# Strong Beginnings: A holistic approach to improve birth outcomes among African American infants.

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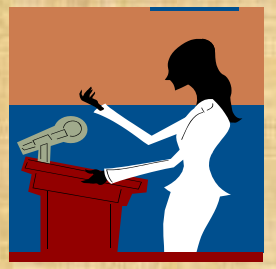
**February 12, 2015**



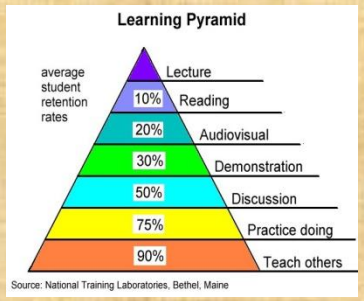
# Objectives

1) Presenter will provide a power point presentation on a clinical treatment model that has proven to be effective in reducing the barriers that prevent the engagement of African American child-bearing women in the Grand Rapids, MI area, into treatment for mental health and\or Substance abuse disorders to improve birth outcomes.

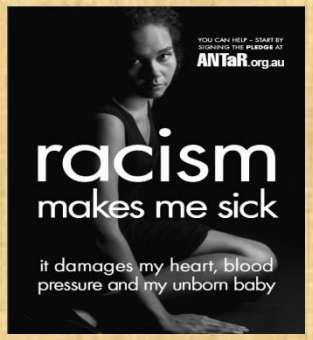
2) A DVD will be included in the presentation.

3) Participants will be able to identify 3-5 practical, psychological or cultural barriers that prevent the engagement of African American women into MI\SA treatment.

4) Participants will be able to describe the life course effects of toxic stress (specifically the stress from racism), on the health outcome of African American child-bearing women and their infants.



# RACIAL STRESS AND BIRTH OUTCOMES





DVD - “When The Bough Breaks” The Traumatic Impact of Racism on African American birth outcomes.

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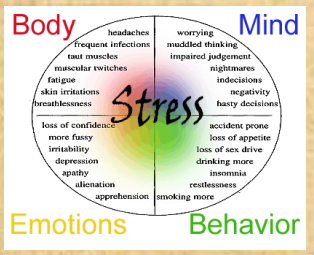
# Introduction




- Multiple research studies have examined Racial and Ethnic disparities in birth outcomes. Perceived racism as a stressor over a lifetime has been shown as a predictor of preterm and low birth weight births among African American infants (Dominquez, Schetter, Glynn, Hobel, and Sandman, 2008).

- Racism is a primary stressor for African Americans. The perception of being made to feel inferior promotes emotional and physiological responses, which could potentially shorten pregnancy duration ( Collins, 2000).

- Research on stress tends to support an adverse effect on pregnancy outcomes, and suggests that the impact of these stressors is modified by social class and/or race. This study explicitly examined social factors such as experiences of discrimination, either racial or sexual, and neighborhood crime as predictors of stress. These kinds of stress can have harmful effects in both pregnant and non-pregnant women, future research should examine forms of discrimination, especially racial discrimination, as a possible reason for the disparity in adverse pregnancy outcomes between African-American and white women. (Stancil, Herrtz-Picciotto, Schramm, Watt-Morse, 2000)

This presentation will provide a holistic approach proven to be effective in addressing this issue.

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# Studies:

- **Pregnant African American women experience a greater number of life events and are more distressed by them than other racial or ethnic groups and this stress is detrimental to their pregnancies (Orr et al. 1996).**

- **African American women living poverty are exposed to more chronic stressors (Belle, 1990), but have fewer family, social and community resources ($) to manage them. (*Continued unreduced stress is a major contributing factor to depression\PMD*).**

- **Converging evidence also suggests that women disadvantaged by poverty or racial and ethnic minority status are more likely to experience depression than the rest of the U. S. population (Bruce, Takeuchi, & Leaf, 1991; Kessler, 2003: Kessler & Neighbors, 1986).**

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- African American women experience depression at greater level of severity and persistence (National Alliance on Mental Health, 2009).

- Misdiagnosis and under-treatment of depression is common in the African American community (National Alliance on Mental Health, 2009).

- Only 12 percent of African American women seek or remain in treatment for MI\SA disorders in traditional mental health setting (National Alliance on Mental Health, 2009; Kessler, 2003).

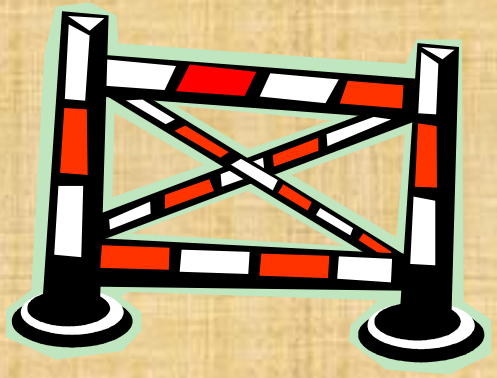
- **A study by the University of Iowa published in the journal *Social Psychiatry* and *Psychiatric Epidemiology* reports that low-income African American women in Iowa are much more likely to suffer from postpartum depression than wealthier women (Medical New Today, 21 Feb 2008).**

- **The Johns Hopkins Bloomberg School of Public Health research study suggests that African-American pregnant women are at greater risk of being assaulted by intimate partners than any other group of women and this study further showed that these women were at greater risk of post partum depression (Gaines, 2011). According to the data, one of every three women abused during pregnancy went on to develop depression in the first 12 months of the child's life.**

■ **Maternal depression has been shown to be associated with many adverse health outcomes among the offspring of depressed women, including preterm birth, low birth weight, newborn irritability, developmental delays, somatic complaints, sleep problems, child abuse, and psychiatric and neurobehavioral disorders. Although considered to be attributable in part to genetic factors, some of the behavioral problems observed among children of depressed women are thought to arise from the negative parenting behaviors that these women display. Such negative parenting behaviors include inconsistent discipline and control, unavailability, and emotional insensitivity (Pediatrics Vol. 113 No. 6 June 1, 2004 pp. e523 -e529)**

# Barriers:

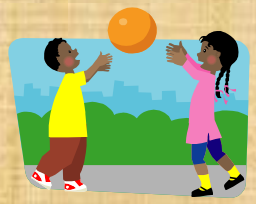
- **Studies further suggest that there are:**
- **Practical Barriers**
- **Psychological\Clinical Barriers**
- **Cultural Barriers**



that prevent African American women from engaging in treatment for MI\SA disorders (Bruce, Takeuchi, & Leaf, 1991; Kessler, 2003; Kessler & Neighbors, 1986).

# Practical Barriers

- Lack of Insurance, can't afford sliding fees or co-pays.
- Lack of Transportation (inconvenient or inaccessible clinic locations).
- Lack of Child Care and other competing priorities (burden).



- Limited Clinic Hours (loss of pay for missing work).
- Fear of ruining their career or losing employment.
- Lack of knowledge on how mental health effects physical health and social functioning.

# Psychological\Clinical Barriers

- Stigma (I am not “Crazy” or “Mentally Retarded”).

- Medication (I’m not taking those “Crazy Pills”).

- African American women worry what others will think of them, if they seek treatment. (they are weak, lazy or unmotivated, Network 180).

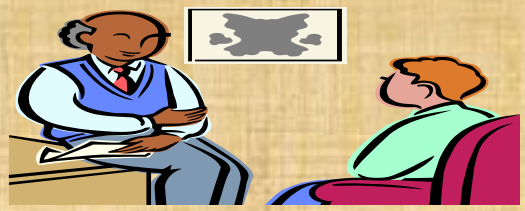
- Many African American women have multiple factors and life experiences that contribute to their stress and depression.

- Many do not want to deal with past physical or sexual abuse (embarrassed).


- Many clinical treatment models and assessments are not "**Culturally Sensitive**" to people of color (Talk therapy alone is not always effective).

- The number of treatment sessions are not adequate to fully address clinical issues.

- There are very few professionals of color or professionals who have the expertise to "engage" this population.



# Engagement Is:

# Cultural Barriers

- Traditionally the African American culture has not embraced mental health services.


- Many African Americans deny symptoms of mental illness. (Blacks people don't get depressed, I am too blessed to be stressed ).
- Many prefer treating their symptoms with alcohol or illegal drugs, instead of psychotropic medication.


- Some religious beliefs can also be a barrier to receiving services. (Just pray about it)

# WHAT WORKS?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- **The 2005 -2009 outcomes at our Healthy Start project showed a completion rate of 98.5% for clients referred for mental health services. During this period 260 of the 264 women referred for depression engaged in treatment.**

- **Among the 330 women served in individual counseling & therapeutic support groups (as of March 2012).**

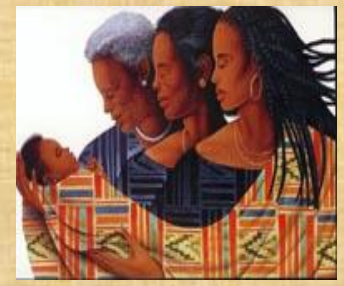
**90% completed referral rate (average is 50%); 18% no show rate vs. 55% for other mental health clients.**

**92% completed program & met treatment goals.**

**94% of PG women in SA treatment remained clean until delivery.**

**Depression & Stress scores reduced 20% - 50%.**

# WHY ?



# FUBU!

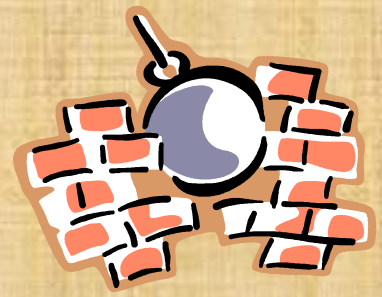
# HOW !

- Our CMH (Network 180) was a partner in the collaborative.
- The collaborative recognized and supported the need for mental health services.
- Mental Health positions are part of the collaborative.
- I received support from the collaborative and my agency.
- As African American mental health professional I was aware of the barriers to treatment in our community and designed a program to reduce them.

# Reducing Practical Barriers

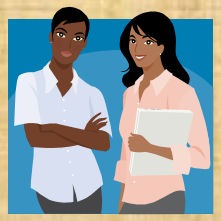
- Free to all women pregnant with or parenting an African American child under 2 yrs.

- Home-based, Group and Outpatient therapy.



- Appointments set around their schedule.
- Services are available until child reaches 2 years.
- Education on mental health is provided First (Normalize).

# Reducing Psychological\Clinical Barriers



**A Multidisciplinary Team (MDT) Approach.**

In an effort to provide effective and efficient care to patients with chronic health conditions, the U.S. healthcare system has done much to redesign its delivery system. Developing an approach to meet the high demands of patients and to best utilize resources became necessary. The result is the common use now of a multidisciplinary team (MDT) approach. This approach provides better care than an individual plan that has in the past, just involved doctor and patient. When properly implemented, this multidisciplinary team approach provides positive measurable outcomes. With a diverse group of healthcare professionals, such as physicians, nurses, pharmacists, dieticians, and health educators, social service and mental health providers there is more certainty that all of the needs of the patient will be met. (Veronica, June 29, 2007)

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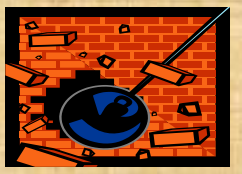
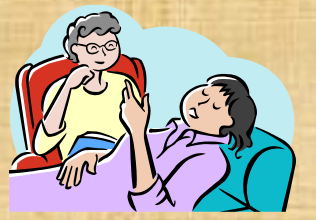


- CHW's and therapists work as a team (Engagers, develop a relationship, I have trained them on symptoms, referral process, do's and don't).
- We go together for the first mental health session.
- Initially, we don't use a lot of psychological language (psycho-babble). (I focus on their feelings and behaviors) (relationship).
- We provide Individual and Group treatment (S.A.D., Stress and Anger management, Grief and Loss and Weight Management).



- The CHW's manage the community resources, so the therapists can focus on clinical issues.

- We use clinical treatment models and assessments that are adaptable to cultural and population specific issues.

- Confidentiality and other Boundary Issues are FOREMOST!


- Accepting them where they are at clinically.

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# Reducing Cultural Barriers

- We are women of color who have a passion for working with other women of color and their families.

- We are experts at working through cultural resistance and ambivalence about MH\SA services.

- We know how to appropriately use cultural religion beliefs and values when treating women of color.

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# CLINCIAL APPROACHES

- Cognitive-Behavioral Therapy.
- Lies That Bind- A Cognitive Reconstructing Program.
- Trauma-Informed Therapy.
- Bereavement ( multiple areas of loss)
- Reality Therapy – Child Welfare.
- Motivational Interviewing.
- IMH Relationship-based Therapy – Parent-Child attachment.
- Life Skills (Empowerment)- Problem-solving.
- Individual and Group Therapy – (Supporting each other).

# PERINATAL ANXIETY DISORDERS

- Posttraumatic Stress Disorder
- Acute Stress Disorder

- General Life Stressors:
  - Poverty
  - Domestic Violence
  - Racial\Gender Discrimination

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# RELAX, RELATE, RELEASE

**A 6 week Stress Management Curriculum designed for African American Childbearing Women.**

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# EXPANSION GRANTS

- Expanded **SB** services to the entire county.

- **"Familias Fuertes y Saludables"** :Expanded **SB model** to Latino Families.

- **Strong Fathers**: Expanded **SB model** to fathers.

- **ARC:** Expanded **SB model** to MIHP families who are not enrolled in Strong Beginnings.

# CONTACT INFORMATION

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