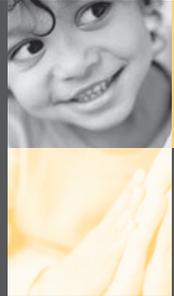


Home Visiting and Maternal Depression

Seizing the Opportunities to Help Mothers and Young Children



THE URBAN INSTITUTE



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Executive Summary

Undetected and untreated parental depression places millions of children in the United States at risk each day. Parental depression can be especially damaging for the growth and healthy development of very young children, who depend heavily on their parents for nurture and care. Treating parental depression and addressing its negative effects early in a child's life could improve that child's development. Several safe and effective depression treatments are available, but the delivery of these services, especially to low-income families, requires new and innovative approaches.

This guide looks at one promising approach: using home visiting programs to identify depressed mothers and connect them and their families to services. Home visiting programs generally involve regular visits to pregnant women and mothers of young children over several months to several years by a paraprofessional or professional (such as a nurse or social worker), with goals that may include enhanced parenting skills, better maternal and child health, achievement of maternal education and employment goals, postponement of subsequent births, and enhanced child development. Researchers have identified different home visiting programs that are backed by solid evidence of improved results, and new funding to expand the programs is included in the Patient Protection and Affordable Care Act (or ACA).

However, despite these programs' promise, the evidence about their current success specifically for depressed mothers and their children is mixed, leading researchers to call for better information about how to redesign or supplement services. This guide helps fill that information gap. By drawing on research as well as new interviews with low-income mothers, home visitors, and other service providers, this guide offers practical insights about how home visiting programs can enhance their own work and their links to other programs in the community—such as mental health treatment—to better serve depressed mothers and their young children.

Low-income mothers of young children, as well as home visitors themselves and other service providers, agree with researchers on the tremendous

potential of home visiting services to reach mothers, build a trusting relationship, and enable moms to get help with depression. The mothers interviewed believe that depression is widespread in their communities among mothers of young children, and many would advise a depressed friend to seek help somewhere. While they do not agree on a single institution or person to go to for help with depression, they do articulate the kind of relationship they look for: one where the other person—whether neighbor, family member, or service provider—has earned their trust through consistency over time.

Yet, interviews and research evidence also make clear the large challenges that face home visit programs in responding to maternal depression—and the practical options that exist for addressing each challenge.

1. **Reaching the mothers who most need help.** As programs expand with new ACA funding, communities should seize the opportunity to use data to learn about and target services to depressed mothers of young children, develop effective referral and recruitment paths that connect depressed mothers with home visiting, and offer many such paths for mothers with young children of different ages.
2. **Helping home visitors identify depression and talk to mothers about its implications and treatment.** Home visiting programs should consider depression screening as part of a more comprehensive approach to engaging and helping depressed mothers. Programs should explain to staff how identifying and treating a mother's depression connects to the core home visiting mission, consider training home visitors to speak honestly to a mother's concerns about child protective services, complement one-on-one attention during home visits with group or community strategies that are not stigmatized, and seek out resources to overcome some of the mothers' practical barriers while also connecting mothers to depression treatment.
3. **Connecting to, supporting, and providing high-quality treatment.** Researchers are studying two promising approaches to this challenge:



developing home-based mental health services that partner with home visit programs, and providing skilled mental health consultation and supervision. Programs should consider combining the two approaches to reach the most families.

4. **Attending to young children's development as well as mothers' treatment.** Keeping a genuine focus on both the child's and the mother's needs is not easy or automatic. Programs should consider partnering (for example, between Nurse-Family Partnership and Early Head Start), multidisciplinary collaborative teams, and cross-training as potential strategies.
5. **Offering ongoing help after home visiting.** Programs should consider an explicit transition

plan for mothers with depression leaving home visiting programs.

Researchers have clearly demonstrated the widespread prevalence of maternal depression and the risks to young children who grow up with mothers with untreated depression. Studies have also shown the clinical effectiveness of treatment once depression is identified. The challenge for policymakers and program leaders is to translate this clear research evidence into service delivery approaches that make a difference. Today, the visibility of home visiting and the opportunity for additional resources offer an opportunity to build on innovations from the field and significantly improve young children's life chances.



Home Visiting and Maternal Depression

Seizing the Opportunities to Help Mothers and Young Children

Undetected and untreated parental depression places millions of children in the United States at risk each day. Parental depression can be especially damaging for the growth and healthy development of very young children, who depend heavily on their parents for nurture and care. Treating parental depression and addressing its negative effects early in a child's life could improve that child's development. Several safe and effective depression treatments are available, but the delivery of these services, especially to low-income families, requires new and innovative approaches (National Research Council and Institute of Medicine [NRC and IOM] 2009).

In this guide, we look at one promising approach: using home visiting programs to identify depressed mothers and connect them and their families to services. We focus on mothers because they are often the primary caregivers, but we also recognize the seriousness of paternal depression.

What Are Home Visiting Programs?

In the United States, an estimated 400 publicly and privately funded home visitation programs now reach 500,000 children (Ammerman et al. 2010). These programs generally involve regular visits to pregnant women and mothers of young children over several months to several years by a paraprofessional or professional (such as a nurse or social worker), with goals that may include enhanced parenting skills, better maternal and child health, achievement of maternal education and employment goals, postponement of subsequent births, and enhanced child development. Some programs, such as Nurse-Family Partnership and Healthy Families America, are built on nationally designed curricula and approaches, while others are locally designed or represent unique local variants of a national approach. Some programs, such as Early Head Start and Head Start, offer home visiting in conjunction with other services (such as center-based early childhood classes) either as an option or as one element of a program.

Researchers have found solid evidence that several approaches to home visiting can produce results for mothers and young children in such areas as prevention of child abuse and neglect, child health,

maternal health, child development and school readiness, family economic self-sufficiency, and positive parenting practices. A recent review identified seven programs as evidence based: Early Head Start, Family Check Up, Healthy Families America, Healthy Steps, Home Instruction for Parents of Preschool Youngsters, Nurse-Family Partnership, and Parents as Teachers (Paulsell et al. 2010).

Thinking about maternal depression in the context of home visitation programs is particularly timely. The Patient Protection and Affordable Care Act (ACA) of 2010 provides \$1.5 billion over the next five years through the Maternal, Infant and Early Childhood Home Visiting Program to improve the health of mothers and children. These funds will be administered by the Health Resources and Services Administration in partnership with the Administration for Children and Families as a section of the Title V Maternal and Child Health block grant. Prompted by this new initiative, states are planning their approaches to expanding and strengthening home visitation.

However, despite these programs' promise, the evidence about their current success specifically for depressed mothers and their children is mixed, leading researchers to call for better information about how to redesign or supplement services (Ammerman et al. 2010). This guide helps fill that information gap. By drawing on existing research as well as new interviews with low-income mothers, home visitors, and other service providers, this guide offers practical insights about how home visiting programs can enhance their own work and their links to other programs in the community—such as mental health treatment—to better serve depressed mothers and their young children.

After summarizing basic information about maternal depression and its effects on children, the three main sections of the guide explore

1. why home visiting offers an opportunity to reach depressed mothers with treatment and support services;
2. what mothers report are the biggest needs and challenges of families coping with depression in low-income communities; and



3. what it will take to revamp home visiting programs and their links to other services to address those needs.

Throughout, the guide includes new evidence about parent and service provider perspectives on maternal depression drawn from weeklong site visits to three cities: Chicago, IL; Cleveland, OH; and Greensboro, NC.¹ Each visit included focus groups with low-income parents (two groups in each city) and interviews with service providers. Most focus group participants were African American and about 10 percent were Hispanic, with one focus group conducted entirely in Spanish.² We asked several different organizations to invite mothers with a child under the age of 4 to attend the focus groups; some parents had participated in home visiting programs, while many others had not. In the three cities, we conducted 54 interviews with service providers who worked with low-income mothers and their young children, including home visitors, early childhood teachers, family advocates, Special Nutrition Program for Women, Infants, and Children (WIC) nutritionists, pediatricians, family practitioners, nurses, mental health counselors, and social workers in health and mental health clinics and practices.

Maternal Depression: Prevalence, Treatment, and Effect on Children

Depression is widespread, particularly among low-income mothers. As many as 15 million children, or one out of every five, live with an adult who had major depression in the past year (NRC and IOM 2009). Our companion study, which for the first time uses a national dataset to look at maternal depression (the Early Childhood Longitudinal Study Birth Cohort or ECLS-B), shows a strikingly high rate of depression. Among infants in families living below the poverty level, one in nine has a mother reporting severe depression symptoms. And more than half (55 percent) of all infants in poverty are being raised by a mother reporting some form of depression, including mild and moderate depression symptoms (Vericker et al. 2010).

Maternal depression frequently coincides with other risks, including other mental health and substance abuse diagnoses, chronic medical conditions, and such social disadvantages as poverty and domestic violence (NRC and IOM 2009). According to the ECLS-B study, among infants in poverty with severely depressed mothers, 16 percent of mothers

report recent physical abuse, and 14 percent report binge drinking in the previous month (Vericker et al. 2010).

Maternal depression affects children's development. Untreated depression interferes with a parent's ability to be positive and nurturing and can impede a parent's ability to ensure consistent care in a safe environment. Depression in parents is associated with poor social development and poor physical, psychological, behavioral, and mental health for children (NRC and IOM 2009). Research also documents depression's link to child abuse and neglect. The incidence of depression among families involved with child welfare systems is high. A national study reveals that one in four parents who were investigated by child welfare systems, but whose children were not removed, reported experiencing major depression in the past year (DHHS 2005).

Fortunately, maternal depression can be treated. Medication, psychotherapy, behavioral therapy, and alternative medical approaches can be used to treat depression in adults safely and effectively. However, the impact of these treatment interventions on parental depression has not been rigorously studied among vulnerable populations, such as low-income women (NRC and IOM 2009). For these particularly vulnerable populations, researchers find that supplementing the usual depression interventions may be necessary. For example, one study finds evidence that for young, low-income minority women, an approach with intensive outreach, child care, transportation, and encouragement to comply with evidence-based medication or psychotherapy works better than "usual" care on its own (Miranda et al. 2003). Further, the National Research Council and Institute of Medicine's 2009 report recommends that a focus on positive parenting and child development should be paired with treatment of parental depression to prevent the child's adverse outcomes, enhance the parent's interactions with the child, and help engage the parent in treatment.

Despite the prevalence of maternal depression among low-income mothers and its effects on children, many mothers still do not receive help. For over two-thirds of infants with mothers living in poverty and reporting severe depression symptoms, their mothers did not speak with a psychiatrist, psychologist, doctor, or counselor in the past year about an emotional or psychological problem (Vericker et al. 2010). Getting help to depressed parents, especially those with young children, is

therefore a major opportunity to enhance children's development, ensure their safety, and prevent abuse and neglect.

Home Visiting: The Opportunity

Researchers, practitioners, and parents agree that home visiting offers promise for reaching and helping vulnerable mothers, specifically those with depression. Rather than asking a depressed mother to find the energy to persist on the phone until she reaches a doctor or counselor, find child care and transportation, and keep the appointment as planned, the home visitor seeks her out and can help her navigate these obstacles. Home visitors are often skilled at and trained for building warm and supportive relationships, which ought to help engage mothers with depression. And since home visiting programs are generally designed to reach mothers during pregnancy or shortly after the baby is born, they offer one of “the earliest portals through which sizable numbers of high-risk mothers come to the attention of service providers” (Ammerman et al. 2010).

Many parents in our focus groups told us they would suggest home visiting as a source of help if they knew a depressed mother of young children.³ They emphasized not only the convenience of having someone come to their home, but also the comfort: home is where the parent feels in control. As one parent said:

They come to your home where you are comfortable. Because I'll tell you right now, they don't come out in suits. They come out dressed like whoever. They don't make you feel uncomfortable . . . If you smoke, smoke, whatever. It's not going into somebody's office. It's almost like sitting down talking to a friend.

However, one parent wasn't convinced that any service provider could make her feel comfortable: “I just really don't like it. I can't deal with them. They're too scary.”

Other parents emphasized the relationship with the home visitor. “They have therapists that come out to your house as well as somebody that comes out to see your child,” one parent said. “There is also somebody who comes just for you, and I still have a relationship with them.” Some parents believed it was advantageous for a home visitor to see a mother

in her real-life context. They thought a home visitor would be less likely than a professional in an office to think a depressed mother was going to hurt herself or her children and needed to be reported to child protective services. Other mothers trusted their home visitor because, unlike a medical doctor, the home visitor has time to sit and listen, allowing them to go into “more detail.”

The home visitors we interviewed agreed that going to the home and getting a close-up view of a family were both key advantages of the model:

We come to their house, which is a huge benefit. Trying to get any place for half these women [costs] \$2.50 for a bus ticket on a daily basis . . . Being able to go in the home and see the conditions, how they are living, whether they keep the blinds closed, whether they get dressed, and whether they keep the appointment [is a benefit].

Sometimes, that close view can lead to identifying challenges early:

The home educator is the first to identify these issues [maternal and family stresses of all kinds] because they're there Monday to Thursday. Sometimes the mom doesn't say, but the home educator observes. Sometimes they see the mom has marks or bruises, or there are marks on the baby, or they find the mom crying.

But while researchers, practitioners, and parents all see a great potential for home visiting to reach depressed mothers, they also see plenty of pitfalls. Home visitors not specially trained to address mothers' depression can face many challenges in responding effectively. The research evidence taken as a whole indicates that “home visitation services alone are insufficient to bring about substantial improvement in depression” (Ammerman et al. 2010, 197 and 199). And the best combination of mental health services, needed to treat depression in at least some mothers, with the alternative kind of support offered by home visitors isn't obvious or easy to do.

Therefore, the question addressed in the remainder of this guide is how to confront these challenges and build on the promising start that home visiting offers. To ground the discussion of challenges and solutions, we begin with a more detailed look at the perspectives of mothers.



Mothers' Perspectives on Depression and Treatment

Low-income mothers of young children view depression as a serious problem for their peers, and they have many ideas about what works and what doesn't work to address it.

Mothers Believe That Depression Is Widespread

In each of our six focus groups, mothers reported that they believe depression, stress, and sadness are widespread among mothers of young children in their communities. Mothers reported that, among the women they know, feeling depressed is “common” or “pretty typical.” Some focus group participants thought that as many as 80 percent of the moms in their community feel depressed. Several women attributed this estimated incidence in part to high levels of community violence, domestic violence, and financial stress, as well as the absence of family support.

Many Mothers Would Advise a Depressed Friend to Seek Help

While their perspectives on seeking help are complex, many mothers in the focus groups said they would advise a depressed friend to seek help somewhere, especially because depression affects children. Some mothers said the negative effects on children make maternal depression particularly grave and serve as a motivation for seeking help. As one mother said,

If someone stays alone in their house, in their world, and they don't reflect on their kids and they don't look for help, it is a problem. The situation doesn't get better, and it hurts the kids and other people. It is a big problem when you don't look for help or information.

These women would encourage a depressed friend to “think about the child” or tell her “Your kids shouldn't suffer because of what you're going through” to motivate their friend to seek help.

Mothers Have No Consensus on a Single Source of Formal or Informal Help

Mothers differed on where to go or whom to ask about help for depression. No single source of help, formal or informal, is trusted universally.

Instead, focus group participants agreed on the characteristics of the person they would count on to help them: someone with whom they have had a caring and trusting relationship over a period of time. Participants applied these criteria to both formal service providers and informal sources of help, such as family or church members. A long-term relationship is important because the person knows the mother well, understands her relationship with her children, and won't jump to conclusions from one disclosure. As one woman explained,

I have found a good pediatrician . . . I'd probably feel comfortable talking to him about it [depression], and he knows me better . . . and sees how I interact with my child. So if I tell him I was feeling really shitty the other day . . . , he knows not to assume that means I'm . . . going to take myself and my kid out.

Another mother explained that seeing the same provider many times allows the provider to see changes in her mood from one appointment to the next.

Mothers also trust providers who “go above and beyond” their duties, who “really care and want to help you” instead of being “really just there for the paycheck.” One mother came to trust her doctor when he followed up on the referral calls he had asked her to make: “He was calling to check up on me. ‘Did you go to such and such?’ I thought that was somebody I could turn to.” In addition, several mothers said they didn't want to be judged for being young or inexperienced parents—a concern that would discourage them from seeking help. “Professional people are very scary to talk to when you are young,” one mother said, “because they are already looking at you like, ‘Oh, you are young. You don't even know what you are doing.’”

Mothers sought out trustworthiness and non-judgmental attitudes in informal helpers as well as professionals. They appreciate someone who takes their concerns seriously and listens carefully. As one mother said,

There's a lady in my neighborhood who everybody seems to go to because she is older, and she has been there a while, and she just listens to you. She doesn't talk down or judge you. It doesn't seem like she is telling you what to do with your life.

Some mothers said they would not seek help from neighbors or family members because they would be negative and unsupportive. Family members might “get down on you,” “think it’s all in your head,” or that “you’re full of it.”

Many Mothers Worry about Child Protective Services, Confidentiality, and Medication

Mothers identified several specific worries that could keep someone from seeking help for depression: for example, that their children will be removed by child protective services, or that the person they seek help from will violate their confidentiality. Some mothers also distrust medication prescribed for depression.

Many mothers in our focus groups have friends or family members involved with child protective services (CPS) or who have lost custody of their children. “A simple phone call [to CPS] is why most women are scared to seek help outside of the home, especially with people you don’t know.” Mothers fear that revealing their depression, sadness, or frustrations will make them seem unfit as parents. “If you tell a doctor or somebody in power, somebody in a certain position, they have to turn it over to social services or they have to tell the authorities,” one mother said. She continued:

There have been times where I literally felt like putting my child on the side of the road while I’m driving down the street and they’re crying. I just want to stop on the highway . . . , pull their car seat out the car, and put them on the side of the road and drive on. I felt like that. I have not done it. But if I say that to my doctor or if I say that to anybody in social services, CPS is gonna be right there at my door.

Mothers worry about the confidentiality of their statements for other reasons as well, including the fear of domestic violence. Depression exacerbated by domestic abuse can prevent some women from seeking help. One focus group participant said that a friend of hers

just broke down and told the doctor everything and whenever her husband found out, he made her switch doctors. When she went to get her medical reports, whatever she said was

in her medical reports. So it’s going to be with her forever. So she thought what she told them was confidential Now she’s scared to tell anybody because she’s scared of what might happen [as a result of her husband knowing].

Some mothers believe medicine can help treat depression, but others are skeptical or concerned about side effects. Some think providers prescribe medication as a quick fix. A doctor “hears a complaint and the first thing they want [is] to fill you up with antidepressants,” one participant said. Some parents worry about side effects that medication will damage their heart or cause drowsiness compromising their parenting, or cause a miscarriage. Others said they could not afford medication.

Partners and Family Members May Be Supportive or May Hold Mothers Back from Seeking Help

Mothers in our focus groups had complex feelings about their family members’ roles regarding depression and treatment. Some mothers said their partners, parents, and other family members were supportive, while others said they were a burden or a barrier to treatment. Some young mothers felt that family members caused them stress by interfering in their parenting or telling them what to do. Others said family members gave them welcome and useful advice.

While some mothers feel the overbearing presence of their family, others struggle with isolation and the absence of a supportive family. Many mothers, especially single parents, feel they have few options for help when overwhelmed by childrearing. Some live far away from family members (e.g., have a partner serving in the armed forces overseas), and others live near family but cannot rely on their support. One mother said,

My son’s father is married, so there is only so much that he can do for me. I know absolutely nothing about raising babies. When I brought my son home the first three nights, I was really pulling my hair out because I had no clue what to do . . . [and had] nobody to call to say “My baby is crying, what do I do?” I had to call the police and ask the police They came to my house and stayed with me for about an hour to figure out what’s going on.



Even when family members and spouses are supportive on practical issues, mothers disagree about whether family members and spouses are the right people to turn to for help with depression. “[Husbands] will not listen to you,” one mother said, and they don’t know about or understand depression. Other mothers fear they will be physically or verbally abused if they talk to their spouses or family members about seeking depression treatment. On the other hand, some mothers would look to their family exclusively for help with depression: “Your family business is family business. You go to a grandparent for wisdom or a problem.”

Trauma, Loss, and Stress Are Part of the Context for Mothers’ Depression in Low-Income Communities

Many mothers we interviewed talked about the trauma and stress they or people they knew faced. Domestic and community violence came up as soon as we asked about depression. “I had a sad and depressing pregnancy,” one mother said. “I had an 11-month-old and the father got killed on the street and I was carrying a child. I was depressed and closed in. It was hard.” The financial pressure these low-income mothers experience also came up as a source of stress. In addition, a lack of resources—such as money, child care, and transportation—can hinder treatment, forcing some mothers to choose, as one participant said, between food and medical treatment.

Home Visiting: What It Takes to Serve Depressed Mothers of Young Children

Based on insights from our parent focus groups and interviews with home visitors, as well as research on depression and child development, we identified six challenges home visiting programs face in helping depressed mothers. We also identified promising approaches to overcome each challenge. Policymakers and practitioners should view these strategies as early efforts to apply experience and evidence to solve problems, but not as proven or universal solutions, since no rigorous research has tested them on a large scale.

1. Reaching the Mothers Who Most Need Help

Home visiting programs serve many mothers with depression—between 28 and 61 percent of mothers

in programs screened positive as depressed, according to one synthesis of available studies (Ammerman et al. 2010). But many other depressed mothers likely are not enrolled for a host of reasons. Roughly 500,000 families are served by home visiting programs in the United States, which corresponds to about 1 in 6 of all young children (under age 3) living in poverty and about 1 in 12 of those living in low-income families (below twice the federal poverty level).⁴ Since we estimate that more than half of infants in poverty live with mothers who have mild, moderate, or severe depression symptoms (about 1.5 million families), a considerable number of depressed mothers are not served by home visiting programs.

In the communities we visited, service providers told us, sometimes with great emotion, about missed opportunities to serve depressed moms and their belief that more home-based services could draw in those mothers. Two mental health clinicians in Chicago pointed out that mothers who need the most help often go without because they can’t keep appointments regularly. “Most of the people who need help don’t get it,” one clinician said. “If there were more home based-services to address their needs [these individuals would do better].” Their supervisor said she would like to refer more clients to a local parenting and home visiting program, but it is “woefully underfunded.”

Both home visitors and staff in other programs that serve low-income mothers thought that budget cuts made reaching high-risk mothers of young children, including depressed mothers, hard for home visiting programs. In Illinois, case management staff for several small programs for high-risk mothers said that a state budget cut forced them to drop nearly two-thirds of their home visit cases, going from 64 to 24 total families. While the funds were later restored, staff worried that they would not be able to find the families. A WIC nutritionist in North Carolina worried when she went home at night about whether the mothers and babies she saw would ever get help for deep-rooted problems, such as depression. She knew of one Medicaid-funded home visiting and case management program, but she thought the program was limited to serving a small group of families.

The additional resources available to states through the ACA offer an opportunity to strengthen home visiting programs and to expand, potentially targeting the enrollment of depressed mothers. We discuss three promising approaches below.



■ **Use community data to learn about and target services to depressed mothers of young children.** States and communities deciding how to use the new ACA home visiting resources should consider bringing together local partners and data sources to assess the needs and service gaps for depressed mothers of young children. Local data about the number and share of infants whose mothers are depressed can be estimated from national data and by drawing on information from local hospitals, existing home visiting and maternal case management programs, early care and education and early intervention programs, doctors and clinics that see pregnant women, pediatricians, community mental health and family support programs, WIC clinics, and parents themselves. With this information, states will be able to better target ACA resources.

We came across two examples of communities using data to target resources to depressed mothers. In one site visit, we learned about a network of service providers committed to helping pregnant women and new mothers and its strategy for targeting services to depressed mothers. Nearly a decade ago, the perinatal network decided to focus on helping pregnant women with depression. The leaders gathered data from health care and other programs that served pregnant women (for example, by asking a small number of providers to administer the Edinburg screening tool for depression during a study period). The network also surveyed a larger number of social services and health providers to find out about relevant practices, such as whether they screen for depression, and existing services. Over the years, that initial assessment has helped shape a communitywide approach to maternal depression that has led to, among other things, common screening tools and a common referral form.

In a smaller-scale example, an early childhood program director in another city told us that her agency's own needs assessment led the staff to implement a home-based (rather than center-based) program in one neighborhood to increase involvement among the mothers of young children there. Many mothers in that community were undocumented immigrants and afraid to take their children to a center-based program. Once the home-based services began, home visitors learned that these mothers also experienced high levels of depression and isolation.

■ **Develop effective referral and recruitment paths, and keep fine-tuning them.** National data from the ECLS-B study offer some hints about likely sources for reaching depressed mothers of young children. These data suggest that clinics providing services under WIC and pediatricians' practices offer particularly good opportunities to reach depressed mothers of infants. Ninety-four percent of infants in poverty with severely depressed mothers lived in a family using WIC services and, on average, these infants had six visits to the pediatrician by the time they were 9 months old (Vericker et al. 2010). Clinicians that treat pregnant women or see mothers and infants right after birth could also be good screening sites and referral sources.

In our site visits, we saw recruitment efforts for home visiting that drew on these sources and that aimed to reach mothers with mental health vulnerabilities. In Chicago, case managers for home visiting programs had an office at the WIC clinic and were able to recruit high-risk pregnant women and mothers of infants into their programs when they came in for WIC. Doctors in North Carolina who saw women for prenatal care referred them to Nurse-Family Partnership, giving preference to those with greater mental health needs. Other referrals to that NFP came from a family planning clinic that saw women during pregnancy and after delivery.

However, referrals only work if service providers who see depressed mothers know the right organizations to refer them to, and our interviews suggested that is not always the case. While this gap may have been partly because not enough programs were available to meet the need, we also heard that for busy professionals, remembering who might be available to help is difficult. For that reason, the leaders of the perinatal network emphasized the need for an ongoing process that keeps everyone in the community who cares about maternal depression abreast of available services, training opportunities, and emerging partnerships and collaborations. The perinatal network started a quarterly task force meeting where health and social services providers can discuss problems they encounter trying to identify mothers with depression and refer them to other partners for services and treatment. Another approach to the same communication and feedback problem is to design and implement a centralized referral



system such as the Child Development Infoline in Connecticut.⁵

- **Offer many paths to home visiting for depressed mothers with young children, enabling referral for mothers in different circumstances and with children of different ages.** Multiple paths to home visiting will likely reach a larger number of families that need help. First onset of depression can occur at any age, and for many the condition is chronic or reoccurring. States and communities should consider pairing an intense focus on pregnancy—an ideal time to identify mothers with or at risk for depression—with home-based services for depressed mothers of slightly older children, including infants, toddlers, and preschoolers. For some mothers, their discovery that a child needs help could be what motivates their own willingness to seek treatment. Ideally, multiple referral opportunities and home visiting programs would allow services to be available for depressed mothers of young children whenever depression is identified and the parent is ready to seek treatment.

2. *Helping Home Visitors Identify Depression and Talk to Mothers about Its Implications and Treatment*

In our site visits, home visitors often told us that they were uncomfortable discussing depression with a mother unless she raised the issue herself or already had a mental health referral or diagnosis. Some were not sure identifying depression was their job. “We don’t do screens for maternal depression,” one home visiting program supervisor said, “so there could be more moms with depression than we know . . . but we focus on child development . . . We don’t necessarily touch on those issues.” Others worried that focusing on depression would detract from their core mission, defined as helping mothers achieve goals they themselves identified. The multiple overwhelming issues in mothers’ lives made prioritizing depression treatment difficult for both mothers and home visitors. “If [mothers] score high [on a depression screen], they may refuse the referral because . . . they think their situation is causing the problem, things they are dealing with all the time,” one home visitor said. “They don’t think it’s related to their pregnancy or postpartum depression. They can’t sleep because they’re worried about how they will feed their children the next day and paying bills

on time, dealing with disconnection notices. They’re thus reluctant to seek help.” A mother in one focus group confirmed this challenge:

My thing is that sometimes you don’t have time to be depressed; you don’t have a choice. You have to get up. You have to take care of the baby. You have to go to school. You have to go to work.

Other home visitors, though, told us that they do not know how to identify depression, and they worry about failing to help mothers because they do not recognize its signs. In Illinois, a home educator from an early childhood program echoed the concerns of others we interviewed when she described how overwhelming being the only lifeline for a depressed and perhaps abused mother is. She wanted training to recognize depression and refer mothers to treatment.

What are the signs? How to convince the family to get help and not just the child? All of our trainings are about the child. If we can get the mom emotionally healthy, then the child will be healthier.

In North Carolina, home visitors told us of their worry of possibly having missed a mental health diagnosis and being unable to engage a mother whose lack of interest perhaps masked underlying depression. One home visitor said she tried to convince a mother to seek mental health treatment but was rebuffed several times. The nurse finally encouraged the mother to see a doctor for a pap smear, hoping at least to involve another professional who might keep an eye on her.

Other research has confirmed that home visitors may have trouble identifying depression and other mental health problems and may get caught up in a mother’s immediate, tangible needs without also prioritizing treatment (Ammerman et al. 2010). One study finds that in the third year of follow-up, home visitors still only recognize 14 percent of the cases of poor mental health in mothers identified through a depression screen (Ammerman et al. 2010). A project in Louisiana that provided enhanced mental health consultation to nurse home visitors was motivated in part by the difficulties nurses report in creating relationships with high-risk clients. The researchers wondered whether depression was one reason the parents, who appeared

“unmotivated or even disinterested” to the nurses, were hard to connect with (Boris et al. 2006, 29). And an experienced clinician pointed out that people with depression have an aura of “hopelessness” that inexperienced, untrained service providers may easily buy into, coming to share the depressed person’s view that all other problems (e.g., poverty or lack of housing) must be solved before addressing depression.⁶

The home visiting programs we visited varied considerably in how much identifying and responding to depression was part of their everyday practices, mission, and training. The following are among the lessons we learned:

■ **Consider depression screening as part of a more comprehensive approach to engaging and helping depressed mothers.** Perhaps the broadest lesson learned was that adding depression screens to home visiting is not a simple, stand-alone fix, but needs to be part of a broader approach.

According to a leader with the perinatal network, implementing a depression screen in the day-to-day work of service providers who saw new mothers took several steps. At first, she said, program staff told her that mothers wouldn’t want to be screened, but a survey conducted by the network suggested that mothers did cooperate and found the screenings valuable. The perinatal network then extensively trained staff. “We did role play, group work, heard concerns and addressed concerns, and slowly got [the service providers] on board,” the network leader said. “The first group, we were shocked about the resistance, and it was so open. ‘I will not break my client’s confidence. We don’t talk to medical doctors. They take away kids.’...We said that once you start, we are here for you to help you with issues And lo and behold . . . they [service providers doing the screen] are the biggest proponents of it now.” In our interviews with programs that don’t regularly screen mothers, we heard the same worries about confidentiality, CPS, and linking to other services from home visitors as well as requests for training that would go beyond identifying depression to engaging a depressed mother, seeing the world from her perspective, and finding ways to convince her to get treatment.

■ **Make explicit how identifying and treating a mother’s depression connects to the core**

home visiting mission, and train home visitors to talk with mothers about the connections. To feel comfortable screening and engaging mothers, home visitors need to see how identifying and treating depression can help them be true to the program’s mission. Especially in programs that prioritize meeting the mother’s own goals, home visitors need to understand and be able to communicate to a mother how depression can make achieving those goals more of a struggle, despite her best efforts—so treating depression and reducing the symptoms will help her get where she wants to go. Mental health training, supervision, and consultation can help home visitors understand and communicate to mothers that no matter how many practical barriers they have, untreated depression makes all the others harder to solve. For example, depression’s symptoms, such as sleeping too much or too little and being irritable or withdrawn, may inhibit a depressed mother from achieving other goals like obtaining a GED, holding a job, or being an engaged parent. Depression can also hinder a mother’s ability to find housing, apply for social services, follow referrals, or even pick up baby formula from the WIC office.

In home visiting programs whose mission centered on the child’s development more than on the mother’s goals, home visitors were particularly receptive to information about depression’s effect on babies and young children. Once they had that information, they saw opportunities for engaging the mother in a conversation around depression.

Because so many mothers cope with multiple challenges, home visiting programs would probably also benefit from a guiding philosophy, informed by mental health clinical knowledge, about how home visitors should prioritize families’ needs. For example, in one successful depression intervention for low-income women, the program’s designer distinguished between time-sensitive crises and ongoing barriers. For crises, such as a child’s upcoming deportation hearing, program staff delayed the mother’s treatment while she went to the hearing, while emphasizing that treatment would give her something in her life she could control. For ongoing barriers, the program encouraged mothers to see how reducing depression symptoms through effective treatment would help them manage their problems.⁷ This particular philosophy





might not be right for an ongoing home visiting program, but some coherent philosophy thought through in advance would help home visitors handle constant priority choices.

- **Seek out resources to help mothers solve some of their other challenges while also working on depression.** Mothers may be able to address some of their multiple challenges as they seek treatment for depression, rather than having to just work on one priority at a time. In particular, home visiting programs often include connections to community resources, some of which can help mothers cope with or overcome their problems. Home visitors had mixed feelings about the right balance, with some seeing such material help (e.g., clothing, baby supplies, and formula) as a distraction; others see it as welcome relief for immediate needs. Some felt donations helped them build a rapport with mothers that can lead to deeper engagement over time: “A lot of parents want to do the program for stuff,” one home visitor told us. “We can use stuff as props to help us get through, and it allows you to build up rapport and then [the clients] warm up.” The Ohio home-visiting mental health clinicians also saw the benefits of combining therapy with case management services, but they thought that doing both slowed the progress of therapy. To make gaining access to other services easier for home visitors, some states have developed an automated community resource inventory.⁸

- **Consider training home visitors to speak honestly to a mother’s concerns about child protective services.** Given the extent of some mothers’ fears that even raising a mental health issue might lead to their children’s removal, home visitors may need to be prepared with accurate information about child protective services and an honest approach to these concerns. Home visitors no doubt already have to deal with this issue as mandated reporters of child abuse and neglect. They may be most effective with mothers by being up-front about what would require reporting, but maintaining a warm relationship so the mother feels understood and does not believe that her statements about mental health concerns or needs will be misunderstood.

One successful intervention trial to treat depression among low-income women trained nurses to address the topic of child protective

services in early meetings with mothers. The nurses went over the criteria for reporting child abuse or neglect and made clear that having depression and being on medications were not reasons for contacting CPS. The nurses said directly that circumstances could come up where they saw a child was in danger, in which case they would have to report that danger.⁹ This trial, while not a study of a home visiting program, provides an example of handling mothers’ concerns about CPS reporting.

- **Complement one-on-one attention during home visits with group or community strategies.** Service providers and mothers recommended fighting the stigma of depression by discussing it in many different public settings where mothers don’t have to come forward individually, then using these settings to send the message that depression is common and treatable and that seeking treatment is good for the mothers’ children. The service providers and mothers suggested many ways to share this message, such as through presentations or discussions at parent support groups, but they all had a common theme: giving mothers information in a group environment that is not stigmatized, following up right at the session or at another opportunity, and perhaps choosing a setting that could include partners or other family members. Depending on the home visiting program, such a mixed strategy might be possible within the program itself (for example, at “socializations,” group activities that are part of home-based Head Start and Early Head Start programs) or through community partnerships. These group or community strategies can complement the one-on-one relationship with the home visitor, increasing the likelihood that parents would be receptive to screening and treatment. In addition, there is excellent evidence that some group experiences are quite valuable for treating depression and that certain groups can have important preventive effects by supporting or helping depressed parents exercise or get out with their children (NRC and IOM 2009).

3. Connecting to, Supporting, and Providing High-Quality Treatment

Home visitors have many concerns about what might happen once a mother starts talking about her depression and looks to them for help. First,

they see challenges in linking depressed parents to treatment. They may know or assume that affordable mental health services are hard to come by, have waiting lists, or require expensive bus or cab rides to other parts of town. One home visitor said:

We do have a family crisis center . . . but in the suburbs. Financial and transportation [obstacles] are big. I know there is a service that would go to the house, but I don't know about funding and how that would work . . . [A person might have] a waitlist of at least six weeks to go through, or to go through emergency because they felt they would hurt themselves or somebody.

Even if they see how a mother could get treatment, home visitors also wonder about their role in helping once a mother is diagnosed with depression. “My [client] mom was afraid of being put on drugs,” a home visitor said. “She didn’t want medication. . . . I respect that but keep an eye on this. It could be dangerous. I gave her vitamin alternatives, but she did not want drugs.” Home visitors are sometimes frustrated that they cannot work with the treating clinician. “We have some clients already receiving treatment for depression, but it still is a challenge because unless the client gives permission for the clinician to talk to the caseworker, we have no idea what’s going on,” a home visiting supervisor said. “This hurts us because if a client is in crisis, we might have a better idea of what to do.”

Researchers have recently written about two promising ways to get treatment to depressed mothers in home visiting programs and address the challenges listed above. One is to create a home-based mental health service to partner with the home visiting program; the other is to provide skilled mental health consultation and supervision to the home visitors so they can deliver some services themselves. These two approaches also could be combined to build on the advantages of each.

In addition to these approaches specifically targeted to home visiting, other related approaches aim to enhance the capacity of caregivers with similar backgrounds to home visitors, such as Head Start and Early Head Start teachers, to be able to deal effectively with depression. The general principle is both to provide the basic service (home visiting or Early Head Start) and then enrich it with special outreach to parents with depression (NRC and IOM 2009).

■ **Develop home-based mental health services.**

Ammerman and colleagues have developed and implemented a model of home visiting for depressed mothers that includes home-based mental health clinicians who provide treatment after a home visitor has made a referral. The home visitor introduces the mental health clinician on a joint visit, after which the clinician makes independent visits (Ammerman et al. 2007). This pivotal preestablished relationship with mental health providers helps facilitate referrals, follow through, and mothers’ active engagement with services.

We interviewed home visitors in North Carolina and Ohio who had some access to such home-based mental health services for their clients; in Ohio, we also interviewed the mental health clinicians. In both sites, home visitors described several advantages of home-based mental health services. With home-based mental health service, clients don’t have to worry about arranging transportation and home visitors are able to introduce the clinician to the client, building on their own relationship to increase the likelihood that the client will be willing to accept the service.

In one Ohio home visiting program, where mental health clinicians and home visitors work for the same agency, the two can work together, learning from each other’s perspectives on how best to serve the family. In that program, once home visitors refer a client with a high depression screening score, a mental health clinician contacts the client within 24 to 48 hours, allowing home visitors to feel confident that a mother they are worried about will receive prompt attention.

Mental health clinicians also see big advantages to the home-based services. Going to the mother’s home gives clinicians a clearer picture of her situation. They have to modify therapy conducted at home (for example, with “family members coming in and out” all the time), but they enjoy the creativity of designing approaches suitable for a home setting, for example built around play and art. One clinician said that home-based services offer an opportunity to engage partners and family.

We do more couples counseling than I thought we'd do. I'm surprised how many men want to talk to me. They want to



tell their side and want help. They don't understand what is going on with the woman. She is changed, mean, irritable, doesn't want sex. We get them to have an understanding.

- **Provide skilled mental health consultation and supervision to enable home visitors to handle depression and other difficult issues.** Louisiana has taken this approach to address the considerable mental health needs of their Nurse-Family Partnership caseload. The state provides extensive training for nurse home visitors and mental health consultants, ensuring they develop a common language (Boris et al. 2006). Nurses receive a 30-hour intensive training program on infant mental health that includes information on caregiver-infant attachment, assessment of the infant and mother, available interventions, when to make mental health referrals, and how to be more conscious of their own attitudes, beliefs, and values as they intervene. The mental health consultants, assigned one to a team of nurses, are generally experienced in treating older children but are not experts in infants and young children. They go through two training sessions: one a 4-month, half-time session and one an 8-month supervised field experience. The mental health consultants work with their team of nurses in team case conferences and consultations on individual cases.

While we did not visit any settings where home visitors had this kind of individualized consultation available, the model has some clear appeal. Given the relationships that home visitors build with families and the amount of time they are able to spend with them (far more time than mental health professionals could likely spend with mothers), enhancing their skills could pay off greatly for families. With ongoing consultation and supervision by skilled mental health clinicians, it seems possible that nurse home visitors could offer sufficient services for some families and learn how to make targeted referrals for others, providing additional support to a more sophisticated clinical intervention. The effectiveness of this model could depend considerably on the home visitors' education level, as nurses may be better prepared to learn from training followed by clinical consultations than paraprofessional home visitors who do not have a nursing education.

- **Consider combining the two models, with added in-home services for some families plus mental health supervision and consultation for home visitors.** Mental health supervision, consultation, and training for home visitors seem important, even with in-home help from clinicians, if only because home visitors will still need to learn how to support clinical treatment. Home visitors may need to support the clinician's instructions to mothers regarding their medication, for example, or give a mother feedback about the way her treatment is helping her parenting. In addition, given the likely limits on the duration and caseloads of in-home services, home visitors may need to support mothers in their program who have finished or are still waiting for treatment. Thus, in many communities, this combination of the two approaches might best meet families' needs.

4. Attending to Young Children's Development as well as Mothers' Treatment

As we have seen, maternal depression is associated with more hostile, negative, and disengaged parenting practices and adverse child outcomes, including problems in children's daily functioning, physical health, and well-being (NRC and IOM 2009). Because maternal depression can be so damaging to the healthy development of young children, it is critical that home visiting programs find a way to address the needs of both mother and child.

As we have seen in earlier examples, though, this focus on both mother and child, or the "dyad," can be hard to accomplish in practice. In most programs we visited, home visitors described their goals as focusing either on the mother as the primary client or on the child. Home visitors in child-focused programs are sometimes frustrated by seeing maternal depression's harmful effects on children and not knowing what to do. A Head Start administrator in Chicago worries that when "[the moms] decide to do nothing [about their depression] and continue living in the same circle . . . the home educator can see the issues are affecting the children. They are behind in the curriculum and have developmental delays." Home educators in this program believe that training could help them convince a mother that addressing her depression may be what the child needs.

In adult-focused programs, home visitors may find an emphasis on the child difficult or distracting



given all the other expectations they face. In one program where a Nurse-Family Partnership added an early childhood component, nurse home visitors trained in maternal health initially struggled with integrating child development lessons into their home visit. One nurse home visitor said about her early experiences:

Doing the home based piece [for the early childhood component] is a different thing altogether. That piece takes away from the other stuff mom may need now. We have to address the child and work on the child development. We have to teach mom how to teach her baby. That was different for me as a nurse. I don't think that way. How to teach a child, it takes more energy, effort, time.

■ **Consider close partnerships, multidisciplinary collaborative teams, and cross-training.** In one site, a recently implemented collaboration between Nurse-Family Partnership and Early Head Start appears to be a very promising approach to focusing on both mother and child. In this program, the nurse home visitor visits and coaches the mother through her pregnancy and becomes the “nurse family advocate” when the baby is born. The nurse introduces the family to home-based Early Head Start and then helps the child transition to a center-based Early Head Start teacher. The program’s director describes this teamwork and feedback loop:

We want to have an in-house conversation between the [nurse] advocate and teacher. The family advocate might say, “The child lost an uncle and may have difficulty.” . . . [Likewise] the teacher [can] say, “I noticed this. Maybe you can check this in the home” . . . This partnership, along with training for both parties, allows the providers to better understand the family’s issues, including maternal depression, and better serve mother and child.

Cross-training appears crucial to create effective partnerships. Few service providers have equal experience working with adults and young children. Training needs to consider what these providers already know and then fill in the gaps.

In augmenting the Louisiana Nurse-Family Partnership with mental health consultation, the project leaders foresaw that nurses would need not just a general understanding of adult mental health, but a specific understanding of early childhood and the infant-caregiver relationship (Boris et al. 2006).

These examples also illustrate that programs that effectively address multidimensional problems like maternal depression and its effect on children probably won’t work perfectly in their very first incarnation. Rather, programs that work well are able to learn from early experiences, because they have clearly defined strategic goals, an expectation that training and other key elements of program design need constant refinement and retooling, and an ongoing plan for gathering information about what elements of the program work and which need improvement.

5. Offering Ongoing Help after Home Visiting

While some adults with depression experience just one episode, it is chronic for others. For 30 to 50 percent of adults with depression, depression becomes a chronic or recurrent disorder (NRC and IOM 2009). Thus, a mother’s need for interventions to treat depression and/or strengthen parenting that has been affected by depression may not be resolved when home visiting ends.¹⁰ In our interviews, home visitors did worry about families who left home visiting early:

We can recognize the clients that won't be in the program very long. [They] may have issues, but in the end, we can't address them, because we can't locate [the clients]. In those cases, we call them or send them a letter. But if we can't reach them after two months, we exit them out.

However, home visitors did not typically think about how to transition out families who had completed the home visiting program; such families represented a success to be celebrated. One exception was home visitors in early childhood programs who regularly worked with the local early intervention program for children below school age. These home visitors were used to helping children and their parents transition to school-based services as children



reached kindergarten, for example, by helping the parent ensure the child continued receiving specialized services.

■ **Consider an explicit transition plan.**

Continuing support for families where a mother suffers from depression requires a community-wide strategy, involving other service partners. For many families, the most likely ongoing source of help is primary medical care—either a mother’s doctor or her child’s doctor.¹¹ Other promising links might be to the child’s early childhood program or school or to early intervention services. In Ohio, we interviewed home visitors who saw establishing a medical home¹² as a core part of their job. One supervisor said:

From my perspective, the way we prevent child abuse and neglect is to connect parents to a medical home. When we first open the case, we connect [the family] with the doctor—vision, hearing, nutrition. We suggest getting immunizations or something to start that process so they get a medical home immediately.

Conclusion and Next Steps

As policy and program leaders at all levels of government and in the community seek to take home visiting to the next level, this paper highlights the promise of home visiting as a platform not only for reaching and identifying depressed mothers, but also for serving them. The relationships and service approaches mothers are looking for to feel comfortable reaching out and talking about their depression match up well with what home visiting can provide.

The suggestions in this paper draw on insights from researchers, clinicians, and practitioners, but they do not add up to a single clear answer that can be applied in every setting. This lack of definitive solutions is partly because of knowledge gaps. We know a great deal about the importance of depression, a considerable amount about clinical treatments, and far less about how best to organize service delivery—let alone the policy, financial systems, staff recruitment, supervision, training, and other administrative systems that undergird effective home visiting.

Even if we knew more, however, a single approach would probably not be right for every home visiting program, given programs’ different

missions, service delivery and policy environments, and target populations. As a result, we urge policy and program leaders to build on the strengths of their existing programs while honestly assessing gaps and weaknesses standing in the way of meeting families’ needs. We also encourage leaders to anticipate ongoing development and quality improvement of these initiatives and to commit to learning along the way, by collecting data about family needs, experiences, and results and fine-tuning initiatives based on those data.

Another theme that cuts across the individual recommendations in this paper is that no single, one-time fix, or even two or three fixes in isolation, is likely to be enough for home visiting programs to fully respond to the needs of depressed mothers and their young children. Instead, programs are more likely to overcome the connected challenges of mission, training, service availability, links among providers, and more if they have an underlying strategy built on a thoughtful assessment of how families with a depressed parent fit into the program’s mission, or possibly how the mission needs to be expanded or modified. This clarifying strategy will help the program build its new approaches step by step, learning each time from trial and error. It may also help staff feel more comfortable with new expectations about screening, engagement, or service delivery.

Finally, changes substantial enough to make a real difference to mothers’ mental health and young children’s development will need to extend beyond the boundaries of a single home visiting program. Whether the changes start from a communitywide commitment or strategic assessment, or whether they begin within one program and ripple outward from there, several features of good practice for these families converge in a cross-program strategy—for example, the need to link home visiting to mental health and medical treatment, build referral networks into home visiting and transitions out, and tap into one-on-one, group, and community interventions.

Researchers have clearly demonstrated the widespread prevalence of maternal depression and the risks to young children who grow up with mothers with untreated depression. Studies have also shown the clinical effectiveness of treatment once depression is identified. The challenge for policymakers and program leaders is to translate this clear research evidence into service delivery approaches that make a difference. Today, the

visibility of home visiting and additional resources offers an opportunity to build on innovations from the field and significantly improve young children's life chances.

Notes

1. The site visits were conducted in Chicago in December 2009, in Greensboro in April 2010, and in Cleveland in June 2010. All focus group and interview quotations or paraphrases in this guide are from these site visits unless otherwise noted. We provide the city in the text except in a few instances where confidentiality required leaving out the location.
2. We asked the focus group participants to describe or imagine a friend's depression, not necessarily speak to their own experiences with depression.
3. One caution in interpreting these perspectives is that we recruited some focus group participants from home visiting programs, though most were recruited from other sources. Those programs might have chosen parents who were particularly pleased with their services.
4. We used the National Center on Children in Poverty factsheet (Chau, Thampi, and Wight 2010) on young children in 2009 to get 3.1 million poor infants and toddlers (out of about 12 million total infants and toddlers) and 5.9 million living in low-income families.
5. Paul Dworkin, University of Connecticut, e-mail with the authors, February 15, 2011.
6. Jeanne Miranda, University of California Los Angeles, discussion with the authors, November 22, 2010.
7. Miranda, November 22, 2010.
8. For example, the United Way of Connecticut Child Development Infoline helps connect service providers to community resources (<http://www.ctunitedway.org/cdi.html>). The service providers we interviewed emphasized the importance that such an inventory be up to date on the available community resources and have informed staff.
9. Miranda, November 22, 2010.
10. In addition, treatment and interventions may effectively reduce depressive symptoms but not resolve underlying circumstances that erode mental health. The National Research Council and Institute of Medicine (2009) report notes that different people will need different treatments.
11. For an account of opportunities and barriers to services linkages for young children and their parents in Medicaid/ CHIP policy, also see Kenney and Pelletier (2010), Pelletier and Kenney (2010), and Golden and Fortuny (2011).

12. "A family-centered medical home is a trusting partnership between a child, a child's family, and the pediatric primary care team who oversees the child's health and well-being within a community-based system that provides uninterrupted care with appropriate payments to support and sustain optimal health outcomes" (American Academy of Pediatrics, "Children's Health Topics: Medical Home," <http://www.aap.org/healthtopics/medicalhome.cfm>).

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