CHAPTER 38

Infant Mental Health and Home Visiting

Needs, Approaches, Opportunities, and Cautions

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Early childhood home visiting programs are widely recognized as effective approaches to provide preventive and early intervention services for hard to reach, at-risk populations. As a result, there has been a rise in support for these programs in the United States. At the federal level, the Maternal, Infant, and Early Childhood Home Visitation (MIECHV) program was created by the Patient Protection and Affordable Care Act in 2010 to provide evidence-based home visiting services to pregnant women and families with young children up to age 5 years. During fiscal year 2017, for example, MIECHV invested $372 million across all 50 states, the District of Columbia, and five territories and tribal entities, supporting 17 different evidence-based home visiting program models, as well as several models considered "promising practice" (Health Services Research Administration, 2017b). This is just one funding source. Because home visiting has many different service system "parents" (e.g., health, education, child welfare, family support), there are multiple fiduciary streams for these programs at local, regional, and state levels.

Home visiting programs vary in their service model, intensity, and professional background of the home visitor, though they often share similar goals of improving maternal and child health, preventing child abuse and neglect, encouraging positive parenting, and promoting child development and school readiness. Generally using preventive and strengths-based approaches, home visitors provide education, guidance, and support to vulnerable families. Links are made to community services when need for additional support or intervention is identified. Client participation is voluntary, and most programs recognize that the home visitor–client relationship is a crucial component of effective service delivery. Home visitors are expected to receive training and supervisory support to ensure program implementation with fidelity. Although there are variable outcomes (see Harden, 2010), evidence suggests that the programs positively impact multiple domains of family functioning (Avellar & Supplee, 2017; Sama-Miller et al., 2017), achievements that are notable because priority for these programs (at least in the United States) is typically at-risk families and communities. For example, during fiscal year 2016, of the families served by MIECHV funded programs (Health Resources and Services Administration, 2017b),

- 74% had incomes ≤ 100% of federal poverty level.
- 66% of adults had less than a high school education.
- 22% of households included pregnant teens.
- 14% of households reported history of abuse.
- 13% of households reported substance abuse.

Notably, many of the risk factors targeted by home visiting programs, such as poverty, history of adversity, and teen pregnancy, are also associated with increased risk for mental illness (Mrazek & Haggerty, 1994; National Research Council & Institute of Medicine, 2009b; Wang, Wu, Anderson, & Florence, 2011; World Health Organization, 2012). While most home visiting programs were not developed to address mental health issues explicitly, there is increasing recognition of the prevalence of mental health symptoms and disorders observed in home visiting clients and their impact on the delivery and effectiveness of services.

To be funded through the federal home visiting program (MIECHV), programs must meet stringent criteria to show effectiveness (Sama-Miller et al., 2017), and once funding is awarded, grantees must show improvement in four of six benchmark domains: maternal and newborn health; reduction in childhood injures, abuse, and neglect; school readiness and achievement; crime or domestic violence; family economic self-sufficiency; or coordination and referral to community resources (Health Resources and Services Administration, 2017b). Table 38.1 provides examples of some of the infant and early childhood home visiting program models that are eligible for MIECHV funding.

Our purpose in this chapter is to describe the range of mental health issues observed in maternal and early childhood preventive home visiting, the impact of these issues on delivery of services, and current approaches for addressing mental health concerns within the context of home visitation. We consider the implications of these issues for home visiting services, including the preparation and support of home visitors and the scope of services that are provided.

Mental Health Issues

Given the well-described impact of clinical and subclinical levels of depression on maternal health, prenatal development, and infant and child developmental outcomes (Center on the Developing Child at Harvard University, 2009; National Research Council & Institute of Medicine, 2009a), much of the available research about the home visiting population of families has focused on depression. Rates of depression during the pregnancy and postpartum period are high for at-risk groups typically served by

TABLE 38.1. Examples of MIECHV Home Visiting Program Models

Nurse–Family Partnership (NFP)
: Uses nurses as home visitors from prenatal period to child's second birthday to focus on child development, well-being, and maternal life-course development. Focuses on first-time mothers only.

Parents as Teachers (PAT)
: Typically uses paraprofessionals as home visitors. Initially focused on school readiness but expanded to broader view of child development support. Families can enter anytime, with curricula available up to 5 years, and some programs enroll prenatally.

Healthy Families America (HFA)
: Typically uses paraprofessionals as home visitors. Initially focused on child abuse prevention but expanded to more holistic view of child development and social–emotional well-being. Families can enter prenatally or just after birth and stay up to 5 years.

Early Head Start (EHS)
: Typically uses paraprofessionals as home visitors. Funded by the Federal Administration for Children and Families through direct grants to local agencies to promote child development. Serves children up to age 3. Programs may begin prenatally. Some EHS services are center-based rather than home visiting, or combine center-based and home-based services.

SafeCare
: Typically uses paraprofessionals as home visitors. Shorter-term heavily structured model (6 months or less) focused on child abuse prevention for families with history of abuse or at very high risk for abuse, from birth to age 5 years.

home visiting programs. A recent Centers for Disease Control and Prevention study found that self-reported rates of postpartum depression symptoms were elevated for young mothers (<19 years: 18.3%), women with less than 12 years of education (13.5%), those who were unmarried (12.7%), those who smoked in the postpartum period (17.7%), and those with more than three stressful life events in the year prior to pregnancy (>14.4%) (Ko, Rockhill, Tong, Morrow, & Farr, 2017). Given the rate of co-occurrence of these risk factors in home visited populations, it is not surprising that rates of depression are also high in these women. In a systematic review of depression and home visiting services across programs, Ammerman, Putnam, Bosse, Teeters, and Van Ginkel (2010) reported rates of clinically significant depression symptoms ranging from 28.5 to 69.8%.

Exposure to violence and trauma also are identified in home visiting populations. One early study found that nearly half the mothers in a home visiting program reported some type of domestic violence over 15 years since program enrollment (Eckenrode et al., 2000). A more recent report showed that in the 12 months prior to entering a nurse home visiting program, 8.1% of program participants experienced interpersonal violence (IPV; Scribano, Stevens, Kaizar, & NFP-IPV Research Team, 2013). More broadly, Stevens, Ammerman, Putnam, and Van Ginkel (2002) reported that 70% of a sample of Healthy Families America (HFA) participants had been exposed to at least one experience of violent trauma, including witnessing violence, relationship violence, rape/sexual assault, childhood physical and sexual abuse, and being a victim of a violent crime; almost two-thirds of the sample had experienced nonviolent trauma, such as auto accidents or natural disasters. These experiences affected the mothers' engagement in services, as evidenced by more incomplete or disrupted visits. Co-occurrence of relational violence and depression is common in home visiting (e.g., Boris et al., 2006; Stevens et al., 2002). A study specifically examining posttraumatic stress disorder (PTSD) in home visiting clients showed that of those mothers identified with major depression disorder, 37% had comorbid PTSD (Ammerman, Putnam, Chard, Stevens, & Van Ginkel, 2012). These findings are consistent with those recently described by the federal Mother and Infant Home Visiting Program Evaluation (MIHOPE; Michalapoulos et al., 2015) study: 40% of participants exhibited symptoms of depression or anxiety when they entered the study, and 10% reported being the victim of IPV during the past year.

There are fewer data about prevalence of substance use or abuse in home visiting. Several studies of the Nurse–Family Partnership (NFP) have found reduced substance use (cigarettes, alcohol, other drugs) during the course of the program and in long term follow-up of mothers and their children (Eckenrode et al., 2010; Kitzman et al., 2010; Olds, Henderson, Tatelbaum, & Chamberlin, 1986). Findings from MIHOPE show that more than one-third of MIECHV home visiting participants reported using tobacco and one-third reported binge drinking in the 3 months before pregnancy, or using illegal drugs in the month before pregnancy (Michalopoulos et al., 2015). Anecdotally, home visitors describe households in which household members are active users of legal drugs (e.g., alcohol and cigarettes), as well as suspected illegal substance abuse, but there are few data regarding illegal substance use of home visiting clients and families.

Qualitative studies of home visitors suggest that they encounter a wide range of mental health problems in addition to depression, trauma, and substance abuse, although less is known about the prevalence of these disorders within this population. Per nurse observation or client report, clients experience diagnosed and undiagnosed disorders such as anxiety, bipolar disorder, anger management problems, personality disorders, learning disabilities and cognitive delays, grief and loss, and rarer but impairing psychotic disorders, trichotillomania, or obsessive–compulsive disorder (Zeanah, 2011; Zeanah, Larrieu, Boris, & Nagle, 2006). Studies rarely formally assess these additional conditions, unless it is to rule out participation in a specific intervention. For example, one study of an in-home cognitive-behavioral therapy (CBT) model found that 18% of those who screened positive for depression were ineligible because of significant co-occurring mental health diagnoses (Ammerman et al., 2011).

In summary, the current evidence suggests that home visiting programs serve families with significant mental health symptoms and disorders. Comorbidity is frequent, complex, and in some cases, long-standing. The type and range of mental health disorders are those commonly associated with parenting difficulties and increased risk of abuse and neglect. Given these complexities, there is an urgent need for sys-

tematic research to determine the range, comorbidity, and impact of a broader range of mental health problems in home visiting clients.

Mental Health Issues and Home Visiting Outcomes

There are relatively few studies that specifically examine the impact of mental health issues on home visiting outcomes, and results are equivocal. As one example, Olds and Korfmacher (1998) found that mothers with "fewer psychological resources" (a construct developed from brief assessment of mental health, intelligence, and perceived feelings of mastery) received more visits in an NFP trial, suggesting that nurses identified increased need, and these mothers were receptive to increased services.

On the other hand, in a different analysis of NFP, Eckenrode and colleagues (2000) found that the preventive effects of the home visiting program on child abuse and neglect were minimized as frequency of domestic violence increased. Scribano and colleagues (2013) found that rates of client-reported IPV decreased during pregnancy compared to the 12 months prior to entering the program, but arose above prepregnancy levels by 12 months postpartum. There were no effects of IPV on pregnancy outcomes, including gestational age and birthweight, but IPV was related to decreased rates of contraception and more rapid repeat pregnancies. A larger systematic review of parenting interventions in the context of IPV (including home visiting interventions) also suggests little clarity regarding how well these interventions address the unique needs of this population in promoting positive parenting outcomes (Austin, Shanahan, Barrios, & Macy, 2017).

The actual moderating impact of mental health conditions such as depression on home visiting outcomes is unclear. In other words, although mothers with depression present challenges to home visitors, and depression is associated with challenges in functioning in different areas that home visiting is expected to improve, research is equivocal on the extent to which participant depression actually interferes with home visiting program effectiveness. Different studies, for example, show a complicated relationship between depression levels in home visiting participants and attachment security in young children (Berlin et al., 2011; Duggan, Berlin, Cassidy, Burrell, & Tandon, 2009; Spieker, Nelson, DeKlyen, & Staerkel, 2005). As noted by Ammerman and colleagues (2010), depression is not always associated with negative program outcomes, and it is possible that mothers' interpersonal capacities may play a more important role in the impact of home visiting services on parent and child outcomes. All of this suggests the need for more careful study to discern how client considerations, such as maternal attachment history, as well as other parenting beliefs and factors, such as exposure to adverse childhood experiences, intersect with mental health and contribute to program engagement and outcomes.

Home Visiting and Mental Health Outcomes

Does the normal provision of support provided in prevention-based home visiting ameliorate or prevent specific mental health concerns? MIHOPE, in preliminary reports, stated that 70% of programs receiving MIECHV funding demonstrated reductions in tobacco, alcohol, or illicit drug use during pregnancy or throughout the program, one of the benchmarks of the MIECHV program (Michalopoulos et al., 2015). Long-term follow-up studies have demonstrated the preventive impact of home visiting across a number of outcomes. For example, in a primarily African American sample, children of low-resource mothers who participated in the NFP were less likely to report using cigarettes, alcohol, and marijuana, and had fewer internalizing, but not externalizing, symptoms at age 12; their mothers had longer partner relationships, a stronger sense of mastery, and less impairment from alcohol and drug use (Kitzman et al., 2010). In the 15-year follow-up of a primarily European American sample, mothers who participated in NFP were less likely to have been arrested or to have impairments due to substance or alcohol use (Olds et al., 1997), and their children were less likely to show antisocial behaviors, such as school behavior problems and suspensions, encounters with the juvenile justice system, and use of cigarettes and alcohol (Olds et al., 1998). Using the same sample, Izzo and colleagues (2005) found that women who participated in the NFP were less vulnerable to the impact of uncontrollable stressful life events, and that mothers reported less alcohol use, less emotional distress, and closer supervision of their children at age 15. Notably, the impact was greatest for young mothers and those

with low personal control, which suggests that nurses recognize the increased needs of these clients and/or these clients are most receptive to the nurses' efforts. At the 19-year follow-up, female children reported fewer arrests and conviction rates than did the comparison sample (Eckenrode et al., 2010).

Other studies suggest that the trajectory of depression symptoms is complex, and involvement in home visiting, in and of itself, does not necessarily lead to lower depression scores (Ammerman et al., 2010; Chazan-Cohen et al., 2007; Duggan et al., 2004). Interestingly, Chazan-Cohen and colleagues (2007) found delayed, positive program effects on maternal depression symptoms of mothers 2 years *after* completion of Early Head Start (EHS); these effects were attributed to program effects on the child and parent. These studies again highlight the complexity of understanding the impact of home visiting programs on immediate and later mental health functioning.

The Role of Home Visitors Working with Clients with Mental Health Challenges

The field of home visiting has struggled to define home visitors' evolving role as service providers, so the lack of clarity about their role supporting families with mental health needs is not surprising. Some of this is historical. The movement of home visiting is not confined to any one system, as this mechanism of service delivery has roots in child welfare, early education, public health, social work, and infant mental health. Home visitors vary widely in professional status, with some home visitors coming from public health nursing, others having other degrees and credentials in early childhood or human services, and still others falling into the ambiguous category of "paraprofessional," which essentially means they are defined by what they are *not* as opposed to what they are (Korfmacher, 2016).

Halpern (1999), in his historical review of human services for vulnerable families, notes that the clinical infant services popularized by Selma Fraiberg and her colleagues existed in an uneasy tension with the more strengths-based grassroots family support movement that drove much of the second wave of home visiting in 1970s. Fraiberg's infant mental health approach acknowledges the complexity of working with challenging families, and of paying attention to the parents' pasts (often involving trauma and neglect), which influence how they take care of children and how they interact with human service professionals. Family support movements, however, focus more on the idea that all families can benefit from support, and this support is best viewed as promoting and reinforcing existing capabilities, empowering families by helping to create an environment in which parents can feel efficacious and responsible for their life success (Kagan & Weissbourd, 1994).

Is it reasonable to expect that home visitors, who focus on promoting and reinforcing existing capabilities, can simultaneously address often undiagnosed mental health challenges in families and work toward easing symptoms caused by unresolved traumas or maladaptive working models of parenting? This is especially important with regard to home visitors who have minimal training in mental health, whether they are paraprofessionals or professionals who come from non-mental-health fields. We believe that the short answer is "No," but the long answer is "It's complicated."

The short answer ("No") is easily given because people who provide mental health services should have the experience and credentials to do so. Home visiting programs, because they exist on the end of preventive services to families, do not typically hire home visitors with this required experience. Program models recognize this. Most popular home visiting models in the United States, such as NFP, EHS, Parents as Teachers (PAT), and HFA, all note in their standards and program materials that home visitors are not expected to provide therapy services and should instead refer cases about which they are concerned.

The longer answer ("It's complicated") acknowledges that home visitors cannot simply ignore the mental health needs of the families they visit—this is clinically unwise and potentially unethical, especially when simple referral to other community mental health services is not practical, feasible, or effective. Even if not the primary intention of the service, home visiting programs recruit large number of parents with mental health challenges, and the mental health concerns are often inextricably linked to the goals of the programs (e.g., increasing effective and safe parenting behavior, promoting child well-being, reducing family isolation), so that they cannot easily be carved out as issues to be addressed by others. Many home visiting programs operate in communities that have

limited mental health services for low-income or disadvantaged families, particularly in rural environments (e.g., Boris et al., 2006; Heflinger, Shaw, Higa-McMillan, Lunn, & Brannan, 2015) providing few opportunities for referral for needed treatments.

Parents are often reluctant to seek out and trust another service provider, preferring to use the home visitor as a lifeline. The nature of the helping relationship that home visitors form with families can take on the elements of a therapeutic alliance, particularly what are known as the nonspecific elements (Marsh, Angell, Andrews, & Curry, 2012; Stern, 2006). Home visitors provide empathic support to parents, engage in problem solving, use active listening skills, and develop trusting relationships with clients that provide a safe space to discuss hopes, fears, and insecurities about parenting (e.g., Paris & Dubus, 2005). For families with significant histories of trauma or neglect, the presence of a caring and nonjudgmental person who comes to the home and provides help can be a powerful, potentially corrective experience. As a result, home visitors may feel pressure to address these issues, even if they are not qualified as therapists to do so, or are uncomfortable discussing topics that move past a strengths-based orientation (Harden, Denmark, & Saul, 2010; Kitzman, Cole, Yoos & Olds, 1997). Their job exists in an uneasy tension between competing demands of setting professional limits and doing whatever works to help a family, including providing services that are needed but perhaps not sufficient.

The primary directive, as always, is to do no harm. There are potentially dangerous consequences as a result of doing nothing or attempting to work with families with significant mental health needs. Home visitors working without proper knowledge, skills, supervisory support, or adequate community resources can experience frustration, ineffectiveness, burnout, and compassion fatigue. Qualitative research demonstrates the emotional exhaustion that can set in when working with extremely challenging families over an extended period of time (e.g., Zerwekh, 1991). Home visitors may come to dread or resent the time working with families when they feel they are in over their heads. Families with heavy histories of trauma can also evoke vicarious or secondary trauma (Stamm, 1995), in which the home visitor becomes preoccupied with the experiences of the family members and develops symptoms similar to a trauma response, including emotional numbness, increased arousal, physical symptoms, and difficulties in concentration and sleeping.

Without a clearer process for how to address mental health issues, the risk for clients is that symptoms are inadequately identified, interventions may be delayed or misguided, and attention given to mental health issues may usurp time and effort from other important client or program goals. The question, then, is how to address mental health issues within home visiting programs while staying true to the original intent of program models.

Mental Health Interventions and Home Visiting Programs

A central challenge for addressing mental health concerns is that within any given program or home visitor caseload, some clients have no mental health needs, others have emerging problems, and still others demonstrate acute or even crisis-level concerns. Symptomatic clients may be either untreated or treated, or have a history of more intensive treatment. In essence, home visiting programs serve clients with mental health needs that cross the entire continuum of behavioral health care (National Research Council & Institute of Medicine, 2009b), from promotion (enhancing the quality of life and well-being) to prevention (universal, targeted, and indicated), to treatment (case identification, standard treatment, and crisis management), including recovery (aftercare or rehabilitation).

By virtue of serving "at-risk" populations, most home visiting programs (besides those using a universal support model, e.g., Family Connects; see Dodge et al., 2014) are considered selective preventive interventions, and programs typically incorporate promotion and preventive strategies such as home visitor–client relationship building; education on health, child development, and parenting; and bolstering self-efficacy by enabling the client to identify and work toward short- and long-term goals. In addition, home visitors may provide education on stress management, communication skills, and anticipatory guidance regarding signs to watch out for more serious concerns, such as postpartum depression.

But for families with needs extending beyond promotion-prevention requiring case identification and treatment, home visitor roles become less clear. Increasingly, home visiting programs

incorporate routine *screening* for depression, anxiety, interpersonal violence, and substance use (e.g., for MIECHV; Health Resources and Services Administration, 2017b), but they do not conduct a formal mental health history, and diagnosis is not within the purview of most home visiting programs.

There is little research on how well home visitors manage interpretation, synthesis, and prioritization of information when multiple screening tools are used, or how they recognize relevant client information revealed during the course of visits, and integrate and incorporate the information within the other requirements of the program and client preferences or priorities. In response to perceived needs, home visitors may increase visit frequency (Olds & Korfmacher, 1998), focus on meeting basic needs (Golden, Hawkins, & Beardslee, 2011), adapt program guidelines or, anecdotally, find information from other sources, but there are few data examining the dose or timing of such strategies, or their effectiveness.

A challenge for home visitors is how to individualize approaches for clients while attending to the program goals (Kitzman, Cole, Yoos, & Olds, 1997). Other than reflective supervision, there is little formal programmatic guidance to help home visitors sort through these issues. One exception is the Strengths and Risks (STAR) approach in NFP, which helps guide nurse home visitors in individualizing program implementation (Olds et al., 2013). In addition, a recently introduced formal process map for home visitors to aid in their decision making around mothers with depression concerns is designed to work across program models (Laszewski, Wichman, Doering, Maletta, & Hammel, 2016).

When symptoms are deemed clinically significant, through the screening process, observations by home visitor, or request by client, home visitors typically recommend referral for further assessment and treatments. At this point, the home visitor's task may be seen as educating, encouraging, and motivating clients to seek treatment for formal mental health services, leveraging their relationship with the client to broker the connection to services. However, research on the effectiveness of screening and referral to mental health services in home visiting is scant (Ammerman et al., 2010).

Limited access to treatment brings forth additional challenges. Often, treatment services are not available, acceptable, or affordable to clients. In addition, home visitors may have clients who are already receiving mental health services. When such situations are known, the home visitor's role may be to encourage the client to continue in treatment services, but guidelines for how the home visitor is to collaborate with mental health treatment service personnel are not always made explicit and also depend on the willingness of the staff in the treatment services to collaborate. Again, there are few data regarding how well such collaboration is carried out.

Per home visitor reports and clinical observations (Ammerman, Putnam, Teeters, & Van Ginkel, 2014; LeCroy & Whitaker, 2005; Zeanah, 2011), mental health *crises* also occur, including violence, suicidal and homicidal ideation, and mania and psychotic episodes, but data on the frequency of these events are lacking. Home visitors typically receive little formal training on recognition of such psychiatric emergencies and immediate crisis interventions, including their role in addressing immediate needs of the infant/child.

Finally, guidance and research on how home visitors work with clients at the *recovery* end of the mental health continuum (after hospitalization for psychiatric or substance use problems) are also lacking. Decisions about monitoring symptoms, ensuring client follow-up on treatment recommendations, collaboration, or coordination with mental health providers, and assessing the impact of symptoms or status on the client's ability or readiness to reengage in the program or care for her child, are typically made on a case-by-case basis, often by a home visitor and/or supervisor with little or no experience in caring for someone in this phase of the continuum.

While the behavioral health continuum is helpful in considering the types of activities the home visitor may need when working with caregivers with mental health issues, it does not adequately frame the role of the home visitor in addressing severe *parent–child interaction challenges,* the relationship-based issues that are the bread and butter of infant mental health. Many home visitors do identify problem relationships. They can make note of harsh verbalizations, witness rough handling, and recognize parents who see their baby as "bad." But most home visitors are not trained to manage sustained problematic parent–infant interactions, or how to assist when relationship needs exceed prevention-focused program resources. When

this occurs, home visitors may feel limited in their ability to provide sufficient guidance and support, and frustrated by how to prioritize time spent on the parent–infant relationship versus other program-mandated or client-preferred activities.

Without clarity of the role of the home visitor along the continuum of mental health services, these challenges may seem overwhelming and, once again, the home visitor is stuck in an impossible gray zone of support and treatment. Nevertheless, recognition of the pervasiveness of the mental health needs of many home visiting clients and families is opening the door to opportunities and approaches that have the potential to make a difference in the most sensitive periods of infant and parent development.

Addressing Parental Mental Health Needs in Home Visiting

We describe three major approaches currently available that specifically address mental health challenges: (1) program-level approaches; (2) "add on" program components; and (3) community- or systems-level approaches.

Program-Level Approaches

Some home visiting programs are adapting their resources and approaches, so that home visitors can better recognize and provide more specific support to clients with mental health conditions. In the NFP, for example, program adaptations have included development of education and tools for nurses to address interpersonal violence (Jack et al., 2012; Jack, Ford-Gilboe, Davidov, MacMillan, & the NFP IPV Research Team, 2017), development of a structured observation of parent–infant interactions, and an approach to assess client strengths and risks. In addition, efforts are under way to fully integrate identification of and interventions to address symptoms of depression and anxiety (Olds et al., 2013).

As another example, PAT (2011) includes modules for educating clients about a variety of mental health and parenting issues, including depression, complex mental health problems, substance-abusing parents, behavior of children in foster care, and others. The modules provide basic guidance for the parent educator, incorporating education, goal setting, development of protective factors, encouragement of parents' reflective capacity, and specific strategies for emergent situations. Related content areas are linked, so the parent educator can easily find the resources he or she needs. Another popular model, HFA, which has positioned itself as an infant mental health-focused model, recommends that home visitors and supervisors receive early childhood mental health endorsements, such as those provided by the Michigan Association for Infant Mental Health (Healthy Families America, 2017), demonstrating basic skills and knowledge in mental health principles and practices.

Finally, there are home visiting program models that more explicitly target behavioral and mental health challenges, including models that have reached the level of evidence-based practices to make them eligible for MIECHV funding. SafeCare is a short-term home visiting model that provides behavioral skills training to families with histories of abuse or neglect (Chaffin, Hecht, Bard, Silovsky, & Beasley, 2012). As another example, Minding The Baby (Slade et al., 2005) adapts nurse home visiting and infant–parent psychotherapy into a home visiting model designed to develop parents' reflective capacities and address relationship disruptions that are a result of early trauma and negative attachment histories. Significantly, the program model uses a team approach, with both a nurse practitioner and a clinical social worker delivering the services. This use of home visitors with specific clinical backgrounds sets Minding the Baby apart from many of the other early childhood home visiting program models and is similar to other approaches that have attempted to add mental health intervention to home visiting services, as described below.

Add-On Services

As shown in Table 38.2, add-on services provide education or support beyond what is typically provided by the program itself. There are three primary ways that these services are used. *Parallel services* are delivered by trained mental health clinicians in conjunction with the home visitor. *Direct integration* refers to services integrated into the program as an additional form of support provided by the home visitor. *Mental health consultation* involves the use of a mental health professional to provide education and guidance for home visitors, so they can better support families.

TABLE 38.2. Examples of "Add-On" Mental Health Approaches for Home Visiting

Type of approach	Delivered by	Target of intervention	Parent–child relationship focus	Role of home visitor
Parallel				
Moving Beyond Depression (Ammerman et al., 2014)	Master's-level mental health professional	Major depression, stress, relationship challenges (treatment)	Transition to parenthood	Initial screening, collaboration during treatment, final planning
Interpersonal therapy plus parenting enhancement (Beeber et al., 2004, 2010, 2013)	Master's-level psychiatric nurse	Depression symptoms	Sensitive and contingent responsiveness, safe supervision, perceptions of child	Screen, communicate, and collaborate with mental health professional
Direct integration				
Mothers and Babies (Tandon et al., 2011)	Licensed mental health provider	Depression (prevention)	Impact of mood and stress on relationship	Reinforce Mom and Baby content during home visits
Domestic Violence Enhanced Home Visiting (Sharps et al., 2016)	Home visitor	Interpersonal violence (IPV)	Secondary	Educate, assess, safety plan, refer
NEAR@home (Region X ACE Planning Team, 2016)	Home visitor	Trauma/adverse childhood experiences	Secondary	Screen, educate
Consultation				
IECMH	Infant and early childhood mental health provider	Parental mental health	Variable	Screen, refer, may provide intervention under guidance of consultant

Parallel Services

Moving Beyond Depression (MBD), a treatment intervention for depressed mothers, is the clearest example of parallel services in home visiting. Developed through a collaboration between Early Childhood Succeeds, a home visiting program in southeastern Ohio and northern Kentucky, and the Cincinnati Children's Hospital Medical Center, MBD includes 15 weeks (plus a booster session 1 month posttreatment) of structured CBT conducted in the home by a trained master's-level mental health clinician supervised by doctoral-level staff. The mother's home visitor provides the initial screening, and treatment is only available for mothers who meet the diagnostic threshold for major depressive disorder, ascertained by a clinical assessment in response to the elevated screening score. The goal is depression symptoms reduction, but treatment is tailored to the needs of younger and stressed mothers, including the transition to parenting and relationship challenges (see Ammerman et al., 2014). During treatment, the therapist and the home visitor remain in close communication, and a mutual session with both providers is planned as part of the 15th (final) treatment session to review progress and incorporate how the home visitor can continue to support the mother in this area.

MBD was evaluated in a randomized clinical trial and demonstrated reductions in number and severity of depressive symptoms, as well as reductions in other symptoms of emotional distress, including anxiety and relationship difficulties. Participating mothers reported improved coping with stress, increased social support, and greater satisfaction with parenting. Participants in the research trial also increased engagement in the home visiting services, with a dose–response relationship between increased participation in home visiting and CBT sessions, and level of reductions in depression symptoms (Ammerman et al., 2014).

Although, at this point, there has only been one research trial of MBD, the program has been disseminated for use in over 10 states beyond the original catchment area. Challenges include the high intensity of involvement of additional (and more costly) service staff, including master's-level therapists and doctoral-level supervisors, who provide weekly support to therapists, and clarifying expectations of the role of home visitors. Initial cost analyses, however, found that these enhanced services lead to an average of 8 months of reduced depression symptoms, translating to potentially large public health savings (see Ammerman et al., 2015).

A similar approach developed by Beeber and colleagues (2004) uses master's-level psychiatric nurse clinicians to provide short term, home-based interpersonal therapy (IPT) to low-income mothers in an EHS program. The IPT was enhanced with parenting support to increase sensitive and contingent responding to the unique needs of the infant and provision of safe care. Content was designed to complement, not supplant, the information provided by the EHS visitors. Mothers randomly assigned to in-home IPT versus care as usual had significantly fewer depression symptoms at follow-up, as well as improvements in parenting skills. A replication with low-income Latina women with limited English-speaking skills showed similar results (Beeber et al., 2010). In a more recent, larger trial, the intervention specifically improved parenting skills (Beeber et al., 2013).

The examples cited here, as well as a previous example, Minding the Baby, suggest that parallel approaches using a variety of therapeutic modalities can be successfully implemented within home visiting programs. Unfortunately, access to such programs is limited, and implementation of such programs can be expensive. Providing treatment in the home often requires significant adaptation for traditional evidence-based therapies (Beeber et al., 2014; Ammerman et al., 2014). Therefore, other options are also explored.

Direct Integration

Mothers and Babies (Tandon, Perry, Mendelson, Kemp, & Leis, 2011) is an example of direct integration of mental health services into home visiting. Mothers and Babies is a short-term (6-week) group-based adaptation of CBT that has been studied with lower-income home visiting participants in Baltimore. Like MBD, it focuses on depressive symptomatology, but the goal is prevention of depression rather than targeting symptoms of mothers with a current major depressive episode. For this reason, depression screening is used instead of a full clinical assessment. Although groups are led by a licensed mental health clinician, home visitors explicitly provide 5–10 minutes of reinforcement of content during home visits. Findings suggest a reduction in depression-related symptoms, both at the end of the group participation and (notably) at a 6-month follow-up (Tandon, Leis, Mendelson, Perry, & Kemp, 2014). It is an open question, however, whether or not home visitors can take on the direct role of intervention; a current trial is examining the impact of the program when the materials are presented by paraprofessional home visitors compared to consultants with more formal early childhood mental health training (Tandon, Snyder, Perry, & Le, 2014).

Both MBD and Mothers and Babies focus on depression, although, as noted earlier, many other mental health challenges face participants in home visiting programs. The Domestic Violence Enhanced Home Visitation Program (DOVE) is a structured approach to addressing IPV by incorporating routine assessment and six 10-minute educational sessions into home visits. The program was developed to enable home visiting programs to address the MIECHV benchmark to reduce domestic violence (Sharps et al., 2013). Preliminary evidence indicates that while home visitors had significant reservations about screening and talking with clients about domestic violence, clients who were willing to discuss their abuse and retention rates did not suffer (Sharps et al., 2013). Recent results from the randomized controlled study found that

women who received the DOVE intervention in addition to usual care (including home visiting) had significant declines in IPV from baseline to 24 months postpartum (Sharps et al., 2016).

NEAR@Home, a toolkit developed by partners in MIECHV-funded programs within federal Region X (in the U.S. Northwest), emphasizes trauma-informed approaches by focusing on home visitor capacity to address adverse childhood experiences sensitively and effectively (Region X ACE Planning Team, 2016). Home visitors use structured guidance and other tools to facilitate home visitors engaging in discussions with families regarding NEAR (Neuroscience, Epigenetics, Adverse Childhood Experiences, Resilience). Although it has yet to be rigorously examined, the toolkit shows potential to increase home visitor comfort in discussing challenging histories of the participating parents.

Infant and early childhood mental health consultation (IECMHC) incorporates a licensed mental health clinical consultant into home visiting programs, with the broad goal of enhancing the capacity of professionals to address psychosocial and mental health needs of children and families. The consultant typically educates home visitors on mental health topics, screening skills, and available mental health resources, and facilitates the referral process. It also helps home visitors to recognize and manage their own stress in work with high-risk families. Consultants may collaborate with individual home visitors with select clients, and in some instances may provide direct services such as accompanying home visitors on visits when the well-being of parent or infant is of concern. Some provide reflective supervision to individual home visitors or home visiting teams (Goodson, Mackrain, Perry, O'Brien, & Gwaltney, 2013).

Project LAUNCH (Linking Actions for Unmet Needs in Children's Health), an initiative funded through the U.S. Substance Abuse and Mental Health Services Administration, has promoted IECMHC as part of its efforts to improve integration of behavioral and physical health services for young children and their families. Findings of the use of IECMHC at eight Project LAUNCH sites show that home visitors improve knowledge of social–emotional and behavioral development, and that such consultants are accepted and valued by the home visitors (Goodson et al., 2013).

Community- and Systems-Level Approaches

There are numerous efforts within policy and systems frameworks to improve availability of services to address the mental health needs of parents of young children. For example, Knitzer, Thebarge, and Johnson (2008) described local, state, and federal efforts to address maternal depression, including increasing awareness and engagement of stakeholders and funders, promoting state legislation to implement depression screening and provider training, providing referral and treatment services, and implementing federal initiatives to develop early childhood systems.

Since 2003, the federal Health Resources and Services Administration (2017a) has supported states with the Early Childhood Comprehensive Systems program, which seeks to develop and enhance interagency and cross-organizational partnerships and create seamless systems of care, with the goal of improving the physical, mental, and social well-being, of infants, young children, and their caregivers and families. State and community systems are developing innovations such as integrated intake processes, infrastructure to improve communication, and data sharing between programs, and identifying funding streams to support mental health enhancements to home visiting (Marchand, 2014; Zero to Three, 2014). Funding remains a barrier. The federal home visiting program (MIECHV) does not provide funding for direct mental health service, though approaches that "enable delivery of coordinated and comprehensive high quality voluntary early childhood home visiting services to eligible families" (Maternal Child Health Bureau, Health Resources and Services Administration, 2016, p. 6), such as consultation, are allowable. Reimbursement for mental health and infant mental health services is a general challenge that states are trying to address (Rappaport, Colvard, Dean, & Gebhard, 2015).

Other Relevant Topics

Our purpose in this chapter is to provide a broad overview of the some of the major challenges, implications, and approaches of addressing parental mental health issues in home visiting. As home visiting grows, more needs are recognized, and more demands are being made

on programs as home visiting is considered an ideal conduit to meet myriad prevention and intervention needs for at-risk families. Space limitations prevent in-depth discussion of home visiting's potential role in providing services for other mental health issues that home visitors face, such as children with significant behavioral or emotional disturbances or specific developmental challenges (e.g., autism), family conflict, or families involved with child protection services. The inclusion of such activities would raise questions similar to the ones we have discussed here. Because comparative research is limited, we have also not discussed whether some types of home visiting programs (or home visitors) are more effective than others in addressing mental health issues.

Conclusions and Recommendations

Despite the enormous complexity of addressing the mental health needs of clients and families served in home visiting programs, there is good news. Most important, parents and infants who otherwise are invisible to traditional systems can receive home visiting services that enable earlier recognition and earlier intervention to address mental health needs that can impact current and long-term health and developmental outcomes. The range of innovative approaches not only provides rich perspectives for how best to work with vulnerable families but also may lead to new insights about identification of mental health needs and provision of care more generally. Home visiting provides opportunities—perhaps mandates—for non-mental-health professionals to provide first-line mental health resources to these vulnerable families, and to strengthen collaboration and coordination between mental/behavioral health services and home visiting. Promising efforts show positive impacts on addressing salient mental health needs for these families.

The challenges also raise important questions regarding the appropriate scope of home visiting practice in addressing mental health issues. Increasingly, home visitors are called upon to provide screening for multiple risks; we have named depression, anxiety, trauma, substance use/abuse, interpersonal violence, adverse childhood experiences, and attachment history, and others are likely to be added. Practical issues include not only the mechanics of identification of the wide range of potential problems but also the implications of how home visitors are to synthesize and prioritize a multitude of problems; effectively engage clients and implement preventive, strengths-, and evidence-based approaches to address the identified problems; track and monitor client progress; decide how and when to engage family members or supportive others; work in collaboration with community services (when available); and identify and deal with one's personal experiences, beliefs, reactions, and stress in highly charged situations. These activities take place with consideration of the client's priorities and desires, and within the contexts of broader program activities and goals, and, of course, busy caseloads. The complexity of such work could challenge many mental health providers, so developing such skills in non-mental-health home visitors is daunting indeed. Our goal in this chapter is to raise awareness and stimulate further discussion about the role of home visiting in work with at-risk families. To that end, we conclude with several recommendations.

First, there is an urgent need for more research, including the epidemiology of mental health symptoms, diagnoses, comorbidities, and related issues in the home visiting population, how mental health issues affect home visiting outcomes, and how clients and families served by home visiting respond to home visitors' efforts. In addition, more research is needed on the "how" and "what" of sufficient screening, including how such screening impacts home visitor recognition of problems, client engagement, and program implementation.

Certainly the home visitors' role along the continuum of mental health care needs further clarification. Because maternal and child home visiting programs were developed as preventive programs rather than problem-focused treatment interventions, and parental mental health/infant mental health were not targets of services in most cases, a coherent framework that integrates theory and "theory of change" to guide the development of such work (rather than simply adding more for home visitors to address) is urgently needed (Ammerman et al., 2010; Harden, 2010). Following the adage "First do no harm," it may be useful to frame home visiting mental health interventions with the attempts of other treatment fields to establish appropriate service delivery, such as the eight "rights" of drug administration that nurses are taught (Lippincott, 2017):

1. The right patient (Who is the client-mother/caregiver, infant, dyad, family?)
2. The right drug (What is the type and level of intervention-education/promotion, screening/prevention, early intervention, treatment, referral or collaboration?)
3. The right dose (How much? What is the impact on other home visiting services?)
4. The right time (At what point are services implemented, such as prevention, or crisis management?)
5. The right route (Are services provided in the home or clinic, and by whom?)
6. The right reason (Does screening and assessment successfully target participants?)
7. The right response (Are clients appropriately monitored?)
8. The right documentation (How do we track service use?)

Additional rights have been suggested as well (Nwagwu, 2016), including the patient's right to have information about the drug (client engagement), and the right to refuse services (client choice), which are particularly relevant for voluntary services such as home visiting. The sheer volume of what is added to the responsibilities of home visitors needs to be addressed, but attending to these aspects of services may go a long way to help home visitors to know when they have "done enough" and alleviate some of the distress they feel when working with complex clients.

Ethical issues also need further consideration:

- How should home visitors ethically identify needs (or not) when services are not available?
- What are reasonable mental health targets (processes, outcomes) for home visiting?
- What are the ethical limits of assessment and intervention for complex mental health problems by non-mental-health, prevention-oriented home visitors?
- What constitutes adequate education, support, and supervision for home visitors when serving such clients?
- What clients may not be appropriate for home visiting?
- Should home visiting programs address mental health in a uniform manner, or should services be tied to program goals, providers, and resources?

The intimate, long-term relationships that home visitors establish with vulnerable clients, of course, raise concerns about professional boundaries, a frequent topic within clinical home visiting. However, better understanding about what clients want from home visiting programs and the home visitor regarding mental health care is also needed. Clients should be informed about what programs can and cannot address.

Finally, there is a need to strengthen advocacy and systems development. Home visiting programs work best when they are part of a system of care, not *the* system of care. That home visiting has become valued as an important resource for families and communities speaks to how well these programs are identifying and addressing needs, and, one might argue, pushing other systems to be as responsive. Home visiting provides a natural opening for parental and infant mental health assessment, prevention, and intervention, but careful delineation of needs, roles, and approaches are urgently needed.

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