Strategies for Addressing Maternal Depression in Home Visiting

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The 2016 National Conference for America's Children
Cincinnati, Ohio
October 20, 2016
HOME VISITING COLLABORATIVE IMPROVEMENT AND INNOVATION NETWORK (HV COIIN)

Mary Mackrain
Project Director, Education Development Center

www.HV-CoIIN.edc.org
### Project Partners and Timeline

A 3-Year Cooperative Agreement between The Maternal and Child Health Bureau’s (MCHB) Division of Home Visiting and Early Childhood Systems and Education Development Center, Inc.

<table>
<thead>
<tr>
<th>Phase</th>
<th>Time Period</th>
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<tbody>
<tr>
<td>Start Up</td>
<td>September, 2013-May, 2014</td>
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<tr>
<td>Phase II</td>
<td>May 2014 – August, 2015 (15 months)</td>
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<tr>
<td>Phase II</td>
<td>September, 2015- August, 2016 (12 months)</td>
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<tr>
<td>Phase III: Extension for Dissemination and Spread</td>
<td>September 1, 2016-August 31, 2017</td>
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</table>
The Breakthrough Series as the HV CoILN Framework

Select Topic

Recruit Faculty

Develop Framework and Changes

Enroll Participants

Prework

LS1: Learning Session
AP: Action Period
P-D-S-A: Plan-Do-Study-Act

Supports:
Email • Visits • Phone Conferences • Monthly Team Reports • Assessment

Summative Congresses and Publications

www.HV-CoILN.edc.org
3 Improvement Topics Identified

Gap Exists and Evidence-based Practice is Known

Alleviating Maternal Depression (MD)
Increase identification, referral, and receipt of service.

Developmental Surveillance and Screening (DSS)
Strengthen the process of developmental surveillance and screening, intentional support, referral and follow-up.

Breastfeeding (BF)
Increase initiation and duration.
Faculty Identified: Science and Application

Darius Tandon
Maternal Depression
Associate Professor, in Medical Social Sciences and Center for Community Health-Institute for Public Health and Medicine, Northwestern University

Linda Beeber
Maternal Depression
Professor, University of North Carolina, School of Nursing

Nancy Topping-Tailby
Maternal Depression
Project Director, Education Development Center

Special Guests:
Robert Ammerman
Deborah Perry
Brenda Jones Harden
• **Many affected**
  – 40-60% of HV mothers experience elevated symptoms; 10-15% have major depression

• **Many missed**
  – Only 65% of mothers in HV are screened for depression

• **Many unserved**
  – Only 57% of mothers with elevated symptoms referred for services
What are We Trying to Accomplish?

Collaborative SMART AIM

SMART Aim
85% of women who screen positive for depression and access services will report improvement in symptoms

Women accessing services for depression get better

Set during review of research and data- where are we and where can we “stretch” during this collaborative?
“Playbook” Developed

Helping Teams with “Why, What and “How”
### Key Driver Diagram- or “Theory of Change”

**Screening and Response**
- **Primary Driver 1:** Standardized and reliable processes for maternal depression screening and response
  1. Identify and address maternal depression
  2. Identify periodically to capture vulnerable windows
  3. Communicate results of screening to clients in a timely, accurate, specific, and sensitive manner
  4. Distinguish urgent from non-urgent

**Home Visitor Capacity**
- **Primary Driver 2:** Capacity of and support for home visitors to address maternal depression in the target population
  1. Home visitors engage in ongoing professional development on maternal depression screening
  2. Home visitors have access to tools, data, manual
  3. Home visitors are immediately supported
  4. Home visitors engage in ongoing professional development on maternal depression screening

**Referral, Treatment, and Follow-up**
- **Primary Driver 3:** Standardize processes for referral, treatment, and follow-up
  1. Home visitors have standardized process for referral response
  2. Home visitors establish referral and link resources to mental health resources (e.g., EHC, health center)
  3. Home visitors have standardized process for referral

**Family Engagement**
- **Primary Driver 4:** Family engagement
  1. Families know where to find help when they need it
  2. Families experience support and confidence to address and manage maternal depression
  3. Family members are connected

**Data Tracking and Use**
- **Primary Driver 5:** Data system for tracking all clients’ maternal depression screening periodicity and results, referral, acceptance of referral and receipt of service
  1. Data system for tracking maternal depression screening periodicity and results
  2. Management and clinical teams analyze and use maternal depression data to inform and shape practice
  3. Home visitor is aware of own client data and regularly discusses these caseload-related data in supervision

**Changes to Test**
1. Policy and Protocol for screening to include use of reliable and valid tools
2. Policy and Protocol for screening to include periodicity (e.g., pregnancy, postnatal, rescreening as needed)
3. Policy and Protocol for sharing results of screening with families
4. Policy and Protocol for home visit to address maternal depression

**Systems components necessary to meet the aim**
1. Establish and maintain a referral and triage system
2. Crisis response protocol
3. Protocol for referral and triage
4. Early childhood mental health consultation
5. Family engagement and education
6. Communication techniques
7. Protocol for helping families identify referral choices
8. Tracking system for maternal depression screening periodicity and results
9. Team meetings to review improvement data and its use for improvement
10. Tracking system for dosage and frequency of treatment

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*Education Development Center Inc. Refined V10 9-2015*
Metrics to Measure Improvement

Process AIMS:

- 85% of women will be screened, using appropriate instruments at appropriate intervals: Within 3 months of enrollment (pre- or postnatal) and within 3 months postnatal.

- 85% of women with a positive screen for MD who do not access Evidence-based services will be rescreened within 30 days (or sooner in cases of crises or worsening symptoms).

- 75% of all enrolled women who screen positive (and are not already in evidence-based services) will be referred to evidence-based services (offsite or in-house) within 1 month.

- 85% percent of women referred to an evidence-based service will have one service contact.

MD has measure(s) that teams report on monthly to assess improvement, for example:

Measure #1 (Primary Driver 1):
% of women screened for MD within 3 months of enrollment and within 3 months of giving birth.
% women w/ +screen for MD at any point not already in EB services who were offered a referral to EB services

Monitoring Data Monthly

Carolina Health Centers NFP

Ingham County

Clark County

LCO Mino Maajisewin

Blackstone Valley CAP

Columbus HFG

Little River Medical Center

Carolina Health Centers HFA

Community Care Alliance

Oakland County

Carolina Health Centers Healthy Steps

Federal Hill House

AXIS KEY

Left axis: scale for blue diamonds & line
Right axis: scale for red-green dots
Teams use Plan-Do-Study-Act Cycles to Test Changes from Theory of Change

- Teams submit PDSA updates monthly which are reviewed by staff and stolen shamelessly by peers.
- Over 230 Maternal Depression PDSA plans on HV CoIIN portal

<table>
<thead>
<tr>
<th>Change Title: Policy and Protocol for Urgent and Non-Urgent Maternal Depression Care</th>
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</thead>
<tbody>
<tr>
<td>Team Name: Carolina Health Center Healthy Steps</td>
</tr>
<tr>
<td>Topic: Maternal Depression</td>
</tr>
<tr>
<td>Primary Driver: Standardize processes for maternal depression screening and response</td>
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**Cycle 1**

**Change # from Refined KQO:**
Start Date: January 1, 2015
End Date: January 30, 2015

**Objective of Cycle**
- Collect Data (Learn)
- Test a change
- Implement a change

**Data Description:**
- What are we trying to accomplish?
  - By January 30, 2015, Carolina Health Center Healthy Steps staff will have increased knowledge and comfort with new policy and protocols for urgent and non-urgent care maternal depression referrals and resources.

**How will we know that a change is an improvement?**
- The percent of staff indicating knowledge of policy, protocol, and available resources will be measured post training. We will know the change is an improvement if 80% of staff indicate the policy is clear and they have adequate knowledge of referral protocol and resources.

**Clear or Not, What Changes can we make that will result in an Improvement?**
- Staff will be involved in development and review of new policy prior to its review by the Board.
- This new clear policy and protocol will be approved by the Board for use across staff for consistency.
- Supervisors will develop a tailored list of resources for use by all staff in conjunction with the new policy and protocol.
- Training will be provided to all staff on the new policy and protocol and referral resource options.

**What question(s) do we want to answer on this PDSA cycle?**
- Will the use of clearly written policy and accompanying resources improve home visitor capacity and comfort in addressing urgent maternal depression? Will training on new policy, protocol, and resources result in clarity for staff and increased consistency in addressing urgent and non-urgent maternal depression?

**Predictions:**
- If clear policy, protocol, and referral lists are developed and staff are trained in their usage, then home visitors’ capacity and comfort with urgent care for maternal depression will be improved. It will also improve follow-up on non-urgent care.

**Tasks/Tools Needed to Complete the Cycle**
1. Research best practice materials and look for templates for policy.
2. Staff review of initial draft policy, revisions made with input.
3. Reassess approval of policy and protocol.
4. Supervisors development and review of resource list.
5. Develop focus group questions for assessing staff knowledge of policy, protocol, and resources.
6. Test group questions in a focus group on urgent and non-urgent knowledge levels.
7. Utilize a focus group for initial feedback on comfort and knowledge levels.

**Plan**

**Problem:**
- Home visitors indicate lack of knowledge of the policies and procedures.
- 100% indicated increase in their level of comfort and confidence in utilization of the protocols.
- Less than 100% of home visitors felt comfortable that they had the most current contact information for mental health urgent resources.

**Plan for Collection of Data**
1. Weekly staff meeting asking focus group questions
2. Monthly staff meeting on January 30, 2015
3. Weekly focus group with staff of knowledge and comfort with new policies, protocol, and resource list.
4. Weekly The Carolina Center administrative office.

**Do**

- Policies as similar settings researched, draft of new policies and protocols presented to staff by January 16, 2015.
- New policies and protocols sent to Board for approval by January 16, 2015.
- Conduct training on new policies, protocol, and resources with staff on January 30, 2015.
- Collected list of resources for review by January 16, 2015.
- Resources, protocol, and guidance materials approved by Board and in place by January 30, 2015.
- Development focus group questions for assessment of knowledge and comfort with new policies, protocol, and resources.
- Conduct focus group questions with staff to assess level of knowledge and comfort.
**Policy and Protocol** for tool used, periodicity of screening, sharing results w/ families and referral response

- **Training** for HVs on what MD is, how to talk with families about it and how to screen for MD
- **Reflective Supervision** to discuss MD
- **Materials** to facilitate response (Decision tree)
- **Community MOU for Treatment**
- **Protocol in place for crisis response and referral**
- **In-house HV provided prevention (Mothers and Babies)**
- **Family friendly tools to use w/ families to discuss MD (more than the blues toolkit)**
- **Using Motivational Interviewing to discuss MD w/ Families**
- **Tracking system for screening referral and receipt of service**
- **Regular team meeting to review data**

**Primary Driver 1:** Standardized and reliable processes for maternal depression screening and response

1. Policy and Protocol for screening to include linkage to care
2. Policy and Protocol for screening to include MD
3. Policy and Protocol for protocol for sharing results of screening and response
4. Policy and Protocol for home visitor response to screening and referrals (urgent and non-urgent care)

**Primary Driver 2:** Capacity of and support for home visitors to address maternal depression in the target population

**Training**

1. Training/education of home visitors on how to screen for MD
2. Training/education to enhance home visitor skills in motivational interviewing, coaching, etc.
3. Training/education to enhance home visitor skills in motivational interviewing, coaching, etc.
4. Training/education to enhance home visitor skills in motivational interviewing, coaching, etc.
5. Support for home visitors on protocol response

**Materials/Resources**

1. Materials available to facilitate support to families [e.g. laminated decision tree, intervention supplies, etc.]
2. Tools/reminder system for rescreening

**Primary Driver 3:** Standardize processes for referral, treatment and follow-up

1. Establish and maintain relationship with community partners
2. Crisis response protocol
3. Protocol for referral and linkage to service for maternal depression
4. Early childhood mental health provider integration
5. Inhouse evidence-based treatment [Mothers and Babies]
6. Home visitor delivered, relationship-based support

**Primary Driver 4:** Family Engagement

1. Materials to use with families to discuss, identify & manage maternal depression & related symptoms, from model curriculum, Family Connections, Talk, Tools & Resources, [www.acmhc.org](http://www.acmhc.org), etc.
2. Communication techniques for engaging families
3. Protocol for helping families identify referral choices

**Primary Driver 5:** Data system for tracking all clients’ maternal depression screening periodicity and results, referral, acceptance of referral and receipt of service

1. Tracking system for screening referral and receipt of service
2. Tracking system for referral, acceptance of referral, and receipt of service
3. Team meetings (e.g. weekly) to review improvement
4. Tracking system for dosage and frequency of MD
RAMP Community Care Alliance

90-Day Aim: CCA Family Home Visiting will increase the percentage of moms with elevated depression screens and offered a referral to mental health (evidence based) from 50% to 90% by February 2016

Change being tested: Though standardized use of a decision tree and standard information regarding making urgent referrals to mental health services, we can increase the number of moms with elevated depression screens who are offered referrals to mental health services from 50% to 90%

<table>
<thead>
<tr>
<th>Test #1</th>
<th>Test #2</th>
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<tbody>
<tr>
<td><strong>What:</strong></td>
<td><strong>What:</strong></td>
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<tr>
<td>Utilizing a decision tree and standard information regarding making urgent referrals</td>
<td>Utilizing a decision tree during home visits with moms with elevated screens</td>
</tr>
<tr>
<td>Create a decision tree and standard protocol for urgent referrals during a team meeting</td>
<td></td>
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<tr>
<td><strong>Who (population):</strong></td>
<td><strong>Who (population):</strong></td>
</tr>
<tr>
<td>Home Visiting Staff</td>
<td>Home Visiting Staff</td>
</tr>
<tr>
<td><strong>When:</strong></td>
<td><strong>When:</strong></td>
</tr>
<tr>
<td>November 2015</td>
<td>December 2015</td>
</tr>
<tr>
<td><strong>Prediction:</strong></td>
<td><strong>Prediction:</strong></td>
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<tr>
<td>If we use a standardized decision tree for all elevated screens, it will result in an increase from 50% of moms with elevated screens being offered a referrals to mental health services to at least 90% being offered mental health referrals</td>
<td></td>
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<tr>
<td>Results:</td>
<td>Results:</td>
</tr>
<tr>
<td>Decision tree was created and used with 2 moms with elevated screens 100% were offered referrals</td>
<td>Decision tree was used with 2 more moms with elevated screens 100% were offered referrals.</td>
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<tr>
<td><strong>Act:</strong></td>
<td><strong>Act:</strong></td>
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<tr>
<td>- Adapt: During team meeting in December 2015, decision tree was reviewed and edited by home visiting staff</td>
<td>- Adopt: Color Laminated decision tree with standard protocol for urgent mental health referral was given to all home visiting staff in January 2016.</td>
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% women w/ +screen for MD at any point not already in EB services who were offered a referral to EB services

N women with +screen...
Our Results and Lessons Learned
1. Over 90% of moms are screened.

2. Over 80% of moms at risk accept a referral to services.

3. Over 70% of moms accepting referral get an evidence-based service contact.

We are starting to see a reliable rate of mom’s with improved symptoms!

% women who accessed EB services w/ 25% improvement in symptoms w/in 3 months of service contact.
% women who accessed EB services w/ 25% improvement in symptoms w/ in 3 months of service contact

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Ingham County

Clark County

LCO Mino Maajisewin

Little River Medical Center

Carolina Health Centers HFA

Columbus HFG

Community Care Alliance

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Blackstone Valley CAP

AXIS KEY

Left axis: scale for blue diamonds & line
Right axis: scale for red-green dots

www.HV-CoIIN.edc.org
“We now have the clients reaching out to us and opening up to us regarding their depression and we as home visitors can handle it, it is not a "dark secret" anymore clients are talking to other clients about the maternal depression services they are receiving.” -LIA Survey Response

“CQI gave us the opportunity to serve our clients more efficiently”- Home visitor
What is Next

- Publications
- Playbooks
- Spread Strategy
Available HV CoIN Resources

Current “playbooks,” articles and information located:

http://hv-coiin.edc.org

National Dissemination of findings in the Winter of 2016

For more information contact: Mary Mackrain at mmackrain@edc.org
The Mothers and Babies Course: Preventing Postpartum Depression Among Home Visiting Clients

The 2016 National Conference for America's Children
Cincinnati, Ohio
October 20, 2016

Darius Tandon, PhD
Associate Professor
Northwestern University Feinberg School of Medicine
The Mothers and Babies (MB) Course

• Uses cognitive-behavioral approaches
  – Encourage pleasant activities (by yourself or with others, including child[ren])
  – Reframe harmful thoughts & encouraging helpful thoughts
  – Increase social support

• Emphasizes attachment between caregiver & infant

• Framed as a “stress reduction” intervention
Mothers and Babies: Previous Studies

- Effective in reducing depressive symptoms, preventing new depressive episodes, improving mood regulation, and improving coping skills (Munoz et al, 2007; Le et al., 2011; Tandon et al., 2011; Tandon et al., 2013; McFarlane et al., 2016)
  - Studies in bold conducted with home visiting programs
- Intervention initially developed and tested as a group-based intervention
- Research studies focused on prevention of postpartum depression
Major Depression is Only Part of the Picture

Intensity of symptoms

Number of people affected

Mild to moderately severe depressive symptoms

Diagnosed depression
MB Course Structure: Group Intervention

• Six group sessions each lasting 2 hours
• Intervention delivered by mental health clinician
• Three intervention modules (2 sessions each):
  1. Promoting pleasant activities (behavioral activation)
  2. Reducing harmful thought patterns and promoting helpful thought patterns (cognitive restructuring)
  3. Promoting social support and contact with others
• Reinforcement of key points and review personal projects (homework) done by home visitors between group sessions
MB 1-on-1 Version

- Despite encouraging results of MB group, not all HV programs have ability (e.g., rural settings, availability of clinicians) or interest in running MB groups
- Resulted in development of “1-on-1” version consisting of 12 sessions that last ~15-20 minutes
- Home visitors integrate sessions into regular home visits
- Personal projects completed between sessions
Current MB Projects

• 1-on-1 Effectiveness Study
• Group Comparative Effectiveness Study
• 1-on-1 Hybrid Effectiveness-Implementation Study
• MB Expansion
1-on-1 Effectiveness Study

• **Aim:** To generate preliminary evidence of the effectiveness of the 1-on-1 version of MB
• 120 study participants
  – 50% controls, 50% receiving MB 1-on-1
• Baseline, 3-month, 6-month assessments
  – Follow-up data collection will be completed Jan 2017
MB Group Comparative Effectiveness Study

• **Aim**: To compare the effectiveness of the Mothers and Babies group curriculum *when led by a home visitor* to Mothers and Babies *delivered by a mental health consultant*

• 3-year project funded by the Patient-Centered Outcomes Research Institute (PCORI)
MB Group Comparative Effectiveness Project Overview

• 42 Home Visiting (HV) programs
  – 18 HV programs will hold MB groups led by their home visiting staff
  – 18 HV programs will hold groups led by a mental health consultant
  – 6 HV programs will serve as a control group.
  – We will recruit about 40 women from each HV program

• Project taking place in Illinois HV programs and states adjacent to Illinois
  – We are currently recruiting sites for our 2nd wave of implementation
1-on-1 Effectiveness-Implementation Study

• **Aim**: To determine effectiveness of MB 1-on-1 on key MCH outcomes and to examine key factors related to intervention implementation
• 2-year project funded by the Robert Wood Johnson Foundation and Florida Association of Healthy Start Programs
1-on-1 Effectiveness-Implementation Study Overview

- 32 Healthy Start coalitions throughout Florida
- Train-the-trainer model
  - Northwestern research team will train mental health clinicians on MB 1-on-1
  - Clinicians will, in turn, train home visitors across the Healthy Start Coalitions
- Intensive examination of implementation that will help support future expansion of MB 1-on-1 model
  - Fidelity, feasibility, acceptability, adoption, & sustainability
MB Expansion

• **Aim**: To support home visiting and other early childhood programs in using MB group or 1-on-1

• Training and supervision provided to programs interested in using MB

• Designed to facilitate use of MB, with minimal research requirements
  – EPDS (depressive symptoms)
  – Perceived Stress Scale
  – Implementation fidelity
Why Are We Focused on Scaling Up Mothers and Babies?  
A Client Testimonial

• The Mothers and Babies group was very helpful to me in better understanding my infant. It was nice to get suggestions and thoughts about situations experienced by other Mothers... I learned how to have a strong support system, which a lot of Mothers like me do not have. I also learned to keep the lines of communication open because if you are not talking, no one will know there is a problem. I would like to see the Mothers and Babies groups continue so other Mothers like me can have the same positive experience.
A Home Visitor Testimonial

• During the first group session I witnessed sad lonely faces that were starving for inner peace to cope with their outer reality as the weekly sessions unfolded. Those same faces started glowing with a new found way to manage all of the other stuff going on in their lives... My career with home visiting started 23 years ago, leaving my house the last day of group was the happiest day of my entire career with the Health Department. While doing the review from class 6 one of the participants stated that she used assertive behavior versus aggressive behavior, she said she used the assertive one and she got what she wanted... Two participants called to share the news that one of their group members had delivered, they had exchanged numbers early on and have continued to be a support for each other. It is now my belief that a home visiting program that provides case management to pregnant women will not be effective without having Mothers and Babies groups as a part of their program... Once again I thank you for this life changing course that I know has made a difference in the lives of the participants.
Contact Information

Darius Tandon, PhD (dtandon@northwestern.edu)

For MB PCORI Project:
Jessica Jensen, MPH (jessica.jensen@northwestern.edu)

For MB Expansion:
Erin Ward, MSW (erin.ward1@northwestern.edu)

All of our materials are available for free download:
www.mothersandbabiesprogram.org
Strategies for Addressing Maternal Depression in Home Visiting: Moving Beyond Depression™

Robert T. Ammerman, Ph.D.
Cincinnati Children’s Hospital Medical Center & Every Child Succeeds

The 2016 National Conference for America's Children
Cincinnati, Ohio
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Number of total mothers served annually: 21,000
Number of home visitors trained: 775
Number of therapists trained: 111
Why Treat Maternal Depression in Home Visiting?

• Profound impact on mother and child.
• Untreated depression is costly.
• Undermines home visiting outcomes.
• Challenges home visitors and implementation.
• Unique opportunity for identification and engagement.
• Potential for synergy between treatment and home visiting.
How many mothers need treatment?

35% of mothers have a BDI-II score ≥17 over 3 years strongly indicating a diagnosis of Major Depressive Disorder*

Estimated 600,000 mothers in home visiting in the USA each year

210,000 mothers in home visiting will likely meet criteria for Major Depressive Disorder and are in need of effective treatment

*Based on N=15,013 administrations at 7 time points
Ammerman et al., 2013
- Stigma and obtaining treatment
- Poor understanding of depression
- Negative history with treatment
- Transportation barriers
- Misidentification and diagnosis
- Diffuse treatment focus
- Inadequate training in perinatal depression
- Inadequate appreciation for mom’s issues
- Insufficient collaboration and coordination

10-30% of HV moms receive treatment (Ammerman et al., 2010)
80% of community treatment is inadequate or insufficient (Ammerman et al., 2013)
Essential Intervention Elements

- Ameliorate depressive symptoms
- Help mother and home visitor/service
- Collaborate with home visitor, no burden
- Implement in home to remove barriers
- Use evidence-based treatment
- Fit with population, setting, & service
Cognitive Behavioral Therapy

• One of two evidence-based psychological treatments for depression.
• As effective as antidepressant medications.
• More effective than antidepressant medications for traumatized women.
• Good relapse prevention.
• Relatively widely trained, amenable to dissemination.
• Theoretically compatible with home visiting models.
IH-CBT Key Elements

• **Length of service**: 15 sessions plus one booster session.
• **Direct clinical contact**: 60 minute sessions, telephone, texting.
• **Setting**: home.
• **Therapist**: Masters level licensed mental health professional, training in CBT and familiarity with serious mental health conditions.
• **Training**: MBD training, CBT workshops, structured readings, pilot cases.
• **Team Leaders**: Doctoral or masters level psychologist or mental health clinician with strong CBT skills.
• **HV Collaboration**: Integral, proactive, joint 15th session.
MIDIS design

Inclusion:
ECS participant ≥16 years old
Baby 2<10 months
EPDS ≥11
MDD using SCID

Screening: EPDS ≥11

Eligibility/Pre-treatment Assessment
SCID Diagnosis of MDD

Randomization

IH-CBT
15 sessions + booster
Ongoing home visitation

Typical Home Visitation
Community resources
Ongoing home visitation

Post-treatment Assessment

3 Month Follow-Up Assessment

34.8% received community treatment
N=93
Retained: 86.8%
≥ 2 points: 95.6%
MDD Diagnosis at Pre- & Post-Treatment & Follow-Up

BDI-II Scores at Pre-Treatment, Post-Treatment, & Follow-Up

- IHCBT
- THV

F = 7.9, p < .01
BDI-II Scores at Pre-Treatment, Post-Treatment, & Follow-Up

- IHCBT
- THV
- IHCBT + PEMD

Assessment Time Point: Pre, Post, 3 mo FU, 6 mo FU, 12 mo FU, 18 mo FU

F = 7.9, p < .01
GSI Scores from BSI at Pre- & Post-Treatment & Follow-Up

F = 8.0, p < .01
Social Support Using ISEL Scale (Total)

F = 5.1, p < .01
Other Benefits of IH-CBT Treatment

- Mothers in IH-CBT received 3.2 more home visits
- 50% of mothers fully completed treatment (average 11.2 vs. 4.3 sessions in typical outpatient)
- Mothers in IH-CBT who fully complete treatment are retained in home visiting for 4 ½ months longer
- Decreased parenting stress
- Increased confidence in parenting
- Hope and optimism for future
- Major life changes
- Sense of accomplishment
- Renewed focus on child
Dayla’s Story in MBD

A Video Testimonial

From www.movingbeyonddepression.org
IH-CBT is cost-effective

Cost-effective at willingness to pay threshold of $25,000 (99.5%)

Over three year time horizon, IH-CBT expected to yield 345.6 fewer days of depression compared to standard treatment in the community

Moving Beyond Depression™

IDENTIFICATION AND ENGAGEMENT

TREATMENT AND FOLLOW-UP

PROGRAM MONITORING AND TRACKING

ONGOING TRAINING & SUPPORT

MBD TREATMENT TEAM
Therapists
Team Leader

HOME VISITING PROGRAM
Managers
Supervisors
Home Visitors
www.movingbeyonddepression.org

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