MOMCare: Collaborative Care for Perinatal Depression in Socio-Economically Disadvantaged Women

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Polling Question

What are the characteristics of the population you work with? (Check all that apply)

- Maternal and Child Health
- Maternal and Child Mental Health
- Perinatal Depression
- Other (Please describe in the Chat box)

Overview

- MOMCare – What is it?
- Culturally relevant enhancements to Interpersonal Psychotherapy (IPT) -- engagement session, case management, etc.
- Integrating depression care into public health settings, esp. for difficult-to-treat depression
- MOMcare design, methods, and sample description, and treatment outcomes
MOMCare: A 5-year Randomized Effectiveness Trial

- 10-site effectiveness study in Seattle-King County public health system – funded by NIMH
- 168 pregnant women on Medicaid
- 3 depression care specialists (DCSs) cover 10 public health centers trained in 3 main components of MOMCare
  
  *1) pre-treatment engagement session
  *2) culturally relevant Brief Interpersonal Psychotherapy
  3) pharmacotherapy (in collaboration with OB provider & MOMCare team M.D.)

During your pregnancy, do you feel...

- hassled?
- no energy?
- sad?
- stressed?
- no pressure?

MOMcare offers a free, brief screening of this public health order to see if our treatment services are right for you.

If you are eligible and choose to enter the MOMcare program, you will receive $20 for each of 3 interviews (total $60) to compensate you for your time and effort.

To be eligible for MOMcare, you must be 18 years or older and 10-20 weeks pregnant.

If you enroll in MOMcare, you will meet with a depression care specialist who will give you information about available treatment options and connect you with the treatment you want.

MOMcare is a depression treatment research study from the University of Washington in partnership with Public Health Seattle-King County.

For HELP call Erin at momcare 206-239-8490
or talk to your MSS provider
**Major or Minor Depression during Pregnancy**

- **Prevalence rates:**
  
  1 out of 10 middle- or upper-income women (Gotlib et al., 1989)

  1 out of 4-5 women living in poverty (Hobfoll et al., 1995; Scholle et al., 2002)

- Negatively affects development of fetus in utero (Field, 2000; Lundy et al., 1999) and may interfere with the attachment bond between mother and infant (Murray & Cooper, 1997)

- Predicts low birth weight and preterm birth, esp. in low income women (Grote et al., 2010)

- Predicts postpartum depression (O’Hara & Swain, 1996) and later maternal depression (Kumar & Robson, 1984)

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**Maternal Postpartum Depression (PPD): Negative effects on child, adolescent, and beyond**

- Maternal PPD predicts:

  - internalizing disorders (depression, anxiety, loneliness) in kindergarten, first grade, middle childhood, adolescence
    (Campbell et al., 2009; Essex et al., 2001; Pawlby et al., 2009)

  - externalizing disorders (conduct disorder, ADHD, conflict with peers and parents) in middle childhood and in adolescence
    (Campbell et al., 2009; Essex et al., 2001)

  - school difficulties, cognitive problems
    (Tronick & Reck, 2009)
Underutilization of Mental Health Services

- **National Comorbidity Survey Replication** (Wang et al., 2005)
  - nationally representative sample of 9282 adult respondents
  - most people with depression and other mental illness remain either untreated (60%) or poorly treated (66%)
  - the unmet need for mental health services was highest for those with low incomes, racial/ethnic minorities, the elderly, and rural respondents

- minimally adequate treatment (APA guidelines):
  - 8 sessions of psychotherapy (at least 30 minutes a session)
  - 2 months of medication & at least 4 check-ups
An Ecological Model of Barriers to Treatment Engagement and Retention

Distal Influences → Proximal Influences → Rx Adherence → Rx Outcomes

Community Barriers
- violence, safety concerns,
- lack of support services,
- unemployment, poverty,
- lack of access to M.H. services,
- chronic stressors

Helping System Barriers
- bias or cultural insensitivity in environment, procedures, providers,
- lack of evidence-based treatments,
- lack of diversity in clients & staff,
- provider overload and burn-out

Social Network Barriers
- negative attitudes toward rx,
- social network strain, chronic stressors

Client Barriers
- practical – time, financial, transportation, child care
- psychological – stigma, low energy, negative RX experiences
- cultural – women’s view of depression, multiple stressors/coping strategies, strong self-reliance

Barriers to Care

- Failure to engage and retain low-income patients, especially persons of color, in beneficial and efficacious mental health services constitutes a serious mental health problem (DHHS, 1999; 2001)

- Poor and minority women rarely seek or receive treatment for depression in mental health settings (Miranda et al., 1988; Siefert, 2000)
**Barriers to Care**

- **Practical** — Do I have time? Can I get there? Can I afford it? I have too many other things I have to do.

- **Psychological** — Can I trust my therapist? Can she/he really understand me and help me? I don’t want to be labelled “depressed.”

- **Cultural** — Will treatment be relevant to my needs, goals, values, cultural preferences and practices?

**Polling Question**

What barriers to care do you see in your work? (Check all that apply)

- Practical
- Psychological
- Cultural
**Development of an Engagement Strategy Before Treatment Begins**

- To deal with practical, psychological, and cultural barriers to care and ambivalence about going for depression treatment

- Integration of two theoretical approaches:
  - Ethnographic interviewing
  - Motivational interviewing

**Spirit of MI**

- The woman is the best guide for how well we are doing in engaging her – observe her responses to your behavior – is she backing off or moving forward?

- Collaboration – “I’m not the expert on you – you are!”

- Evocation – “What are your ideas about what helps you?” Be curious!

- Autonomy – “It’s up to you!”

- Traps -- the woman should be talking more than the helper
Think about how you are already engaging the people you work with in the services you are giving. Think about what is already working for you.

**Engagement Session: 5 components**

(unpublished manual, Zuckoff, Swartz, Grote et al.)

Total time: 50-60 minutes -- These components can be used separately if time is limited or repeated as needed.

1) Getting her story – how she is feeling? What is contributing? How is it interfering with what is important to her?

2) Feedback and psychoeducation about depression and its treatment:

   “Depression is not your fault, but there is something we can do about it”

3) Past efforts at coping and attitudes toward treatment/therapist

   Explore potential differences between women and her therapist – race/ethnicity/nationality, SES, gender, etc.

4) Addressing practical, psychological, and cultural barriers to care

5) Eliciting commitment and planning for treatment engagement
After Engagement: 
Choice of treatment for depression 
during the perinatal risk period 

ACUTE Brief IPT and/or Meds → IPT and/or Meds Maintenance

GOAL
- Reduce antenatal depression BEFORE BIRTH

GOAL
- Prevent depressive relapse from post-rx → 18 months postpartum
**What Comes after Engagement? - Interpersonal Psychotherapy (IPT)**

- Time-limited (12-16 weeks) individual psychotherapy for depression
- Structured, manualized treatment that has been used in research protocols – see meta-analysis by Cuijpers et al., 2011:
  
  **IPT efficaciously treats depression, both as an independent treatment and in combination with pharmacotherapy**
- Demonstrated efficacy in general and for antenatal depression and postpartum depression (Grote et al., 2009; O’Hara, Stuart et al., 2000; Spinelli & Endicott, 2003)
- Therapists and patients like it: “it makes sense”

**Attachment Theory**

- Maintenance of relationships and "attachment" are adaptive for survival & crucial for development
- Infants of many species desire proximity with their caregivers
- Separation from the caregiver → anxiety, protest → despair → detachment
- Disturbances in relationships are an antecedent of depression
- Depression makes it difficult to connect in one’s relationships
Introduction: What is IPT?

- Goals: symptom alleviation & improved social functioning

- Builds on empirical findings that interpersonal (IP) difficulties are linked to depressed mood & that depression impairs IP functioning

Introduction: The bio-psycho-social-spiritual formulation of depression

Depression is a medical illness with interpersonal triggers and consequences

IPT targets depression through its focus on current interpersonal functioning
Structure of Brief IPT (8 vs. 16 sessions)
(Swartz et al., 2004, *Psychiatric Services*, 55, 448-450)

- **Initial Phase (1-2 sessions)**
  - Psychiatric and social assessment
  - Case formulation of the interpersonal problem are most linked with the onset or exacerbation of the depression

- **Middle Phase (5 sessions)**
  - Choose only one interpersonal problem area:
    - Role transition, role dispute, complicated bereavement
    - Build on existing strengths
    - Choose a “manageable” problem – problem-solving
    - **Work on relationship with unborn child**
  - Behavioral activation with an interpersonal and culturally relevant focus → explicit “homework assignments”

- **“Ending Phase” (1-2 sessions)**
  - Support self-efficacy

The Four Interpersonal Problem Areas

- **Grief** (complicated bereavement) – lack of mourning the death of a significant person or pregnancy loss

- **Role Dispute** – non-reciprocal expectations in any significant relationship (e.g., father of the baby)

- **Role Transition** – a major + or – life change: a move, job loss/gain, illness, graduating, getting married, unplanned or complicated pregnancy, becoming a parent

- **Interpersonal Deficits/Sensitivities** – life-long history of impoverished relationships; a “default” category
Polling Question

Have you worked with women who have or have had a complicated pregnancy?

- Yes
- No

Characteristics of a complicated pregnancy:

- Ambivalent, detached or hostile feelings toward the pregnancy or fetus
- Unplanned or untimely pregnancy
- Previous medical problems or sexual trauma
- Previous pregnancy loss or stillbirth
- Medical complications of pregnancy
- Poverty or homelessness
- Previous childhood trauma
**IPT Cultural Enhancements to Promote Treatment Engagement and Retention**

- Engagement Session before rx to address barriers to care – practical, psychological, and cultural (manualized)
- Brief IPT -- Full course of IPT in 8 vs. 16 sessions (Swartz, Frank, & Shear, 2002) and maintenance IPT
- Phone IPT-B, if needed (Simon, Ludman et al., 2004)
- A specialized case management component integrated with IPT-B to deal with chronic social and economic problems (i.e., FOOD, BED, housing, job training, baby supplies)

**IPT Enhancements to Promote Treatment Engagement and Retention**

- Flexible scheduling of sessions in the public health clinic serving a diverse population of women
- Intensive outreach in the clinic and on the phone
- Reminder letters and phone calls before each rx session
- Culturally sensitive clinicians who had worked in public health MSS and were experienced in working with this population of women
Cultural Enhancements to Brief IPT
(Grote et al., 2009, Psychiatric Services, 60, 313-321)

- **Pragmatic enhancements regarding culture of poverty:**
  - case management; facilitation of access to social services; offering rx in a non-stigmatizing public health setting, phone therapy

- **Enhancements for race/ethnicity/nationality** (Bernal et al., 1995)
  - providing psychoeducation and treatment information in line with patient’s cultural preferences and values (e.g. therapy = a class; depression could be re-labeled “stress,” “nerves”)
  - treatment setting served others from same racial/ethnic group
  - incorporating cultural resources and strengths
  - using stories from patient culture to support treatment goals

MOMCare Design

- Eligible public health clients consented to be randomized to:
  - **Public Health MSS in 10 public health centers** (the care they received as a MSS client – increased meetings with public health social worker, nurse, nutritionist, psychoeducation about depression, treatment referral, parenting and nutrition classes)
  - **MOMcare intervention** (public health MSS; engagement PLUS choice of evidence-based psychotherapy or anti-depressant medication)
    - 8 sessions acute rx BEFORE BIRTH and monthly maintenance sessions to 1 year postpartum in public health center or by phone
    - Depression care specialists were former MSS social workers
Randomized Controlled Trial

Brief Screening by Depression Care Specialist

Eligible Pregnant Women (n=168)
Age > 18, Major Depression or Dysthymia

Public Health MSS (n=85)
Engage & Brief IPT/ Meds
Before birth to 1 year PP
(n=83)

3, 6, 12 and 18 months post-baseline
(before birth up to 1 year postpartum

MSS Group (n=85)
- education about depression and rx options and a book
- Referral for psychotherapy, medication or both
- Therapist in community or OB doctor or both
- MSS services – social worker, nurse
- 5 Research interviews to check on client progress until baby is 1 year old
- $30 per interview

MOMCare Group (n=83)
- education about depression and rx options and a book
- Referral for psychotherapy, medication or both
- MOMCare depression care specialist/OB doctor or both
- MSS – social worker, nurse
- 5 Research interviews to check on client progress until baby is 1 year old
- $30 per interview
**Study Questions**

- Will MOMCare lead to more treatment engagement and retention than public health MSS?

- Will MOMCare be more effective than public health MSS in reducing depressive symptoms and improving social functioning before and after the birth?

- To what extent will co-morbid PTSD moderate the effects on depression severity of MOMCare compared to public health MSS?

  - The previous literature shows that PTSD may also delay or diminish, and thus moderate, treatment response for those with MDD (Hegel et al., 2005; Hollon et al., 2005; Green et al., 2006)
MOMCare Sample

Sample - 168 depressed, pregnant women on Medicaid from PHSKC MSS

Inclusion criteria:
- ≥18 years old
- 12-32 weeks pregnant
- MDD or Dysthymia
- Access to household phone
- Fluent in English

Exclusion criteria:
- Suicidal/homicidal
- Psychotic/organic problem
- History of mania
- Recent drug/alcohol abuse
- Receiving psychotherapy
- Severe intimate partner violence

Demographic and Clinical Variables for Study Participants (N=168)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age in years</td>
<td>27.4 (18-44)</td>
</tr>
<tr>
<td>Weeks pregnant</td>
<td>22.4 (12-32)</td>
</tr>
<tr>
<td>Married</td>
<td>29%</td>
</tr>
<tr>
<td>Non-White</td>
<td>58%</td>
</tr>
<tr>
<td>Homeless</td>
<td>13%</td>
</tr>
<tr>
<td>Some college or higher</td>
<td>59%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>65%</td>
</tr>
<tr>
<td>Income: less than or = to $10K</td>
<td>42%</td>
</tr>
<tr>
<td>Unplanned Pregnancy</td>
<td>72%</td>
</tr>
<tr>
<td>Major Depression/Dysthymia</td>
<td>100%</td>
</tr>
<tr>
<td>PTSD</td>
<td>65%</td>
</tr>
<tr>
<td>At least one childhood trauma</td>
<td>53%</td>
</tr>
<tr>
<td>Emotional abuse</td>
<td>32%</td>
</tr>
<tr>
<td>Emotional neglect</td>
<td>39%</td>
</tr>
<tr>
<td>Fearful attachment orientation</td>
<td>47%</td>
</tr>
</tbody>
</table>
Treatment Choices of Intervention Group (n=79)

- 80% started with Brief IPT (n=63)
  - of those who started with brief IPT, 36% augmented with medication (n=23)

- 15% started with Brief IPT and medication (n=12)

- 5% have selected anti-depressant medication alone (n=4)

Will the MOMCare intervention lead to more treatment engagement and retention (in the community) than public health MSS?
MOMCare Engagement Results:
% Attendance at an Initial Treatment Session

* Less than 1/3 of phone intakes attend 1 Rx session in community mental settings

Retention in Treatment:
Average Number of Acute Sessions Attended

Typical number of Rx sessions attended in community mental health = 1
Will the MOMCare intervention be more effective than public health MSS in reducing depressive symptoms and improving social functioning before and after the birth?

Main effects for treatment group:
- SCL-20, \( p = .01 \)
- Remission on the SCL-20 (<.5), \( p = .05 \)
- Work and social functioning, \( p = .09 \)
- PTSD severity, \( p = .04 \)

3-month = \( p < .07 \) (before birth)  
6-month = \( p < .05 \) (2 months pp)  
12-month = NS (8 months pp)  
18-month = <.05 (12 months pp)

Group x time interaction = NS  
Main effect for time significant.  
Main effect for group significant (effect size .26)
Significant differences on Clinical Variables between Depressed Participants with and without PTSD

<table>
<thead>
<tr>
<th>Baseline Functioning</th>
<th>MDD &amp; NO PTSD (n=58)</th>
<th>MDD &amp; PTSD (n=106)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCL-20 Depression</td>
<td>1.4 (+.5)</td>
<td>2.0 (+.5)****</td>
</tr>
<tr>
<td>Social Functioning (&gt;2.2 = impaired)</td>
<td>2.8 (+.60)</td>
<td>2.9 (+.55)*</td>
</tr>
<tr>
<td>Generalized Anxiety Disorder (GAD)</td>
<td>29.3%</td>
<td>65.1%****</td>
</tr>
<tr>
<td>At least 1 anxiety disorder - not PTSD</td>
<td>36.2%</td>
<td>100% ****</td>
</tr>
<tr>
<td>Any prior depressive episode</td>
<td>67.2%</td>
<td>90.6%****</td>
</tr>
<tr>
<td>At least one type of childhood trauma</td>
<td>41.4% 31.0%</td>
<td>59.4%* 55.7%*</td>
</tr>
<tr>
<td>Fearful Attachment Orientation</td>
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</table>
To what extent will co-morbid PTSD moderate the effects of MOMCare compared to public health MSS on depression severity?

- Significant treatment group by PTSD severity interaction \([F(1,159)=5.2, p=.02]\)
- Stratification of sample into MDD & PTSD subgroup and MDD alone subgroup

No significant differences by treatment group
SCL 20 For Intervention Groups with MDD & PTSD

Significant main effect for treatment group
Effect size = .39

Remission of Depressive Symptoms at 18-Month Follow-up (SCL-20 score <.05)

Remission of PTSD & MDD: 42% (MOMCare) vs. 25% (MSS), p=.04
Remission of MDD alone: 47% (MOMCare) vs. 37% (MSS), NS
Secondary Outcomes for MOMCare vs. MSS in MDD & PTSD Subgroup

- Work and Social Functioning (WSAS) $p = 0.05$
- Engagement in an initial treatment session $p = 0.0001$
- $\geq 4$ mental health treatment sessions attended $p = 0.0001$
- Any antidepressant medication use in past 3 or 6 months $p = 0.01$
- Moderate to high satisfaction with care received $p = 0.008$
Conclusions about MOMCare

- MOMCare is modestly more effective than MSS in ameliorating antenatal depression and preventing postpartum depressive relapse across all time points from pregnancy up to one year postpartum.

- MOMCare is moderately more effective than MSS in reducing antenatal and postpartum depression severity for women with MDD and PTSD (about 2/3rds of sample) across all time points from pregnancy up to one year postpartum.

- By 6-months post-baseline (2 months postpartum), 95.5% of the sample had given birth and about 67% of the sample had shown a significant reduction in depression severity.

Initial Observations:

1) The timing of depression amelioration after childbirth is critical, given the well-established adverse effects of postpartum depression on maternal and infant health and mental health.

2) Most women did not want anti-depressant medication, but did want psychotherapy and case management.

3) Most women appreciated the flexible scheduling of rx appointments in the clinic or by phone.

4) Public health centers are great places to connect with this population -- convenient, non-stigmatizing settings serving a diverse pregnant population on low incomes.

5) Take Home Message: Screen for PTSD and add more intensive depression care services from pregnancy up to one-year postpartum.
Next Steps – IPT Training
March 20-21, 2015

- Public health MSS social workers
- Postpartum Support International
- Washington State Psychiatric Association
- U WA School of Social Work
- https://iptinstitute.com/events/