

Screening for Postpartum Depression before Discharge

A Clinical Scholarly Project by

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## ABSTRACT

### Screening for Postpartum Depression before Discharge

by Adriana Hernandez

Postpartum Depression (PPD) is a common complication in pregnancy, affecting 20% of women. Perinatal mood disorders such as postpartum depression that are left unidentified and untreated can have a significant impact on the mother, child, and family. Currently, there are no standardized screenings for postpartum depression in the United States. However, California has mandated that beginning in the year 2020, all mothers will be screened for risk of PPD before discharge from the hospital after having their baby. Ventura County Medical Center provided an in-hospital training by Perinatal Advisory Council: Leadership, Advocacy and Consultation (PAC-LAC) on Perinatal Mood and Anxiety Disorders (PMADs), and nurses were educated in the use of the Edinburgh Postnatal Depression Scale. The project is to implement a validating tool to assist in identifying women at risk for postpartum depression prior to being discharged home and increase referral rates to seek out treatment for postpartum depression. In addition, the charts were reviewed to ensure the results of the EPDS were correct, and no data was missing in the electronic medical records. A Chi-Square of goodness fit was used to compare the social services referrals rates from July of 2019 to July of 2020. The chi-Square value is 5.681. The  $p$ -value is .01715. The results are significant at  $p < .05$ . The results suggest that the proportion of women being referred to in 2020 is higher than expected when compared to 2019.

*Keywords:* postpartum depression, standardize screening, hospital, perinatal nurses screening in hospital

## Chapter 1

### Chapter 1: Background and Significance

#### Overview Screening for Postpartum Depression before Discharge

The experience of birth can be a very powerful event in a women's life. Some women experience joy and excitement with the arrival of their new baby. Some mothers experience depression that can leave the mother feeling overwhelmed, anxious, and sad (American Psychiatric Association [APA], 2019). Depression is a common mood disorder among this population. It affects women twice as much as men, with an initial onset in the woman's reproductive years (The American College of Obstetricians and Gynecologists [ACOG], 2018). Postpartum depression (PPD) is known to be the most common medical complication, with 10% to 20% of new mothers reporting symptoms of PPD. (Friedman et al., 2016). Perinatal mood disorders such as anxiety, depression, and post-traumatic stress that are not identified and treated, can cause women to experience long term effects that negatively impacts her, infant, and family. (ACOG, 2018). When the mother goes untreated for postpartum depression, it can affect the child's ability to bond and can have a negative effect on the child's emotional, behavioral, cognitive, and developmental behavior. (Friedman et al., 2016). Perinatal depression often goes undetected, and if undetected, it can lead to a change in the mother's sleep, libido, and appetite. (ACOG, 2018).

In order to detect PPD in the postpartum period, the providers, nurses, and multidisciplinary team needs to be educated on the contributing risk factors for mothers in the antepartum period or postpartum period, risk factors related to the onset of postpartum depression. These factors include a history of depression, financial stress within the family, recent loss of newborn, unresolved grief, marital unrest, lack of emotional support, and both

present and prior medical complications from childbirth (Postpartum International, 2019). PPD is differentiated from a more common mood disorder, known as "baby blues," which presents as a feeling of sadness and can happen for a few days after delivery and last up to two weeks. Postpartum, or "baby blues" occurs in about 80% of new mothers. (March of Dimes, 2017). According to the Diagnostic and Statistical Manual of Mental Disorders, fifth edition, (2013) true PPD is defined as a depressive disorder with the addition of a peripartum onset. The specifier of PPD includes the onset of a major depressive episode occurring during pregnancy or within four weeks after birth (American Psychiatric Association, 2013), and is usually diagnosed within the first 6-12 weeks postpartum, with depressive symptoms occurring up to 12 months after childbirth (Emerson et al., 2018). Suicide has been noted as a leading cause of maternal death during the postpartum period, and drug overuse has been identified as the second leading cause of death in California mothers within a year after giving birth (Michigan State University Today, 2019). The American College of Obstetricians and Gynecologists (2015) recommends that all women be screened throughout their perinatal period with the Edinburgh Postnatal Depression Scale (EPDS). Despite the severe consequences that postpartum depression (PPD) has on both the mother and the newborn, many cases of PPD go undetected. PPD goes untreated due to the lack of screening practices among health providers. The economic cost to society and the individual can be considerable. The types of loss can range from emotional suffering, poor treatment outcomes, increased mental health visits, medication treatment, loss of wages, reduction in productivity, and a negative impact on the mother's relationships (US Preventive Services Task Force [USPSTF], 2016). It is estimated in the United States that the financial impact of treatment for depression and loss of productivity is approximately 23 billion dollars in 2011 (US Preventive Services Task Force, 2016).

Patient awareness and patient education can help to normalize symptoms of PPD. It is important that the mother be given support earlier rather than later (Emerson, 2018). Therefore, implementation of a program to screen mothers in a perinatal hospital prior to discharge and educate nurses and staff on early identification of PPD through screening with the EPDS tool is of utmost importance and the objective of this project.

In order to detect postpartum depression early, treatment, referral and providing community resources are critical components in dealing with a common medical problem affecting 20% of mothers in their reproductive years (ACOG, 2018; Friedman et al., 2016).

### **Background and Significance**

In the United States, the birth rates in 2018 were registered at 3,791,712 births (Center for Disease Control and Prevention, 2019). The birth rate is 11.6 per 1,000 population, and the report indicates low birth weights are at 8.3%, preterm birth weights at 10.0%, the mean age at first birth is 25.9%, and the percentage of unmarried women is 39.6% (Center for Disease Control and Prevention, 2019). Births in the United States were lower by 2% in 2018 compared to births reported in 2017 (CDC, 2019). Even though births continue to fall in this country, there continues to be barriers that impact life expectancy of males and females (Riley, et al., 2016). The USA is experiencing worse birth outcomes when compared to similar economically stable countries, with continuing issues surrounding geographical disparities, racial disparities, as well as social and economic disparities (Riley et al., 2016). Relative to 17 other high-income countries, we have the worst outcomes, including low birth rate, infant mortality, teen pregnancy, sexually transmitted diseases, cardiovascular disorder, endocrine disorders, chronic lung disease, drug-related disorders as well as AIDS (Riley, et al., 2016; Ertel et al., 2011). The disproportionate barriers continue, especially for mothers who are at greater risk of experiencing multiple

adversities that affect how they function due to economic, psychosocial, divorce, and health care issues (Ertel et al., 2011). Understanding these barriers and knowing the impact it can have on a mother is one of the key reasons to further explore the topic of postpartum depression. According to DSM-5 (2013) the symptoms that patients experience with depression last for greater than two weeks representing change from what they had experienced previously. Depression is a common mental disorder, impacting over 265 million people globally, leading to major disabilities and contributing to the global burden of disease and mental health disorders which continue to rise (Center for Disease Control and Prevention,2020; Yonker et al., 2009). Depression tends to be more prevalent among women than men, and women can experience an initial onset in their reproductive years. It can also start during their pregnancy and in the postpartum period (Center for Disease Control and Prevention, 2020; Yonkers et al., 2009; ACOG, 2019; Learman, 2018; USPTF, 2016). It is known that depression can lead to suicide (Yonkers et al., 2009; WHO, 2020). Death is the second leading cause between the ages of 15-29 years (Yonkers et al., 2009; USPSTF,2016).

Maternal health disorders occurring in women who are childbearing are known as perinatal mood and anxiety disorders (PMADs). PMADs disorders are related to mood and anxiety symptoms affecting up to one in five mothers during pregnancy and up to the first year after giving birth (University of North Carolina School of Medicine [UNCSOM] 2020). Examples of mental health disorders include anxiety, obsessive-compulsive disorder (OCD), Post-Traumatic Stress Disorder (PTSD), postpartum depression, and psychosis, which requires an immediate medical response (Task Force California, 2017).

Postpartum depression (PPD) has been known to be the most common medical complication among new mothers by 10-20 %, affecting 1 in 7 women (Friedman et al., 2016; Lomonaco

Haycraft, 2018). ACOG, (2015), reports PPD to be common about 10-15% of new mothers.

Women in their childbearing years are at risk for postpartum depression, which can be disabling during these challenging times, however, treatment is available (Vigod & Stewart, 2016).

Postpartum depression can appear as an episode of major depression during their pregnancy or after delivery (DSM- 5, 2013). The DSM- 5, (2013), does not specifically define postpartum depression but classifies it as a major depressive disorder. To be diagnosed with PPD, a patient can exhibit five symptoms within two weeks or more, including depressed moods daily; a sense of sadness, emptiness or hopelessness, reduced pleasure in their daily activities, weight loss, insomnia, feelings of fear, being slowed down, feeling a sense of guilt, worthlessness, inability to concentrate, suicidal ideation, and suicide attempts.(DSM- 5, 2013).

The key definition of postpartum depression is that it can happen within two to four weeks, three months, six months, or up to one year after giving birth (Vigod & Stewart 2016; Curry et al., 2019). Experiencing any of these symptoms may significantly impact the mother, causing her distress, social impairment, and inhibit her ability to work (DSM- 5, 2013). Baby blues in the postpartum period is commonly experienced among mothers, normally occurring 80% of time, showing itself in a mother feeling overwhelmed, irritable, overly sensitive, and crying easily. Baby blues normally occur within approximately 10 days. It is important to differentiate baby blues from perinatal depression (Curry et al., 2019). Mothers are also subject to depression due to changes in hormonal levels that influence the brain and make them more sensitive (O'Hara & McCabe, 2013).

The US Preventive Services Task Force Recommendation Statement cites risk factors that can contribute to mothers experiencing postpartum depression such as comorbidities during pregnancy, such as gestational diabetes, preeclampsia, and cardiovascular diseases (Curry et al.,

2019). Other factors that are equally important are stressful events, unwanted pregnancies, domestic violence, teen pregnancies, low social-economic class status, substance abuse, and lack of support from family and friends. A family history of depression can impact the mother as well (Curry et al., 2019). The list of stressors that contribute to postpartum depression and anxiety include; stressful experience due to unexpected complications such as Cesarean sections, operative deliveries, precipitous deliveries, trauma to the perineum, fetal demise, fear of pain, and feelings of powerlessness (Gable et al., 2005; Beck, 2001). The mother's response to these unexpected experiences can lead to the mother responding with fear, stress, and anxiety (Gable et al., 2005). Along with recognizing factors that impact the woman, there is great interest in understanding how Covid-19 will impact pregnancy. A study by Lebel et al., (2020) explains the impact of PPD on individuals. If the symptoms get exacerbated, it may increase the risk of behavioral issues in children and can place the mother at risk of preterm labor and PPD. The study observed 1,987 pregnant individuals for symptoms of depression and anxiety during the COVID-19 pandemic to determine contributing factors impacting their well-being. The researchers checked for depression, anxiety, and the type of support they received (Lebel et al., 2020). The study concluded that mothers were significantly impacted by COVID-19 due to life-threatening concerns for the mother and her offspring. Individuals had concerns regarding obtaining appropriate prenatal care, strains in relationships and personal and social isolation (Lebel et al., 2020). However, mothers did feel that having support led to a reduction in psychological symptoms (Lebel et al., 2020). The COVID-19 pandemic study showed that it could impact the pregnant mother and have a long-term impact on her offspring. (Lebel et al., 2020). The study suggests that there are ways to lessen the long-term impact on the mother and offspring through exercise and social support (Lebel et al., 2020). Other studies have suggested



that infants of depressed mothers are at risk for having long-term complications with attachment, low birth weight, developmental delay up to 18 months of age, and pulmonary hypertension (Yonkers et al., 2009). PPD can affect the mother and how she functions in the world. This can affect the development of the child and the mother-child dyad relationship, which is important for the development of the child (Nguyen, 2017).

Another key issue that impacts mothers is having ethnic and cultural differences, which contributes to a mother experiencing maternal mental health illnesses (Watson, 2019). A systematic review was conducted in the United Kingdom evaluating, different minority groups concerning themes that encompassed the understanding of a woman's knowledge on mental health and how that impacted her experience. The review focused on the woman and the family's acceptance of depression in their culture, with the lack of family's acceptance of depression influencing the mother's ability to access coping strategies, leading to feelings of isolation (Watson, 2018). The study concluded that the impact on minorities' lack of understanding of maternal mental health, along with cultural expectations, stigma, and dismissal of healthcare providers in the cultural aspects of healthcare, can lead to mothers not receiving adequate support (Watson, 2019).

Despite the severe consequences that PPD has on both the mother and the newborn, many cases of PPD go undetected. PPD goes untreated due to the lack of screening practices among health providers. The types of consequences can range from emotional suffering, poor treatment outcomes, increased mental health visits, medication treatment, social-economic status, adverse child outcomes, loss of wages, reduction in productivity, and a negative impact on the mother's nuclear family (USPTF, 2016; Logsdon et al., 2018). The American College of Obstetricians and Gynecologists (2015) recommends that clinicians screen women during their perinatal period by

using a standardized screening tool, the Edinburgh Postnatal Depressive Scale (EPDS). It is recommended for a patient who experiences mild to severe depression to seek out services that fit according to the diagnosis, such as continued evaluation, medication, and psychotherapy (ACOG, 2015). Using the EPDS for mothers within 6 weeks after giving birth helped detect postpartum depression by 85% between 2 to 3 months (Emerson et al., 2018). Experts are recommending early screening of depression to help identify who is at risk for PTSD or PPD, as well as anxiety (Gamble et al., 2005). US Preventive Services Task Force recommends routine depression screening at different stages throughout their pregnancy and up to one year of age of their newborn (2016). In July 2019, the California laws changed for healthcare providers who provide prenatal or postpartum care services. The law is requiring providers to screen mothers prior to discharge from the hospital for risk of postpartum depression requiring hospitals to implement a program for screening starting January 1, 2020 (Open States, 2019). This bill would require the physicians or surgeons to implement an educational training to assist in addressing the requirements the bill has outlined (Open States, 2019). This will help address any barriers that keep us from identifying perinatal depression, provide education to the mother about mental health, provide the appropriate referrals with the goal in mind to reduce this preventable disease and consequence it entails (Curry et al., 2019; ACOG, 2015).

### **Problem Statement**

Postpartum depression has several clinical implications related to poor outcomes for the maternal mother and newborn child. Postpartum depression (PPD) is frequently undiagnosed and untreated due to a lack of routine screening for PPD among health care providers. Universal screening for PPD with a standardized questionnaire such as the self-administered EPDs may positively influence health care provider's compliance in providing recommended depression

screening to all women during the postpartum period. All health care providers caring for women and their children play a major role in promoting comprehensive postpartum depression screening interventions for best practice. Provider education, in conjunction with the EPDS screening criteria within the electronic health record (EHR), has been associated with increased screening rates for postpartum depression. Postpartum depression (PPD) is one of the most common disorders in a women's reproductive ages, between 10-20 % or one in seven women, and can initiate during pregnancy or in the postpartum period. PPD is the leading cause of disability in women 15 years or older; it disproportionately affects women more than men. PPD symptoms interfere with maternal role functioning; mothers also experience suicidal ideation and even suicide. When a mother is experiencing PPD, this impacts the infant's cognitive development, psychological and motor development and these impacts are resolved once the mothers resumes stability (ACOG, 2015; Agency for Healthcare Research and Quality [AHRQ](2016; Clevesy et al., 2019, Dennis & Dowswell, 2013; Learman et al., 2018; Longsdon et al., 2018; Lomonaco et al., 2018; USPSTF, 2019; Watson et al., 2019; Wisner et al., 2013). Despite all the current knowledge in the literature regarding postpartum depression, researchers point out the most important weakness: the lack of universal screening for perinatal mood and anxiety disorders (PMADs). Financial disparity leads to a lack of adequate insurance: in fact, the healthcare system in the US lags behind most economically stable countries. Societal problems create barriers to a lack of education, inaccessible quality healthcare, and poor transportation. PMAD's are the leading cause of maternal morbidity and mortality rates. Another barrier experienced during these vulnerable times is the limitation to mental health care access, especially for the underserved, and those who lack proper health insurance. There is a need for standardized screening, in addition to access to medical, psychological treatment. Also, it is

important to provide resources for community support for women suffering from PMADs. Finally, mothers are not being screened or evaluated for PMADs in hospitals during their stay in antepartum or the postpartum period when it is a vulnerable time for the mother. Mothers are not being screened in hospitals that have their babies in the Neonatal Intensive Care Unit (NICU), and screening can help in identifying mothers experiencing any emotional distress. In summary, PPD frequently is undiagnosed because there is a lack of standardized screening among providers (ACOG, 2015; AHRQ(2016); Clevesy et al., 2019; Dennis & Dowswell, 2013; Learman et al., 2018; Longsdon et al., 2018; Lomonaco et al., 2018; USPSTF, 2019; Watson et al., 2019; Wisner et al., 2013).

Contemporary research concludes that universal screening is essential in capturing mothers who are at risk for PMADs such as postpartum depression. Prompt attention is needed, which includes an appointment, treatment, and referrals. Improved screening increases the identification of PPD and impacts mental health outcomes for the mother and her offspring. The universal screening will also help standardize care, promote early recognition, reduce barriers, and suicidal risk. The US Preventive Services Task Force. Interventions to Prevent Perinatal Depression: US Preventive Services Task Force Recommendation Statement. JAMA (2019), reports provide convincing evidence that action can be taken to reduce the incidence of perinatal depression, such as cognitive-behavioral therapy, counseling interventions, and interpersonal therapy. ACOG (2015) recommends that the provider perform a full assessment of the mother with PDAMs and her emotional well-being during the postpartum period and provide referrals that enhance benefits to her. Evidence suggests that screening mothers can have benefits, but treatment and referrals are necessary to provide continuity of care. Screening does not supersede clinical judgment, but if a patient screens for PPD, then additional assessments must be

conducted to identify other disorders (AGOG, 2015). The US Preventive Services Task Force. Interventions to Prevent Perinatal Depression: US Preventive Services Task Force Recommendation Statement. JAMA (2019), recommends having a collaborative approach when standardizing PPD screening, including screening during the postpartum stay prior to discharge, and providing education and referrals as needed. It is essential for providers of perinatal services to receive training on PMADs.

In conclusion, addressing the issues that are impacting pregnant women and mothers is vitally important. Issues include COVID-19, social barriers, cultural beliefs about mental health disorders, stigma, and cultural insensitivities. We must stress the importance of social support, such as cultivating support groups for new mothers in addition to providing medication and treatment for perinatal mood disorders. This is critical in identifying and treating women at risk (ACOG, 2015, AHRQ. 2016; Clevesy et al., 2019; Dennis & Dowswell, 2013; Learman et al., 2018; Longsdon et al., 2018; Lomonaco et al., 2018; USPSTF, 2019; Watson et al., 2019; Wisner et al., 2013).

### **Historical and Societal Perspective**

There is a growing body of literature that recognizes the importance of understanding the prevalent, hindrances, and disabilities that depression causes throughout the world, and how it impacts the mother, her offspring, partner, and family (USPSTF, 2019). The World Health Organization (2005) gained interest many decades ago on the impact mental health disorders have on humanity. There is growing evidence reflecting an association between mental health and the basic protection of civil rights, social economics, cultural, political, and social rights (World Health Organization, 2005). Increased discord continues to rise in people and their communities as the disparities continue to broaden. As a result, policymakers have been

encouraged to pass into law, measures to improve the mental health and the well-being of varying communities, particularly for those at greater risk. Mental health issues continue to grow in recognition of its impact on a person's physical well-being. (WHO, 2005; Office of the Surgeon General, 2001). Health disparities are being proven to have a direct impact on an individual's outcomes in education, productivity, and capacity to develop relationships. It has been established that poor mental health contributes directly to an increase in crime as well as drug and alcohol abuse. Ideally, the goal of mental health intervention should be targeted at improving educational outcomes, programs that lead to improved health and safety in communities (Center for Disease Control and Prevention, 2005). Depression is the most common disability worldwide, it is universal, and accounts for 4.2% of health disorders, and is rated as the fifth leading cause of disabilities (Cox, Henshaw & Holden, 2014). Postnatal depression in women is due to their vulnerable state, and when left unidentified, it can last for many years. There is an alarming statistical increase in rates of postnatal depression (Cox, Henshaw & Holden, 2014). Postpartum depression can create havoc in their relationships, negatively impacting the mother's relationship with her infant, husband, and their social support structure. For these reasons, the Edinburg Postnatal Depression Scale (EPDS), a self-reporting questionnaire, was developed to detect postpartum depression (Cox, Henshaw & Holden, 2014). Previously, it was speculated in the 1970s, and 80's that depression was primarily recognized by the Western hemisphere, but a thorough investigation of this phenomenon began recognizing that PPD occurs in women from different parts of the world and different cultures (Cox, Henshaw & Holden, 2014). Postpartum depression is known to pose an enormous risk that needs public health support, given the evidence that has been produced on how postpartum depression impacts the entire nuclear family (Cox, Henshaw & Holden, 2014). Given the prevalence in prenatal

mood disorders, scientists continue to research treatments that can help improve the disorder's impact on the mother, the infant, the family, and the community. The current practice is to screen mothers at least once during their perinatal period in order to detect early risk or signs of PMDs. A predictive factor in identifying postpartum depression is when women experience postpartum blues, and screening is widely used in the early postpartum period with various screening tools used by different providers of healthcare. The tools are listed as the Edinburgh Postnatal Depression with a sensitivity of 59% to 100% and specificity 49%-100%, Post-Depression Screening Scales with a sensitivity of 91% to 94% and specificity of 72%-98%, in other tools such as; The Beck Depression Inventory, and The Zung Self-Rating Depression Scale (ACOG, 2015; USPSTF 2019). In the last decade, providers have screened mother's for postpartum depression to help reduce adverse effects to the mother, infant and their families (ACOG, 2015; Rafferty et al., 2019). The US Preventive Services Task Force (2019) recognizes that there is a significant benefit in screening for perinatal depression and that universal screening of mothers helps to alleviate the prevalence of depression, including a resulting reduction in comorbidities that are a result of postpartum depression. Rafferty et al., (2019) reports universal screening to be far from universal, with approximately 50% of women who experienced depression during their postpartum period going undiagnosed or treated, hence postpartum depression being the most common complication among women of childbearing age (US Preventive Services Task Force, 2019). Presently, many hospitals within the US do not provide screening for mothers, and therefore are not offering the necessary resources to women who are at high risk for PPD (Logsdon et al., 2018). Contributing factors to underdiagnosing PPD are the perceived stigma that mental health carries, leading to mothers not feeling comfortable discussing symptoms they may be experiencing, and some providers not feeling comfortable talking with their patients

about PPD. In fact, approximately 50% of women do not receive appropriate treatment and referrals for mental health services. (Logsdon et al., 2018). As of January 2020, the California Assembly Bill 845 passed, requiring providers to screen mothers prior to being discharged from the hospital for risk of postpartum depression. It is now mandated that hospitals implement a plan addressing the barriers to identifying postpartum depression, such as the stigma that is attached to mental health and educating the patient to better understand their resistance to accepting their diagnosis. It is important to normalize the experience and understand a woman's stressors and provide a support system to accompany psychological treatment and proper medication if needed. (Logsdon et al., 2018; Rafferty et al., 2019; ACOG, 2015). ACOG (2015) reports that screening by itself can be beneficial; however, there is an additional benefit when screening is accompanied by treatment and referrals. It is mandated that all hospitals in California initiate an in-hospital screening for depression to detect those at risk for depression.

The screening process will need to have an in-service for perinatal nurses to understand PMADs, why they are important to detect, when to screen, and to engage in a program that screens, refers, and provides treatment when necessary. It is equally important that screening should not supersede clinical judgment, and to be sensitive to the patient's privacy, her fear of being judged for not being as happy as expected, and to normalize the feeling she is experiencing when there are so many physiological changes happening to her during her transition to motherhood (Rafferty et al., 2019; ACOG, Logsdon, et al., 2018; Cox, Henshaw & Holden, 2014).

### **Incidence and Prevalence**

Perinatal mood and anxiety disorders (PMADs) are common psychiatric health conditions that affect one in seven women during their childbearing years. The onset may begin in and during



and up to one year after birth, with a prevalence of up to 20% of all births (Kendig, 2017). There is a looming crisis occurring in the world surrounding mental health disorders. Learman et al., (2018) report minor to major depression rates ranging between 6.5% to 12.9% during pregnancy and up to one year after delivery. The most common mental disorder is depression and anxiety, and women are at twice the risk of experiencing depression than men (Learman et al., 2018).

The United States has a maternal mortality rate ranging approximately 26.2% per 100,00 live births, a much higher rate about three times greater when compared to Canada and Europe. The factors that contribute to maternal mortality are untreated perinatal mental health disorders and when not treated mothers are at risk of suicide, maternal and neonatal death and increase morbidity (Mind the Gap, 2019). There is a great need to further educate mothers and to educate professionals of available resources to aid in improving screening practice, as well as available resources for referrals and treatments. (Mind the Gap, 2019). It is important to continue to develop research in maternal mental health since it is the second leading cause of death related to pregnancy. Women of color are disproportionately experiencing a much higher rate of maternal mortality rates with African American having twice the likely hood of experiencing undesirable perinatal outcomes compared to non-Hispanic white women (Bagley, 2019).

### **Healthcare Cost**

Presently, depression is an economic burden in the United States, estimated to be 210.5 billion dollars (Greenberg et al., 2015). Postpartum depression is a serious issue that requires diagnosing, prevention, and treatment (Nguyen, 2017). Postpartum depression (PPD) poses a public health challenge, and it is associated with potentially harmful effects on children (Hahn, Holbrook et al., 2018). Common PMADs in the United States, defined as depression and anxiety, frequently go undiagnosed, but more attention is now being given to these disorders. According

to Luca et al., (2019), Mathematica's policy research releases information on social cost and the economic impact that occurs when PMADs go untreated. The evaluated costs include during the mother's pregnancy and up to age 5 of the child (Luca et al., 2019). The Mathematica Policy Research reported on the social cost in their "Issue Brief" that untreated PMADs in the USA cost \$14.2 billion for all births in 2017. The Mathematical Model followed mother-child couplet care from a woman's pregnancy and up to her child, turning five years of age (Luca et al., 2019). The Mathematical Model performed a comprehensive analysis of the financial burden in the United States due to PMADs.

The information gathered through extensive literature review and other resources quantifying social costs (Luca et al., 2019). Three of the domains addressed in the analysis are; 1. productivity loss of the mother, 2. increase use of welfare and Medicaid cost and, 3. worse maternal and child healthcare outcomes attributed to the increasing cost of healthcare. A societal burden of untreated PMADs cost of mothers in California accounted for 14.2 billion dollars for all births in 2017 following mother-child couplet care from her pregnancy and up to her child, turning five years of age. About \$32,000 pertained to mothers with untreated PMADs, including her child (Luca et al., 2019). About 60% of financial cost is attributed to productivity loss, \$2.9 billion for maternal health, and \$699 billion by obstetrical health cost (Luca et al., 2019). In the remaining societal cost, 40% of the societal cost is related adverse child outcomes; preterm births account for \$3.3 billion, developmental disorders accounting for \$ 1.6 billion, and injury to the child for approximately \$1.6 billion dollars. Most of the costs that are incurred for couplet care happen within the first year (Luca et al., 2019).

During pregnancy and the postpartum period, PMAD's are the most common complication impacting the medical cost significantly, approximately \$17,100 per couplet care

up to a six-year time period (Luca et al., 2019). A complication of mothers, such as gestational diabetes, hypertension, or hemorrhage accounts for \$3,300 per mother. The American College of Obstetricians and Gynecologist, the American Psychological Association, and the Association of Women's Health, Obstetric, and Neonatal Nurses are making a strong recommendation to reduce the barrier that impacts the mother and her child by implementing universal screening, assessment, and comprehensive treatment for a woman who is having mental health disorders (ACOG, 2015; Luca et al., 2019). In economic terms, this reduces the prevalence of PMADs and helps increase woman's productivity, reducing the usage of social services, improves the mother and child's health if the mother can have access to an effective treatment plan and options to improve her outcomes (ACOG, 2015; Luca et al., 2019).

### **Introduction of Picot Foundation**

Postpartum Depression (PPD) is a common complication in pregnancy, affecting 20% of women. Currently, there are no standardized screenings for postpartum depression in the United States (American Psychiatric Association, 2019). Despite the severe consequences that PPD has on both the mother and the newborn, many cases of PPD go undetected. PPD goes untreated due to the lack of screening practices among health providers. The types of loss can range from emotional suffering, poor treatment outcomes, increased mental health visits, medication treatment, loss of wages, reduction in productivity, and a negative impact on the mother's relationships (USPSTF, 2016). It is estimated in the United States that the financial impact of treatment for depression and loss of productivity was approximately 23 billion dollars in 2011 (USPSTF, 2016). Postpartum depression is a serious issue that requires diagnosing, prevention, and treatment (Nguyen, 2017). Depression has been identified as a leading disability and the second leading cause of global burden in the world between the ranges of 18-44 years of age, and

the women are affected by this disease two times more than men, with poor outcomes (Ko et al., 2012). Statistics on US births in 2017 showed the economic impact due to perinatal mood disorders to be approximately 14.2 billion dollars, with the largest loss as a result of a loss of maternal productivity at 669 million dollars. (Luca et al., 2019).

## Chapter 2: Literature Review and Theoretical Framework

### PICOt Question

Working and having experience in an acute care setting as a lead nurse and providing patients care has given me the opportunity to experience complications that arise in this setting. I have been privy to current hospital practices, nurse's education and work environments. When observing all these factors, complication, lack of mental health services has inspired me to bring change in order to improve the quality of care and improve outcomes. The formulated question is outlined as an acronym "PICOt", P stands for patient, the important group of patients being looked at, I for the intervention that will be performed or implemented, C stands for comparison, what important intervention will be done comparison to another group of patients, O for outcome, was is the outcome of the intervention provided, and t for Time, the time interval that will measure the outcome (Zaccagnini & White, 2017; Grewal, Kataria, & Dhawan, 2016). This outline supports in formulating the research questions and finding keywords to guide the literature review and find a solution to the research study (Zaccagnini & White, 2017; Grewal, Kataria, & Dhawan, 2016).

The formulated question is: In women, 18-45 years of age (P), who are in the maternity unit following delivery, does the use of the Edinburgh Postnatal Depression Scale (EPDS) screening tool (I) prior to hospital discharge, compared to current practice (C) result in an increase in referrals to mental health (O) due to early detection of postpartum depression (t)?.

Keywords used to refine the search included: screening practice, maternal mental health, anxiety, hospitals, perinatal nurses, NICU mothers, perinatal screening, managing postpartum depression, maternal outcomes, perinatal nurses, providers, well-child visits, tool kits for providers, mothers at risk, recommendations for improving screening, and interventions used in

helping depressed mothers. The literature review was developed by searching reliable databases such as; Brandman University library, National Institute of Medicine, PubMed, Google Scholar, Cumulative Index to Nursing and Allied Health Literature (CINAHL), ProQuest, the Cochrane Database, Professional Journal, PLOS ONE, National, Ovid Medline, Up To Date, Elsevier, California Maternal Quality Care Collaborative (CMQCC), and Healthcare Research and Quality (AHRQ). These search engines helped develop a systematic process to gather substantial evidence to answers the PICOt question. Specific keywords were used that did not limit the search to depression but provided an opportunity to broaden the search.

The initial research articles were selected to understand the general principles of postpartum depression. A report by Wisner et al., (2013) discussed the onset, timing, diagnosis, and self-harm thoughts of women who screen positive in the postpartum period utilizing a validating tool, Edinburgh Postnatal Depression Scale (EPDS). The research article concluded that women who screen positive in the postpartum period are experiencing major depressive disorder in conjunction with other comorbidities. What physiologically promotes destabilization in the postpartum period includes a massive withdraw from gonadal steroids that are a contributing factor to mood, neurobiology, influencing sleep patterns, and circadian rhythms (Wisner, et al., 2013).

There were over 100 articles reviewed on postpartum depression. Some of the topics were broad to specific, but upon addressing the PICOt question re: screening mothers before being discharged in a hospital setting, research seemed more limited. Keywords used to advance research were in-hospital screening, perinatal nurses, and recommendations for screening in hospitals. Finding were that some organizations developed bundles, including recommendations for standardizing screening based on evidence-based practices. Some organizations have created

professional guidance such as the Healthcare Research and Quality (AHRQ), Council on Patient Safety in Women's Health Care, American College of Obstetricians and Gynecologists, American Academy of Pediatrics, and Postpartum Support International (PSI) concerning screening mothers in hospitals.

### **Synthesis of Evidence**

The American Academy of Pediatrics (AAP) (2019) recognizes perinatal depression as one of the most common complications in the United States, with a prevalence of 10-15% in new mothers. Therefore, the AAP recommends routinely screening mothers for postpartum depression to identify the disease and appropriate the proper treatment, services, and referrals if required (Rafferty et al., 2019). While many pediatricians are consistent with their screening for depression, many mothers continue to go unrecognized, which has led to mandated routine screening of PPD for mothers during the well-child check to ensure additional support to the mother and her family (Rafferty et al., 2019).

A recent update from The American College of Obstetricians and Gynecologist [ACOG] committee opinion Number 757, in November 2018, concurs with the AAP that perinatal depression is a common complication that recommends screening patients at least once during the perinatal period. ACOG states that screening for depression must include initiating referrals to mental health providers and include collaborative reporting. The recommended guidelines for obstetric providers include obtaining a comprehensive assessment for mood and emotional well-being using a validating tool to screen for anxiety and postpartum depression. Screening can take place during pregnancy or in the postpartum period (ACOG, 2018).

The US Preventive Services Task Force (USPSTF) has assessed the efficacy of screening mothers with a validating tool such as the Patient Health Questionnaire-9 (PHQ-9) or the

Edinburg Postnatal Depression Scale (EPDS) in the perinatal period. In hospital screening of the adult population, 18 years or older have been found beneficial.

In a study by Wilkinson et al., (2017), they prefaced their study in understanding the impact postpartum depression has on attachment, the development of the child, family discord, suicide and infanticide. They recognized that screening is not a standard of practice. Wilkinson et al., (2017) provided a study which was based on a hypothetical cohort of 1,000 pregnant women. The woman had experienced one live birth over a two-year period. A cost-effective model was used when screening mothers for postpartum depression to evaluate the effectiveness of the intervention. They quantified the results by measuring the cost incurred per remission and cost per quality-adjusted life-year (QALY). The conclusion of the study identified that screening for PPD is a cost-effective intervention, should become a common practice, and making adjustments recommended by the U.S. Preventive Services Task Force (Wilkinson et al., 2017)

The Council on Patient Safety in Women's Health Care (2016) provided training online to help address the rising concerns of mental health during the perinatal period, dealing specifically with postpartum depression and anxiety. The patient safety bundles include four-parts titled: Readiness, Recognition and Prevention, Response, and Reporting/Systems Learning (Council on Patient Safety in Women's Health Care, 2016). The domain of Readiness is to equip and educate the healthcare providers in a clinical setting or inpatient facilities with the appropriate screening tools regardless of the setting during the women's perinatal care and a protocol to assess the patient over time regarding her mental health. It stresses the importance of identifying community resources. (Council on Patient Safety in Women's Health Care, 2016).



## **Literature Research Proposed A Solution to The Problem**

In the literature review process, the concepts were narrowed down to screen mothers in the hospital setting. This specifically guided the project to standardization and universal screening for postpartum depression in the hospital prior to discharge and following delivery. The following are the key articles that helped support the implementation of the quality improvement project.

The first article states that postpartum depression (PPD) is one of the most common complications in childbearing women that negatively impact the mother and her offspring (Emerson et al., 2018). Screening mothers for postpartum depression is not mandated in routine well-child visits. Inconsistent PPD screening practices exist in approximately 50% of the maternal population (Emerson et al., 2018). Mothers at risk for postpartum depression were screened using the Edinburgh Postnatal Depression Scale (EPDS) at 2 months, 4 months, and 6 months postpartum during their postpartum clinic visits. This study was conducted to determine the prevalence of PPD with the use of the Edinburgh Postnatal Depression Scale [EPDS] (Emerson et al., 2018). In this study, 43 women in the postpartum period reporting prevalence rates were as follows: 2 months  $p=.10$ . 4months  $p=.13$ . 6 months  $p=.14$  (Emerson et al., 2018). The study concludes comparable results to other studies on the prevalence of PPD. The study's conclusion suggests it is a benefit to screen all mothers and provide referrals and resources for women identified at risk.

A descriptive cross-sectional study design was implemented at the University Teaching Hospital of Kathmandu, Nepal, to determine the validity of the Edinburgh Postnatal Depression Scale (EPDS) to screen and identify a woman at risk for PPD (Bhusal, Bhandari, Chapagai and Gavidia, 2016). The study evaluated 346 mothers between weeks 4 and 14 postpartum. Positive

and negative predictive values were included in order to validate the EPDS. The results of the study concluded a prevalence of PPD of 17.1%. The positive and negative predictive value of the Nepalese was found to be 92-93%, with cutoff points for depression between 12 and 13. The study concluded that the EPDS demonstrates good validity, as well as being a valid tool for early detection of PPD, leading to early intervention and reducing complications due to PPD (Bhusal, Bhandari, Chapagai, and Gavidia, 2016).

A quantitative research project by Clevesy et al, (2019) was conducted to improve knowledge and increase postpartum depression screening practices in a women's healthcare clinic serving low-income women and minorities utilizing a framework identified as model of act, plan, study and do model. The clinic did not have a protocol in place, and after a single in-service given to the providers on effective screening practices utilizing a validating tool and essentials on documentation on the electronic health record, the analysis of the project concluded that the providers improved awareness of the importance of screening mother for postpartum depression, rose from 56% to 92% ( $P < .5$ ) Clevesy et al., (2019). Clevesy et al., (2019) concluded that educating providers and implementing a design program for screening for postpartum depression increases rates of screening for PPD. Screening for PPD in a clinical setting was found to be beneficial in early recognition of signs and symptoms of PPD, treatment, and, ultimately, improved health outcomes (Clevesy et al., 2019).

A recent empirical, quantitative study evaluated how mothers experienced receiving PPD education and were screened prior to being discharged with the Edinburgh Postnatal Depression Scale (EPDS) by a perinatal nurse. The participants were followed up by a phone call 2-3 weeks later as to their openness to being screened for depression and education provided by their perinatal nurses (Logsdon et al., 2018). The study took place in the United States, with the age

group ranging from 18- 39 years of age; recruitment came from the University of Louisville Hospital (Logsdon et al., 2018). Patients were screened the night prior to discharge, and the patients that were "high risk" was defined as first-time mothers who screen greater than or equal to 10 and compared to a "low-risk" group identified as mothers whose EPDS score was 10 or less. Both groups agreed to being screened in-hospital and being educated by a nurse who checked to determine if the patients had received screening by their primary care provider during their clinic visit. (Logsdon et al., 2018). The study concluded that mothers accepted screening and education on postpartum depression in hospital and accepted community resources available to them. No correlation was noted among demographics and those being at risk for depression (Logsdon et al., 2018).

According to Emerson et al., (2018), in a prospective cohort study design identified that mothers are screened during well-child visits, but the frequency, and the process of referrals, along with documentation of findings, requires further evaluation. In the study, three key components were looked; at rates of prevalence, accessibility of screening, and documentation of mothers being screened. They conducted an empirical, longitudinal study with a cohort design, screening mothers with the EPDS during their well-child checks at 2, 4, and 6 months-expanding on current screening practices. The study evaluated documentation via the electronic health record after their doctor's visit (Emerson et al., 2018). The results of the study determined a postpartum prevalence rate between 10-12.5% between 2 months, 4 months and 6 months in a well-child visits. The study showed a variance in how mothers who were at risk for PPD were screened in electronic records. Recommendations were put forth to improve screening in clinics, identify who is at risk, and to allow additional time to discuss community resources and referrals for mothers with PPD (Emerson, et al., 2018).

A retrospective cohort analysis of the Edinburgh Postnatal Depression Scale studied the prevalence of positive screening in the women who delivered with no prenatal care compared to women who had prenatal care. Implementing the screening of women in labor and delivery with no prenatal care, increases positive screening rates compared to women who received prenatal care. Mothers at risk EPDS scored  $> 10$  scored at 21.1 %, mothers at low-risk score was EPDS  $< 10$  scored at 10.9 %,  $p = 0.003$  (Magliarditi et al., 2019).

In a cross-sectional study, women were evaluated to include their demographics, health status, and postpartum screening scores utilizing two different screening tools. The two tools used were; Patient Health Questionnaire-9 (PHQ-9 scale) and the Edinburgh Postnatal Depression Scale (EPDS). The purpose of this study including the examination and feasibility of referring women with signs and symptoms of postpartum depressions and note limitations to screening, treatment with signs a symptom of postpartum depression (Coffman et al., 2020). Women who screened greater than ten on either screening tool were referred for case management programs, nutritional program, and identify the barriers to screening. The sample size of 302 women was screened for postpartum depression, demonstrating feasibility for screening in clinical care settings. The participants that were referred to case management were nine (47%); however, some participants did not receive mental health services due to a variety of barriers and recognizing the greater need to integrate mental health providers in a clinical care setting (Coffman et al., 2020).

In summary, the research validates the necessity to screen for postpartum depression, detailing the poor outcomes related to untreated depression. It supports the efforts to address the issues associated with the lack of standardizing screening, treatment, and referrals in vulnerable times, such as the postpartum period.

## Theoretical Framework

Leininger's Culture Care Theory Diversity and Universality Theory and model is based on anthropological observations and concepts of caring that derived from nursing. Studies were derived from different cultures, beliefs, values, and in different settings. This theory has a holistic approach to care. This theory is strong in education and research (Butts & Rich, 2015). Barriers to health care communication, such as poor health communication and literacy skills, do not match the general population. Language barriers; examples are limited proficiencies; health communication does not address syntax, readability, and interpretation of the words (Schiavo, 2014). In order to provide culturally competent care, there is a great need for health communication, therefore informing health information in a culturally relevant way to diverse cultures and vulnerable populations. The language is one of the most significant barriers (Schiavo, 2014). Cultural Care Theory provides cultural care that is essential for the patient's well-being, embrace cultural care values, beliefs and practices, and delivers care to help the patient regain their health and well-being, thereby reducing the risk of postpartum depression in a woman when services are tailored to their culture (Nursing Theory, 2016). The federal agency supports improving health communication to improve patient outcomes (Healthy People, 2020).

Madeleine Leininger conveys important assumptions regarding "care and caring" in relation to the competency of culture. It is important to care in order for healing to take place; every culture has transcultural practices. They have beliefs, values, and are influenced by their experience (Butts & Rich, 2015). In order to facilitate culture congruence in the Theory of Care Diversity and Universality, there are three modalities discussed in this theory based on research that support the provider to provide culturally congruent care (Butts & Rich, 2015). These modalities refer to being assistive, supportive, and facilitative, which support the patient, family,

and the community. A model is Culture Preservation /maintenance-the provider will retain and preserve culture care values; this will help recovery from disease. Release preconceived ideas (Butts & Rich,2015). Culture Care accommodation/negotiation-providers provide actions and decisions to support their adjustment by having positive health outcomes. Supportive practices that bring healing to the patient. Activities and interventions result in positive effects (Butts & Rich,2015). Culture Care repatterning/restructuring-helps promote actions and decisions which allow change behaviors that have positive outcomes and enhancing their health outcomes (Butts & Rich, 2015). Leininger's model assumptions of care are important in its application when caring for mothers with respect to their values, beliefs, and practices because they vary. It is important to understand when assessing and screening for the history of depression and identifying women at risk with postpartum depression (Butts & Rich, 2015).

This Theory of Care Diversity and Universality will be pivotal during the implementation of the Clinical Scholarly Project when screening mothers at risk for postpartum depression. When planning culturally tailored and competent care, it enhances patients' outcomes in a multicultural setting and reduces disparities (Mandle, 2013)

Applying these principles by providers, interdisciplinary teams, and nurses, it will help tailor care according to the needs of the women's beliefs, values, and cultural difference. It will provide a solid foundation in developing a trusting relationship hence patient feeling trust, being valued, seen, and heard. When a trusting relationship develops, the patient opens, she is more honest about her feeling, and healing can occur (Butts & Rich, 2015).

## Chapter 3: Methodology

### Study Design.

According to a recent project at Cedars-Sinai Medical Center, in order to implement perinatal mental health programs during postpartum, there should be a low rate of false-positive results. In addition, the mother should be educated on the meaning of screening results. If the results of the screening reveal risk, there should be immediate consultation and referral to treatments, as well as early follow-up. (Accortt,2017). The project design performed a measured quantitative design. The project was approved by Brandman University Institutional Review Board in December 2019 and the Ventura County Institutional Review Board on May 15, 2020.

The project followed a quantitative study by Cleversy et al., (2019), taking place within a community setting, that created a framework, “The plan–do–study–act model” to improve the knowledge and screening practices of healthcare providers in PPD. The 2019 study was conducted among 6 participants using a pre-and post-education questionnaire along with a review of the electronic health record. The study concluded that a single educational intervention increased the rates of postpartum depression screening from 56% to 92.7% ( $p < .5\%$ ) (Clevesy et al., 2019)

The project began on June 8, 2020, through July 8, 2020, including all women from 18-45 years of age. It included all women who delivered at Ventura County Medical Center Hospital and Santa Paula Hospital. Screening for PPD by the perinatal nurses was completed on the day prior to discharge. English speaking screening only was not required, as the EPDS tool is provided in fifty languages. Patients were able to participate if they were in an intact cognition. All perinatal nurses had an in-service on postpartum depression and the importance of screening by the hospital in January 2020. The education was provided by the

hospital to meet the new State of California Assembly Bill 845 that recently passed, requiring providers to screen mothers prior to being discharged from the hospital for risk of postpartum depression (California Legislative Information, 2019-2020).

All mothers on admission to the postpartum unit were given a welcome packet. The packet provided all the essential educational pamphlets on mother and infant care. In addition, mothers were informed of the new standard of care implemented by the hospital to address mental health by participating in a standard screening with the EPDS. A pamphlet was given to the patient detailing signs and symptoms of postpartum depression and when to call her primary care physician. The perinatal nurses were educated via a video presentation, describing how to provide the patient with information and allow the opportunity for the patient to feel safe to share her feelings. Also, the nurse was encouraged to open a dialogue on mental health to normalize and assist in reducing the stigma around mental health disorders. All patients that were screened with the EPDS were given an educational pamphlet on postpartum depression, local community services, and referral numbers.

Regardless of the screening results, all mothers received PPD education. In the event that the questions asked caused stress or anxiety or any unanticipated event, the patient was provided immediate intervention. The social workers and nurses on that unit were trained to identify unusual stress and anxiety and provide additional support if needed. All mothers that screened between 10-12 on the EPDS scale received a consult by the social worker, and her provider was notified on the EPDS score. The recommended cut-point is an EPDS  $\geq 13$ . When the patient scores were positive, the nursing action included notifying the Physician and ensuring the patient had a social service referral prior to discharge. Social Services ensured the patient had a referral for a home visit prior to her first postpartum checkup.



In addition, patients were given information for self-referral to a psychiatrist provider through a walk-in clinic, if desired. A mother who screened greater than 10 on the EPDS screen was given a follow up with their primary care provider, and a message was sent to the PCP with a follow-up appointment via Electronic Medical Record with EPDS scores to keep him/her informed.

### **Population and Sample**

The project was conducted at Ventura County Medical Center (VCMC), located in Ventura, California. Ventura is one of the largest cities in Ventura County. Ventura's population is about 854 thousand, with a median age of 38. The community comprises 45% White, 42% Hispanic, and another category of race is 13%. The common language spoken is Spanish, Tagalog, and Chinese, and the poverty level is 10.1 % (Data USA, 2017).

VCMC is a 223-bed general acute care hospital and Level II Trauma Center, including a 43-bed Inpatient Psychiatric Unit. The hospital has a Labor & Delivery unit with (11) Labor & Delivery Beds and 20 postpartum beds. The hospital employs over 80 maternal-child health nurses (Department of Health Care Services, 2018). Ventura County Medical Center is a Health Care safety-net facility providing care to a diverse population with multiple/complex health care needs and provides care for the underserved population (Department of Health Care Services, 2018). The sister to Ventura County Medical Center is Santa Paula who has an acute, 49 bed general community hospital. Provides critical medical care, labs services, surgeries and has a labor and delivery unit with seven postpartum beds and two labor and delivery beds (Ventura County Health Care Agency, 2020).

The sample size for the project was  $n = 147$ . The sample was selected by meeting the criteria of adults from 18-45 years of age, of women who delivered a baby at the Ventura County

Hospital and Santa Paula Hospital. The sample frame was identified from patients registered at the hospital. All participants received a detailed description of the purpose and the methods of the project. After receiving the description, each participant was screened for PPD prior to discharge. Formal consent was not required to participate in the project and was covered under general hospital consent that the patient signs on admission. All patients are asked to complete the EPDS on the day of discharge; however, every patient has the right to refuse participation.

The sample consisted of patients from both hospitals, 100 % female. The mean age of the sample  $M= 29.66$  (S.D. = 6.321). Fifty-point two percent were white (50.2) and .8% of the sample African American and 1.1% were Native American. Most of the sample (30%) were identified as single, and 24 % identified as married or domestic partners, 1.1% divorced, and .8% reported unknown (see table 1).

### **Instrumentation**

The data collection process was designed to collect data relevant to answering the PICOt question. The project question indicates the need for a quantitative methodology. The data was collected using the Edinburgh Postnatal Depression Scale (EPDS). Additional quantitative data was collected using items from the patient charts. No permission is required for the use of the EPDS as long as the author's work is cited (Cox, Holden, and Sagovsky, 1987).

The Edinburgh Postnatal Depression Scale (EPDS) is a ten-item self-reporting questionnaire validating too for childbearing women in assisting in detecting postpartum depression. The EPDS tool was developed due to recognizing bipolar disorders in both underdeveloped and developed countries (Cox et al., 2014). The EPDS is a proficient tool that has a level below the US sixth grade, and the scale is comparable to other scales for postnatal

depression screening (Cox et al., 2014). This most widely used screening tool has been validated and given to different populations and numerous types of language. The sensitivity and specificity can range from 59.5-100% and 49-100% commonly and can be due to the cut-off points and participants (Ing et al., 2017).

### **Data collection**

Data collection took place from June 8, 2020, to July 8, 2020. Data was collected at Ventura County Hospital and Santa Paula Hospital.

The state of California has mandated that postpartum nurses will be screening all mothers for PPD a day prior to discharge. An algorithm is provided to implement for mothers who screened positive, and a list of resources available was given to the mother. After an in-service that was provided by the hospital, time was provided for questions and concerns if the staff had additional concerns. The electronic health records reviews were conducted after July 8, 2020, to measure how many patients were screening PPD and referral rates results.

### **Data analysis**

Results of Data Analysis: The analysis of the data occurred in three phases. The first phase involved the cleaning of the data to ensure that there were no data missing because of data entry errors. The data was also assessed for compliance with the requirements of the statistical test. The project used a paired samples t-test to compare the pre-intervention to the post-intervention scores. A histogram was used to examine the data for compliance with the assumption of normality. This assumption was not violated. The data were also evaluated for outliers in the EPDS scores. Outliers were determined by values more than 3 standard deviations above the mean EPDS score. The data contained a single outlier and that value was addressed through a process of winsorizing. Following the data cleaning, descriptive statistics were

produced for the main demographic data in the study. Percentages and frequency distributions were used to present nominal data, while means and standard deviations were used to describe interval or ratio level data. A paired sample t-test was conducted comparing the pre-test and post-test EPDS scores.

### **Summary**

The project makes a practical contribution to the discipline by providing an approach to reduce depression by introducing a screening program for postpartum depression. The project had a significant impact on nurses, staff, and the patients in gaining greater knowledge on postpartum depression. After the project, the principal investigator determined that better interdisciplinary support is needed. The project was the initial step in helping identify women at risk for postpartum depression in order to provide appropriate treatment, referral and support.

## Chapter 4: Results

Descriptive statistics

### Tables

**Table 1.**  
*Sample Participant Characteristic*

Characteristics	n (%)	M (SD)
Age (18-47)		29.56 (SD=6.32)
Race		
White	132 (89.8)	
Black	2 ( 1.4)	
Asian	4 ( 2.7)	
Unknown	6 ( 4.1)	
Native American	3 ( 2.0)	
Gender		
Female	147 (100)	
Marital Status		
Single	79 (53.7)	
Married/Domestic Partnership	63 (42.9)	
Divorced	3 ( 2 )	
Unknown	2 (1.4)	
Insurance		
Private	30 (20.5)	
Public	114 (78.1)	
Self-pay	2 ( 1.4)	

Note.  $n=147$

**Table 2.**

*Referral rates comparison*

Referral Type	Yes n (%)	No n (%)
Social Service Referral 2019	13 (11.2)	103 (88.8)
Social Service Referral 2020	25 (17)	122 (83)
Therapeutic Referral 2020	12 (8.2)	135 (91.8)

*Note for 2019 n=126; for 2020 n=147*

A Chi Square of goodness fit was used to compare the social services referral rates from July of 2019 to July of 2020.

**Result:**

The Chi Square value is 5.681. The p-value is .01715. The result is significant at  $p < .05$ .

This suggests that the proportion of women being referred in 2020 is higher than expected when compared to 2019.

In addition, this year the social services initiated a new referral process for patients being identified with PPD.

**Table 3.***Case Processing Summary*

	Valid N	Percent	Cases Missing N	Percent	Total N	Percent
Year 2019 and 2020	263	100%	0	0.00%	263	100%

**Table 4.***Year 2019 and 2020 Crosstabulation based on gestational percentage*

	<b>Pre- term</b>	<b>Early- term</b>	<b>Full-term</b>	<b>Late-term</b>	<b>Total</b>
<b>Year 2019 Count</b>	10	34	61	11	
<b>% with Term</b>	34.50%	49.30%	42.70%	50.00%	116
<b>Year 2020 Count</b>	19	35	82	11	147
<b>% with Term</b>	65.50%	50.70%	57.35%	50.00%	55.90%
<b>Total Count</b>	29	69	143	22	263
<b>% with Term</b>	100%	100%	100%	100%	100%

## Chapter Five: Discussion

### Implications

The project implemented a practical contribution to the discipline by the implementation of a standardized tool to identify postpartum depression (PPD). Prior to starting the screening for mothers at risk for postpartum depression, the hospital at Ventura County Medical Center educated nurses on the prevalence and signs and symptoms of postpartum depression. An introduction to perinatal nurses training on screening for postpartum and the use of the Edinburgh Depression Screening Scale. The implementation of universal screening practices increased the number of patients being supported for signs of PPD. A Chi Square of goodness fit was used to compare the social services referrals rates from June 2019 to July 2020. The Chi Square value is 5.681. The p-value is .01715. The result is significant at  $p < .05$ . The null hypothesis is rejected. This suggests that the proportion of women being referred in 2020 is higher than expected when compared to 2019. The results do support the literature and current body of evidence.

Through the implementation of the project, the author noted that better interdisciplinary support is needed. The hospital could further benefit from ongoing education on the impact of PPD on the mother, her newborn, her family, and her community. The Findings validated the literature findings on the use of the EPDS by increasing identification of mothers at risk for postpartum depression and providing medical treatment, referrals and community resources. The treatment of PPD can improve through by recognizing the gap in care and implement evidence-based practice in the underserved population (Selix, 2015).



## **Limitations**

The population was limited to just two facilities, Ventura County Medical Center and Santa Paula Hospital. Only having these two facilities made it a convenience sample. The research design can have a bias that can exist from nurses who do not feel strongly about the subject as evidence on the reduction of screening. In addition, bias can be experienced on my behalf due to the passion I have for this subject. Another limitation in this project is the lack of including residents and other nurses from different units that float and did not receive training. The project was conducted over a period of one month, with a 17% referral rate. A year analysis could evaluate the consistency of screening for EPDS, the identification of depression, and referral rates. There were two underage patient that did not participate in the project, four patients were screened too early during the initial period of the project. Nurses were requesting emotional support to effectively support the patients and the families. Finally, there was a limited availability of social workers. The social workers can benefit for additional support hence the availability of spending more time with the patient,

## **Sustainability**

The sustainability of this project will take place at a local or national level allowing for continual sustainability of this project and improving outcomes. A frequent in-service throughout the year will help sustain the project, keep the stakeholders up to date based on evidence. In addition, providing a monkey survey to evaluate the experience, questions, concerns will help address issues that come up throughout the screening process and helps improve the screening process. It is important for the main stakeholder to buy into screening for postpartum depression by ongoing reinforcement of the importance of early identification and referral rate in improving patient outcomes.

In the year 2019- 2020, the California Assembly Bill 845 recently passed a law, requiring providers and surgeons to receive education on maternal mental health, addressing barriers, understand best practices to screen mothers, and when primary care provider should refer patient to a psychiatrist. Also, physician is required to screen mothers prior to being discharged from the hospital for risk of postpartum depression (California Legislative Information ,2019-2020). The sustainability of the project will be further reinforced due to the California Assembly Bill 845 and meeting the tier 1 requirement for BETA Healthcare Group (BETA) professional liability insurer at Ventura County Medical Center for 2021 and when the second tier gets implemented at the beginning of the year the hospital will have a saving of approximately \$197,000 thousand dollars per managers' report.

### **Dissemination**

The project results will be distributed in a traditional poster present discussing with participants in person regarding the poster in a poster room through a professional practice organization called; the Association of Women's Health, Obstetric and Neonatal Nurses that will take on June 12-16, 2021 in Orlando. The results of the project will also be disseminated to Ventura County Medical Center to be educated on the results and be able to work towards sustaining the project and improving any of the limitation found in this. The manuscript will be disseminated to the Leatherby Library and ProQuest.

### **Supporting Evidence for Advanced Practice Registered Nursing.**

A Doctor of Nursing Practice (DNP) relies on more substantive information and less traditional pathways to patient health. A DNP researches current evidence-based knowledge that gets translated into practice. Advanced Practice Registered Nurses (APRNs) have a responsibility to provide appropriate and evidence-based innovation to improve patient outcomes

while elevating the profession (Zaccagnini & White, 2017). In the clinical scholarly project (CSP), the intent was to implement screening of mothers in the early postpartum period for postpartum depression patients between 18-45 years of age. The predictive measures for evaluating postpartum depression for this project are based on a validated questionnaire, the Edinburg Postnatal Depression Scale (EPDS) screening tool. The objective of the project is to identify mother's at risk for postpartum depression, to provide education, early intervention, community resources, follow-up, and medical treatment if needed. The primary goal is standardizing testing methods to properly identify patients that are at risk for PPD (2020 MOM, 2018). The results of the project in screening for postpartum depression was reinforced with the literature reviewed. Mothers were identified with postpartum depression using the Edinburgh Postnatal Depression Scale (EPDS); nursing education on screening for PPD increases the rate of screening by better understanding the significance of the screening and identifying risk factors that could contribute to the patients positive PPD screening as mentioned in the literature.

A DNP scholarly project applies DNP core essentials, which include the use of evidence-based practices (EBP), education, training, in order to improve patient outcomes and provide support to practicing health care professionals through the implementation of a clinically scholarly project, which directly impacts the delivery of care provided to the health and wellbeing of the community. Following are three of the key DNP essentials supporting the CSP at Ventura County Medical Center and Santa Paula Hospital.

## **Clinically Scholarly Project: DNP Essentials important for the CSP**

### **Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking**

The second essential builds on the first essential and on emphasizing the Doctor of Nursing Practice (DNP) graduate's role which includes the organization and systems improvement by improving outcomes, patients safety, assessing the organization, their delivery of care, and evaluating the effectiveness of cost and quality of care delivered (Zaccagnini & White, 2017). The skills obtained through our doctoral education have developed into practical use that is congruent with the nursing profession that support eliminating health disparities and the opportunity to improve patient safety. The DNPs have the opportunity to work directly with patients, target specific populations and assess the needs of the community, thereby conceptualizing the models of delivering care that is in alignment with the nursing profession, the organization, public policy and the economic needs and the community (Zaccagnini & White, 2017). The skills of the DNP must be proficient in quality improvement strategies, sustainability by evaluating the cost-effectiveness, the applicable principles of economics and finances, and assess potential risk problems that arise, as well as ethical dilemmas (Zaccagnini & White, 2017).

In recognizing the lack of screening for postpartum depression in the obstetrics unit and high prevalence of postpartum depression, this merits the leadership of a DNP to create change by preparing the staff to be educated in the subject matter, screen mothers, and provide proper referrals in order to improve patient and family outcomes. Practical and standard guidelines are important with evidence-based interventions and evaluations (American Psychological Association, 2020). The desire to be the catalyst in how patients screen in hospitals, normalizing

mental health illness by helping reduce the stigma, address ethical dilemmas that arise, promote healthy outcomes, and advance the nursing profession with excellence inspired this project.

### **Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes**

This essential focus on the importance of interprofessional collaboration and communication within different branches in the healthcare industry (American Association of Colleges of Nursing, 2006). Nurses are constantly collaborating with other staff, but as a DNP, this takes it into another level of expertise, leadership, and consult on different levels of this profession. As a DNP graduate, I will have the opportunity to model, advocate, lead and analyze complex systems through implementing my CSP by demonstrating my values, communication, inspiring others to share my vision, and build partnerships through collaboration and competence (Zaccagnini & White, 2017). While implementing my CSP project in the maternity ward, I was cognizant of my strength and my ability to make improvements as a leader, thereby developing strategies, and removing barriers to strengthen leadership qualities in the healthcare organization (Zaccagnini & White, 2017).

### **Essential VII: Clinical Prevention and Population Health for Improving the Nation's**

Clinical prevention is one of the ways in which the DNP is skilled in promoting health, prevent illness, and supporting families to reach these goals (American Association of Colleges of Nursing, 2006). The U. S Patient Protection and Affordable Care Act changed their position from emphasis on illness to prevention and shifting the focus on prevention, safety, empowering the individual, and analyzing ways to eliminate barriers (Zaccagnini & White, 2017). The VII Essential supports the DNP focus on health promotion and risk prevention, a framework that

includes understanding the problem, the etiology, evidence base recommendation, and assessing, in general, the health of the population and community practice (Zaccagnini & White, 2017). Through the education of the DNPs, they are trained in assisting the patient in improving health and preventing disease. Patients will be educated on signs and symptoms of depression when looking for treatment and normalize maternal mental health as a stigma that comes with mental health illness. I will be emphasizing the importance of a strong support system.

### **Essential VIII: Advanced Nursing Practice**

This essential describes the prerequisites that require the DNP to function within the terminal degree in different areas that the professional nurse chooses to practice and gaining expertise in that area that is chosen (Chism, 2016). The DNP graduate ensures competency in the specialty with advanced knowledge, advanced assessment skills, evidenced based practice on the application of behavioral, social, political, and cultural (American Association of Colleges of Nursing, 2006).

In the role of a Psychiatric Mental Health Nurse Practitioner, and while implementing my CSP, Essential VIII is critical in my role. The skills that will be utilized in this project to be effective will be through the use of therapeutic relationships with family and professionals, assess their health, developing interventions, and mentor nursing professionals in the process (Chism, 2016). Through the implementation of all these essentials, these will be the guiding forces and foundational framework to further the Advance Practice of the Nursing profession.

### **Conclusion**

The Doctor of Nursing Practice is an arduous path that requires drive, dedication, and hope for the future for a healthy community with an opportunity to be skilled and highly trained with all the necessary tools to meet the needs of the healthcare system. The DNP has a unique

role in empowering the community, to lead, mentor, and impact change in the community she serves. I applied these principles to my CSP and the vehicle for change while at the same time, mentor nurses to assist in elevating our nursing profession. Being prepared at a doctoral level will provide the framework to influence change at a local and national level (Zaccagnini & White, 2017).

The project was a success in utilizing the standardized tool in the identification of postpartum depression screening with increase referral rates. In 2019 the referral rate was 11.2 %, and in 2020 the referral rate was 17 %, all due to PPD. It is important to mention that the referral rates in 2019 of 11.2%, none were related to postpartum depression; at this time, the screening process was not implemented, and screening was not being conducted. The primary referrals had to do with neonatal consults, adoptions, child protective services, and community services for basic needs prior to discharge.

Other positive outcomes of the project are the staff collaborated with enthusiasm and enjoyed participating in a project they felt was deeply needed. Nurse learned a lot about postpartum depression; they were able to identify patients at risk even when they scored low on the EPDS. The physician and nurse were able to formulate a plan of care, follow up appointments with her primary care, and provide emotional support when needed. There were great questions asked; nurses collaborated with each other to ensure they followed the guidelines and provided resources to the patient. The Obstetric unit manager ensured there were enough pamphlets, questionnaires, and support throughout the project. The implementation of a new protocol screening mothers for postpartum depression. The patients and her family members were willing participants in the screening process, good questions asked on the subject matter, and were content the implementation was taking place. It is beneficial for the mothers to be

identified at risk for PPD in order to provide education and the necessary resources from her provider, therapist, and the community. The prevalence of PPD concurred with the findings in the literature.



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*APPENDIX A*

IRB approval email

BUIRB Application Approved: Adriana Hernandez

**Institutional Review Board** [my@brandman.edu](mailto:my@brandman.edu)

April 6, 2020, 2:01PM

Dear Adriana Hernandez,

Congratulations! Your IRB application to conduct research has been approved by the Brandman University Institutional Review Board. Please keep this email for your records, as it will need to be included in your research appendix.

If you need to modify your BUIRB application for any reason, please fill out the "Application Modification Form" before proceeding with your research. The Modification form can be found at [IRB.Brandman.edu](http://IRB.Brandman.edu)

Best wishes for a successful completion of your study.

Thank You,

BUIRB  
Academic Affairs  
**Brandman University**  
16355 Laguna Canyon Road  
Irvine, CA 92618  
[buirb@brandman.edu](mailto:buirb@brandman.edu)  
[www.brandman.edu](http://www.brandman.edu)  
A Member of the Chapman University System

This email is an automated notification. If you have questions, please email us at [buirb@brandman.edu](mailto:buirb@brandman.edu)

## APPENDIX B

### Institutional Review Board Application



Institutional Review Board

#### **Part 1 – Administrative Information**

This form is to be used for requesting IRB review of any new project. IRB approval is required before any research involving human subjects may be initiated.

Full details must be provided, and all necessary documentation submitted. Brandman University is committed to safeguarding the rights and welfare of all people who participate in research conducted by Brandman faculty and students. Brandman University supports responsible experimentation which promises to increase knowledge and understanding and encourages the highest ethical standards among Brandman researchers.

The central aim of the BUIRB is to protect the rights of human participants in research studies, including their rights to give informed consent and to have their safety protected from undue risk. The BUIRB has the responsibility and authority to review and approve all research projects by Brandman faculty and students involving human or animal participants. It will approve only research that conforms to the professional standards as understood within the relevant discipline.

The BUIRB Application becomes the researcher's record of compliance with laws and regulations protecting the rights and welfare of human participants in research described in the Department of Health and Human Services (DHHS) regulations 45 CFR 46, as specified in the Office for Protection from Research Risks (OPRR) 1983 report on Protection of Human Subjects.

Submit an electronic copy of the Application for Exempt, Expedited, and Standard Review found within this form. For questions, please contact [buirb@brandman.edu](mailto:buirb@brandman.edu).

#### **Institutional Review Board Application**

**IMPORTANT:** Please respond to all the questions. Do not leave any items blank. Responding to each question on this application fulfills one of the requirements for the ethical conduct of researchers. If a question does not pertain to your study, indicate not

applicable (NA) following the question. Do not delete or modify questions from this application. Please note that incomplete applications will be returned without review.

### **Part 1A: Research Information**

#### Research Information

Researcher's Assurance: I certify that the information provided in this application is complete and correct. I understand that as principal researcher, I have ultimate responsibility for the conduct of the study, adherence to ethical standards, and protection of the rights and welfare of human participants. I agree to:

(1) Conduct the study according to the approved protocol; (2) Make no changes to the approved study without prior IRB approval; (3) Use the approved procedure and form(s) for obtaining informed consent; and, (4) Promptly report any significant adverse events to the IRB within five working days of occurrence.

**Researcher's Name: Adriana Hernandez**

**Date: 3/16/2020**

**Student ID:** [pre-populated based on login]

**Phone Number: 805 558 1162**

**Email Address:** [pre-populated based on login]

**Address:**

### **Part 1B: Application Information**

**Title of proposed research study:**

Option 1. Early screening for detecting postpartum depression.

**Type of Review Requested:**

**Exempt Review:** As defined in 45 CFR 46, there are six exemptions to the regulatory requirements described in section 46.101(b) of 45 CFR 46. See BUIRB Research Review Policy for "exempt" review requirements.

**Expedited Review:** Surveys considered minimal risk; research on individual or group behavior or characteristics where research does not cause stress to subject and confidentiality is maintained; research involving deception that poses no more than minimal risk; performance of non-invasive tests; collection of data using noninvasive procedures; collection



of blood samples by finger stick or venipuncture by trained personnel; research using existing documents, records, pathological specimens, or diagnostic specimens.

**Full BUIRB Review:** Research with greater than minimal risk; research of a sensitive nature; research with vulnerable populations (children, prisoners, pregnant women, mentally disabled, elderly individuals, non-English or English as second language speakers, or economically/educationally disadvantaged individuals); research involving invasive procedures; research inducing physical pain or potential injury.

**Type of Research:**

- Institutional Research
- Graduate Research
- Undergraduate Research

**Principal Researcher Position:**

- Faculty
- Doctoral Student
- Master's Student
- Brandman Staff Member
- Non Brandman Researcher

**Principal Researcher's College Affiliation:**

- Arts and Sciences
- Business and Professional Studies
- Education
- Nursing and Health Professions

**Category that applies to your research:**

- Doctoral Dissertation
- Master's Thesis
- Faculty Professional/Academic Research
- Course Project
- DNP Clinical Scholarly Project

**Part 2 – Study Design, Methods and Procedures**

Provide a summary of the study, including the purpose and research questions:

Postpartum Depression (PPD) is a common complication in pregnancy, affecting 20% of women. Currently, there are no standardized screenings for postpartum depression in the United States (American Psychiatric Association, 2019). The incidence of postpartum depression is 1 in 7

women during any of the three trimesters and up to one year from their delivery (Friedman et al., 2016). Despite the severe consequences that PPD has on both the mother and the newborn, many cases of PPD go undetected. PPD goes untreated due to the lack of screening practices among health providers. The types of loss can range from emotional suffering, poor treatment outcomes, increased mental health visits, medication treatment, loss of wages, reduction in productivity, and a negative impact on the mother's relationships (US Preventive Services Task Force, 2016).

It is estimated in the United States that the financial impact of treatment for depression and loss of productivity to be approximately 23 billion dollars in 2011 (US Preventive Services Task Force, 2016). Presently, depression is an economic burden in the United States estimating to be 210.5 billion dollars (Luca et al., 2019). Postpartum depression is a serious issue that requires diagnosing, prevention, and treatment (Nguyen, 2017). Depression had been identified as a leading disability and the second leading cause of global burden in the world between the ranges of 18-44 years of age, and the women are affected by this disease two times more than men, with poor outcomes (Ko, et al., 2012). Statistics on US births in 2017 showed the economic impact due to perinatal mood disorders to be approximately 14.2 billion dollars, with the largest loss as a result of loss of maternal productivity at 669 million dollars (Luca et al., 2019).

Early screening for postpartum depression allows early intervention and can assist in providing the mother with community resources and medical treatment, if needed. If mothers experience complications during their delivery they can be at greater risk of experiencing PPD. Implementation of a screening process will help identify mothers that are at risk for postpartum depression when they are evaluated in their postpartum period. It is important to note that when a mother's mental health issues are addressed this also helps improve the infant's emotional and physical wellbeing. (US Preventive Services Task Force, 2016).

The American College of Obstetricians and Gynecologists (ACOG, 2015), recommends that all women be screened throughout their perinatal period with Edinburgh Postnatal Depression Scale (EPDS). The economic cost to society and the individual can be considerable. The types of loss can range from emotional suffering, poor treatment outcomes, increased mental health visits, medication treatment, loss of wages, reduction in productivity, and a negative impact on the mother's relationships (US Preventive Services Task Force, 2016).

Using an Edinburgh Postnatal Depression Scale (EPDS) for mothers within 6 weeks after giving birth helped detect postpartum depression by 85% between 2 to 3 months (Emerson et al., 2018).

The purpose of this project is to understand the prevalence of postpartum depression in the immediate postpartum period and describe the effects/impact it has on the mother, newborn and family and make the recommendation to provide support.

The goal of this project is to implement the following items:

- The prevalence of postpartum depression during their hospital stay
- Educate patients regarding perinatal mood disorders (postpartum depression) signs and symptoms and normalize mental health issues.
- Provide continuous support for staff while screening patient for postpartum depression

- Describe available support systems/resources for patients who are at risk for postpartum depression.

Need PICOt here

In women, 18-45 years of age, who are in the maternity unit following delivery, does the use Edinburgh Postnatal Depression Scale (EPDS) screening tool prior to hospital discharge compared to current practice result with an increase in referrals to mental health due to early detection of postpartum depression.

**Describe briefly how this study will contribute to existing knowledge in the field: (literature review)**

A significant study by Cleversy et al., (2019) within a community setting created a framework “The plan–do–study–act model” to improve the knowledge and screening practices of healthcare providers in PPD. The study conducted among 6 participants using a pre- and post-education questionnaire along with a review of electronic health record. The study concluded that a single educational intervention increased the rates of postpartum depression screening from 56% to 92.7% ( $p < .5\%$  (Clevesy et al., 2019).

A short-term longitudinal study by Shie et al., (2018) that screened Chinese women prenatally for depression after admission to the hospital for childbirth. Depression rates were reported lower, and an increase in the incidence of suicidal ideation higher was documented. Higher prenatal suicidal ideation prenatally; depressive symptoms at immediate prenatal, and early postpartum stage (Shi et al., 2018).

A study carried by Logsdon et al., (2018) evaluated the acceptability of being screened for postpartum depression and the importance of further evaluating screening of postpartum depression in the hospital. The results indicated mothers' acceptance of being screened for depression in the hospital setting and mothers benefitting from being screened for depression, evaluation, treatment,

Experts are recommending early screening of depression to help identify who is at risk for possible developing PTSD or PPD, and in same case anxiety as well (Gamble, et al., 2005). and referral.

When patients at risk of postpartum depression or other associated mental health issues are identified in the prenatal period, it can help reduce maternal morbidities that are related to postpartum depression and reduce associated risk to the newborn, such as low birth weight, intrauterine growth restriction and behavior issues (Nguyen, 2017).

## **Description of Human Subjects**

### **Target Population**

The target population will be women ranging in ages from 18-45 years who just delivered. This population will be obtained from the obstetric department at Ventura County Medical Center.

### **Number of Participants or Sample Size**

Approximately 100 patients

### **Characteristics of Population**

All women who have delivered a baby and are about to be discharged home.

English speaking only is not required, as the EPDS tool is provided in 50 languages.

Cognitively able to participate.

### **Specify Age of Subjects**

18-45 females

Do your subjects include any of the following:

- Pregnant women/neonates
- Minors ages seven through seventeen
- Infants or children younger than seven years of age
- Cognitively impaired
- Inmates or prisoners
- Elderly/aged persons
- Non-English-speaking persons
- Economically or socially disadvantaged
- Adults with physical or mental disabilities
- Patients
- Other special populations targeted in the study protocol
- None of the Above

## Recruitment

Specify how you will gain access to, recruit and select your subjects? Describe when, where and how participants will be contacted. How will potential participants be initially identified? From what sources will participants be identified, i.e., school, business, health care, law enforcement, non-profit organization, etc. Attach letters or email from all organizations on official letterhead granting permission or IRB approval from the organization. Attach all recruitment documents i.e., flyers, brochures, bulletin boards, media, electronic media, social media, etc.

No recruitment will be required due to screening will be part of their discharge. The EPDS tool will be part of the ongoing nursing assessment process. Every patient has the right to refuse any questions asked by staff, but they do not need to be recruited as all patients will be screened on the day of discharge.

## Data Collection

- In-person Interview
- In-person Questionnaire
- Observation
- Mail Survey/Questionnaire
- Telephone Survey/Interview
- Experimental Procedure
- Biometric Data
- Archival Data
- Electronic Survey
- Audio/Video Recording Analysis
- Focus Group Interview
- Standardized/Educational Test

## Data Collection

List all instruments, assessments, tests, questionnaires, interviews or other materials developed specifically for this research. If no special assessments were developed and used in this study, state “non- applicable” or NA. In Part 6 of this application, attach copies of any materials listed here, and attach verification of permission to use the materials in this research.

Data Collection Table

Resource (Names and numbers for providers, local support and community resources).

**List the titles of all instruments, assessments, tests, questionnaires, interviews or other materials developed commercially or by a third party. If no commercially developed materials were used in this study, state “non-applicable” or NA. In Part 6 of this**

**application, attach copies of any materials listed here, and attach verification of permission to use the materials in this research.**

Edinburgh Postnatal Depression Scale (EPDS) questionnaire screening tool- (permission not required, see attach questionnaire).

Maternal Mental Health NOW (Brochure).

2020MOM (Education materials).

**Describe in detail and in sequence the study procedures that involve human participants, including tests, treatments and research interventions**

After IRB approval

The patients will be screen by nursing staff for postpartum depression utilizing the Edinburgh Postnatal Depression Scale (EPDS) questionnaire screening tool prior to being discharge home. The recommended cut-point is an EPDS $\geq$ 13. When the patient scores positive the nurse's action will include-notifying the Physician, and ensuring the patient has a social service referral prior to discharge. Social services will ensure the patient is referred for a home visit prior to her first postpartum checkup. Education material will be included and reviewed in her discharge packet. The number of referrals for follow up care will be compared to the number of referrals for follow up care that were done for the same time period one year ago. Data will be analyzed using SPSS.

Are you offering payment or other inducements to participants in this study?

No

Yes, Describe the amount of the payment or inducement and how it will be received.

Will participation in the study involve any cost to the participant?

No

Yes, If yes, indicate the anticipated costs and rationale.

### **Part 3 – Risks and Benefits**

Please select all of the potential risks that are involved in your study.

Use of private records (such as educational or medical records)

Manipulation of psychological or social state such as sensory deprivation, social isolation, psychological stress

Probing for personal or sensitive information in surveys or interviews such as private behaviors or employer assessments

Presentation of materials which some participants may consider sensitive, offensive, threatening or degrading

Possible invasion of privacy of subject's family

Social or economic risk (reputation, cultural, employability, etc.)

- Identification of child, spousal, or elder abuse
- Identification of illegal activity
- Risk of injury or bodily harm
- None of the Above

**Please indicate other risks in the field provided above.**

What level of risk does this research present to dignity, rights, health, welfare, or privacy of the participants?

- Less than Minimal Risk to Participants - Justify your rating below
- Minimal Risk to Participants - Justify your rating below
- More than Minimal Risk to Participants - Explain and specify risks below

**Describe the steps that will be taken to minimize risks or harms and to protect the welfare of participants. Include a description of how you will handle an adverse or unexpected outcome that could be potentially harmful against any risk.**

Routine screening for depression in the obstetrical unit is an efficient method to identify patients at risk for postpartum depression (PPD). Utilizing the Edinburgh Postnatal Depression Scale (EPDS) poses minimal risk or harm.

Patients at risk, the following services will be at their disposal.

Primary care provider notified

Social service consult

Community resource material

Emotional support

Follow up a consult with her primary care provider

Referral for a home visit.

In the event that the questions asked cause increased stress or anxiety or any unanticipated event, the patient is provided immediate intervention since she is still in the hospital. The social worker and nurses on that unit are specifically trained to handle these possible events.

**Describe any benefits that individuals may reasonably expect from participation. If there are none, state "None."**

This project will help identify woman at risk of postpartum depression and provide them with the tools for early intervention.

Education for the patient about postpartum depression; signs and symptoms and when to notify her primary care physician.

**Describe any anticipated benefits of this study to society, academic knowledge or both.**

Increase awareness of clinical presentations. Screening for PPD will add to the body of knowledge, increase detection of postpartum depression, and explore how to manage patients who screen positive for depression. Improve mother, infant outcomes. Patient can improve loss of productivity and reduce health care cost related to postpartum depression (Postpartum Progress, 2018).

**Part 4 – Privacy and Confidentiality**

Will you or any member of your research team collect or have access to any of the personal identifiers listed below? Select all that apply.

- Name
- Date of Birth
- Mailing or email address
- Phone numbers
- Social Security number
- Medical records
- License
- IP address
- Photos/images/audio recording
- Signatures, handwriting samples
- N/A

Any unique identifier not mentioned above: N/A

**Describe the procedures for how the subject’s privacy will be maintained during the study. What provisions have been made to protect the confidentiality of participants? Where will you securely store data and research records? How will you dispose of signed consent, data and research records after the research is completed?**

Patient privacy and documents will be maintained in the electronic medical records. Special consents will not be used, as the Edinburgh Screening tool will be a part of the nursing assessment screening that will be done prior to their discharge. No personal data on any individual will be collected.

All data collected will not contain any personal info but will be kept on a password protected laptop and/or locked in a file cabinet on the unit. All data will be shredded and/or deleted three years after completion of the project.



## **Part 5 – Consent Process**

Include any of the following attachments applicable to this application:

### **Informed Consent**

The entire informed consent process involves giving a subject adequate information concerning the study, providing adequate opportunity for the subject to consider all options, responding to the subject's questions, ensuring that the subject has comprehended this information, obtaining the subject's voluntary agreement to participate, and continuing to provide information as the subject or situation requires. Identify and describe the procedures you will use to obtain Informed Consent. Attach a copy of the informed consent form in Part 6 (see Brandman University requirements and Sample Informed Consent form) and include the script of oral explanations. Include any Informed Consent forms required by other participating organizations.

- Consent Required: Participant informed consent required
- Consent Required: Written assent for children and individuals under 18
- Consent Required: Parent/Guardian permission for children and individuals under 18
- Consent not required

### **Informed Consent Procedures**

N/A

### **Attachments to be included with IRB Application**

[IRB Awareness+Flyer-2020Mom-print Hernandez\\_Adrina.pdf](#)  
[IRB Edinburgh Postnatal Depression Scale Hernandez\\_Adrina.pdf](#)  
[IRB Final Grief brochure 6 11 18 Hernandez\\_Adrina.pdf](#)  
[IRB MMHCVC Directory Hernandez\\_Adrina.pdf](#)  
[IRB PATIENTS SCREENED FOR POST PARTUM DEPRESSION Hernandez\\_Adrina.pdf](#)  
[IRB Perinatal Mental Health Services Hernandez\\_Adrina.pdf](#)  
[IRB permission from Ventura County Medical Center Hernandez\\_Adr.pdf](#)  
[IRB Protecting Human Subject Research Participants certificate for Adriana Hernandez 9 24 2018.pdf](#)  
[IRB Speak Up Perinatal Mental Health Task Force Hernandez\\_Adrina.pdf](#)

## **Part 6 – Attachments**

**Include your NIH Certificate and any of the following attachments applicable to this application:**

- Consent/Assent Forms (All parental/guardian consent forms, Information sheets for Waiver of Consent, Internet Consents, Verbal Consent scripts, etc.)

- Screening Materials (Demographic questionnaires or measures used in screening subjects for inclusion or exclusion)
- Site Permission/Support Letters (Letters from agency or organization granting permission – on official letterhead)
- Recruitment Materials
- Data Collection Instruments (Questionnaires, copyrighted tests, focus group questions, interview questions, scripts, etc.)

### **Part 7 – Assurance**

I agree:

- To comply with all BUIRB policies, decisions, conditions and requirements.
- This study protocol has been designed, to the best of my knowledge, to protect human participants engaged in research in accordance with the applicable principles, policies, regulations, and laws governing the protection of human subjects in research.
- To obtain prior approval from the BUIRB before amending the research protocol or the approved consent/assent form.
- To report to BUIRB any adverse event(s) and/or unanticipated problem(s) involving risks to participants.
- To submit the Annual Review Form as needed.

I have completed the NIH Certificate and included a copy with the proposal.  
[Please Check NIH Certificate box.]

Researcher's Typed Signature:

Date:

## APPENDIX C

### IRB Approval forms

**Darlyn Roseco, LMFT:** 805-727-4017, Thousand Oaks. Specializing in anxiety, depression, parenting, behavioral changes, self-esteem, relationship problems, life transitions.

**Pat Stepler, LMFT:** 805-386-6315, Ventura, Therapeutic interests in the areas of parenting and family issues, infertility, grief and loss, and managing chronic illness. Accepts sliding scale

**Tracy Smith, MS, LMFT:** 818-259-7650, Westlake Village. Specializes in the areas of depression, divorce, co-parenting and family addiction, women's issues, Accepts GCHP/Beacon, Aetna, HealthNet, Care 1<sup>st</sup>, CHIPA

**Joyce Weick, CNM, PMHNP, MSN:** 805-654-0926, Ventura. Specializes in treating women with reproductive changes, PMAD, PMS, menopausal mood issues, breastfeeding, loss and infertility. Accepts Aetna, Anthem, Cigna, Optum

**Vanessa Schor-Yakobian, LMFT:** 818-485-2624, Ventura. Specializes in parenthood: preparing for pregnancy, ambivalence, adjusting to motherhood, baby blues, PMAD, Accepts Aetna, Beacon, Blue Cross, Cigna, Optum, United Healthcare, Value Options, sliding scale

**Sara Rector, MFT:** 805-494-1414, Thousand Oaks, supporting individuals, couples, and families from pre to post conception, relationship and communication issues, parenting, pregnancy loss, infertility, post-partum adjustment and depression.

#### Online resources:

**Postpartum Support International:** 800-944-4773(4PPD), [www.postpartum.net](http://www.postpartum.net)  
**PPD MOMS:** 800-PPD-MOMS, [www.1800ppdmoms.org](http://www.1800ppdmoms.org)  
**The Mighty:** [www.themighty.com](http://www.themighty.com)  
**Postpartum Progress:** [www.postpartumprogress.com](http://www.postpartumprogress.com)  
**2020MOM:** [www.2020mom.org](http://www.2020mom.org)  
**Online PPD Support Group:** [www.ppdsupportline.com](http://www.ppdsupportline.com)

#### Other Services:

**2-1-1 Ventura County:** [www.211ventura.org](http://www.211ventura.org), 24 hr referral and information service  
**NAAMI:** 805-500-NAAMI (6864), emotional support, education and resources for families affected by mental illness, support groups



**1 in 7** mothers of every age, income level and ethnic background will be affected by **Perinatal Mood and Anxiety Disorders (PMAD)**. Although the term "postpartum depression" is often used, there are actually several overlapping illnesses, including anxiety, posttraumatic stress disorder, bipolar disorder, and psychosis. Symptoms can appear any time during pregnancy and the first year after childbirth. PMAD can be debilitating, but there are effective and well-researched treatment options.

The **Maternal Mental Health Coalition of Ventura County (MMHCVC)** was established in 2017 as a non-profit, volunteer public and private network dedicated to promoting maternal mental health and wellness through education, advocacy, assessment, treatment and training.

We welcome individuals passionate about maternal mental health, and maternal and child wellness to join us in our efforts to improve care for new mothers and babies of Ventura County.



## Maternal Mental Health Services

Ventura County



Find us on Facebook  
**Call us: 805-340-0040**  
**Email us: [MMHCVC@gmail.com](mailto:MMHCVC@gmail.com)**



## Counseling Services:

### **Ventura County Crisis Team:**

866-998-2243

### **National Suicide Prevention:**

800-273-8255

**A New Start for Moms:** 805-981-9250, services for alcohol and drug related issues

**Action Family Counseling:** 800-367-8336 Crisis Line, 805-584-3258 office, Drug abuse related issues for adolescents, support groups for parents & teens, prevention programs, family counseling.

**Beacon:** Behavioral provider for Gold Coast Health Plan, 855-765-9702

**Butterfly Center at Horizon Hills- [www.butterflycenter.org](http://www.butterflycenter.org)**  
818-599-8420, Thousand Oaks, Education classes and new parent support classes, breastfeeding support.

**Center for Creative Change:** 805-499-8511, counseling, alcohol and substance abuse

**Clinicas del Camino Real:** 805-647-0991, various locations, bilingual staff, counseling and comprehensive mental health services provided

**Community Counseling Group:** 805-373-1033, individual and family counseling, alcohol and substance abuse.

**The Coalition for Family Harmony:** 805-983-6014, Bilingual Hotline 800-300-2181, Oxnard, Crisis counseling, Emergency shelter, Batterer's Intervention, Child Abuse Intervention

**Community First Counseling Center:** 805-658-1830, 38 Teloma St., Ventura.

**Free Clinic of Simi Valley:** 805-522-3733, Simi Valley, Call weeknights 5-8 for all services, Counseling available, \$20/ session, Individual & family, Legal services from volunteer lawyers & paralegals, \$20 donation requested.

**Gladstone Counseling Center:** 905-646-9724, counseling, no insurance accepted

**Interface Children & Family Services:** 805-485-6114, Locations in Thousand Oaks, Camarillo, Oxnard, Santa Paula, Safe Haven for women & children, DV shelter

**Jewish Family Services:** 805-641-6565 Ventura, 805-496-3896 Thousand Oaks, Individual and family counseling, Parenting classes, Rental Assistance, Justice clinic.

**Morbrosk Institute:** 805-484-7868, Camarillo, Accepts Medical for children, sliding scale.

**New Parent Resource Center:** 805-658-2229, Ventura, Well-Mama Emotional wellness support group, (free of charge), Mommy and Me classes, lactation support

**Oasis Counseling:** 805-484-2029, Camarillo, [www.oasiscounselinggroup.com](http://www.oasiscounselinggroup.com), Sliding scale.

**Services United:** 805-604-4430, Oxnard, Sliding scale  
**Ventura Counseling Center:** 805-644-1650, Ventura, Sliding scale & insurance.

**Ventura County Behavioral Health S.T.A.R.:** 866-998-2243, Intake for county's behavioral health system, accepts Medical, Gold Coast, sliding scale, self-pay and private insurance

**Victim Resources:** Ventura County DA Crime Victim's Assistance 805-654-3622, provides funds for counseling, Oxnard PD Victim Resources 805-385-7629, Interface Hope & Sexual Assault Treatment Services 805-485-6114

**Westminster Free Clinic:** 805-241-8366, East Ventura County, Resource & referral services and bi-lingual counseling

## Psychiatrists Specializing in Maternal Mental Health:

**Dr. Sarah Shah,** 805-658-5800, Ventura and Camarillo, special interest in maternal mental health, accepts private insurance



## Therapists specializing in Maternal Mental Health:

**California Lutheran University:** 805-493-3390, Thousand Oaks, 805-493-3059, Oxnard, Counseling for Individuals, Couples & Families, Parent-Child Center, Accepts sliding scale

**Nan Tolbert Nurturing Center:** 805-646-7559- [www.nantolbert.org](http://www.nantolbert.org), Oak View, Play groups, lactation support, individual and group therapy, in-home peer support, Accepts sliding scale.

**Laurel Connel, LMFT:** 805-242-0054, Ventura, specializes in the prenatal and postpartum period, loss, infertility, Doula trained, Accepts sliding scale

**Debra Decker, PhD:** 805-522-1700, Simi Valley, Accepts GCHP

**Darla Dixon, PsyD:** 818-925-5007, Camarillo, Specializes in parenting, family conflict, mood disorders, Accepts GCHP

**Lisa Dyck, MS, MFT:** 805-222-6882 ext. 1, Westlake Village, Specializes in marital and women's issues, Accepts Aetna, GCHP, Blue Cross, Kaiser, CHPA, Care-First, etc.

**Lauren Fox, LCSW:** 805-706-0987, Ventura, specializes in PMAD and maternal issues, Hypnotherapy, Bilingual, Accepts GCHP/Beacon, Magellan, PPO, and out of network, sliding scale

**Allisa Gianni, LMFT:** 805-706-8940, Trained in Positive Parenting Program, Parent Child Interactive Therapy, and Trauma Focused Cognitive Behavioral Therapy, Accepts sliding scale

**Siohhan McDevitt, MFT Intern:** 805-725-5346, Ventura, Certified parent-infant coach, Accepts GCHP, sliding scale

**Amelia Mora Mars, MS:** 805-876-9079, Moorpark, Specializes in women's issues and parenting, Accepts GCHP/Beacon, sliding scale

**Deborah Paster, MA:** 818-261-7713, Westlake Village, Specializing in anxiety, depression, use of alcohol or drugs, women's life transitions, Accepts GCHP/Beacon, Kaiser, sliding scale

\*The above list of resources is not exclusive, is for informational purposes only, and is subject to change. It does not imply endorsement by the MANHC. It is the responsibility of the individual to verify accepted insurances.

## Online Support

The CI Foundation for SIDS on Facebook: supports grieving families, medical research advancement, parent and professional education, and advocates for the health and survival of all children. CI Foundation supports the efforts to eliminate sudden unexpected infant deaths and early childhood deaths.

[wendy@cjsids.org](mailto:wendy@cjsids.org)

[www.firstcandle.org](http://www.firstcandle.org)

Offer bereavement support for grieving families. First Candle supports the efforts to reduce the rates of Sudden Infant Death Syndrome (SIDS), Sudden Unexpected Infant Death (SUID), and preventable Stillbirths by educating caregivers and families, and supporting research.

Grief Counselor is available 24/7 at 800-221-7437

[www.compassionatefriends.org](http://www.compassionatefriends.org)

Ability to post a remembrance, educational information relative to various topics, online newsletter, and current media updates.

1-877-969-0010

[www.marchofdimas.com](http://www.marchofdimas.com)

Current research information, community resources, bereavement materials, and information regarding community action groups, events and fundraising.

<https://mlsfoundation.org/>

Grief counseling, support services, forums, education, advocacy, newsletter, and research information for families experiencing a child's death. Families have the opportunity to post a child's remembrance and Facebook connection.

## Ventura County Resources

Interface Children Family Services  
(800) 339-9597

Website: [www.ifcs.org](http://www.ifcs.org)

Camarillo Health Care District  
(805) 388-1952

Website: [www.camhealth.com](http://www.camhealth.com)

Ventura County Behavior Health Services:  
Youth and Family services: 1-866-998-2243.

Ventura County Jewish Family Services:  
Provides non-denominational services for the people of Ventura County as well as services for the Jewish Community. Individual, group, couples and family therapy are provided through both agency contracts and on a sliding scale to people of all ages.

805-641-6555

740 E. Main St, Ventura, CA 93001

Death certificates or certificates of stillborn  
Can be obtained from: The funeral home, or  
The Public Health Office of Vital Records (Monday to  
Friday, 9 AM to 4 PM)

805-981-5172

2240 E. Gonzales Road, Suite 150, Oxnard, CA 93036

### Medical Examiner office

#### PERSONAL PROPERTY

ANY PERSONAL PROPERTY RECOVERED BY A MEDICAL EXAMINER INVESTIGATOR AT A DEATH SCENE MAY BE CLAIMED, UNDER MOST CIRCUMSTANCES, BY THE NEXT OF KIN DURING NORMAL OFFICE HOURS, MONDAY THROUGH FRIDAY, 8 A.M. TO 4:30 P.M.

805-641-4400

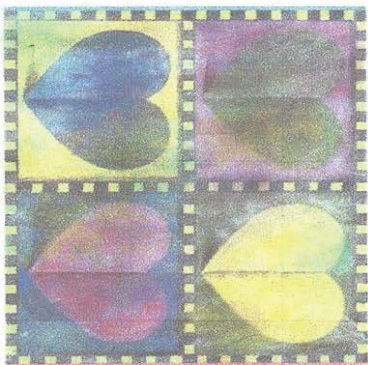
3291 Loma Vista Rd, Ventura, CA 93003

2-1-1 Information and Referrals: is available 24 hours a day, 7 days a week and help is available in multiple languages (including Spanish) and in 150 additional languages through phone interpretation services.



## Grief and

## Bereavement Resources





## Support Groups

**Camarillo Hospice**  
400 Rosewood Ave., #102  
Camarillo, 93010  
805-389-6870  
SPANISH SERVICES/SERVICIOS EN ESPAÑOL  
[www.camarillohospice.org](http://www.camarillohospice.org)

There is no charge for services; donations are accepted. Drop-ins are welcome for group sessions. Appointment for individual counseling. Please call for more information regarding the support groups.

1. Individual, couple, and family grief counseling
2. Counseling for caregivers and individuals with a terminal illness.
3. Bereavement Grief Support Groups:
  - General Bereavement Groups Wednesdays 1-2:30 pm and Thursdays 6-7:30 pm
  - Young Widow and Widower's Grief Support Group Tuesdays 5:30-7 pm
  - Caring for You, the Caregiver 1st and 3rd Wednesdays 1-2:30 pm
  - Survivors of Suicide Loss Support Group 1st and 3rd Wednesdays 6:30-8 pm
  - Adult Loss of Parent Support Group 1st and 3rd Thursdays 6-7:30
  - Reinvesting in Life after Loss Support Group 2nd and 4th Thursdays 3-4:30 pm
  - Children and Teen Grief Support Groups (Good Grief Club and Teenage Grief Groups) 1st and 3rd Tuesday of every month 5:30 to 7:00 pm
  - Grief Support Group in Schools as scheduled
  - Healing Grief through Journaling as scheduled
  - Understanding Your Grief, 10 week grief support group as scheduled
  - Healing Grief through Art as scheduled
  - Meditation and Grief as scheduled

## Support Groups

**Ted Mayr Funeral Home**  
3150 Loma Vista Road, Ventura, 93003  
805-643-9977

Grief recovery sessions offered during the year in selected months. Call for session schedule information. No charge, reservations necessary.

**The Compassionate Friends**  
Meeting Address: Los Robles Hospital  
215 W Janss Rd, Thousand Oaks, CA 91360

Janice (805) 579-7065 or Lynn (805) 443-1905  
[www.compassionatefriends.org](http://www.compassionatefriends.org)

Self-help support group that offers friendship and understanding to families who are grieving the death of a child of any age, from any cause. There are no membership dues or fees and all are welcome.

**Hospice of the Conejo**  
805-495-2145

SPANISH SERVICES/SERVICIOS EN ESPAÑOL

[www.hospiceoftheconejo.org](http://www.hospiceoftheconejo.org)  
80 E. Hillcrest Drive, Thousand Oaks, CA  
Call for support group information.

- Youth Groups
- Caring Companions
- Newly Bereaved Group
- Pregnancy or Infant Loss:
  - This support group is for parents who had a child die in utero, at birth or shortly after birth. The group is intended for both mothers and fathers

**Healing Hearts Mom's Grief Group**  
Foothill Technology High School  
100 Day Road Ventura 93003  
Contact: Debbie Freeman: 805-252-5922  
(Group meetings are only while school is in session)

## Support Groups

**Livingston Memorial VNA**  
SPANISH SERVICES/SERVICIOS EN ESPAÑOL

Please call more information:  
805-642-0239

1996 Eastman Ave., Suite 101, Ventura, 93003.  
(Enter Suite #112 door nearest to Suite 111)  
[www.livingstonvna.org](http://www.livingstonvna.org)

*Teen Support Groups/As scheduled*  
Offered at local high schools.

Literature (both available in Spanish) related to loss and grief and crisis counseling related to public tragedies.

Staff includes licensed medical social workers, licensed marriage, family, child therapists, chaplains and volunteers specializing in grief support.

Free of charge, however, space is limited. To register call 805-642-0239

Help of Ojai- West Campus  
370 Baldwin Rd, Ojai  
Please call Kathy Leary-Wilde, MFT  
(805) 218-9798

**First Presbyterian Church Grief Support Group**  
850 Ivywood Drive, Oxnard  
805-983-0204

Check your hospital for support groups and bereavement resources

**Local Churches**

Many local churches offer support groups and bereavement



**VENTURA COUNTY PUBLIC HEALTH  
NURSING REFERRAL**

Submit by E-mail

[http://www.vchca.org/public-health/maternal-child-adolescent-health-\(mcah\)/public-health-nursing](http://www.vchca.org/public-health/maternal-child-adolescent-health-(mcah)/public-health-nursing)

**Office: (805) 981-5115 FAX: (805) 654-7610 E-mail: [CHNReferrals@Ventura.org](mailto:CHNReferrals@Ventura.org)**

This information is intended only for the use by the office checked. If you are not the intended recipient, please deliver it to the intended recipient. Disclosure, copying, dissemination, distribution or the taking of any action in reliance on the contents of this transmitted information is strictly prohibited.

**SECTION I REFERRING SOURCE**

Date: \_\_\_\_\_ Referral by: \_\_\_\_\_

Agency: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

If from CalWorks/Family Stabilization ONLY -  West County  East County

**SECTION II CLIENT INFORMATION**

(Print) Last Name: \_\_\_\_\_ First: \_\_\_\_\_ AKA: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX:  M  F Primary Language  English  Spanish  Other: \_\_\_\_\_

MediCal #: \_\_\_\_\_ Chart #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK: \_\_\_\_\_ CELL: \_\_\_\_\_ OKAY TO TEXT:

NAME OF PERSON LIVING WITH: \_\_\_\_\_ RELATIONSHIP TO CLIENT: \_\_\_\_\_

**SECTION III REASON FOR REFERRAL**

Pregnancy  EDC Date: \_\_\_\_\_ Postpartum  Delivery Date: \_\_\_\_\_ Client Aware of Referral   
4P's Attached  Date of Next OB Appointment: \_\_\_\_\_

Identified problem/needs are:

Signature/Title: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION IV REFERRAL STATUS (For use by Nursing Referral Center Staff Only)**

No follow-up  Unable to locate  No such address  Client refused  Case open

Plans/Goals:

Notified Referral Source by:  Phone Date: \_\_\_\_\_  Fax Date: \_\_\_\_\_  E-mail Date: \_\_\_\_\_

Signature/Title: \_\_\_\_\_ Date: \_\_\_\_\_

**(Nursing Referral Center Staff use only)**  
Referral Review:   
  
Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Program \_\_\_\_\_ Nurse \_\_\_\_\_ Priority \_\_\_\_\_ NRS # \_\_\_\_\_  
  
Researched  Previous Providers/NRS # \_\_\_\_\_

REVISED 12/13/2016

S:\PH-PHN\Nursing\FIELD\Referrals\Nursing Referral Forms



## Nursing Referral Center

### Ventura County Public Health

### When To Initiate A Public Health Nursing Referral

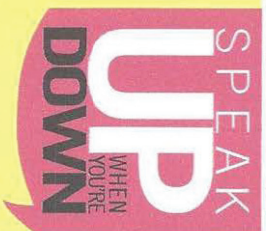
Public Health Nurses (PHNs) will collaborate with you to improve your client's quality of life and access to care by providing comprehensive nursing assessments, education and linkage to community resources.

Types of referrals that can be made to Public Health Nursing are:

- ◆ Assistance with access to health care services
- ◆ Complex issues that endanger the existing level of health
- ◆ Inconsistent, late-entry into or no prenatal care
- ◆ At-risk for or currently using harmful substances during pregnancy
- ◆ Maternal or postpartum mental health concerns
- ◆ Premature births (under 37 weeks gestation)
- ◆ Newborn or child prenatally exposed to harmful substances
- ◆ Failure to thrive infant
- ◆ Concerns regarding infant or child growth and/or development



## Moms get Distressed – Sometimes it's Serious



MATERNAL MENTAL  
HEALTH DISORDERS  
ARE TREATABLE.

### SIGNS CAN INCLUDE:

SLEEP DISTURBANCE &  
CHANGES IN APPETITE

FEELINGS OF HOPELESSNESS,  
HELPLESSNESS, GUILT & DESPAIR

FEELING INADEQUATE AS A MOTHER

ANXIOUS OR IRRITABLE FEELINGS

FEELING EMOTIONALLY  
DISCONNECTED FROM YOUR BABY

LACK OF INTEREST  
IN FAMILY AND FRIENDS

OBSESSING OVER BABY'S SAFETY

CALL POSTPARTUM SUPPORT INTERNATIONAL

1.800.944.4773



2020Mommy.org

TheBluedot  
p.r.o.o.j.e.c.t

thebluedotproject.org

UP TO 20% OF  
PREGNANT & NEW MOMS  
WILL EXPERIENCE SOME FORM OF  
MATERNAL MENTAL  
HEALTH DISORDER.



# SPEAK UP WHEN YOU'RE DOWN

EVERY NEW MOM & MOM-TO-BE  
SHOULD KNOW ABOUT  
PERINATAL DEPRESSION

## 6 THINGS

**1**  
*Perinatal depression is common.*

It is, in fact, the number one complication of pregnancy. In the US, 15% to 20% of new moms, or about 1 million women each year experience perinatal mood and anxiety disorders, and some studies suggest that number may be even higher.

**YOU ARE NOT ALONE.**  
*Perinatal depression can affect any woman regardless of age, income, culture, or education.*

**2**  
*You may experience some of these symptoms*

- Feelings of sadness.
- Mood swings: highs and lows, feeling overwhelmed.
- Difficulty concentrating.
- Lack of interest in things you used to enjoy.
- Changes in sleeping and eating habits.
- Panic attacks, nervousness, and anxiety.
- Excessive worry about your baby.
- Thoughts of harming yourself or your baby.
- Fearing that you can't take care of your baby.
- Feelings of guilt and inadequacy.
- Difficulty accepting motherhood.
- Irrational thinking; seeing or hearing things that are not there.

Some of the ways women describe their feelings include:

- I want to cry all the time.*
- I feel like I'm on an emotional roller coaster.*
- I will never feel like myself again.*
- I don't think my baby likes me.*
- Everything feels like an effort.*

**3**  
*Symptoms can appear any time during pregnancy, and up to the child's first year.*

Baby blues, a normal adjustment period after birth, usually lasts from 2 to 3 weeks. If you have any of the listed symptoms, they have stayed the same or gotten

worse, and you're 5 to 6 weeks postpartum, then you are no longer experiencing baby blues, and may have a perinatal mood or anxiety disorder.

**4**  
*You did nothing to cause this.*

You are not a weak or bad person. You have a common, treatable illness. Research shows there are a variety of risk factors that may impact how you are feeling, including your medical history, how your body processes certain hormones, the level of stress you are experiencing, and how much help you have with your baby. What we do know is, **THIS IS NOT YOUR FAULT.**

**5**  
*The sooner you get treatment, the better.*

Recent studies show that your baby's well-being and development are directly tied to your physical and emotional health. You deserve to be healthy, and your baby needs a healthy mom in order to thrive. Don't wait to reach out for **HELP**. It is available.

**6**  
*There is help for you.*

There comes a time in every woman's life when she needs help, **NOW** is the time to reach out to a caring professional, who is knowledgeable about perinatal depression, and who can help you through this time of crisis. He or she can understand the pain you are experiencing and guide you on the road to recovery. Contact Postpartum Support International, 1.800.944.4773 or [www.postpartum.net](http://www.postpartum.net), for referrals and support near you.



LOS ANGELES COUNTY  
PERINATAL MENTAL HEALTH TASK FORCE  
[LACountyPerinatalMentalHealth.org](http://LACountyPerinatalMentalHealth.org)  
For referrals and resources, call 211  
OR  
1.800.944.4773 | [www.postpartum.net](http://www.postpartum.net)

Los Angeles Community Child Abuse Council  
[www.lacchildabusecouncils.org](http://www.lacchildabusecouncils.org)



# Edinburgh Postnatal Depression Scale<sup>1</sup> (EPDS)

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Your Date of Birth: \_\_\_\_\_  
Baby's Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- Yes, all the time
- Yes, most of the time This would mean: "I have felt happy most of the time" during the past week.
- No, not very often Please complete the other questions in the same way.
- No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
  - As much as I always could
  - Not quite so much now
  - Definitely not so much now
  - Not at all
2. I have looked forward with enjoyment to things
  - As much as I ever did
  - Rather less than I used to
  - Definitely less than I used to
  - Hardly at all
- \*3. I have blamed myself unnecessarily when things went wrong
  - Yes, most of the time
  - Yes, some of the time
  - Not very often
  - No, never
4. I have been anxious or worried for no good reason
  - No, not at all
  - Hardly ever
  - Yes, sometimes
  - Yes, very often
- \*5. I have felt scared or panicky for no very good reason
  - Yes, quite a lot
  - Yes, sometimes
  - No, not much
  - No, not at all
- \*6. Things have been getting on top of me
  - Yes, most of the time I haven't been able to cope at all
  - Yes, sometimes I haven't been coping as well as usual
  - No, most of the time I have coped quite well
  - No, I have been coping as well as ever
- \*7. I have been so unhappy that I have had difficulty sleeping
  - Yes, most of the time
  - Yes, sometimes
  - Not very often
  - No, not at all
- \*8. I have felt sad or miserable
  - Yes, most of the time
  - Yes, quite often
  - Not very often
  - No, not at all
- \*9. I have been so unhappy that I have been crying
  - Yes, most of the time
  - Yes, quite often
  - Only occasionally
  - No, never
- \*10. The thought of harming myself has occurred to me
  - Yes, quite often
  - Sometimes
  - Hardly ever
  - Never

Administered/Reviewed by \_\_\_\_\_ Date \_\_\_\_\_

<sup>1</sup>Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

<sup>2</sup>Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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Perinatal Mental Health Services for VCMC

AFMC/Dr Bale and psychology interns  
Primarily for AFMC and medi-cal  
Referral slips in Ron Bale's mailbox in bowling alley

Maryellen Bendetto ,LCSW(English)  
Ventura  
VCHCP, Beacon, Blue Cross  
644-1831

Peggy Ruesnick, MFT (English)  
Ventura  
Beacon/VCHCP  
656-5218

Laura Hughes, MFT (English+ Spanish)  
642 3661  
Beacon Provider  
Most carriers (not Cigna or Healthnet)

Rebecca (Becky) Schwartz, MA  
Offices in Ventura and Thousand Oaks (Mostly Ventura)  
658-9202  
30yrs LCSW  
VCHCP/Blue Shield/Beacon (currently not but will likely soon)

Sylvia Leidig, MSW  
Ventura  
644-0678  
Beacon/Medi-cal  
VCHCP/Blue Cross/Blue Shield/Aena  
Background in child development

Susan Martinez Lee (English and Spanish)  
Ventura  
Provides both faith based and non-faith based counseling  
Beacon/Medi-Cal  
654-1422

Psychiatry:

Joyce Weckl, Psychiatric NP  
Private practice  
654 0926