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Addressing Maternal Depression in Home Visiting Programs:

Current Issues and Innovative Approaches

THIS ISSUE AND WHY IT MATTERS

With the expansion of home visiting through the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), much attention has focused on how to make home visiting programs more effective. Helping depressed mothers in home visiting has emerged as a promising way to enhance outcomes and improve the lives of families served by these programs. Depression is a devastating condition that results in considerable human and economic costs. Depressed mothers struggle to parent effectively. Their children are at great risk to develop problems in emotional, cognitive, and social domains. Up to one half of mothers in home visiting experience clinically significant levels of depression during their participation in services. The symptoms of depression—low energy, sadness, sleep problems, and poor memory to name a few—make it difficult for mothers to fully engage in and benefit from home visiting. Unfortunately, most depressed mothers in home visiting do not receive effective treatment. Treatment in the community is typically difficult to access. Availability of evidence-based interventions is often lacking, and capacity is limited in many areas. Effective prevention and treatment options are needed that are specifically designed for mothers in home visiting. Such efforts can change the lives of depressed mothers and their children for the better and optimize outcomes in home visiting programs.

This issue of *Zero to Three* presents a series of articles on maternal depression in home visiting. In addition to thoughtful reviews of important topics involving maternal depression and home visiting, several articles present innovative approaches to prevention and treatment. Together, they capture the exciting and important work that is being done in this area. The first article synthesizes the research on the impact of maternal depression on children, documenting how depression affects growth and development. Much is known about how depression alters maternal life course and emerging child capabilities. Promising approaches to intervention are considered and the appeal of home visiting as an important setting to reach depressed mothers is highlighted. The next article considers universal screening for depression. With the MIECHV Program, home visiting programs are regularly screening mothers for depression. Challenges associated with screening are discussed, and components of effective screening are presented. Four articles on promising treatment and prevention strategies follow. These include (a) an adapted form of cognitive behavioral therapy that is highly integrated into ongoing home visiting, (b) an approach to facilitate referral and linkage of depressed mothers to mental health resources in the community, (c) an adaptation of interpersonal psychotherapy that has been enhanced with a component on parenting, and (d) a prevention program using cognitive behavioral strategies that has been adapted for mothers in home visiting.

Together, these initiatives hold considerable promise and are accruing an impressive body of empirical evidence. Each takes advantage of home visiting to identify, engage, and support depressed mothers. They confirm that nontraditional settings such as home visiting are excellent sites to reach and help depressed mothers who might otherwise go undetected and untreated. The next article examines the moderating effect of maternal depression on home visiting outcomes. This is a complex literature, and the authors are thorough and careful in drawing conclusions and offering guidance for continued work in this area. Finally, the issue ends with an examination of the costs and benefits of treating maternal depression. This, too, is an emerging area of inquiry, and preliminary conclusions are presented along with suggestions for future research and economic analyses of this important topic.

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Moving Beyond Depression

A Collaborative Approach to Treating Depressed Mothers in Home Visiting Programs

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It is widely recognized that maternal depression leads to significant functional impairment and contributes to poor developmental outcomes in children (Pearson et al., 2013). Debilitating symptoms of depression result in mothers having great difficulty meeting the social and emotional needs of children. The impact of maternal depression is particularly pronounced in the first year of the child's life, a sensitive period for the emergence of foundational developmental capabilities (Bagner, Pettit, Lewinsohn, & Seeley, 2010). As a result, maternal depression contributes directly to the emergence of infant mental health problems. Depression typically occurs in discrete episodes that can vary in length and severity. As a result, depressed mothers struggle to develop and maintain a consistently nurturing and stimulating environment for children. This, in turn, contributes to toxic stress, which has been identified as an important determinant of negative outcomes throughout development (Garner, 2013).

The primary risk factors for developing depression in pregnancy and postpartum—trauma history, young age, social isolation, educational underachievement—are widely represented among mothers enrolled in home visiting programs. Depression is relatively common in these mothers. Ammerman, Putnam, Bosse, Teeters, and Van Ginkel (2010) reviewed the research on prevalence of maternal depression in home visiting and concluded that between 28% and 61% of mothers have clinically elevated symptoms at some point during service. Rates vary depending on screening instrument, cutoff used, and timing and frequency of assessment. In a study of 231 mothers followed over 18 months and assessed at three time points using the Beck Depression Inventory-II (Beck, Steer, & Brown, 1996), 39.5% met or exceeded a cutoff (≥17) associated with the psychiatric diagnosis of major depressive disorder (MDD), the most serious manifestation of depression (Teeters, Ammerman, Shenk, Putnam, & Van Ginkel, 2014). Given that maternal depression moderates and undermines home visiting outcomes (Duggan, Berlin, Cassidy, Burrell, & Tandon, 2009; Easterbrooks et al., 2013; McFarlane, Crowne, Burrell, & Duggan, this issue, p. 53), it is imperative that approaches are developed to identify, prevent, and

Abstract

Research indicates that up to half of mothers in home visiting experience clinically significant levels of depression during their participation in services. Depression alters maternal life course, negatively impacts child development, and contributes to poorer home visiting outcomes. This article describes the Moving Beyond Depression (MBD) program, an innovative and evidence-based approach to treating depressed mothers in home visiting. MBD uses In-Home Cognitive Behavioral Therapy, an empirically validated and collaborative intervention that overcomes barriers to treatment and contributes to recovery from depression and prevention of relapse. MBD has been successfully disseminated to other home visiting programs nationally.

treat maternal depression in home visiting. Such efforts will protect the sizable public investment in home visiting and has the potential to result in considerable cost savings.

Given the high proportion of mothers who enter home visiting with histories of MDD, or who develop the condition while receiving home visiting services, treatment is often necessary (Myers et al., 2013). Yet, depressed mothers in home visiting rarely obtain effective treatment in the community. Failure to identify clinically significant depression, stigma in seeking mental health services, lack of availability of mental health clinicians trained in evidence-based treatment of perinatal depression, child care needs, and transportation challenges are a few of the key barriers faced by mothers. Studies indicate that only 14%–48% of depressed mothers in home visiting access treatment in the community (Ammerman et al., 2010), and for most of these it is likely that treatment is inadequate or insufficient to bring about recovery. Moreover, when they do obtain treatment, low-income adults are more likely to receive antidepressant medications than evidence-based psychological treatments (Huybrechts et al., 2013) despite the fact that pharmacological treatment has been found to be less effective in depressed women with trauma histories (Klein et al., 2009), a common feature of mothers in home visiting.

Home visiting offers a unique opportunity to reach and engage depressed mothers who would otherwise not receive treatment. Mothers may not seek treatment because they do not think it is needed or will be helpful. However, because mothers join home visiting to provide the best start for their children, appealing to this altruistic motive can be a powerful way to inspire them to consider treatment as a way to benefit their child's health and development. Scheduled screening for depression increases the likelihood that mothers will be identified early in their depressive episode. Providing treatment at that time may accelerate recovery and reduce the child's exposure to the effects of a depressed primary caregiver. Engagement in treatment is facilitated by leveraging the strong relationship that mothers have with their home visitors. Encouraged to consider treatment by a trusted home visitor, depressed mothers may be more open to entering treatment. There is a clear need for focused and effective treatments that (a) are designed for the unique needs of new mothers in home visiting, (b) engage mothers in treatment, (c) overcome barriers to obtaining effective care, and (d) leverage ongoing home visiting to optimize outcomes for both mothers and children.

Developing an Adapted and Collaborative Treatment

In response to these needs, we systematically adapted cognitive behavioral therapy (CBT) to address the needs of depressed mothers receiving home visiting (Ammerman et al., 2011). CBT is an established, evidence-based treatment that has consistently been found to be effective in the treatment of depression (Hoffman, Asmundson, & Beck, 2013). In-Home Cognitive Behavioral Therapy (IH-CBT) was developed and field tested at Every Child Succeeds, a regional program in Cincinnati, Ohio, that provides home visiting to new mothers and their children in southwestern Ohio and northern Kentucky. It is implemented by therapists who provide treatment concurrently with ongoing home visiting. IH-CBT combines the core principles and techniques of CBT (Beck, 2011) with procedures and strategies that promote engagement, makes content relevant to the needs of mothers in home visiting, facilitates delivery in the home, and explicitly fosters a collaborative relationship between the therapist and home visitor in order to smoothly coordinate services. IH-CBT is an enhancement to standard home visiting that emphasizes the reduction of maternal depressive symptoms and recovery from MDD, thereby allowing home visitors to attend to issues related to parenting, maternal functioning, and child development.

In developing IH-CBT, we were guided by six objectives:

1. Maintain a steady focus on the amelioration of depressive symptoms. Depressed mothers often have comorbid conditions (particularly anxiety), complicated histories of trauma and hardship, and multiple stressors in their lives. An overly broad treatment focus runs the risk of insufficiently addressing each area of need. We reasoned that if mothers could effectively manage their mood and had more energy and motivational drive, they would be more available to their children and able to work more effectively with their home visitors to overcome other challenges.
2. Treatment must benefit both mothers and home visitors. The benefits to mothers of improved mood are clear, but we envisioned an approach that would also engage home visitors and enjoin them to be collaborative partners in effective treatment.
3. Minimize burden on home visitors. To do this, masters-level clinicians were selected to deliver treatment. Not only do they have the foundational training required to effectively treat MDD, but bringing in these clinicians allowed home visitors to focus on their primary responsibilities of delivering home visiting curricula.
4. Treatment was to be provided in the home to overcome the primary barrier in obtaining mental health resources in the community.
5. CBT was chosen as the evidence-based treatment. CBT is widely trained in graduate programs (Norcross, Hedges, & Prochaska, 2002) thus facilitating dissemination to other home visiting programs. Also, CBT is theoretically and practically compatible with different home visiting models, thereby ensuring seamless integration and ready adoption.
6. CBT was systematically adapted to meet the needs of mothers participating in home visiting, work effectively in the home, and take full advantage of the opportunity to partner closely with home visitors. In the absence of such adaptations, it would be expected that treatment would go the way of most evidence-based interventions that are moved from highly controlled research settings to the real world—it would likely lose its potency and have limited effectiveness (Westen, Novotny, & Thompson-Brenner, 2004).

Photo: ©iStockphoto.com/sundikova

Depression typically occurs in discrete episodes that can vary in length and severity.

Treatment Components and Adaptations

IH-CBT is organized around specific components and adaptations made to enhance efficacy and facilitate mater-

Photo: ©iStockphoto.com/JackF

Home visiting offers a unique opportunity to reach and engage depressed mothers who would otherwise not receive treatment.

nal engagement in treatment. These are described below.

Treatment Components

IH-CBT is designed for use with mothers 16 years and older who have MDD. Treatment consists of 15 weekly sessions that last about 60 minutes plus a booster session at 1 month post-treatment. The focus and content of treatment primarily target depression reduction. Treatment components include behavioral activation, identification of automatic thoughts and schemas, thought restructuring and reframing, and cognitive rehearsal (Hollon & Dimidjian, 2009). Relapse prevention is the focus in later sessions. The goals of relapse prevention are to reduce the likelihood of additional MDD episodes, delay the onset of the next episode, ensure that a subsequent return of depression is identified early, and entrench learned skills that mothers can apply to facilitate a more rapid recovery. IH-CBT is structured, in that therapists use specific tools and follow a treatment manual. Yet it is also individualized, such that the clinical content of treatment sessions is guided by what is important to mothers in their return to a healthy emotional state. IH-CBT is provided by licensed masters-level mental health professionals who have prior experience in CBT and treating depressed adults, and who have familiarity with serious mental health conditions.

Adaptations to Population

IH-CBT addresses the primary concerns of young, low-income, new mothers who are typically socially isolated (Levy & O'Hara, 2010). Treatment content focuses on issues relevant to this population, such as transition to adult roles, stress management, parenting challenges, and family relationships. For the youngest mothers, additional contextual and developmental issues are incorporated into treatment (e.g., school attendance, living with parents). Given the high prevalence of trauma in depressed mothers (Putnam, Harris, & Putnam, 2013) in home visiting, issues related to trauma (e.g., shame, anger, feelings of inadequacy) are common themes of treatment. Psychiatric comorbidities are addressed but in such a way that depression is the primary focus of treatment.

Adaptations to Home Setting

There are unique challenges in administering mental health treatment in the homes of young, low-income mothers. These require creative solutions and accommodations to ensure effective treatment delivery in environments where privacy is often difficult to guarantee, the child is typically present, and unexpected interruptions occurred. However, providing treatment in the home offers advantages in that many of the clinical issues that are addressed in treatment occurred in the home setting, and the therapist is able to observe elements of the home that may contribute to clinical presentation.

Adaptations to Home Visiting

Collaboration between therapists and home visitors is explicit and planned. By working together outside of sessions and home visits, therapists and home visitors can coordinate efforts ensuring that they are aligning each other's efforts on behalf of the mother and child. Collaboration between therapist and home visitor occurs through written communication, email, and telephone contact. Interim and final reports are prepared by therapists and shared with home visitors. One important factor is that the home visitor attends the 15th session with the mother and therapist. This is an opportunity to review mothers' progress in treatment, identify ways in which home visitors can continue to support mothers after treatment, and celebrate completion of a successful effort. A secondary benefit of integrating IH-CBT into home visiting is to make available to home visitors a mental health professional for consultation. This resource allows home visitors to ask questions and acquire information about mental health issues that may be helpful in working with other mothers who are not in treatment.

Team Approach

Therapists work in teams of 4–6 under the oversight of a doctoral-level team leader and meet weekly for 2 hours. The purpose of the team is to provide a forum to discuss challenging cases, share new learnings and observations, acquire and master CBT skills, maintain fidelity to the IH-CBT approach, and provide support for therapists. Just as home visitors benefit from supervision to avoid drift from home visiting model requirements and to process difficult and emotionally powerful experiences in the home setting, IH-CBT therapists profit from team meetings. Doctoral-level team leaders bring training experiences and familiarity with current developments in the field that enhance the quality and effectiveness of treatment delivery. Team leaders monitor IH-CBT fidelity and listen to audiotapes of treatment sessions to ensure adherence to IH-CBT procedures and to enhance clinician skills.

Empirical Foundation of IH-CBT

Empirical support for IH-CBT was obtained in a clinical trial (Ammerman, Putnam, Altaye, Stevens, et al., 2013; Ammerman, Putnam, Altaye, Teeters, Stevens, & Van Ginkel, 2013) comparing mothers who received IH-CBT and concurrent home visiting with those who received home visiting alone. In this study, 93 mothers were first identified using the

Edinburgh Postnatal Depression Scale (Cox, Holden, & Sagovsky, 1987) administered at 3 months postpartum. This identification was followed by diagnosis of MDD using a semi-structured interview. Following random assignment to treatment or control groups, mothers were re-assessed at post-treatment and at a 3-month follow-up. Results indicated that mothers receiving IH-CBT experienced significant benefits in terms of depression reduction relative to controls. Compared to those receiving home visiting alone, mothers in the IH-CBT condition were less likely to meet diagnostic criteria for MDD at post-treatment (see Figure 1), reported fewer depressive symptoms, and obtained lower scores on clinician ratings of depression severity. Mothers receiving IH-CBT also reported increased social support, improved functioning in day-to-day activities, and decreased psychological distress. Gains were maintained at 3-month follow-up. Findings remained when controlling for other psychiatric conditions, severity of MDD, therapist, home visiting model (Healthy Families America and Nurse-Family Partnership), and number of home visits. It is noteworthy that some mothers in the standard home visiting condition received treatment in the community, although as expected, this was often insufficient or ended prematurely. Mothers received a significantly larger dose of IH-CBT treatment than what is typically observed in center-based mental health settings (11.2 vs. 4.3 sessions). Mothers who completed all sessions of IH-CBT treatment did especially well, with 78.3% no longer meeting criteria for MDD at post-treatment and 90.5% recovered at follow-up. Mothers who recovered from depression reported increased ability to cope with stress related to the parenting role and more nurturing parenting of their children (Ammerman, Putnam, Altaye, Teeters, Stevens, Zou, & Van Ginkel, 2013).

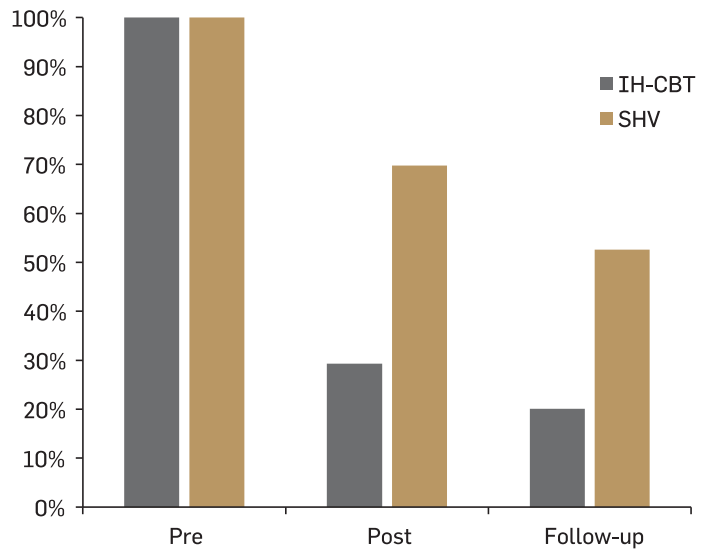
> The primary risk factors for developing depression in pregnancy and postpartum—trauma history, young age, social isolation, educational underachievement—are widely represented among mothers enrolled in home visiting programs.

The importance of the collaboration between the IH-CBT therapist and home visitor was striking in this research. Feedback from both mothers and home visitors highlighted the value of the working relationship between therapists and home visitors. For example, one home visitor noted "The therapist kept in contact with me from the beginning to the end of sessions, and she was clear about the services she was providing and how I would be involved." Mothers were enthusiastic about the convenience of having treatment provided in the home setting. Several mothers noted the "hard work" of psychotherapy, but acknowledged its ultimate value. When asked what she thought other mothers should know before beginning treatment, one mother said "They need to be willing to make a change in their life before it will get better," and another suggested that "To get the most out of therapy you have to take personal risks and go outside of your comfort zone."

The synergy between IH-CBT treatment and home visiting was further demonstrated in a study of predictors of post-treatment outcome. Ammerman, Peugh, Putnam, and Van Ginkel (2012) examined the degree to which clinical and service parameters predicted low scores on a depression screen at post-treatment among mothers receiving IH-CBT. Young maternal age, fewer episodes of MDD, lower depression severity at pre-treatment, lower levels of symptoms of personality disorders, and more treatment sessions and home visits predicted lower levels of depression. When considered in combination, number of home visits and number of IH-CBT sessions emerged as most strongly predictive of improvement. Mothers largely asymptomatic at post-treatment received 58% more home visits during the treatment interval in contrast to those mothers ending with residual depressive symptoms. Clearly, the combined efforts of IH-CBT therapists and home visitors contribute to robust improvements in maternal depression.

Figure 1. Percentage of Mothers Meeting Diagnostic Criteria for Major Depressive Disorder

Percentage of mothers in In-Home Cognitive Behavioral Therapy (IH-CBT) and Standard Home Visiting (SHV) groups meeting diagnostic criteria for major depressive disorder at pre-treatment, post-treatment, and 3-month follow-up.



Going to Scale: The Moving Beyond Depression Program

In order to disseminate IH-CBT to other home visiting programs, we established the Moving Beyond Depression™ (MBD) program. MBD is designed to facilitate adoption of IH-CBT treatment. It contains elements that promote implementation and sustainability, including establishing an infrastructure for screening, identification, and data collection; creating partnerships between home visiting programs and mental health resources that will provide therapists; training and oversight of home visitors and IH-CBT therapists; program evaluation and continuous quality improvement; and mastery of skills and full integration into home visiting programs.

Establishing an Infrastructure

The first step in deploying MBD in a home visiting program is to establish an infrastructure that will support a system of identification, referral, and treatment. Many

Photographer: Michelle K. Rummel

Sallymae (with her child Serena) learned how to manage her depression from the collaboration between her IH-CBT therapist Amy and her home visitor Molly.

home visiting programs have multiple sites that use different home visiting models. These sites must agree on a common measure for depression screening and consistent rules for identifying potentially eligible mothers, a centralized process for referring mothers to treatment, procedures for allowing therapists and home visitors to work closely together and communicate on a regular basis, and a data coordination system to allow program evaluation and continuous quality improvement. These issues are examined and resolved via telephone and on-site meetings. An implementation plan is prepared for the home visiting site in advance by MBD staff and shared with program leadership for refinement. The plan includes and incorporates MBD procedures, local considerations and procedures, process maps, key contacts and their responsibilities, and timetables for each phase of the program's roll out.

Learn More

Moving Beyond Depression
www.movingbeyonddepression.org

Every Child Succeeds
www.everychildsucceeds.org

Urban Institute, Information on Depression in Low Income Women
www.urban.org

SAMSHA Toolkit for Family Service Providers Including Home Visitors
Substance Abuse and Mental Health Services Administration. (in press). *Depression in Mothers: More Than the Blues—A Toolkit for Family Services Providers.* Rockville, MD: SAMHSA.

MedlinePlus, National Institutes of Health and National Library of Medicine
www.nlm.nih.gov/medlineplus

National Network of Depression Centers
www.nndc.org

Training and Ongoing Support

Both home visitors and therapists are trained separately. Therapists and team leaders attend 2 days of training to learn IH-CBT. Training includes didactics, review of audiotapes and videotapes, assessment procedures and interpretation of clinical measures, handling of challenging situations, collaboration with home visitors, and role-playing. Prior to or shortly after IH-CBT training, therapists are asked to attend an intensive workshop on CBT in order to further immerse themselves in CBT principles and prepare them for providing treatment in a challenging and nontraditional setting. Therapists see three pilot cases prior to full launch of the program. Audiotapes of treatment sessions are reviewed by the MBD team for fidelity to the IH-CBT model and adherence to CBT principles and practices. Home visitors are trained on site. Training addresses perinatal depression and its impact on mothers, children, and home visiting; screening and identification; presenting treatment and engaging mothers; and collaborating with therapists. Ongoing support is provided to home visitors, program leadership, and therapists and team leaders through scheduled telephone calls.

Screening and Referral

Home visitors identify potentially eligible mothers through scheduled screenings using one of several self-report depression measures (Rush, First, & Blacker, 2008). The home visitor then presents the program to mothers who receive scores at or above a predetermined cutoff. This stage is especially important as home visitors must engage mothers in the possible benefits of treatment while also addressing questions and concerns. These concerns include assumptions about treatment that may be inaccurate, stigma, or prior poor experiences with the mental health system, among others. If mothers are interested in participating in IH-CBT treatment, a referral is made to the therapist. Scores on screening measures need to be recorded in a centralized data system so that program leadership can monitor rates of screening, proportion of mothers who are eligible, and whether or not interested mothers are consistently referred.

Clinical Assessment

Interested mothers receive a pre-treatment clinical assessment consisting of a diagnostic interview and mothers' completion of several measures addressing trauma history, social support, and parenting stress. The purpose of the assessment is to confirm that mothers meet diagnostic criteria for MDD, identify other forms of psychological distress, and establish baseline levels of emotional and social functioning prior to treatment. The clinical assessment is also a time for therapists to educate mothers about depression, answer questions, and allay concerns about treatment. Assessment data is stored in a centralized data system and used to evaluate the impact of IH-CBT treatment at the site. Assessment measures are re-administered after the 15th session at post-treatment in order to determine change.

Treatment and Collaboration

IH-CBT sessions are scheduled so as not to interfere with ongoing home visiting. Therapists strive to communicate with home visitors weekly, even if it only involves a brief update. A written mid-treatment summary is prepared for home visitors that presents key issues being addressed in treatment. Collaboration centers on how the therapist

and home visitor can help each other and work on shared issues in such a way that mothers are fully supported throughout treatment. Therapists and home visitors communicate directly during crises and transitions, such as unanticipated moves or domestic violence. The home visitor attends the 15th treatment session during which a written treatment summary (which has been prepared by both the mother and therapist) is shared with the home visitor. This joint session is a time when the mother's gains and achievements are noted and celebrated, and ways in which the home visitor can support the mother in the future are reviewed. A booster session is provided 1 month later to establish gains and promote continued improvement.

Maintenance

At the end of IH-CBT treatment, home visitors play an essential role in maintaining treatment gains. Home visitors remind mothers to use skills learned in treatment or help mothers identify when they might be experiencing a return of depressive symptoms so that they can seek treatment resources early, before a full relapse occurs. Following the end of treatment, some mothers may choose to seek additional treatment for psychiatric conditions that remain.

Dissemination of MBD

Since 2008, MBD has been disseminated to a number of different programs (see box Dissemination of Moving Beyond Depression). These dissemination efforts included training and support of 36 masters-level therapist and 12 doctoral-level team leaders; more than 425 mothers treated with IH-CBT to date; implementation in more than 10 different types of home visiting models; and treatment provided with ethnically and racially diverse populations living in urban, rural, and suburban settings. To our knowledge, this is the most extensive dissemination to date of a cross-model, evidence-based enhancement specifically designed for home visiting.

We have learned a number of lessons in the dissemination of MBD. Some of these demonstrate the versatility of the IH-CBT approach and its broad appeal. First, IH-CBT has been equally effective with different racial and ethnic groups and nationalities. The cognitive model fits well into different personal and cultural world views. Feedback from several mothers noted that the structure of IH-CBT contrasts favorably with prior treatment experiences that were perceived as looser and open-ended. Second, implementation of IH-CBT has been seamlessly integrated into different home visiting models. As anticipated, the overarching approach of IH-CBT is compatible with the format and approach of divergent home visiting models. The use of depression measures to identify eligible mothers aligns with Maternal, Infant, and Early Childhood Home Visiting directives to regularly screen mothers for depression. Third, home visitors are pleased to have a treatment option for depressed mothers as they were otherwise frustrated when identifying depression through screening and having few viable resources for obtaining evidence-based treatment.

Challenges have also been encountered. Home visitors are very busy and balance multiple demands in implementing complicated curricula with high-need and low-resource families. Consistent screening, identification, and referral are difficult for some home visitors under these circumstances. Continuous quality improvement approaches, such as generating process maps to uncover vulnerable steps in the identification to referral progression, and careful collection and review of process flow are needed to ensure smooth implementation of MBD procedures. We have learned that some therapists are uncomfortable providing treatment in the home setting, preferring the professional environment of the office or clinic. Pre-screening for this attribute is essential to avoiding therapist turnover. Yet, some turnover of home visitors and therapists is inevitable and requires replacement and new training to maintain quality implementation and fidelity to the overall treatment program. As is often the case with new programs, maintaining consistent and stable funding is a challenge that must be met with creative blended and braided funding strategies.

Scaling up of MBD has also revealed common clinical issues and complications that must be considered in IH-CBT treatment, most notably intimate partner violence, which is strongly associated with depression. Maintaining therapeutic focus on depression and its management in the context of ongoing safety issues is a challenge that must be adequately addressed. Mothers in home visiting may face acute crises, such as impending eviction, loss of income, or urgent health needs. These, too, must be tackled without becoming the focus of IH-CBT treatment. In center-based mental health care these crises would likely lead to "no shows" or cancelled appointments, but when treatment is delivered in the home there is greater likelihood that the session will actually take place. This regularity provides opportunities for highly meaningful and effective intervention even though it is sometimes difficult to balance acute needs with higher level therapeutic goals. Psychiatric crises (e.g., suicidality) also require careful attention. Both the team meetings and ongoing training and support calls provide forums for addressing these needs while maintaining a focus on enhancing coping and mood management skills.

Dissemination of Moving Beyond Depression

The following timeline describes the dissemination of Moving Beyond Depression (MBD).

2008
- Connecticut—Nurturing Families Network
- 23 home visiting sites serving 5 counties

2010
- Boston, MA—Boston Home Visiting Collaborative (United Way of Massachusetts Bay and Merrimack Valley)
- 6 home visiting sites serving Allston-Brighton and adjacent communities

2011
- Kentucky—Health Access Nurturing Development Services Program
- Home visiting sites serving 50 counties

2013
- Kansas—Kansas Maternal, Infant, and Early Childhood Home Visiting Program
- 5 home visiting sites serving Wyandotte County

2013
- Massachusetts—Massachusetts Moving Beyond Depression: Massachusetts Home Visiting Initiative
- 8 home visiting sites serving 15 urban centers and environs

Conclusion and Implications

Recognition of the problem of depression among mothers in home visiting has greatly increased in recent years. In 2011, Golden, Hawkins, and Beardslee reviewed available programs for depressed mothers in home visiting and highlighted "the promise of home visiting as a platform not only for reaching and identifying depressed mothers, but also for serving them" (p. 20). Since that time, important progress has been made in developing evidence-based approaches to treatment (Ammerman, Putnam, Altaye, Stevens, et al., 2013; Beeber et al., this issue, p. 35) and prevention (Perry, Tandon, Edwards, & Mendelson, this issue, p. 45) of depression in the home visiting setting. We have described one of these approaches, IH-CBT, that has recently been nationally disseminated through the MBD program. With half of

mothers in home visiting reporting clinically elevated levels of depressive symptoms, and more than one third meeting criteria for the psychiatric diagnosis of MDD, this is an enormous issue that requires a coordinated and focused response from policymakers and mental health practitioners. Successfully treating depressed mothers in home visiting holds the potential to boost program outcomes, alter the developmental trajectories of children, and protect the sizable public investment in early childhood initiatives.

Robert T. Ammerman, *PhD, is professor of pediatrics at Cincinnati Children's Hospital Medical Center, University of Cincinnati College of Medicine, and scientific director, Every Child Succeeds. His research interests include enhancement of home visiting programs to improve outcomes for mothers and children, elucidating the impact of maternal depression and its treatment on mother and child outcomes, and engaging fathers in home visiting. He is the recipient of grants from the National Institute of Mental Health, National Institute of Child Health and Development, and National Institute on Disability and Rehabilitation Research.*

Frank W. Putnam, *MD, is professor of psychiatry at the University of North Carolina at Chapel Hill. From 1999 to 2011, he was professor of pediatrics and director of the Center for Safe and Healthy Children at Cincinnati Children's Hospital Medical Center, University of Cincinnati College of Medicine. Prior to that, he directed a research program on the psychobiological effects of maltreatment at the National Institutes of Health for 20 years. His current research interests include the dissemination of interventions for the prevention and treatment of child abuse.*

Angelique R. Teeters, *PsyD, is currently a postdoctoral fellow at Cincinnati Children's Hospital Medical Center. Dr. Teeters' research interests include enhancing early childhood home visiting programs with a focus on maternal and infant mental health, the impact of trauma on parenting and child development, and retention in home visiting. She is a recent Early Career Home Visiting Research Scholar awarded by the Home Visiting Research Network.*

Judith B. Van Ginkel, *PhD, is president of the regional Every Child Succeeds home visiting program which she co-founded 15 years ago, and professor of pediatrics at Cincinnati Children's Hospital Medical Center, University of Cincinnati College of Medicine. Hallmarks of the program include documented outcomes, use of quality improvement strategies in a community setting, and a return on investment for public and private sector funders. Her work has focused on the development of public policy to support initiatives for women and children and the application of social enterprise in the public sector.*

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