing women. The authors felt it was necessary to develop a screening tool that could be

completed in a client's home and one that did not require any special knowledge of psychiatry for the health care work administering it. As the authors developed the EPDS, they referred to questions from three other screening tools: the Irritability, Depression, and Anxiety Scale (IDA), the Hospital Anxiety and Depression Scale (HAD), and the Anxiety and Depression Scale (Cox, Holden, & Sagovsky, 1987). In addition to obtaining questions from these scales, the authors created questions of their own. While the initial screening tool developed contained 21 items, the authors eventually decided on 10 items after completing several pilot interviews (Cox, Holden, & Sagovsky, 1987). In order to test positive for postnatal depression on this scale, the woman completing it would need to score a 12/13. Validation of the EPDS was completed in the community setting by health visitors in Edinburgh and Livingston (Cox, Holden, & Sagovsky, 1987). In addition to completing the EPDS, the 84 participating mothers also completed the Standardised Psychiatric Interview (SPI) as a means of comparing the results. After analysis of the results, the authors determined that the scale showed 85% sensitivity, 77% specificity, and an 83% positive predictive value (Cox, Holden, & Sagovsky, 1987). The EPDS was administered a second time, following a counselling intervention study. From this second screening, the mothers whose depression remained the same showed little difference on their EPDS score, while those who were depressed at the first visit and not the second showed a significant decrease in their EPDS score (Cox, Holden, & Sagovsky, 1987). From these results, the authors determined that the EPDS showed satisfactory validity and was also sensitive to changes in a mother's depression over time (Cox, Holden, & Sagovsky, 1987).

Therapy in a Home-Based Setting

Segre et al. (2010) conducted a study to evaluate the effectiveness and acceptability of Listening Visits (LV), a type of home-based therapy originating from the United Kingdom,

within the United States. The purpose of LV is to provide a non-directive form of counselling while exploring the client's problems through reflective listening and collaborative problem solving (Segre et al., 2010). Eight *Healthy Start* home-visiting staff received training through a workshop regarding the LV intervention and the necessary skills associated with it. Nineteen *Healthy Start* clients with a score greater than or equal to twelve on the Edinburgh Postnatal Depression Scale (EPDS) participated in this study (Segre et al., 2010). The *Healthy Start* clients received up to six one-hour sessions of LV. To evaluate the effectiveness of the LV, Segre et al. completed pre-LV, post-LV, and follow-up interviews with each of the participants (Segre et al., 2010). During these evaluations, each woman's depression status was evaluated using the EPDS, Panic Disorder Severity Scale (PDSS), Hamilton Rating Scale for Depression (HRSD), and the Structured Clinical Interview for DSM-IV-TR, Nonpatient Edition (SCID-I/NP). In addition to assessing for depression, participants completed the self-report "General Activities" subscale of the Quality of Life, Enjoyment and Satisfaction Questionnaire (Q-LES-Q) to assess their overall life satisfaction (Segre et al., 2010). Each woman also completed the Client Satisfaction Questionnaire (CSQ) and the View of LV Interview (a tool developed for this study) to express her acceptability of the LV. At the end of the study, the authors assessed that the LV were an effective form of depression treatment for 94.7% of the participants (Segre et al., 2010). The women also gave uniformly positive feedback on the helpfulness of LV. From this study, LV have shown potential for being both an effective and acceptable form of treatment for depression, especially for women with few health care resources (Segre et al., 2010).

In another randomized study, the authors implemented a six-week cognitive behavioral therapy (CBT) program among sixty-one low-income women enrolled in a Baltimore City home visiting program, who were either pregnant or six months postpartum (Tandon, Perry,

Mendelson, Kemp, & Leis, 2011). The women considered eligible for this study must have had elevated depressive symptoms or have a history of a lifetime depressive episode. However, women experiencing a depressive episode at the time of the initial screening were not included in the study (Tandon et al., 2011). The participants were randomly placed into either the experimental group, which received group-based CBT in addition to home visits, or the control group, which received the standard home visits. The depressive symptoms and major depressive episodes of each woman were assessed prior to the intervention and then again at one week and three months following the intervention using the Beck Depression Inventory II and Maternal Mood Screener (Tandon et al., 2011). During the three-month follow-up assessment 33% of the women in the control group displayed symptoms of depression compared to the 9% who had received the intervention. The findings from this study suggest that cognitive behavioral therapy is effective in both the prevention and treatment of perinatal depression (Tandon et al., 2011).

Involvement of the Partner

Brandon, Ceccotti, Hynan, Shivakumar, Johnson, & Jarrett (2012) completed a “proof of concept” study in order to test the safety, acceptability, and feasibility of Partner-Assisted Interpersonal Therapy (PA-IPT). This open-series proof of concept study followed eleven women with major depressive disorder who were greater than twelve weeks pregnant, but less than twelve weeks postpartum and their partners (Brandon et al., 2012). Recruitment took place in the Women’s Mental Health Center of the University of Texas Southwestern Medical Center. During the course of this study, each couple participated in eight acute-phase sessions and one six-week follow-up assessment (Brandon et al., 2012). The acute-phase sessions were divided up into three sessions, each phase having a specific purpose. The first phase focused on encouraging the couples to describe their understanding of the mother’s depression and what events may

trigger the symptoms, at both the onset and the current episodes (Brandon et al., 2012). The middle phase allows the couple to describe the expectations for self and other as well as describing interactions, which are perceived as supportive or unsupportive. During the final phase, additional sources of support are addressed and the couple described their individual experience of the therapy (Brandon et al., 2012). While one couple was excluded due to partner violence and another did not return for the follow-up interview, none of the women from the remaining couples exhibited a decline in their condition according to the Hamilton Depression Rating Scale (HAM-D₁₇). Additionally, all of the partners expressed that they received personal benefit from the therapy (Brandon et al., 2012). The authors concluded that while additional studies will need to be completed on this topic, PA-IPT had proven to be a safe, acceptable, and feasible form of perinatal treatment (Brandon et al., 2012).

Gremigni, Mariani, Marracino, Tranquilli, & Turi (2011) explored the role of partner expectations in association with postpartum depression in this longitudinal study. Data was collected from seventy Italian women in two stages. During stage one, the third trimester of pregnancy, each participant completed the Support Expectations Index (SEI) as a measurement of her expectations for support from her partner and the Dyadic Adjustment Scale (DAS) to measure conflicts within her relationship (Gremigni et al., 2011). Stage two, three months postpartum, served to measure the women's depressive symptoms using the Edinburgh Postnatal Depression Scale (EPDS) and her validation of receiving marital support was measured with the Expectancy Confirmation Scale (ECS). At the three-month postpartum assessment, 55.7% of the women presented with depressive symptoms (Gremigni et al., 2011). A higher portion of these women reported greater violations of their expectations from their partners than women without depressive symptoms. This finding indicates that if a woman feels her expectations are not met

by her partner, then she is more susceptible to developing postpartum depression (Gremigni et al., 2011).

In this qualitative-descriptive study, Habel, Feeley, Hayton, Bell, and Zelkowitz (2015) sought to describe and explore the differences between both men's and women's perceptions of the causes of postpartum depression. Thirty heterosexual couples were recruited from two different tertiary hospitals in Quebec, Canada for this study. Each female participant was required to have scored at least 12 on the Edinburgh Postnatal Depression Scale (Habel et al., 2015). The semi-structured interviews were conducted in the participants' homes and lasted between 45 and 90 minutes. In order to provide each participant with the opportunity to speak freely, the women and their partners were interviewed separately, but simultaneously (Habel et al., 2015). Common themes mentioned in the interviews included: "societal expectations of women, physical health problems, the transition to parenthood, lack of support, personality characteristics and history of mental health problems, child-related challenges, unmet healthcare needs, unmet childbirth expectations, and other stressing events" (Habel et al., 2015, pg. 732). The authors suggest that by understanding the perceptions of both women and their partners will aid healthcare professionals in the development more acceptable services and treatments for women with postpartum depression (Habel et al., 2015).

May and Fletcher (2013) wrote an article outlining recommendations based on relevant research for the content, specific to men's needs, of childbirth education classes. The authors include six recommendations that relate to the role of a father, relationship changes, paternal psychological distress, infant communication, the parenting relationship, and infant crying (May & Fletcher, 2013). Of most significance to this thesis is the third recommendation, which discusses the role of a father as a support person. Currently, it is the norm for mothers to rely on

their partners as their main support person throughout the perinatal period (May & Fletcher, 2013). Yet, research has shown that often times fathers do not know how best to fill this role. The authors pointed out that when fathers receive adequate instruction, they proved to be effective supporters and reduce negative outcomes such as postpartum depression (May & Fletcher, 2013).

Summary

Evidence from various authors and researchers has suggested several different approaches for treating antenatal depression. Home visitation programs provide women, particularly those from low socioeconomic backgrounds, with greater accessibility to mental health care. The Listening Visits program may prove beneficial as an additional outreach program to women when mental health professionals remain unavailable. Additionally, assessing a mother's expectations of her partner may be a key to preventing postpartum depression. By encouraging both the mother and partner to discuss their feelings, they will be better able to understand one another during this transition. By understanding the mother, the partner will also be better equipped to help her and reduce feelings of stress and depression. These treatments provide additional option aside from the traditional pharmacotherapy and psychotherapy, which have proven effective in the past, yet some women wish to avoid them. Research found through this review of the literature has provided valuable information, which was used to develop a best-practice protocol for nurses in the care of women with antenatal depression.

Chapter 3

Best Practice Protocol: Nursing Care for Pregnant Women with Antenatal Depression

The purpose of this thesis is to create a best practice protocol for the treatment of women with antenatal depression. This chapter presents the proposed recommendations for the nursing care of women diagnosed with depression during their pregnancy and the necessary training for nurses. An algorithm for the propose protocol has been included in the Appendix.

The literature presented in Chapter 2 provided evidence for the appropriate screening of pregnant women in addition to the development of a home visitation program and the involvement of the partner during treatment. The Listening Visits program has shown to be a promising form of treatment when delivered by a trusted nursing professional (Segre et al., 2010). Actual or perceived lack of support from her partner increases a pregnant woman's risk for developing depression (Gremigni et al., 2011). By including a pregnant woman's partner in her treatment, the partner may not only gain a better understanding of the illness, but learn how to fill the role of supporter (Brandon et al., 2012).

Screening

The benefits of antenatal depression screening have been questioned; however, the ACNM (2013) has maintained its stance on universal screening for all women. The recommended screening tool for antenatal depression is the EPDS, as it has shown the highest sensitivity and specificity for this population (Breedlove & Fryzelka, 2011). Episodes of depression among pregnant women are highest during the first and third trimesters (Bowen et al, 2012).

The screening portion of the proposed protocol is based on the information above. Screening will be administered to all women, as recommended by the ACNM, at the initial visit

during the first trimester and again at the beginning of the third trimester. Additional screenings will be completed for the women identified with antenatal depression, which will be discussed later in this chapter. The screening tool that will be used at each of the screenings is the EPDS, in order to maintain consistency and achieve the highest accuracy.

Home-Based Treatment

Of all the women who receive depression screening during their prenatal visits and are identified as potentially depressed, approximately only 13.8% receive treatment due to various barriers (Segre et al., 2010). Home visits overcome some of these barriers and provide the opportunity for more pregnant women with depression to receive treatment. Listening Visits provide an additional treatment option for these women as nurses with limited or no prior mental health training may conduct them (Segre et al., 2010).

The proposed protocol of offering antenatal depression treatment through home-based Listening Visits requires that the home-visiting nurses attend a four-hour education program taught by an experienced LV home visitor. In order to reduce costs, it is recommended that one nurse from the Birth Center be assigned the responsibility of attending a LV conference. Once this nurse returns from the LV conference, she will be designated the expert of this field for the Birth Center. This will require that she lead the training session offered to the home-visiting nurses at the Birth Center. The training will describe the LV intervention, skills (active reflective listening and problem-solving), and agency-specific procedures. Upon completion of the required education program, the home-visiting nurses will begin providing LV to their clients with depression, who have given assent for this treatment. Considering the demand of this position, it may be beneficial to hire an additional nurse with the responsibility of completing all

the home visits. An additional option is to spread the workload over the nurses already employed at the Birth Center.

The pregnant women enrolled in the LV program will receive up to six one-hour sessions, which will be held over the course of eight weeks, allowing flexibility for the client's schedule. The sessions will begin following the EPDS screening completed in either the first or the third trimester if the pregnant woman has tested positive, which is a score of 12 or greater. During these sessions, the home visitors will practice active reflective listening and collaborative problem-solving. Through reflective listening the home visitor will demonstrate interest in the client as she reflects on both the verbal and non-verbal messages given during the conversation. To demonstrate collaborative problem-solving, the home visitor will encourage her client to create a list of problems she is facing and possible solutions. Together, the home visitor and client will select one problem as the focus and evaluate the solution that the client created. If the solution is deemed appropriate, the home visitor and client will then work to create a plan of implementation.

The intent of LV is to provide the clients with a supportive and non-threatening model of treatment, which will assist the clients in working through the problems they face during their depression. In order to evaluate the progress of a client, the home visitor will ask her client to complete the EPDS at the end of the first, third, and sixth visits. If no progress is evident or the client's symptoms worsen, the home visitor will refer her to a mental health professional.

One nurse will be designated as the "expert" on LV and provide annual assessments on each of the home visiting nurses in order to evaluate their effectiveness and adherence to the protocol. Nurses trained in LV will be required to strictly follow the non-directive counselling

guidelines, as they are not trained mental health professionals, and administer the EPDS assessment at each visit.

Involving the Partner During Treatment

Partner support is essential to a woman during her pregnancy, so much so that if a woman even feels that her expectations for support are not met, her risk for developing depression increases (Gremigni et al., 2011). For those women already diagnosed with depression, research has shown that involving her partner in her therapy is beneficial to both parties (Brando et al., 2012).

Communication between the pregnant woman and her partner will be the key concept of this portion of the best practice protocol. Couples will be given the opportunity to enroll in an optional program, which consists of six sessions and one six-week follow-up appointment. These sessions may be included as part of the home-visit or may be completed at the Birth Center. These visits are not intended to provide therapy for the couple, but to encourage communication and provide information regarding additional resources.

During these visits, the registered nurse will lead the pregnant woman and her partner in a discussion about antenatal depression and each person's understanding of the condition and the factors each believes triggers the woman's depression. The couple will be encouraged to develop a process of communication in which they discuss their expectations for self and the other. They will also be encouraged to discuss interactions that are perceived as either supportive or unsupportive. As a final step in this process, the registered nurse will provide the couple with a list of resources local mental health resources. These resources may include CODAC, COPE, and South Arizona Mental Health Corporation (SAMHC). During the six-week follow-up

appointment, the registered nurse will evaluate the progress of the couple and refer to the additional resources as needed.

As with the Listening Visits, this protocol will require that one nurse be designated as the “expert” on partner-involved treatment. Each nurse delivering this model of care will be evaluated annually to determine proficiency in these sessions and that she is not going outside of her scope of practice.

Summary

The objective of this protocol is to identify pregnant women at risk for antenatal depression and provide them an accessible and supportive model of treatment. Through Listening Visits, nurses will become more available to their clients as care is brought directly into their homes. This particular type of treatment also creates a partnership between nurse and client as they work together to create feasible solutions to the client’s problems. When appropriate, partners of the pregnant women may be included in the treatment, which will aid them in learning how to fill the role of a support person during the pregnancy and throughout the perinatal period.

In addition to recommendations for the nursing care of pregnant women with antenatal depression, the training and evaluation of this protocol were briefly discussed. Greater detail regarding the implementation and evaluation of this protocol will be given in the following chapter.

Chapter 4

Implementation and Evaluation

This chapter will focus on the hypothetical implementation and evaluation for the screening of and treatment of antenatal depression of the pregnant clients at the El Rio Birth and Women's Health Center. A protocol for screening and referral is currently in place at the Birth Center. On the initial visit, the Patient Health Questionnaire-9 (PHQ-9) is administered to all pregnant clients. Any history of mood or anxiety disorders or additional risk factors are recorded in the patient's history and taken into consideration at each subsequent visit. If a client contacts the Birth Center with concerns about her emotional wellbeing, she will complete the EPDS and may receive a referral to a behavioral health facility, such as SAMHC, if self-harm is a concern. However, there is no protocol currently in place for treating depression.

The innovation-decision process, developed by Everett M. Rogers (2003), will be used for the implementation of the proposed protocol. This five-stage process has been used in multiple settings, including health care, for the integration of new ideas. Each stage is an integral part of inclusion of a change into the specified setting. The five stages of the innovation-decision process are knowledge, persuasion, decision, implementation, and confirmation.

Knowledge

In this stage, individuals are exposed to a change and learn of its purpose and function (Rogers, 2003). Staff, including certified-nurse midwives and registered nurses, at the El Rio Birth and Women's Health Center will be introduced to the proposed protocol during their quarterly staff meeting. The current protocol for pregnant women with antenatal depression will be reviewed first. During this review, the issues of concern will be addressed such as the lack of treatment options for patients with antenatal depression.

Following the review of the current protocol, the nurses will be presented with a review of the literature on evidence-based recommendations for the screening and treatment of pregnant women with antenatal depression. Literature presented to the nurses may include the studies reviewed in Chapter 2 of this thesis. The themes found in the reviewed literature and the strengths and weaknesses of the studies will be discussed. After the nurses have been informed of the current research regarding this topic, the proposed protocol will be presented. Each part of the protocol (screening, home visits, and partner involvement) will be discussed in detail and supported by the literature. The role of the nurse in this intervention would also be discussed, including the education process, home visitation model, and documentation process.

According to Rogers (2003), it is important for individuals to receive sufficient knowledge on the proposed idea before moving on to the persuasion stage. In order to assure that the nurses understand the new protocol and what will be expected of them, discussion will be encouraged following the presentation. This will provide the nurses with the opportunity to clarify any misunderstandings and ensure they acquired all the information presented.

Persuasion

During the persuasion stage, individuals form an attitude, whether favorable or unfavorable, towards the proposed change (Rogers, 2003). When developing an attitude, the individual will usually seek to know the advantages and disadvantages of the new idea (Rogers, 2003). The advantages and disadvantages will be addressed during the quarterly meeting presentation of the proposed protocol.

There will be several advantages discussed that will help to persuade the nurses of the value of the proposed protocol. Of most significance when discussing the advantages of implementing a new protocol for the screening and treatment of patients with antenatal

depression is the patient-centered focus. Changing the screening tool to the EPDS will increase the ability of the Birth Center to identify pregnant women at risk for antenatal depression. The model of the Listening Visits delivered to the patients in their homes will provide an affordable and accessible form of treatment. Finally, incorporating the partner of the pregnant client will provide an additional support person into the treatment model.

In addition to presenting the advantages of the proposed protocol, it is necessary to address the disadvantages as well. The main disadvantage to be discussed is the cost of the implementation of the proposed protocol. The training programs for the LV and partner involvement program as well as the compensation of travel will create an additional expense for the Birth Center. These aspects of the protocol will also introduce the issue of time, which will be necessary to attend the training programs and travel to the clients' homes. Another part of the protocol that may present an issue is ensuring that the nurses remain within their scope of practice in both the LV and partner involvement program. While the disadvantages are necessary to discuss, they will be presented in a positive light so as not to dissuade the nurses' attitudes for the proposed protocol.

Decision

At this point in the innovation-decision process, the individuals will decide whether to adopt or reject the proposed change (Rogers, 2003). In order to encourage the individuals to accept the new idea, it is often beneficial to implement the change on small scale at this point (Rogers, 2003). Due to the low volume of clients that the Birth Center provides care, the screening protocol, using the EPDS, would be implemented among all pregnant clients at their initial visit during the first trimester and those entering their third trimester. From the clients screened, five clients who are considered at risk for antenatal depression and have expressed

interest in the small-scale trial would be selected. These five clients would then be presented with the options of receiving the home-based Listening Visitor and participating in the partner-involved treatment. After completing the selected programs, the clients would again complete the EPDS to determine if improvement had been made towards their risk for antenatal depression. In addition, the clients' views regarding these programs would be evaluated. The nurses would also discuss their feelings toward the protocol and decide to accept or reject the full implementation of the protocol.

Implementation

Upon accepting the change, the proposed protocol will be put into practice at the institution. Over time, the change will no longer be considered a new idea, but rather a part of the normal process of the institution (Rogers, 2003). The implementation stage at the Birth Center will begin with the education of the nurses regarding the two new treatment programs put into place. The nurses designated to fulfill the roll as home visitors and facilitators in the partner involved treatment programs will be required to attend a four-hour training session for each program.

After the nurses have received the training necessary to fulfill their new roles, implementation of the EPDS screening among all pregnant clients will begin. Each patient determined to be at risk for antenatal depression will receive information regarding the two new available programs. Once each client has determined if she would like to participate in the programs, she will be enrolled and begin treatment at her earliest convenience.

During the initial stages of the implementation process, continual support and guidance will be made available to the nurses responsible for these programs. This support system will

prevent the nurses from becoming overwhelmed with their new duties and ensure that the protocol is carried out correctly.

Confirmation

During the final stage of the innovation-decision process, the protocol will be evaluated to determine if it has been implemented correctly. This process is necessary to determine if the institution will continue forward with the protocol and incorporate it into the normal processes (Rogers, 2003). Chart audits and direct observations of the visits will be conducted at random in order to ensure that both of these assignments are completed correctly.

Barriers that may interfere with this expectation include insufficient knowledge to carry out the programs in spite of the training sessions and dissatisfaction of the nurses with the programs. In order to prevent or address these issues if they arise, the nurse expert will provide support and information to the nurses involved.

Appropriate documentation of each visit and implementation of the EPDS are necessary tools to evaluate the effectiveness of the proposed protocol. Considering that the nurses delivering the proposed programs are not trained mental health professionals, it is essential to closely monitor the mental status of each pregnant client using the EPDS. Auditing the administration of this depression scale and appropriate referrals to mental health professionals as needed will ensure that the patients are receiving safe and effective care. It will also help determine the effectiveness of each program and aid in the determination if the programs should continue. Documentation of the visits will provide a written record of the issues discussed and how they were addressed. This will be necessary in auditing each nurse to determine if she has remained within her scope of practice.

Additionally, the outcomes of the clients enrolled in these programs will be assessed. To determine the effectiveness of the LVs and the partner involved treatment, the number of referrals to mental health facilities and rates of medication prescriptions will be monitored. Also, at the routine six week postpartum visit completed by the Birth Center, the score from the EPDS will help determine if the depression issues have been resolved or if they have carried over in the postpartum period. Patient and partner satisfaction will also be taken into consideration during the evaluation process. The final consideration for the evaluation is the health of the infants, since there are numerous adverse outcomes related to antenatal depression. To assess infant outcomes, gestational age and birth weight will be monitored.

The desired outcome of the proposed protocol, if implemented correctly, is to increase the accurate determination of at risk or currently depressed pregnant women and to provide low-cost, convenient treatment that will improve their depression. This change would occur as the client learns to problem-solve and receive increased support from her partner. By acknowledging and treating antenatal depression in these women, the desired outcome is to create healthier outcomes for both mother and child, both mentally and physically, while increasing partner support.

Strengths/Limitations and Recommendations for Future Research

The primary strength for this proposed best-practice protocol is that it has been developed using evidence-based research articles. Also, the selected population for the focus of this protocol is one that has received limited attention. The purpose of the proposed protocol is to provide a standard framework for the screening and treatment of pregnant women with antenatal depression. While the proposed protocol is recommended for the El Rio Birth and Women's

Health Center, it can also be implemented at other offices as well. Organizations with a previously established home-visitation program may find the recommendations to be beneficial.

While the selected population serves as a strength to this protocol, it also may be considered a limitation. Due to the lack of attention given to women with antenatal depression, there are few research recommendations for this population. Of the studies that were identified, many were proof-of-concepts studies and others included few participants. With this in mind, the conclusions drawn from many of the research articles used to develop the protocol may be considered weak.

Recommendations for future research studies include a more in-depth study of the Listening Visit model. While this visitation model is well established in the UK, it has only recently been introduced to the United States. Further studies should be completed to determine if this delivery model of care is effective for the treatment of women with antenatal depression. Partner involvement in the treatment of women with antenatal depression is also a relatively new concept within the United States. Additional studies would strengthen the theory behind including the partner in the treatment of antenatal depression.

Summary

The innovation-decision process, a five-stage model for improvement, will provide the framework for the implementation of the proposed protocol. During the knowledge stage, information regarding the protocol, such as best practice recommendations for screening and treatment of antenatal depression, will be presented to the nurses at the El Rio Birth and Women's Health Center. The persuasion stage will require that the nurses be informed of the advantages, patient-centered care, and the disadvantages, cost and time, be addressed. This will allow the nurses to form a favorable or unfavorable attitude towards the protocol. Following this

stage, a small-scale version of the protocol will be implemented, which will result in the nurses either accepting or rejecting the protocol during the decision stage. At this point, the implementation stage will occur as the protocol is carried out in its entirety. Finally, during the confirmation stage, the nurses will review the results of the screenings and programs and determine if the protocol will be incorporated into the normal processes of the Birth Center.

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APPENDIX

Figure 1. Management algorithm for antenatal depression.

