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## Evaluation of the CARE Program at Goodall Hospital's Center for Women's Health

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# Evaluation of the CARE Program at Goodall Hospital's Center for Women's Health

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## Collaboration Allows Real Empowerment (CARE)

Sanford was designated by Maine's Governor in 2009 as a "medically underserved community." Communities with this designation have limited primary care providers, and high infant mortality and poverty rates. Goodall Hospital developed the CARE Program in response to this issue, which serves pregnant women by connecting them with a social worker designated as the CARE Coordinator (CC).

### The Focus of the CARE Program

-  Assess and intervene for depression during and after pregnancy
-  Improve compliance with regular prenatal care
-  Provide support and resources by meeting with the CARE Coordinator regularly
-  Reduce use of emergency department for non-emergent care

One in five pregnant women experience depression, though few seek treatment despite the direct and indirect risks associated with depression during pregnancy. Premature labor, low birth weight, and long-lasting psychological and behavioral health problems are all risks to the unborn child when a pregnant woman is depressed (Field et. al., 2010). Prenatal depression can also increase a mother's risk for post-partum and non-postpartum depression (Sockol, Epperson, & Barber, 2011). Depressed women are more likely to smoke, use alcohol, and lack the motivation to follow doctor's orders (Bonari et. al, 2004). Woman who are compliant with prenatal care show improved outcomes in maternal parenting practices, health behaviors, and child health (Reichman et. al, 2010). Prenatal care has been found to encourage use of pediatric care after delivery, making these families less likely to visit the emergency room for an illness that can be treated by a primary care doctor (Reichman et.al., 2010)

## Hypothesis

The purpose of this descriptive study is to gain a better understanding of the characteristics that can affect depression and overall compliance in prenatal care. Researchers anticipate that women's involvement in the CARE Program will lead to a decrease in depression scores measured between the first and second trimester. The continued assessment and support provided by the CARE Coordinator is also expected to lead to fewer untreated cases of perinatal and postpartum depression.

## Evaluation of the CARE Program

This study examines the effectiveness of the program's interventions which assess and treat depression and encourage engagement in prenatal care. Primary data was collected from health records of women enrolled in the CARE Program at Goodall Hospital's Center for Women's Health. This study extracts data related to demographics, compliance with prenatal care, use of the emergency department for non-emergent care, and number of meetings with the CARE Coordinator (CC). The data was analyzed as it relates to Edinburgh Postnatal Depression Scores (EPDS) collected in the first and second trimester during meetings with the CC. An EPDS score of 10 or more has been shown a reliable, cost-effective screening point to identify symptoms of depression (Bergink et al., 2009)

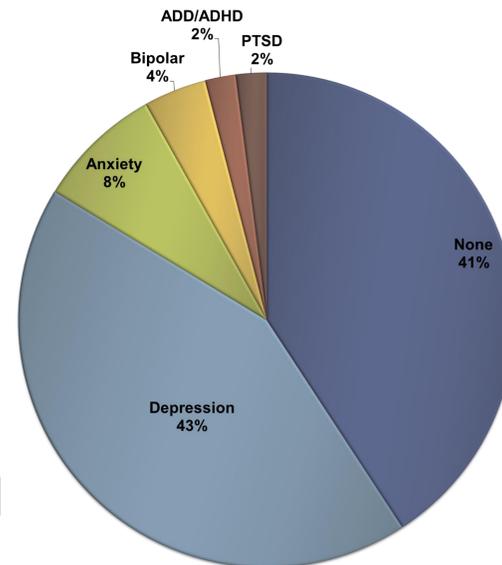


Chart 1

History of Mental Illness

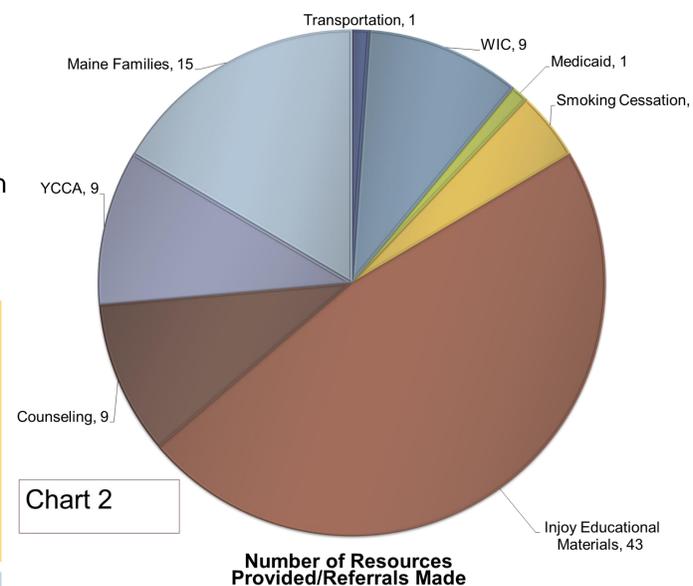


Chart 2

Number of Resources Provided/Referrals Made



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## Results

- 57.1% of women enrolled in the CARE Program have a history of Mental illness. 43% of those women have been diagnosed with depression, a major focus of the CARE Program. (Chart 1)
- 18% of women scored 10 or higher on the EPDS, a score that has been validated as a reliable point for identifying depressive symptoms. (Bergink et al., 2009).
- Women began the CARE Program on average at 9.8 weeks gestation, supporting the goal of intervening in the first 14 weeks of pregnancy. (Chart 4)
- 78.6% of program participants met with the CARE Coordinator (CC) twice or more during the six-month period of this study, all at least once. During these meetings educational materials, resource information, and referrals to outside agencies were provided, as well as support, encouragement, assessment of individual strengths and barriers. (Chart 2)
- 16.1% of subjects admitted to currently using drugs. As supported by the literature, proportionately less of these women live with the father of their child (7.1%), as compared to those living with close family or alone (42.9%).
- The average age of women at the start of their participation in the CARE Program was 25 years old. (Chart 3)

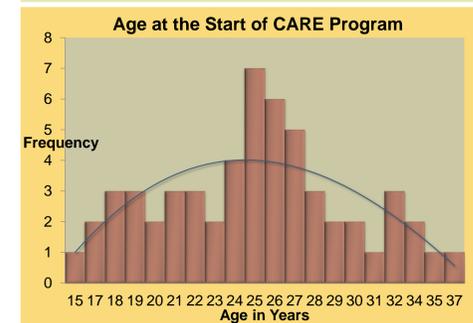


Chart 3

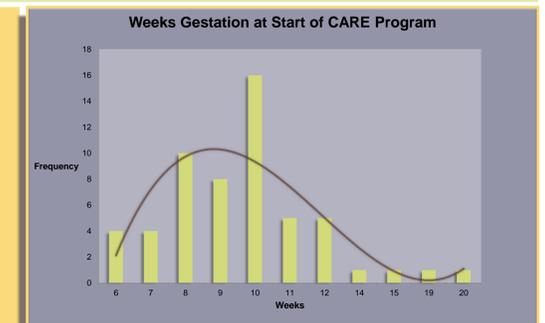


Chart 4

## Implications

The interventions used in The CARE Program identified many women in need of resources and experiencing symptoms of depression that may have otherwise been overlooked and untreated. Tobacco and drug use were also indicated in a substantial amount of women and should not be overlooked when revising the focus and goals of the program. Using this evaluation as a guideline, the CARE Program at Goodall Hospital will be able to provide effective, individualized support that can help to empower pregnant women in their community.

## Acknowledgements

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## References

- Bergink, V., Kooistra, L., Lambregtse-van den Berg, M., Wijnen, H., Bunevicius, R., Baar, A. V., & Pop, V. (2011). Validation of the Edinburgh Depression Scale during pregnancy. *Journal of Psychosomatic Research*, 70, 385-389.
- Bonari, L., Pinto, N., Ahn, E., Einarson, A., Steiner, M., & Koren, G. (2004). Perinatal risks of untreated depression during pregnancy. *Canadian Journal of Psychiatry*, 49(11), 726-735.
- Field, T., Diego, M., & Hernandez-Reif, M. (2010). Prenatal depression effects and interventions: A review. *Infant Behavior and Development*, 33, 409-418.
- Reichman, N. E., Corman, H., Noonan, K., & Schwartz-Soicher, O. (2010). Effects of prenatal care on maternal postpartum behaviors. *Review of Economics of the Household*, 8, 171-197.
- Sockol, L. E., Epperson, N., & Barber, J. P. (2011). A meta-analysis of treatments for perinatal depression. *Clinical Psychology Review*, 31, 839-849.