

Moving Beyond Depression™

Location: Ohio

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Category: **Best Practice**

BACKGROUND

Moving Beyond Depression (MBD) was designed to provide effective treatment to depressed mothers who are participating in home visiting or other early childhood programs. MBD was developed in response to the (1) high rates of depression observed among low income mothers participating in these programs, (2) the poorer outcomes often observed in depressed mothers participating in these programs, (3) low rates of community treatment observed in this population, and (4) opportunity to leverage ongoing home visiting and other interventions to improve engagement and efficacy. Depression is the most common mental health condition in women of child-bearing age. Research demonstrates that about 13% of women experience depression postpartum. This rate is doubled in low income populations, where the stressors of poverty and experiences of violence increase vulnerability to developing severe and persistent depression. Often depression begins during pregnancy, and can extend beyond infancy and through early childhood.

The impact of depression is profound and can be devastating to mothers and children. Depression negatively affects attachment, sensitivity to infant cues, and positive interactions with the child. Depressed mothers talk less to their children, read less, interact with them less, and engage in harsher and less positive parenting behaviors. Depression decreases initiating and sustaining of breastfeeding, lowers use of child safety devices, and contributes to elevated risk of child abuse. Children of depressed mothers are at risk for over-reactivity to stress, internalizing and externalizing behavior problems, and poor academic performance. Experiencing a depressed primary caregiver during the first years of life can interfere with the development of critical social, emotional, and cognitive capacities, leading to behavioral maladjustment into adulthood. Early and efficacious treatment of depression can lead to recovery, improve outcomes in home visiting and other prevention programs and positively impact mothers and children.

TITLE V/MCH BLOCK GRANT MEASURES ADDRESSED
#04. A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Research clearly indicates that most depressed mothers do not get effective treatment. In the general population, only 20-30% of depressed mothers receive any kind of treatment, and among mothers in home visiting this rate drops to about 14%. Even when mothers receive treatment, it is often inadequate, insufficient, or poorly implemented. Health inequities create formidable roadblocks for low income mothers to receive effective treatment, including lack of transportation, poor experiences with the mental health system, stigma, poor access to mental health systems, and insufficient training of mental health professionals. Home visitors and other early childhood professionals are challenged by serving depressed mothers, and struggle to bring about optimal outcomes for their programs with this population.

To address these issues, MBD was developed by Every Child Succeeds and Cincinnati Children's Hospital Medical Center. In-Home Cognitive Behavioral Therapy (IH-CBT), the core feature of MBD, is implemented by therapists who provide treatment concurrently with ongoing home visiting or other early childhood services. IH-CBT combines the core principles and techniques of CBT with procedures and strategies that promote engagement, make content relevant to the needs of mothers in home visiting, facilitate delivery in the home, and explicitly foster a collaborative relationship between the therapist and home visitor to smoothly coordinate services. IH-CBT is an enhancement that emphasizes the reduction of maternal depressive symptoms and recovery from major depressive disorder (MDD), thereby allowing service providers to attend to issues related to parenting, maternal functioning, and child development.

PROGRAM OBJECTIVES

The primary objective of MBD is to identify, engage and treat depressed mothers enrolled in home visiting and other early childhood prevention programs.

MBD provides the following:

- Training of home visitors or other early childhood professionals to understand, identify, and support depressed mothers.
- A system for regularly screening mothers for depression.
- Masters level therapists trained in an evidence-based treatment for depressed mothers, called In-Home Cognitive Behavioral Therapy (IH-CBT).
- Close coordination and partnering between therapists and home visitors or early childhood professionals to ensure integrated and coordinated intervention.
- Ongoing training and support to become proficient at identification and treatment of depressed mothers.
- Data reports and continuous quality improvement to maximize program impacts.

TARGET POPULATION SERVED

MBD is a multigeneration program that serves mothers and children enrolled in home visiting or other early childhood programs or settings in which mothers and children are seen. The latter include such programs and settings as Healthy Start, Healthy Start, WIC, pediatric practices, community health workers, and early intervention. Mothers are typically low income, unmarried, live in low resource and violent communities, and have experiences abuse and neglect (adverse childhood experience—ACEs) in their lives. Their children are at risk for development delays, academic underachievement, and emotional and behavior problems.

PROGRAM ACTIVITIES

Identification and Treatment

Home visitors or other early childhood professionals are trained to recognize the symptoms and associated features of depression. The impact on mothers, children, families, and service providing is emphasized. Mothers are identified based on scheduled screenings by home visitors or other early childhood professionals. Mothers with elevated levels of depression are then assessed to determine if they have major depressive disorder (MDD). Treatment is provided by master's level mental health clinicians who deliver 15 weekly treatment sessions and a one month booster. The program establishes a strong working relationship between home visitors/early childhood professionals and therapists, who collaborate closely during treatment. A team leader provides weekly support to therapists. The team leader is responsible for ensuring fidelity to the IH-CBT model, providing a forum for discussion of challenging clinical situations, and continually augmenting and refining the therapist's clinical skills. Clinical and program data are collected and monitored to determine treatment impact and efficient implementation of the MBD program. The masters level therapists are also resources for home visitors and other early childhood professionals for other aspects of maternal mental health,

providing guidance, education, and appropriate referrals where needed.

Replication and Scaling

Adoption by home visiting or other early childhood programs or system involves three phases of training and support, which take place over a period of two years. In the implementation phase, new sites work closely with MBD central staff to map out and develop elements necessary for a successful launch and maintenance of the program. In phase two, therapists, team leaders and home visitors receive specialized trainings to ensure effective deliver the program. Phase three is ongoing training and support. In this phase therapists attend monthly calls to ensure mastery of skills and successful program implementation. Program leadership calls are scheduled to monitor program progress and assess needed support. Regular reports on screening, referral, eligibility, and treatment outcomes are provided and discussed during telephone calls. CQI methods are used to identify problems in implementation and to monitor efforts to fix these and boost outcomes.

PROGRAM OUTCOMES/EVALUATION DATA

Empirical support for IH-CBT was obtained in a clinical trial (Ammerman et al., 2013a, 2013b) comparing mothers who received IH-CBT and concurrent home visiting with those who received home visiting alone. In this study, 93 mothers were first identified using the Edinburgh Postnatal Depression Scale administered by home visitors at three months postpartum. This was followed by diagnosis of major depressive disorder (MDD) using a semi-structured interview. After random assignment to treatment and control groups, mothers were re-assessed at post-treatment and at a three-month follow-up. Results showed that, relative to controls who did not receive IH-CBT but often sought treatment in the community, mothers receiving IH-CBT:

- Had substantial drops in symptoms of depression (note: results from a second trial that is currently in the analysis stage reveal that these gains are maintained over 18 months post-treatment).
- No longer met criteria for major depressive disorder (70% recovery) at the end of treatment.
- Reported improved ability to cope with stress, fewer relationship difficulties, increased social support, and more satisfaction in the maternal role.
- Reported substantial drops in self-reported psychological distress and increased social support.
- Reported greater ability to function effectively at home, school, work, and in relationships.
- Had an average of 11.2 treatment sessions, in contrast to the average of 4.3 in adult outpatient clinics.

In addition:



- Mothers who had the biggest gains were younger and received more IH-CBT sessions and home visits, demonstrating the important synergy created through therapist and home visitor collaboration.
- Mothers who themselves were maltreated in childhood showed an increase in the number of people in their social networks following treatment.
- Mothers who recovered from depression reported that they coped better with stress related to the parenting role, and they had more nurturing and stimulating interactions with their children.
- Mothers receiving IH-CBT had an average of 3.2 additional home visits during the treatment phase relative to controls.
- Mothers who fully completed IH-CBT treatment stayed remained in home visiting up to 4 ½ months longer in contrast to mothers who did not receive treatment.

An economic analysis (Ammerman et al., 2017) revealed that IH-CBT is a cost-effective strategy relative to treatment in the community over three years provided a willingness-to-pay threshold of \$25,000/Quality Adjusted Life Years. Mothers receiving IH-CBT were expected to have 345.6 fewer days of depression relative to those receiving standard home visiting and treatment in the community.

PROGRAM COST

MBD implementation cost are broken down into three categories training fees, licensing fees and ongoing training and support. Program cost is based on client site specific needs; estimates are shown below.

Training fees:

- Therapist and team leader training \$2,900
- Onsite home visitor training - \$5,940, *plus travel*

Licensing fees:

- Organization licensing fee - \$2,500
- Therapist licensing fee (per therapist) - \$1,375

Ongoing training and support

This include therapist training calls, leadership calls, session audio review and data collection and analysis.

- Year one range - \$10, 000 to \$18,000
- Following years range - \$6,000 to \$12,000

It costs a client site approximately \$2,500 to provide 18 sessions to a mother, this includes the eligibility assessment, 15 IH-CBT treatment sessions, post-treatment assessment and booster.

ASSETS & CHALLENGES

Assets

- Treatment approach specifically adapted to meet the needs of young, low income mothers with experiences of adversity.
- Treatment designed to overcome barriers to receiving mental health care.
- Treatment provided in close coordination with other ongoing social and related services of mothers and children.
- Treatment is manualized and structured.
- Data-driven program includes comprehensive clinical assessment battery to document outcomes.
- Treatment is reimbursable through Medicaid.

Challenges

- Sustained funding for additional expenses associated with in-home treatment is challenging. Blended funding is typically needed (Johnson et al. 2014).
- Bringing together mental health and social service or related systems can be challenging and requires shared objectives and commitments.

Overcoming Challenges

- Securing local, state, and federal public funding and seeking out private support has contributed to strong programs.
- Building strong collaborative relationships prior to implementation has led to smooth deployment and effective implementations.

LESSONS LEARNED

- The most successful MBD sites have had a “champion” who has worked hard to ensure that the infrastructure and support is in place to adopt the program.
- Mothers in MBD often make major life decisions during and shortly after treatment, including returning to school, obtaining employment, and leaving unsafe living arrangements.
- Many mental health clinicians welcome the opportunity to work in the home setting, and to collaborate with other professionals in providing the highest quality of treatment.

FUTURE STEPS

Despite our success in scaling the program, there is considerable room for expansion. Of the estimated 600,000 mothers who receive home visiting each year in the USA, we have determined that up to 210,000 (35%) suffer from major depressive disorder at some point during services. Yet, few receive any kind of mental health treatment. Continuing to



launch new sites will allow an increased number of mothers the ability to receive this effective treatment.

COLLABORATIONS

Development and research of MBD has been supported by the National Institute of Mental Health and Interact for Health (Cincinnati, OH). These efforts were carried out with the collaboration of Healthy Families America and the Nurse-Family Partnership. MBD is grateful for the support of and partnership with the United Way of Greater Cincinnati, Ohio Help Me Grow, and Kentucky H.A.N.D.S..

PEER REVIEW & REPLICATION

All peer review articles can be found on our website: <http://www.movingbeyonddepression.org>

Selected publications are below:

Ammerman, R.T., Putnam, F.W., Altaye, M., Stevens, J., Teeters, A.R., & Van Ginkel, J.B. (2013a). A clinical trial of In-Home CBT for depressed mothers in home visitation. *Behavior Therapy*, 44, 359-372.

Ammerman, R.T., Putnam, F.W., Altaye, M., Teeters, A.R., Stevens, J., & Van Ginkel, J.B. (2013b). Treatment of depressed mothers in home visiting: Impact on psychological distress and social functioning. *Child Abuse & Neglect*, 36, 544-554.

Johnson, K., Ammerman, R.T., & Van Ginkel, J.B. (2014). *Treating maternal depression in home visiting programs: Opportunities for states*. Every Child Succeeds, Cincinnati Children's Hospital Medical Center, Cincinnati, Ohio.

Ammerman, R.T., Peugh, J.L., Teeters, A.R., Putnam, F.W., & Van Ginkel, J.B. (2016). Child maltreatment history and response to CBT treatment in depressed mothers participating in home visiting. *Journal of Interpersonal Violence*, 31, 774-791.

Ammerman, R.T., Mallow, P.J., Rizzo, J.A., Putnam, F.W., & Van Ginkel, J.B. (2017). Cost-effectiveness of in-home cognitive behavioral therapy for low-income depressed mothers participating in early childhood prevention programs. *Journal of Affective Disorders*, 208, 475-482.

MBD has been successfully disseminated to 18 home visiting and early childhood programs covering over 18,000 mothers in 12 states across the country. To date, we have trained over 800 home visitors and over 130 therapists and team leaders.

In addition to Every Child Succeeds and Cincinnati Children's Hospital Medical Center, below are the

organizations that adopted MBD in their home visiting and other early childhood programs:

- Massachusetts Department of Public Health
- Kentucky H.A.N.D.S
- Kansas Department of Health and Environment
- Lancaster General Health (PA)
- Centerstone of Tennessee
- TEAM for West Virginia
- Nevada County Public Health Department (CA)
- Children's Trust of South Carolina
- Promise 1000 Home Visiting Collaborative (MO)
- Yolo County Health & Human Service Agency (CA)
- Florida MIECHV
- Cradle Cincinnati (Healthy Start) (OH)
- Hopple Street Neighborhood Health Clinic (OH)

RESOURCES PROVIDED

MBD resources and materials include:

- Customized MBD implementation plan
- IH-CBT treatment manual
- IH-CBT CD of clinical tools
- MBD marketing materials
- Depression screening and referrals report templates
- Clinical data reports for each site, compared to clinical trial results
- Program implementation reports to be used for CQI
- Monthly informational and educational emails targeted to therapists and home visitors/early childhood professionals
- Ongoing training and consultation

Key words: depression, perinatal depression, postpartum depression, maternal mental health, perinatal mood disorders, child development

****For more information about this program please**

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