Linking Depressed Mothers to Effective Services and Supports: A Policy and Systems Agenda to Enhance Children’s Development and Prevent Child Abuse and Neglect

Summary of the May 2013 Culminating Roundtable

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September 2013
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The authors would like to thank the Doris Duke Charitable Foundation for its support of the Linking Depressed Mothers to Effective Services project and commitment to this important issue. We would also like to thank the participants of the 2013 Spring Culminating Roundtable, members of the federal planning group, and the participants in the three federal convenings at the Urban Institute for their thoughtful contributions and energy. We would like to express particular gratitude to William Beardslee of Children’s Hospital, Boston; Larke Huang of SAMHSA; David de Voursney of ASPE; and project team member Embry Howell of the Urban Institute, for their valuable feedback on this paper.

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Linking Depressed Mothers to Effective Services and Supports

Identifying and treating low-income mothers suffering from depression is of critical importance for both mother and child and represents a major public health opportunity. Untreated depression in mothers can jeopardize young children’s safety, learning, and emotional development and adversely affect their long-term mental and physical health (Council on the Developing Child 2009; National Research Council [NRC] and Institute of Medicine [IOM] 2009). However, while depression is one of the most treatable mental illnesses, far too few mothers, particularly low-income mothers, ever receive treatment or support. These mothers’ higher risk of depression and lower rates of treatment, along with the other interacting stresses associated with low income, put children born into poor or near-poor families at particularly high risk (NRC and IOM 2009; Santiago et al. 2012).

On May 13 and 14, 2013, the Urban Institute’s “Linking Depressed Mothers to Effective Services” research team convened an invited group of 40 distinguished state and federal policymakers, researchers, policy experts, advocates, philanthropic funders, and practitioners across a range of service systems to address this crucial challenge. The roundtable built on a series of Urban Institute research and policy papers¹ and earlier collaboration with federal experts,² to identify high payoff opportunities for systems and policy change. The meeting represented the first test of these ideas with a broader group of national, state, and local experts.

Dr. David Sanders, executive vice president for systems improvement at Casey Family Programs, gave the keynote address. He emphasized that today's service systems miss opportunities because the focus is on safety and risk issues facing children. For example, he said when case workers arrive at a home for a visit, it is not standard practice to check for signs of maternal depression—even though we know what a profound effect this can have on the mother, her children, and family. Dr. Sanders said we must reassess the skills and resources available to the child welfare investigator to ensure that he or she has support to recognize this disorder. He added that this issue requires more than just policies or laws, and should include changing interactions between families and service providers.

Dr. Sanders' comments illustrate the need for bold ideas to bridge the disconnect between what is known about maternal depression—especially among low-income mothers—and what actions can be taken to prevent, identify, and treat these mothers. He highlighted that seizing these

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¹ For more information and reports from the Urban Institute’s Linking Depressed Mothers to Effective Services project, visit the web site at [http://www.urban.org/depressed-mothers-effective-services.cfm](http://www.urban.org/depressed-mothers-effective-services.cfm).

² Federal agencies represented on the Federal Planning Committee and three federal convenings at the Urban Institute include the Administration for Children and Families (ACF), the Substance and Mental Health Services Administration (SAMHSA), the Centers for Medicaid and Medicare Services (CMS), the National Institutes of Health (NIH), the Assistant Secretary for Planning and Evaluation at HHS (ASPE), the National Academy of Sciences (NAS), the Health Resources and Services Administration (HRSA), the Food and Nutrition Service (FNS), the Department of Defense, the Department of Education, the Office of Management and Budget (OMB), and the Department of Housing and Urban Development (HUD).
missed opportunities requires connections across systems—in this case linking the child welfare and mental health service systems—to identify and treat depressed mothers.

**Why Maternal Depression Matters and What We Know**

Depression is a prevalent and treatable mental illness affecting millions of men, women, and children across the United States. The National Research Council and the Institute of Medicine estimate that 1 in 6 adults in the United States have experienced symptoms of major depression at some point in their lives, and at least 15 million children in the United States live in households with at least one depressed parent. Research also finds that the prevalence and severity of depression follows socio-demographic trends, with higher rates of depression found among racial minorities and the socially disadvantaged (NRC and IOM 2009). Key findings from Urban Institute research on prevalence, severity, and treatment among mothers with infants and young children are presented in box 1 below:

**Box 1.**

This box presents key findings from previous Urban Institute research on prevalence, severity, and treatment among depressed mothers with infants and young children:

- Eleven percent of infants born into poverty have a mother with severe depression; 41 percent have a mother with some form of depression.
- Infants born into poverty with depressed mothers are more likely than their peers with non-depressed mothers to be exposed to domestic violence and substance abuse.
- Ninety-six percent of infants in poverty with severely depressed mothers live with someone who receives benefits from the Women, Infants and Children (WIC) program; 82 percent live with someone who receives Medicaid; 70 percent live in household receiving Supplemental Nutritional Assistance Program (SNAP) benefits (previously known as food stamps).
- Among low-income mothers (those with incomes up 200 percent the federal poverty level), 1 in every 11 experienced major depression in the last year and more than 1 in every 3 did not report receiving any form of treatment.
- Compared to higher-income mothers, low-income mothers reported experiencing more severe depression to the extent that interfered with their daily life.
- Uninsured low-income mothers with depression were less likely to receive treatment for their major depression than insured mothers with depression; those on Medicaid had similar treatment rates to those with private or other insurance.

**SOURCES:** Vericker, Macomber, and Golden (2010); McDaniel and Lowenstein (2013).

The risks of untreated maternal depression on the healthy development of children can be widespread and lasting, potentially damaging a child’s cognitive, social, and emotional development as well as long-term physical and mental health. Research suggests that this could be the result of the negative effect that a mother’s depressive symptoms have on her ability to parent effectively. Parenting qualities found to be associated with maternal depression include
less responsiveness or sensitivity to a child’s needs, less mother-child interaction, and strained mother-child relationships often marked by overly intrusive and harsh parenting (NRC and IOM 2009). Additionally, the effects of a mother’s depression may interfere with her ability to take the necessary steps to ensure the health and safety for her child, such as taking her child for fewer vaccinations or well-child visits (Minkovitz et al. 2005), or using a car seat properly (McLennan and Kotelchuck 2000). Research indicates that the risk of long-term consequences for a child’s development is highest during infancy and early childhood, and it is often exacerbated by an array of socioeconomic circumstances, most notably poverty. The various stressors associated with poverty and other forms of social disadvantage may not only trigger depression in parents but also make it more difficult to receive and maintain effective treatment and support.

The lasting impact of a mother’s depression, particularly in the early years of her child’s life, has been highlighted in clinical and child-development research, as well as first-hand accounts such as those of Jacki Lyden in her memoir, Daughter of the Queen of Sheba. The roundtable group was extraordinarily privileged to have Ms. Lyden, also a contributing host and correspondent for National Public Radio’s weekend program All Things Considered, offer a deeply moving lunchtime keynote address. Her presentation touched on the lifetime effect that her mother’s bipolar illness had on her sense of truth and framework for life, highlighting the important role that adults have in the formation of a child’s reality. She also told the group about the other adults who gave her strength and helped her understand her mother’s illness, including her grandmother and a friend’s parents, underlining the role of a child’s own informal support network. Her remarks served as a powerful reminder to roundtable participants of the importance of this issue and the necessary, yet challenging, work that lies ahead for the group.

“In other illnesses this would be intolerable”

Unsurprisingly, treatment rates for low-income mothers with depression are low, as reported by Dr. Marla McDaniel, senior research associate at the Urban Institute and coprincipal investigator on this project. Greater than one-third of low-income mothers with young children who suffered from a major depressive episode in the last year did not receive any sort of treatment for their very serious condition (McDaniel and Lowenstein 2013). While measures and definitions differ across studies, clinicians and researchers in the group found this trend to be true in their own experiences: the prevalence of depression among mothers is high, and the treatment rates are low—especially among the poor.

Experts in the group emphasized the importance of addressing depression at lower levels of severity as well. One research expert said, “If you look at the literature on depression and [the impact on] kids, it’s not just major depressive disorder. There are deficits for the kids at all levels

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3 In this study, “low-income mothers” are those with at least one biological child in their household who is 5 years old or younger and with household incomes less than 200 percent of the federal poverty level. A major depressive episode (MDE) is a concentrated collection of severe depression symptoms, defined by the American Psychiatric Association as experiencing five of the nine criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) in a two-week period.
of severity … we need to think broadly.” Further, multiple participants highlighted the research evidence suggesting that major depression can be prevented, and thus it is imperative to identify mothers with mild depression symptoms and intervene effectively in order to prevent the development of major depression (NRC and IOM 2009). Dr. William Beardslee, the Gardner/Monks Professor of child psychiatry at Harvard Medical School and director of Baer prevention initiatives in the Department of Psychiatry at Boston Children’s Hospital, also called attention to the necessity to devote resources to address maternal depression in mothers with children up to age 5—not just infants and toddlers.

“Families, not individuals”

Participants also developed at length the limitations of today’s service system, where most programs are oriented to either adults or children but not both, and explored the implications of a more family-oriented treatment system that would successfully address the impact of maternal depression on both mother and child. As one health expert put it, “The service system is designed to treat individuals, not families, and places that focus on taking care of children (including health care providers) are not set up to address the needs of parents. This lack of fit includes skills, billing and reimbursement, on-site resources, etc.” At the same time, participants wanted to make sure that fixing this problem through a two-generational or family-oriented approach did not mean giving short shrift to one generation or the other. For example, a health care expert emphasized the importance of remembering the pain of the mother suffering from depression rather than justifying investment in depression treatment solely on the basis of the impact on the child. Child welfare experts, on the other hand, worried that too little attention is currently directed to the developmental outcomes for the child. Previous Urban Institute research with mothers and service providers involved with two-generational models suggested that while difficult, these approaches might be more effective at engaging mothers (Golden, Hawkins, and Beardslee 2011). Conversely, roundtable participants pointed out that if mothers don’t understand the harm that their depression has on their children, they may be less inclined to seek help or treatment.

As participants also acknowledged, a family-oriented or two-generational approach to engagement and treatment ought to go beyond mother and child, although research about just how to expand the focus is less developed. In particular, participants noted the need for more attention to fathers (as suggested in the research recommendations below) and for exploration of the role of grandparents and others in multigenerational families.5

Participants also discussed the effect of negative social stigma associated with mental illness. Many mothers may not recognize or seek treatment for depression because of the stigma attached to it. In addition, given the complex problems low-income mothers experience, one researcher at

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4 Dr. Beardslee serves as an expert consultant on the Urban Institute’s Linking Depressed Mothers to Effective Services research team.
the roundtable thought that “some of these women might find [depression] irrelevant in the context of other issues they have.” Participants discussed the complex interaction of stigma and the real-life barriers to quality care experienced by low-income and minority families; that is, would mothers seek treatment if they had better experience of health, mental health, and social services interactions with people they trusted? Many participants felt that these obstacles required a two-prong strategy: improving public services while also finding ways to reach out to local communities and to mothers themselves to hear their perspectives and to educate and engage them. This discussion of engagement was a key component of the roundtable discussions on both days.

**A Vision of Effective Services—and How to Get There**

The rich discussions on the first day of the roundtable yielded a clear vision of the service system that participants were looking for. They sought a network of services that would include the following features:

- oriented to the family, not just the individual, and in particular to parents and young children;
- grounded in and respectful of natural supports within families and communities;
- characterized by many opportunities to access services (e.g., pregnancy and perinatal periods, but also early childhood, when a child’s challenges might prompt a mother to seek treatment);
- characterized by effective, evidence-based interventions and well-trained staff in each service system;
- aligned with each individual service system’s mission and goals (e.g., better health, children’s development, or prevention of abuse and neglect); and
- supported by financing mechanisms that get the incentives right and promote each system’s involvement

To achieve this ambitious vision, participants honed in on recommendations for reform in existing systems that are particularly well-positioned to better serve mothers and children. To provide a convenient way to think across the many different service systems that touch these families, participants worked from the system and policy map developed in advance by the Urban Institute research team and federal partners (figure 2). The map identifies several service systems that could play important roles and identifies some of the support that they might need. One group—including home visiting programs and the Women, Infants and Children (WIC) nutrition program—sees many low-income mothers with young children, providing an important opportunity to identify and engage mothers experiencing depression. A second group—including primary care health services and mental health services—offers the opportunity for treatment when mothers are identified.
Improving Outcomes for Young Children of Depressed Mothers: A System and Policy Map

OUTCOMES
Reduce levels of maternal depression symptoms
Reduce child abuse and neglect
Improve young children’s developmental outcomes

System Supports Needed for Effective Service Delivery
1. Provider training and capacity-building
2. Funding stream for services available to these mothers
3. Support for provider collaboration, both as part of teams and in hand-offs
4. Support for parent access (child care, transportation, work schedules, etc.)
5. Supportive mission – clear articulation of role for maternal depression.
6. Data tracking for operations and assessment/ fine-tuning
7. Community outreach/ messaging
8. Research/ knowledge building
9. Healthy Physical Setting
10. Support for Fiscal and Policy Complexities/Service Integration

Service Opportunities
- Prenatal Care
- Substance Abuse Substance Abuse
  Hospital Treatment Centers
  Pediatrician CWS and CPS
- Primary Care Criminal Justice System
- Home Visiting Early Care/Education
- Early Intervention WIC
- Place-Based Strategies
  Mental Health
  Family Services
  Primary Care
  Home Visiting with Clinical Support

Figure 2
Opportunities to Identify and Engage Mothers

The roundtable particularly focused on home visiting programs, WIC and other nutrition assistance programs, and child care and early childhood programs as opportunities to engage mothers with depression. Home visiting programs, in which a professional or paraprofessional regularly visits the homes of pregnant women and new mothers to offer parenting support and education, offer promising opportunities for identification and engagement because of the trusting relationships they develop with mothers, their connection to the whole family, and their role of connecting mothers to other services (Golden, Hawkins, and Beardslee 2011).

In his presentation on the Maternal, Infant, and Early Childhood Home Visiting Program, a federal program that provides the states with $1.5 billion over five years to support and enhance home visiting programs, Dr. Michael Lu, associate administrator for the Maternal and Child Health Bureau in the Health Resources and Services Administration (HRSA), highlighted both opportunities and challenges. In particular, Dr. Lu highlighted three issues for attention: reaching the mothers who most need help, in part by developing effective referral paths from other services such as WIC and pediatric care; helping home visitors identify depression and understand how it may affect the outcomes they (and mothers themselves) are seeking for both parent and child; and connecting to, supporting, and providing high-quality treatment. As he noted, home visitors cannot improve outcomes if there is not treatment available.

Potential solutions to the lack of treatment concern include improving the capacity of home visitors to support parents themselves, through mental health consultation to home visitors; connecting mothers to high-quality office-based treatment; or developing home-based interventions provided by skilled clinicians in partnership with home visitors. Dr. Robert Ammerman, scientific director at Every Child Succeeds and professor of pediatrics at Cincinnati Children’s Hospital Medical Center, presented the model that he and colleagues have developed and tested, In-Home Cognitive Behavioral Therapy (IH-CBT), which places CBT-trained therapists with master’s-level credentials in homes in partnership with home visitors after a mother has screened positive for major depressive disorder. Specifically adapted for the home visiting population and setting, IH-CBT has led to an array of positive outcomes for mothers, including reductions in the self-reported and clinical ratings of their depression symptoms (Ammerman et al. 2013). Participants discussed whether providing mental health consultation and training to home visitors could reach any of these mothers as an alternative to the higher-credentialed in-home services or whether consultation should be conceived of as a complementary strategy rather than a substitute to help home visitors respond to mothers with lesser symptoms and more skillfully support the therapists’ intensive work.

Participants also highlighted the obstacles that must be addressed to successfully “scale-up” the home-visiting model to support the greater population of mothers. For example, as highlighted

6 Dr. Lu noted that all three issues are explored in Golden and colleagues (2011), http://www.urban.org/publications/412316.html.
by implementation science, plans to expand IH-CBT and other evidence-based programs need to include training and workforce development, quality control and monitoring, financial sustainability, and other systems-level supports—not just replication of the direct services themselves.

Dr. Janey Thornton and Marta Kealey from the U.S. Department of Agriculture addressed the role of the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and other nutrition programs in identifying and engaging mothers. One reason to consider these programs is the extraordinary reach of WIC among depressed mothers with young children, highlighted by earlier Urban Institute research that found 96 percent of infants with severely depressed mothers lived in a household served by WIC (Vericker, Macomber, and Golden 2010). However, the challenges the WIC program faces include competing priorities, a variety of topics that need to be addressed in time-limited appointments, and a lack of mental health referral resources. WIC has been working on a multipronged strategy, including consultation with the Substance and Mental Health Services Administration (SAMHSA) that grew out of previous working group meetings. Its strategies include adding depression screening to the assessment tool used to assess nutrition risk, educating mothers and staff on the important link between breastfeeding and depression, and providing state WIC programs with solid resources to help them design their own approaches to screening and develop good treatment linkages. Participants agreed that collaboration at the federal level and at the service level with mental health services systems must continue to develop in order to provide the “warm handoff” necessary to link mothers who have been identified as depressed through the WIC program with the effective treatment they need.

Linda Smith, deputy assistant secretary and interdepartmental liaison for early childhood development in the Administration for Children and Families (ACF), spoke of the potential opportunities through early care and education programs, which have relationships with both children and parents. However, a particular challenge they face is the very low education level of many staff—a high school education, rather than the professional skills of, for example, nurse home visitors. As a result, a tool kit for the child care workforce needs to focus in on appropriate strategies. She also noted that depression is likely an issue for the child care workforce itself, and that collaboration with other systems, such as health and mental health, could offer opportunities for staff as well as children and parents.

**Opportunities to Treat Mothers**

A significant portion of the roundtable discussion centered on health reform, specifically the immediate and long-term opportunities under the Patient Protection and Affordable Care Act

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7 Existing research finds that breastfeeding mothers show lower levels of depressive symptoms than mothers who bottle feed, and mothers with depressive symptoms who bottle feed may discontinue breastfeeding earlier than non-depressed mothers. There is limited evidence suggesting a relationship between depressive symptomology and breastfeeding initiation (Dennis and McQueen 2012).
Panelists told the group that the ACA offers crucial opportunities both to improve access and to improve the quality of mental health services to low-income mothers. Dr. Sherry Glied, formerly Assistant Secretary for Planning and Evaluation (ASPE) at the U.S. Department of Health and Human Services, highlighted three types of opportunities from the ACA: expanded coverage for low-income parents, coverage for screening and prevention, and opportunities to improve quality and delivery systems. She urged participants to “think about the world as it will be post-ACA” in order to seize these opportunities.

Expanded coverage through state options for Medicaid expansion and the new health insurance marketplaces will address one of the major obstacles faced by this population: the discontinuity of health care coverage that new mothers currently face under current Medicaid policies. Today, during pregnancy and immediately after birth, low-income mothers and their children both have Medicaid coverage, but shortly after giving birth, most mothers lose this coverage because of very low income eligibility standards for low-income parents. As a result, many are left uninsured soon after delivery, although their children are still covered.

Once the ACA takes effect, many low-income mothers in the 26 states that (as of the time of the roundtable) have chosen to expand Medicaid to individuals with incomes up to 135 percent of the federal poverty level will have new access to health insurance coverage (Kenney et al. 2013). Roundtable experts emphasized that all states are expected to have increases in Medicaid participation among low-income mothers who are currently eligible but not participating. In addition, the ACA provisions, along with recently issued regulations to ensure parity for mental health and medical coverage, will ensure that the health insurance package includes appropriate services.

Both Dr. Glied and Dr. Larke Huang, senior advisor for children, youth, and families in the Administrator’s Office of Policy Planning and Innovation and director of the Office of Behavioral Health Equity at SAMHSA, also highlighted a recent study of Medicaid coverage in Oregon that showed substantial improvements in participants’ depression as a result of insurance coverage alone. Following year two of the Oregon health insurance experiment, the study finds that observed rates of depression decreased by 30 percent as a result of Medicaid coverage (Baicker et al. 2013). Dr. Glied noted, based on the scale of those impacts, “Giving people insurance is about as good as anything we’ve ever figured out how to do.”

Dr. Glied and Dr. Huang also emphasized opportunities in the ACA and other legislation to promote screening for maternal depression. Depression screening is now covered without cost-sharing because it is included in the package of preventive services recommended by the U.S. Preventive Services Task Force, and parental depression screening during infant pediatric care is now part of the Bright Future Guidelines from the American Academy of Pediatrics. As part of her broader point about grasping the new world after the ACA, Dr. Glied suggested thinking about interventions that could build on this new emphasis on screening and fit into the
primary care context—for example, screening, a brief intervention, and referral for those who need more help.

However, increasing insurance coverage and improving screening are only part of the puzzle; other crucial elements are enhancing quality and engaging mothers themselves. Dr. Jeanne Miranda, offering lessons from her extensive work designing and implementing interventions for low-income mothers, highlighted the need to focus on quality: “There is a lot of bad mental health care in the community.” She also emphasized the relationship between improving financial access to treatment and improving engagement; once treatment is available, it is possible to ask parents and community members about the concerns that hold them back and target education to the right topics and trusted partners. Before treatment is actually available to all parents who need it, the value and ethics of increasing engagement are a lot less clear: parents risk coming forward with their needs but receiving no treatment.

Dr. Embry Howell’s presentation framed a lively discussion about the barriers in today’s Medicaid program to quality and integrated services for mothers with depression and the opportunities offered by the ACA (Howell, Golden, and Beardslee 2013). Issues include reimbursement and billing obstacles, disconnects between primary care and mental health treatment, and a lack of providers needed to meet today’s demand for mental health services, let alone the increasing demand anticipated with expanded coverage. Dr. Howell highlighted various mechanisms in the ACA designed to encourage states to improve service delivery and reduce fragmentation between physical and mental health service delivery and between care for adults and for children. Opportunities highlighted by Dr. Howell include federal funding for integrated health care models, such as the advanced primary care practice demonstrations (funded by the Center for Medicaid and Medicare Innovation), the health homes state plan amendment, SAMHSA’s integrated services demonstration, patient-centered medical homes, and state redesign of managed care (Howell et al. 2013). Dr. Howell’s list led to a rich discussion of current activities at the national, state, and local level to take advantage of these opportunities. Many participants felt that working relationships between mental health, Medicaid, and public health officials at the federal level were strengthening but that a great deal of detailed work remains to be done. At all levels of government, participants highlighted the extraordinary complexity and uncertainly of the issues and the new playing field created by the ACA. Dr. Glied’s overall advice, echoed by others, was to try many different strategies, because there is no answer yet about how best to strengthen and integrate service delivery and align financing for depressed mothers.

Finally, multiple participants expressed concern about the overall availability of mental health providers. Participants noted that funding in the ACA for workforce development initiatives is a step in the right direction. An HRSA participant noted his agency’s role in filling workforce gaps, through programs like the National Health Service Corps. He highlighted the opportunities
for both integrated services and workforce improvement through collaboration among CMS, SAMHSA, and HRSA.

**An Agenda Going Forward**

Participants developed a rich agenda of practical next steps, some of which have already moved forward since the meeting. In framing this agenda, they not only recommended actions for others but also made commitments themselves. For example, state and county officials described meetings they would call to bring strategies for identifying and treating maternal depression into their jurisdiction’s planning for ACA implementation, child welfare reforms, and mental health services.

More broadly, the participants proposed an approach to cross-system change that included both **improvements within systems** (e.g., initiatives to help child welfare practitioners understand the implications of mothers’ depression) and **improvements across systems** (e.g., training initiatives that could promote a shared understanding of principles across mental health, primary care, and social services professionals and paraprofessionals). Special categories of action steps had to do with **the implementation of the Affordable Care Act, research and data, financing and financial incentives, populations that need special attention, and engagement strategies.**

**Improvements within service systems and policy areas**

Participants saw many opportunities to use the information about maternal depression to enhance service delivery within their own organizations. The following recommendations were included:

- Use the information about maternal depression to improve service design for community, county, and state early learning and child welfare programs. For example, consider adaptations to Child Protective Services (the front end of the child welfare system) that could include mental health consultation from the very first moment.
- Infuse this knowledge into existing work that addresses youth substance abuse, pregnancy, and teen parenting.
- Consider a special issue of a leading child welfare journal to generate research and practice attention to maternal depression and effectively disseminate key insights.
- Consult with experts from the group to design an improved home visiting strategy for very low income mothers likely to experience depression and trauma, as part of an ongoing demonstration initiative.
- Federal officials could broaden distribution of materials and technical assistance—for example, provide letters written to inform state health officials about mental health opportunities to the full range of partners who work with mothers and young children—or work jointly to develop new materials targeted to the needs of each group of stakeholders.
Improvements across service systems and policy areas

As participants discussed what they would need to drive change in their own systems, and what they thought others would need, they began to crystallize strategies where federal and outside experts would work jointly across fields to develop effective cross-cutting materials and use them in demonstrations and technical assistance. Examples of these ideas include the following:

- CMS and SAMHSA joint development and dissemination of one or more informational bulletins on maternal depression for state Medicaid directors and mental health directors, to summarize evidence regarding the importance of addressing maternal depression, effective treatment for depression, and opportunities to integrate this knowledge into state Medicaid plans. The bulletins could be modeled on previously successful joint letters to state health officers, such as a May 2013 bulletin regarding behavioral health services for children, youth, and young adults with significant mental health conditions (Mann and Hyde 2013).

- A package of intervention recommendations and treatment options (the depression “tool-kit”), tailored to a diverse audience to disseminate what is known about evidence-based practices and interventions for mothers with a range of depression symptoms, could help make the knowledge useful across systems. For example, Medicaid officials and others with responsibility for financing could better understand which treatments have a solid evidence base, practitioners in different programs could better understand how they could play a useful role, and program and policy leaders could better see what gaps to fill in. Already in the weeks since the roundtable, a small subgroup of participants has met to further conceptualize and develop this product.

- Federal agencies could also jointly fund and support ongoing training and technical assistance activities to help connect professionals and paraprofessionals from different fields around common principles for helping mothers with depression. For example, federal agencies could consider jointly funding an initiative to bring primary care and mental health clinicians together, or could engage ACF and include home visitors, child welfare staff, and/or early childhood teachers. A model for this work could be ACF’s and SAMHSA’s joint funding of a successful ongoing technical assistance center to bring together substance abuse and child welfare agencies and professionals.

- Build on existing initiatives to provide more support for WIC clinics and home visiting programs as settings to identify and engage mothers with depression and to link them to prevention and treatment. Links between relevant federal agencies (particularly SAMHSA, HRSA, FNS, and ACF) have already emerged as a key result of earlier discussions, and participants proposed to intensify the work in the coming months.

- Partnerships between small groups of federal officials and interested local settings to develop pilots; for example, the Children’s Bureau, CMS, outside experts, and one of the participating counties to pilot mental health consultation in a child welfare setting.
Medicaid and the Affordable Care Act

Participants were struck by the extraordinary opportunities offered by the ACA, an enormous change with the potential to influence treatment of depression across several service systems, including primary care, mental health, and related child welfare and social services programs. Yet they also remarked repeatedly that there were few connections in their own worlds between the people thinking about the ACA and the people thinking about the needs of low-income children and families. Health care experts in the group thought the problem was too little engagement in health reform by nonhealth experts who focus on children and families; nonhealth experts felt they had trouble getting in the door, if only because they didn’t know enough to ask the right questions. As a result, suggestions included ways to build in learning and joint involvement in the work, as well as immediate action steps:

- Participants made personal commitments to get engaged in the health reform implementation planning in their jurisdictions or (for those on the health side) to ask human services and mental health officials to get more involved, in order to develop effective strategies to address maternal depression. A local Medicaid director made a commitment to get better at explaining Medicaid’s parameters to mental health and social services colleagues, rather than expecting them to know what they want. One participant proposed to write a blog about maternal depression as part of a broader strategy connecting experts and advocates who care about low-income children and families to health reform implementation.

- More broadly, participants suggested ongoing mechanisms to keep health, mental health, and child and family experts talking about maternal depression and the ACA. Ideas ranged from those spearheaded by the federal government, such as an ongoing working group of representatives from all the relevant agencies, to continuing foundation-supported meetings.

- Participants agreed with former Assistant Secretary Sherry Glied that there should be active experimentation using all the mechanisms that the ACA offers to provide effective mental health services integrated with primary care to mothers with depression. They argued that there is not yet enough information to know which mechanism will work best for which families.8

- Participants also highlighted the need for continued work to reduce the unintended consequences of existing reimbursement and billing requirements in many states’ Medicaid plans that hinder integration of mental health and primary care. This includes prohibitions of same-day billing for multiple services (such as a primary care visit and a mental health visit), or limitations on providers other than MDs (e.g., master’s-level mental health clinicians).

- Participants recommended an immediate focus on managed care contracts and quality measures (including federal technical assistance). With so many states using managed care

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8 Besides the opportunities already highlighted in Howell, Golden, and Beardslee (2013) (e.g., integrated health homes, patient-centered medical homes, and accountable care organizations), the group added the State Innovation Models Initiative. A first group of these initiatives has already been awarded, and there may be opportunities to add a focus on maternal depression to their plans.
for Medicaid, and particularly for newly added Medicaid expansion participants, the exact design of those contracts will be critical. A Medicaid director participating in the roundtable planned to explore this idea immediately, as her jurisdiction was about to re-procure its managed care contracts.

**Additional financing and financial incentives**

The most important financing mechanism discussed by the group was expanded Medicaid support for mental health services through the Affordable Care Act, yet other financing recommendations included reinvesting any ACA savings in important mental health and social services that are not supported by Medicaid and exploring the potential role of social impact bonds in supporting prevention and treatment. Some participants worried that the expansion of eligibility for Medicaid under the ACA would erode support for other funding streams, such as national and state support for home visiting and public health, because legislators would believe that the spending is duplicative; thus, clarity and advance planning to define the needed support for these families will be crucial.

**Furthering our understanding of the issue: implications for future research and data**

While participants believed that we know enough to take action, they also strongly recommended continued research and data analysis to fill gaps and guide future expansion. Among the key questions and ideas identified by the group were the following:

- How does depression interact with other child and family circumstances, particularly in a two-generational context? What possible partnerships could exist to mine relevant datasets with this information?

- What patterns of treatment quality or gaps in treatment exist? Researchers were eager to explore local and state partnerships on this topic to identify Medicaid and other data sets that contain information about the intensity and duration of services.

- How can maternal depression be addressed through integration with existing evaluations? (e.g., the evaluation of CMS’s Strong Start initiative to address the perinatal period.)

- Populations that need special attention: What are the prevalence and severity of depression among fathers, and what is the impact of parental depression on children? Other populations requiring further exploration may include immigrants and refugees, teen parents, parents with co-occurring substance abuse problems, and parents and families that have experienced trauma and violence.

- How do existing evidence-based approaches work in different settings and for different populations? In particular, how well can they be adapted for staff with different levels of professional skills?
In what ways can public agencies and community partners engage mothers and reduce stigma? One idea that roundtable participants wanted to explore is the role of technology in reaching young mothers; for example, through telemedicine or “apps” on cell phones that track a mother’s mood and behavior changes.

What is the return on investment for treating maternal depression? Is showing a net savings (how the benefits to children and mothers may lead to reduced medical, mental health, special education, and other costs in later years) helpful, or is translating these benefits into dollars an ineffective approach?

Conclusion

“I believe the stars are aligning... We have not had an opportunity like this to fit together the pieces that are necessary on the front lines.”

Effectively identifying, treating, and preventing depression among low-income mothers is a public health opportunity that cannot be missed. There is no doubt that across the many sectors, policy areas, and levels of government represented at this roundtable, there is shared enthusiasm for moving forward with this important agenda. Despite the large-scale coordination and mobilization that will undoubtedly be required in this effort, the process begins with thinking about small changes and opportunities in the immediate future. The discussions at this roundtable led to a variety of these concrete action steps, some of which have already been carried out and many of which are currently under way.

Going forward, the roundtable participants saw this moment as one of great opportunity, given the burgeoning research knowledge about the scope and impact of the problem, the financing and service delivery opportunities associated with the Affordable Care Act, and the chance to align new ideas in fields as diverse as home visiting, primary health care, behavioral health care, early childhood programs, and nutrition programs. Participants felt strongly that the broader world of policymakers, researchers, advocates, and public and philanthropic funders who care about low-income families need to move promptly and aggressively to seize this opportunity to improve parents’ lives and children’s life chances.
References


