



Evaluation of the implementation of an internet intervention in well-baby clinics: A pilot study



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ABSTRACT

Purpose: Despite promising results, internet interventions are not widely accessible or well-integrated in health services. The objective of this study was, therefore, to examine the implementation of an internet intervention ('Mamma Mia') for the prevention of perinatal depression in Norwegian well-baby clinics (i.e., primary care).

Methods: Mamma Mia begins in mid-pregnancy and lasts up to 6 months after childbirth. It consists of 44 online sessions, supported by midwives and public health nurses at up to 5 contact points during this period, following principles of empathic communication. Well-baby clinics offer free, universal services to all pregnant women and children aged 0 to 5 years in Norway and were recruited via an intermediary organization for this study. Data were collected at pre- and post-training, but before the delivery of Mamma Mia in clinics, and at 3 and 6 months follow-up. Quantitative and qualitative data were used to evaluate the training in Mamma Mia, examine program implementation (i.e., number of pregnant women registered for the program), and identify barriers and enablers of implementation.

Results: Twenty-four self-selected healthcare professionals from 14 well-baby clinics were recruited, for this study. Training increased participants' knowledge about Mamma Mia and exceeded their expectations. The program review and implementation plan were necessary training components. Implementation climate was related to the number of colleagues working with Mamma Mia and overall satisfaction with implementation, while characteristics of the intervention predicted the number of registered women at 6 months. Organizational re-structuring, leadership, and competing activities were identified as barriers to implementation that need to be considered further.

Conclusions: The dissemination and implementation of a health-service supported internet intervention appears to be promising but requires further research.

1. Introduction

It has long been known that internet interventions can be effective for mental health problems such as stress, anxiety, and depression in general or clinical populations (Heber et al., 2017; Karyotaki et al., 2017; Spek et al., 2007). In recent years, there has also been a greater interest in previously understudied sub-groups in research on internet interventions, such as pregnant and postpartum women. In the first systematic reviews on perinatal women, Ashford et al. (2016) concluded that computer and internet-based interventions seem promising for perinatal mental health, while Lee et al. (2016) conducted a meta-analysis where they found, more specifically, that therapist-supported internet-based cognitive behavioral therapy (iCBT) can improve depression among postpartum women. A similar meta-analysis, that

included more and recent studies, confirmed these findings and found that iCBT could also improve stress and anxiety in new mothers (Lau et al., 2017).

All these systematic reviews concluded that this is still a developing field and point toward several future challenges for research such that there is a lack of studies on internet interventions based on principles other than CBT, of exclusive self-help programs, and that all of the interventions considered, were delivered after childbirth (Ashford et al., 2016; Lau et al., 2017; Lee et al., 2016). A recent study by Forsell et al. (2017) has indeed investigated the effect of iCBT among pregnant women and found positive results on antenatal depression, but there are still no studies of internet interventions that follow expectant mothers from pregnancy and through childbirth. This may be particularly important in view of the fact that maternal depression may occur before,

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during pregnancy, and after childbirth (Wisner et al., 2013), thereby making it important to prevent and intervene throughout the entire perinatal period.

Despite promising results, internet interventions are still not very accessible, widely disseminated or well-integrated in health services. There have been some discussions about various dissemination and implementation strategies in the literature such as service delivery models (Andrews and Williams, 2015; Batterham et al., 2015), and papers describing ‘lessons learned’ in the development and delivery of iCBT (see e.g., Hadjistavropoulos et al., 2011). However, a recent review of the existing research literature, showed that there are few, if any, primary implementation studies on internet interventions for depression (Drozd et al., 2016). It appears that the available knowledge of their implementation, in general, is very poor, and especially aspects related to leadership and organization. In fact, concerns about the integration of iCBT in the mental health care systems and their long-term sustainability were also shared and expressed by managers and clinical staff in a recent multi-national, comparative study on iCBT (Folker et al., 2018). However, questions about what activities must be carried out to implement and sustain an internet intervention in practice, remains unanswered. There is thus a gap between what we know about internet interventions (i.e., *knowing*) and how we translate this knowledge into practice (i.e., *doing*). To bridge this knowledge-action gap, we need to understand the barriers and enablers for the delivery and sustainability of internet interventions in practice.

The objective of this study was, therefore, to examine the implementation method for an internet intervention (‘Mamma Mia’) designed to prevent perinatal depression in a primary care setting (i.e., well-baby clinics). More specifically, we first aimed to evaluate knowledge gain, recommendations, and expectations of training, and identify which training components that were regarded as the most and least useful. Second, it was hypothesized that there would be a positive relationship between the number of pregnant women registered for the program, implementation climate, and participants’ report of the integration of Mamma Mia in their well-baby clinics. Finally, we examined whether attitudes and program implementation fit predicted the number of pregnant women registered for Mamma Mia in well-baby clinics, and identified barriers and enablers of the implementation, which emerged during coaching.

2. Methods

2.1. Design

This study was a pilot evaluation of the implementation of a guided internet-based intervention in well-baby clinics. This means that the primary focus for the study was on the implementation process and outcomes, rather than the intervention objectives. The study was approved by the Norwegian Centre for Research Data (www.nsd.no; project number: 41361).

2.2. Internet-based intervention

‘Mamma Mia’ was originally developed as an unguided, self-help program available for PC/Mac, smartphones, and tablets. The goal of the program is to (1) prevent the onset or development of depression and (2) enhance subjective well-being from mid-pregnancy and up to 6 months after childbirth. The main program components include (1) identification and monitoring of depressive symptoms, (2) help and support for depressive symptoms, (3) maternal mental health and quality of life, (4) couple relationship and (5) the child’s development. Mamma Mia is a universal preventive intervention that targets all expectant mothers, most of which will experience few symptoms of depression. Thus, the program emphasizes components 3–5 as described above (i.e., health promotion). However, all women are screened for symptoms of depression, using the Edinburgh Postnatal Depression

Scale (EPDS; Cox et al., 1987), at 6 timepoints in the program. Women with an EPDS-score ≥ 10 (i.e., cut-off for depression) are provided with immediate, in-program help and support based on metacognitive therapy (Wells, 2009), and are encouraged to seek help by either calling a mental health hotline or contacting their midwife, public health nurse (PHN) or general practitioner (GP). Further details about the program components are also described elsewhere (Drozd et al., 2015; for a demonstration, see: Changetech, 2015).

Initial research examined the feasibility of the program (Haga et al., 2013), before the commencement of a randomized trial (for protocol, see: Drozd, 2013). In parallel to the trial, perinatal women were interviewed about the quality of the program and recommendations for future improvements. The results suggested that (optional) support or guidance could be beneficial, even for women low on depressive symptoms (Drozd et al., 2017b). Consequently, we developed clinical and implementation guidelines for use in well-baby clinics (Drozd et al., 2017a), including up to 5 contact points with midwives and PHNs in a blended care model, and a supplementary training for the delivery and implementation of Mamma Mia. The guidelines for clinical use were carefully designed to fit with existing national guidelines for pre- and postnatal care for well-baby clinics (Norwegian Directorate of Health, 2005, 2013), whereas the implementation guidelines were designed to address the core components of implementation according to the Active Implementation Framework (see Procedures below; Fixsen et al., 2005).

The “blending” combines the Mamma Mia program, which is pre-structured protocol with some built-in tailoring, with face-to-face follow-up from midwives and PHNs. According to the clinical guidelines, midwives and PHNs are supposed to follow principles of empathic communication (Brudal, 2014; Rogers, 1951) by drawing attention to women’s mental health, and to raise their affective consciousness, reflect on their experience, and help making sense of their joys and worries during the perinatal period. The important thing, is not to discuss the program per se, although face-to-face contact may improve adherence rates, but to allow midwives and PHNs to the woman’s specific needs, discuss her thoughts and feelings, and assist with practical application or adaptations of program contents to her unique situation.

2.3. Participants and clinical settings

Participants were recruited via the Regional Center for Child and Adolescent Mental Health’s website (RBUP; www.r-bup.no) from December 2014 to February 2015. RBUP is an intermediary organization devoted to aiding, strengthening, and developing primary and secondary child and adolescent mental health services. Their role is to offer supplementary education, research, and act as an intermediary between program developers and health services that want to adopt these, which implies that the health services initiate contact with RBUP for support and quality improvement of their services. Therefore, participants were recruited via RBUP based on self-selection.

The primary target group for the implementation of the current internet intervention, were midwives and PHNs in well-baby clinics. Midwives and PHNs are (a) registered and licensed in nursing, (b) with a 1- or 2-year post-graduate education, (c) have experience with perinatal women, and (d) providers of primary community services. Well-baby clinics offer free, universal services to all pregnant women and children aged 0 to 5 years in Norway. In 2016, about 85% of all pregnant women used the midwifery service offered at well-baby clinics and 98–100% of new parents attended the routine child-health examinations during the first year postpartum (Statistics Norway, 2017). The majority of the target group for the program can be reached by delivery in well-baby clinics, including mothers with or in high risk of depression (Glavin and Schaffer, 2013). Other professionals working in well-baby clinics or with specialized care of pregnant women in primary care settings such as community psychologists and GP, were also considered eligible. However, these were considered a secondary target group for

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