

# PERINATAL SERVICES AT THE CENTER FOR CHILD & FAMILY HEALTH (CCFH)

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NCIOM Task Force on Perinatal Systems of Care - July 29, 2019

### **AGENDA**

- Overview of CCFH
- Importance of perinatal supports
- CCFH perinatal supports: Overview of services, program evidence, and funding
  - Family Connects Durham
  - Healthy Families Durham
  - Durham Early Head Start Home Based Program
- Connections to services: A deeper dive
- Statewide efforts



#### **OUR MISSION**

Define, practice, and teach the highest standards of care in treating and preventing childhood trauma.



#### **OUR STRATEGIES**



Treat child traumatic stress and related diagnoses



Prevent child maltreatment



Transform systems of care to be trauma-informed and guided by evidence-based practices



### **OUR PROGRAMS**

#### Treatment

Outpatient Mental Health Clinic

Post Adoption
Support Services

#### Prevention

Family Connects

Durham

Healthy Families

Durham

Durham Early Head Start (Home-Based)

#### **Transformation**

NC Child Treatment Program

PCIT & CARE Training

Family Connects Dissemination

Training Grants & Contracts



### **ANNUAL REACH & IMPACT**



Children and families in Durham and surrounding communities through clinical and community services



3,500+

Child-serving professionals in NC and beyond through trainings and consultation



# PERINATAL SUPPORTS AS CHILD MALTREATMENT PREVENTION

- Positive maternal health and mental health, sensitive parenting skills → better child outcomes and reductions in maltreatment
- Public health approach with services from universal to targeted

#### Tertiary

Provide interventions for children experiencing maltreatment

#### Secondary

Programs targeted at families in need to alleviate identified problems and prevent escalation

#### Primary/Universal

Programs targeted at entire population in order to provide support and education before problems occur

#### IMPORTANCE OF PERINATAL SUPPORTS

- Critical to maternal health (morbidity/mortality) as well as infant health and development
- Risk factors
  - Prior health history, depression, trauma (childhood maltreatment, sexual violence, intimate partner violence), substance use
- Role of racial/ethnic disparities
- Areas of need
  - Health, mental health, parenting, social support
- Role of prevention and public health approaches
  - Preventing problems in maternal health, mental health, and parenting BEFORE they emerge



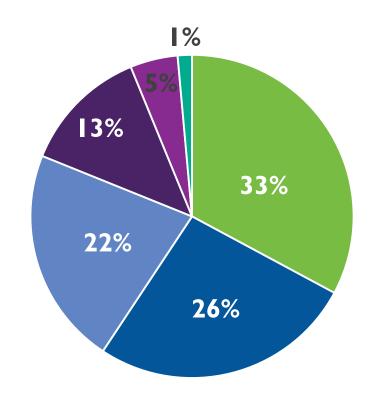


- Target population:
  - Available to all families in Durham (typically when newborns are 2 - 12 weeks of age)
- Services offered:
  - I-3 home visits from a registered nurse
  - Physical assessment of mother and newborn
  - Supportive guidance/teaching
  - Assessment of 12 risks/needs in 4 domains
  - Connection to community services
  - Follow up contacts and call at I month



#### **FUNDING**





Total Funding 2019 ~ \$945,000

- Private foundations
- County government
- State grant
- Program income (training)
- Billing
- Local grant



### EVIDENCE



- Health
  - Lower rates of maternal anxiety
  - 50% fewer child emergency room visits and hospital overnight stays in Ist year
    - Cost savings: Every \$1 spent resulted in \$3.02 in savings on emergency care by 6 months, and \$3.17 in savings by 24 months
- Parenting
  - More self-reported positive parenting (comforting, reading to infants)
  - More observed maternal sensitivity and acceptance
  - Reduced child maltreatment
- Service linkage (will return to this later)
  - Community connections increased by 15%
  - Families used higher quality child care



### FAMILY CONNECTS IN NC

- Current Family Connects programs in NC
  - Guilford County
  - Forsyth County
- Family Connects programs in planning stage for delivery within ~ year
  - Watauga County
  - Cumberland County
  - Transylvania County

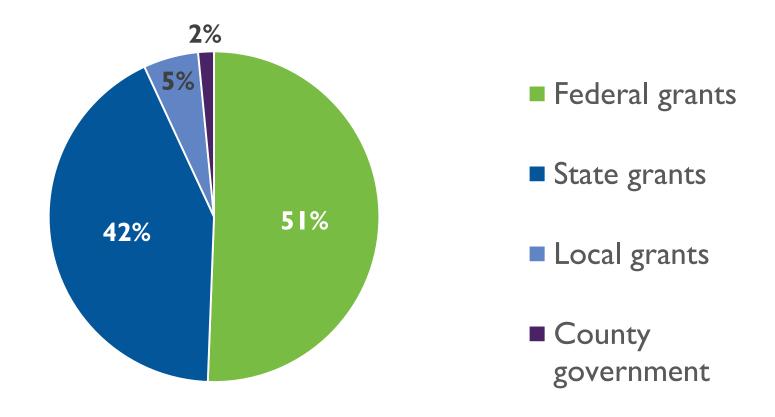


### PROGRAM OVERVIEW Healthy Families Durham\*

- Target population:
  - Enrolled prenatally or < 3 months child age, services till age 3
  - Families with at least one risk factor for child maltreatment
- Services offered:
  - Weekly or bi-weekly home visits
  - Parent group meetings
  - Support for connection to medical home
  - Developmental screenings
  - Case management (screening for risks and referrals to needed services)

### **FUNDING**





Total funding 2019-20 ~ \$780,000



#### **EVIDENCE**



- Health
  - Improved maternal health (pregnancy complications, MH, risky behaviors)
  - Improved child health (LBW, breastfeeding, ED visits)
- Parenting
  - Increase in positive parenting practices
  - Reduction in child maltreatment
- Service linkage
  - Increased linkages to essential services



### HEALTHY FAMILIES IN NC Healthy Families America

- Mitchell-Yancey Healthy Families (MIECHV)
- Catawba Valley Healthy Families (MIECHV)
  - Burke County
- Healthy Families Mecklenburg (Smart Start)



#### PROGRAM OVERVIEW



- Target population:
  - Low-income families, children with disabilities, children in foster care or experiencing homelessness
  - Prenatal to age 3
- Services offered:
  - Weekly 90-minute home visits
  - 2 socialization/parent-child groups per month
  - Case management and connection to resources



### **FUNDING**

DITTE I A Start

- Total funding 2019 ~ \$295,000
- All through a contract with the local EHS federal grant recipient



### **EVIDENCE**



- Health outcomes
  - No reported effects on maternal or child health
- Parenting
  - Positive parenting practices esp. re: cognitivelystimulating environment
  - One study found reduction in physical punishment
- Service linkage
  - Improved linkage to educational and employment services, identifying and connecting with disabilities services for children, and transportation assistance

#### EHS HOME-BASED IN NC



 18 home-based EHS programs in NC serving 28 counties



# CONNECTIONS TO SERVICES: A DEEPER DIVE

- FCD referral follow up data (2019)
  - Of those reached at I-month post visit: 75% had contacted the referral; 78% of those had received svc
- River et al., 2019 MH service utilization study
  - Barriers
    - Transportation and accessibility of services (inc financial)
    - Demands of parenting
    - Demands of multiple appointments
    - Cultural differences/barriers
  - Solutions
    - Improve agency-client relationship
    - Offer comprehensive care (practical resources+MH ones)
    - Expand preg-related services (groups, peer mentors)
    - Increase community knowledge about services
    - Improve accessibility (transpo, child care)



# FCD PERINATAL DEPRESSION STUDY (REEVES ET AL.)

- Sample: 332 mothers who participated in FCD and subsequent interview at infant age 6 months
- Measures: Edinburgh Postnatal Depression Screener (EPDS)
- Results: Mothers who exhibited depressive symptoms at FCD visit and who received a MH referral were less likely to have a positive screen for depression 6 months later
- Conclusion: community connection may decrease the experience of PPD symptoms



# ADDITIONAL SUPPORTS: PERINATAL DEPRESSION

Mothers and Babies Program (Northwestern Univ.)

- Target population:
  - Pregnant (2<sup>nd</sup>-3<sup>rd</sup> trimester) and postpartum women
- Service:
  - Perinatal depression prevention intervention
  - Teaches pregnant women and new mothers how to effectively respond to stress (changing thoughts and behaviors), connect with others and to baby
  - Group (6 sessions, weekly, 2 hours) or individual (home-based, 12 sessions, weekly, 15-20 minutes)



# ADDITIONAL SUPPORTS: PERINATAL DEPRESSION

#### Mothers and Babies Evidence:

- 3 RCTs of M&B groups demonstrated:
  - Fewer new cases of clinical depression
  - Reduction in depressive symptoms
  - Improved mood management

- CCFH implementation description
  - <u>https://www.ccfhnc.org/resources/mothers-babies/</u>



## ADDITIONAL SUPPORTS: MATERNAL TRAUMA, DEPRESSION, & ATTACHMENT

- Cognitive Processing Therapy
- Child Parent Psychotherapy

Attachment & Biobehavioral Catch-up



### STATEWIDE PROGRAMMING

- Multiple agencies working on similar home visiting models
  - NC Partnership for Children, DHHS, DPH, Head Start/Early Head Start
  - NC Home Visiting Landscape study
- What could be done to expand?
  - Role of universal home visiting
  - Role of PPD support



# FOR ADDITIONAL INFORMATION, REFERENCES, AND DETAILS

- Family Connects International
  - www.familyconnects.org
- Healthy Families America
  - www.healthyfamiliesamerica.org
- Early Head Start
  - https://eclkc.ohs.acf.hhs.gov/programs/article/earlyhead-start-programs
- Mothers and Babies
  - <a href="http://www.mothersandbabiesprogram.org/">http://www.mothersandbabiesprogram.org/</a>
- HomVEE (Home Visiting Effectiveness of Evidence)
  - <a href="https://homvee.acf.hhs.gov/">https://homvee.acf.hhs.gov/</a>



#### NC RESOURCES

- NC Home Visiting Landscape Study
   <a href="http://jordaninstituteforfamilies.org/wp-content/uploads/2018/09/NC-HV-Study-09\_07\_18-FINAL.pdf">http://jordaninstituteforfamilies.org/wp-content/uploads/2018/09/NC-HV-Study-09\_07\_18-FINAL.pdf</a>
- Maternal Infant and Early Childhood Home Visiting program <a href="https://publichealth.nc.gov/wch/aboutus/ebhv.htm">https://publichealth.nc.gov/wch/aboutus/ebhv.htm</a>
- Think Babies NC <a href="https://www.ncearlyeducationcoalition.org/think-babies-nc/">https://www.ncearlyeducationcoalition.org/think-babies-nc/</a>
- NC Early Childhood Action Plan <a href="https://www.ncdhhs.gov/about/department-initiatives/early-childhood/early-childhood-action-plan">https://www.ncdhhs.gov/about/department-initiatives/early-childhood/early-childhood-action-plan</a>



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