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Partnering for Mental Health Promotion: Implementing Evidence Based Mental Health Services Within a Maternal and Child Home Health Visiting Program

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The prevalence of perinatal depression has been found to be disproportionately high among urban African American women living in low-income communities (Hatcher, Rayens, Peden, & Hall, 2008). While the literature supports the need for clinically sound and culturally responsive interventions specific to this population (Abrams & Curran, 2007), evidence-based practice implementation strategies for clinical social workers working with this population are less well defined. A lack of interest or desire to integrate EBP on the part of the agency or practitioner may not be the primary challenge to translating research to practice. Instead, implementation challenges often emerge from logistical concerns around training, support, and capacity (Proctor et al., 2009). In this article, we argue that social workers, who are experienced practitioners who work extensively within authentic community contexts, are in an optimal position to lead evidence informed practice implementation responsive to the needs and capacity challenges within low-income communities. As social workers, we possess skills that enable us to recognize the inherent strengths of the individual, within context of the family and the social environment. Social workers also have a broad educational base which may be conducive to specific, targeted training in evidence based models translated to community practice. Therefore, social work leadership in applying research to practice within low-income communities provides a bridge between individuals at risk and the evidence-based mental health services that may otherwise remain out of reach.

The Enhanced Engagement model discussed in this article details the clinical foundations of a social work focused community-based participatory research (CBPR) project promoting women's mental health during and around the time of pregnancy. The model was informed by consumers and agency staff over a five year period through a CBPR partnership with the second author. The integration of evidence-informed practices into the organizational infrastructure is guided by Gambrill's (2006) systemic definition of EBP as, "a philosophy and process designed to forward effective use of professional judgment in integrating information regarding each client's unique characteristics, circumstances, preferences, and actions and external research findings" (p. 339) into this existing child and maternal home visiting program. Operating under this EBP philosophy fostered a collaborative environment, moving the researchers away from an authoritarian position by integrating consumer perspective,

environmental context, and agency staff expertise into the Enhanced Engagement model's development and implementation.

Scope of the Problem

The prevalence of depression and its associated risk factors during and around the time of pregnancy is well documented within the literature (Ammerman et al, 2010; Banti et al, 2011; Gavin et al, 2005; Beeghly et al., 2003; Evans et al., 2001; O'Hara and Swain, 1996). Studies reinforce that maternal depression profoundly influences the health and well-being of both the mother and her children (Barker, Jaffee, Uher, & Maughan, 2011; Sandman, Davis, Buss, & Glynn, 2012). Furthermore, multiple studies have focused specifically on the negative consequences of maternal depression and its potential impacts on the mother-child dyad, including mother-child interaction, maternal sensitivity, and engagement in vital health, literacy and functional well-being (Ammerman et al, 2010; Field, 2002; Field, et al., 2007, Palaez, et al., 2008; Radke-Yarrow, 1993; The NICHD Early Child Care Research Network, 2005).

A systemic social work perspective, however, moves beyond an individually focused examination of depression's negative consequences and considers the unique characteristics of groups and communities who may be disproportionately impacted by the effects of depression. Ethnic minority women, particularly those living alone in low-income communities may experience multiple life stressors which, over time, may negatively impact their physical, mental, and emotional health. Notably, trauma has been shown to have adverse impacts on well-being and perinatal health (Dailey, 2009). Moreover, environmental risk factors such as financial and food insecurity, access to childcare, housing, education, and health care resources present further psychosocial challenges that low-income women and families navigate on a daily basis (Abrams, Dornig, & Curran, 2009; Author, 2010; Davis, et al., 2008).

Clinical Framework

As practitioners, we realize that people who have positive attachments, social supports, and effective coping skills are typically better able to manage their mental health in a stressful world. The stressful world experienced by low-income women in our study includes intergenerational poverty, food insecurity, housing instability, and employment challenges coupled with stigma, negative social perceptions, and racism. The NASW code of ethics emphasizes the importance of human relationships, and the vital role of self-determination in fostering positive changes in individuals, families, as well as organizations and communities. The clinical framework and community context of our study is informed by two key domains: (1) attachment, which addresses how we

experience ourselves in primary relationships, including both receiving and giving care and (2) informed behavioral change, which addresses the identification and strengthening of coping and cognitive processes. In developing the current model, we blended the available evidence surrounding attachment and behavioral change with the identified life experiences and risk factors discussed by low-income women served by maternal and child health (MCH) home visiting programs. The model focused on meaningful engagement with both parenting programs and community systems (including mental health) but began with a multi-module brief intervention topically situated around common life challenges. The Enhanced Engagement model began with motivational interviewing to promote treatment engagement, and then integrated working components of Interpersonal Psychotherapy and Cognitive Behavioral Therapy into the brief intervention modules.

Treatment Models

Interpersonal Psychotherapy (IPT)

Interpersonal Psychotherapy has been extensively described and researched over the past decade (e.g. Grote, Bledsoe, Shwartz, & Frank, 2004; Miller, Gur, Shanok, & Weissman, 2008; Weissman, Markowitz, & Klerman, 2000). As applied to perinatal depression, IPT echoes Bowlby's theory of attachment which posits that all human beings must build and maintain healthy attachments in order to navigate emotional challenges (Bowlby, 1980). The reciprocal processes of attachment between mothers and children are essential to healthy development and well-being. Poor attachments may lead to increased feelings of social isolation from peers as well as parental inadequacy. Thus, challenges to the interpersonal experience may negatively impact women's ability to value themselves, care for their children and cope within a multi-stress environment. Using brief IPT in their research on perinatal depression interventions for low-income women, Grote and colleagues (2009) found that women receiving brief IPT had significant reductions in depressive symptoms and improvements in their social functioning associated with this intervention strategy over usual care.

Cognitive-Behavioral Theory (CBT)

Beck's Cognitive Theory argues that individuals prone to depression possess negative beliefs about themselves, their environment, and their future. Cognitive theory, and by extension cognitive-behavioral intervention, assert that changing these cognitive distortions leads to enhanced coping, greater emotional self-regulation, and more proactive behaviors (Beck, 1979; 1993). For example, negative self-beliefs (i.e. "I am a bad mother") may preclude full participation in a parenting program or could impact a mother's ability to effectively

care for herself or her children. In their application of CBT with low-income women participating in a home visitation program, Ammerman and colleagues showed sizeable reductions in symptoms of depression among women who participated in a 15 session in-home CBT intervention as compared to those who were participants in the standard home visiting program alone without CBT intervention (Ammerman et al., 2011; Ammerman et al., 2010). In MCH home visiting, a CBT approach may be well suited when working with cognitive distortions around maternal role adaption or health beliefs regarding depression that may impede health, parenting, and help-seeking behaviors.

Home Visitation Context

The context of the home visiting agency with whom we partnered for the study is important in understanding our primary aim: to integrate a specific, evidence-based brief mental health intervention into an existing parent support program. It is important to note that the Enhanced Engagement model was incorporated into the maternal and child home visiting agency under the umbrella of an existing evidence-based parenting education model entitled Parents as Teachers (PAT). PAT works to promote attachment and meaningful connections within family systems, augment health, safety and nutrition knowledge, as well as to facilitate relationships between families and communities. The agency staff included licensed clinicians who were able to provide supportive counseling and crisis management as needed. The Enhanced Engagement model was designed to fill a gap in existing services by ensuring that all clients would receive targeted assessment for mental health which offered initial mental health promotion followed by ongoing intervention, if needed. The Enhanced Engagement model offers a framework to assist mental health clinicians provide temporary symptom alleviation to clients while mutually determining whether more extensive mental health services are needed or desired. The mental health clinicians are members of the home visiting team and will continue to offer psychosocial support and community linkage and referral beyond the initial brief intervention.

We recognize that there is controversy around adapting long-term EBP's to accommodate specific situations and brief therapeutic encounters. However, this study aims to bridge an existing gap in services available to low-income women and families by maximizing the therapeutic impact of existing, public-health supported community maternal and child health programs. Many women participating in maternal and child health home visiting programs are either referred by other community agencies or self-refer for parenting and health education support. Their mental health challenges are either unknown or unidentified. In this study, we seek to add evidence-

based adaptations of mental health interventions, delivered by trained clinical social work professionals, into a community program that is already involved in the psychosocial well-being and parenting capacity of a segment of the community in need of intervention. Social workers are trained in a distinct, multi-system view where we recognize that mental health is intrinsically linked with stressful life events and parenting challenges. In this study, it is our goal to engage women in brief intervention that can raise awareness of mental health symptoms and symptom reduction techniques, comprehensively assess, and strategically link participants with the additional services that can continue to foster lasting and meaningful change.

Informing the Enhanced Engagement Model

The community-based research partnership at the foundation of this study was initiated in 2006 and continues to the present time. At the partnership's inception, the second author engaged with the agency in a qualitative inquiry regarding the meaning and significance of depression and grief/loss to women served by the maternal and child health home visiting agency. The initial focus groups and interviews from that project, which have been fully described elsewhere (author at al., in press), provided a foundation of knowledge regarding service delivery preferences, women's lived experiences, and even specific life situations and phrasing/wording which reflected the experiences of depression, grief, and stressful life events within the population served by the agency.

Through a collaborative and iterative process, the identified psychosocial concerns of agency clients from that initial study were considered, along with the conceptual framework of other programming taking place within the organization, including parenting education. Considering the available literature supporting evidence based practices addressing perinatal depression, the research team and staff initially discussed the possibility of engaging in a solely brief-IPT based intervention, combined with engagement to treatment techniques grounded in motivational interviewing. This combination was being successfully implemented with a similar population in another state (Grote et al., 2009; Grote, Swartz & Zuckoff, 2008) which increased the agency's receptivity to the model.

The first case-based application of IPT was introduced into the agency in 2009, targeting five purposively selected clients with a variety of issues relevant to IPT: interpersonal disputes, role transition (applied to parenting in this setting), grief and loss, and interpersonal deficits. The team was engaged in training by outside facilitators in both IPT as a clinical intervention, and motivational interviewing as applied to treatment engagement. The researcher provided open-ended case consultation during this initial series of IPT-based case applications. Across

case studies, we found more success with IPT as the basis for interventions focusing on interpersonal disputes and grief/loss, but less applicability to parenting and role transition. Participants selecting these themes vocally stated that they wanted more problem-solving based approaches and help pragmatically dealing with negative thoughts (and social stigma) of being judged as a "bad mom" when acknowledging depressive symptoms and seeking treatment**.** We also found that the recommended 10-12 sessions of IPT were not feasible within this agency, given the multiple staff members within the home visiting program simultaneously scheduling visits. Failed visits with the mental health clinician occurred much more frequently after 6 visits, in favor of nursing and parenting education. None of the five initial case applications succeeded in over 8 scheduled counseling visits; mental health clinicians reported that their initial goals were being met at that time and the sessions began to shift to other topics. Based on these consumer and staff experiences, the recommended length of the intervention was fixed at 6-8 sessions. A similar feasibility concern is described by Tandon et al. (2012) in applying CBT in a home visiting population where a six-session intervention was ultimately implemented in their perinatal depression prevention program.

Based on these initial case applications, the research team and community agency discussed the working components of the models, reviewed theoretically grounded and empirically supported strategies, and used this process to guide clinical decision making which moved beyond specific client situations to inform organizational best practice. While rarely discussed in the literature, this process of organizational level evidence-based practice application allowed for a great degree of practitioner input and acknowledged a shared expertise between researchers and practitioners that echoed the voiced concerns and suggestions of consumers emerging from the process evaluation and case applications.

As a result of these formative evaluation processes, the final Enhanced Engagement brief intervention model retained two IPT based modules focused on topical areas where development of inner strengths and interpersonal resources were deemed essential ("Relationship Conflicts" and "Grief and Loss") and added two CBT based modules ("Parental Stress and Coping" and "Understanding and Coping with Depression") which contained extensive cognitive restructuring, decisional balance, and psycho-education components. All four modules retained between-session homework focused on social support enhancement in addition to reinforcement of each session's key working components. Using knowledge of the lived experiences within the MCH home visiting client population, the co-authors of this article finalized the flow of the 6 – 8 session modules and developed accompanying case application scenarios that illustrate the step-by-step processes of a worker-client interaction in

each module. The modules and case applications, which we will describe in detail, served as the training components leading up to the formal research pilot.

Enhanced Engagement Model Components

The enhanced engagement model was designed to introduce a new agency standard of care which integrated evidence-based mental health promotion into the overall team-delivered services of a maternal and child health home visiting program. The expectation was that this approach would not only improve health and parenting outcomes, but also would improve mental health outcomes for women enrolled in the program. Women with elevated symptoms of depression and/or recent stressful life events were asked to choose one of the four topical modules. Motivational interviewing approaches were introduced at this early stage to facilitate treatment engagement and topical selection. The mental health clinician led in-home brief intervention sessions using the manualized guide on the selected topic. The session outlines were provided to all members of the home visiting team, who were encouraged to concurrently integrate and reinforce the content into their routine parenting and health-related visits. The overall goal of the model was not total resolution of the problem; the thematic modules were designed for short term intervention and symptom alleviation, with key goals of strengthening interpersonal resources, introducing coping skills which promote mental health, as well as expanding social support while building an initial relationship with the mental health clinician within the home visiting team. The flow from initial assessment through model implementation and follow-up is shown in Figure 1. The four Enhanced Engagement Modules are briefly described below, offering condensed case vignettes illustrating the client situations targeted through the intervention.

[Insert Figure 1 about here]

Module 1: *Grief, Loss, & Life Transition*

This IPT based module helps the client focus on the "here and now" while simultaneously supporting the grieving process or life transition impacting her daily life. The overarching goal of this module is to facilitate emotional discussion through identification and labeling of feelings, providing interpersonal communication around the loss, and building social supports and emotional strength to extend beyond the intervention. When a client is able to understand and communicate regarding her emotional and interpersonal processes, she is able to engage in more meaningful communication within her primary relationships and improve her adaptive outlook on life. Women subsequently pregnant after prior perinatal loss were encouraged to use this module, as well as those with

other grief experiences. The following case vignette illustrates one example of a client who may elect to engage in the Grief, Loss, and Life Transition module.

Case Vignette: "Nadine"

Nadine is an only child from a single parent home who had a very close relationship with her mother who passed away unexpectedly from a stroke 5 months ago. Nadine is pregnant with a girl and her due date is two weeks away. Nadine is struggling to cope with the loss of her mother. She is engaged to the father of her baby and states that while he is supportive, he has not been able to help her deal with her grief. Nadine expresses that she has a lot of anxiety about the upcoming delivery and is resentful that her mother cannot be there to support her. She has expressed concerns about her ability to bond with and care for the baby once she arrives because she feels that she has a void that her baby won't be able to fill. She had anticipated that her mother would be there to help and support her through her pregnancy and new parenting.

When applying this module to Nadine's case, the social worker might begin by taking a loss history focused on helping Nadine articulate her emotions of grief. In early sessions, the social worker might work to educate Nadine about depression and its association with grief while also emphasizing ways in which her interpersonal strengths and skills can help her navigate the intensity of her symptoms. During middle sessions, the goal will be to help Nadine understand grief as a process. The social worker will work jointly with Nadine to further facilitate communication about her current struggles and the obstacles that prevent her from processing her grief. These sessions will build on Nadine's existing strengths and will focus on helping Nadine explore the ways in which her grief impacts her current relationships. Later sessions might revolve around balancing care of self with care of baby and implementing a self-care plan that will help Nadine continue to navigate her grief and expand her social support system. The end result is that Nadine will begin to have improved interpersonal relationships, the skills to recognize and articulate her feelings, and an understanding of the ways in which her grief shapes and impacts her immediate relationships.

Module 2: *Relationship Conflict/ Interpersonal Dispute*

This module is also grounded in IPT and primarily focuses on building a strong sense of self and identity, while helping the client better understand and prepare to take an active role in addressing the interpersonal relationships that are causing her emotional distress. The aim of the module is to encourage the client to think about

the core issues of her relationship dispute, understand the stage in which the dispute is currently manifesting itself in her life (an active conflict, an impasse, or a dissolution) and recognize her emotional response to the dispute. Simultaneously, the module focuses on building capacity and interpersonal skills of sufficient magnitude to effectively approach the conflict with a clear intention to seek resolution. The following case vignette illustrates one example of a client who may elect to engage in the Relationship Conflict/ Interpersonal Dispute module.

Case Vignette: "April"

April has two daughters, the first age 3 years and the youngest 14 months old. She is currently living with her parents but expresses that she wants to move out on her own. April reports that she has had a rocky relationship with her parents since the pregnancy of her first daughter at age 16. She feels that her parents are embarrassed by her and also feels that they don't trust her to be a good mother. April expresses that she is interested in going to college for a culinary degree but states that her parents do not support her decision and feel that she needs to secure a job and establish herself so that she can provide for her children. April recognizes that her parents are helping her co-parent and she is aware of her complete financial dependence on them to provide for her and her children, yet she expresses that she has become increasingly frustrated by her lack of independence and feels that her parents do not respect her decisions as a mother. April reports that her relationship with her parents has worsened over the last month because she now has a new boyfriend and her parents are not supportive of the relationship. She recognizes the need for communication and vocalizes her role in initiating change, but doesn't know where to begin.

In April's case, the social worker would likely begin by gathering history about April's relationship with both her parents and her children. Initial sessions would center on helping April learn to express her feelings and helping her understand the different stages of dispute, ultimately assisting April in making linkages between her symptoms and the conflict she is having with her parents. Middle sessions would emphasize further exploration of April's relationship with her parents, encouraging her to identify both positive and negative attributes of the relationship while also striving to build her own sense of self within the relationship. A large part of these sessions would likely focus on different strategies (e.g. use "I" statements when expressing feelings, identify patterns in emotions and how they relate to patterns in relationships, role play activities) aimed at building April's confidence and providing the skills needed to communicate openly with her parents. Later sessions will focus on helping April introduce more positive relationship attributes into her own life while also helping her to establishing goals and

desired outcomes to address her ongoing relationship with her parents. At the end of six sessions, April will have the self-confidence, resources, and skills in place to approach a healthy discussion with her parents. She will also continue to benefit from the supportive relationship with the home visiting team members as she navigates these relationship challenges.

Module 3: *Parental Stress and Coping*

This module, grounded in CBT, emphasizes awareness of negative thought processes that can impede positive parenting choices and cognitive restructuring and psychoeducation around alternative coping strategies. The aim of the module is to bring awareness to the client of her negative thought processes, to build confidence in her parenting abilities by teaching the client coping skills, and to help the client learn to substitute her current negative thoughts and images with more positive and productive thought patterns. The module builds on the assumption that positive changes in her thought processes will positively impact her self-esteem, behavior, and parenting techniques. The following case vignette illustrates one example of a client who may elect to engage in the Parental Stress and Coping module.

Case Vignette: "Megan"

Megan is the single mother of a 2 month old daughter; both live in the home of Megan's step-father. Megan's mother is currently in rehab for crack cocaine addiction. Megan has a high school diploma but is not employed. She spends her day caring for her baby as well as her younger half-brother, age 4, who is in legal custody of Megan's step-father. While Megan has cared for her half-brother for several years, she is having a difficult time adjusting to her own parenthood. She is resentful that she cannot spend time going out with her friends and reports feeling angry with the fact that she doesn't have her mother's support, while simultaneously trying to provide the children in the household the care and nurturing she never received herself. She reports that the baby frustrates her when she won't stop crying, and that she feels like she is going "crazy" by having to stay at home to "baby sit " both her brother and own daughter all day, when she doesn't really even know if she is caring for them well enough "so they don't grow up to have problems."

When working with Megan, a social worker would begin with a psychosocial history of Megan's relationship with her daughter, younger brother, and step-father. Initial sessions would provide psycho-education on the cognitive impacts of parenting stress and depression, describing some of the negative thoughts that often

accompany depression and stress. During the initial phase, the social worker would work with Megan to identify one negative cognition related to her parenting role that will be the focus of future sessions (e.g. "I am too stressed out to be a good parent") while assisting Megan in identifying trigger events and depressive symptoms that contribute to her negative cognition. Middle sessions would likely focus thought stopping and restructuring using specific activities (e.g. realigning thoughts with reality, thought substitution, mental imaging) along with learned relaxation techniques that will help Megan manage and cope with the stresses of parenting. These will be practiced during sessions and through weekly homework assignments. The restructuring of Megan's negative cognition into a more realistic cognition (e.g. "I have a lot on my plate but I am doing the best that I can") will assist in building Megan's confidence in her ability to parent. Later sessions will include goal-setting and linkage with additional resources as needed, based on Megan's progress. In the end, Megan should be armed with a number of tools that will help her manage the stresses of parenting, with an increased awareness of the problematic thought patterns that can impede her psychosocial well-being as well as tools to adapt them.

Module 4: *Understanding and Coping with Depression*

This module is also grounded in CBT and focuses primarily on problematic thought patterns that keep the client from making progress toward seeking and accepting mental health services and support. The aim of the module is to help the client develop useful coping skills to manage her depressive symptoms and to gain a level of control and decision-making over her emotional health and well-being through changing her cognitive framework. The desired outcome is that the client will begin to experience emotional relief and simultaneously will become more empowered in her ability to actively change her behaviors and thoughts that interfere with the community service utilization that would support her mental health. The following case vignette illustrates one example of a client who may elect to engage in the Understanding and Coping with Depression module.

Case Vignette: "Kisha"

Kisha is the mother of a 9-month old son. She is originally from Louisiana but moved away to a different region of the country with her boyfriend last year. Kisha and her boyfriend broke up two months ago and she reports feeling isolated, angry, and depressed. Kisha is not sure if she wants to move back to Louisiana because she does not have a lot of family support at home and is hopeful that she will be able to rekindle the relationship with her child's father in the future. She once saw a counselor and took an anti-depressant before she got pregnant, but now she has stopped that because she doesn't have a regular physician. She is

working part time doing housekeeping for a local motel but states that she thinks she may get fired because she hasn't been going into work consistently. She has a friend across town who will watch her son, but many days Kisha wakes up and just doesn't feel like she has the energy to take the bus across town to her friend's house, get to work, and then come back home to care for her son after work so she calls in sick instead. Kisha reports that she does not have a lot of other friends and spends almost all of her non-work time at home with her son, watching television and just "hanging out" in their apartment.

Applying this module to Kisha, a social worker would begin with a psychosocial history followed by an in-depth discussion of Kisha's relationship with her son and her son's father. Initial sessions would include psycho-education about the cognitive impact of depression and would encourage Kisha to identify a symptom of depression that she experiences, share an event which has triggered the symptom in the past, and discuss the ways in which the symptom has impacted her life. The social worker would then work with Kisha to focus on the symptom and the specific thoughts associated with that symptom. The worker encourages Kisha to replace the negative cognition with a more realistic positive or neutral cognition. The new cognition can be reinforced during visits with other members of home visiting team, using the same positive language to assist Kisha in restructuring her thought processes. Middle sessions will focus on teaching Kisha cognitive restructuring techniques and brief relaxation exercises that will help Kisha manage the symptoms of her depression while simultaneously realigning her thoughts with reality. Kisha will be encouraged to practice these techniques both in sessions and through homework assignments. The middle phase will also work to build Kisha's support system and reduce her social isolation. The social worker may spend time building Kisha's confidence so that she can begin to reach out and connect with other women in her neighborhood or in the home visiting program. In later sessions, the social worker and Kisha will review Kisha's progress and will develop a self-care plan that will include future short-term and long-term goals, including an evaluation of longer-term counseling or psychopharmacology. By the end of session six, Kisha experiences a decreased sense of social isolation, becomes more receptive to the home visiting program, and realizes that she might gain something from ongoing mental health services to address her persistent depressive symptoms.

Clinical Implications

The vignettes in this article reflect the real experiences of women served through MCH home visiting programs. The situational struggles women face may not be regarded as "mental health" challenges either by women themselves, or by paraprofessional and health focused staff members who work with them. Many times,

women characterize their experiences as “stress” or “dealing with life” rather than as a mental health challenge, warranting intervention. Often, it is only when the increasingly stressful and complicated events of daily life take a negative toll on parenting or daily decision-making that women are screened for mental health. At that point, mental health services may not be accessible or willingly utilized. By considering the lived experiences of low-income women parenting in difficult circumstances, clinical social workers can apply intervention strategies which can build emotional capacity, promote mental health, and support existing strengths in young mothers. In the context of home visiting, these families are concurrently provided with a case management and support system promoting physical health and positive parenting through the home visiting program. We have specifically worked in partnership with a maternal and child health home visiting program to determine if this integrated approach is feasible and whether staff can effectively learn and implement the key components of the Enhanced Engagement module within a short time. In addition, we spent considerable time building the receptivity of team members to an intervention model that holistically encompasses mental health in addition to other home visitation program components.

The Enhanced Engagement model and its four thematic modules, as described, are being implemented and evaluated as a part of routine practice in one local MCH home visiting program. It has taken several years of training, open communication, and capacity-building support for the overall agency to embrace a mental health inclusive philosophy. One of the biggest challenges to overcome was the presumption among home visiting program staff that all mental health activity belonged “somewhere else” such as the public mental health sector. As many social workers are already aware, the public mental health system is already overburdened and cannot adequately respond to all situations involving elevated depressive symptoms. Low-income women served through MCH home visiting report extensive waiting lists, triaging services for those with only the most severe symptoms, and time-constrained providers valuing pharmacology over behavioral counseling (author, in press). It takes effort and persistence to develop an inclusive mental health philosophy. Additional partnership activities focused on creating coalitions and linkages so that agency staff felt supported and adequately linked to community referral resources. We worked collaboratively to define the breadth and limitations of clinical social work services that could reasonably be provided within the home visiting context in order to insure that appropriate management and referrals were made between agency staff and community mental health services. Importantly, training was provided not only on the clinical models, but also on defining and asserting limitations that were beyond the scope of the program and warranted guided support and direction to other appropriate providers. Overall, this

comprehensive approach to screening, assessment, brief intervention, and re-assessment of need was one which fit well within the MCH home visiting infrastructure. The Enhanced Engagement model offered an alternative to the usual "screen and refer" procedures which may leave many women with unmet mental health needs when services to which they are referred are not available, accessible, or affordable.

Discussion

This article discusses the development and implementation of an Enhanced Engagement model, which was designed with the specific intent of addressing the unmet mental health needs of women participating in maternal child health home visiting programs. The Enhanced Engagement model is a culturally informed and responsive brief intervention that clearly integrates existing theory, as described, with empirical evidence that is currently under investigation. The model offers social work practitioners a structured approach to the delivery of brief mental health intervention within the MCH home visiting setting based on working components of IPT and CBT while offering consumer choice among evidence-informed modules that are specifically designed around commonly encountered life experiences. Each of the four unique modules is designed to be delivered in the home, consistent with other aspects of MCH home visiting. Therefore, the model provides immediate mental health support to newly enrolled clients while simultaneously building trust and concurrent engagement with the home visiting team members and the program's parenting and health education curricula. The enhanced trust and embrace of mental health within the home visiting team is intended to facilitate future targeted referral to additional community services as needed. Simultaneously, stigma is reduced by delivering mental health promotion up-front as a central component of the team's services along with parenting and health promotion. In addition, we anticipate that the cost-efficacy of a timely delivered brief intervention by social work team members may be comparable (or even improvement) to usual care case management and referral. Tiered service delivery models such as Enhanced Engagement are especially important when there are limited community resources and/or lengthy wait lists for specialty mental health services.

At the present time, the formal intervention pilot translated to overall agency practice is under investigation using a prospective, quasi-experimental research design. Anecdotally, there have been positive benefits observed and reported on a case-by-case basis by the social work and interdisciplinary team staff members who have voiced consensus that the modules are easy to implement, flexible, and well-received by the women participants in the home visiting program. Specifically, the formal research study underway will examine the outcome of the

Enhanced Engagement Model compared with usual care (which includes general social work and mental health support), focusing on outcomes of maternal depression (primary), anxiety, functional social support, emotional social support, as well as staff time and cost comparisons for the MCH team members as well as community resources as secondary outcomes. We are optimistic about the research findings based on preliminary data and anecdotal reporting, and anticipate publication of results at the conclusion of the project in late 2012. Following this pilot, we hope to consider additional pathways for translational research implementation of the Enhanced Engagement modules to other groups of underserved women who could benefit from mental health promotion. Concerted effort is needed to document cost efficacy and leverage the funding support necessary to deliver relevant and responsive clinical social work services within public sector family support programs such as MCH home visiting (which is funded largely through Title V of the Social Security act through state-level public health providers). Clinical social workers may consider the utility of such an approach in underserved practice settings where brief intervention may be an important pathway to mental health promotion. In addition, clinical practitioners may focus on ways to partner and create coalitions among providers across varied practice settings who respond to mothers and families at risk. The time has come to move beyond documenting the negative impact of depression and towards creation of meaningful and sustainable service delivery mechanisms which reach into the community and target intervention within settings where other support services are provided.

The Enhanced Engagement model is not designed as a free-standing treatment to address the clinical challenges within complex life situations; rather its purpose is to target symptom alleviation while building success with realistic goals which enhance confidence and self-esteem. The strength of the Enhanced Engagement model is its ability to act as the foundation for building a meaningful and trusting relationship with a mental health professional while simultaneously helping the client improve their current situation through symptom alleviation within a relatively short amount of time.

It is noteworthy to mention that while the model described here is discussed within the context of at-risk mothers and their families, the model has significance for broader trends in eliminating health care disparities and improving health care delivery and financing through the integration of behavioral health care for all populations. This assertion is supported by language and policies supported through the Patient Protection and Affordable Care Act (PPACA). The guiding principles and supported activities of the PPACA posit that our ability to eliminate disparities depends on our capacity to produce culturally appropriate interventions and policies that integrate care

across systems and populations (Gorin, Gehlert, & Washington, 2010). Social workers are ideally situated with the clinical skills as well as administrative and policy expertise necessary to foster system level changes that promote maternal and child health and well-being in an integrated manner, including evidence-based response to mothers at risk for perinatal depression.

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