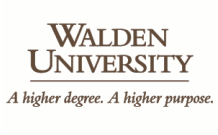

2019

Screening for Depression During the Early Perinatal Period

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This is to certify that the doctoral study by

Loretta Ann Moreno

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2019

Abstract

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by

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MSN, Walden University, 2011

BSN, Molloy College 1982

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

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Abstract

The clinical practice guideline (CPG) is the implementation of a depression screening tool to be used in the early perinatal period. The practice change occurred in a rural Obstetrical and Gynecological (OBGYN) practice in the southern United States. The CPG change has been guided by recommendations from both the American Congress of Obstetrics and Gynecology and the American College of Nurse Midwives. Implementation of this CPG change addresses the gap in practice of not doing depression screening during the perinatal period, and only screening during the postpartum period, which was being done at the OBGYN office. Theorist Lewin's 'change theory' guided the implementation of the project. In order to apply this project, a process of changing practice guidelines was needed at the OBGYN office. The DNP project presented the practice change guideline of implementing the Edinburgh Postpartum Depression Screening (EPDS) tool. The need for the CPG development was evaluated by 3 nurse leaders using the AGREE II tool and was recommended 100% without modifications by all 3 evaluators. The CPG, with the results, was presented and discussed with the practice site's practitioners. The practitioners implemented the EPDS to be given at the 12- week checkup appointment versus the confirmation of pregnancy appointment, which was suggested through the DNP project's CPG. The implementation of this CPG has the potential to provide a safer environment for pregnant women, their newborns and their families.

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I want to acknowledge support from my children, parents, and family.

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Section 1: Introduction

Introduction

According to the American Congress of Gynecology (ACOG) and the American College of Nurse Midwives (ACNM), recommendations are in support of using depression-screening tools during the early perinatal period. At the practicum site, depression screening was only done during the postpartum period. The Doctor of Nursing Practice (DNP) project, proposes the use of the Edinburgh Postpartum Depression Screening (EPDS) Appendix B, at the *confirmation of pregnancy* appointment.

Problem Statement

The DNP project is a clinical practice guideline (CPG) change to implement the use of the EPDS tool, to be used during the early perinatal period in an obstetrical and gynecological (OBGYN) provider practice. The Institute of Medicine (IOM) defined clinical practice guidelines as "statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options" (Institute of Medicine, 2011, p. 26). According to ACOG (2015), identifying pregnant and postpartum women with depression is important because untreated perinatal depression can have devastating effects on women, infants, and families. The OBGYN clinic was only doing a postpartum screening during the postpartum period. The gap in practice at the practicum site is not adhering to current ACOG guidelines, of screening for depression during the perinatal period.

The objective of this CPG was to provide all pregnant women at the local OBGYN practice with a depression screening tool, specifically the EPDS, during the early perinatal period**.**

Practice-Focused Question/PICO

In perinatal clients within a rural OB/GYN practitioner's outpatient office in the southern United States, how does providing a depression screening tool (EPDS) during the early perinatal period align with recommendations from ACOG, ACNM and a review of current literature, compare to the existing guidelines of the OBGYN office and improve client's care?

The purpose of this project is to develop a proposed guideline change to be implemented during the early perinatal period and provide the OBGYN clinic with information on the need for the clinical practice guideline change.

Goal**:** Provide the CPG change with recommendations from ACOG, ACNM, a review of current literature, and an evaluation using the AGREE II tool, to implement a depression screening tool, the EPDS, to perinatal women during their 'confirmation of pregnancy' appointment, at the OBGYN clinical practice site.

1. Objective 1: The DNP student will address the CPG problem: no screening guidelines of perinatal clients for depression, by initiating the use of the EPDS at the 'confirmation of pregnancy' visit.
2. Objective 2: The DNP student will apply recommended clinical practice guidelines from the ACOG and the ACNM into the area of evidence basis of early perinatal depression screenings.

3. Objective 3: The DNP student will demonstrate the achievement of learning objectives related to the AACN DNP Essentials, VI. Interprofessional Collaboration for Improving Patient and Population Health Outcomes and VII. Clinical Prevention and Population Health for Improving the Nation's Health (DNP Essentials, 2006), by creating a CPG of providing a depression screening tool during the early perinatal period

Purpose Statement

The need for an effective screening tool to evaluate pregnant women during the perinatal and postpartum period is vital. A CPG change, to include a perinatal depression screening, the EPDS tool, will be given to the clients at their confirmation of pregnancy appointment. The EPDS will be included in their intake packet.

Nature of the Doctoral Project

The problem of post-partum depression (PPD) is global and has been diagnosed for more than one-hundred years (Bergink, Rasgon, & Wisner, 2016). Esquirol described the first appearance of PPD (Bergink et al., 2016). Esquirol described 92 women with postpartum psychosis, of which 53% had predominantly manic symptoms, 38% had depressive symptoms, and 9% had nonaffective psychosis (Bergink et al., 2016). Ambrosini, Donzelli, and Stanghellini (2012) described personality traits associated with postpartum depression perceived during the perinatal period. The need for perinatal depression screening was proposed to help identify women who are at high risk for developing PPD and to begin treatment antepartum (Ambrosini et al., 2012). The pathophysiology related to perinatal depression shows how changing of hormones may

impact the potential increase in risk for depression in perinatal women and that the chronic stress associated with pregnancy may also lead to an increased chance for perinatal depression (Latendresse, Elmore, & Deneris, 2017). According to ACOG (2017), as many as one in seven women may have perinatal depression or PPD. A global public health study done in 2009 affirmed that PPD is a more significant problem than first thought; the rates globally for PPD are higher than 10%—15% of all pregnant women (Almond, 2009). However, this percentage may be an underestimate of the actual existence of depression, given the social and cultural stigma about mental health (Latendresse et al., 2017).

The postpartum period or puerperal period is considered from immediately after childbirth to 6 weeks post-birth. However, after reviewing the literature, studies are considering pregnancy-related deaths, up to 1-year post-birth as associated with PPD (Palladino, Singh, Campbell, Flynn, & Gold, 2011). A 2001 study showed that only one in five pregnant women who had a previous diagnosis of depression were screened during pregnancy for depression and had documentation of receiving treatment for depression (Kelly, Zatzick, & Anders, 2001). A challenge with a depression diagnosis before pregnancy is that women may not want to continue with treatment, especially pharmacological, due to effects on the fetus (Latendresse et al., 2017). Another study of perinatal clients screened for depression in obstetric settings reported that 20% of those women scored above the cut off (of the depression scale used), but only 13.8% of those women reported receiving any treatment for depression (Miller, Shade, & Vasireddy, 2009). Perinatal depression, in its most serious form, can be a catastrophic but

preventable cause of maternal and infant mortality (Kendig, 2017). According to Rope (2013), one in five women had thoughts of harming themselves during their pregnancies. With screening, these women could have been treated. Suicide is the second leading cause of death in postpartum women, according to Palladino et al. (2011). In a study conducted from 2003-2007 by Palladino, (2011) he determined that there was a pregnancy-associated suicide rate of 2.0 per 100,000 live births, 43% which occurred during the pregnancy and 50% which occurred postpartum. (see Appendix C).

Significance

The indications of perinatal depression and PPD may go unnoticed due to the vague symptoms noted by the women or their unwillingness to discuss it with their provider (Palladino et al., 2011). Some of these symptoms could be related to a normal pregnancy. Symptoms such as changes in appetite, sleep disturbances, and changes in libido could be considered normal changes during pregnancy (ACOG, 2017). Risk factors for perinatal depression are (a) maternal anxiety, (b) life stress, (c) history of depression, (d) lack of social support, (e) unintended pregnancy, (f) Medicaid insurance, (g) domestic violence, (h) lower income, (i) lower education, (j) smoking, (k) single status, and (m) poor relationship quality (ACOG, 2017). According to ACOG (2017), perinatal depression is a widespread complication of pregnancy with potentially overwhelming consequences if it goes unrecognized and untreated. Screening women in the early perinatal period might provide the healthcare practitioner foresight into problems with depression or mental illness before the delivery. Being able to assess the

pregnant woman and treat her proactively could potentially help decrease the problem of postpartum depression. According to Rope (2013),

> Thirty percent of the women who showed signs of depression after delivery had experienced an episode of the condition before pregnancy, 40 percent had one during pregnancy, and more than two-thirds of the women also had signs of an anxiety disorder, the symptoms of which are not often associated with depression. (p. 1)

The United States Preventive Services Task Force's (USPSTF, 2016) evaluation of women who had previously been given an EPDS in primary care offices, and were shown to have depression, were followed and re-evaluated during their pregnancy for depression. A percentage of the women had interventions with pharmacological and counseling visits during the pre-and postpartum phases (USPTF, 2016). There were different variables in effect during these studies, but the results were reasonably consistent across the range of designs, there was a decrease in symptoms of depression noted when the client followed the chosen intervention (USPSTF, 2016).

Potential effects on both maternal and child health represent essential safety issues. Perinatal depression has been associated with adverse pregnancy and neonatal outcomes, including insecure maternal-newborn attachment (Kendig, 2017), eventually ending in increased mental health issues for the mother that could potentially affect the newborn.

The EPDS is the most commonly used screening questionnaire for PPD (Gibson, McKenzie□McHarg, Shakespeare, Price, & Gray, 2009). According to Friesen,

Peterson, Squires, and Fortier (2017), "The EPDS was created specifically to screen for perinatal depression" (p. 1). The EPDS is an exam that consists of 10 self-reported items. The tool takes less than 5 minutes to complete; it has been translated into 12 languages, has a low required reading level, and is easy to score (ACOG, 2015). When choosing a screening tool, cost, availability, ease of administration, and interpretation along with validity and acceptability are some of the characteristics that should be offered (Kendig, 2017). The usefulness of the EPDS is its free availability, simplicity of administration, and its general acceptability to women. Therefore, this remains a useful tool in the field of perinatal mental health (Gibson et al., 2009). In a study done by Friesen et al., the EPDS tool was found to be valid, reliable, and acceptable for perinatal women. Ensuring the use of the EPDS for the DNP project would be effective.

Summary

PPD and perinatal depression are a population health problem that could be prevented or decreased by following the guidelines presented by the ACOG. Perinatal depression is an increasingly recognized maternal mental health problem (ACOG, 2017). Diagnosing and treating maternal mental health issues is critical in providing maternal safety (Kendig, 2017). Due to indicators and expert medical recommendations, the need to create a CPG change by implementing a perinatal depression tool is essential in this OBGYN clinical practice. After meeting with the providers of the OBGYN practice, it was decided to require the EPDS during the early perinatal period, at the confirmation of pregnancy appointment. The EPDS will be part of the intake information for the client at her appointment and will be clarified by the healthcare staff. A protocol has been enacted

for the use and results of the EPDS as a collaborative effort by the DNP student, the practice providers, and healthcare staff. The client and provider will review the EPDS.

Section 2: Theories, Evidence, and Review of Literature

Introduction

The sequence of depressive illness with the onset during the perinatal period, including the severe physiologic and psychological dilemmas which provide unique challenges to this time period, are likely to complicate the identification and management of perinatal depression (Gaynes et al., 2005). In 2016, ACOG recommended depression screening during the perinatal period (ACOG, 2017).

Concepts, Models, and Theories

The nursing theory for the DNP project is Lewin's (1947) change theory. Lewin observed that three stages that need to occur for a change to happen (Mitchell, 2017). The first is *unfreezing*, being able to see, through an evidence basis, the need for a change (Mitchell, 2013). Second is *moving*, when the change is introduced, and third is *refreezing*, making the changes permanent, and establishing the new way (Mitchell, 2013). For this CPG, implementing the EPDS during the early perinatal period is the protocol change.

The nursing process of assessment, planning, implementation, and evaluation is also a process for this CPG. Considering evidenced-based information, from recommendations from ACOG and ACNM, the need for a depression screening to be used during the perinatal period, is essential. Following the assessment, the nurse collaborates with the OBGYN practice providers and nurse leaders to determine how to address this need as a plan. Implementation of the CPG change and evaluation of the change should be included in the client's care. Challenges that can occur during the

stages of change can be resistance from staff, and financial barriers, among other obstacles (Flood, 2017). A good nurse leader is beneficial when discussing changes with staff (Flood, 2017). The EPDS is currently used at the practicum site and it is readily available so there is no extra financial burden. Therefore, the use of a tool, already being utilized by the staff, with their understanding of the tool would be practical to implement, with no added expense to the facility and client.

Relevance to Nursing Practice

The practice of nursing is to improve patient care and safety through evidence-based occurrences (Melnyk, 2013). By using this CPG, the OBGYN practice providers can diagnose and treat clients for depression earlier in their pregnancies, it will provide an improved outcome. Through literature review and studies done on postpartum depression, it is noted that many of the clients should have been given depression screenings during their pregnancies. If the women had been provided with screening during their perinatal period, it might have provided a better outcome for the clients and their families (see Fura, 2014).

Local Background and Context

After discussing this problem with my preceptor, the conclusion was to offer the DNP project as a CPG change. I made suggestion of implementing a perinatal depression screening to all pregnant women during the early perinatal period, and encouraging the recommended implementation from both, ACOG, and ACNM for depression screening in the perinatal period. The OBGYN practice was only providing a depression screening

during the postpartum period. The EPDS tool is currently used at 1-2 weeks postpartum and again at 6 weeks postpartum.

Role of the DNP Student

The role of the DNP student related to this project was to provide evidence-based information on the practice problem of perinatal depression at a local OBGYN practice. I became interested in this project while being involved in precepting nursing students in their obstetrical and gynecological clinical rotations. I am currently a nurse educator for both LVN/LPNs and BSN, RN students. The topic of postpartum depression came up in one of the postclinical discussions. Reviewing articles on perinatal depression, it was evident that many OBGYN clinics and facilities were not adhering to the recommendations of ACOG for depression screening during the perinatal period. Discussing this CPG change with a nurse midwife at the local OBGYN clinic, preparations were discussed to present the implementation of a perinatal depression screening tool.

The role of the DNP student, according to DNP Essentials VII, is to help with "clinical prevention and population health for improving the nation's health" (DNP Essentials, 2006 p. 15). Implementing this CPG will encourage the OBGYN practice to adhere to evidenced based practice changes, from ACOG and ACNM.

Develop Evidence Selection Criteria

In this literature review, I examined the use of a depression screening tool during the perinatal period and explored literature for research that will support the need for perinatal depression screening. I researched studies that discussed the symptoms of

perinatal depression and risk factors that may lead to perinatal depression and the recommended perinatal depression screening tool that was used. Additionally, I researched studies that demonstrated barriers or challenges to the research that may dissuade perinatal depression screening. I also explored research that discussed the use of perinatal depression in different states in the United States and their mandates for perinatal depression screening.

Search Literature Description

Several combinations of search terms were used to search the current literature. Those key terms searches were *perinatal depression, pregnancy and suicide, mental health and pregnancy, postpartum depression, pregnancy related depression screening tools, treatment for perinatal depression, depression tools for pregnant women, baby blues, depression screening,* and *states with recommended or mandated perinatal depression screening and depression*.

These terms were entered into several relevant nursing databases, of CINAHL plus, MEDLINE full text, Google scholar, PubMed, ACOG website, ACNM website, JAMA website NIH, IOM, USPSTF, and perinatal depression blogs. Most of the 28 resources gathered for the review used current literature from within the last 13 years. ranging from 2005-2018. The resources were mainly current peer-reviewed journal articles; however, web articles, radio interviews, and blogs were also accessed to relate to more current personal views.

The overall exclusion criteria for this literature review was maternal depression with an onset greater than one year postpartum and articles not written in English and without an English abstract.

I delineated the sections of the literature review into three parts. I reviewed literature in connection with the need for perinatal depression screening, the qualifications for the use of the EPDS for perinatal depression screening, and the barriers and challenges perceived to dispute the necessity and appropriateness of perinatal depression screening.

Critical Appraisal of the Literature

According to Latendresse et al. (2017), 6-30% of pregnant women have perinatal depression, which corresponds to research in ACOG and the NIH and estimated the problem as one in seven women (ACOG, 2017). ACOG has recommended perinatal depression screening since 2015 and by ACNM since 2003 (ACNM, 2013). However, in the 2003 ACNM recommendations, there were no parameters for screening frequency, tools, or referrals for treatment. The 2015 recommendations by ACOG spelled out screening frequency, the screening tool preferred, EPDS, and the need for treatment and referrals to mental health providers when indicated (ACOG, 2016). Discussions of the research showed that Ambrosini et al. (2012) developed a risk personality scale to define the risk factors for pregnant women in relation to maternal mental health issues, including perinatal and postpartum depression. ACOG and research done by Gaynes et al. (2005) have similar risk factor identifiers. Risk factors specific for perinatal depression are life stress, lack of social support, unintended pregnancy, Medicaid insurance, domestic

violence, lower income, lower education, smoking, single status, and poor relationship quality, research showed that all pregnant women should be screened for perinatal depression, but that women with higher risk factors including depression and perinatal mood disorders warrant more frequent assessment (ACOG, 2016). Recommendations for depression screening at least one time during the perinatal period is endorsed by ACOG, ACNM, and the USPSTF (ACOG, 2017, ACNM, 2013, Siu, 2016). The USPSTF (2016) considers perinatal depression as a preventable and treatable mental health problem, and it recommends a "B" grade for a suggestion of medical practices to offer or provide this service. The "B" grade details that "The USPSTF recommends the service, there is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial" (Siu, 2016, p. 1). In January 2016, a U.S. government panel of medical experts recommended screening for mental health in all pregnant women, previous medical expert panels recommended screening, only if follow up treatment was available (Belluck, 2016). In a study of nearly 9,000 perinatal women who were screened both during the perinatal period and the postpartum period, 7 % or 576 screened positive for depression during the perinatal period (Venkatesh et al., 2016). Venkatesh et al. (2016) conducted their study at a large university; therefore, treatment, both through counseling and pharmacological, had a higher rate of compliance. The study showed that more women were apt to seek and accept treatment during the perinatal period than during the postpartum period (Venkatesh et al., 2016). In a study done by Goodman (2009), the women in the study stated that during the perinatal period, they had more time for treatment, especially if it was the first child. Time constraints and stigma were given

as reasons for not attending treatment after the birth of the child (Venkatesh et al, 2016). The literature supports the need for perinatal depression screening.

Three states have mandated maternal depression screening: New Jersey in 2008; and Illinois and West Virginia, in 2009 (Rhodes & Segre, 2013). The only state with a follow-up evaluation was New Jersey (NJ). A study was conducted by Kozhimannil, et al., and reported on findings of 30,955 perinatal clients from the NJ Medicaid program. According to the study they "found that neither the required screening, nor the educational campaign that preceded it, was associated with improved treatment initiation, follow-up, or continued care" (Kozhimannil et al., 2011, p. 301). Twelve states, including Massachusetts and New York, have tried to mandate perinatal screening but have been unsuccessful due to reimbursement and follow up issues that may have resulted in legal matters (Belluck, 2016).

California bill AB 2193, a bill that was proposed in early 2018, would require OBGYN providers to screen pregnant women for mental health problems and require insurance companies to refer case management programs to help mothers find mental health care (Dembosky, 2018). This bill is being endorsed by women with a history of perinatal depression, who stated that they had wished this proposed bill was in place when they were pregnant. Mental health professionals are also supporting it. Suggestions for treatment of perinatal depression in the Dembosky blog, are counseling, suggested pharmaceuticals that weigh the risk-benefit during pregnancy, and follow-up appointments. Perinatal preventive group therapy interventions were also studied for effectiveness in decreasing symptoms of PPD. This study done by Kosinzky et al. (2012)

conducted a randomized controlled trial for 1,719 perinatal women in 62 antepartum centers. Seven hundred and ten pregnant women were included in a four-week perinatal preventative group intervention therapy session. The control group of over 1,000 pregnant women was given the same information, but in a conventional means, by way of office visits and handouts. Clients who had been diagnosed with depression during this study in 2012 showed a positive outcome with the perinatal preventive group therapy. The therapy provided coaching in stress management, improving coping skills, and developing social support, and it was shown to decrease symptoms of PPD. In an article by Latendresse et al. (2017), they discussed pharmacological treatments for women during both the perinatal and postpartum periods of the pregnancy. The article covered the use of the EPDS, as recommended by the USPSTF, the pathophysiology of depression in pregnant women, the need for differential diagnosis, and the risk-benefit for pharmacological treatment. The article revealed that there is not a recommended treatment for perinatal and postpartum depression, but that an individual approach was advocated. It was concluded in the Latendresse article that although the recommended pharmacological treatment is not without risk, the medications suggested for depression during pregnancy, can be taken relatively safely as an effective treatment. More studies need to be researched in the future for complications of pregnancy and to the fetus with the pharmacological treatment options of depression (NIMH, 2009).

Screening for perinatal depression has shown that the EPDS is an appropriate screening tool. ACOG recommends the EPDS as a valid and sensitive tool for perinatal depression screening, as aligned with the NIH as reliable and sound (Boyd, Le, &

Somberg, 2005). The EPDS is recommended as the screening tool of choice by most researched journals and professional medical organizations ("Screening for Perinatal Depression - ACOG," 2016). The USPSTF also recommends the EPDS as a sensitive and specific screening tool for depression and that the questions ask the perinatal client about depressive symptoms during the previous seven days (Latendresse, Elmore & Deneris, 2017). The EPDS consists of 10 questions, it takes five minutes to complete, it is available in twelve languages, it has a low required reading level and is easy to score ("Screening for Perinatal Depression - ACOG," 2016). In a study using the EPDS during the perinatal period, OBGYN providers were more effectively able to treat and support their clients when they had a definitive EPDS score, cutoff of ≥13 (Wickberg, Tjus, & Hwang, 2005). Six hundred sixty-nine women were included in this study and were given the EPDS questionnaire by 32 midwives, who also evaluated the results of the screening. The results effectually provided a better treatment plan due to the findings of the EPDS.

A barrier for screening for perinatal depression is the resulting recommended treatment. In California (CA), bill 2193 is being reviewed for passage to mandate perinatal depression screening. Obstetricians and Pediatricians are fighting the CA bill, stating that it is difficult to treat the client who's screening is positive for depression, and that follow-up was challenging for the providers to attain (Dembosky, 2018). Many obstacles influenced treatment, including no insurance coverage for treatment, medications prescribed may cause harm to the fetus, long waits for mental health providers, and mental health providers who were not trained in the complex treatment of

pregnant women (Dembosky, 2018). Physicians in CA will be disciplined for not screening. "Because a willful violation of the (CA) bill's requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program" (*Bill Text - AB-2193 Maternal mental health*, 2018, p. 1). The World Health Organization (WHO), has prepared an intervention guide to help mental health providers with specific mental health diagnosis. The mental health providers will have access to this guide, 'mhGAP Intervention Guide,' this guide is a model that has been developed by mental health care providers and integrates the management of significant conditions using protocols for clinical decision-making (WHO, 2010). The guide is designed to help recommend guidelines of treatment for specific non-specialist health settings.

Seventy-eight percent of the clients that screen positive for depression do not get treatment, as described in the blog by Dembosky, which is the reason for being proactive for the CA bill, it is also aligned with the study by Kelly et al. (2001) that only one in five women receive treatment. In the study by Kelly et al., they screened 186 women during their prenatal care appointments with the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire. Of the 186 women, 70 or 38% screened positive for psychiatric disorders, only 23% received treatment (Kelly et al., 2001). ACOG details that the perinatal screening should ensure follow up, and treatment. According to an article in the *Journal for Nurse Practitioners*, depression symptom screening does not decrease perinatal or postpartum depression; follow up is essential (Selix & Goyal, 2018). The provider may be accustomed to prescribing pharmacological treatment, but as stated in this article, a mental health support system must be in place, and a collaborative effort

by healthcare providers must be prepared for screening and treatment of maternal mental health issues (Selix, & Goyal, 2018). In the findings of a study done by Goodman & Tyer-Viola (2010), they discovered that of the 23% of women diagnosed with perinatal mental health issues, only 15 % of them had documented mental health follow-up care. The study was done in 2010 and involved 491 women from a large urban hospital. The conclusion to the study found indications that detection, treatment, and referral of perinatal depression by obstetrical providers was seriously lacking and needed to be addressed (Goodman & Tyer-Viola, 2010).

Barriers to treatment are possible preterm births, clients not following up with treatment, and the cost of the screening and the treatment (Grajkowski, Dolinsky, Abbott, & Batig, 2016). Treatment concerns were concurring with the National Institute of Mental Health (NIMH) through the NIH, that pharmacological treatment for depression can lead to premature birth (*NIMH*, 2009). According to a study in the *American Journal of Psychiatry* (2009), the risk/benefit for treatment must be measured, "both continuous selective serotonin reuptake inhibitor (SSRI) exposure and continuous untreated depression were associated with preterm birth rates exceeding 20%" (Wisner et, al., 2009). This study obtained by blinded review of delivery records and infant examinations, of 238 women, 71 women were exposed to SSRI's. The study concluded with results showing depressed pregnant women, with both continuous SSRI exposure and continuous untreated depression, were associated with preterm birth rates exceeding 20% (Wisner et al., 2009).

In a study conducted by Goodman (2009), she found other barriers to treatment for perinatal depression. She provided a questionnaire to 509 women during their third trimester of pregnancy and asked that if they were diagnosed with perinatal depression, in which form of treatment would they participate. The results showed that 92% of the women would participate in individual counseling, only 35% would take medication, and only 14% would participate in group counseling. In the study, Goodman also found that the most significant perceived potential barriers to treatment were lack of time (65%), stigma (43%), and childcare issues (Goodman, 2009). Not only are cost and medication effects a deterrent to treatment, but also the reasons that prevent the women from participating in treatment. Finding what would be acceptable and preferable treatment is one of the only solutions Goodman found in order to improve depression treatment rates. Discussion of the outcomes of the positive depression screening and the necessary follow-up with the pregnant women's treatment and preferences to treatment needs to be accessed.

The providers in CA, where bill 2193 is being reviewed, were also concerned with costs, as they were not being reimbursed for the testing. Other states have tried to mandate perinatal depression screening, but it did not result in more women being treated (Dembosky, 2018). "Illinois, New Jersey, and Massachusetts have created unique programs that can be used as exemplars for other states looking to create comprehensive programs to address perinatal depression" (Selix & Goyal, 2018, p.123). More government-funded insurance programs are being reviewed for helping to support screening and treatment costs. Some States have created unique programs to address this

problem. In an article by Rhodes and Segre (2013), Perinatal depression: a review of US legislation and law, they assembled an interdisciplinary team of academics specializing in law, as well as perinatal mental health to help examine the subject of perinatal depression in the U.S.. They accessed the states that have mandated perinatal depression screenings, the results of the outcomes of the screenings, and the need for other states to follow legislative mandates. The conclusion of the article details that even though three states have mandated perinatal depression screenings, there is no evidence of these screenings decreasing perinatal or postpartum depression. In 2003 Texas enacted the *Andrea Yates bill*, which mandated perinatal depression education. Between 2000 and 2006, NJ and Virginia joined Texas in adopting mandatory training for perinatal depression, and between 2007 to 2012, nine more States followed the procedure. However, only 24% of the States have legislation that mandates for perinatal depression (Rhodes & Segre, 2013). Having a recommendation from ACOG, ACNM, and the NIH should improve reimbursement for providing the screening for perinatal depression as well as treatment costs. Reviewing other states with similar bills regarding perinatal depression screening, is recommended for an increase in improved screening practices. However, treatment for depression also must be accepted and achievable by the client. In an article by Yu & Sampson, 2016, they conclude that the reason there is a problem with consistency regarding perinatal depression screening across the States is due to discrepancy between policy and practice goals, lack of regulations on capability building among perinatal care providers, and few pathways for creating collaborations between medical providers and

mental health professionals (Yu & Sampson, 2016). Establishment of a protocol for screening and treatment is essential for effective client care.

Research shows a need for perinatal depression/mental health screening. There are treatments that are effective, both non-pharmacological and pharmacological. The risk/ benefit must be measured for pregnant women who need medication treatments. Follow-up for recommended treatment is crucial. If perinatal women are being diagnosed with mental health issues, a plan must be in place for follow-up. A plan of care for positive screenings and treatment will included in the client's medical records for tracking results. Future research may consist of an analysis of interventions that promote social support to pregnant women, the need for specific screening tools for pregnant women, and more research on pharmacologic treatment for pregnant women. State/government mandated screening and treatment with appropriate follow-up and reimbursement for perinatal depression must also be considered.

Summary

The OBGYN practice was only providing a postpartum depression screening at one to two weeks postpartum, and at six weeks postpartum, the EPDS is used for the post-partum depression screening. The DNP project was a CPG change and proposed the implementation of the EPDS tool to assess depression symptoms in perinatal clients. The literature reveals that the implementation of perinatal depression screening is being reviewed by many states in the U.S. to be mandated in future legislation. Insurance providers are also studying evidence-based practice and guidelines for providing perinatal depression screenings. Through ACOG, ACNM recommendations, and a review of current literature, I have encouraged the use of a depression screening tool during the early perinatal period in the OBGYN practice.

Section 3: Clinical Practice Guidelines Development

Introduction

The proposal of this DNP project is promoting a CPG change to include a perinatal depression screening tool, specifically the EPDS, to be given to all pregnant women during the early perinatal period. Boyd et al. (2005) studied the soundness of the EPDS tool and found that it was most appropriate for postpartum women with reasonable psychiatric accuracy and for use during the perinatal period as well. The Appraisal of Guidelines Research and Evaluation (AGREE II) is a tool that was established to create a generic instrument to assess the process of guideline development and reporting of this process (AGREE Enterprises, n.d.). Using the AGREE II to develop the practice guidelines changes has increased the strength of the practice change proposed (AGREE Enterprises, n.d.). This DNP project provided an opportunity to promote the CPG into the current clinical practice at the OBGYN office.

The details of the CPG were presented to the OBGYN practitioner's office at their weekly meeting. Statistics of perinatal and PPD were discussed. The practitioners had wanted to incorporate a perinatal depression screening scale into the practice but had not yet had the opportunity. After I met with the practitioners, I asked for suggestions about the timing of the screening. The screening and treatment plan will become part of the client's electronic health records so that the appropriate follow-up and treatment can be given.

This proposal information has been discussed with the provider's office staff and healthcare professionals for their input. The video documentary *Dark Side of the Full*

Moon (Fura & Silliman, 2014) has been presented to the nurses and staff. The video portrays the evidence and potential tragedy of postpartum depression and the need for perinatal screenings. The staff was included in the project due to their interactions with the clients regarding perinatal appointments, follow-up appointments, and medications prescribed. Ideas had been discussed, and changes had been made as necessary. Challenges that potentially can occur with this proposed clinical practice guideline change, is the noncompliance of the providers and staff. After I met with both providers and staff, statistics were provided to show evidence-based practice information regarding the need for perinatal depression screening during the perinatal period. The need for this practice change is evidenced by literature and recommendations of the ACOG and ACNM. Recommendations for follow-up of the clinical practice change have been made to the providers. The follow up included the practice staff to review the compliance of the guideline change and reorient the staff as needed for the encouragement of implementation of the EPDS tool.

The stakeholders for this project are the pregnant women, their families, obstetric healthcare providers to including physicians, nurse midwives, nurses at the obstetrical clinic, and nurses, staff, and administration at the women's services department at the healthcare facility. If depression or mental health problems are discovered in the perinatal stage, potentially mental health care providers would be stakeholders as well. Collaboration with the stakeholders and end-users have alleviated barriers to the project and prepared them for the implementation.

Description of the Development of the CPG and the Adoption of the Tool

According to the ACOG (2017) the following observations and recommendations were made:

- Although definitive evidence of benefit is limited, the American College of Obstetricians and Gynecologists recommends that clinicians screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool.
- Women with current depression or anxiety, a history of perinatal mood disorders, or risk factors for perinatal mood disorders warrant particularly close monitoring, evaluation, and assessment.
- Although screening is important for detecting perinatal depression, screening by itself is insufficient to improve clinical outcomes and must be coupled with appropriate follow-up and treatment when indicated; clinical staff in obstetrics and gynecology practices should be prepared to initiate medical therapy, refer patients to appropriate behavioral health resources when indicated, or both.
- Women with current depression or anxiety, a history of perinatal mood disorders, or risk factors for perinatal mood disorders warrant particularly close monitoring, evaluation, and assessment. Systems should be in place to ensure follow-up for diagnosis and treatment.

The ACNM (2013) also recommend perinatal depression (PD) screening. Although the ACNM first recommended PD in 2003, it was updated in 2013, but the recommendation lacked specific guidelines (Selix & Goyal, 2018). The Postpartum Support International

(PSI) Legislation, in 2016, was the first entity to present guidelines for perinatal depression screening during the first prenatal visit and also during the second and third trimesters, continuing through the postpartum period, using either the EPDS or the PHQ-9 (Selix, & Goyal, 2018). My CPG was for the EPDS to be given to women during their confirmation of pregnancy appointment. According to the concept in the change theory there are three processes in order to adopt this CPG changes at the OBGYN practice. Unfreezing is the first stage, the OBGYN practice realizes, through evidence-based practice and literature review, the need for the implementation of the depression screening during the early perinatal period (see Mitchell, 2013). The second stage is moving: introducing the implementation of the CPG change, adding the EPDS tool to the OBGYN practice protocol (see Mitchell, 2013). The last stage of the theory is refreezing. I have proposed the implementation of the CPG change to have the EPDS included in the perinatal appointment paperwork, to be made a permanent change, and establish the new procedure (see Mitchell, 2013). The adoption of this tool will become part of the early perinatal appointment's paperwork and part of the permanent chart. The EPDS will be given to the women by the nurse or medical assistant, with an explanation that the practitioner will review the screening tool.

The Expert Evaluation Panel

I assembled an expert panel in the OBGYN field to discuss steps in order to evaluate and promote the CPG. An expert panel focuses on making evidence-based policy judgments needed to direct the implementation of a practice request (Jonas, Crawford, Hilton, & Elfenbaum, 2017). The expert panel consisted of a nurse educator,

RN, MSN who teaches Maternal-Childcare in a BSN program, an RNC-OB (credential in inpatient obstetric nursing), MSN, who has been a nurse manager in Women's Health at various healthcare facilities and is currently the nurse manager of the Women's Health unit at the local hospital, and an RNC-OB, MSN with ten years of experience in Women's Health services at the local hospital, and now is also a nurse educator. This panel is relevant to this Capstone project, given that they all have a stake in the CPG change that will be presented in their practice.

Experts Use of Agree II to Evaluate the CPG and Tool

Agree II is the framework that was used by the expert panel to evaluate the robustness and quality of the CPG. The expert panel has received the review of the literature regarding the need for a depression screening tool as the CPG, and I provided the documented recommendations of nationally accredited organizations that promote perinatal depression screening.

The expert panel was provided with information on the purposefulness and the intention of the CPG. I described the stakeholders of the guideline change and the population who will be affected by the proposal. I provided the panel with information on the appropriateness of the CPG and likely barriers of the CPG that were detected and then the resolutions. I proposed the use of the EPDS as the screening tool because it is available at the OBGYN office. The EPDS is free and it is an easy read and scored tool. Expert panels are the final process used for gaining understanding into what experts believe about the implications of the evidence for a given treatment or practice change (Jonas et al., 2017).

Revision of the Guideline and Tool, Based on Feedback from Experts

Following the expert panel evaluation and critique, I had made changes to my proposed CPG. Relying on the expert opinions and their review of the review of the literature and recommendations of the ACOG, and ACNM, I used their analysis of the CPG and revised it to be more aligned with the Agree II framework, the expert panels suggestions and recommendations of what worked and what will not at the OBGYN practice site. Since the expert panel works with the CPG change during practice, they know the routine of the healthcare staff of the practice, they are able to foresee potential changes that could be made to make the change less stressful, have fewer hindrances, and be easier to implement.

Section 4: Findings and Recommendations

Introduction

This doctoral project was a CPG concerned with evaluating the need for depression screening during the perinatal period. The gap-in-practice was the lack of a guideline in using and addressing a time frame in order to screen for depression during the perinatal period. The Agree II instrument was used to evaluate the CPG. Agree II is a tool created to access the practical quality of practice guidelines (AGREE Enterprises, 2013). Using the AGREE II tool to evaluate this CPG assured that the guidelines were rigorously evaluated and were found sound and that this guideline could potentially be recommended for use at other healthcare facilities. A group of three experts in the obstetrics field of nursing volunteered to evaluate the CPG; they were given the Disclosure to Expert Panelist Form for Anonymous Questionnaires acquired from the Walden University Institutional Review Board (IRB). The expert panel consists of three nurse leaders with proficiency in obstetrics and gynecology disciplines. Panel Expert 1 is a nurse educator, RN, MSN who teaches Maternal-Childcare to BSN students at a local university. Panel Expert 2 is an RNC-OB, MSN, and has been a nurse manager in Women's Health at various healthcare facilities and is currently the nurse manager of the Women's Health unit at the local hospital. Panel Expert 3 is an RNC-OB, MSN with 10 years of experience in Women's Health Services at the local hospital, and now is also a nurse educator. This expert panel was asked to assist me with the evaluation of my DNP project CPG due to their experience in women's health, and they volunteered to complete the AGREE II evaluation. The expert panel was given the CPG proposal and the Agree

II instrument and the user's guide. The expert panel reviewed the six domains and 23 target items of the Agree II tool. Each section was rated by a score from 1-7, with 1 not meeting the criteria of the Agree II item, and 7, the criteria of the item was fully met.

Findings and Implications

The AGREE II scale was used to measure the extent to which a criterion has been fulfilled in the development of the proposed guideline for the use of the EPDS during the early perinatal period. The results of the AGREE II scale are shown in Table 1. The percentage scores are a result of adding up the scores associated with each of the AGREE II's six domains and using the scoring recommended by the AGREE II manual. The expert panel scored the evidence-based recommendations and also provided qualitative comments on the scope, content, and presentation of the guidelines.

Table 1

AGREE II Data for the CPG: Screening for Depression During the Early Perinatal Period

AGREE II Domain	% of Appraiser agreement
Domain 1- Scope and Purpose	94%
Domain 2- Stakeholder Involvement	94%
Domain 3- Rigor and Development	94%
Domain 4- Clarity of Presentation	94%
Domain 5- Applicability	94%
Domain 6- Editorial Independence	86%
Overall Guideline Assessment	92.6%
Recommendation of guidelines for use	100% Yes, without modifications

The results of applying the AGREE II instrument's six quality domains to the CPG were assessed using the questionnaire, which contributed to the data information for this DNP project. The following is a summarization of the AGREE II description and results from Table 1, retrieved from the Appraisal of Guidelines for Research & Evaluation II instrument (2013). Domain 1: Scope and practice, the CPG should show that the health question and overall objectives of the guidelines were specifically described (AGREE Enterprises, 2013). Comments from evaluators on Domain 1 related that the objectives were clearly described, the healthcare concern and question were clearly defined, and that the client population was clear to the readers. Domain 2:

Stakeholder involvement, ensures that all personal relevant to the project and clients affected by the guidelines were included in the development of the guidelines (AGREE Enterprises, 2013). Domain 3: Rigor of development confirms that evidence-based sources were used to develop the CPG and that there is a relationship between the sources of evidence and the recommendations of the CPG (AGREE Enterprises, 2013). Comments for Domain 3 detailed that the benefits and risks of the CPG were fully discussed, and that an expert panel reviewed the material prior to publication. Domain 4: Clarity of presentation, discusses that the recommendations of the CPG are specific and identifiable and that healthcare options are presented for the CPG (AGREE Enterprises, 2013). The comments for Domain 4 clarify that the recommendations described in the CPG were clear and specific to the project. Domain 5: Applicability, tools for the CPG are present and barriers to the application were discussed (AGREE Enterprises, 2013). Comments for Domain 5 were that the tool that was recommended for application to practice was discussed and furnished the guidelines on how and when to use the tool were provided. Domain 6: Editorial independence, describes that there are guidelines in place to prevent a conflict of interest in either the funding or competing interest of the CPG (AGREE Enterprises, 2013). Domain 6 was graded the lowest score, with an average of 86%. The reviewer was either not able to extract the source of the funding or was not able to assess any conflicting interest of the CPG. This CPG's overall guidelines assessment had a 92.6% overall appraiser agreement, "the data for 'Overall Guideline Assessment' can be calculated with high reliability using a standardized score" (Seto, 2017, p. 716) of the six domains.

The project goal was to evaluate the need for the use of the EPDS during the perinatal period and it was met. IRB approval was achieved, and no human subjects were involved in this project.

Revision of CPG Based on Recommendations

The findings of this DNP project confirmed, through the use and results of the AGREE II tool, that there was a gap-in-practice of OBGYN providers not using a depression screening during the early perinatal period. Both the ACOG and the ACNM recommend the use of a depression screening tool during the perinatal period (ACOG, 2017). The CPG solution to this gap-in-practice was the necessity of providing a depression screening tool, specifically the EPDS questionnaire, to be given to women during their early perinatal period. The CPG has been developed and, once implemented, guidelines will be in place for the use of the EPDS, with recommendations for the timing of the screening.

A revision of the CPG, specifically domain # 6, editorial independence, was addressed due to the comments by the expert panel. Complying with recording and addressing any competing interest and funding have not influenced the CPG. The writer of this CPG does not have any influence over the implementation of the use of the screening, and the EPDS is a free screening tool available on the internet.

Key stakeholders for this CPG are the practitioners, healthcare employees at OBGYN practice offices, and perinatal clients. The practicum site referred to in this CPG has three full-time OBGYN physicians and five Certified Nurse Midwives. The main OBGYN practitioner at the practicum site was very complimentary to the need and

overall quality of the CPG project. She is willing to proceed with implementing the CPG, with one change in mind. The practice would change the early perinatal depression screening tool to be used at the 12-week appointment instead of the confirmation of pregnancy appointment, as portrayed in this DNP project. The OBGYN practice did not have the depression screening ordered during the perinatal period, which was the gap-in-practice that prompted this DNP CPG project. As per the main OBGYN practitioner at the practicum site, the EPDS screening will be part of the intake form for OBGYN clients during their 12-week check-up appointment. It will become part of the client's healthcare records.

Overall safety for the perinatal client is the most important reason for this CPG. The news conveys frequent reports of perinatal and postpartum depression related to violent incidences. If by implementing this CPG, it can help one mother and fetus from a tragedy, then this project will have been a success.

Strengths and Limitations of the Project

The strength of this DNP project was the ongoing involvement of the leadership and expert panel members. They assisted in the commitment to develop a guideline for this gap in practice. The overall quality of this CPG was given the highest possible grade from the expert panel. Overall guideline assessment by the expert panel recommended the CPG by 100% agreement. Comments were that there is a much-needed application of available tools/ information in the specified client population and that for one reviewer who recently had a joint commission survey, stated that the surveyor also noted the need

for this CPG in the gap in practice for client safety in the necessity of a perinatal depression screening.

The limitation of this project was that this practice guideline was developed for a small private OBGYN practice in a suburban Texas town. State regulations and guidelines may vary from state to state, private versus public practice, and the size of the practice. As a result, this CPG may need to be modified or adapted to be appropriate for various OBGYN practices in other states. However, the guidelines followed for this CPG were recommendations from American associations of ACOG and the ACNM.

Recommendations for future projects with a similar topic could include screening antenatally for depression and mental health issues so that practitioners would be more alert to providing depression screenings during the pregnancy. “Although there are risk factors for perinatal depression and interventions exist that may help prevent perinatal depression, the effectiveness of these interventions and the subpopulations who could most benefit need further evaluation” (OConnor, Senger, Henninger, Coppola, & Gaynes, 2019, p. 589).

Section 5: Dissemination Plan

According to Zaccagnini and White (2011), there are two purposes to disseminating the results of a DNP project: (a) report the results of the project to the stakeholders and leaders and (b) share them with other professionals in similar settings. The information and data obtained in this DNP project were disseminated to the practicum site experiencing the gap-in-practice. The dissemination of this project included presenting the CPG to a local OBGYN practice office for review and eventual integration of the guidelines. The results of the CPG DNP project were reviewed with key stakeholders of the practicum site as well as the nurses and staff.

The audience for this CPG DNP project was the OBGYN practitioners, office staff, and pregnant clients. The purpose of this CPG was to propose the use of a depression tool during the early perinatal period. The use of the EPDS tool has been established as a reliable tool for use during the perinatal period (Gibson et al., 2009). With the assistance of the expert panel and the evaluation of the CPG with the Agree II tool, this will give acceptance and provide an evidence basis for the need for this practice change.

The key stakeholders, practitioners, and staff members will benefit from the findings because the information provided to them is in the form of a poster presentation, available at the practicum site. Another option for the dissemination of this DNP project would be to submit an abstract to a scholarly journal for a potential article publication. Publishing this DNP project in a scholarly journal would allow for broader dissemination and would inform others beyond the scope of nursing. The information acquired from

preparing and developing the CPG will be beneficial to individuals interested in preventing depression during the perinatal period.

A CPG can improve the quality of decisions made by clinicians. The guideline offers a clear recommendation based on evidence-based practice. A CPG can improve the consistency of care and provide reliable recommendations that support the practitioner's concerns about the appropriateness of their medical treatment policies. Guidelines based on evidence-based practices can clarify which interventions are proven beneficial and verify the quality of the supporting data (Woolf, Grol, Hutchinson, Eccles, & Grimshaw, 1999). Dissemination of this DNP project to similar OBGYN practices and women's healthcare facilities would provide an evidence basis for providing perinatal depression screenings.

A CPG can help patients by influencing public policy (Woolf et al., 1999). Guidelines call attention to less recognized health problems and preventive interventions. Services that were not previously offered to patients may be made available as a response to newly released guidelines and CPG's that are developed with attention to the public's benefit can promote equal fairness, and advocate for better delivery of services (Woolf et al., 1999). According to the USPSTF's most recent recommendations, there is a moderate net benefit for perinatal depression screening leading to counseling interventions to prevent perinatal depression (OConnor et al., 2019). There are many resources and documentation for postpartum depression, but a limited amount on perinatal depression. Perinatal depression is a less recognized health problem, but with true preventative recommendations and interventions acknowledged by the USPSTF.

Analysis of Self

The reason I chose this topic was that I felt there was limited information regarding depression screening during the perinatal period. The gap in literature shows a lack of evidence-based practice regarding perinatal women and depression screening. With the promotion of this guideline, I hope to increase the use of depression screening to perinatal women in OBGYN practices, in order to expand this critical CPG. I believe this guideline would be beneficial to others outside of my practicum setting and by submitting this CPG to a peer-reviewed nursing journal with a focus on the topic of obstetrical nursing.

My role at this time is to continue to educate the practitioners, nurses, staff involved in caring for pregnant women as well as the clients, in order to provide a safer environment for the pregnant woman, her infant, and her family. As a nurse educator, I will also discuss the CPG DNP project and the outcomes I have discovered after researching this topic with my nursing students. I have shown the documentary, *Dark Side of the Full Moon* (Fura & Silliman, 2014), during my maternity course, and I will continue to do so. I have had many students comment on this documentary that they had not realized the ramifications and the actual disease process of depression during and after pregnancy.

Summary

After reviewing the results of the AGREE II score and discussing the findings with key stakeholders of the practicum site, I have begun to develop a final narrative of

the DNP CPG project. Through research and discussions, the need for this practice change was evident. Preceptors and key stakeholders had been discussing the need for the proposed project. Guidance was needed to assist in formulating a practice guideline for this gap-in-practice. ACOG and ACNM have recommendations for the necessity for a perinatal depression screening, but it was not a regulation. OBGYN and women's health practices were meant to interpret the recommendations as needed. After reading blogs and articles from pregnant and post-partum women, it was obvious that a reliable guideline was needed.

Throughout this project, I worked closely with nurses and practitioners from the practicum site. According to Melnyk (2013), the DNP scholarly project should focus on translating "research findings into clinical practice or policy to positively influence health care and patient and policy outcomes" (Melnyk, 2013, p. 444). The focus of the CPG was to propose the use of a depression screening tool during the early perinatal period. Sharing the developed clinical practice guideline with the practicum site may increase the likelihood of them adopting evidence-based practices and improved patient care practices regarding depression screenings.

This DNP project was a CPG that addressed a gap in practice and proposed to provide a safe resolution for perinatal clients. The lack of guidelines in using a depression screening tool during the perinatal period is not only a national priority but also an international one, as discussed on the World Health Organization's website for maternal health and the research done for this project. The project outlined the gap-in-practice seen at the practicum site, and the need to present the ACOG's recommendations

to use a depression screening tool during the perinatal period. The goal of this DNP project was to develop the CPG for use at the practicum site. Safe management of the client is the optimal outcome for all clients in order to achieve better treatment outcomes. The practicum site is associated with a mid-sized medical facility, including a large women's health department. Dissemination of this CPG to key stakeholders at the medical facility, including the nurses and staff in the Women's health department, benefited from the evidence-based outcome of this proposal.

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Appendix A: Proposed Clinical Practice Guideline Change

All pregnant women in a rural OBGYN office in South Texas will receive the Edinburgh Postpartum Depression Screening tool during the early perinatal period; ‘confirmation of pregnancy appointment. The proposal will be reviewed by an expert panel of healthcare professionals with specialties in the OBGYN practice and by using the Agree II framework.

Appendix B: Edinburgh Postnatal Depression Scale (EPDS)

Name: Date:

We would like to know how you are feeling. Please UNDERLINE the answer which 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 No, not very often No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

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, 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

Reference: Cox, Holden, & Sagovsky, 1987

Appendix C: Pregnancy-associated Suicides[*]: Demographics compared to all Live Births

	Pregnancy-Associated Suicides[a] *n* (%)	Live Births n (%)	p
Age			
15–19	12 (12.8)	456,478 (9.5)	0.27
20–24	18 (19.1)	1,153,503 (24.1)	0.26
25–29	19 (20.2)	1,296,074 (27.1)	0.13
30–39	29 (30.8)	1,746,560 (36.5)	0.25
40–54	16 (17.0)	132,660 (2.8)	<.01
Race/Ethnicity[c]			
Non-Hispanic White	70 (74.5)	2,837,502 (59.4)	<.01
Non-Hispanic Black	11 (11.3)	845,448 (17.7)	0.10
Hispanic	7 (7.2)	780,470 (16.3)	0.02
American Indian	5 (5.1)	76,131 (1.6)	<.01
Unmarried	57 (58.8)	1,267,030 (34.7)	<.01

[*]pregnancy-associated=deaths occurring during pregnancy or the first year postpartum
[a]*n*=94
[c]cells suppressed for other races due to low number of cases; Asian/Pacific Islander
Reference: Palladino et al., 2011