

**MOSAIC (MOTHERS' ADVOCATES IN THE COMMUNITY)**

Taft, A. J., Small, R., Hegarty, K. L., Watson, L. F., Gold, L., & Lumley, J. A. (2011)

<b>Description of intervention</b>	MOSAIC (Mother Advocates In the Community) is an intervention featuring the use of nonprofessional mentor supports to reduce IPV occurrence and rates of depression among pregnant and recent mothers at risk of or currently experiencing IPV. The intervention consisted of 12 months of weekly home visits by community mentors (mothers who lived in the community) who offered companionship, advocacy, parenting support, and referrals. Women were referred to the intervention through their general practice clinics (GP) or Maternal Child Health teams (MCH)
<b>What was the intervention designed to do?</b>	Reduce IPV occurrence and symptoms of depression
<b>Underlying conceptual or theoretical model(s)</b>	<p>The MOSAIC mentor mother intervention was developed around three evidence-based social support strategies in the context of IPV and social disadvantage:</p> <ol style="list-style-type: none"> <li>1. Randomized trials of home visiting (by nurses or paraprofessionals) and peers (nonprofessional women) among new mothers</li> <li>2. A randomized trial of domestic violence advocacy provided by trained paraprofessional female university students for women exiting refuges/shelters</li> <li>3. Controlled study testing a mentor mother model that combined domestic violence advocacy with home visiting or phone calls by trained mentors from the local community</li> </ol>
<b>Rationale for developing the intervention</b>	<p>For pregnant women and women in early motherhood, there is a critical need to provide social support. Women with better social support will have better mental health. The underlying basis of this model was “women helping women”. The role of mentors in MOSAIC was not to give advice or provide professional help but rather to befriend and listen to the needs and concerns of survivors. Primary care practitioners can identify, support and offer care to pregnant and parenting women who are experiencing or at risk for IPV. MOSAIC aims to increase women’s safety, reduce their exposure to abuse, and improve their mental health and well-being so they feel better able to take additional steps. In addition, women feel keenly about parenting and their relationships with their children and often prioritize their children’s well-being over their own, hence the focus on new mothers or soon-to-be-mothers.</p>
<b>Who is the intervention designed to help?</b>	Pregnant or recent mothers who had experienced IPV and were identified in primary care

<p><b>What are the eligibility criteria for the intervention study?</b></p>	<ul style="list-style-type: none"> <li>• Women aged 16 and over attending GPs or MCH nurses</li> <li>• Pregnant or had at least one child five years or younger</li> <li>• Disclosed IPV or were psychosocially distressed (women who had not disclosed but whose symptoms (depression, anxiety, frequent attendance without obvious cause) were indicative of abuse</li> </ul>
<p><b>Rationale for specific inclusion/exclusion criteria</b></p>	<p>Not provided</p>
<p><b>Study Design (type of design; measurement time points)</b></p>	<ul style="list-style-type: none"> <li>• Cluster randomized control trial</li> <li>• Baseline and post-intervention (at 12-months)</li> </ul>
<p><b>Outcome variables and Measures</b></p>	<ul style="list-style-type: none"> <li>• <b>Intimate Partner Violence:</b> Composite Abuse Scale (CAS; Hegarty, Bush, &amp; Sheehan, 2005)</li> <li>• <b>Maternal depression:</b> Edinburgh Postnatal Depression Scale (EPDS; Murray &amp; Crothers, 1990)</li> <li>• <b>Mother-child bonding expressed as parenting stress and attachment:</b> Parenting Stress Index Short form (PSI-SF; Abidin, 1995)</li> <li>• <b>Social support:</b> Medical Outcomes Scale Short Form (MOS-SF; Sarason et al., 1983)</li> </ul>
<p><b>Level of scientific rigor</b></p>	<p>Randomized control trial: Yes          Appropriate outcome measures: Yes          Active Control group: Yes          Effect size: Small for outcomes other than incidents of abuse</p>
<p><b>What adaptations were made specifically for IPV survivors?</b></p>	<ul style="list-style-type: none"> <li>• Safety protocols for women:             <ul style="list-style-type: none"> <li>○ Suicidality concerns in comparison group were followed up by team</li> <li>○ Coordinator would check in with women every four months to see how mentor relationship was working</li> <li>○ When child safety was a concern, coordinator was notified as they are required by law to report any instances of child abuse</li> <li>○ Safe contact details were required for communication between mentors and women</li> <li>○ Study information and consent took place at a safe time and place for participants</li> </ul> </li> <li>• Mentor/Researcher Safety             <ul style="list-style-type: none"> <li>○ Purchased cell phones for mentors specific to the project</li> <li>○ Coordinators aware of mentors' schedules and when they left and returned from sessions</li> <li>○ Protocols established to ensure that mentors and women were aware of meeting times and locations (phone check ins)</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>○ Safety concerns were directed to coordinator</li> <li>○ Protocols in place if partner came in or arrived unexpectedly</li> </ul>
<b>Considerations and/or adaptations related to culture and identity</b>	<ul style="list-style-type: none"> <li>● Women were asked which mentor they would like to work with; matched with mentors who understood their situations</li> <li>● Offered language congruent mentors where possible</li> <li>● Cross-cultural mentorship where possible</li> <li>● As part of training, mentors were exposed to cultural concerns and issues; do not make assumptions based on cultural backgrounds; be aware of cultural stereotyping</li> <li>● Mentors recruited from various backgrounds: Vietnamese; Sudanese; Somalian; Muslim</li> </ul>
<b>Considerations and/or adaptations related to experiencing multiple types of trauma (individual and collective)</b>	Not provided
<b>What is the mode of delivery?</b>	In-person, individual
<b>What were the key findings?</b>	<p>For the 86 women mentored, abuse and depression were reduced in comparison to non-mentored group</p> <ul style="list-style-type: none"> <li>● There was evidence of a true difference in mean abuse scores at follow-up in the intervention compared with the comparison arm (15.9 vs 21.8, AdjDiff -8.67, CI -16.2 to -1.15)</li> <li>● There was weak evidence for other outcomes, but a trend was evident favoring the intervention: <ul style="list-style-type: none"> <li>○ CAS scores <math>\geq 7</math>, 51/88 (58.4%) vs 27/42 (64.3%)</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>○ Depression (EPDS score <math>\geq 13</math>) (19/85, 22% (I) vs 14/43, 33% (C))</li> <li>○ Physical wellbeing mean scores (PCS-SF36: AdjDiff 2.79; CI - 0.40 to 5.99)</li> <li>○ Mental wellbeing mean scores (MCS-SF36: AdjDiff 2.26; CI - 1.48 to 6.00).</li> </ul> <ul style="list-style-type: none"> <li>● There was no observed effect on parenting stress</li> <li>● 82% of women mentored would recommend mentors to friends in similar situations</li> </ul>
<b>Author's reflection on study results/ findings</b>	<p>The effect was not as large as was hoped for, however, MOSAIC was successful in both reducing depression and instances of abuse. The findings and feedback also support the argument for the widespread use of mentoring-based interventions like MOSAIC. Women are not always ready to take that first step to getting help so support and mentoring interventions can make a difference. Doctors and nurses in general practice do widespread screening of their patients for IPV but they do not always have the skills or the time to offer additional support and mentoring, so funding more programs like MOSAIC would be beneficial.</p> <p>Findings also demonstrated that the physical health of women in MOSAIC improved as compared to the control group. This may have been the result of the self-care element that was promoted by mentors that encouraged women to look out and care for themselves.</p> <p>For future research, Dr. Taft also expressed that including a measure for self-efficacy would be ideal. In addition, including mentor training around providing parenting support would also assist in strengthening the mother-child dyad after violence.</p>
<b>Implementation challenges and strategies for addressing those challenges</b>	See Author's reflections above
<b>What, if any, professional qualifications are required to deliver the intervention?</b>	<ul style="list-style-type: none"> <li>● Mentors were not required to have any specific academic background</li> <li>● Coordinator was a social worker/ex-refuge worker with professional experience in community based work</li> </ul>
<b>What intervention-specific training is required to use this model?</b>	<ul style="list-style-type: none"> <li>● There was no certificate, but mentors were required to attend training for 5 days over 5 weeks</li> <li>● Training included: <ul style="list-style-type: none"> <li>○ Parenting support; working with depression; emotional support (particularly related to attachment and relationship)</li> </ul> </li> </ul>

	with children); reflecting on one’s own empathy; advocacy in relation to connecting women with supports; listening skills; emotional intelligence skills
<b>In what settings can the intervention be delivered?</b>	<ul style="list-style-type: none"> <li>• Women were referred from general practice and primary care offices</li> <li>• Mentors would often meet with women in the woman’s home but the location was chosen by the woman</li> </ul>
<b>Ongoing research regarding this intervention</b>	<p>Author’s own ongoing research:</p> <ul style="list-style-type: none"> <li>• HARMONY: New study with Bilingual South Asian General Practitioners and advocates</li> <li>• In working with samples of refugee women, the study team also recruited mentors from the Moroccan, Sudanese, Somalian, Muslim communities.</li> </ul> <p>Research by other investigators:</p> <ul style="list-style-type: none"> <li>• In Netherlands, MEMOSA, a shorter form (12 weeks) of MOSAIC, has been evaluated in a primary care setting. Results also demonstrated less depression and less abuse among women in mentored groups. The findings indicate that women-centered care by peers who support, befriend, and listen plays a role in the success of the intervention.</li> <li>• A similar intervention has also been reviewed in Brazil.</li> </ul>
<b>Author’s recommendations and reflections</b>	<ul style="list-style-type: none"> <li>• Underlying message was the importance of providing “women-centered care” and of staying present, listening, and attending to what each individual wants <ul style="list-style-type: none"> <li>○ Mentoring differs from what a professional provides and this kind of support can make a difference, especially for women who are isolated and do not have other options</li> </ul> </li> <li>• Good coordination, training, care, and monitoring are musts</li> <li>• In the future, referrals should not be restricted to clinics or GPs, only and in situations where referrals do come from doctors and nurses, it would be beneficial to assist doctors in making better and more frequent referrals</li> <li>• MOSAIC could also be implemented well at the community level</li> <li>• It would be interesting to examine this intervention over both longer and shorter time frames, depending on the preferences of the women receiving the intervention. Other research has examined the model on a shorter term and the results were similar to MOSAIC.</li> </ul>
<b>Citations – article of intervention</b>	Taft, A. J., Small, R., Hegarty, K. L., Watson, L. F., Gold, L., & Lumley, J. A. (2011). Mothers' AdvocateS In the Community (MOSAIC) – non-professional mentor support to reduce intimate partner violence and depression in

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