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Adapting an Evidence-Based Intervention for Rural Women with Depression

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ADAPTING AN EVIDENCE-BASED INTERVENTION FOR RURAL

WOMEN WITH DEPRESSION

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BACKGROUND

- Prevalence of depression among rural women is nearly 4 times the national average
- Depression prevalence particularly high in Central Appalachia
- Limited services and social barriers restrict treatment access

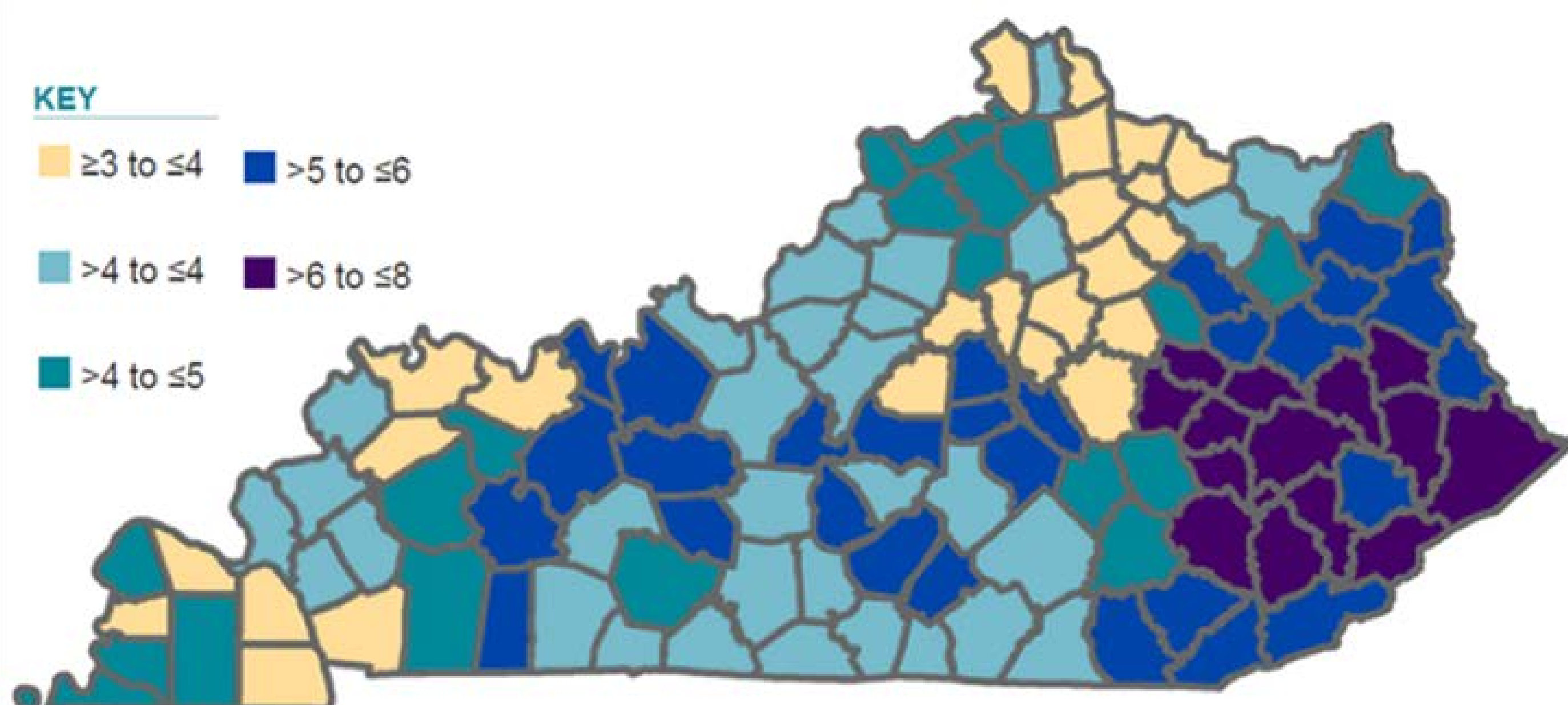


Figure 1: Mentally Unhealthy Days (per month): Kentucky Counties, 2008-2010. Data Source: BRFSS.

METHODS

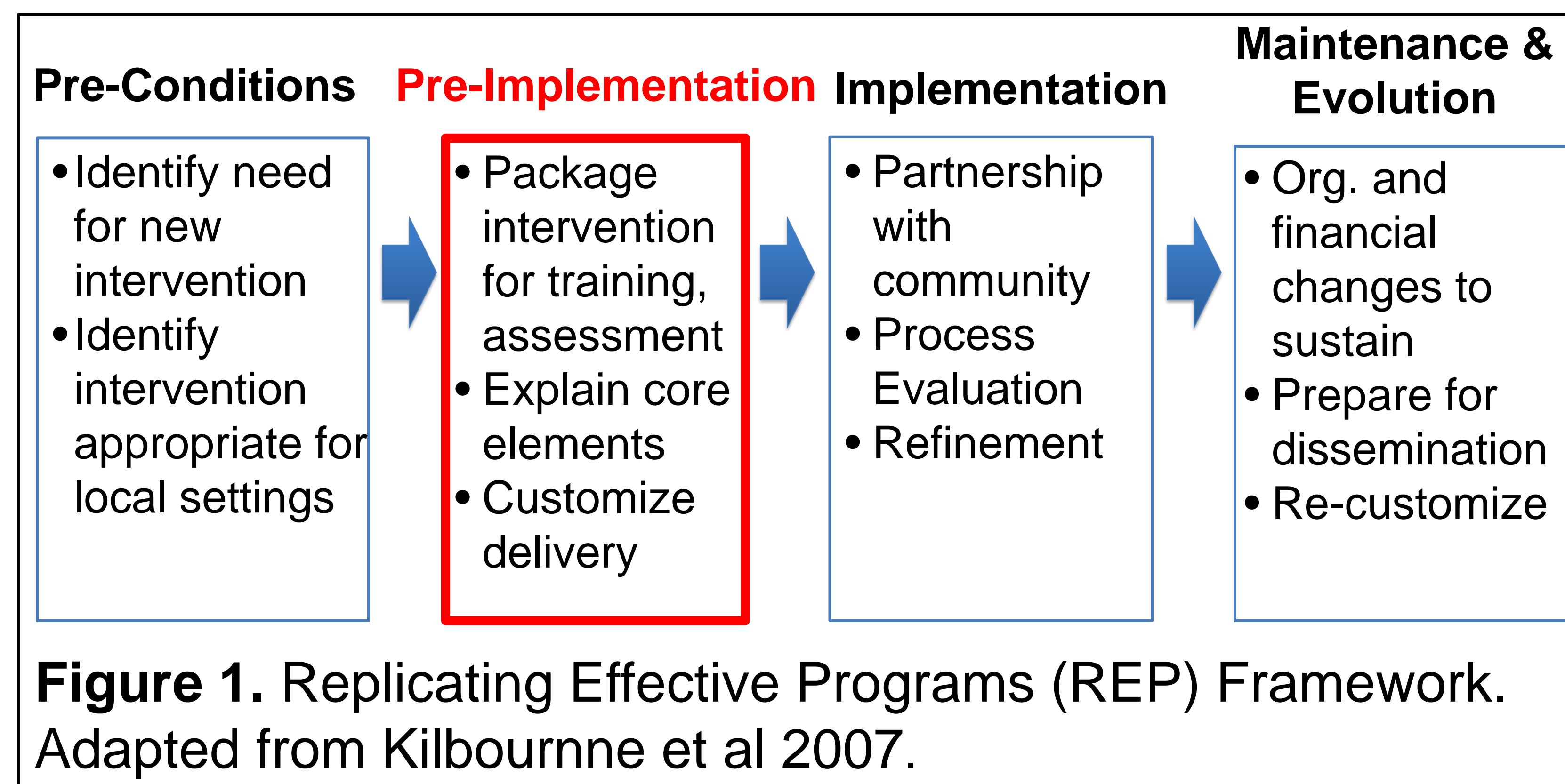


Figure 1. Replicating Effective Programs (REP) Framework. Adapted from Kilbourne et al 2007.

- **Partnership:** in rural area without a peer provider workforce, we will have community health workers (CHW) from region's Kentucky Homeplace program serve as facilitators for adapted intervention after receiving WRAP training
- **Data Collected** in focus groups (N=4) with Appalachian women with depression (N=10) and diverse health professionals (N=10)
- **Analysis** performed of inductive and deductive themes
- **Adaptations** made to evidence-based model
- **Checking** through individual follow-up interviews will be conducted with Appalachian women with depression (N=5) and health professional stakeholders (N=5)

RESULTS

Table 1: Themes and Application to Adapted Intervention


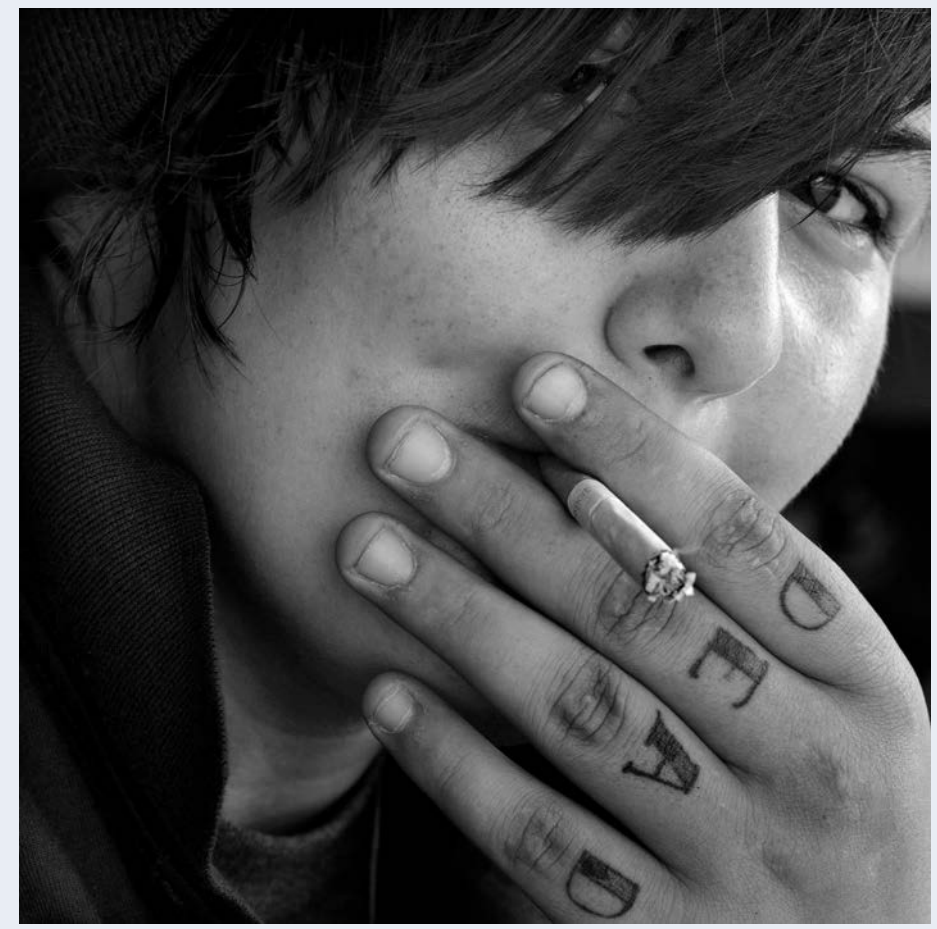



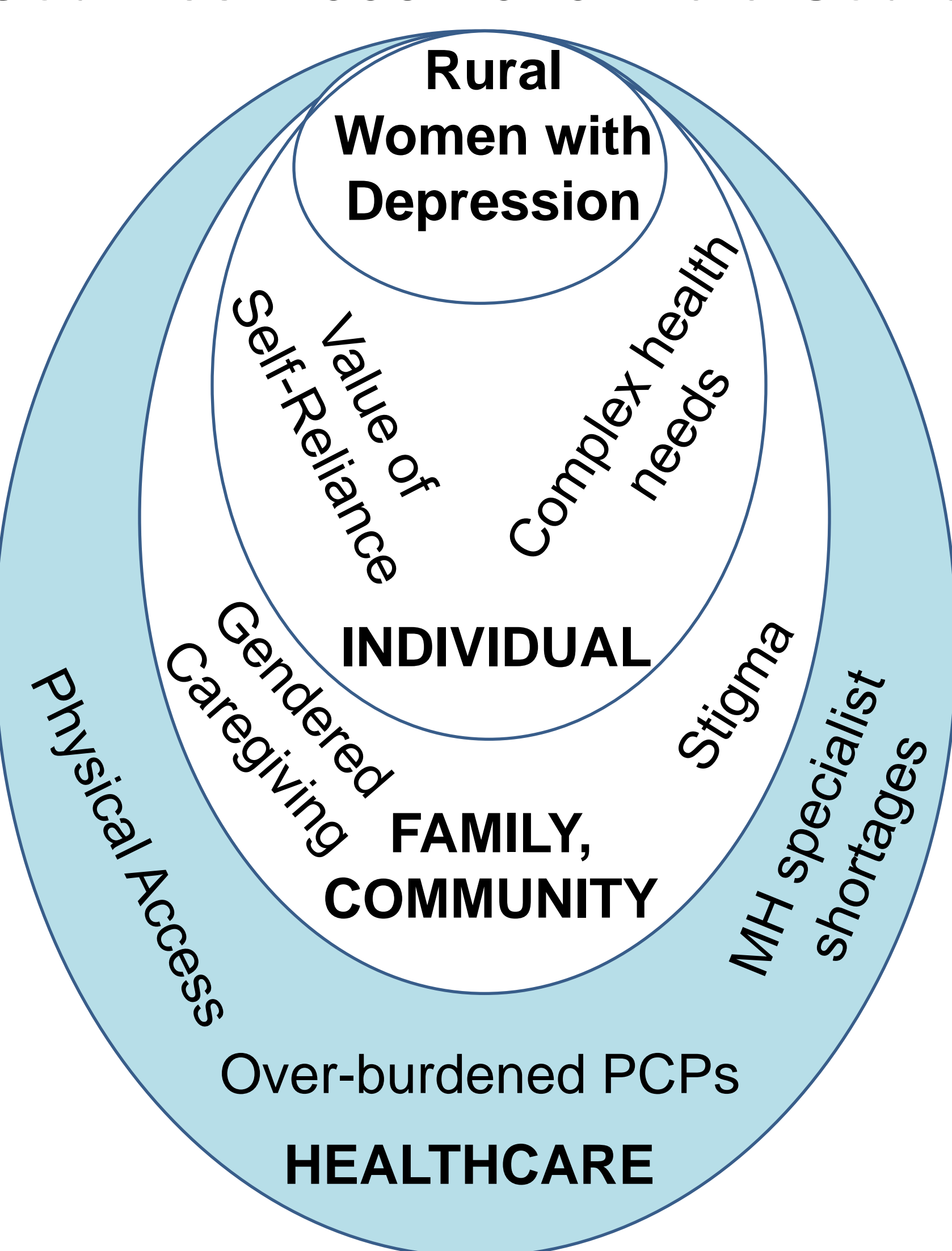
Theme	Facilitator Role	Suspicion of any treatment	Wellness	Legitimization of Mental Health	Setting
					
Quote	If you visit them at home and you explain all this, they're going to be like, 'hey I trust that; that might work; I'm going to go see what's that about.' –Provider	If they have some issue with mental health care or they haven't been treated well, emphasize that this would be different. –Provider	We have to present it in a way without saying, 'Oh it's all about depression'; I think we need to present it that it's a way to feel good. –CHW	It's not presented [as] 'well would you like to do this'; It's, 'well this is going to be part of your discharge planning.' –Provider	A great advantage of having it at a clinic-type setting [is that] women wouldn't have to call it anything, it could just be 'going to the doctor.' –Provider
Potential Adaptation	Before intervention begins, CHW (as facilitator) holds individual introductory session with each participant	In introductory session, discuss past and present experiences with treatment	Connect WRAP to women's overall health needs and self-care through messaging, wellness toolkit	Have providers refer patients to WRAP	Implement WRAP in primary care setting central in rural county

Figure 2. Multi-level Barriers to Accessing Treatment Among Rural Women with Depression.

Rural mental health intervention research has concentrated on decreasing healthcare-level barriers to accessing treatment (blue), yet social barriers (white) persist that make it difficult for women to access adequate treatment. Consequently, rural women access less mental healthcare than their urban counterparts.



- To meet these needs, we identified Wellness Recovery Action Planning (WRAP), an evidence-based recovery-oriented self-management program to augment treatment-as-usual
- WRAP is 8-session non-clinical program facilitated by trained peer providers created for individuals with serious mental illness
- Adaptations needed to be made to encourage participation of women whose poverty and depression would be barriers to involvement

OBJECTIVE

Identify strategies to adapt WRAP in order to encourage participation and retention of rural women with depression

CONCLUSIONS

- Non-clinical peer-provided programs hold great potential to improve rural women's mental health by decreasing the social barriers that obstruct their access to adequate traditional treatment
- Adaptations to recovery programs can make them feasible even in rural underserved settings where people may do not identify as mental health consumers

For more on Claire Snell-Rood:



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