

HEALTHY START IMPACT REPORT

Introduction

I. Overview of Racial And Ethnic Disparity Focused On By Project

The Women's Wellness Initiative, a perinatal depression project, focused on the targeted disparity population of the larger eliminating-disparities funded Missouri Bootheel Healthy Start (MBHS) project. The data supporting MBHS' focus on eliminating disparities in the project region for African-American mothers and infants is briefly summarized as follows, since the Women's Wellness Initiative focused on the same target population:

Missouri Bootheel Healthy Start: Focus on Eliminating Perinatal Disparities

The project area of Missouri Bootheel Healthy Start consists of Dunklin, Mississippi, New Madrid, Pemiscot and Scott Counties located in the southeast corner of Missouri in a region nicknamed "the bootheel" because of its shape. This region has some of the most negative health status indicators in the state. The region, according to 1990 U.S. census data, is populated by 130,000 residents living within the 2,500 square mile area. The nearest urban areas, St. Louis and Memphis, are 150 miles away. The largest town in the project area, Sikeston, is home of the Missouri Bootheel Healthy Start central office and is less than 20,000 in population. Wide expanses of farmland separate the small towns and isolate the rural inhabitants. Of the 130,000 residents, 28,000 or 21% are women of reproductive age.

Per 1990 census data, 85% of residents are Caucasian and 15% are African American, with less than 1% Hispanic and other ethnic origins. The Caucasian heritage is generally Appalachian, and before that, English. The Hispanic population swells during the growing season with an influx of 5,000 migrant workers. Language barriers have isolated the Hispanic community, primarily migrant workers, from Caucasian and African American communities.

According to Missouri Department of Health Statistics, there were 1,924 average annual live births in the 1996-1998 time period. Of these, an annual average of 1,436 (75%) were Caucasian and 472 (25%) were African American. About two-thirds (65.9%) of Caucasian births are Medicaid and more than nine in ten (92.9%) of African American births are Medicaid.

In the Missouri Bootheel, the African American infant mortality rate is nearly 3 times the rate of Caucasian infant deaths. On average 8 Caucasian infants die annually while an average 7 African American infants suffer the same fate. This translates to a Caucasian infant mortality of 6.5 per 1,000 and an African American rate of 16.9 per 1,000. On the average, 6 Caucasian and 6 African American infants die annually during the neonatal period, and 2 Caucasian and 1 African American infant die annually during the postneonatal period.

More than 30% of children under the age of 18 live in families with incomes below the Federal Poverty Level. According to Missouri Regional Social and Economic Profiles, the average rate of unemployment in the Missouri Bootheel from 1996-1998 was 7.1%, far greater than the 4.3% rate of Missouri overall. The Bootheel's main industry is farming. Other major employment

industries include the public utilities, social services, health care and schools. Major employers in the Bootheel counties include two of the three hospitals that serve the region – Missouri Delta Medical Center and Pemiscot County Memorial Hospital. Manufacturers Noranda Aluminum, Inc.; Plastene Supply Co.; and Rowe Industries are also major employers as is a chicken processing plant, Tyson Shared Services, Inc. One of these major employers, Plastene, is partially shutting down. This will negatively impact the already poor rate of employment.

The economic status of the Missouri Bootheel is poor. Poverty, unemployment and lack of education are all problems that impact the overall health and well being of the population as well as the perinatal health of the women of the Missouri Bootheel. The rates of infant mortality, birth defects, child abuse and neglect, infant injuries, HIV exposure, childhood immunizations and perinatal smoking are all disproportionately high in this area of the state. Racial disparities also compound the already problematic issues of late and inadequate prenatal care, low birthweight, births to teens, lack of education of birth mothers and infant death. Many of these issues are dually identified by the Missouri State Title V Action plan as needing attention, especially in the African American population.

Perinatal Issues of the Missouri Bootheel

- Birth Defects. The rate of birth defects in the target area is about 8% higher than in the State of Missouri as a whole. Birth defects occurred in about 4.3% of births from 1993-1996, according to Missouri Department of Health Statistics, while the state rate was about 4.0%.
- Child Abuse. Probable cause child abuse/neglect cases per 1,000 children under age 18 is on the rise over the past several years. According to Kids Count Missouri 2000 data, from 1995 to 1999 cases rose from about 30 per 1,000 to about 39 per 1,000 in the five county area.
- Infant Injuries. Statistics indicate that injuries to children 2 and under are steadily increasing each year from 1996 to 1999 in the five county project area. Rates are as follows: 1996-15.1%, 1997-15.5%, 1998-16.3%, and 1999-16.6%.
- HIV Exposure. HIV exposure cases in infants have declined from 42 reported cases in 1996 to 33 cases in 1999 according to Missouri Department of Health, Office of Surveillance epidemiological profile reports, this is likely due to better medical knowledge of this relatively new disease. These numbers were not available specifically for the Bootheel counties, but apply to the entire state. However, more than 50% of these cases were reported in out-state Missouri, which means rural areas like the Bootheel. Other communicable disease cases in the five county target area were too few to really indicate trends.
- Childhood Immunizations. Public clinic immunization levels show room for improvement based on data from the Southeast District Health Office. Rates peaked in 1997 but have dropped off considerably: 1996-75.7%, 1997-89.5%, 1998-79.3%, and 1999-80.8%.
- Perinatal Smoking. Women smoking during their pregnancies is a problem. Missouri Department of Health Statistics indicate that one in four Bootheel women displayed this behavior in the 1996-1998 time period. That compares with one in five for the entire state. Smoking during pregnancy is not a problem more predominant in African Americans, however. More than twice the rate of Caucasian women as African American women smoke during pregnancy in the target area.

Perinatal Issues of Racial Disparity in the Missouri Bootheel

- Prenatal Care. Missouri Department of Health Statistics indicate that in 1997-1998 15% of Caucasian women and 30% of African American women entered prenatal care late (in the second or third trimester). Similarly, adequacy of prenatal care was problematic. On average from 1996-1998, 16% of Caucasian women and 38% of African American women received inadequate prenatal care. These issues of prenatal care are dually identified by the Missouri State Title V Action plan as needing attention, especially in the African American population.
- Low Birthweight. According to Missouri Department of Health Statistics, the rate of low birthweight is 8.5% for Caucasian mothers, while the African American low birthweight rate is 16.1%.
- Teen Births. The rate of births to teens under age 18 is higher in the Bootheel than the rest of the state and also is marked by disparity. About 11% of all Missouri African American births are to women under age 18 compared with 16% of African American births in the Bootheel. Likewise, 4% of all Missouri Caucasian births are to women under age 18 compared with 7% in the Bootheel.
- Maternal Education. According to Missouri Department of Health Statistics from 1994-1998, one-third of Caucasian mothers and more than four in ten African American mothers giving birth had less than a high school education. This compares to Missouri state rates of 17% and 31% for Caucasians and African Americans, respectively.
- Infant Death. According to Missouri Department of Health Statistics, there were 1,924 average annual live births in the 1996-1998 time period. Of these, an average annual 1,436 (75%) were Caucasian and 472 (25%) were African American. On average 9 Caucasian infants die annually while an average 8 African American infants suffer the same fate. This translates to a Caucasian infant mortality of 6.5 per 1,000 and an African American rate of 16.9 per 1,000. On the average, 6 Caucasian and 6 African American infants die annually during the neonatal period, and 2 Caucasian and 1 African American infant die annually during the postneonatal period.

Women's Wellness Initiative: Focus on Disparities in Depressive Symptoms and Service Use

The Women's Wellness Initiative was originally conceived as a way to contribute to the existing services of MBRC through a focus on symptoms of loss and depression that co-existed in the target population. Based on the project's location in an underserved rural area, there was evidence that women of reproductive age were not receiving needed support services to target existing perinatal depression or to prevent the occurrence of depression during and around pregnancy. No formal or informal services existed to support women experiencing loss during and around the time of pregnancy and there were no self-help support groups existing in the project area for either loss or depression. The following summary of needs assessment data collected prior to Healthy Start funding highlights the community needs that were considered in formulating a perinatal depression initiative.

Prior to project implementation of the Women's Wellness Initiative, there was no collaborative planning to address mental health needs of women during and around the time of pregnancy. Scattered services, a disconnected delivery system, and a lack of knowledge and

assessment of depressive symptoms were serious problems in the rural Missouri Bootheel. This fragmentation of services became an essential concern and focus for the Women's Wellness Initiative.

Prior to implementation, mental health services did exist within the localities continued in the target region for this project. The primary providers of outpatient mental health services, including screening and treatment for depression, were Bootheel Counseling Centers and Family Counseling Center, Inc. Family Counseling Centers has main offices in Kennett, Missouri (Dunklin County), as well as satellite offices in Dexter, East Prairie, Malden, New Madrid, Portageville, and Steele. Bootheel Counseling had a central office in Sikeston. These office locations spanned the geography of the target region, however large travel distances were required for women seeking services. Additional outpatient mental health services are provided by Lutheran Family and Children's Services and several local treatment programs for alcohol and chemical dependency, including the CSTAR program located in Hayti (Pemiscot County) which has a specific program for women, adolescents, and children. Additional substance abuse outpatient treatment is available throughout the region. Although there are no inpatient psychiatric treatment centers in the 5 county target region, inpatient mental health treatment is available in a neighboring county within Southeast Missouri at the Southeast Missouri Mental Health Center. Inpatient detoxification services are available both at the Stapleton Center in Hayti (Pemiscot County) and at the Twin Rivers Regional Medical Center in Kennett (Dunklin County).

Family support services are another means by which women may access support and limited mental health services. Prior to project implementation, case management and family support providers were sought out. The goal of these programs was to provide intervention and case management for women and families experiencing economic, medical, or psychosocial problems which our project believed may influence their overall mental health and wellness. Providers of family support services within the target region for this grant included local health department prenatal case management systems, as well as community providers. Several target programs exist for pregnant and parenting teenagers, including Missouri Mentoring, Tiny Touch (Mississippi County Health Department), the Building Blocks program of Southeast Hospital, and Healthy Birth Outcomes Programs (Dunklin, Scott, Pemiscot, and New Madrid County Health Departments). In addition, a specific program at Lutheran Family and Children's Services (located in Cape Girardeau) provides counseling and support services for families within the target region as well. Local social service programs such as local health department peer support programs, WIC, the TEL LINK prenatal care information call center provide information and referral services which include referral to mental health services. In addition, local and regional hospitals such as Missouri Delta Medical Center in Sikeston, Southeast Hospital in Cape Girardeau, Twin Rivers Regional Medical Center in Kennett, and Three Rivers Health Care in Poplar Bluff all provide family support services that are accessed and utilized by pregnant and parenting women in the target region for this project.

Although many of the mental health and family support services provided psychosocial assessment, there were no specific services that link mental health and psychosocial support specifically for women during and around the time of pregnancy. Because this target population receives services from a variety of providers, there is potential in a rural area for women to "fall between the cracks" or to have areas of unmet need due to geographic distance and

compartmentalization of services. Collaboration and coordination are key elements to meeting the mental health information, screening, and treatment needs in a rural community.

One of the challenges of intervention in the area of perinatal depression is the absence of tracking information specific to this population. Because depressive symptomatology may go undiagnosed or treated, the ability to identify the extent to which depression is a significant issue for women during and around the time of pregnancy has been identified as a crucial need. At the present time, there is no formal tracking system to assess the actual numbers women with depression within the target region. Individual providers of mental health services have their own records, and it is likely that many women who may experience depressive symptomatology have discussed this with primary care providers without a formal, tracked assessment or screening instrument.

Due to the absence of knowledge in this area, a research study was initiated several years ago including the Bootheel region. The presence of prenatal psychiatric disorders was the focus of a previously funded research study at St. Louis University under the direction of Dr. Cynthia Cook. This study examined a group of pregnant women with psychiatric diagnosis and a comparison group without psychiatric diagnosis in order to evaluate birth outcomes, the use of health services, and the overall cost of health services. As a result of this study, attention was given to the prevalence of psychiatric diagnosis, including depression, in the Bootheel region. However, the study did not contain aspects of intervention or community support/linkages. It was anticipated that the interventions proposed through Women's Wellness would expand on the knowledge obtained from prior research in the project region.

In order to obtain an initial understanding of the extent of need and service availability within the region prior to Healthy Start funding, a needs and services assessment was conducted of a representative sample of 10 pre-natal care, family/social service, and mental health service providers. Telephone interviews were conducted with appropriate staff members at each agency who would be familiar with the services provided to women during and around pregnancy. Both quantitative and qualitative information was collected regarding the provision of services and the perception of need in the 5 county Missouri Bootheel area. The significant findings related to perinatal depression prior to receipt of Healthy Start funding are summarized as follows:

Screening for Depression:

- 50% of respondents (those in the mental health sector) stated they provided some type of screening for depression.
- Of those that provide screening, 60% stated that assessment was subjective impression only, without any formal screening procedures.
- None of the prenatal care providers interviewed provided depression screening for clients.

Treatment of Depression:

- 20% of respondents stated they provide some type of treatment for depression.
- Only mental health providers were providing treatment of any type for depression.
- Of those that provided treatment, psychosocial intervention was used for treatment and there had also been referrals to psychiatric services for medication management.

Case Coordination and Referral:

- All service providers interviewed indicated they refer depressed clients to mental health treatment services, although many were unaware of referral outcome.
- Providers were aware of appropriate mental health referral agencies in all counties, although geographic distance was cited as a major service barrier in one county.
- One provider stated “clients would rather just see their primary MD and get medication”. The provider also expressed concern regarding drug contraindications during pregnancy.
- All social services and mental health providers cited formal follow-up procedures.
- 70% of respondents felt that there were sufficient community services to meet the mental health needs of their clients.

Quality Concerns and Gaps Identified by Providers:

- “access and knowledge are the biggest barriers to women receiving services”
- “women...and especially young women...are definitely falling between the cracks”
- “for those identified as depressed there are services...I suspect there are many women who are never identified, though”
- “targeted services to pregnant and parenting adults are lacking”
- “specific services for teen parents are needed...I suspect many of the clients I work with have undiagnosed depression”
- “there are definitely lapses between prenatal care and mental health services...there’s not a lot of communication”
- “I had a client who lost her baby...she needed counseling and I was able to connect her with a mentor who had a similar experience. That helped her so much...I wish we could do that all the time”
- “There are system wide gaps between providers”
- “Most of these women have more issues than just their pregnancy...I think more are depressed than we may be aware of”

Thoughts on Collaboration and Linkage:

- “We have good relationships with individual providers, but we definitely should work more closely together”
- “Linkage is essential, but it’s not currently a strength in this area”
- “I see two separate entities that need to work together more”
- “There aren’t many links...you have to know who to refer to”
- “There are cooperative efforts, but nothing has been formally addressed. It would be easy to transition because we want to work together more”
- “Individual providers have good collaboration”
- “There is a desire for cooperation and joint programs, but no one has had the time or money to make that happen”

In light of the needs identified in this assessment, three priority areas emerged in the development of the Women’s Wellness Initiative:

- Community education to raise awareness of depression and available community services
- The development of identification and screening procedures that can be easily accessed by women during and around the time of pregnancy throughout the community
- Formalized linkages and collaborative programs between community agencies that address

the concurrent needs of women who experience depression and are pregnant or have infants and young children.

These three overarching areas continued to remain the essential focus of the Women's Wellness Initiative throughout its four-year funding cycle, along with the eventual addition of a case-management component. As this impact summary demonstrates, all three priority areas were substantially influenced by the project and these original three project priorities were empowered to continue in the community beyond the funding period.

II. Project Implementation

Based on this project's status as a funded Perinatal Depression Initiative, a summary of the ways in which each core component was operationalized within the framework of depression services will be addressed, along with a summary of how these services evolved throughout the project period and any unforeseen complications in meeting our stated objectives. Major changes occurred both in overall MBHS and Women's Wellness from the time of project start-up through the close of Healthy Start services on May 31, 2005. Since the larger MBHS project also provided general perinatal services under each category (reflected in the impact summary of that separately-funded project), our approaches to *management of perinatal depression* in our community through the Women's Wellness Initiative will be referenced in the following discussion of Healthy Start core services and components, including evolution of services throughout the funding period.

Outreach and Client Recruitment

Initially, outreach and client recruitment was conducted by our Women's Wellness Coordinator (BSW level practitioner) who focused on work with women educated through the efforts of MBHS's community education. The original plan was to develop and introduce a curriculum addition to all education efforts of MBHS (originally, our MBHS project did not provide internal client case management, but rather a focused multi-session community education module). Beginning January 1, 2002 the process of outreach and client recruitment for Women's Wellness services began by introducing "Mental Health is Part of Every Woman's Wellness" as a topic covered in all Healthy Baby classes. At the conclusion of the presentation, participants were asked to complete a depression screen as well as a pre-post test evaluation. The depression screening provided the opportunity for women to self-refer for additional information and support to the Women's Wellness Initiative. Originally, this was completely separate from perinatal case management, which was subcontracted out by MBHS to local health departments. Therefore, women contacted through outreach were recruited to be a part of Women's Wellness efforts separately from any other type of case managed support.

The major change in this protocol occurred during year two when it was clear that a demand for Women's Wellness services far exceeded the project's expectations or the confines of the MBHS Healthy Start project. Women were self-referring from community partners with a desire to address perinatal depression apart from a need for MBHS's educational programs. Therefore, a significant change in outreach and recruitment occurred. Supplemental funding was sought in order to partner with three specific collaborative agencies: Delta Area Economic Opportunities Corporation (DAEOC); Parents as Teachers (PAT); and Mission Missouri. These organizations sent staff members to a training to be familiarized with the Women's Wellness

Initiative's curriculum, programs, and depression screening. While those specific services will be addressed later, the significance to outreach and recruitment was that referrals into Women's Wellness now took place not through our internal staff, but through our collaborative partners. This freed our internal staff (which was expanded to 2 full-time social workers) to focus on client case management and provision of support services and guided referrals into community treatment across multiple sectors of care.

There were no obstacles in meeting stated outreach and recruitment goals. In fact, as illustrated above, the original goals for the ENTIRE 4 year project period were met by the end of year 1. By the conclusion of the project, we had exceeded our client recruitment goals by over 300% and had sought out additional funding to meet the community's need and desire for Women's Wellness services.

Case Management

Case management in the Women's Wellness Initiative has always employed a modification of the Healthy Start core service requirement by focusing on the participant's mental health and wellness, rather than her pregnancy or child, in the provision of case management services. What this means is that a woman defined as receiving Women's Wellness case management does so based on her status as a woman of reproductive age with unmet mental health challenges. The focus of case management is to assist the participant in building her own social support network and engaging her in the service(s) she needs and desires to become and remain mentally healthy through her pregnancy and/or parenting. Case management is provided by BSW-level practitioners under the supervision of the MSW project director. Case management continues for the duration of time needed to assist the woman in obtaining needed services and a follow-up period of 6 months after (longer, if the client needs or requests additional follow-up).

While the case management component of Women's Wellness has remained consistent throughout the four years of project funding, its emphasis has increased throughout the funding period. While initially, the plan was to focus on case management within Healthy Start participants, this became expanded to the larger community through outreach efforts. Therefore, staff was expanded from 1 FTE to 1.5 FTE in year two to 2 FTE employees by year 3 of the project. The focus of Wellness Coordinator time became case management of referred clients, rather than outreach or education which became the domain of our collaborative partners. Based on this change in emphasis, the Women's Wellness Initiative was able to expand case management well into the local community through four years of funding.

Similar to our recruitment and outreach goals, case management also exceed original project expectations by over 300%. By the conclusion of the Women's Wellness Initiative, 287 women had received case management services (original objective was 75).

Health Education and Training

The original focus of health education and training for Women's Wellness was to develop a health education module on depression and positive adaptation to pregnancy and parenting that could be included as a part of MBHS's health education program. Until the present project, depression and positive mental health had not been a part of this health education curriculum and it was felt that a holistic approach to health promotion would optimize success. This education component was completed in an original curriculum called, "Mental Health is Part of Every

Woman's Wellness". While this was successful, the community-based enhancements that were occurring throughout other aspects of the project created the need for a comprehensive health education component that could be provided not just by project staff, but by collaborative partners and MBHS case managers (as that project changed to provide direct case management) as well. Therefore, the focus of health education changed from group presentations targeted at healthy start community participants to an individual model of health education regarding mental health promotion and depression awareness. In order to facilitate this health education on an individual level, a new curriculum was developed based on the National Institute of Mental Health's depression awareness curriculum "Depression: What Every Woman Should Know", amended to include a series of interactive discussion questions throughout the educational materials. This was accompanied by a series of educational fact sheets related to mental health promotion, including: "Clues About the Blues"; "How to Talk to your Physician about Stress and Depression"; "Up with Wellness, Down with Stress"; and "Helping a Loved One Who is Depressed". These educational fact sheets included revision by the local community, inclusion of photographs of women intrinsic to the project region, and culturally appropriate references throughout in order to make them readable, interesting, and applicable to our target population. Copies of these materials are included with this impact summary.

Health Education efforts were modified throughout the course of our project funding as previously discussed, integrating health education with community outreach and recruitment. Education also became a significant "co-requisite" of depression screening efforts as a way to educate women about their own mental health and begin the process of empowerment about their wellness, community resources, and benefits of treatment that would continue through case management. Health education is a vital part of our project and is provided by all staff and contractors: Wellness Coordinators, collaborative partners, and the project director. Additionally, health education modules were created for "train the trainer" workshops with collaborative partners, community peer support volunteers, and to educate Physicians and Medical Office Staff about the latest developments in screening and treatment of Post-Partum Depression. Copies of these materials and curriculum modules are also included with this impact summary.

No unforeseen challenges were encountered for our education components. Similar to outreach, our project impact of community health education has exceeded original project estimates.

Interconceptional Care

Specific programs targeted to interconceptional women were not included with our project, since our defined population was all women of reproductive age. The focus of education and case management remained the amelioration of depression systems and promotion of positive mental health, regardless of the woman's status as preconceptional, pregnant, interconceptional, or parenting children older than age 2. In completion of required forms, women were tracked for their status as pregnant or interconceptional and this detail is included where required. However, preventative depression services did not differ based on interconceptional status.

Depression Screening and Referral

The Women's Wellness Initiative's primary purpose was to integrate depression screening, referral, and preventative treatment into the existing programs and services of MBHS and,

eventually, into other existing community service agencies as well. From the project's onset, baseline data indicated that there were serious problems with stigma, educational deficits, and professional unwillingness to address depression in women of reproductive age. Therefore, our approach to depression screening, referral and treatment maintained a dual approach: 1) to address depressive symptoms in women receiving outreach, education and case management thereby directly addressing depression and 2) provide a consistent, widespread educational and health promotion campaign in the community at large that reduced stigma, broke down barriers to referral and treatment, educated professionals on the advantages of universal depression screening for this target population and left a lasting impression that Mental Health Is A Part of Every Woman's Wellness. We deliberately used a health promotion approach, rather than a symptomatic approach in the belief that this would contribute to the empowerment-oriented model selected for our project. This was further heightened by the community's involvement in empowerment evaluation and capacity building activities to place positive mental health and wellness promotion at a high priority among professionals and consumers alike in the community. This approach has been extremely successful and resulted in overwhelmingly positive response to the programs and services provided through the Women's Wellness Initiative. The following narrative provides an overview of the ways in which core services were integrated together through the Women's Wellness model, beginning with year two of project funding:

Case management has become an important feature of the Women's Wellness Initiative, aimed at keeping women at risk for depression from "falling through the cracks" of the formal and informal mental health care system. Marketing this idea of case management for depression in a rural area with a demonstrated high degree of stigma poses a significant challenge. Because of the stigma surrounding mental health, we have taken the emphasis away from a "clinical", "illness-oriented" approach. The focus on "Women's Wellness" is a lifetime commitment to taking care of oneself and each other. The program philosophy is that Women's Wellness staff are available along the way for the support, referrals, and empowerment strategies to assist women in achieving their goals. This approach has resulted in women receiving services without stigma and hopefully, will make an impact in the community's perception of mental health promotion.

A decision made early in the initial development of the Women's Wellness Initiative was to market the project to the community using a strengths-based perspective. We chose the motto, "Mental Health is Part of Every Woman's Wellness" to acknowledge the mental health emphasis of the project within a context of overall wellness. This emphasis on wellness over illness was intended to address the stigma we knew existed in our rural area. Likewise, we reference our core screening and case management/community referral services as "Wellness Link" to reinforce this continuity of care. Case management in the Women's Wellness Initiative consists of meeting the needs of referred or self-referred women where they are at, regardless of diagnostic level. Case management may include mental health information, psycho-education, supportive counseling visits, or assisted community mental health referral.

Presentations to general community groups (including Healthy Start educational events) are given by Women's Wellness staff, as well as by collaborating agency professionals trained through the project to provide this education, based on the NIMH depression awareness materials and additional culturally-specific information related to our project region. At the conclusion of the 30-45 minute presentation on maintaining positive mental health and awareness of stress and depression that may occur during and around pregnancy, attendees are encouraged to complete a depression screen using the PRIME-MD, Patient Health Questionnaire (Spitzer et al., 1994) which

screens for depression at both major depression and minor depression symptom levels. Accompanying the screen is a referral request that a client may sign in order to receive contact from Women's Wellness regarding the results of the screen and any additional information or services.

It has been our experience that the self-referral process has been very successful; those with screening levels of major and minor depression have self-referred to the project in about 90% of all women screened. This, rather than a diagnostic level "mandated" referral, keeps the participant in control of her own care. Those not wishing a referral are provided with information and encouraged to refer at a later date; again this has occurred only on rare occasions. During the first year of the project, 260 people (including consumers and professionals and well as people of all genders) were educated regarding depression and wellness, with 66 known to be pregnant at the time. Of the women who were educated, 77% (184/240) were voluntarily screened for depression and provided staff a confidential copy of the depression screen for evaluation purposes. By the conclusion of the project, 1,264 women had been screened for depression and 946 (75%) voluntarily provided demographic and screening information for evaluative purposes.

Results from this screening indicate that depression symptoms, at both clinically diagnostic levels and significant symptoms not meeting diagnostic criteria, is a serious issue for the project region. At baseline, total of 19% of women (35/184) met criteria for clinical Major Depression; an additional 16.8% (31/184) met criteria for Minor Depression; and an additional 14.7% (27/184) displayed a non-diagnostic level of significant symptoms of depression combined with a self-report that the symptoms caused problems in their overall daily functioning. These figures represent mutually exclusive categories. This rate had significantly declined by project baseline with year four totals of Major Depression at 11%, Minor Depression at 9% and non-diagnostic significant symptoms at 16%. A reliability coefficient for the PRIME-MD instrument used was calculated to further assess the scale's ability to measure depression in the population ($\alpha = .86$), demonstrating that the instrument is consistent with measurement in this population as compared with earlier reliability studies of the instrument.

When a participant self-refers to the Women's Wellness Initiative following community depression screening, she is encouraged to meet with the Women's Wellness Coordinator via an in-home or office visit and create a plan to manage her own situation; these plans may include information, supportive visits, connection with mental health system providers, health referrals, community support and self-help groups, and phone and mail follow-up. Knowing the client's screening level and symptoms of depression prior to these visits helps direct the supportive counseling visit towards symptom understanding and management, and also allows our staff to explain community services for which she may or may not be eligible. While a specific counseling technique is not used during visits, the approach clinically suggested is consistent with cognitive-behavioral techniques and general emotional support and validation.

The central goal of visits is to understand the client's perceptions of depression, including community stigma, and to build trust with the client in order to overcome existing barriers to treatment. As noted, barriers may be tangible (transportation, diagnosis, service availability) or intangible (stigma, perceptions about depression and personal weakness, self-esteem). The goal of visits and case management is to develop and implement a realistic plan for "treatment", including either assisted referrals or use of internal & community resources to address the client's presenting problems. The case management protocol and supportive counseling visits do not take the place of other existing resources (counseling, Medicaid or Healthy Start prenatal case management, etc.).

Challenges often encountered by project staff are women with low incomes who have significant symptom levels of depression impacting their daily functioning, but who are not service-eligible due to restrictions on Medicaid reimbursement for services. Additionally, providers in our rural area are scarce; both long waiting lists for services and geographic barriers to accessing care are real concerns in the project region. This is addressed by the availability of ongoing psychosocial support through our Women's Wellness Coordinators (BSW social workers) during transition or for those not meeting diagnostic criteria, and through the availability of funds to assist with transportation. Additionally, community-based support groups have been formed for those women desiring support and with low symptom levels who do not otherwise qualify for services.

Case Managed Services available through the Women's Wellness Initiative include:

- Supportive counseling from BSW Women's Wellness Staff
- Peer volunteer support for those who have experienced perinatal loss
- Follow-up via phone, mail, email and/or in-person visits by Women's Wellness staff for the duration of case managed support
- Community self-help support group development & maintenance (5 affiliated support groups have been established and maintained)
- Guided referral to specialty mental health counseling with two subcontracted providers for assessment & formal treatment planning (when major depression as a diagnostic level is suggested)
- Transportation assistance (reimbursement and gas cards) when needed to access mental health support
- Psycho-educational materials, including stress management, depression, postpartum depression, and coping with perinatal loss

Community-based Services provided through Women's Wellness include:

- Primary physician training manual (and in-person training) to provide accurate, recent information about depression screening, treatment, and research (this can be provided routinely or directed to particular physicians as needed)
- Community education (individual and large-market) to reduce stigma associated with stress, depression, loss and pregnancy
- Sustainable community support network development for support groups and empowerment-oriented activities for women of reproductive age
- Education to collaborating agencies to introduce depression awareness and stress management to existing, ongoing community services (non mental health providers) for women during and around pregnancy.

Women's Wellness Coordinators are directly responsible for case management and are the foundation of case-managed support. As professional, BSW level social workers indigenous to the local community, they are responsible for navigating their own case loads. The Women's Wellness Project Director (MSW) provides assistance in this area as well, providing clinical supervision and case discussions of clients served and working directly with clients as requested by the Women's Wellness Coordinators. On-call is maintained by off-time availability of staff via cell phone, with the Women's Wellness Project Director providing time-off coverage and on-call assistance for the Women's Wellness Coordinators. Subcontracts are in place with two

community mental health centers for emergency psychiatric care that may be encountered during the project.

Evaluation of client progress is monitored via follow-up depression screening at routine intervals (3 months in most cases), as well as qualitative self-report measures of awareness of stress, adaptive coping mechanisms, and overall benefit of the project. Because clients are managed at different levels depending on their situation, treatment preferences, and diagnostic levels, there are not sufficient intra-group samples to make quantitative comparisons of progress at this time. Qualitative results from the end of year one of client services suggest that clients report having been connected to services when desired, describe an increase in their sense of social support and self-esteem, and are able to identify and put in place adaptive coping mechanisms to manage stress and depressive symptoms during and around the time of pregnancy.

Significant challenges remain, based on the available staffing and funding of the project. The Women's Wellness Initiative focuses on depression and perinatal loss, but has received numerous referrals for domestic violence, alcohol and substance abuse, complex mental illness and suicide, and basic service provision needs for extremely impoverished clientele. In these cases, we work collectively with other area service providers in an attempt to meet the needs of these women. In these cases, we do not have enough staff to meet all needs in this community that has a lengthy history of being underserved. However, by working collaboratively with other service providers, women are assisted and maintained by a number of providers working collectively. This has not been without difficulties and challenging cases, each one of which has been a learning experience that has strengthened the knowledge of the community and reinforced the need to continue to re-evaluate community services through every client situation.

Women's Wellness has continued to evolve through its four years of Healthy Start funding as evaluation results were obtained, reviewed by the "Women's Wellness Subcommittee" of the Regional Consortium, and implications from the evaluation were turned back into program development and new initiatives. However, the overall model that links education, outreach, screening and case management services and then integrates successful consumers back into the cycle as volunteers, peer supports, and committee members has been tremendously successful in giving ownership of Women's Wellness back to the local community. That is the final step to long-term sustainability which we hope to achieve by ongoing community integration of the model established by the Women's Wellness Initiative during its four years of funding.

Local Health Systems Action Plan

One of the original over-arching goals of the Women's Wellness Initiative was to bring together providers from various service sectors (mental health, maternal/child health, family services, community social services, health care) in order to create a more consistent, smooth network of providers that women could access in order to insure promotion of both physical and mental health during and around the time of pregnancy. This goal led to invitation of multiple providers to participate on the "Women's Wellness Subcommittee", as will be discussed under consortium activities. In addition to our own local health system action plan, we worked together with MBRC's eliminating disparities project to contribute our own "spin" to the local health system action plan worked on by the overall Healthy Start Regional Consortium.

During our four years of funding, the LHSAP changed several times. First, the LHSAP devised by MBRC's Regional Consortia was to bring a FIMR project to the Missouri Bootheel. Since the Women's Wellness Initiative's Project Director had past experience with FIMR,

extensive efforts were put forward to educate and train staff members on the FIMR process and to provide start-up assistance with FIMR on both a local and statewide basis. However, ultimately, the LHSAP of providing FIMR services was abandoned by the Regional Consortium due to numerous perceived and actual challenges in implementing FIMR services. When this occurred, the Regional Consortium elected the issue of obesity as one of concern to the project. Therefore, during this final year, the Women's Wellness Initiative has integrated Consortia and project time to developing programs targeted mental health promotion through physical activity and healthy lifestyle into our programs. The Women's Wellness Subcommittee sponsored a community challenge between groups for a "Fit and Fun You" project where total pounds lost over a 3 month period were compared and prizes awarded to all groups participating. Our "Up With Wellness, Down With Stress" handouts included information on stress management through exercise, and our support groups featured sessions on healthy lifestyle complete with women preparing and sharing healthy meals together.

While changing action plans mid-stream was a challenge and giving up the idea of FIMR implementation was disheartening, our involvement with the larger LHSAP of the Regional Consortia was able to bring a new dimension to community programs and services to enrich the lives of women. These projects will continue to be a part of the Regional Consortia, and the ongoing collaboration between the Women's Wellness Network and the MBRC Regional Consortia is anticipated to continue even after the conclusion of project funding.

Consortium

Initially, the Women's Wellness Initiative was introduced as a part of the larger programs and services of MBHS/MBRC. Rather than forming a separate Consortium for this project, a decision was made to create a subcommittee of the Regional Consortium that included persons interested in the Women's Wellness Initiative and promotion of mental health throughout the project region. However, in a short time, the Women's Wellness Subcommittee felt the need to meet separately from the MBRC Consortia in order to allow more dedicated time to issues of program evaluation, development, and building new initiatives between provider organizations. Additionally, while community-at-large participants were encouraged, the Women's Wellness Subcommittee had a large number of professional members who could not meet at the times the Bootheel Healthy Start Regional Consortia was meeting. Therefore, in addition to Regional Consortia participation, the Women's Wellness Subcommittee also met separately once each quarter for a 2-3 hour planning meeting. This became a very successful technique with membership expanding throughout the four years of funding. At the conclusion of Healthy Start funding, this group has elected to break away from MBRC and instead function as a self-sustaining community coalition of consumers and providers known as the "Women's Wellness Network". The group continues to meet quarterly and engages in mutual fund-raising, community support, and empowerment evaluation initiatives.

The Women's Wellness Network also adopted an empowerment evaluation model early on during the Healthy Start funding cycle. Since year 2, the Network has been the primary source of sharing evaluation information, planning subsequent evaluation, and turning evaluation findings into programmatic changes and new initiatives. The empowerment evaluation model (Fetterman, 1999) is based on the concept that evaluation can produce community change and that evaluation itself is a collaborative process, bringing together the evaluators, the community, service providers and service recipients with the same goals and objectives. This model has proven to be extremely successful in this community with natural leadership emerging from the array of professionals and consumers

participating in the Women's Wellness Network.

Consortia: Establishment

The Women's Wellness Network was originally established as a subcommittee of the larger Missouri Bootheel Regional Consortium. In order to begin our new project with input from the community, we turned to the existing consortia for interested consumers. Quickly, as we invited providers involved in aspects of Women's Wellness to join the subcommittee, the need to establish independent meetings from the larger MBRC emerged and a quarterly independent meeting schedule was established. One barrier encountered was that the addition of more professionals to the subcommittee required alternative meeting times to the times used by MBRC (6-8 p.m., which did not allow professionals enough time to leave the work place and attend to families). Therefore, we conducted a needs assessment and determined that a morning meeting time would be the most convenient for the major of participants. A quarterly morning meeting was established for the independent subcommittee meetings.

Consortia: Working Structure and Composition.

The working structure of the Women's Wellness Subcommittee has been an informal, empowerment oriented group under the facilitation of the Project Director. The subcommittee elected its own leadership to engage in activities independent of the facilitator. The facilitator's role was to organize the meetings, present data and findings, and help address concerns that arose. However, the subcommittee maintained their own direction and engaged in collaborative planning efforts of their own suggestion and creation throughout the project. The subcommittee was also responsible for reviewing requests for collaborative funds and providing these to community groups for use in promoting community wellness activities.

The composition of the Women's Wellness Subcommittee is approximately 75% providers and 25% consumers (with some overlap between roles). By the conclusion of the project, there were 38 active subcommittee members. All subcommittee members (100%) were women, 23 African-American (61%) and 15 Caucasian (39%) subcommittee members. In total, 47 people have participated in Women's Wellness Subcommittee during the four years of the project, resulting in a total of 81% of all consortium participants remaining active throughout the project.

Consortia: Needs assessment, resource identification and collaboration.

The Women's Wellness Subcommittee used an Empowerment Evaluation approach (Fetterman et al., 1996) to guide program development and evaluation of the Women's Wellness Initiative. Beginning at project inception, a community needs assessment was developed through subcommittee participation to measure the community's perceptions of stigma surrounding maternal depression, assess help-seeking preferences, and determine to what extent depression presented a concern for the local community. Questions to be included on the survey were developed through subcommittee participation, and committee members assisted with community distribution of the survey. On an ongoing basis, findings from internal program evaluation are reviewed with the subcommittee for the purpose of allowing the committee to understand strengths and challenges faced by the Women's Wellness Initiative and suggest changes or additions to services and programs offered. Additionally, the subcommittee oversees spending of

“collaborative community funds”, a line-item amount that is available to provide seed money to small community initiatives aimed to reduce depression and improve women’s mental health and self-esteem.

The Women’s Wellness subcommittee is the first group in the region to bring consumers and providers together around the issue of promoting women’s mental health. Until the end of Healthy Start funding, the subcommittee was an ongoing part of the overall Healthy Start Consortium of MBHS and subcommittee leadership were encouraged to actively participate in the overall initiatives of MBHS/MBRC. Additionally, representatives from the subcommittee participated in other community initiatives such as the Southeast Missouri Health Network and as representatives to the statewide Missouri Women’s Health Coalition, aimed at promoting positive approach to addressing women’s health and mental health throughout the state.

Consortia: Community strengths

Since the beginning of the Women’s Wellness Initiative, there has been strong community support for the idea of addressing maternal depression. A dedicated group of professionals and concerned citizens have been willing to give of their own time to assist Women’s Wellness in its start-up and in expanding the reach of maternal depression services throughout the Missouri Bootheel. This commitment to addressing maternal depression has proven to be a powerful asset in consortium development. Collaborating agencies (DAEOC, Bootheel Counseling, Caring Communities) have lent space for meetings, willingly supported staff’s attendance at subcommittee meetings, and lent their own resources to promoting activities of the Women’s Wellness Subcommittee. This commitment among concerned providers who participated on the subcommittee has allowed for great success of the program during a short time of available funding.

Consortia: Challenges and barriers

The only barrier to subcommittee formation was the relationship between the Women’s Wellness subcommittee and the overall MBHS Regional Consortia. Those providers and consumers who were committed to the Women’s Wellness subcommittee felt that, while the two programs were linked, the Regional Consortia meetings did not allow them sufficient time to address the concerns related to maternal depression. Therefore, separating out the subcommittee from the main MBRC meetings was essential in order to allow the subcommittee to devote sufficient time to the concept of maternal depression. The agencies with staff participating activity on the Women’s Wellness subcommittee were interested in integrating depression services into their ongoing programs, but not necessarily the prenatal health and case management services provided through MBHS/MBRC. Therefore, a barrier of creating a separate identity and purpose for the overall MBHS Regional Consortia and the Women’s Wellness subcommittee had to be addressed in order to insure continued active participating of individuals and agency representatives on the Women’s Wellness subcommittee. At project’s close, the subcommittee was operating separately of the MBHS Regional Consortia and choose to continue on after project’s close as a separate community organization of voluntary consumers and providers, known as the “Women’s Wellness Network”.

Consortia: Consumer participation

As previously noted, the Women's Wellness subcommittee consists of both providers and residents/consumers. Initially, interested consumers from the MBHS/MBRC Consortia were encouraged to participate in the Women's Wellness subcommittee. This created an initial, core group of consumers to aid early project implementation. As the project grew and developed case management services, program participants who "graduated" and were willing to contribute to ongoing program development were encouraged to participate on the subcommittee. In addition, anyone receive funds from the collaborative community funding available (primarily community-based groups including churches, community action partnerships, and self-help groups) were encouraged to participate on the subcommittee, again boosting resident and consumer participation.

For the Women's Wellness subcommittee, it was very likely that the "provider" and "consumer" roles burred over time. Often, women who were professional participants originally acknowledged seeking mental health support services and help for community self-help peer support networks and groups. Meetings discussed these experiences openly, reducing stigma surrounding mental health. Ultimately, the subcommittee adopted a "Women Helping Women" approach as an overall goal to impacting maternal depression in this rural community, choosing to eliminate distinctions between providers and consumers by focusing both on individual wellness and promoting the wellness of other women encountered both in the personal and professional lives of participants. This powerful model has resulted in a motivated and change-oriented network of women who will continue to build and grow even after the conclusion of Healthy Start funding.

Consortia: Consumer input

As described above, consumers are active parts of the subcommittee and have been elected to leadership positions in the ongoing Women's Wellness network. Using the empowerment evaluation model, all program planning, sustainability, and evaluative aspects of our project took place with active input from consumers and providers participating on the Women's Wellness subcommittee.

Consortia: Consumer suggestions

As described above, consumer suggestions were voiced throughout the process of empowerment evaluation and to guide program planning. Each meeting contained a review of programmatic findings, a discussion of how these could be used to enhance programming, and the creation of a targeted approach to community problems uncovered through the discussion. Suggestions were discussed among staff and consortia members until a successful plan was reached that could be implemented. The results of the suggestions and changes were then reviewed at the next subcommittee meeting.

Collaboration and Coordination with State Title V and Other Agencies

During the four years in which the Women's Wellness Initiative was funded, there were several collaborative efforts between the project and statewide initiatives to improve women's health and mental health. These collaborative efforts are briefly discussed as follows:

Missouri Office for Women's Health: Rosie Davis, Women's Wellness Coordinator served as one of 15 representatives from around the state on the Women's Health planning committee. This committee sponsored numerous health initiatives and provided the structure to assist local communities to advocate for and educate women regarding health and wellness promotion. Through this participating, consumers and professionals participating on the Women's Wellness subcommittee were able to plan and sponsor an Annual Women's Health Conference. This began first in the Caruthersville area (southernmost counties) during year 2 and continued annually. A second conference in the Sikeston area (northernmost counties) was initiated during project year 4. The Women's Wellness Initiative supported these community efforts and worked with state officials to provide start-up funding, speakers, and disseminate women's health information to the many community women who attended the Women's Health conferences. This was a successful collaboration to bring the latest health and wellness promotion topics to women in our local communities who otherwise may not have had access to comprehensive women's health information.

Missouri Department of Health and Senior Services, Maternal and Child Health Department: Sarah Kye Price, Women's Wellness Project Director, collaborated with the Missouri DHHS Maternal and Child Health Department on several initiatives. The first initiative introduced FIMR projects to the state of Missouri for the first time. While the local FIMR project for the Bootheel was not able to be successfully implemented, FIMR projects were established in both St. Louis and Kansas City. The Project Director's role with statewide FIMR implementation was to provide statewide education regarding the impact of bereavement and perinatal loss on women and families, and to train potential FIMR staff on the process of conducting the maternal interview. This training was provided to a total of 20 professionals around the state who were responsible for some aspect of FIMR start-up. Additionally, as the project is coming to a close, Sarah Kye Price continues to work with the Missouri DHHS Maternal and Child Health Department (Karen Schenk) as they attempt to integrate depression screening efforts into community based prenatal and postpartum care.

Missouri Chapter, National Alliance for the Mentally Ill (NAMI): One of the hopes of the project was to establish a chapter of NAMI in the Bootheel area, since no chapters existed in southeast Missouri. A great deal of effort was put into place through staff's attendance at NAMI training and attempts to recruit families who would wish to be a part of a peer support program for families of those with mental illness. Unfortunately, the community was not able to attract the number of families needed to successfully carry out the peer support program. However, the collaboration with NAMI laid the ground-work for future efforts to bring this self-help and mutual support program into the project region in the future if community interest arises.

Sustainability

Efforts to promote sustainability of the Women's Wellness Initiative are focused not on sustaining the project as it current exists, but on working with the community to empower them to carry on aspects of the project by claiming them as their own and going forward. We believe this will allow Women's Wellness to continue to evolve as a community-based project that extends beyond Healthy Start funding. One essential factor to consider is that sustainability is in the hands of the community, with support from project staff as needed.

At the beginning of this project, we had little understanding of the magnitude of community need and demand for services that we would encounter during four years of funding.

By the conclusion of the project, we have become so integrally involved with the community and the lives of its women that we realize the community can be the best source of future problem-solving to promote positive mental health. Rather than take on a paternalistic approach that our project someone offers the solution to the problem of depression, we recognize that the women of the community are keenly aware of both their challenges and resources and are willing to take action to improve the health and wellbeing of each other and their communities. So, to do this, we offer support to their efforts but are allowing individuals and agencies to take the lead in creating sustainability efforts integrating a Women's Wellness approach to their organizations and communities.

Sustainability: Managed Care

Our perinatal depression project was not eligible for third party billing or insurance reimbursement. Those services are provided by the community mental health centers we collaborated with. The preventative services we provided are not insurance reimbursable.

Sustainability: Resources to continue major components

Sustainability of major components of our services has two aspects: short term continuation and long-term planning. Short-term continuation is managed through a grant received from the Missouri Foundation for Health (MFH). MFH funded the Women's Wellness Initiative and its collaborators to supplement the current Healthy Start grant. In light of the conclusion of Healthy Start funding, MFH worked with SIDS Resources to reallocate funds and provide continuity of services to the Bootheel Community through April, 2006. This will be accomplished through subcontractual arrangement between SIDS Resources, Inc. and Missouri Bootheel Regional Consortia, as well as the other continuing collaborators on the MFH Wellness Link project (DAEOC, Mission Missouri, Parents as Teachers).

Long-term planning has involved working with collaborators and the Women's Wellness Network members to identify ways in which other organizations can incorporate the Women's Wellness model into their services and agencies on an ongoing basis. Currently, the integration of depression screening and information is a part of local Parents as Teachers curriculum, as well as through efforts of DAEOC with its case managed clients. A grant has been written to the Children's Trust Fund (local foundation) through DAEOC to create a Women's Wellness model program for use in their family case management program. The outcome of that grant is pending at the time of this summary. Depression screening and referral has also been incorporated into the ongoing programs of Missouri Bootheel Healthy Start with their case managed clients.

Finally, the consumers on the Women's Wellness subcommittee prioritized the need to perpetuate "collaborative community funds" to continue to support small, community projects that otherwise could not get off the ground. A presentation and request is being made to the Oprah Winfrey foundation to continue this aspect of community-based support.

Sustainability: Overcoming barriers

We continue to address barriers of uncertainty regarding the ultimate sustainability of the project. While individual efforts are underway for sustainability, the process involves letting go of "control" of the project from the formal way it has been conducted over the past four years and

trusting that the community can and will do what it takes to continue necessary programs to improve the lives of women and children. This is addressed by our continued, voluntary commitment to the community to assist with grant-writing, development, and other functions that help program continue to grow and thrive in the project region. Although technically, our project funding has concluded, our commitment to the project region continues and we hope to continue to expand the reach of Women's Wellness programming into the Bootheel community.

III. Project Management and Governance

- A. Briefly describe the structure of the project management which was in place for the majority of the project's implementation.

The Women's Wellness Initiative is a small project with a simple organizational structure. The program ran parallel to the main Missouri Bootheel Healthy Start project. The project was directed by Sarah Kye Price, Women's Wellness Project Director who was housed at the grantee's office (SIDS Resources, Inc.) in St. Louis and reported to the Executive Director of SIDS Resources. Project staff consisted of two Women's Wellness Coordinators who reported to the project director, as well as one Evaluation/Data Entry Assistant who also reported to the Project Director.

- B. Describe any resources available to the project which proved to be essential for fiscal and program management.

Not Applicable; resources outside the project and grantee organization did not need to be utilized.

- C. What changes in management and governance occurred over time and what prompted these changes?

Not Applicable; no changes in project management or governance occurred during the four years of Healthy Start funding.

- D. Describe what process had to be developed to assure the appropriate distribution of funds and what happened with the process over time.

The process in place for assuring appropriate distribution of funds is a simple, internal process that is also subject to external audit on a yearly basis. A flow form for distributions was established; the Project Director reviewed all proposed distributions for appropriateness to program. The form was then reviewed by the Executive Director if the amount exceeded \$1,500. Each distribution was tracked for purpose (support, education, management and general), specific line item account number, and program. Once approved, the form was given to Accounts Payable who recorded the categories of distribution, paid out the distribution and keep an accounting of Federal dollars. Budgets were reviewed on a monthly basis by the Project Director for attention to line item spending. This process was consistent throughout Healthy Start funding.

- E. As the project moved forward with implementation, what additional (non-HS) resources obtained for quality assurance, program monitoring, service utilization, and technical assistance became important especially as contractors were funded or additional staff members were hired?

Because of the small size and dedicated purpose of the Women's Wellness initiative, there was not a need for external service development or technical assistance in carrying out the activities of the project.

- F. To what extent was cultural competency of contractors and of project staff an issue? If cultural competency was an issue, how was it addressed, and were any noticeable benefits realized?

Cultural competency was not an issue in project staff or subcontractors; two community mental health agencies are subcontracted using Healthy Start funds, and three collaborative agencies act in a contractual manner using non-Healthy Start funds to accomplish program goals. All five agencies are committed to cultural competency and were active participants in community cultural competency workshops sponsored in the community. Project staff were hired indigenous to the population and were well aware of community issues surrounding cultural competency and stigma surrounding depression. Project staff and collaborators worked together to further break down stigma surrounding depression and mental health service utilization. In addition, ways to enhance cultural competency were addressed continuously in the development of programmatic materials and services. This commitment to social justice and cultural competency is reflective of the empowerment approach adopted by the project and inherent in the community ownership of the project that has been demonstrated.

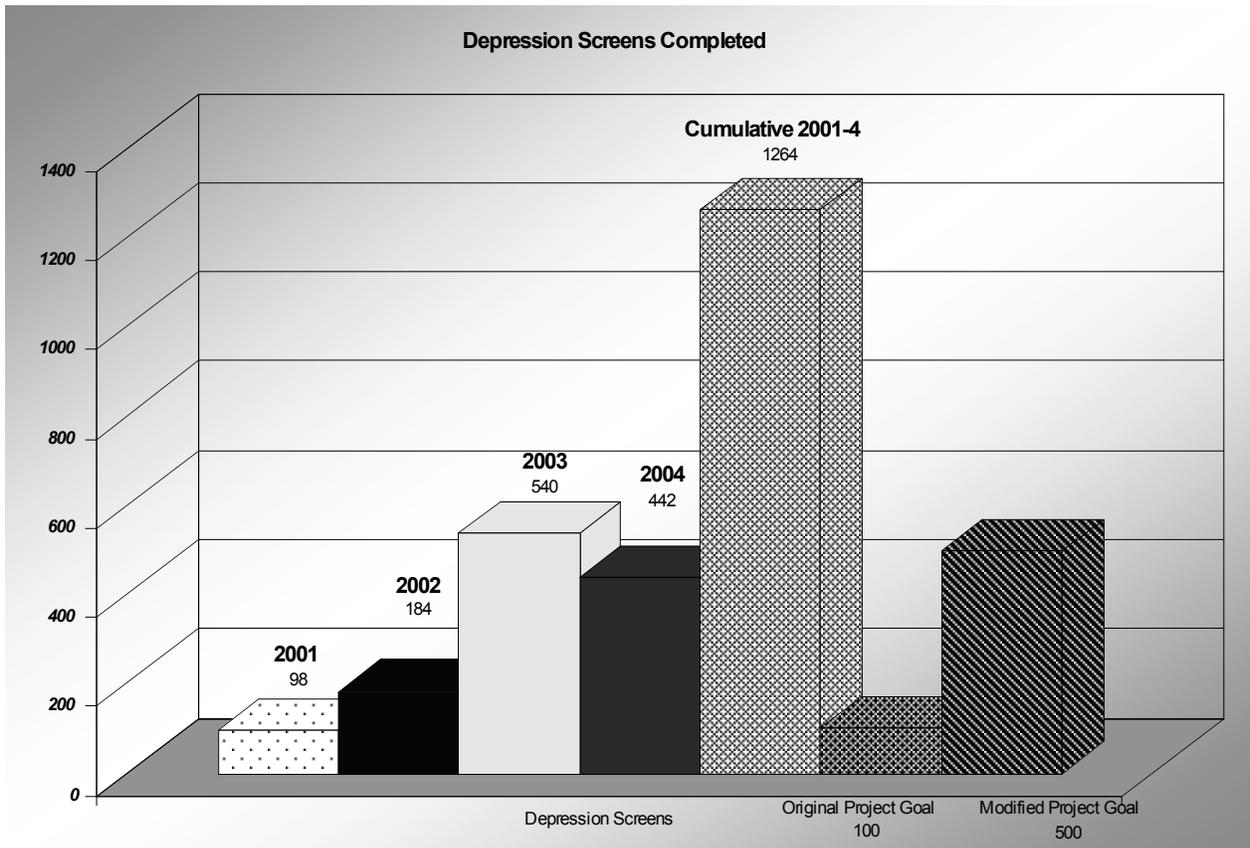
IV. Project Accomplishments

Please refer to Attachment A for a summary of the project's success in accomplishing stated goals and objectives using the Implementation Plan tabular format.

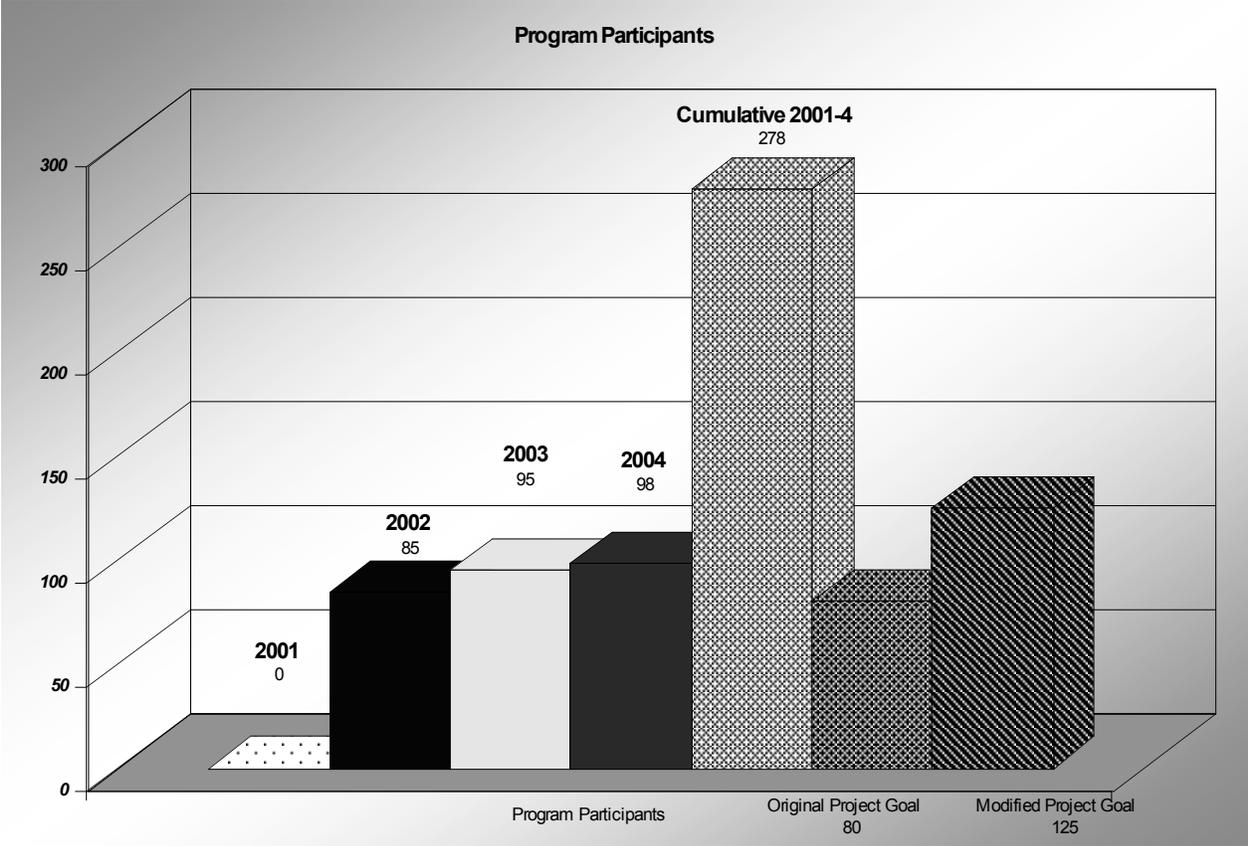
Overall, the Women's Wellness Initiative was successful in all major program strategies implemented. Programs and services were widely accepted by the community and original four-year target objectives were met by the close of Year 1. Attachment A has been completed as an outline for the manner in which goals were accomplished. Lessons learned from Women's Wellness are summarized at the conclusion of this narrative, in the hopes that they will be useful for projects seeking information on the integration of depression services into the Healthy Start model.

In addition to the reporting format for accomplishing goals and objectives, the following graphs illustrate our project's success in a) extending the reach of depression screening into the local community, b) attracting program participants c) addressing the magnitude of depressive symptoms identified in the community at baseline and d) enhancing service utilization in program participants across sectors of care.

1. Extending the reach of depression screening into the local community

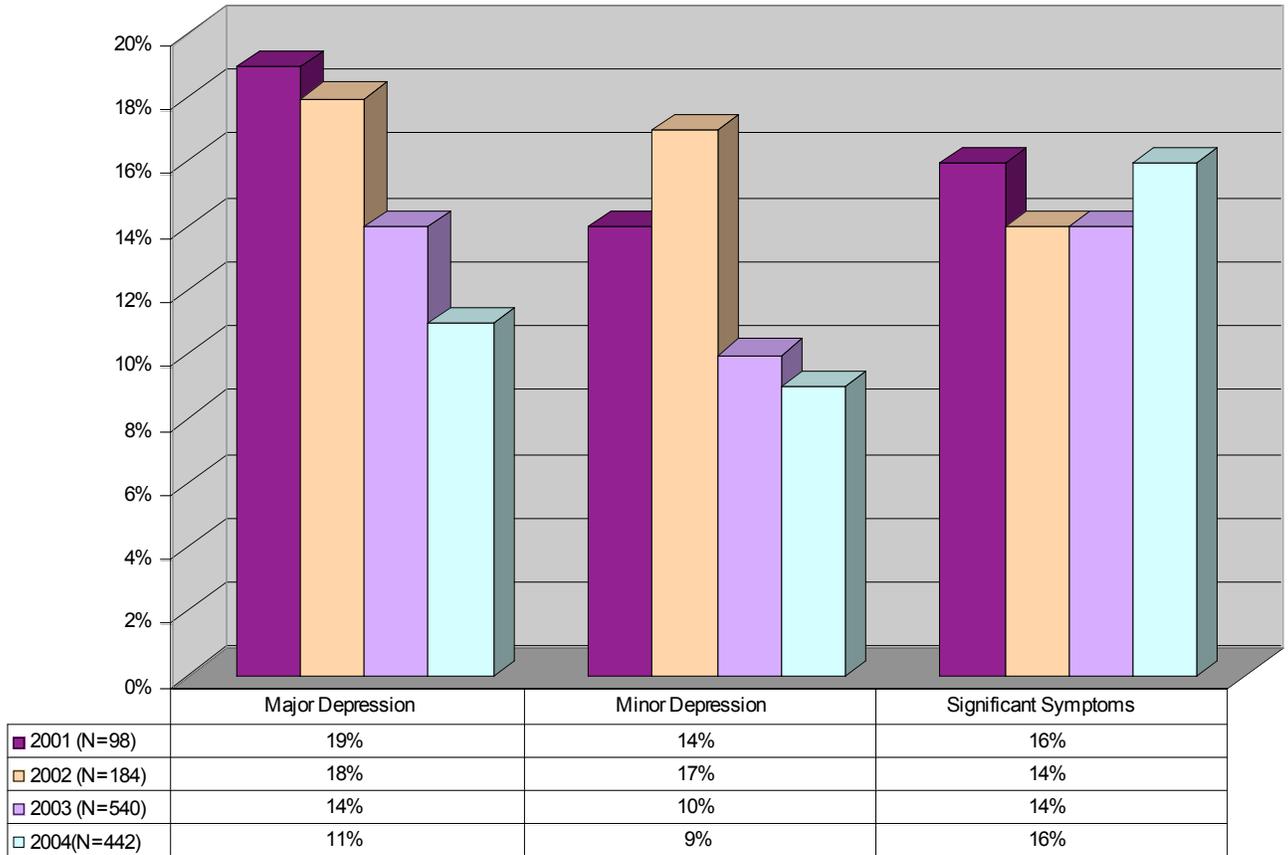


2. Attracting program participants

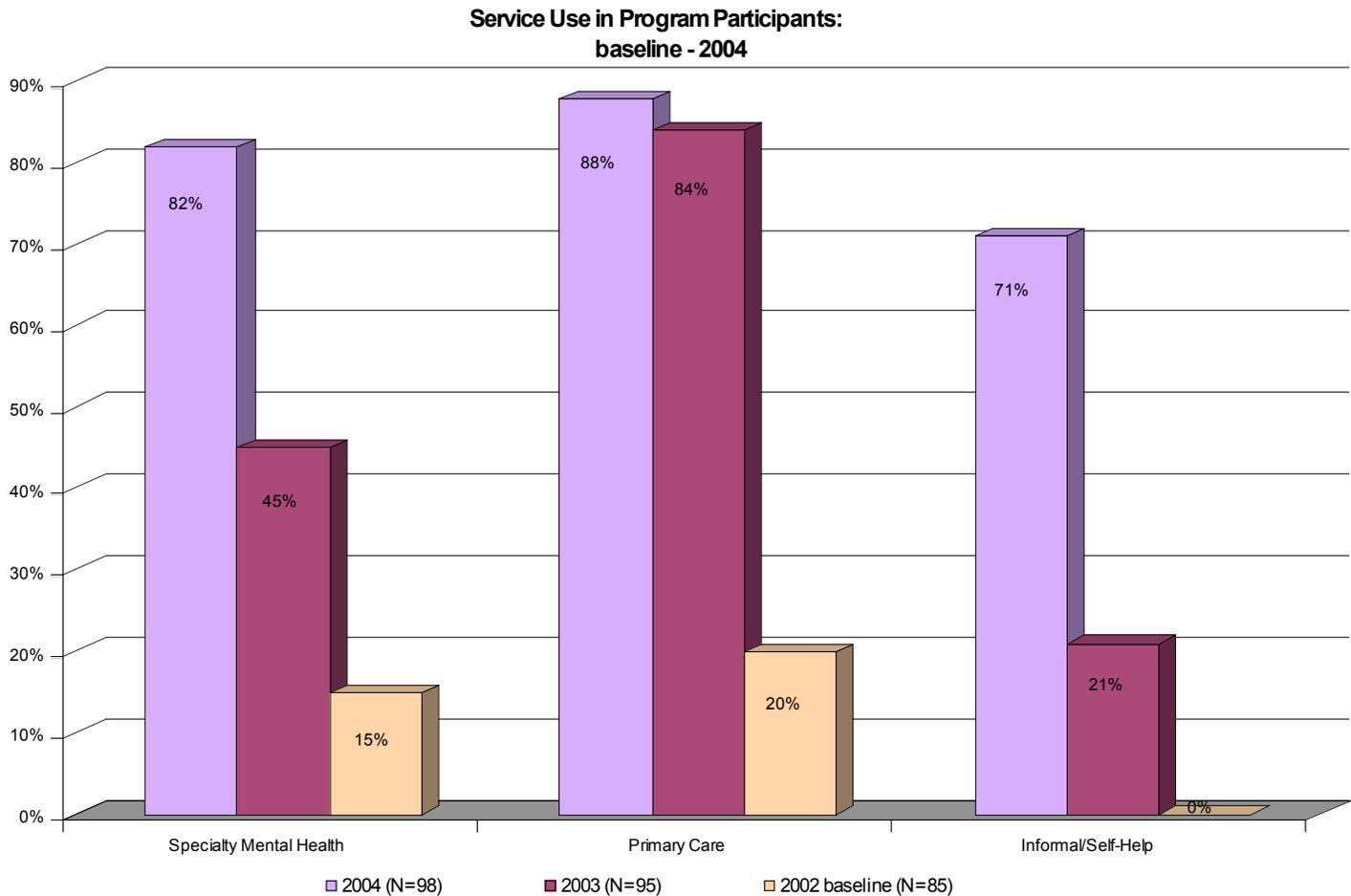


3. Addressing the magnitude of depressive symptoms identified in the community at baseline

Depression Levels in Community Screening



4. Enhancing service utilization in program participants across sectors of care



Mentoring and Technical Assistance

The Women's Wellness Initiative did not receive either mentoring or technical assistance from any other project site or organization.

As a part of ongoing collaboration with other Healthy Start sites, the Project Director provided informal technical assistance to both the St. Louis Healthy Start project and the Southern Illinois Health Care Foundation Healthy Start project around the topic of depression screening. The project director has substantial clinical and research experience in the area of maternal depression and perinatal bereavement. Presentations were given to the St. Louis Healthy Start staff on three separate occasions regarding depression screening and support services (2001-2003). Additionally, two conference presentations were provided for the Southern Illinois Health Care Foundation on topics of depression screening and supporting women and families experiencing perinatal loss (2001-2002). These services were provided through direct communication between Healthy Start grantees in an effort to support regional Healthy Start projects and were not arranged through MCHB.

V. Project Impact

Based on a review of all of your project's HS grant submissions during the project period, and the services and strategies implemented, describe the impact of Healthy Start on your Project Area and community. Please organize your description using the outline below.

- A. Systems of Care: Describe how the project has enhanced collaborative interaction among community organizations and services involved in promoting maternal and infant health and social support services.

1. Describe the approaches utilized to enhance collaboration.

Provider collaboration in the Women's Wellness Initiative has been enhanced by bringing together representatives from various agencies involved in the care and support of women AT RISK for depression and those agencies who are involved in treatment for depression. This occurred primarily through the consortium activities of the Women's Wellness Network. The goal of this collaboration was to introduce two previously divergent groups together in order to facilitate communication and enhance community care approaches for women. For example, the Women's Wellness Network brought together several providers of basic community support (shelter, food pantry, domestic violence) along with representatives from community counseling centers. Together, these professionals worked with us in establishing priorities for Women's Wellness to fit "between the cracks" of these programs and help establish linkages so that women of reproductive age had access to multiple community services, including those to address depression. Through working on joint projects such as culturally competent educational material development, these professionals built relationships that helped support their clients and enhanced understanding of the ways each of these organizations could interact to support women of reproductive age in the target region.

2. Identify the extent to which structured changes, such as procedures or policies, have been established for the purpose of system integration.

Structured policies have changed little due to the fact that mental health services are largely influenced by reimbursement. Even though there has been enhanced communication between community agencies serving women at risk and the mental health agencies that provide treatment, the growing gap in funding for mental health services meant that throughout the project, the safety net grew wider and wider. Women's Wellness was able to provide this safety net for women in the Bootheel throughout its funding. When it was clear that services provided through Healthy Start would not be able to be fully continued, the community worked together in an attempt to insure that the most vulnerable women were able to continue to receive services. Unfortunately, there are women desiring services in the project region who are not eligible for them. This is illustrative of the need for expanded mental health services throughout the United States, not merely in our project region. What has changed as a result of our project is that these women are now identified, participate in peer support programs if they are unable to access formal counseling, have enhanced communication with their primary care providers who are aware of the impact of depressive symptoms on their daily lives, and have a voice in the consumer-provider network that advocates for further changes in the delivery of mental health services.

3. Describe key relationships that have developed as a result of Healthy Start efforts covering the following areas:
 - a. Relationships among health service agencies; between health and social service agencies; and with community-based organizations;

As a result of the Women's Wellness Initiative, enhanced relationships have developed between the three key community service sectors that knew little about each other before: providers of basic support services that are utilized by women during difficult times of their lives, providers of maternal and child health care who interact with women during and around pregnancy, and providers of specialized mental health assessment and treatment services. The relationships that have formed are professional capacity-building relationships where each agency works together in an effort to enhance the comprehensive care that is available for women. Through involvement in joint activities to educate the community and break down stigmas surrounding depression, these providers have learned from each other about the services offered, the unique perspective of each agency about the needs of women and families and the limitations of each agency. A prior problem is that every agency assumed other agencies "did it all"; as a result, women often fell through the cracks. Enhanced communication and collaboration between providers has set the groundwork for ongoing collaborative efforts, including grant applications that are underway in the near future.

- b. Relationships that focus on involvement of consumers and/or community leaders (who are not employed by a health or social service agency) with any of the agencies/organizations listed above or any additional agencies.

Another crucial step in services improvement in the Bootheel region has been the involvement of community leaders who are volunteers on the network along with professionals. Professionals have seen that voluntary support group leaders have a great deal to offer to women who may not be eligible for formal mental health services, but need a positive outlet for social support and emotional growth. There has been an enhanced awareness of the contributions of volunteers and civic groups through the use of collaborative community funds to offer start up assistance to small programs. This has been instrumental in building trust between professionals and consumers and breaking down barriers that may have previously existed. Over time, the roles between consumers and providers became less and less evident as the focus of the project's effort became to promote a "women helping women" approach to alleviating the burden of depression in the rural community.

4. Describe the impact that your HS project has had on the comprehensiveness of services.

Perinatal depression services are distinctly different from other services offered through Healthy Start grantees. Depression, as a mental disorder, has a stigma surrounding it that pregnancy does not. When providers gather with a goal of helping women achieve healthier pregnancies, everyone has something to offer, whether it is tangible or intangible support.

When a depressed woman is faced with the prospect of addressing her depression, help is not as easy to find. In fact, one of the major problem encountered in the treatment of depression is the alarming number of people who never seek out help.

What Women's Wellness has done to address this comprehensive problem in the social service and health care delivery system is to make the discussion of depression (or, more accurately, the discussion of mental and emotional wellness) something that is openly discussed across multiple sectors of care. As a result of our efforts, depression screening is now used at the time of initial assessment with all women at the major women's health clinic in the region, primary care and OB/GYN providers, social service agencies providing shelter, food, and job relocation assistance, Parents as Teachers, and through faith-based organizations. Depression and its impact on the lives of women is now discussed actively and without shame. Women feel empowered to seek out services because they have information available about depression at the agencies they already use and frequent for other means of support.

Unfortunately, with statewide cut-backs in mental health and social services funding, treatment options for depression have become more narrow over time. However, the advantage in discussing depression routinely with general support providers is that women have a growing sense of social support and empowerment to access support services before depression levels become severe. We hope and anticipate that the degree of preventative services that were put into place that will continue to function even after project funding will continue to assist women in building adaptive coping and social support during times of transition and challenge in their lives in order to remain mentally healthy.

5. Describe the impact on enhancing client participation in evaluation of service provision in the following areas:
 - a. Provider responsibility in maintaining client participation in the system and provider sensitivity to cultural, linguistic and gender (especially male) needs of the community;

In order to enhance cultural competency, consumers and providers work together as part of the Women's Wellness Network (consortia subcommittee) to develop materials that are culturally specific to the Bootheel region. This is done through reviewing drafts of written materials for vernacular language changes, integrating photographs of consumers from a variety of service sector settings (with disclosure & consent to release photographs) and considering the needs of readers from an array of backgrounds. While our target audience for Women's Wellness is women, we have also developed and designed materials for a larger audience of family members, friends, and spouses to consider the issues related to mental health promotion in women. Since clients are involved as consumer representatives on the Women's Wellness Network, their input is vital to insuring cultural competency and extending service parameters to diverse individuals in the community.

- b. Consumer participation in developing assessment and intervention mechanisms and tools to serve perinatal women and/or infants, and the extent of implementation and utilization of these tools or mechanisms.

Prior to project implementation, there was no uniform way of screening for depression although initial baseline needs assessment indicated that providers from a wide array of agencies felt that depression was a serious concern in their clients. One of the early goals of our project was to resist the urge to introduce a depression screening instrument that was validated, but not necessarily acceptable to the community. Given the range of our target population extending beyond pregnancy and the post-partum period, we examined several instruments that measured women in a wider range of women. Consumers (at that time, volunteers and those involved in other Healthy Start educational programs in the region, since we did not yet have active clients for Women's Wellness) were engaged in a focus group to review the EPDS, BDI, CES-D, and the PRIME-MD. By this process, the PRIME-MD was selected for use based on established, published validity and choice by the target consumer group. The same process continued for introduction of other tools and evaluation mechanisms; draft materials would be designed by the Project Director and staff and then sample of these materials would be reviewed by the Women's Wellness Network to discuss changes, strengths, limitations, and ways to enhance utilization of these tools in the community. This process continues even after close of the formal project as community agencies bring to the group their information for new initiatives, evaluative approaches, and service ideas to brainstorm the ways in which effectiveness and implementation can be increased.

- B. Impact to the Community: Describe the impact the project has had on

developing and empowering the community, at a minimum in the following areas:

1. Residents' knowledge of resource/service availability, location and how to access these resources;

In order to enhance knowledge of resource/service availability, the Women's Wellness Initiative worked with the community to assess the domains of services they wished to be affiliated with and put together a frequently updated list of area support groups as they were forming, area primary care providers, and area specialized mental health support services. In addition, providers from related areas (substance abuse, domestic violence, food pantries, shelters, job/employment assistance) worked together to create resource lists for distribution to clients. Since representatives from these various agencies collaborated and participated in the Women's Wellness Network, providers also had the opportunity to learn about other resources in the local community and work together to keep their clientele informed. Women's Wellness worked with the eliminating disparities project of Missouri Bootheel Healthy Start to produce a community resource directory available to all clients of MBHS/Women's Wellness and freely distributed in the community. This community resource guide included detailed information on accessing mental health and psychosocial support.

2. Consumer participation in establishing or changing standards and/or policies of participating service providers and local governments, that affect the health or welfare of the community, and have an impact on infant mortality reduction;

Consumers were involved in all aspects of Women's Wellness. Frequently, informal meetings or more formal group activities would focus on the concerns women experienced in accessing services, obstacles they experienced in the local community, and issues related to policies at the local, state, and national levels. Consumers were encouraged (and their attendance supported) at meetings to advocate for changes at the National level through meetings with congressional representatives; access to public officials was provided on several occasions at the Annual Women's Conferences held in the area including representatives from the State Office for Women's Health, Department of Health and Senior Services, and the Governor's office. Finally, local governments were the focus of extending advocacy for inclusion of depression screening by local health departments (partially accomplished) and community representatives from Women's Wellness became advocates for inclusion of Women's Wellness and depression screening information at WIC offices and other social service and support organizations.

3. Community experience in working with divergent opinions, resolving conflicts, and team building activities;

In order to work together as a community network, participants in Women's Wellness had to overcome many obstacles. Initially, subcommittee representatives were brought together as distinct members of agencies in the local community, but without a common vision. Needless to say, there were many differing opinions about the creation of services, the counties in which they would be implemented, and the emergent needs observed by various agencies. The team members

worked together to develop an integrated approach to addressing maternal depression. Collaborative grant applications have been written to advance new ideas for expanding the scope of services and ongoing creation of community-level interventions and evaluation continues. The process through which the subcommittee has worked through individual perspectives to reach a joint vision has been a learning opportunity, but more importantly a positive tool that has transformed a group of individuals into an effective and supportive team engaged in advocating for the needs of women in our local communities.

4. Creation of jobs within the community.

Women's Wellness has not worked on job creation. The focus of our small project could not accommodate job needs, but we made efforts to use only services located within the Bootheel region and to support local businesses whenever possible. Hopefully, our presence benefited the local economy through our four years of funding.

- C. Impact on the State: Over the past four years Healthy Start has supported activities to strengthen and develop relationships with the State Title V program. In some states where there was more than one HS project, the Division of Healthy Start and Perinatal Services (DHSPS) encouraged coordinated activities across these sites. Describe the activities and impact that this approach has had on your relationship to the State Title V Agency, State Children with Special Health Care Needs Program(s), your state Medicaid and SCHIP programs, your State Early Intervention Program and other state programs. Highlight any benefits and lessons learned from these relationships.

Women's Wellness is in a unique position, having been a perinatal depression focused program rather than the typical Healthy Start maternal and child health program. However, we have used this role to work with statewide efforts to promote depression screening as a part of an integrated approach to addressing women's health. The Project Director has worked (and continues to work post-funding) with the Missouri Department of Health and Senior Services, Maternal and Child Health Department to develop protocols surrounding the introduction and implementation of depression screening to women following pregnancy across the state of Missouri. Additionally, information on the impact of reproductive loss and infant death on the mental health of mothers continues to be a focus of the Project Director through the past grantee agency, SIDS Resources, Inc. on a statewide basis. The accomplishments and lessons learned from the approaches taken by Women's Wellness are valuable information that is freely shared with the our state DHSS to help introduce depression screening efforts more widely.

One lesson learned is that there are two approaches to addressing depression during and around pregnancy. The first is to limit the scope of screening and services to the highest risk time (late pregnancy and early post-partum period, as supported by research studies) in an effort to track and address those women at highest risk statistically for depressive symptoms that could interfere with pregnancy outcomes and early infant care. This is the approach endorsed by our state health department and we are supporting them in this effort. Our project used this approach to identify high risk women as well as implementing wider, preventative services aiming to target depression before there was high risk and creating an atmosphere where service utilization could be enhanced in the community so that women can (hopefully) be reached prior to a crisis. This approach will

require future replication and testing, but requires a higher cost “up-front” for later benefit, making it difficult to attract funding. The goal is to engage future research activities to support this approach and explore future cost savings and cost effectiveness of preventative approaches.

- D. Local Government Role: Highlight activities/relationships at the state and local level that facilitate project development. Briefly describe barriers at the state and local level, and the lessons learned in dealing with these barriers.

The majority of our project work focused on outreach and services to women who were NOT being reached by traditional sources of care during and around pregnancy. As a result, we worked with local health departments to assist them in supporting the mental health needs of their clients, but did not want to duplicate services. In local communities, our project was seen as a positive force to support women and empower them to take action to address the importance of women's mental health. Initiatives were undertaken each year for “National Depression Screening Day” as well as during Women's Health Month. Local governments and agencies supported these initiatives and many self-help groups were able to receive free publicity and announcements in local community newsletters. Given the small, rural nature of our project, there was a lack of major media outlets or large governmental support. Instead, a grassroots approach where community leaders from Women's Wellness engaged with community leaders in government, business, and public/community relations to promote the goals and objectives of Women's Wellness.

Our major lesson learned is that it is far more time consuming than we realized to work with fragmented local governments and townships. When we tried to do this using our small project staff, our time was greatly eroded. When we, instead, turned this over to our project's voluntary community leaders on the network, things were accomplished much more efficiently. The addition of local residents of specific communities requesting support was also effective. This approach requires dedicated volunteers who are committed to raising awareness and not afraid to address the issue of mental health promotion.

- E. Lessons Learned: If not discussed in any sections above, please describe other lessons learned that you feel would be helpful to others.

Lessons learned have been discussed throughout this project. However, there are several specific lessons that the Women's Wellness Initiative would like to pass on to Healthy Start sites that are integrating depression screening and intervention.

Lesson #1: Promote Wellness, Not Depression

One of the important decisions that the Women's Wellness Initiative made during its early start-up was to focus on Wellness Promotion, rather than "depression". While identification of depressed women is, of course, a primary concern it is equally important to insure that women who do need services will be willing to use them. By taking the focus and stigma away from problem identification, we were able to make Wellness Promotion something that all women were eligible for and encouraged to receive. Even someone with less than clinical symptom levels of depression or who was experiencing life stress could benefit from emotional support and education surrounding depression. In taking this approach, Women's Wellness became a service any woman felt comfortable using since it did not target those with perceived "problems". This decision was instrumental to our project's success.

Lesson #2: Maximize Choice to Enhance Service Utilization

Initially, we thought that women who were depressed would want to use community mental health centers but experienced barriers to those services. We were wrong. What we needed to learn is that no one wants to be "told" what service to go to or feel they have the choice between services through agency A, or no services at all. When women were asked their treatment preferences, many preferred informal self-help, faith-based services, or services such as Women's Wellness that were not stigmatizing and did not involve a medial approach to managing symptoms of stress and depression. When women were offered a range of services including specialty mental health, primary care treatment, and informal/self-help support, they often chose to use more than one service rather than rejecting the one service we would have originally referred them to (i.e. women may have started attending a support group and over time, decided to go for specialized treatment). Choice is power, and by offering women a choice in service sector, they became empowered to make positive changes to their own mental and emotional health during the time frame that was most appropriate to their own lives.

Lesson #3: Listen to the Community...They Know What They're Doing

When designing a program, it is easy to listen to a number of different sources of expert advice about how to implement services. When Women's Wellness was initiated, information was received from various expert source and evidence-based materials including research articles, best practices, and advice from experts in the field. An important decision for me during start-up, though, was to listen to the community. One of the things I learned as project director is that whenever we encountered a potential problem, it was far easier solved when brought to the immediate attention of the community who would help work together toward problem resolution. This was true when budget cut-back sheared away available mental health services (we found a number of grassroots organizations, faith-based initiatives and other organizations who willingly sent their staff to be trained to provide information and support for mild-moderate depression), when we had difficulty getting physicians to buy-in to our education program (several subcommittee members spoke to their own nurse practitioners

and we built up a new program using health clinics and non-physician health professionals to engage in screening), and when we faced the prospect and eventual reality that there would be no future Healthy Start funding for perinatal depression specific projects (they are currently working on an array of alternatives to keep essential programs going). The community is the expert and they will help you get where you need to go, as long as you are willing to take the trip together.

Lesson #4: Screening is Useless without Services

I've had many Healthy Start projects and other community organizations approach me about depression screening. What I've learned, and I readily share with them, is that screening is useless without a comprehensive set of community services in place that want to work with you. It doesn't help to know that someone is depressed if your staff isn't trained and still believes every woman with depressive symptoms is suicidal or needs a lifetime prescription of Prozac. What helps is to build a network of care partners who are able to work with women with a variety of issues: family/relationship problems, domestic violence, parenting stress, employment assistance, educational opportunities, help with basic daily needs and finally, mental health services. Women experiencing depression may need support from any or all of the above. When this network is in place, screening takes on a new meaning.

You are informing a woman about what her symptoms may mean in terms of impact to her life and her family. Screening offers the opportunity to converse with a woman about not just what she feels, but why she feels that way. It offers the opportunity to talk about the way life events and stress can impact our emotional health and it provides the opportunity to find out about her current support system and unmet needs. In this context, screening offers the initial opportunity for comprehensive assessment and guided referral to resources that will enhance her coping. There will, of course, be challenges along the way. When screening is offered in the context of supportive, community services that may help a woman address the potential challenges in her life that now present themselves on paper, it becomes the first step towards empowerment. In our view, no one ever "screens negative" or "screens positive"; a screen is a filter that sifts away some of the coating to our inner emotions and allows us to begin a journey together. When you look at it that way, is it any wonder that 1,300 rural women willingly participated with us in screening efforts during the past four years?

Lesson #5: Family and Friends are Your Friends

When asked who they would turn to if they thought they were depressed, women in the community overwhelmingly responded to our community survey by stating "family and friends". This does not necessarily mean they didn't want other services, but it did mean that the informal support system was going to be a part of what made their treatment successful or not. So, an important lesson for us was that our project's education efforts had to reach beyond just the women in our target population. During our free moments, we also found time to give presentations to groups of men about depression in the lives of their partners (can you believe men were a little jealous we didn't have a program just for them, too?!), and to develop written materials about how to help a friend or family member who was depressed. This was an essential component of our project's success because women felt more comfortable talking about their mental health when they knew their family and friends had resources of their own. Many family and friends also became future clients of Women's Wellness, since we all can benefit from enhancing our mental wellness.

Lesson #6: What's Loss Got to Do With It?

Loss has much more to do with it than most people think. Healthy Start focuses on reducing infant mortality. But, how often do we talk with our clients about the impact of loss in their own lives? One of our surprising lessons is that even professionals had a great deal of reluctance talking about past reproductive losses with clients. It was a taboo topic, one that even our main Healthy Start project had a difficult time being willing to accept. Examining our Women's Wellness clients, our

demographic information indicates that 15% of women (27/178) identified as having experienced a pregnancy loss or infant death. This does not include losses unreported by our clients. We started a small project, a memory tree, where women could receive a small silk butterfly to attach to a tree and write on it a memory, name, or other information about a loss they or a loved one had experienced. Women began to write amazing stories, memories, and tributes to pregnancies that had not been carried to term, children who died shortly after birth, SIDS deaths, and losses in early infancy after complications. Women told us they had no where else to share this information and were grateful for this opportunity to acknowledge their loss. Our lesson, and a lesson that may help other Healthy Start initiatives, is not to shy away from acknowledgement of loss. Working in a public health setting, we see fetal and infant mortality as negative outcomes we don't want to have associated with our project. Considering it from the woman's point of view, past losses are also part of their inner emotional and psychological identities, intimately connected to their mental health and attitudes toward future pregnancies and children.

VI. Local Evaluation

This information is found using the suggested format in Attachment C. Evaluation reports attached include the following:

- Community Context of Service Delivery
- Impact of Women's Wellness Education on Community Stigma
- Impact of Women's Wellness on Provider Perceptions and Identification of Depression
- Giving Sorrow Words: The Experience of Life Events and Depression in Rural Women
- Women's Wellness Consumer Satisfaction and Project Impact
- Multi-Sector Service Utilization

VII. Fetal and Infant Mortality Review (FIMR)

In spite of efforts to introduce a Fetal and Infant Mortality Review (FIMR) into the community, this was not able to be accomplished due to external factors beyond the control of Women's Wellness. As previously noted, the focus of attention after the decision was made by the primary Healthy Start project not to pursue FIMR became assistance to other organizations statewide who wished to start up a FIMR initiative through providing training and support.

VIII. Products

The following materials are included with this impact summary, as developed by the Women's Wellness Initiative during the funding period 2001-2005. They are included in the order they were developed:

- 1) "Women's Wellness Initiative" Introductory brochure (over 5,000 distributed)
- 2) "Clues About the Blues" community awareness fact sheet (over 5,000 distributed)
- 3) "Coping with the Loss of a Baby" informational brochure (over 1,000 distributed)

- distributed)
- 4) "Mental Health is Part of Every Woman's Wellness" group education curriculum (approximately 50 presentations given)
 - 5) "How to Talk With Your Physician about Stress and Depression" (over 4,000 distributed)
 - 6) "Women, Loss, and Depression" Community Physician Training Manual (40 produced and distributed to primary care physicians and clinics in the 5 county area)
 - 7) "What Every Woman Should Know About Depression" tri-fold brochure (over 3,000 distributed)
 - 8) "Peer Support Volunteer Training Manual" (37 peer support volunteers trained)
 - 9) "Up With Wellness, Down With Stress" community awareness fact sheet (over 2,500 distributed)
 - 10) "Helping a Loved One Who is Depressed" oversized community brochure (over 1,500 distributed)
 - 11) "Depression: What Every Woman Should Know" oversized, full-color curriculum booklet for individual education (over 1,000 distributed)

IX. Project Data

Project Data has been attached in electronic format, including the following documentation for all years:

- MCH Budget Details (Form 1)
- Variables Describing Healthy Start Participants (Form 5)
- Common Performance Measures and Intervention Specific Performance Measures (Form 9)
- Characteristic of Program Participant (Table A)
- Risk Reduction/Prevention Services (Table B)
- Major Service Table (Table C)