

HOME VISITING

Maternal Mental Health Outcomes and Children's Mental Health and Home Visiting

¹Robert T. Ammerman, PhD, ²S. Darius Tandon, PhD

¹Cincinnati Children's Hospital Medical Center and University of Cincinnati College of Medicine, USA, ²Johns Hopkins University Department of Pediatrics, USA

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Introduction

Mental health problems (of which maternal depression is the most common) are highly prevalent in low-income women. This is unsurprising given that they are at elevated risk due to risk factors such as stressful life events, low social support, child care stress, marital difficulties and poverty.^{1,2} Children of depressed mothers, including those with subclinical depression, may experience a range of negative outcomes including developmental delays, cognitive impairments, and attachment insecurity.^{3,4} Given the large number of perinatal women they serve, home visitation programs are in a unique position to address maternal depression. In this chapter, we focus on recent research related to home visitation programs' identification and response to maternal depression, identify gaps in this existing research, and provide recommendations for the practice and policy community on addressing maternal depression within home visitation.

Subject

Home visiting programs are common in developed countries reflecting efforts to optimize child development and maternal life course. A substantial social and financial investment has been made in these programs. Research has demonstrated that a large proportion of mothers served in home visiting suffer from mental health problems, with up to 50 percent experiencing clinically elevated levels of depression during the critical first years of their child's development.⁵ There is evidence that many depressed mothers fail to fully benefit from home visiting.⁶ Identifying depressed mothers or those at risk for depression who are participating in home visiting, and treating or preventing the condition and its deleterious consequences, can improve program outcomes and foster healthy child development.

Problems

Depression in new mothers has profound and often long-term negative effects on parenting and child development. Depressed mothers are often overwhelmed in the parenting role, have difficulty reading infant

cues, struggle to meet the social and emotional needs of their children, and are less tolerant of child misbehaviour.⁷ Offspring of depressed mothers, particularly if they are exposed to depression in the first year of life, are more likely to be poorly attached to their caregivers, experience emotional and behavioural dysregulation, have difficulty with attention and memory, and are at greater risk for psychiatric disorders throughout childhood.⁸ Home visiting focuses on fostering healthy child development by improving parenting and maternal functioning. To the extent that depressed mothers have persistent mood problems during participation in home visiting, they may benefit less from services and their children will continue to be at risk for poor outcomes. Moreover, one of the objectives of home visiting is to link mothers with other professional services in their communities, including mental health treatment. However, home visitors may not recognize the need for such a referral in depressed mothers, and, even when they are successfully identified and referred to mental health providers, few mothers receive effective treatment.⁶

Research Context

Despite the growing number of studies on the efficacy of home visiting, only recently has attention been paid to maternal depression. Research has been conducted to determine the prevalence of maternal depression among home visitation clients,^{9,10,11,12} with these studies reporting depressive symptom rates around 50 percent. A smaller number of studies have examined home visitation programs' identification of maternal depression,^{9,11} and challenges related to programs' identification and response.^{13,14} In recognition of the prevalence of maternal depression and home visiting programs' limited response to this issue, interventions aimed at preventing and treating maternal depression have been developed.

Key Research Questions

There are three key research questions:

- First, how does maternal depression impact outcomes of interest in home visiting, including parenting, maternal life course, and child health and development?
- Second, what is the prevalence and course of maternal depression in the context of home visitation? A related issue is understanding the implications of elevated depressive symptoms versus diagnosis of major depressive disorder.
- Third, what is the best approach to preventing and treating depression in new mothers participating in home visitation programs?

Recent Research Results

Home visitation and maternal depression

To date, there is limited evidence that home visitation programs impact maternal depression. One *randomized controlled trial* comparing home-visited families with control participants who received other community services found a statistically significant difference in mean depressive symptoms at two years post-enrollment, but this contrast was nonsignificant at three years post-enrollment.¹⁵ A second study of Early Head Start found no differences in depressive symptoms between intervention and control group participants post-intervention, although a difference was detected at a longer-term follow-up prior to children's enrollment in kindergarten.¹⁰ Other randomized controlled trial studies have not found effects of home visitation on maternal depressive symptoms.^{12,16,17}

There is evidence that depression can have a negative impact on the effects of home visiting programs. Depression has been associated with negative views of parenting and limited knowledge of child development.¹⁸ In the Early Head Start Research and Evaluation Project,⁶ depressed mothers showed deficits in mother-child interaction and in obtaining education and job goals relative to those without depression. However, depressed mothers also showed gains in some aspects of engaging with their children during structured tasks. Duggan et al.¹⁹ found that depressed mothers with lower levels of attachment anxiety showed improvements in sensitivity to child cues relative to those with higher levels of attachment anxiety and those who did not receive home visiting. Research on the Nurse-Family Partnership²⁰ has consistently shown that mothers with low psychological resources, a construct that includes some symptoms of depression, benefit most from home visitation. Taken together, it is evident that depression affects home visiting outcomes in complex ways.

Identification and response to maternal depression

Home visitors typically do not identify or respond to maternal depression during the course of their home visits with clients.^{11,12,17} Several reasons appear to contribute to home visitors' lack of attention to maternal depression, including feeling they do not have appropriate training on approaches to discussing the topic with clients, perceptions that depressed clients are more difficult to engage, challenges in prioritizing discussion of poor mental health in the context of clients' other pressing needs, and lack of clarity on the extent to which they should address maternal depression.^{13,14} Systematic screening and referral at time of home visitation enrollment can help identify women needing supports for maternal depression.

Treatment of maternal depression

Because depressed mothers rarely obtain effective treatment in the community, two approaches have been developed that provide treatment in the home. Ammerman and colleagues created In-Home Cognitive Behavioral Therapy (IH-CBT).²¹ IH-CBT is a structured and manual-driven approach that is provided by a master's degree-level therapist. It is an adapted form of an evidence-based treatment for depression that has been modified for the home setting, addresses the unique needs of new mothers who are socially isolated and live in poverty, and engages the home visitor to facilitate a strong collaborative relationship in order to maximize outcomes for mothers and children. A recent clinical trial²² found that mothers with major depressive disorder receiving IH-CBT alongside home visiting, relative to those receiving home visitation alone, had lower levels of diagnosed major depressive disorder at post-treatment (29.3 percent vs. 69.0 percent) and at three-month follow-up (21.0 percent vs. 52.6 percent). They also reported larger drops in self-reported depressive symptoms, increased social support, lower levels of other psychiatric symptoms and increased functional capacity.

Beeber et al.²³ conducted a clinical trial of interpersonal psychotherapy (IP) with 80 newly immigrated Latina mothers ages 15 years or older who were participating in Early Head Start. Depressed mothers were randomly

assigned to IP treatment or a “usual care” condition. Treatment was delivered by psychiatric nurses who partnered with a Spanish interpreter. Eleven sessions were provided by the team, and five additional boosters were administered by the interpreter. Results showed significant drops in self-reported depression in the IP relative to the usual care group that were maintained at one month post-treatment.

Interventions to prevent maternal depression

Given the large number of home visiting clients at risk for developing clinical depression, Tandon and colleagues have adapted an intervention – the Mothers and Babies Course²⁴ – for use in home visitation as a depression prevention intervention. Findings from a recent randomized controlled trial^{25,26} found that depressive symptoms declined at a significantly greater rate for intervention participants than usual care participants between baseline and one week, three months, and six months post-intervention, with the strongest effects found at six months post-intervention. Intervention participants were also less likely to have a depressive episode at six months post-intervention compared to usual care participants (14.6 percent vs. 32.4 percent), as assessed by a structured clinical interview.

Research Gaps

Research on depression in home visitation is still in its early stages. There is a need for theoretically-driven studies examining how maternal depression impacts mother and child outcomes in home visiting programs. The primary focus of this effort should be a better understanding of how depression severity and course interacts with program elements to bring about positive or negative outcomes. Relatedly, few studies have distinguished elevated depressive symptoms from the clinical condition of major depressive disorder. It is possible that such a distinction may be important for understanding how depression impacts home visiting and how it should best be addressed. Identification of moderating influences and mechanisms of change will guide the improvement of home visiting programs to better meet the needs of this population. Such program refinements will likely involve home visitor training and supervision, curricular changes, systematic screening and identification, and augmented approaches that seek to prevent depression or provide effective treatment to those already suffering from major depressive disorder. Regarding prevention and treatment, there is a dearth of information on long-term impacts of these program additions. Major depressive disorder is episodic, and relapse is common. As a result, prevention and treatment approaches that decrease relapse risk and/or increase the intervals between major depressive episodes over the long term hold the greatest promise to benefit mothers and children. Finally, there is a need to better understand how to disseminate empirically-supported prevention and treatment programs on a large scale and across different home visitation models.

Conclusions

Maternal mental health, in particular depression, in home visitation programs is a serious concern. Evidence suggests that depression is highly prevalent. Home visitors are often challenged when working with depressed mothers, have difficulty identifying depression, and struggle to link mothers to effective mental health treatment in the community. Research on the impact of depression on home visiting outcomes is mixed with some studies reporting negative results while others suggesting that depressed mothers may benefit from these programs. However, studies show that home visiting alone has little positive impact on maternal depressive symptoms. To the extent that mothers are depressed during home visiting, this factor is likely to have implications for child health and development. Several evidence-based approaches to preventing and treating depression have emerged. Although continued research is warranted, preliminary findings are encouraging and suggest that home visitation is an important setting in which to reach depressed mothers or those at risk for depression.

Implications for Parents, Services and Policy

Because depression is highly prevalent among women enrolled in home visitation, systematic multimodal approaches need to be employed to effectively and efficiently identify and respond to this issue. First, systematic screening should take place for every newly enrolling home visitation client. Reliable, valid and brief screening tools are readily available that can be integrated into programs' standard intake processes. Second, programs need to provide training for home visitors on how to address maternal depression during home visits. Home visitors should understand when and how maternal depression should be addressed and when they should make referrals to mental health professionals. Training should also provide guidance on balancing conversations about family-identified needs with discussions pertaining to maternal depression and other psychosocial risk factors that impair effective parenting. A premium should be placed on developing home visitors' skills and assuring that these skills are used. The use of reflective supervision²⁷ and coaching²⁸ are two approaches that have been used effectively in other contexts to develop and maintain staff skills. Third, efforts to augment existing home visitation services with mental health interventions aimed at preventing and treating maternal depression should be further tested with rigorous research studies and scaled up as appropriate. Efforts should also be made to integrate preventive and treatment interventions within a single home visitation program so the full spectrum of women needing intervention for maternal depression is supported. In each of these recommended areas for policy and practice, multiple stakeholders (including home visiting staff and clients) must be involved to ensure the development of ecologically-valid approaches and secure community buy-in and ownership.

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