



Addressing Maternal Depression in the Context of Home Visiting: Opportunities and Challenges

Introduction

Maternal depression is a widespread public health concern that can negatively affect mothers and their families. According to a 2011 national survey, 10 percent of mothers in the United States had experienced depression in the previous year.¹ Research has indicated that maternal depression is linked to negative impacts on child development and health outcomes, and is a significant risk factor for child maltreatment.^{2,3,4,5,6}

While there is no standard definition of maternal depression, many researchers, practitioners, and advocates use the term to describe depression experienced by a mother caring for a child. Although much of the focus is on postpartum depression—which typically extends up to 1 year after giving birth—maternal depression can also impact women caring for older children or even teenagers.

Within home visiting programs serving low-income women, maternal depression rates have been measured as high as 61 percent.⁷ Some women participating in home visiting also experience high levels of chronic stress, intimate partner violence, and substance abuse—which can contribute to and exacerbate depressive symptoms.^{8,9,10}

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Although most research focuses on postpartum depression in the first year after childbirth, maternal depression can impact women caring for older children or even teenagers.

Home visitors are uniquely positioned to help address maternal depression because of the deep relationships they form with participants in their homes. Most are not equipped to treat depression themselves, but they can play a role in screening for depression and referring mothers to community resources. Additionally, home visiting programs can enhance services with qualified practitioners who can help treat depression in a home or group setting. Despite this potential, many home visitors report low levels of perceived self-efficacy in addressing maternal depression, in part because they have not received sufficient training.^{11,12}

This brief summarizes the existing research to provide insight into three key questions:

- ✔ Why should home visiting programs address maternal depression?
- ✔ How can home visiting programs address maternal depression?
- ✔ What are the implications for research and practice?

Why Should Home Visiting Programs Address Maternal Depression?

Maternal depression can make it difficult for mothers to meet their children's physical and emotional needs during critical developmental periods, leading to potential long-term impacts. Compared to nondepressed mothers, mothers experiencing maternal depression are less likely to engage in nurturing behaviors like breastfeeding, talking with, or reading to their children.^{13,14} They tend to be less sensitive to their children's cues¹⁵ and less likely to engage in preventive practices like taking them to well-child visits.¹⁶ Maternal depression is also associated with dysfunctional parenting practices like disengagement, emotional neglect, and child abuse.^{17,18}

Research shows that maternal depression limits the positive effects of home visiting and that women with depression are more difficult to engage in program services.^{19,20,21,22} During a study of the Healthy Families Alaska Program—in which more than 25 percent of mothers in the study met criteria for depression—researchers found that program effectiveness was moderated by maternal depression and attachment insecurity. Specifically, mothers experiencing depression and attachment insecurity did not demonstrate increased maternal sensitivity to infant cues compared to mothers without depression and secure attachment. A 2013 study of first-time mothers enrolled in Healthy Families Massachusetts found that maternal depression potentially interfered with the program's impact reducing Child Protective Services report rates.²³

The home visiting field can play an important role connecting women with needed resources and treatment for maternal depression. Home visitors are especially well-situated to understand mothers' personal beliefs and preferences regarding mental health to provide effective support (see sidebar).

How Can Home Visiting Programs Address Maternal Depression?

In this section, we discuss three promising approaches to address maternal depression through home visiting:

- ✔ Targeted training for home visitors
- ✔ Maternal depression screening and referrals
- ✔ Cognitive Behavioral Therapy (CBT) as a program enhancement to home visiting models

Although we present these approaches sequentially, they would ideally be implemented in tandem. Comprehensive training for home visitors (promising approach 1) is necessary to support implementation of screenings and referrals (promising approach 2) and CBT program enhancements (promising approach 3).

Promising Approach 1. Targeted Training for Home Visitors

Home visitors need specialized training to address maternal depression effectively. Yet despite disproportionately high rates of depression among home visiting participants, many home visitors report low levels of knowledge, training, and self-efficacy related to addressing depression with participants. A survey of 159 home visitors found that most respondents “rarely” or “sometimes” managed maternal depression among their clients.²⁸ Another study found that 44 percent of home visitors felt that they had not received sufficient training to help support families with mental health problems, including maternal depression.²⁹

A later study indicates that while home visitors reported sufficient knowledge around depression, they needed more training on how to take action to address it.³⁰ The same study

Research conducted by Price and Cohen-Filpic (2013)²⁴ found that some female participants believed depression to be a widely experienced “part of life.”

Studies also indicate that women enrolled in home visiting programs—

- Have negative perceptions of mental health care providers and treatment, particularly medication²⁵
- Tend to feel more comfortable seeking help from friends, family, or religious leaders²⁶
- Are less likely to seek professional treatment²⁷

These findings point toward the importance of culturally appropriate interventions that harness and build on existing social networks and trusted relationships, including those with home visitors.

found that some home visitors had trouble raising the topic of depression in the face of what they perceived as more urgent issues, including housing and food insecurity. Other research posits that some home visitors may be comfortable discussing depression with parents, but only if there are appropriate community resources available to address identified needs.³¹

There are a growing number of projects working to address training gaps related to maternal depression (see boxes 1 and 2).

Box 1. Maryland's Home Visitor Training and Certificate Program

The Maryland Department of Health, in partnership with University of Maryland, Baltimore County, and Johns Hopkins University Bloomberg School of Public Health, developed a [statewide training and certificate program](#) to help participants develop key competencies and practice addressing sensitive topics. Over the course of 3 months, home visitors and supervisors participate in 7 full days of training covering topics such as maternal depression, substance use, domestic violence, and child behavior management. The program is grounded in adult learning principles and emphasizes interactive training.

Preliminary results from a randomized control trial show that home visitors who completed the training showed gains in partnership and empathy while communicating about sensitive issues.³² Since its inception in 2015, the training has reached all home visitors working at Maryland Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) sites and continues to grow.

Box 2. Family Connections: A Mental Health Consultation Model

Developed by the Family Connections Program at Boston Children's Hospital, Family Connections is a mental health consultation and training approach currently implemented across Head Start and Early Head Start programs. The initiative includes a variety of materials to help staff deal with parental depression, including [four training modules](#) organized by topic:

- Defining depression and the benefits and challenges of engaging patients
- Using a strength-based approach with families
- Supporting social-emotional growth
- Strengthening referral processes

Promising Approach 2. Maternal Depression Screening and Referrals

Although home visitors are not typically trained to address maternal depression directly, evidence suggests that they can effectively administer maternal depression screenings and referrals. There are several screening tools that reliably assess depression among home visiting participants. A 2012 study of women enrolled in a home visiting program found that the Edinburgh Postnatal Depression Scale, Center for Epidemiologic Studies Depression Scale, and the Beck Depression Inventory-II accurately detect major depression among pregnant women and new mothers.³³ There are also promising approaches for home visitors completing maternal depression screenings and following up on screening results. In box 3, we describe a feasibility study of home visitors completing maternal depression screenings.

Box 3. Home Visitation Enhancing Linkages Project Protocol

The [Home Visitation Enhancing Linkages Project \(HELP\)](#) protocol is a three-phase approach where home visitors provide (1) behavioral health screening, (2) motivational interviewing, and (3) case management services and referrals. A feasibility study of the HELP protocol found that home visitors effectively screened a majority of mothers for depression; however, they were less likely to deliver the motivational interviewing and case management components of HELP. Home visitors reported several factors that interfered with their ability to deliver the full intervention, including client disclosure of risk, barriers to treatment, and challenges integrating HELP into the broader home visiting program curriculum.³⁴

Screening for depression in home visiting programs is becoming more common. In 2001, the Health Resources and Services Administration began requiring all Healthy Start home visiting programs to implement processes for maternal depression screenings and referrals. A longitudinal feasibility study of depression screening and referrals in the Des Moines Healthy Start program found that implementing universal screening successfully identified women suffering from depression and connected them to needed resources.³⁵ By the end of the 7-year study, nearly all program participants (98 percent) had been screened for depression, 64 percent had accepted a referral to treatment or community resources, and 47 percent had received treatment.³⁶

Moreover, depression screening is 1 of 19 program performance measures collected by MIECHV awardees. In 2014, 68 percent of MIECHV awardees reported increased screening and referral rates among pregnant mothers, postpartum mothers, and mothers enrolled in home visiting services.³⁷ Additionally, in 2016, 44 states reported an overall screening rate of 82 percent, with 15 states reporting screening rates of 95 percent or more.³⁸

These studies suggest that depression screening is a viable first step for addressing maternal depression through home visiting services. For this approach to be effective, home visiting programs need to—

- ✔ Help home visitors understand if and how depression screening fits into their responsibilities
- ✔ Provide clear guidance and training on how to handle a positive result from a depression screener
- ✔ Instruct home visitors on how to handle referrals when community resources are limited or full

Promising Approach 3. Cognitive Behavioral Therapy as a Program Enhancement to Home Visiting Models

Program enhancements can help directly address maternal depression by building on existing [home visiting models](#). An example enhancement is the use of CBT, a goal-oriented form of psychotherapy focused on developing coping mechanisms to change problematic thoughts, beliefs, and behaviors. CBT has been widely implemented in a variety of settings to address mental health issues, including depression. Compared to other psychological treatments, it focuses on current difficulties as opposed to childhood traumas.³⁹

Within the past several years, CBT has been increasingly used as an enhancement to standard home visiting services, both in group therapy and individual in-home (IH-CBT) settings. Qualified therapists deliver the CBT intervention, enabling mothers to receive professional treatment for depression along with traditional supports provided by home visiting programs. Recent studies, including the three randomized control trials summarized in table 1, demonstrate that CBT is a promising approach for treating maternal depression.

Table 1. Studies of Cognitive Behavioral Therapy in Home Visiting

Intervention	Population	Results	Reference
15 weeks of IH-CBT delivered by a licensed clinical social worker in addition to standard home visiting model (either Healthy Families America or Nurse-Family Partnership); joint final session with social worker, home visitor, and mother	93 new mothers enrolled in a home visiting program in southwestern Ohio and northern Kentucky Diagnosed with major depressive disorder	Among intervention group, significant reduction in measures of psychological distress and increased social support Effects remained at 3-month follow-up	Ammerman et al. (2013) ⁴⁰

Intervention	Population	Results	Reference
6-week group-based CBT enhancement (Mothers and Babies Course) to home visiting (either Healthy Families America or Parents As Teachers)	95 low-income mothers of young children enrolled across three home visiting sites in Hawaii Did not have major depression	Among intervention group, improved coping and reduced stress and depression Impacts were attenuated at 6 months	MacFarlane et al. (2017) ⁴¹
Standard home visiting services plus an adapted six-session version of group-based CBT enhancement (Mothers and Babies Course)	78 low-income African American women who were pregnant or had a child younger than 6 months enrolled in one of four home visiting programs Elevated depressive symptoms or a lifetime depressive episode, but not currently exhibiting depressive episode	Among intervention group, depressive symptoms declined at a significantly greater rate than control group 1 week, 3 months, and 6 months after the intervention 15% of intervention group experienced a major depressive episode by 6 months following the intervention compared to 32% of control group	Tandon et al. (2014) ⁴²

In table 1, we summarize studies by Ammerman et al. (2013),⁴³ MacFarlane et al. (2016),⁴⁴ and Tandon et al. (2014).⁴⁵ In each of these studies, researchers investigated how CBT can be used to treat maternal depression within the context of home visiting programs. The three study populations were similar but slightly different. Notably, the MacFarlane study excluded mothers who had already been diagnosed with major depression, while the Ammerman and Tandon studies focused on mothers diagnosed with depression either at the time of the study or in the past. The Ammerman study tested an in-home variant of CBT where a practitioner works with the mother individually within the home. The other two studies tested a group-based enhancement in which a small group of about 10 mothers jointly engaged in a CBT intervention for approximately six sessions.

Each of the three studies found statistically significant results, including reductions in stress and depressive symptoms^{46,47,48} and improved social support.⁴⁹ The long-lasting impacts of these interventions were mixed, with two of the studies (Ammerman and Tandon) showing sustained improvements at 6 months following the intervention, and one (MacFarlane) finding that the comparative positive impacts had disappeared after 6 months.

These studies suggest that CBT can be delivered in conjunction with home visiting services to reduce depressive symptoms among home visiting participants. Indeed, evidence from the 2013 Ammerman study has informed the development and scale up of the Moving Beyond Depression intervention developed by researchers at Every Child Succeeds and Cincinnati Children's Hospital Medical Center. The intervention, now being implemented in eight states as part of the Moving Beyond Depression program, is most commonly delivered as an enhancement to Healthy Families America, Nurse-Family Partnership, and Early Head Start.

Research suggests that Cognitive Behavioral Therapy can be delivered in conjunction with home visiting services to reduce depressive symptoms.

What are the Implications for Research and Practice?

This brief identifies opportunities and challenges for supporting mothers with depression in the context of home visiting. There are a number of implications for research and practice:

- ✔ Home visitors need comprehensive training on depression (not just knowledge acquisition) and clearly defined roles and guidance about what they can and cannot provide participants. Training should focus on home visitor skill development and processes for completing depression screenings and referrals.
- ✔ There are some promising practices for bridging the current training gap. More research is needed, however, about the types of training, technical assistance, and professional development home visitors need to address maternal depression in their work.
- ✔ Additional research is also needed to understand the mechanisms behind maternal depression that lessen the positive impacts of home visiting services. Results could help programs identify families who need tailored support outside of traditional home visiting services.
- ✔ Paired with standard home visiting services, CBT interventions delivered in either home or group settings reflect a promising approach to treating mothers with depression.
- ✔ Distrust of medical professionals, stigma surrounding depression, and negative perceptions of psychotherapy and medication can interfere with depression treatment. Home visitors should work closely with families and supervisors to identify culturally appropriate supports.

Conclusion

Maternal depression cannot be ignored if home visiting programs are to meet their goals of improving maternal and child health and reducing child maltreatment. This brief highlights how home visiting can help address maternal depression through screening, referrals to community resources, and program enhancements. We also discuss challenges to this work, including maternal depression's tendency to limit the positive effects of home visiting, and gaps in available training and technical support. There is no one-size-fits-all approach for addressing maternal depression. Instead, leaders in the field must assess the goals of particular programs and work within the local service delivery system and policy environment to tailor interventions. Efforts should include comprehensive training and professional development support for home visitors, as well as culturally appropriate approaches to maternal depression screenings, referrals, and treatment options.

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