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POSTNATAL SUPPORT SERVICES FOR INTENDED PARENTS:

A GAP ANALYSIS

JEAN SALERA-VIEIRA

RHODE ISLAND COLLEGE

Executive Summary

In 2015 there were nearly 11,000 babies born in the state of Rhode Island (RI) (March of Dimes, 2018). Most of those births occurred at one healthcare system; a large maternity care teaching hospital, where postpartum (the time immediately following birth up to six weeks) support services for mothers, including mental health services are offered to recently delivered mothers and their families. A review of the RI perinatal hospital public websites affirms postpartum support groups and services for mothers, including breastfeeding support groups and postpartum support groups. Hospital-based support services for individuals who become parents through surrogacy or through a gestational carrier, defined as intended parents, are not apparent on the hospital websites. Intended parents are defined as the intended recipients of the infant carried by another in a surrogacy arrangement (Gugucheva, 2010). The woman carrying the infant may be a traditional surrogate, contributing her own egg, or a gestational carrier who does not contribute her own genetic material to the pregnancy. There is a gap in postpartum, or postnatal, services for intended parents. While the population of intended parents who deliver in RI is only 0.08 percent of the total deliveries, support services should be available to assist in the transition to parenthood for parents from all paths of life.

The purpose of this project is to identify the gaps in postnatal support services for intended parents, and subsequently develop a plan for population specific postnatal support. Short-term objectives of this project include identification of gaps in postnatal support services for intended parents at the local level and increasing the awareness of the specific postnatal needs of this population through discussions with perinatal colleagues and those who provide services to postnatal parents. Long-term objectives include

identification of gaps in postnatal support services for intended parents at the national level and completion of a business case for population specific postnatal support services. A comparative analysis of the status of postnatal support services for intended parents in RI with at least two other perinatal care settings will be conducted in preparation for the creation of the business case for population specific postnatal support services.

Through discussion with a larger audience of perinatal professional colleagues and dissemination of the project findings, the expected outcomes of this DNP project include an increased awareness within the perinatal community of a gap in postnatal support services for intended parents. Awareness of a gap in services will start the conversation among perinatal professionals regarding what services should be put into place to provide the appropriate supports. On a national level, expected outcomes include awareness of the need for postnatal services for intended parents. Oral presentation of the findings and dissemination through publication is planned. The dissemination will describe the gap in services and the plan for population specific postnatal support services, providing a platform for dialogue at the local and national level. Most importantly, the increase in awareness and design of appropriate services will help intended parents on their transition to parenthood and potentially decrease the risk of difficulties with the transition, including potential postnatal depression.

Acknowledgements

The fruition of this Doctorate of Nursing (DNP) project would not be possible without the support, guidance, and mentorship of nurse leaders, researchers, and teachers. First, it is with deepest gratitude that I acknowledge the faculty and readers who have tirelessly reviewed this work. Dr. Sylvia Ross, a dear colleague, is a leader of best practice in the field of maternal child health. Dr. Carolyn Wood, a long-time mentor, is a leader in educational practices within the perinatal field. Dr. Lauren Thorngate, a neonatal clinical nurse specialist, is a leader in research methods in the neonatal and perinatal fields. Thank you for lending me your expertise throughout this process.

Secondly, I am grateful for the continued guidance of Dr. Marie Wilks throughout the DNP course of study. Her patience as we worked through this program kept me on track and moving forward. Other mentors who were instrumental in guidance throughout the DNP include Dr. Joanne Costello, for which I am very grateful.

Mentoring a nurse throughout their career is a very special role. I would like to take a moment to mention one of my most instrumental mentors, Patricia Beezer. Professor Beezer exemplified professional nursing and nursing education. She served as a constant reminder of the pinnacle for which to strive. Although she is not here to witness this project completion, I know that she is here in spirit continuing to guide my practice.

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Postnatal Support Services for Intended Parents:

A Gap Analysis

Statement of the Problem

Intended parents may be single or married and live in the United States (US) or have traveled to the US from other countries. In the US, the trends of becoming parents through gestational surrogacy and the use of assisted reproductive technology (ART) are increasing (Perkins, Boulet, Jamieson, & Kissin, 2016). While the number of intended parents who deliver in RI may be small, this is a growing population with potentially specific postnatal needs. While the literature review will show social support as a strategy to decrease the risk for postpartum depression for mothers and fathers, the risk for postpartum/postnatal depression could be extended to intended parents, although there is a gap in the literature specific to transitioning to parenthood for intended parents. The gap extends to postnatal support services for intended parents.

In the hospital setting in RI during the intrapartum and postpartum time periods, the surrogate/gestational carrier and the newborn are considered the “patients” at the hospital. If the hospital has received the legal document called a *pre-birth order* prior to the delivery of the newborn, the intended parent(s) can make all medical decisions regarding the care of the newborn. The hospital staff teach the intended parent(s) about newborn care. The attorney that represents the intended parent(s) assists with any additional legal paperwork, helps the family find a place to stay while in Rhode Island, and assists with securing a passport for the newborn should the family reside in another country. The intended parents will often take the baby to see a local pediatrician prior to leaving RI.

The aim for this project is to highlight the gap in supportive services for intended parents in the postpartum period. The primary question for this Doctorate of Nursing Practice (DNP) project is *what are perinatal professionals doing to support all intended parents, be they single, married, live locally, or live in another country?*

The state of Rhode Island has several programs designed for supporting parents through home visits, including the *First Connections* home visiting program (Rhode Island KIDS COUNT [RI Kids Count], 2018, p. 4). First Connections is one of the services offered by the Office of Family Visiting at the Rhode Island Department of Health to provide care to families that improves outcomes (Rhode Island Department of Health [DOH], 2019). While certain parents may qualify for a First Connections home visit, this is a voluntary program designed for a short-term home visit which includes screening for maternal depression in most families visited (RI Kids Count, 2018, p. 4). All families who have their baby in Rhode Island are eligible. Identification of those families eligible for a First Connections home visit occurs at each birthing hospital within the state. Some families are offered a visit but may decline.

Depression after the birth of a baby can have devastating consequences for the family, including impact on the infant's development and health (Earls, Yogman, Mattson, & Rafferty, 2019). Current literature supports screening mothers for depression during the perinatal and postpartum period. More recent literature emphasizes the importance of screening partners/fathers of the baby as well (Earls et al., 2019; Freitas, Williams-Reade, Distelberg, Fox, & Lister, 2016). Research has found that adoptive parents may also experience depression post-adoption (Foli, South, Lim, & Hebdon, 2012, 2013, 2016; Foli, South, Lim & Jarnecke, 2016; Hebdon, Foli, South, & Lim,

2012; Levy-Shiff, Bar, & Har-Even, 1990; Levy-Shiff, Goldshmidt, & Har-Even, 1991). Social support during the transition to parenthood, especially in the immediate postpartum period is one strategy described in literature as a protective factor during the transition to parenthood for adoptive families, as well as biological families (Evans, Donnelle, & Hume-Loveland, 2012; Foli et al., 2013; Levy-Shiff et al., 1991; Negron, Martin, Almog, Balbierz, & Howell, 2013). There is a gap in literature addressing the postnatal supports to assist with the transition to parenthood for the population of intended parents, and the potential risk for postnatal depression.

Purpose Statement

Social support is a strategy to decrease depression after childbirth. A review of the literature demonstrates the need to provide social support to all parents as a strategy to decrease depression after becoming new parents (Emmanual, St. John, & Sun, 2012; Evans et al., 2012; Foli et al., 2013; Levy-Shiff et al., 1991; Negron et al., 2013).

The purpose of this project is to identify the gaps in local postnatal support services, as well as gaps in services in other areas of the country where intended parents seek to deliver their newborn. A plan for a population specific postnatal support program will then be created.

Needs Assessment and Literature Review

Having a baby is a life transition. As parents are getting to know their baby, and learning to care for their baby, they are adjusting to their new role as a parent. Providing support to parents is a strategy to aid in the transition to parenthood. Support may also serve to identify more serious issues that may arise following the birth of the baby prior to such issues causing a substantial impact on the family. The American Academy of

Pediatrics (AAP) recently published a technical report on management of perinatal (defined as the weeks before and after childbirth) depression which also included detailed descriptions of the ramifications of untreated perinatal depression (Rafferty, Mattson, Earls, Yogman, & Health, 2019). Maternal depression can impact the infant's social and emotional development and could lead to short-term and long-term delays in cognition and intellect, as well as difficulties with attachment (Earls et al., 2019; Rafferty et al., 2019). The AAP recommends that pediatric providers screen mothers for depression at one, two, four and six-month well child visits (Earls et al., 2019, p. 4). The stress of becoming a new parent not only affects mothers but can also affect partners/fathers as well. Parental stress is found to contribute to postnatal depression in both mothers and fathers (Anding, Rohrle, Grieshop, & Schucking, 2016, p. 304).

Paulson and Bazemore (2010) report that paternal depression positively correlates with maternal depression (p. 1968). Gawlik et al. (2014) found depressive symptomatology in fathers during the prenatal and postnatal periods. An integrative review on studies conducted on postnatal depression in fathers found that a history of depression was one risk factor for postnatal depression in men (Edward, Castle, Mills, Davis, & Casey, 2015), furthermore the presence of maternal depression during the perinatal period also influenced whether fathers became depressed postnatally (Edward et al., 2015). A meta-analysis found that the estimated prevalence of paternal depression is approximately eight percent during the peripartum period (defined as the time before or immediately after childbirth), with prevalence varying based on maternal depression and study location (Cameron, Sedov, & Tomfohr-Madsen, 2016, p. 196). Paternal depression may compound the effects of maternal depression on the newborn (Rafferty et al., 2019,

p. 9), leading to the AAP recommending that partners/fathers be screened for depression at the six-month well child visit (Earls et al., 2019, p. 4).

Depression in adoptive parents was first recognized in the mid-1990s (Foli et al., 2016) with symptoms described as “panic, anxiety, and depression” (Bond, 1995, as cited in Foli et al., 2016, p. 210). Defined in the literature as *post-adoptive depression*, various studies have sought to define the prevalence of depression in adoptive mothers and fathers (Foli, et al., 2012, 2013, 2016; Foli et al., 2016; Hebdon, Foli et al., 2012; Levy-Shiff, Bar, & Har-Even, 1990; Levy-Shiff et al., 1991). Levy-Shiff et al., (1991) compared the stress related to transition to parenthood of biological parents to adoptive parents. Findings support that family adjustment for adoptive parents is as stressful as with biological parents. Moreover, Foli et al. (2013), maintains that lack of social support is a risk factor for paternal depression in adoptive fathers as it is with biological fathers (p. 418). Adoptive parents may feel pressure to be “perfect parents”, holding high expectations due to the long process of adoption (McKay & Ross, 2010, as cited in Foli, Hebdon, Lim & South, 2017, p. 484). This pressure, along with the potential financial burden of adoption, and adjustments to the stressors of parenthood contributes to the stress for post-adoption parents, increasing the risk of depression in the postnatal period (Foli et al., 2017).

The National Perinatal Association (NPA) position statement on depression and mood disorders, clearly states “Evidence reflects that fathers, partners, and other non-gestational/non-biological parents (e.g. foster and adoptive parents) are also affected by the stress of having a newborn and may experience anxiety and depression” (NPA, 2018, Fathers, partners, and non-gestational parents, para. 1). Intended parents are considered

non-gestational and could be included in this position statement as well. However, most professional organizations only recommend screening biological mothers for depression during the perinatal period (American College of Obstetricians and Gynecologists [ACOG], 2015; Association of Women's Health, Obstetric and Neonatal Nurses [AWHONN], 2015; (US Preventative Services Task Force [USPSTF], 2019).

Social support programs for new parents traditionally provide support to biological mothers.; e.g. breastfeeding support group, or a postpartum/new mothers group. The support groups may be in-person or through an online group (Evans, Donelle, & Hume-Loveland, 2012; Sawyer et al., 2017). Sawyer et al. (2017) suggest that online postpartum support groups may be effective in providing women with a safe environment to receive support. Social support, including peer support, is a preventative strategy for postpartum depression (Evans et al., 2012; Negron et al., 2013). Emmanuel et al. (2012) found that social support is predictive for a higher quality of life during the perinatal period. A systematic review of interventions to reduce stress in postpartum women revealed that postpartum interventions should include programs for stress management (Song, Kim, & Ahn, 2015, p. 190). To help with the transition to parenthood, nurses can assist mothers with recognition of support needs, focusing on social support (Negron et al., 2013). In a secondary data analysis of *Pregnancy Risk Assessment Monitoring System* (PRAMS), home visits to pregnant women at risk for developing depression decreased the odds of developing postpartum depression (Ruyak, Flores-Montoya, & Boursaw, 2017), providing further evidence that support for women at risk improves outcomes for mothers in the postpartum period.

The concept of social support for new fathers is also present in the literature. In 2007, Kim and Swain discussed paternal postpartum depression and stressors on fathers during the postpartum period and providing support as one intervention to aid in the transition to parenthood (Kim & Swain, 2007). As previously reported, lack of support is one risk factor for depression in biological and adoptive fathers. Freitas et al. (2016) point to employer supports that are family friendly for fathers as one protective factor, as well as others (p. 134). Support groups for new fathers are not readily apparent on local hospital websites, creating a gap in potential interventions to assist family members other than the mother with the transition.

After an extensive search no literature was identified that touched solely on the postpartum psychological stressors of intended parents. There is literature examining the trends of gestational surrogacy and the outcomes of the births (Perkins, Sahy, & Beckett, 2016). In the Netherlands researchers sought to understand the support that intended parents needed as they entered in to cross-border surrogacy arrangements (Hammarberg, Stafford-Bell, & Everingham, 2015). However, there is no mention of the intended parent's postnatal needs. A search for literature on surrogacy (defined as when a woman carries and delivers a baby for another person(s)) identifies research on the relationship between intended parents and surrogates (Blake et al., 2016; Braverman and Corson, 1992). What appears to be consistently lacking in the contemporary body of literature is discussion of what the intended parents need to successfully transition to new parenthood. There is a need to develop population specific postnatal support services; i.e. intended parents. Providing the appropriate support for the intended family during the transition to parenthood, provides a potential strategy to decrease the risk of postnatal

depression. Appendix A outlines the potential pathway leading to postnatal depression in intended parents.

Theoretical Framework

Mercer's Theory of Maternal Role Attainment and Foli's theory of Postadoption Depression provide the theoretical foundation for this DNP project. Both theories underscore the importance of support to parents as they transition to parenthood, especially parental role achievement. While Mercer's theory provides guidance on supporting parents through the stages to parenthood (Meighan, 2006; Noseff, 2014); Foli's theory supports the consideration that non-biological parents need supports during the transition (Foli, Lim, South, & Sands, 2014).

Mercer's Theory of Maternal Role Attainment

Ramona T. Mercer's Theory of Maternal Role Attainment (MRA) considers the process and stages of becoming a mother (Meighan, 2006; Noseff, 2014). Mercer's work expands on Reva Rubin's theory of maternal role attainment, which was first developed in the 1960's (Noseff, 2014). Mercer describes four stages of becoming a mother – the anticipatory stage, the formal stage, the informal stage, and the personal (or maternal) identity stage (Meighan, 2006; Mercer, 2004; Noseff, 2014;). The four stages are based on Thornton and Nardi's work on role acquisition from the mid-1970s (as cited in Mercer, 2004). There are many concepts that are part of MRA, including maternal role attainment, maternal identity, overall and mental health status of the mother, relationship between parents, conflict and strain within the role, as well as the infant's temperament and health (Meighan, 2006; Mercer, 2004; Noseff, 2014).

Mercer's four stages offer detailed descriptions of maternal role attainment (Meighan, 2006). The first stage, the anticipatory stage starts during pregnancy when the mother is preparing for birth. The mother adjusts to the psychological and social expectations of the role, develops a relationship with her fetus, daydreams about the role, and role-plays (Meighan, 2006, pp. 612-613).

When the infant is born, the formal stage commences. This stage also includes learning about and taking on the role, the mother is guided by formal expectations of those in her social system and experts on mothering skills (Meighan, 2006; Noseff, 2014). During the informal stage, the mother begins to develop and use her own judgement about caring for the infant. It is during this stage that the mother fits this new role into her lifestyle drawing on her wisdom of the past and goals of the future (Meighan, 2006; Mercer, 2004; Noseff, 2014). Finally, the mother enters the personal or maternal identity stage when she internalizes the role. In the personal stage the mother feels a "sense of harmony, confidence, satisfaction in the maternal role, and attachment to her infant" (Mercer, 2004, p. 227). Maternal and infant variables influence the stages of maternal role attainment, including social support, relationships between parents, functionality of the family, temperament of the infant, and health status (Mercer, 2004).

Foli's Theory of Postadoption Depression

Foli's Theory of Postadoption Depression (Foli's Theory) is a middle range grounded theory on depression in parents after adoption (Foli, Lim, South, & Sands, 2014 p. 14). Postadoption depressive symptomatology may occur related to unrealized societal expectations of the adoption, or those of becoming a parent, or the child (Foli, 2010, p. 395). Foli reports finding unmet parental expectations following adoption with parents

feeling alone or letdown after placement of the child and across time, stating that parents reported “I’m not ready for this” or “this is not what I expected” (K. Foli, personal communication, February 8, 2019).

Mercer’s and Foli’s theories provide the foundation for this DNP project, and the need to provide support to all parents as they transition to parenthood. While Mercer’s theory provides guidance on supporting parents through the stages to parenthood, Foli’s theory supports the consideration that non-biological parents need supports during the transition.

Project Objectives

The short-term objectives of this project include identifying gaps in postnatal support services for intended parents at the local level and increasing awareness within the local perinatal community of the specific postnatal needs of this population. Long-term objectives include identification of gaps in postnatal support services at the national level through a survey of nurses who self-identify as postpartum nurses and are members of the Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN). Completion of a business case for population specific postnatal support services is a second long-term objective.

Project Plan

Scope of the changes

The changes anticipated at the completion of this DNP project include an increased awareness within the community of perinatal professionals regarding the need for postnatal support for intended parents after determining a gap in current postnatal services for this population. Identification of the need to add depression screening during

the postnatal period for intended parents will also be addressed. A business case for the creation of support services for intended parents will be developed. The timeline for the project, creation of the business case, and presentation to the academic community are outlined in Appendix B using the Gantt timeline process (Smartsheet, 2018). At the completion of the project, the business case will be disseminated to community stakeholders through a variety of venues including professional nursing organization meetings, poster presentations, and one-on-one conversations. Additionally, dissemination will occur through publication and presentations within the perinatal community to increase awareness as to the gap in services and the need for increased support for intended parents.

Setting

As a clinical nurse specialist and doctoral student who has collaborated with members of the perinatal professional community locally and nationwide, expert clinical knowledge and extensive professional experience serves as a foundation for this DNP project. The initial steps of the project take place within the local Rhode Island (RI) perinatal and legal community.

Utilizing the current literature, extensive conversations with other professionals involved in the care of intended parents and a local attorney who works with this population who provided insight into the legal advocacy and support that intended parents receive in RI, a survey was developed. After several reviews from pre-identified academic community mentors, a research proposal was put forth to the Rhode Island College (RIC) Institutional Review Board (IRB) for approval. Once the proposal was confirmed in September of 2019, a survey was sent to a randomized sample of self-

identified postpartum nurses who are members of AWHONN and live in the United States. During the survey development, the initial conversations with stakeholders at AWHONN supported the development of a survey for postpartum nurses.

The target audience for the findings of this project includes individual and corporate stakeholders. Individual health care providers, including nurses, advanced practice providers, and physicians, could incorporate the appropriate postnatal education and supports into their practice. Health care executives who lead a corporation serving the population of intended parents receiving care could use the planned business case to develop population specific postnatal services. Publication of the findings of the survey results and findings of the project will assist in reaching a large audience of stakeholders.

Tools/measures

A mixed-methods design survey was developed to meet the long-term objective of identification of the gap in postnatal services for intended parents and was created by this DNP student and vetted by other professionally experienced nurse mentors in the academic community. The final version of the survey and was then uploaded to the web-based survey tool Qualtrics^{®XM} and was distributed to a random selection of AWHONN members (Appendix C).

AWHONN randomly chose 2,000 nurses from the more than 7,000 nurse members who self-identify as mother/baby (postpartum) nurses. Electronic letters, serving as the IRB approved informed consent, were then sent to the 2,000 randomly selected members during a two-week time period in November of 2018 (Appendix D). One-hundred and seventy-one respondents viewed the survey (response rate of 8.5%), with 167 respondents starting the survey. The initial question was a qualifier and

indicated whether a respondent should go forward with the survey. The total “yes” responses to the first question were 125, leading to a survey completion rate of 6.3%.

The design of the survey questions was to gather information from respondents regarding the postnatal support services that were offered to mothers, fathers, or both, as well as to intended parents. Additional questions were designed to garner information on postnatal depression screening and on what postnatal depression scales were most frequently used, if any.

Project Tasks

Project tasks follow the recommended steps of a DNP project, as well as the steps to analyze and disseminate survey data. An academic podium presentation is planned for spring of 2019, with manuscript submission to perinatal professional journals planned for later in 2019 (Appendix B).

Resources and Supports

In Rhode Island (RI) there are numerous local support groups and systems currently in place to support mothers during the postpartum period, including hospital based postpartum and breastfeeding support groups. The location and format of the various groups can be found on hospital websites, offering support to new mothers. The website of the largest birthing hospital in RI (approximately 8,000 births) lists a support group for mothers, outpatient lactation services, and a day program and outpatient services for women with mental health needs. A more thorough examination into the support group area of the website brings the reader to a page for “new or expectant parents support groups” where one support group is for new mothers and the other support group is for “single women and lesbian couples who are building a family

(Women and Infants, 2018a). Based on this nurse author's clinical experience and a review of the hospital websites, there is a gap in services for new fathers and intended parents.

Several hospitals have a "warm line" that provides parents with answers to questions. The Warm Line at Women and Infants (WIH) encourages parents to call with any questions (WIH, 2018b). The WIH Warm Line site uses the word 'parents' to encourage all parents to call. However, an on-line review of the various RI birthing hospital websites shows that most hospital based postpartum support services do not use the word parents in the description of the offered services, but will use the word mother. This further leads to the conclusion that support information on the public side of hospital websites is for mothers, and thus underperforming in the areas of support for both parents.

A review of social media sites reveals support groups for intended parents. Personal and e-mail conversations with colleagues at two perinatal care settings outside RI that care for intended parents show a consistent practice of support during pregnancy, but little support after the birth of the child (K. Devine, personal communication, March 8, 2018; T. Marlette, personal communication, February 20, 2018).

One fertility clinic setting in Kentucky reports approximately six gestational carriers that become pregnant per year with the third-party reproductive process. (K. Devine, personal communication, March 8, 2018 and March 31, 2018). The clinic staff provide support to the gestational carrier and intended parents as part of the initial care process. At approximately 10 weeks gestation prenatal care is then transferred to an obstetric provider (K. Devine, personal communication, March 31, 2018). Once the

transfer of care takes place, the fertility clinic is only informed that a healthy baby was born via a birth announcement sent to the clinic.

At a hospital-based childbirth education program in South Dakota, after receiving a referral from a case manager, the childbirth educators meet individually with surrogates and intended parents (T. Marlette, personal communication, February 20, 2018). The hospital does have coaching services for parents listed on the women's center website (Sanford, 2016). The coaches provide strategies for successful parenting. It is encouraging to see the hospital website use the word parents and parenting, which may provide a more inviting approach to male partners, or to adoptive or intended parents seeking support for the transition to parenthood. However, the hospital does not have a formal program of postnatal support for intended parents (T. Marlette, personal communication, March 25, 2018).

Reflecting on the postpartum services offered in RI and perinatal care settings across the United States, the support for new mothers is generally a consistent strength, both in our local community and nationwide. However, the support for new fathers and intended parents is less apparent. There is significant inconsistency in the support systems available to assist individuals who become parents in non-traditional ways.

Risks/Threats

Currently, there are not any postnatal support services offered in RI specifically designed to support intended parents. The lack of population specific postnatal support services creates an opportunity for the development of new programs at the local level. Although parents may be offered a First Connections home visit, this voluntary program includes maternal postpartum depression screening. Services are not specifically designed

to include fathers or intended parents. Based on the findings for this study a business case will be developed that supports the creation of a new postnatal service in RI. These services will be created without financial support, which may pose a potential threat to continuation of postnatal supports for intended parents and sustainability to any new programs.

Offering support services to new parents is within the scope of practice of nurses trained in care of the postpartum family. Both registered nurses providing postpartum care and Advanced Practice Registered Nurses (APRNs) could provide postnatal support services to intended parents. The education and competencies are in place within hospital and community nursing settings. It is the transference of these skills to the intended parent population that is not in place.

As with all services, the professionals providing the population specific services need to be financially compensated for their work. Without a payment structure in place, sustainability of this postnatal service would be difficult. One option would be to have intended parents pay privately for the services; however, sustainability could be an issue. Another possibility would be to collaborate with an attorney who creates the legal documents for intended parents. The professional nursing cost could be a bundled payment system that includes monies for postnatal support services. Contracts would need to be created that accounted for any ethical concerns regarding payments for a care service being made simultaneously with payments for legal services.

The opportunity to provide postnatal support for intended parents would fall under the core competencies for nurses and APRNs educated to care for postpartum families. A new business case and market plan would provide opportunities to grow a

postnatal service for intended parents. Rhode Island is one of the states that welcomes deliveries via surrogate or gestational carrier regardless of whether the surrogate/gestational carrier or the intended parents reside in the state (Creative Family Connections, 2016). There are no proposed regulations that would threaten the opportunity to provide postnatal care to intended parents.

Financial Plan

When considering the financial costs of this DNP project, most costs could be met with in-kind donations, including donations from professional mentors in the academic and professional community who are either familiar with the project or providing direct guidance. In order to make this a successful project, covering the costs in the form of in-kind donations have been the responsibility of the student/author for this DNP project. One fixed expense was the cost of the survey distribution through AWHONN; \$275.00 per 1000 surveys. The staff at AWHONN filtered the membership list to those who work in postpartum care settings. The ability to selectively discriminate nurses who self-identify as working in the postpartum care setting will provided cost containment. Opportunities are available for AWHONN members to apply for research grant funding. However, the timing of the application process did not coincide with the DNP project timeline. Grant applications from local organizations were pursued as potential funding sources based on availability but have yet to yield any monies for the project.

Evaluation Planning

The planned evaluation of this DNP project is based on both quantitative and qualitative data. The survey consists of questions designed to gather quantitative information such as demographic data, selection of depression screening scales, and

which parents receive postnatal services. The qualitative data gathered from the survey includes questions that ask for descriptors around postnatal services offered at a hospital or, more specifically, postnatal services offered for intended parents. The survey was purposefully designed with both methods to provide survey participants with many opportunities to describe current services, or the perceived gap in services.

The quality improvement model of plan, do, study, act (PDSA) designed by Deming (as cited in Moen & Norman, 2010 and White & Zaccagnini, 2017) will be implemented to evaluate the proposed postnatal services for intended parents (p. 482). The use of the PDSA model is evident in the planning of the project where information was gathered from stakeholders as to the lack of postnatal services for intended parents. The planning stage also included a review of literature to help in developing the proposed business case following the results of the gap analysis. The next step is to work on would be the “do” in the PDSA model, including the development of population specific intended parent programming. This step would lead to the studying of the effectiveness of the population specific postnatal support services offered. Analysis of the services based on feedback from intended parents who utilized the proposed postnatal support services would assist on making any changes to future services; i.e. acting on any modifications of the business case/support services that are offered. PDSA is an effective quality improvement model applicable to the initiation of a new service or change in practice. Future evaluation of the service can continue using PDSA.

Implementation

The initial IRB application was submitted in late August of 2018. The initial review of the application by the IRB Chair noted some required revisions. The last

question of the initial survey initially submitted for consideration provided survey participants with an optional question to submit their e-mail address to participate in a drawing for a gift certificate to the AWHONN bookstore. The IRB Chair required the optional question to be separate from the survey to protect the anonymity of survey respondents. Working with the Lead Instructional Technologist at the RIC User Support Services, we were able to create a new link for participants who chose to complete the optional question for e-mail submission. Once the separate link was created, the revisions were accepted by the IRB Chair. Approval for exempt status was received on September 22nd, 2018.

With the IRB approval in hand, the next step was to get the survey scheduled through AWHONN. The survey was scheduled for release on November 5th, but then was pushed back to accommodate another survey scheduled for release by AWHONN. The initial release of the survey was on Thursday, November 8th, with one e-mail reminder sent the following week. The survey remained open for two full weeks. The release of this survey so close to the release of another survey is a potential threat to increasing the number of survey respondents. The AWHONN staff randomly chose the two-thousand nurses to receive this survey, therefore there could be some cross-over between survey respondents. All survey e-mails from AWHONN have a similar professional “AWHONN look” that is familiar to members. With similar appearance of the surveys distributed through AWHONN, this DNP student speculates that some members may have ignored yet another e-mail from AWHONN requesting participation in another study.

Interpretation of Data

Demographic data collected included the home state of the RN, years in practice, practice setting, deliveries per year, and hospital level of care. Thirty-seven states were represented by the survey respondents. Years of service ranged from one year to over forty years, with the highest number of respondents practicing from 30 to 40 years. Inpatient practice settings were the most heavily represented at 87.22%. The number of births reported in varied practice settings ranged from 120 deliveries to over 30,000 per year. Over 40% of the respondents work in a Level III hospital (a high risk, referral hospital center), followed by Level I facilities, then Levels II and IV.

The survey queried respondents as to whether postpartum support services were offered to new parents after discharge from the hospital setting. Sixty-nine percent of respondents indicated that there are postpartum services offered for families after leaving the hospital. Support groups were identified as the most common method used to deliver postnatal support services. Nurses (N=93) who responded to the question about the availability for support services for mothers, fathers, or both parents: 37% reported that postpartum services are for both parents.

Qualitative data provided a richer description of postpartum support services. Survey respondents were asked to write a descriptor of the support services. Of the survey respondents who described the postnatal support services at their practice setting (N = 73), most respondents described a postpartum or breastfeeding support group, follow-up phone calls, or a lactation clinic. Responses ranged from formalized services to calling into the nurses' station with questions. One respondent who works in an office setting described an office visit creating a safe space for mothers to discuss mental health.

Home visits, with some support from the department of health, were also included in the descriptor of support services for mothers. Two respondents specifically described postpartum depression support groups.

To ascertain the current status of postpartum depression screening practices, respondents were asked if postpartum depression screening was conducted in their practice setting. Eighty-five percent of respondents said yes, but only two respondents (1.71%) said that fathers were screened for postpartum depression. The nurses reported intended parents are screened for postnatal depression in only 25% of the respondents' practice settings. A cross tabulation of the questions asking if intended parents are screened for depression with the question regarding who is screened using a postnatal screening scale demonstrated that only 2 respondents report screening all parents for postpartum depression, but no respondents reported screening intended fathers. While the results of the cross tabulation are not statistically significant (p-value 0.07), this does provide more evidence of the gap in screening for depressive disorders after arrival of the newborn.

Respondents were asked to provide any additional comments regarding postnatal support services for intended parents. The qualitative responses ranged from intended parents receiving a private room and post discharge phone call to not offering any services at all for intended parents. One respondent indicated that a barrier to postnatal support was the inability to document postnatal screening for fathers and intended parents in the electronic medical record.

The responses from several study participants demonstrated a gap in services for intended parents are illustrated as follows:

“To my knowledge we don’t offer any postnatal support to intended parents.”

“The intended parent population gets no such prenatal services or upon taking their little one home.”

“I do not believe families receiving infants are encouraged to call for assistance.”

“Nothing is used.”

“We currently do not have any postnatal support services for intended parents.”

“I never thought about screening them for depression.”

“I’m not sure...sorry!”

“None.”

Although the data from the survey are not statistically significant, the responses from survey participants demonstrate a gap in postnatal support services for intended parents, as well as for fathers. While statistical inferences may not be made from the survey results, this survey does provide a glimpse at areas of opportunity to provide support for new parents, including intended parents, on their journey to transition to parenthood.

Limitations

Potential limitations included the timing of the survey administration by AWHONN immediately following another survey. While survey respondents were randomly selected from the vast number of nurses who self-identify as mother/baby nurses, nurses may have received more than one similarly looking communication from AWHONN in close proximity. Additional limitations could include the design of the survey. The number of survey participants who completed the qualitative responses were smaller than the total number of participants who answered the survey questions.

While the survey successfully identified areas of gaps in postnatal services and depression screening, the questions designed for qualitative responses could have provided more directions and thus evoked richer qualitative data.

Utilization of Results

Meeting Objectives

The project objectives were met throughout the DNP project implementation. Identification of the gap in local support services for intended parents was identified through conversations with perinatal colleagues, as well as a thorough review of on-line resources for parents during the postnatal period. The survey distributed by AWHONN led to further identification of gaps in available services for intended parents, as well as fathers.

Completion of a business case for population specific postnatal support services was a secondary long-term objective. This objective will be met by designing of a concierge postnatal support services business led by the author of this project, the licensed women's health/gender specific Clinical Nurse Specialist (WHCNS). The future vision of the concierge postnatal support services includes collaborating with community agencies and legal professionals that provide services for intended parents in Rhode Island.

Marketing Plan

A future marketing plan will be developed as part of the concierge business case supporting postnatal services for intended parents. The customers for this new service include perinatal leaders and professionals within the local community. Once the business

case and a model of the postnatal services are created, the plan for postnatal services will be shared with hospitals who welcome intended parents for delivery.

Dissemination

As stated in the projected scope of changes prior to project implementation, the design and services of the concierge business to assist intended parents during the postnatal period will be disseminated to community stakeholders through various venues, such as through meetings with hospital based and community providers. The findings from the survey will be disseminated similarly to support the rationale and need for postnatal support for intended parents. Anticipated dissemination includes publications and presentations to the local and national perinatal communities, as well as participation in nursing research conferences. Within the year, a submission to a peer-reviewed national maternal child health journal is anticipated. Dissemination of these findings will start the conversation with other perinatal professionals on how best to meet the postnatal needs of intended parents.

Practice Implications and Recommendations

Nurses working in the perinatal setting support families, as they become new parents, whether they become new parents through biological means, adoption, or through surrogacy /gestational carriers. Modeling best practice during care of the newborn will assist parents through the states of transitioning to parenthood, including techniques to soothe the newborn, safe sleep practices, and paced feeding. DNP prepared nurse scholars can provide education and guidance for postpartum care nurses, encouraging a model of care that centers on individualized patient centered care for all new parents. Utilizing Mercer's theory as a background, parental teaching should consist

of assisting families as they attach to their infants, including providing opportunities to demonstrate care of an infant with a difficult temperament and identifying those parents that are at risk for attachment difficulties and depression.

The creation of a postnatal support program will require intra- and interprofessional collaboration within both the hospital and community settings. Interprofessional collaboration competencies (Interprofessional Education Collaborative [IPEC], 2016) provides guidance on the utilization of knowledge and values to address and advance the health needs of populations, as well as application of interprofessional team principles and values to “plan, deliver, and evaluate patient/population centered care” (p. 10). DNP prepared nurse leaders can apply these competencies to the creation of programming and policies to address the gap in postnatal support services for intended parents with health professional colleagues, including other advance practice nurse colleagues who may see parents during the postnatal period, as well as attorneys and social workers in the community working with intended parents. Advocating for care services for all parents, including intended parents, would decrease the potential lapse in postnatal support during the transition to parenthood for any new parent.

Family nurse practitioners, women’s health nurse practitioners, and psychiatric clinical nurse specialist could come together with the WHCNS to consider the delivery of care from an intraprofessional perspective. Dissemination of this DNP project findings to obstetric and pediatric providers, as well as policy and practice leaders at the state level, could lead to a larger interprofessional perinatal practice committee focusing on population specific postnatal services for intended parents, as well as for all parents. The gap in postnatal services identified included services for intended parents and for fathers.

The proposed larger interprofessional committee could also work to enhance postnatal support for fathers. Providing postnatal supports for intended parents, as well as fathers, serves to address issues that may arise with the transition to parenthood and thus potentially decrease the risk of postnatal depression. With the knowledge of this service gap the DNP prepared nurse leader is compelled to disseminate this new knowledge and implement support services as intended parents transition to parenthood.

DNP nurse leaders are uniquely positioned to affect change at the local and national levels. As experts in the clinical setting, an important aspect of their role is to start the conversation by leading discussions, both in the academic and community arena. Intended parents should be included to provide their unique perspective on postnatal needs. DNP prepared professional nurses can teach and educate nursing and medical students, by bringing awareness of important contemporary issues to the forefront, especially when it pertains to marginalized or disenfranchised groups of individuals.

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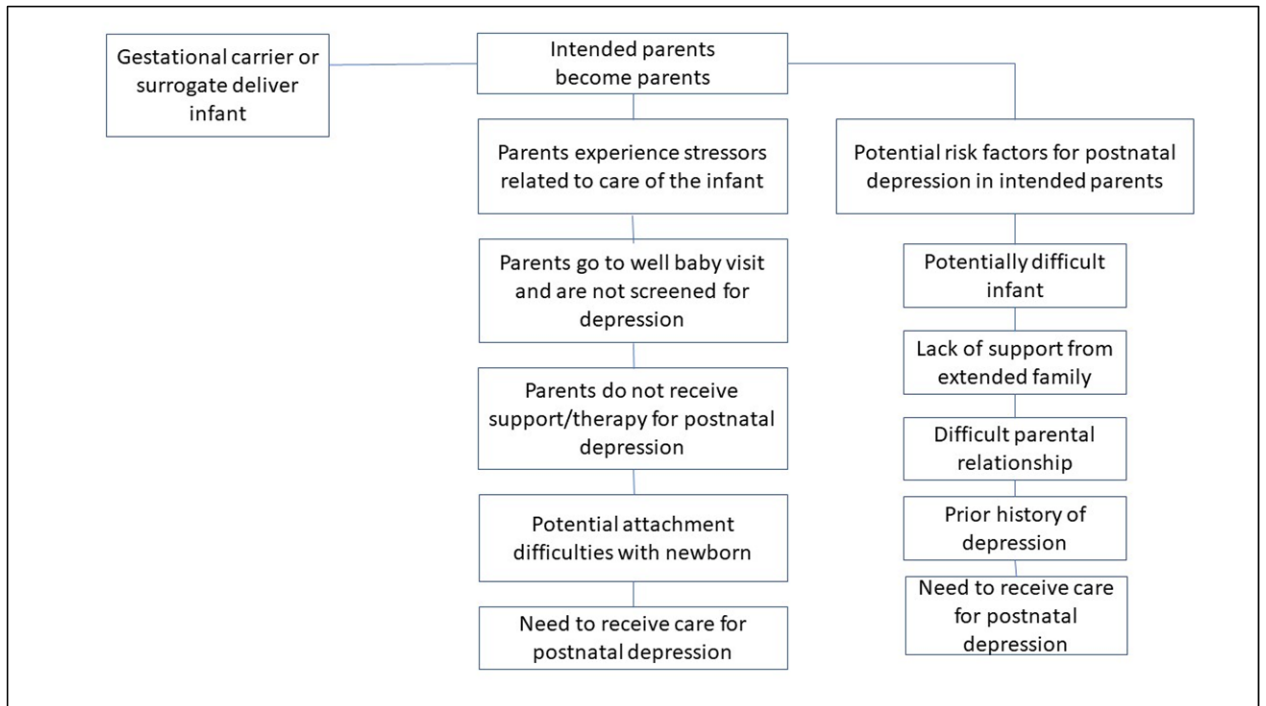
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Appendix A: Critical pathway

Critical pathway leading to potential postnatal depression screening and referral for care for intended parents.



Appendix C: Electronic survey

Postnatal support services for intended parents

In your current nursing practice, are you involved in the care for families who have a baby by surrogate or gestational carrier: e.g. intended parents, defined as parent(s) who are the intended recipients of a baby carried by a gestational carrier or traditional surrogate?

Which state do you work in?

Years in practice

Practice settings:

Inpatient
Outpatient
Clinic
Other

Do you practice in a hospital setting or a part of a hospital system?

How many deliveries per year?

Level of care at hospital

Level I (Well newborn nursery)
Level II (Special Care Nursery)
Level IV (Regional NICU)
Unknown

Does your practice setting provide postpartum support services after discharge from the hospital?

Please describe the services.

Support group
Home visits
Clinic
Other

Are postpartum support services available for mothers, fathers, or both?

Please describe support services

In your practice setting, is screening conducted for postpartum depression?

When during the postpartum period does screening occur?

In your practice setting, are fathers screened for postpartum depression?

When during the postpartum period does screening occur?

In your practice setting, are intended parents screened for depression?

When during the postpartum period does screening occur?

Which postpartum depression screening scales are used in your practice setting?

Edinburgh postnatal depression scale
Postpartum Depression Screening Scale
Other depression scale (fill in the blank)
No particular scale is used
Unknown

If postpartum depression screening scales are used in your practice setting, who is screened?

Only mothers
Mothers and fathers
All parents

Please describe any additional comments regarding postnatal support services for intended parents.

Appendix D: AWHONN electronic recruitment and consent letter

Dear Colleague,

We invite you to participate in a research study conducted by investigators at Rhode Island College. The purpose of this study is to identify gaps in postnatal support for intended parents. Intended parents are defined as the intended recipients of the infant carried by another person in a surrogacy arrangement.

You are invited to participate because you care for postpartum families (Mother/Baby) and are affiliated with the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). Approximately 2,000 nurses will be invited to take part in this study.

If you agree to participate by clicking on the link to the survey below, we will ask you to complete an online survey regarding postnatal services for intended parents. Clicking on the link to the survey serves as your consent. It will take approximately ten minutes to complete the survey

After the survey closes, there will be an optional random drawing for a chance for a \$100 gift certificate to the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) store. If you choose to participate in both the drawing and the survey, please click on the link on the link at the bottom of the survey is you wish to enter your email address to be entered into the optional drawing

Information that you provide as part of the survey will be kept confidential. However, the Rhode Island College Institutional Review Board (a committee that reviews and approves research studies) may inspect records pertaining to this research. The survey tool will keep your e-mail address and survey results separate and we will not attempt to link you to your survey responses.

Once the drawing is completed, all e-mail addresses will be deleted. No other personal identifiers will be collected.

There are no risks to you directly for being part of this study. If any of the questions in the survey cause discomfort or stress, please skip them. There will be no direct benefit to you for your participation in this study.

Taking part in this research study is completely voluntary. If you do not wish to participate in this study, do not respond to the survey link or answer any questions. If you do not respond, you will not be enrolled.

If you have any questions, you may contact the research team: Jean Salera-Vieira at jsalera1@ric.edu or Sylvia Ross at sross@ric.edu. Dr. Sylvia Ross, assistant professor at Rhode Island College School of Nursing is the Primary Investigator for this study, and

Doctor of Nursing Practice (DNP) student, Jean Salera-Vieira is the student investigator for this study.

If you think you were treated badly in this study, have complaints, or would like to talk to someone other than the researcher about your rights or safety as a research participant, please contact the Chair of the IRB committee Dr. Emily Cook, at IRB@ric.edu, or by phone at 401-456-9720

Thank you for your consideration for participation in this research study.

AWHONN
1800 M Street N.W., Suite 740 S
Washington, D.C., 20036
(202) 261-2400

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