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Maternal Depression Screening and Referral to Mental Health Services: Best Practices for Home Visitors

Background

Maternal depression is very common in home visiting programs, with rates ranging from 35% to 57% (Ammerman et al., 2010; Easterbrooks et al., 2016). Maternal depression can limit the effectiveness of home visiting, and traditional home visiting services alone may not be sufficient to improve depressive symptoms for all mothers (Ammerman et al., 2010; Tabb et al., 2022).

Increasingly, home visiting programs have implemented universal maternal depression screening to identify mothers in need and refer them to mental health services in the community. However, more information is needed about how to improve the depression screening and referral process.

In this study, PAT home visitors, supervisors, and mothers from different parts of the country were interviewed about the depression screening and referral process to identify best practices and recommendations to further improve services.

Parents as Teachers

Parents as Teachers (PAT) is an evidenced-based home visiting model that offers services for families, prenatally through age 5, focusing on early childhood development and promoting positive parenting behaviors. PAT's model goals are as follows:

- **Increase parent knowledge of early childhood development and improve positive parenting practices**
- **Provide early detection of developmental delays and connection to services**
- **Improve parent, child, and family health and well-being**
- **Prevent child abuse and neglect**
- **Increase children's school readiness and success**
- **Improve family economic well-being**
- **Strengthen community capacity and connectedness**

The PAT model is backed by nearly 40 years of independent research. A global network of affiliates and trained parent educators deliver the PAT evidence-based model, which has four components: Personal Visits, Group Connections, Resource Network, and Child and Caregiver Screening.

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Mothers' Experiences of Depression Screening

Many mothers stated that they appreciated that their PE took the time to talk to them about their mental health. For mothers that did score high on the tool, some shared that the screening helped them realize what they were experiencing. For example, one mother shared:

"...at first, I thought I was really just going crazy. And then part of me felt like I knew something was wrong, but I didn't really know what. Because I was having too many emotions. Once they gave me the diagnosis, I mean, I felt relieved because I knew what was going on."

Barriers and Facilitators to Maternal Depression Screening

In interviews, parent educators (PEs) and their supervisors shared different perspectives on barriers and facilitators to depression screening within PAT.

Barriers to Screening:

- Stigma
- Client reluctance to disclose feelings
- Issues with screening tool (wording, time span, etc.)
- Lack of preparation or training to needed to conduct screening
- PE's concerns about their role
- PE workload

PEs and supervisors also shared examples of facilitators that promoted successful screening. Many PEs and supervisors discussed how the process of developing confidence and buy-in took months or years as they gained more experience in their positions. Growing in this capacity appeared to have a developmental trajectory, with many PEs describing an initial period of anxiety, stress, and feelings of inadequacy. Respondents also discussed the importance of having in-house support at PAT, either in the form of supervision or access to a mental health consultant to discuss specific cases.

Facilitators for Screening: PE confidence and buy-in, and the use of several basic counseling skills with clients, including:

Skill	Definition	Example
Building rapport	Developing a positive, trusting relationship with the client	"I know the clients that I have made a really a strong connection to and they tend to be more open, more honest with me as opposed to some clients, for whatever reason, whether it's me or whatever, I haven't made that strong connection."
Asking about well-being generally	Frequently check-in about the mother's well-being overall, rather than just relying on the screeners	"I make sure I check in with them. Talk about self-care. What are they doing for themselves? And I think for me, that's about it. My thing is not to be the too pushy because I know how I would respond if I've told you, "I don't want to talk about that, I'm not dealing with that. I'm fine." If you keep coming at me with something. So every now and then I just try to remember to check in with them, and not just the ones who I know are dealing with depression or other mental health

		disorders. I just try to check in with all my moms every now and then.
Preparing the client for screening	Providing advance notice that the depression screening will be conducted	"…Parent educators, prior to the visit that they planned to do the screener, they give the families notice that during the next visit we're going to do a mental health [screening]. Oftentimes they will let them know that they might want to make sure that they are in a private area just to protect their answers when they are going to complete the survey."
Personalizing the approach	Adapting the screening approach to each individual client (e.g., treating each client on a "case by case basis" and "meeting the client where they are")	"Depending on the family response, the parent educator might then ask the family member if they agree with the score, if it seems accurate, and then if family is still a little hesitant, the parent educator might, then, offer for our infant mental health consultant to join on the next visit to further discuss the results and next steps, if the family is interested."
Providing psychoeducation	Providing information about depression and mental health concerns (e.g., etiology, prevalence, symptoms, treatment options, etc.) within scope of their role	"Like my parent educator has done a really good job to remind me that therapy and medication, it doesn't have to last forever. It's not like a death sentence, it's something that you have to do for the rest of your life. It can be there to help you. Once you are in a better place, you don't have to continue it."
Normalizing depression	Explaining that depression and depressive symptoms are common or normal (specific form of psychoeducation)	"Just as a parent educator, letting them know that just because they may be depressed or feel down that it doesn't mean something is wrong with them. It can be a hormone imbalance, change of life experiences. Just letting them know that it's normal and that it can happen..."
Addressing affect	Moving beyond the screener to ask about the client's emotional expression in session	"And being comfortable enough to bring these issues up with the client and being open and honest and transparent, like, "I know that you're telling me that you're not feeling this way, but I'm physically seeing you cry. So can you tell me a little bit about more what is causing you to have these emotions at this time?"
Using shared experience	Leveraging an aspect of shared experience (e.g., identity, background, lived experience with mental health concerns)	"I was a mother that had it (depression) and so it's becoming easier for me to identify mothers that might potentially have it. So whenever they have a new baby, it's always something I keep on my radar if I'm seeing clients or I have my girls reach out to me if they have concerns about a parent who just seems to be off or something like that so that I can go in and just give them my opinion and we based off of what their depression scale comes back [as]."
Leaving the door open	Stating that you can provide emotional support at a later time if needed	"…the screening came back that she was fine, but I could tell there was something wrong... But I knew her long enough that I could just be like, "There's something going on with you." And so I just brought up very casually, "Hey, I'm always here. If you need to talk to anybody, please give me a call. Don't care what time of the day it is. I've been there, I've been with the transition with children. I know how hard it is. I'm here if you need me." Probably about two days later she called me about 5:30 in the morning. "Liz, I think I have postpartum depression and I don't know what to do."
Screening consistently	Screen when indicated according to guidelines and also if you are concerned	"…if I have a mom that scores high and I'm concerned, I'm going to do her screens more often, I check in on her, and that's just because I want to make sure she's getting the referral and the help that she needs."

Cultural Factors that Affect Maternal Depression Screening

Respondents also shared several insights related to cultural differences and depression screening.

Cultural Barriers to Screening:

- Stigma regarding mental health
- Lack of information about mental health
- Cultural expectations of motherhood
- Norms about sharing information outside the family
- Religious beliefs

Cultural Facilitators for Screening:

Skill	Definition	Example
Practicing cultural humility	Gently inquire about the client's cultural/family background	"I think also it's always being mindful and trying to navigate and ask questions about their culture like what do they think about certain things so that way you can then move forward to see how they would take the [depression] questionnaire."
Promoting linguistic competence	Attempt to provide materials/services in the client's primary language, and promote communication when this is not possible	"Dual language learners have been difficult to screen because I don't think that they completely sometimes understand the questions that are being asked, even if we're able to translate it."

Supporting Mothers Who Are Experiencing Mental Health Concerns

Staff also shared about resources they provided to mothers in their role as PE to help with lowering stress and promoting self-care, including mindfulness and breathing exercises, etc. Some mothers expressed that this was helpful and provided a new perspective about the importance of taking care of themselves. However, one mother shared her experience of receiving this type of resource:

"I got one worksheet or a guide or something like that. I don't know what to call it, honestly, but it's about self-care, which felt like a slap in the face because, again, placing the onus on the individual [as if] you need to self-care your way into it, and that's not possible for me."

It appears important to discuss the role of situational factors and concrete needs in contributing to maternal mental health issues with both PEs and clients. It also seems important to consider supportive approaches PEs can utilize that address these factors in addition to referring to mental health services. For example, considering how to address clients' concrete needs, utilizing group connections, etc. PEs and mothers shared several different life experiences that they felt contributed to maternal depression, including a lack of social support, death and loss, unemployment, medical problems, poverty, etc., not just welcoming a new baby or having difficulties with parenting. The most cited cause or contributor in this sample was a lack of social support.

Perspectives on Barriers and Facilitators to Accessing Mental Health Services

Staff and mothers also discussed the process of referring PAT clients to mental health services. Some PEs were very actively involved in advocating for clients. For example, one mother shared:

"[My PE] actually helped me make a doctor's appointment for [myself]...she called me that morning of my appointment. She talked to me the whole time I was driving to get there. And then I called her right when I got back in my car after the doctor's appointment. So, I mean, she was there every step of the way."

PE strategies to promote successful referrals to outside services included verifying that a mental health resource was available, providing information to the client about what they would likely encounter when reaching out for help, making the initial call with the client if extra support was needed, reminding the client before the appointment, and following up to see if the client was able to attend the appointment. Several PEs and PE supervisors discussed the amount of time it takes to provide this level of support to mothers. One supervisor stated:

"I think it's a lot of leg work that sometimes goes into case management, but it's a little difficult because, as parent educators, that's not really... part of their job duties. But there is a lot of case management that goes into that when you're referring to an outside agency or even inside our agency for mental health services because there's a whole process that has to happen. We try to do warm handoffs as much as we can."

Once clients were referred, respondents reported that there were a variety of barriers to accessing mental health services. These included clients' difficulty paying for services, difficulty qualifying due to documentation status, inability to attend services due to child care needs, lack of fit with providers, language barriers, difficulty finding time to participate in treatment, transportation challenges, stress or anxiety that interfered with initiating services, and a general lack of mental health services in their area, which was the most commonly cited challenge. A facilitator that was noted by some staff was having on-going relationships with mental health providers in their area.

Recommendations to Improve Maternal Depression Screening

Recommendations from **staff** included:

- Providing more training focused on depression screening, particularly about the real-life scenarios that might unfold
- Providing updated information about maternal depression and its treatment
- Helping PEs identify mental health concerns beyond depression
- Changing the screening tool so it is not limited to a short time span
- Identifying more accurate/culturally competent screening tools
- Adding a question after the screening about whether the mother feels that she has been able to bond with her baby

Recommendations from **mothers** included:

- Providing more psychoeducation and normalizing depression when introducing the screener
- Making sure to screen after any major life event (job loss, death in family, etc.)
- Training PEs to have more open-ended conversations about mental health and well-being

Recommendations to Improve Referrals to Services

Recommendations included:

- Take a hands-on approach during the referral process to make sure mothers feel comfortable reaching out for help
- Do not push the client too much if they do not want to seek services
- Identify more mental health services in the community
- Develop additional in-house mental health services, including a virtual counseling center for sites that don't have reliable outside services, like in some rural areas
- Provide more PAT-run group connections and support groups for mothers experiencing depression

Conclusion

PEs described their evolution in becoming comfortable and effective in screening and noticing maternal maternal mental health concerns. PEs utilized basic counseling skills that can be clearly identified and trainings should focus on these skills. In particular, it would be help to provide experiential and reflective training and supervision opportunities to help home visitors practice real-life scenarios. Internal PAT mental health support is also crucial. Community mental health supports were difficult to access across PAT sites, and PAT may want to consider building additional internal capacity to address maternal mental health.

Methodology

Semi-structured qualitative interviews were conducted with 15 mothers who participated in depression screening and 16 parent educators (PEs) and supervisors who conducted screenings. Interviews were conducted across four PAT sites in the United States (in CA, NC, LA, and PA) that were chosen to maximize ethnic/racial and geographic diversity. Three mothers were interviewed in Spanish. A third of staff identified as Black, a third identified as White, and a third identified as Hispanic/Latino. Almost half of mothers identified as Hispanic/Latino, a quarter identified as White, just under a quarter identified as Black, and one mother identified as biracial.

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