

Moving the Bar for Maternal Depression

Afternoon, everyone. This is Nancy Topping-Tailby from HV-ImpACT. And it's my pleasure to welcome you to our webinar this afternoon Moving the Bar for Maternal Depression, System and Practice Strategies That Work.

Sounds good.

It is good.

[INAUDIBLE].

We're looking forward to talking with you today about lessons learned from the Home Visiting Collaborative Improvement and Innovation Network or HV CoIIN that awardees can apply to system and practice strategies when you screen primary caregivers for depression and when you are referring caregivers with a positive screen to services who receive one or more service contacts.

And this is our slide that we always share, because we want to be sure that we are able to hear you. We ask that you do mute your computer speakers so that you don't get an echo while you're listening. You can mute your phone, although we have muted you by pressing the star pound.

If it's noisy where you are, please use the Chat feature for comments and questions. You always do that and we get such rich feedback. So we hope that you will do that again today.

We are recording. And we are posting all of the recordings on the portal for you to look at or come back and revisit when you have more time.

Please use the Technical Support box if you need to reach our support team, although we hope that it will be seamless today.

And there is one handout, which is a PDF of the slides that we'll be looking at today, that you can download. You can find the slides directly on the right-hand corner underneath the screen and just click on the File and then click the Upload button and you'll be directed to another screen where you can download the file and save it to your computer. If you have technical issues, please let us know.

And at the bottom left-hand screen you'll see the link to the Evaluation Survey, which will come out automatically at the end of the broadcast. But if you know you need to leave early and can't stay the whole time, please copy that link, because we do want to hear from you. Your feedback is very important to us.

So as you know, recipients may coordinate with and refer to direct medical, dental, mental health, or legal services and providers covered by other sources of funding for which non-MIECHV sources of funding may provide reimbursement. The MIECHV program generally does not fund the delivery or cost of direct medical, dental, mental health, or legal services.

However, some limited direct services may be provided-- typically, by the home visitor-- to the extent required in fidelity to an evidence-based model approved for use under this FOA.

On today's webinar, Darius Tandon and Linda Beeber, faculty from the Home Visiting CoIIN, will be sharing lessons learned from the Home Visiting CoIIN on maternal depression. You will also hear from Eric Bellamy, the South Carolina awardee, about why his state chose to participate in the maternal depression CoIIN and from Georgia Deal at Carolina Health Centers, a local implementing agency in South Carolina, about what their team did to move the bar.

Dr. Tandon will be talking with you about the mothers and babies course. This is just one approach that awardees can use. There are many activities that MIECHV programs can do outside of the provision of mental health services from a licensed clinician that can improve the lives of families dealing with a maternal depression. Prevention-based activities or possible model enhancements can be completed by home visitors within regularly scheduled home visits or by LIAs through organizational policy and practice refinement.

The strategies that we're sharing with you today are all sensitive to MIECHV program requirements. Contact your HRSA project officer if you have questions related to budgeting or policy implications and to contact your model developer representative for guidance on incorporating any of the strategies that we're sharing today.

So it's my pleasure to introduce our presenters. Darius Tandon is an associate professor at Northwestern University Feinberg School of Medicine and associate director of Northwestern Center for Community Health.

Trained as a community psychologist, Dr. Tandon has considerable expertise in the design and the implementation of community-level interventions. He has been the principal investigator on numerous public and private grants. Much of his recent work has focused on the development and replication of mental health interventions aimed at preventing the onset and worsening of depression among perinatal women in home visitation and early childhood programs.

Dr. Tandon is the lead faculty for a HRSA Collaborative Innovation and Improvement project aimed at improving home visiting programs the recognition and response to maternal depression.

Linda Beeber has taught or practiced psychiatric nursing for over 35 years. Her research has focused on developing mental health interventions for populations that have difficulty gaining access to health care and depression in a variety of patient populations. Her recent work has been to embed depression care into home visiting programs for mothers, infants, and toddlers at risk.

Eric Bellamy has served as a South Carolina [? paternal ?] infant and early childhood home visiting. Oh, I will-- manager. I'm sorry. I lost my next page here. Says 2010. I'm sorry, Eric.

Overseeing the operation of the project's initiative. His past experience includes working on various adolescent and young adult health initiatives, Hurricane Katrina and Rita relief projects, and infrastructure building for children's mental health and substance abuse services.

And finally, Georgia Deal is the director of early childhood services with Carolina Health Centers. In this role, Georgia is involved in the daily management of the early childhood division, providing leadership and supervision to all staff and direct supervision to the Nurse-Family Partnership nurse and the clinical supervisor. Georgia has worked professionally with families strengthening services for over 24 years.

She holds a Bachelor of Science degree in economics and elementary education from South Carolina State University, and a Masters of Arts degree in human resource management from Webster University. She's a certified supervisor in healthy families, parents and teachers, and growing great kids, and a certified administrator in Nurse-Family Partnership.

So we have quite a lineup for you today. So before we get started, we're going to pull up some polls and do our Jump-Start the Brain, Take 1. Please do your best-- take your best guess at answering these questions.

A major focus of the maternal depression CoIIN was to help women who screened positive for depression to access services and experience a 25% reduction in symptoms within 12 weeks from the first service contact.

Local implementing agencies who participated in the maternal depression Home Visiting CoIIN identified discomfort with talking about the topic as a common barrier to screening for depression.

And the last question-- all of these are true or false-- is a lesson learned in the CoIIN is that training cannot alleviate the fear of home visitors that talking about depression may increase a mother's risk of suicide.

So it looks like most of you have a fair degree of confidence that the first two questions are true. On the last one it's showing up a little bit differently. So it looks like it's a scattering of true and false responses. I will give you just a moment more. And as you know, we'll return to these at the end of the broadcast.

All right. Let's move on. Thank you, Kate.

OK. So at this point, it's my pleasure, I'm going to turn it over to Darius who will talk with you now about some of the work of our Home Visiting CoIIN starting back in 2013. Darius.

Thanks, Nancy. I'd just like to start by saying I'm getting a real treat out of looking at the Chat box and seeing where everybody is joining us from today. And welcome to everybody. And thanks for taking the time out of your busy schedules to hear this presentation on a topic that I know I feel is an important one and I'm sure many of you are grappling with in your programs.

So I'm going to start by talking a little bit about the Home Visiting Collaborative Improvement and Innovation Network, which is a mouthful, which is why we refer to it in shorthand as the Home Visiting CoIIN.

And for those of you who aren't familiar with the Home Visiting or HV CoIIN, this was initiated in the fall of 2013. And the CoIIN selected different areas where home visiting programs could focus their efforts. And these areas were areas that were deemed to be, quote, "ripe for improvement." Maternal depression was one of those areas. Breastfeeding, family engagement, developmental screening were the other areas of focus for these Home Visiting CoIINs.

And the idea is to try to work with programs that were part of the CoIIN to identify and implement evidence-based practices that could result in breakthroughs or improvements to their programs if those activities and experiences were implemented at a program level.

And it's also important to note that the improvements that we were shooting for through the Home Visiting CoIIN really were intended to map on to benchmark areas that were mandated for MIECHV programs.

So I have the good fortune of working with Nancy Topping-Tailby, who you've heard from already today, and Linda Beeber, who you're going to hear from a little bit later on in the webinar. The three of us were the core faculty for the maternal depression CoIIN.

We also had additional faculty who assisted with us throughout the process. And Doug and Bob Ammerman, Deborah Perry, Brenda Jones-Harden were those faculty members.

Here's the diagram that visually depicts what the Home Visiting CoIIN and what CoIINs are aiming to accomplish. And this is a very busy figure. Let me spend some time trying to break it down for you.

At the core of Home Visiting CoIINs and CoIINs in general is the idea of doing plan, do, study, act, or PDSA cycles, to essentially test changes that are being implemented at a program level. So if you look at this diagram, you will see really towards the right-hand side those cycles where you see PDSA and you see these learning session one, learning session two, learning session three.

And you also see the arrows. And underneath the arrows you see action periods.

Really, the idea in working with home visiting programs was to get them to select a change package or an action that they wanted to test by a plan, do, study, act cycle to see how that change was working for them at a program level. And you'll see in a few minutes that these changes could be in different areas related to addressing maternal depression. Some could be related to screening. Some could be related to service delivery. Some could be related to building capacity of home visitors to address maternal depression.

But really, the idea here is to have programs, as I said earlier, select changes that they felt could make an impact at their program really identifying where they felt they needed to focus their energies and then use these plan, do, study, act cycles as a way of testing how those changes or those activities were working at a program level.

Just to give some background, these data may not be a surprise to many of you on the webinar today. One of the reasons that maternal depression was selected as a high priority topic and a focus for the Home Visiting CoIIN is the fact that many women in Home Visiting are affected by maternal depression.

There's been a number of studies that have demonstrated that around half of the women in Home Visiting experience elevated depressive symptoms with another 10% to 15% experiencing major depression. If you add those two numbers together, you get about 2/3 of women in home visiting programs who either would meet criteria for major depression or who would have elevated depressive symptoms.

And what we know is that for women both experiencing clinical depression and those in that mild to moderate range, even if you're in that mild to moderate range, it has a substantial impact on mom's own functioning and quality of life, but also the quality of interactions that she's going to have with her child and other individuals in her life.

We also know that many of the women who are experiencing depressive symptoms, whether it's mild or moderate or severe depression, many of them do not get services. So again, a number of studies have been done within the home visiting context, including some of our own work, that shows that women who are identified at a program level as needing mental health services oftentimes are not getting services. And that is for a number of reasons.

So bringing it back to the work of the Home Visiting CoIIN, the first step that we took as a faculty team was to really set an aim for what we wanted to accomplish through the Home Visiting CoIIN work. And so we selected a very ambitious aim for the Home Visiting CoIIN, which is to have 85% of women who screen positive for depression, who also access services, exhibiting a 25% symptom reduction in 12 weeks after receiving a first contact for their depression.

And what you see on the slide in that big green box is another way of thinking about the SMART aim, which is that women who access services are going to get better. And we went back and forth on what the appropriate aim should be for this collaborative. And ultimately, we said, well, access to services alone is not sufficient. We really want to see symptom reduction. And we want to see meaningful symptom reduction. Thus the development of this SMART aim.

So this was really the aspirational aim that all programs that were part of the CoIIN were asked to focus on as they were selecting change packages that they were going to work on.

In terms of thinking about how programs, how home visiting programs were going to get to that SMART aim, what we did was to develop five primary drivers or five primary approaches to focus our efforts. And these five are depicted here in this pie chart. So active family involvement in maternal depression support, standardized and reliable processes for referral treatment and follow-up, competent and skilled workforce to address maternal depression, standardized and reliable processes for screening and response, and also a comprehensive data tracking system.

When you look at those drivers in this visual, you then see how the drivers are related to specific changes or interventions that the programs that were part of the Home Visiting CoIIN were asked to implement and test.

So if you were to take a look at that first primary driver at the top of the slide, Standardized Reliable Processes for Maternal Depression Screening and Response, that is the focal point, but the specific changes or activities programs were asked to implement are in that blue box numbered one through five at the top of the right-hand side of this slide. So things like having a policy and protocol for screening that includes the use of reliable and valid tools. The final one, a reminder system for re-screens.

So at the end of the day, programs were asked to select not just the primary driver that they were interested in, but also the specific changes or interventions that they wanted to test.

And reiterating a point that I made earlier, programs that were part of the CoIIN, they selected which one of these drivers was going to be most impactful for them. So if they felt like they had screening under control, they probably would not have selected primary driver one, but would have selected one of the other primary drivers.

So this is a visual giving you a sense of some of the LIA members and the CoIIN faculty who were part of this important work that we were undertaking.

And with that, I am now going to pass it along to Linda Beeber who's going to be talking more specifically about some examples of the activities or the changes that some of the local implementing agencies implemented as part of their work with the CoIIN.

Great. Thank you, Darius. Welcome, everybody. And I just want to tell you that this experience in the CoIIN was a first for me.

And I just learned so much from the various programs and LIAs who were a part of it. And just was blown away by the process that went on there and how rapidly people could learn from each other. Of course, fanned on by the motto of shamelessly steal from each other. Steal shamelessly from each other. In other words, there was a lot of, oh, that looks like a great thing. I think I'll try that too. So it was a really rich experience for me as well.

I want to move on here to primary driver one and, first of all, to talk about primary driver one and talk about what the programs did with this first primary driver. Most of our LIAs had reliable instruments already in place, but needed help overcoming the barriers to starting the screening. And in a reliable way across all home visitors, knowing how to respond to mothers who screen positive for symptoms as well as knowing how to handle mothers who are not ready to accept the referral to an evidence-based service and mothers whose symptoms got worse. All of those were issues that came up in that first driver.

So I was curious, if you could type in the Chat box for a minute, let's take a look at some of the barriers to depression screening that you have experienced. I should say don't all type at once, but I think with the number of people, everybody will type at once. So just feel free.

All right. Yes, culturally unacceptable to get help. You bet. Domestic violence, yep. Client doesn't want to screen. Don't think they need to complete it. I love that cultural, we don't complain. Yep, that's a very strong one. Yep. Yep. Mothers don't want to talk about it. So many make the assessments, you forget this one. Yep, that can happen. Stigma, definitely.

Yes, so all of these were constant issues that programs brought forward. And I think that these were ones that we heard a great deal about. I think the overwhelmed one is a great one by Kylie, because there was just so many, many pieces of data and so many pieces of paper to get out to families that people did not know what to do with them.

Active substance abuse is another one we often see, that mothers and even fathers are medicating themselves, so to speak, treating themselves for what is an underlying depression. Sometimes it's a response to recovering from substance abuse. When the substance is withdrawn, depression is very common during that process.

Waiting list for treatment. That's a great one, because the-- thank you, Valerie-- there were definitely issues about what are we going to do once we find this? There's no services for these mothers. Some of them like a nurse-family partnership program that might be serving pregnant women, the people will not treat pregnant women.

Yes, family member stepping in. Husband not wanting the mom to have services, because it will be embarrassing or bring shame on the family.

Lots of cancellations and difficulty getting out the door to get to these other issues. Instrumental barriers like transportation, these are all the issues that came up when we worked with CoIIN folks. So you all have had a lot of experience.

OK, I'm going to deal with a few of these, talk about a few of these that came up. These were ones that were very, very common in our discussions as we worked with our CoIIN participants.

The issue here of discomfort with the topic was definitely a big one in terms of home visitors actually being able to talk about it. A lot of home visitors would express the idea of producing depression or producing even suicidal ideas, if I ask about it, then it will happen. Then the issue of inadequate resources, which you've mentioned, making the fear of making the problem worse by talking about it, concern about liability issues. These were mentioned repeatedly.

So what I'd like to do is talk some about what were some of the solutions that various programs came up with, and just to give you some ideas about what might be out there. The first, I call it broaching the topic, using-- bringing up the topic. And there were three good approaches that came up repeatedly and seemed to work successfully for programs.

Using the business as usual approach was great. And often programs were initially hesitant to offer a depression screener on the first visit or the second visit during assessment, but that actually turned out to be a good time to offer this up. The idea here being that we screen everybody. We ask all of our mothers how they're feeling, because it's so important to their

health and their baby's health. Our program believes that mental health is part of being healthy overall.

We screen it. We screen all our mothers, because it happens a lot. A lot of our mothers are under various stresses. And stress is one of the drivers of depression development. Or we just think your mental health is really important. And so we screen along with it.

So just offering a screener when you're doing all of the other assessments kind of takes the edge off it. It's like saying we screen for a variety of things and mental health happens to be one of them. And therefore, we're not singling you out, because you're the depressed mother, which is often something that happens to moms and how they feel about it.

The second approach was weaving the topic in the program material. And in this approach, sometimes with particularly a wary mother or a mother that does not engage or perhaps refuses or has a lot of stigma associated with it, you can choose a child's behavior that the mother is concerned about and link it to how she's feeling. This requires caution, because you don't want to get into the issue of causality here, of you've caused your child's behavioral problem. But you can approach it from the standpoint of anticipating that you're going to approach it this way and then choosing appropriate program guidance that you're going to bring with you and then make it the focus of the visit.

So the interaction might go something like this. I notice when Manuel cries, you look upset and you try to feed him. How do you feel when he cries? And then the mom talks about that. And then, well, I brought something to help with that. And then do the program-based activities. And then you're in a place where you can start talking about, your feelings are important. Also, to how Manuel behaves. Tell me about how you've been feeling lately.

You need to be sure, and the programs talked a lot about this, about being sure that you had all the screening forms and you were ready to broach the topic and screen and start the process if the mom decided to talk about it with you.

A third approach that the programs brought up was we called it the *carpe diem* or seizing the moment approach, and that is that you are going to anticipate that the mom will have something that she's going to bring up, because she's brought it up before. And so you prepare an opener that the home visitor expects and is ready to seize on.

So of course, again, you bring the depression screening forms and you're ready to start that conversation. So a sample opener would be to use open-ended questions or statements. And those, of course, are features of motivational interviewing. And you might say something like, I saw you had to really work hard to be patient with Curtis just now, more so recently. Have you noticed that too? Tell me about that.

Or you brought up feeling tired several times today. I think it's important to talk about. Tell me how long that's been going on.

So in other words, these are moments that you're ready to seize upon and bring depression screening into the conversation. So those are three approaches that the programs came up with that we just thought were wonderful.

Here's an example of what Rappahannock did, Healthy Families Rappahannock, Virginia, did. First of all, creating this tool here of general guidelines for home visitors. In this, it's very interesting. And it's been borne out, I think, by a number of studies, including the work I've done, that you avoid the word depression without being devious or ingenuine. You can focus on the mother's words that she uses herself or the parent's words.

And that means that, I noticed that you look sort of sad lately. What do you call it when you feel that way? And then get the mother's words of her own. And then from that point forward, you use that. These are some questions we ask when mothers feel like this, instead of, again, using the word depression, which is often a stigmatized mental health [? misused ?] word.

They were using the PHQ-9, so they were giving guidance on the score that the PHQ-9 produces. And then, also, if you notice about risk assessment, because that asks directly about suicide, the PHQ-9 does. So they had immediate guidance on that.

Then the remainder of the tool here was to create a talking point tool, which we thought was just wonderful. Again, using those same kind of open-ended questions, reflective kind of questions, the question of you deserve to feel better. How can I support you to feel better? How can I help you get connected with other sources of support? These were wonderful talking points that Rappahannock produced.

Moving to primary driver two, which was creating a competent and skilled workforce to address maternal depression. We, of course, went into a lot of different strengthening devices that programs could use to build in in-service kinds of strength in their home visitors.

So one of the issues that came up that many programs use, one of the programs was motivational interviewing. It's one evidence-based approach that many programs can find useful, because it fits just about any sort of program model. It employs about four to five core communication skills that include open-ended questions, which we've looked at already, affirmations, reflective listening, and summarizing.

And we worked with the programs to provide coaching. We encouraged the programs to test out rapid cycle testing changes using motivational interviewing communication skills.

This is a example of Stark County. They created this tool to support implementation of motivational interviewing. They tested repeated cycles of motivational interviewing by adding one technique or communication skill at a time, so that the home visitor could develop their confidence incrementally by applying the newly acquired skills.

One of the other things that they did that was very clever was that they encouraged their home visitors to talk about mundane kinds of issues. Not go directly into how the mom was feeling or a mental health issue right out of the box, but to talk about other kinds of things, like eating or

playing with the child or exercising or some of these other topics that wouldn't be quite as charged. And then as they built up their confidence and their repertoire of skills, as they enlarged it, then they can move to address maternal depression. We thought that was an incredible way to test that out.

So we wanted to know whether any of you had integrated motivational interviewing into your MIECHV program. And do you have any helpful hints about how you did that? Again, use your Chat box.

I see some wonderful hints there about taking the name of the depression screener off the top Yep, that's a great one.

So Allison says they use MI with MFP. Oh, what a great idea! So Megan types that we read the motivational interviewing book and have a book club to review. That's a great way of doing it.

And I wonder if you practice with role plays. One of the things that's really important with all of these rapid tests is to make sure that the home visitor's using their own words. And there's something about saying it out loud that really makes it different than just keeping it in your head.

Here's Shani Armstrong who says they have MI coaching sessions every month to help implementing this with our families. That's great.

And then, OK, in Maryland, we were able to produce [INAUDIBLE], a new home visiting certificate program that uses it to address difficult topics. Absolutely.

Looks like there's a lot of movement beyond the initial training to actually offer practice sessions and informal and formal practice sessions and to actually, again, get people to actually use these in a role play or use these in sort of conversational ways with each other. And that really helps make it part of their language and make it part of their usual way of conducting business with the family.

All right. So there's a workshop and role play from Melissa. Oh, back from Shani Armstrong again.

OK. Well, keep those coming. I'm going to move on here. Some great ideas coming forward on how to actually make MI part of your program.

The third primary driver was on standardized processes for referral treatment and follow-up. Many of our programs, as Darius mentioned, already were really doing well with screening. But where they needed to strengthen their programs was on how they were referring, who they were referring to, and how those referrals were followed up on.

So three things that we found that came up during the CoIIN that were very, very helpful were, first, the decision tree for screening responses, crisis response protocols, and the Mothers and Babies course. So we're going to cover those next.

I had worked with Nurse-Family Partnership to develop a mental health augmentation to the Nurse-Family Partnership and was able to adapt a screening and rescreening and referral decision tree actually that I had started developing in Early Head Start when I worked with them. And the Ingham County-- from Oakland County, Michigan, the Ingham LIA from Oakland County, Michigan, developed this protocol using the PHQ-9.

Each program can develop one that fits their program, fits your program, fits your community, fits the kind of resources that you may have. But you can see that in the PHQ-9, you need to have people who are under, perhaps, maybe a bit close to that threshold line, how do you follow up with them? People who are not at all symptomatic, how do you follow up with them?

That's important, because life changes. And even positive changes can trigger depressive symptoms in mothers. So it's often important to follow up on your negatives on the people who don't score at all.

Close to threshold. You'd want to figure out a way to follow up with them in some reasonable period of time that makes sense to your program.

For those who score at threshold or above, then you definitely can enact a few different interventions. You can offer services. You can do follow up to find out whether the mother has taken the services. You can then follow up to see whether the services are reducing the symptoms.

Then you need a way of following up on a parent who refuses treatment. What do you do? Obviously, you don't want to just leave that parent, but you want to figure out a way to come back, to rescreen, to reintroduce the idea again.

Sometimes, and one thing that we talked about a lot with programs was, you may be doing exactly the right thing, but it may be the wrong time for this parent. And so as a consequence, you want to reappear and reoffer, give them another opportunity. It may be a matter of where they are or where they are with you, the home visitor, or a variety of other factors.

So each program could develop its pathway that looks a lot like the Oakland County, Michigan, program.

This was another one that was developed. It was a crisis response protocol. And this came up repeatedly that, of course, people were worried, well, what if this mother in particular has a suicidal crisis? What do I do? How Who do I communicate with? How do I prepare for this? Because it doesn't happen very often.

And we often use the analogy of it's like a cardiopulmonary resuscitation. It doesn't happen very often, so you have to have a protocol for it and you have to practice periodically to make sure that you understand or that you feel like you're confident and you know what to do when it happens.

So the Carolina Health Centers in South Carolina had this great protocol that actually walked the person right through it. And that's what we thought was a great example of what a program could do.

This is something that I have found very helpful with programs is this is a template here. And if you notice, it has things like phone number. In other words, there are steps that the home visitor can follow. There are communication lines about who they call. There are issues of concern, like who's going to take care of the child? Who do we call to come and be with the child if the mother needs to go to the hospital?

And so if you can take this template and adapt it to a home visiting program, you can make it fit the kinds of resources and the kinds of communication lines that you want to set up in your program. So that's just another example

OK, at this point, I'm going to turn it back to Darius to talk about the third topic, which was, again, building within program capacity through the Mothers and Babies course. Go Darius!

Thanks, Linda. And I'm going to ask Kate if she can pull up the poll. And we have the poll questions on this slide for you, which are whether your program is already using Mothers and Babies, whether you're interested in learning more about Mothers and Babies, as well as using other approaches to address maternal depression.

OK, it looks like the numbers are-- well, the numbers are still going. So it looks like there are a few programs that are already using Mothers and Babies. I know I saw some of you from the Home Visiting CoIIN that are on the webinar. So that does not surprise me that some of you are. Great to hear that many of you are interested in learning more. I'll be giving a very high level overview for a few minutes right after the poll.

And it also looks like a number of you are using other approaches to address maternal depression at your program. And obviously, as Linda said, Mothers and Babies is one approach of many that programs can use. So it's good to know that many of you are already doing something to respond to those moms who are exhibiting depressive symptoms.

OK. Thanks, Kate.

OK. I'm not seeing my slides. There we go. OK. Thank you.

So high level overview of Mothers and Babies. So this is an intervention that we have been working with for a number of years. It was initially developed about a decade or so ago. And we have done a lot of work to really try to adapt it and to make it fit the context of home visiting and other early childhood programs, but primarily home visiting.

So it uses largely cognitive behavioral approaches. And we give some examples of what that means. It encourages engagement in pleasant activities. It encourages individuals to reframe harmful thoughts and encourage helpful thoughts. And it focuses on increasing social support.

There's also a strong attachment component to Mothers and Babies whereby we promote attachment between caregiver and infant. So as an example, our curriculum focus on encouraging engagement in pleasant activities, we talk about how pleasant activities could be things that you do by yourself, but they could also be pleasant activities that you do with your child or your children. And so in that sense, it's promoting that attachment or interaction between mom and child.

Importantly, we don't really refer to Mothers and Babies as a depression intervention. It really is framed as a stress management course or a stress management intervention. And if you were to look at our materials, you would see that that really is how we start the conversations in the curriculum by talking about the fact that everybody has stress in their life. And the skills in Mothers and Babies, the cognitive behavioral skills, are really intended to be skills to help you manage those stressful things in your life.

There have been a number of studies that we've conducted that have demonstrated that Mothers and Babies is effective in reducing depressive symptoms, preventing depressive episodes, improving mood regulation, and improving coping skills. The studies that are in bold there are studies that were done specifically in home visiting settings.

Mothers and Babies was initially developed and tested as a group-based intervention. Very quickly, the group-based intervention is six sessions. Each session lasts about two hours in length. I'm not going to spend as much time today talking about the group model, but I will show you at the end of the presentation where you can get more information on the group model.

This is a slide that I shamelessly stole from Linda, which I think really nicely shows why we are doing Mothers and Babies and what our focus is with Mothers and Babies.

So Mothers and Babies traditionally has been more focused on preventing the onset and worsening of major depression. It is not so much focused on treating major depression among women who are already exhibiting major depression.

And if you look at this slide, what you see is that there's a much smaller percentage of women who have that diagnosed depression, that major depression, that are on the far right-hand side of this image, but you have a much larger group of individuals who have mild to moderate symptoms. And if you remember back to one of the earlier slides I presented, we talked about that 10% to 15% experiencing major depression and that 40% to 60% in that mild to moderate range. And that's exactly what's depicted here in this slide.

So related to Mothers and Babies and the one-on-one modality, so, again, we are continuing to implement the group version of Mothers and Babies, but we also know that not all home visiting programs have the ability or the interest in running groups. Thus we created a one-on-one version of Mothers and Babies, which is really taking the same core content in the group curriculum and has turned into 12 sessions that last 15 to 20 minutes in length. And the idea is that by doing the curriculum in these 15 to 20-minute chunks, home visitors should be able to integrate these sessions into regular home visits.

I will say that while the gold standard is to deliver the material in person, we also give flexibility to programs to have home visitors deliver the content by phone or by telehealth like Skype if in-person visits is not possible.

We also encourage completion of personal projects between sessions. This really boils down to the fact that this is a cognitive behaviorally-based intervention where we really are trying to get folks to practice some of those cognitive behavioral skills between sessions. And that's really what the personal projects are focusing on, practicing the skills that are being taught during the one-on-one sessions.

This gives you a sense of what's in the one-on-one curriculum. The first two sessions are very much sort of an introduction, laying the foundation for why Mothers and Babies is useful. That is also where we talk about the stress management orientation to the curriculum.

And then there are three modules that map on to those core cognitive behavioral concepts. So a module on pleasant activities, on thoughts, and on contact with others. And then, finally, a session that is really course review and planning for the future.

This gives you a sense of what a session looks like in Mothers and Babies. So within each session. So again, if you think about the previous slide, there are those 12 sessions. So within a session, there are different topics. And for each topic, the facilitator is given the key points, which are the main messages that need to be communicated to the home visiting client.

Then the facilitator is also given a very detailed script that can be used when communicating the material. Really important point. We provide that script to the facilitator, but we really encourage the facilitator to use their own words, to use their own language, to use their own examples in delivering the content. So the script is there as a safety net and a guide, but we really want the facilitator to use their own words, their own language, their own examples.

We have a number of interactive activities throughout the curriculum, so that it isn't just the facilitator speaking at the client, but rather it is something that is interactive, discussion-oriented.

And then, finally, I mentioned a second ago that there are personal projects that are given to clients related to practicing skills between sessions.

Really quickly. We have many, many programs around the country that have been doing Mothers and Babies and many, many programs that have provided us feedback. I've just pulled out one client testimonial and one home visitor testimonial.

Here's the client testimonial. It speaks to a number of different aspects of Mothers and Babies. Says, "I learned how to have a strong support system, which a lot of mothers like me do not have. I also learned to keep lines of communication open, because if you're not talking, no one will know there's a problem. I understood that I need to do activities to feel good. I also recognized the activities I like to do alone and what activities I can do with my baby."

So it really nicely touches on a number of things that we're really trying to get at with the curriculum.

In terms of the home visitor testimonial, very succinctly, a home visitor said, "Mothers and Babies can be useful for all mothers to help them learn how important it is to take care of their mood and emotions not just for themselves, but also because it influences the way they parent their baby."

Which, again, is one of the reasons that we are really fond of Mothers and Babies, because we not only believe it can improve mom's mental health, but it can also improve the way that she's interacting with her baby.

For those of you who might be interested in exploring Mothers and Babies further, we typically suggest that to implement Mothers and Babies that you would go through a day and a half training, which would be in person, which provides a detailed overview of the intervention, practice doing some of the Mothers and Babies activities, and discusses some of the logistics of what implementation would look like at your site.

We also recommend that staff who implement Mothers and Babies and their program supervisors would attend that training. And then after the training, we also provide six structured supervision sessions to support providers who are implementing Mothers and Babies for the first time.

So really, the idea is that the training alone is going to be necessary, but not sufficient. And the supervision is really useful as you start implementing to see how things are going and to be able to troubleshoot.

In terms of cost, there is a sliding scale for the training and supervision. Our bottom line is we want programs to be using this intervention, so we're very willing to work with programs.

There are travel costs that may be associated, depending on where your program is.

Printing of materials. There's no cost for that. I'm going to show you in a couple of slides where you can actually download all of the materials for free.

If you end up using the group version of Mothers and Babies, you may have costs associated with transportation or child care. And if you are having somebody who is not a Home Visiting staff member deliver the intervention, you may need to pay for a group facilitator.

One of the things that I didn't mention explicitly earlier, but I will say now is that, really, what we're gravitating towards with Mothers and Babies is having home visitors be the facilitators, to be the ones who are delivering the curriculum, whether it is the one-on-one modality or the group modality. And the idea there is that home visitors are in a place where they can be trained, they are seeing clients on a regular basis, and they really can be effective providers of this intervention.

So this is my contact information. If folks have additional questions, I'm very willing to answer any questions that you have via email. This is our website mothersandbabiesprogram.org. And on that website, you can take a look at the one-on-one and the group intervention materials. You can download them for free. And that's a way for you to really get a sense of what's in the curriculum. And perhaps you'll have additional questions after taking a look at that material.

So why don't I stop there. Those are all of my slides.

There are some questions, Darius--

OK.

--in the Chat. Do you see them? Do you want to take a couple now or you want to wait to the end? What do you think?

Yeah, so let me go through these. So do those who use it over the phone find it effective? I think the answer to that is yes, with the caveat that I think it is more effective doing it in person. I think, typically, what we see is that it is not just phone only, but phone is done if there's a reason that you can't get to a client.

So in the Midwest here, we have snowstorms. Some of you may be living in other places where there are long drives for a home visitor to get out to see a client. And there may be issues in terms of getting out to see a client.

So I would say that it is effective. But again, the gold standard that I would push is for it to be done in person.

Has this been adapted for use with fathers and babies? Great question. We actually have a grant right now where we are working to develop the Mothers and Babies [? Dad ?] curriculum.

So if you ask me that same question in about nine months, I would be able to show you a draft of what we have been developing. We're really excited about this. And we're going to be pilot testing the curriculum probably early next year with a very small number of programs here in Illinois. So I would say stay tuned to that.

Looking at other questions here. I also want to be cognizant of time.

Can this be used with foster parents, mothers and fathers, as well as adoptive parents? I think we are very flexible on who this would be used with. I think we tend to give home visiting programs the discretion to use this with who they think it's going to work best with. So I would say that that certainly is a possibility.

Is Mothers and Babies training provided to clinicians working in embedded clinics, like a pediatrician office? Yes. We've done Mothers and Babies largely with home visiting, but we've done it with a number of different settings. We did a trial in a pediatric primary care clinic. We've done work in WIC clinics. We've done work with the curriculum in NICU settings. So I

think that there are a variety of different settings where we have demonstrated that this can be feasible.

Nancy, do you want give me sort of a gong if I'm going over my time?

Yeah, I was actually about to give you a gong and say, they're great questions. But why don't we keep moving and then we can circle back if there's time at the end. How does that sound?

Perfect.

And people have your contact information. So if they have questions and you haven't answered them for want of time--

Thank you so much.

--not willingness, they can get in touch with you, OK? Thanks.

Perfect. Thank you.

All right. So we're back to Linda.

Yep.

Yep. OK, and hello again. Glad to be back with you.

This slide shows you that the Home Visiting CoIIN resources are available to you. And I'll show you another slide that has even more resources. But the current kind of articles and the various playbooks that the home visiting programs use are available through this website.

And also, the CoIIN is offering one-hour overviews. So if you're interested in that, you have Mary Mackrain who is our project director. You can reach out to Mary and schedule that for yourself or your program. I encourage you to do that.

The next slide shows the actual Maternal Depression Change Package. And you have in this package access to all the PDSAs that the CoIIN participants developed. So if you want to explore one of the change packages, you copy and paste the URL into your browser and that'll give you access to live links in this Google doc. They're all in Google docs And you can review the PDSA cycles that the agencies tested and see how they went.

Again, I suggest that you contact the CoIIN before trying to use the materials. It will really help to understand the background and context for these various maternal change packages.

And also, since these are continuous quality improvement tools, awardees will want to involve your CQI leads in implementing them, as well as everybody else who needs to be onboard. That was one of the takeaway lessons was it was really an effort from everybody. Everybody needed to be involved in these change packages.

The other takeaway was to start small. One of the things that the faculty worked with programs over and over and over again was, why didn't you scale that back? And let's think about a feasible next step for you. We, of course, always want to make that big jump ahead. And it really will work better if you can break that big jump into a series of small steps and take each step as a PDSA.

So what did we get out of all of this? We, of course, had set 85%. And we exceeded that in terms of the moms that were screened. And the programs were great on that. I don't know if you can see my cursor. But we had a continuous actual change here in terms of the number of months that we stayed above 85%. So we exceeded that.

And then on the second aim, which was the aim of 75% of moms at risk would accept a referral to evidence-based services, we reached 80% in the CoIIN.

And then the third aim was that the mothers would get an evidence-based-- actually get a service contact once they accepted the referral. And our aim was 85%. And we had reached consistently around 70% of mothers accepting referrals by the end of the time that the CoIIN ended. So we didn't quite reach that one, but it was looking like it was going in that direction.

So basically, what we were able to do was really see some movement across many different programs, all of whom were different, all of whom used different change cycles and different ways of approaching these issues.

It's important when you see these, and you will have access to seeing these improvement diagrams, that one of the variables that impacted them was the number of programs who were actually trying to do that particular change. Sometimes if the numbers were very small, then it exaggerated the differences and made them seem even larger. So just keep that in mind as you move through those graphs.

So I need to ask you, if we have time, if there are any questions about the strategies that were tested or results from the CoIIN? Anything that you need to know? Or again, we might want to circle back and answer these at the end after we have our two final presenters.

I think that sounds like a good idea, Linda. Why don't we do that one.

Yeah.

And we'll come back at the end.

OK, so now I'd like to turn it over to Eric Bellamy who's the program director and MIECHV state lead for the Children's Trust of South Carolina. Eric will talk about why they joined the CoIIN. So Eric, take it.

Well, good afternoon, everyone. I'm pleased to be here. I have two objectives. One, again, is to talk a little bit about why at the state we decided to be a part of the CoIIN and focus there. And two, really, to give my piece and get out of the way and let our wonderful presenters tell you

about the real, true work of how it was done on the national and local implementing agency level.

So I'll jump right in. Very briefly. So really, we wanted to focus on early on, as Darius mentioned, in late 2013, 2014, being a part of the CoIIN due to the fact that we really wanted to show impact from a service provision standpoint as well as a systemic approach to services through home visiting.

So we worked with several of our-- at the time we had eight local implementing agencies. We are now up to 16. And surveyed them and worked with them on who had the ability to be a part of the CoIIN, the capacity to do this work, and to move it forward and really sustain it over the life of the program.

So we really wanted to focus on the maternal depression part of it. So we had three LIAs that did participate. Carolina Health Centers, who will be presenting-- Georgia will be presenting here momentarily-- and did some wonderful work. But we really wanted to focus on maternal depression piece, because it was one of the key focuses for benchmark data under the six legislatively mandated benchmarks.

The program focus, we really were looking to implement home visiting in medical homes and do that integration, as well as if we were going to holistically serve families and mothers, we really needed to focus on the data coming out of the maternal depression benchmarks and constructs there.

So we really wanted to build a culture of quality improvement using the CoIIN work. So we were looking at the state level as well the local implementing agency level. And we also wanted to incorporate that culture with partners as well. So we were inviting them to the table to be a part of the work that we were doing due to quality improvement.

We wanted to look at operationalizing and standardizing some key strategies with lessons learned through the CoIIN due to the fact that we're implementing five models of home visiting in South Carolina. So we really wanted to standardize some things and see how we could look at the importance of the peer-to-peer interaction and, as Linda mentioned before, how they could steal shamelessly from each other and really have these rich conversations about how to implement better and more efficiently and effectively around maternal depression and other drivers.

And we really wanted to look at the improvements in early detection and connections to resources through these strategies. So we thought it was important working in the CoIIN aspect and using the strategies we learned.

So what did we learn? So after we were part of the first CoIIN and we had implemented a first learning collaborative around quality improvement, we took the lessons learned from the initial HV CoIIN nationally and built our second learning collaborative moving forward, although some different strategies we were focusing on, developmental screening and family engagement, the framework really helped us structure our approach. It helped us identify key drivers and

standards moving forward, as well as it reinforced that peer-to-peer interaction and reinforced the use of data in the implementation of home visiting and strategies moving forward.

We also used the IHI Breakthrough Series in mirroring the work of the CoIIN. And we found it to be very efficient. It gave clarity, as well as it gave good structure to the approaches that we were working with and hoping to standardize moving forward.

And we wanted to really have some common outcomes to really look at how we were going to sustain the gains that we were looking to improve with the maternal depression piece.

So finally, for me, really, the next steps that as we were looking forward and continue to look forward is that we look to use the new CQI efforts in spreading the structure and strategies within and beyond our MIECHV initiative as well as throughout South Carolina.

We've built a Home Visiting consortium here in South Carolina that we're looking to not only take the lessons learned from our maternal depression in the CoIIN work and the work that we've done also on the state level, but how can we spread that to other initiatives in the state to put it through partnerships and collaborative efforts.

And again, it's speaking to the inclusion of other Home Visiting networks in the state through the Home Visiting Consortium And we want to continue those peer-to-peer learning efforts with our local implementing agencies as well as our partners in the field to continue building that culture of QI.

A critical component was the link to medical homes and that care coordination piece and the outcome-driven strategies that we looked at in targeting maternal depression. And it really gave us a true focus and some true strategies of how to implement and work towards a more common goal and getting that richness from the CoIIN work.

So that's really all the slides I have. I can pause for a second. I'm really-- again, brief presentation at TF, the true work that was done at the local implementation agency level. And Georgia will be joining us here momentarily. But I can pause for a couple of seconds to see if anybody has any questions.

And if not, we will move on. So again, Georgia Deal, who's the director of early childhood services at the Carolina Health Centers based in Greenwood, South Carolina, will talk to you more about their implementation strategies, the work that they did with the CoIIN, and how they continue the work moving forward with maternal depression. Georgia?

Thanks, Eric. Hi, everyone. So where we started when we started with it, what we wanted to do was we wanted to increase the number of mothers screening positive for maternal depression being referred for treatment and accessing treatment from 25% to 85%.

So primary driver one, we standardized and reliable processes for maternal depression screening and response. And so what changes we made was we changed NFP screening from the PHQ-9 to the Edinburgh. And then we went back to the PHQ-9 later.

We created new policies and protocols for urgent and non-urgent care responses with accompanying resource materials. And our resource materials was be created a folder for every home visitor that went out on a visit. They had a folder that had all of the resources. And we shared with them the keywords that they needed to say and when they're calling the different agencies to ensure that they could get the family the services that they needed.

We also trained all of our staff on the processes. We identified new materials needed. We measured the staff's knowledge and, extremely important, their comfort. How comfortable they were sharing that information with the family. And we reviewed the utilization following actual urgent family interactions. And we identified needs for improved external mental health provider crisis protocols.

In primary driver two, competent and skilled workforce to address maternal depression. So we improved our data management for home visitors, we revised our protocols, and we used motivational interviewing to increase the rescreening within 30 to 45 days following a positive screening.

We created a script for youth with mothers who declined the referral. And we also created a registry of mothers with elevated scores prior to adding primary driver five.

Two of our home visitors got certified in perinatal mood disorder. And four home visitors were trained in mental health first aid. They came back and they shared their knowledge with the team. And they measured knowledge and comfort following both trainings. And we discovered that they were more comfortable after they had some tools in their hands.

And also, one of the things that happened was we met on a regular basis to ensure that everyone was comfortable and they could share some of their discomfort with the team. So that we were more intentional with that, and that brought in more cohesiveness with the team.

So our key findings were the home visitors were afraid of increasing the risk of suicide. They wanted to make sure that the information that they were sharing with the families was correct and would assist them in accessing services. So the training that we provided, again, alleviated their fears.

Now, the results. Once everyone was trained in Mothers and Babies, we implemented the stress management courses where the home visitors were the facilitators. And as you can see, once we did the training and after we did the training, we actually exceeded our goal.

Now, primary driver three, Standardized and Reliable Processes for Referral, Treatment, and Follow-up. What we wanted to do was increase the number of mothers with a 25% improvement in depression symptoms.

So we developed internal treatment resources. We piloted a group meeting for mothers with elevated screenings in a family-friendly location, which was right in our pediatric clinic. And we tested them for the best time to meet and document barriers to their accessing of services. And

one of the barriers was transportation. So because they were coming to a pediatric clinic, they could actually use the Medicaid van to transport them to the group meeting.

Then we also trained all of the home visiting staff on Mothers and Babies services. So implemented with coaching. We measured the home visitor's knowledge, comfort, and skill.

We tested introductory messaging with the mothers and measured the mothers' responses, improvement in symptoms and participation rate. So once we got that in place, their participation rate went up.

And so as you can see from our results with both healthy families and NFP, the mothers who accept evidence-based services, they had 25% improvement in their symptoms within three months of the service contact. And with one program we went beyond our goal. And even with Nurse-Family Partnership, we're at the goal.

So some of the lessons that we learned. Data collection tools are needed to facilitate, focus, and improve quality. What we think we're doing and what we're actually doing is not always the same.

But we did regular huddles as needed to influence the change. And we had policies and protocols we needed to keep pace with the best practices. And we empower families in service design and delivery, which was very critical.

Change is hard, but seeing the improvement is motivating. So like I said, we met regularly. We met on Fridays. And so we shared our results with each other. And so it became motivating to see that we were making some strides.

The peer support is as critical in families as skill building. Peer support is also significant to staff during the PDSA cycle. So if we can do it, anybody can do it.

The breakthrough moments that we had was the creation of a registry for mothers with elevated scores. So it facilitated data collection, it increased the home visitors' access to their own data, so they knew that they needed to pay attention to the family because of the high scores. So they had that.

And even during the supervision, it improved the supervision, because this registry was part of the supervision. There was a discussion around this.

And then another breakthrough moment was the successful pilot of internal services. So we reduced the barriers to accessing services, we provided clear successes, and engaged families and empowered home visitors.

Access to evidence-based internal service models with the mothers and babies. That was huge for us, because that was something that the home visitors had readily available. So if a mom scored high, they could actually start the sessions on their next home visit.

And then the family focus group motivated the mothers and their responsiveness. So they shared with us exactly what they needed. And they were motivated and they came out after we moved the barrier of transportation out of their way.

So the impact of our home visit CoIIN involvement is the home visitors felt more supported. It increased the depth to program services. It created a problem-solving culture. We focused on areas of improvement. We improved collaboration with the physician. It increased the focus on family input. It increased the knowledge of the community resources that were available.

Peer support for clients in our new group. So they actually connected with each other. There was leadership development in both staff and families.

And then there was that we became better organized. We received the advanced training and even improved in the supervision when it came to talking about maternal depression.

And the catalyst for the team building, that was huge, because we were meeting on a weekly basis.

And depression is an inability to construct a future. And we're building future fighting depression early.

So here's our team, the Nurse-Family Partnership and the Healthy Families.

Thank you, Georgia. That was a wonderful presentation. So before we move to the Jump-Start the Brain, let me just pause for a moment and see-- Linda, I know, was writing some responses to Edwin. But does anyone have questions for Darius, for Linda, for Eric, for Georgia?

Jeannie is saying that, Linda, we do the same here as home visitors. We do a lot of connections.

Yes. Yeah. And the power of what is called social support, which is kind of an understatement, the power of connecting to others, is huge. Huge antidepressant. So I can only stress that those connections of getting families connected with each other is a very powerful approach.

Thanks, Linda. And Darius, there was a question from Sean. Our staff supervisors provided training and how to provide ongoing supervision to staff and how often beyond the initial coaching are staff provided supervision to support them around the issues that-- oh, I'm sorry. I was thinking it was Mothers and Babies. But I'm not sure, Sean, if you were asking about the service during the-- yes, I think you are, that service during the Mothers and Babies visits. You want to try and tackle that one, Darius?

Sure. Sure. So what I said in my presentation is that when we do trainings, we want home visitors, but we also want their supervisors or managers to be at the training, so that they are feeling comfortable with the curriculum as well.

And the idea is that the first time a home visitor delivers the intervention, we, our Northwestern team, can provide that supervision. But really, on an ongoing basis, after we provide that first

round of supervision, it would be the supervisor or the manager who would be doing the supervision.

And we can provide additional guidance to the supervisors on how to do the check-in. But I would also argue that the majority of questions do come up the first time somebody is implementing. So really, the manager or the supervisor probably is not going to have to do a whole lot of active supervising in terms of new questions, but they may need to monitor difficult cases. There might be some issues around sort of compliance with doing personal projects. But my sense is that supervisors and managers are well-equipped to take that on.

Thank you, Darius. Lots of comments coming in, I think. Talking about partnerships with community. Providers in mental health for children and parents as well as staff. Compassion fatigue is a concern for supervisors and staff. Absolutely.

All right. So I'm going to, I think, move us forward. So Kate, can you pull up the poll one more time? I'll let you read the questions. So now we-- it was pretty high Fair amount of folks, almost all of you, in fact, said true to the first two questions on the first go around. Now it looks like 100%. And that is actually correct. Both of the answers to those first two questions are true.

And then the last one about a lesson learned in the HV CoIIN is that training cannot alleviate the fear of home visitors. Most of you are, in fact, correct that the answer to that is false. Georgie talked about that, that training was really a powerful change agent for helping home visitors realize that it was really safe to talk about depression and that it would not hurt moms, but, in fact, would indeed help them.

All right. Can you take down the poll, Kate?

So I'm going to thank you all for joining us today. And here is the evaluation survey. So it will come to you after the end. But please, if you care to or have to scoot, would you copy the link? Because we will very much appreciate your feedback.

We'll be taking a break. And there will not be a webinar in July. But watch for a save the date coming out soon about our next webinar, which will actually be in August, recognizing Breastfeeding Awareness Month. And our topic for our August webinar will be on breastfeeding.

So until we rejoin you, I hope that you all have an enjoyable summer, that you manage to stay cool and safe. And we'll look forward to talking again in August.

If you have other questions, certainly you could always write us at hvcoiin@edc.org and we're happy to respond. Take care, everyone, and thank you.