

Promoting Infant-Early Childhood and Parent Mental Health in Home Visiting Programs Serving Diverse Families:

PROMISING STRATEGIES TO SUPPORT CHILD AND FAMILY WELL-BEING

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Introduction

Early home visiting programs offer unique opportunities to enhance the mental health of parents and their infants or young children. While home visiting programs are highly varied in their design and source of funding, several features common to most of these programs can be leveraged to address the mental health-related needs of families. One of these features is sustained contact with families, which can help home visitors build trusting, supportive relationships with parents; these relationships, in turn, help retain families in the program and benefit from services. Another is the provision of guidance and coaching to foster responsive parenting and close, nurturing parent-child relationships, conditions that are foundational to children’s social-emotional well-being and development. In their efforts to help families overcome challenges related to health problems and basic needs, either through direct services or connecting families to other programs, home visiting programs can also significantly reduce parent stress and enhance family well-being.

While all home visiting programs have the potential to offer strong supports for parent and infant-early childhood mental health, the field is still learning about ways to maximize these supports.¹ Many aspects of program design and implementation may make a difference in the strength of supports for infant-early childhood mental health and related outcomes. Programs funded under the Maternal and Infant-Early Childhood Home Visiting (MIECHV) and Tribal Maternal and Infant-Early Childhood Home Visiting (TMIECHV) programs have mental health-related performance standards and required screening practices that strengthen their capacity to

identify parent and child mental health problems.² (See box on MIECHV and TMIECHV performance measures.) However, these programs often face challenges with retaining families and helping them engage in mental health services once needs are identified.³

Finding and recruiting home visitors who can establish trusting relationships with families has been found to be key to family retention in home visiting programs, a likely prerequisite for families to fully experience all of a program’s benefits.⁴ Although evidence is mixed, some research suggests better

SELECTED MIECHV AND TMIECHV PERFORMANCE MEASURES RELEVANT TO PARENT AND CHILD MENTAL HEALTH

- Percent of primary caregivers enrolled in home visiting who are screened for depression using a validated tool* within 3 months of enrollment (both MIECHV and TMIECHV)
- Percent of primary caregivers enrolled in home visiting who receive an observation of caregiver-child interaction using a validated tool* (both MIECHV and TMIECHV)
- Percent of postnatal home visits where primary caregivers were asked if they have any concerns regarding their child’s development, behavior, or learning (MIECHV)
- Percentage of primary caregivers who are screened for parenting stress using a validated* tool within three months of enrollment and at least annually thereafter (TMIECHV)
- Percent of primary caregivers referred to services for a positive screen for depression who receive one or more service contacts (MIECHV)
- Percent of primary caregivers screening positive for depression or parenting stress using a validated* tool who receive a timely referral for services and a follow up (TMIECHV)

**Indicates that there may be no validated tool in American Indian and Alaska Native communities, but grantees would select and use the most appropriate tool for their program and community*

outcomes in programs where services are delivered by home visitors who come from the same communities and who match the racial/ethnic and cultural backgrounds of the families they serve.⁵ While most home visiting staff are not mental health clinicians, they often receive training and ongoing support that focuses on parent and infant-early childhood mental health, but research on the efficacy of these supports for home visitors with different educational backgrounds and experience is still limited.⁶

Given the central importance of positive parent and infant-early childhood mental health to children's long-term mental health and development, it is important to examine a wide range of approaches that show promise for strengthening supports for parent

and infant-early childhood mental health in home visiting programs, especially programs serving diverse families. This report provides a view of promising strategies from the perspective of staff in home visiting programs that span multiple types and models and serve families from different cultural, racial/ethnic, and linguistic backgrounds. Following a brief discussion of the project's methods for identifying and learning from a sample of home visiting programs, the report examines key strategies for promoting parent and child mental health as described by home visiting staff and expert respondents. The report concludes with recommendations for policy, program implementation supports, and research that could help advance the field's understanding and use of the most effective strategies.



Methods

Initial consultations with national home visiting research and policy experts helped determine the approach used to identify strategies for supporting infant-early childhood mental health (IECMH) in home visiting programs serving diverse families. This approach began with the wide distribution of a survey that asked key home visiting organizations, state agencies, and informants to identify statewide or local home visiting programs that provide exceptionally strong supports for the mental health of the infants, young children, and parents they serve. Respondents were asked to prioritize the identification of exemplary programs that serve racially, culturally, and linguistically diverse families. The survey included questions about:

- Funding and governance of the programs (e.g., MIECHV, TMIECHV, and state-funded/administered)
- Home visiting models
- Areas of exceptional strength in IECMH and parent mental health (e.g., screening and referral, IECMH consultation, staff recruitment, workforce training and ongoing support, and embedded interventions)
- Other features of the program and system supports that help ensure exceptionally strong strategies for addressing family mental health needs
- Characteristics of the families served

The survey was sent to state, territory, and Tribal MIECHV leads, the Association of State and Tribal Home Visiting Initiatives, state offices of refugee

resettlement, state immigrant advocacy organizations, and disseminated via the Health Resources and Services Administration MIECHV newsletter, the National Home Visiting Resource Center newsletter, and the Home Visiting Applied Research Collaborative listserv. Qualtrics, a web-based platform, was used to administer the survey. Fifty-eight responses were received.

Project staff selected exemplary programs from the survey responses for follow-up phone interviews to obtain more detailed, qualitative information. The follow-up process prioritized programs that appeared to use one or more strategies to offer exceptionally strong IECMH-related supports and engage racially, culturally, and linguistically diverse families. Interviews were then conducted with representatives from 21 home visiting programs, which included agencies delivering home visiting services, model developers and representatives, state-level home visiting program administrators, and organizations offering supports, such as mental health consultation, to home visiting programs. (See box for list of interviewees.)

A topical coding scheme was developed to analyze content from these interviews, as well as relevant home visiting program profiles from [PRISM](#), an online collection of profiles that provide information about IECMH strategies and policies used in scaled initiatives. Coding was conducted using Dedoose, a qualitative analysis software program. Analysis of the coded interview content identified the key strategies discussed in the next section.

**INTERVIEWS CONDUCTED WITH AGENCIES DELIVERING HOME VISITING SERVICES
(HOME VISITING MODEL IN PARENTHESES, IF APPLICABLE)**

Community Action Inc. of Central Texas
(Parents as Teachers*)

El Sol Neighborhood Educational Center, California
(Healthy Children, Resilient Families)

Global Perinatal Services, Washington State

Great Plains Tribal Leaders Health Board
(Family Spirit*)

Healthy Families Kansas
(Healthy Families America*)

Healthy Families Massachusetts
(Healthy Families America*)

Healthy Families Mississippi
(Healthy Families America*)

Las Cumbres, New Mexico
(Confident Parenting)

Latino Community Development Agency, Oklahoma
(SafeCare)

Massachusetts Early Intervention Parenting Partnerships

Michigan Infant Mental Health-Home Visiting Nurses for Newborns, Missouri

Power of Two, New York
(Attachment and Biobehavioral Catch-up*)

RefugeeOne, Illinois
(Baby TALK)

Sisseton Wahpeton Oyate Indigenous LAUNCH
(Family Spirit*)

South Puget Intertribal Planning Agency, Washington State (Parents as Teachers*)

University of Nevada, Reno, Early Head Start
(Early Head Start*)

MODEL DEVELOPERS AND ORGANIZATIONS THAT SUPPORT HOME VISITING

Best Starts for Kids, Washington State

Child First*

Family and Child Education

Georgia Home Visiting Program

Louisiana MIECHV

Mothers and Babies

Parent Possible Enhanced Home Visiting, Colorado

Smart Support, Arizona

Texas Home Visiting

** indicates model is eligible for MIECHV funding*

Key Strategies

As noted earlier, home visiting programs of every type and model offer some level of support for child and family mental health. At a minimum, this support resides in the efforts of home visitors to offer parenting, child development, and self-care guidance and help families secure necessities to ease both material hardship and stress related to inadequate resources. The strategies discussed in this section represent exceptionally strong approaches to building the capacity of home visiting programs and home visitors to identify and address the mental health needs of families. (A compilation of these strategies can be found in the Key Strategies table.)

Home visiting programs recruit home visitors who can forge close connections with the families they serve, including staff who share backgrounds similar to families

Many programs discussed the connection between close home visitor-family relationships and the ability of home visitors to support families' mental health. Without these close relationships, families are often reluctant to discuss sensitive topics with home visitors, including parental depression and challenges with child behavior, and therefore are less likely to receive needed supports. When hiring home visitors, programs responded that they look for applicants who not only speak the primary language of the families they serve, but also share a cultural background. More broadly, respondents said that they seek home visitors who share similar lived experiences with the families they serve, which allows home visitors to bring a better understanding of families' circumstances to their interactions. Program leaders emphasized the importance of seeking candidates who display a passion for the work and the ability to communicate with and engage families, rather than those with particular formal qualifications. Many of the programs participating in our interviews do not require home visitors to have an associate or bachelor's degree, giving programs more latitude to focus on the background and characteristics of home visitor candidates who are likely to promote close, supportive relationships with families.

Practices that Support Recruitment and Retention of Effective Home Visitors

Programs reported on several practices that help them find home visitors who share backgrounds and experiences with the families they serve. They translate job postings into multiple languages and post them at frequently visited locations in the communities they serve, such as churches, community centers, and restaurants. They seek referrals via word of mouth from community members and current home visitors, and a number of programs actively reach out to former program participants. At one agency offering doula services, **Global Perinatal Services** in King County, Washington, the director is a certified doula trainer. To meet the needs of Oromo- and Somali-speaking families in the community, the director trained a cohort of Oromo- and Somali-speaking doulas and then hired those who proved best suited to the doula role. **Healthy Families Kansas** pays home visitors three percent more if they are bilingual and reduces the caseloads of home visitors who provide a significant amount of translation for the families they serve. **Healthy Families Massachusetts** is also able to reduce the caseloads of bilingual home visitors in recognition of the additional translation-related work they may need to do. Multiple programs mentioned that hiring Black home visitors has been a challenge, with one program, **Massachusetts Early Intervention Parenting Partnerships**, noting that they see a substantial increase in referrals of Black families when they do.

Home visiting programs emphasize infant-early childhood and family mental health knowledge and skills in pre- and in-service professional development and support

Programs discussed the importance of training designed to help home visitors gain the knowledge and skills needed to support children's and families' mental health. Many home visitors do not have previous educational or work experience in mental health when they enter the field and rely on home visiting programs for training in this area. Because mental health issues are some of the most sensitive,

KEY STRATEGIES FOR PROMOTING IECMH IN HOME VISITING PROGRAMS SERVING DIVERSE FAMILIES

- Home visiting programs recruit home visitors who can forge close connections with the families they serve, including staff who share backgrounds similar to families
- Home visiting programs emphasize infant-early childhood and family mental health knowledge and skills in pre- and in-service professional development and support
- Home visiting programs use reflective supervision and infant-early childhood mental health consultation to build home visitors' capacity to address diverse families' mental health needs
- Home visiting programs employ multiple strategies to retain a skilled workforce with the capacity to support the mental health and well-being of children and families
- Home visiting programs use a variety of efforts to reach and enroll harder-to-reach families in the communities they serve
- Home visiting programs use shared cultural experiences and program flexibility to help home visitors build close relationships with the families they serve
- Home visiting programs use individualized and culturally tailored strategies to conduct child and parent screening related to mental health and support families' engagement in needed evaluations and interventions
- Home visiting programs help ensure access to needed mental health evaluations and interventions through their model design, referrals, and home visitor training
- Home visiting programs offer other critical services and concrete supports that can reduce family stress and enhance the mental health and well-being of children and families
- Home visiting programs engage in continuous quality improvement (CQI) efforts and use data to better identify and address mental health needs of children and families
- Home visiting programs inform and benefit from systems-level supports

challenging, and important concerns for home visitors to discuss with families, this training is critical.

Programs described a range of topics covered in training offered to home visitors, including foundations of infant mental health, maternal depression, attachment and early relationships, trauma-informed care, and diversity-informed practice. Home visitors may also receive training on evidence-based and research-informed interventions and approaches, such as **Brazelton TouchPoints**, **Facilitating Attuned Interactions**, and **Motivational Interviewing**, which help them build stronger relationships with families and achieve the goals that families identify. Other interventions, such as **Mothers and Babies**, a post-partum depression prevention intervention, (see Mothers and Babies box for more information) and **Circle of Security**, a parenting program to promote close, positive parent-child attachment, can be implemented by home visitors without mental health backgrounds.

Relevance of Training Content

Trainings should be accessible and meaningful to the diverse home visitor workforce and the families it serves. In King County, Washington, the **Best Starts for Kids (BSK)** initiative offers infant-early childhood mental health in-service training to King County home visiting providers. To identify training topics, BSK surveyed King County providers and found

that home visitors wanted to ground their practice in social justice and equity. Topics such as trauma-informed practice, infant mental health 101, reflective supervision, maternal mental health, and attachment are therefore considered within a broader policy and societal context. For example, trainings address fears about family separations among immigrant families served by BSK. Some trainings have been delivered in Spanish and American Sign Language, and those delivered in English have interpreters available.

Leaders from home visiting programs delivered by the **Great Plains Tribal Leaders Health Board (GPTLHB)**, which serves 18 tribes in Iowa, Nebraska, North Dakota, and South Dakota, attended a **Mothers and Babies** training and agreed that this maternal depression prevention intervention, which can be integrated into most home-visiting programs, would benefit the families they serve. They recognized the need to adapt it for tribal communities and reached out to the developers of Mothers and Babies about developing a version specifically tailored to Lakota families. This collaboration resulted in the adaptation of the facilitator and parent manuals for Lakota language and culture, including visual depictions, other design elements, and cultural and spiritually grounded content incorporating the Lakota worldview. The process of adapting Mothers and Babies for Lakota families and, then the Dakota community, produced a sense of ownership among

MOTHERS AND BABIES

Mothers and Babies (MB) is an evidence-based intervention to prevent onset of major depression and reduce depressive symptoms in pregnant and parenting people. Based on cognitive behavioral therapy and attachment theory, MB uses a psychoeducational approach to help parents learn to use coping strategies. These include methods for monitoring their moods and managing stress with a focus on pleasant activities, thoughts, and social supports. MB is delivered in-person or virtually, either one-on-one (for nine sessions of 20-25 minutes) or in groups (for six sessions of 90-120 minutes).

MB offers a range of training pathways that differ for individual service providers, individual agencies or organizations, or statewide networks. Training participants complete a 75-minute self-led module that provides an overview of MB, followed by two half days of live virtual training. An additional train-the-trainer session is available for those who are interested, and it is critical for sustaining MB since home visiting programs often have high rates of staff turnover. MB offers monthly consultation to all training participants for the first year to support implementation.

home visitors and program leaders that strengthened their commitment to implementing and supporting Mothers and Babies. Apart from these adaptations, Mothers and Babies already aims to be responsive to the needs of diverse families. Materials for implementing Mothers and Babies are available in various languages, including English, Spanish, Haitian Creole, and Arabic. The developers encourage home visiting programs to adapt Mothers and Babies for the particular populations they serve, and they provide guidance on allowable adaptations that maintain fidelity to the model.

Ongoing Support for the Application of New Knowledge to Home Visiting Practices

Programs use a variety of strategies to provide ongoing support for home visitors' use of skills and knowledge acquired in training. **Healthy Families Mississippi** has a 10-tier system of professional development that home visitors can progress through over the course of five years. **In Louisiana, MIECHV-funded programs** require participation in an initial training on the foundations of infant mental health. This is supplemented by quarterly in-service trainings about mental health, which are developed at the state level by regional infant and early childhood mental health supervisors and delivered to home visiting teams by mental health consultants. These trainings focus on applying knowledge in the everyday work of home visitors (e.g., how to conduct a child social-emotional screening and discuss results with parents). Home visiting teams may request additional mental health training tailored to their individual needs.

In the case of preservice training, both **Washington South Puget Intertribal Planning Agency** and **Healthy Families Kansas** have new home visitors shadow experienced ones, while **Healthy Families Mississippi** has new home visitors conduct five practice home visits. Home visitors funded through an **Indigenous LAUNCH (Linking Actions for Unmet Needs in Children's Health)** grant serving **the Sisseton Wahpeton Oyate tribal nation** in South Dakota participate in infant-early childhood mental health consultation to follow up on trainings and integrate new learning into their practice (see the following section for more information on reflective consultation/supervision and mental health

consultation). Training on the **Mothers and Babies** maternal depression prevention intervention includes regular consultation calls with trainers for a year or more to support implementation fidelity. **Great Plains Tribal Leaders Health Board** and **Georgia Home Visiting**, both of which also offer Mothers and Babies in home visiting, received train-the-trainer trainings and have the capacity to deliver training on this model to home visitors without relying on external trainers. Georgia Home Visiting also offered a six-month community of practice to participants in each Mothers and Babies training cohort.

Training for Supervisors and Program Leaders

Home visiting supervisors and other program leaders also benefit from trainings that develop knowledge and skills related to infant-early childhood and family mental health. **Best Starts for Kids (BSK)** established a 10-month **BIPOC Community of Leaders in Reflective Practice (BIPOC CoL)** to build this capacity. All participants in the BIPOC CoL were People of Color, including the trainers, three mentors, and 82 participants from BSK grantee organizations. Participants included supervisors, as well as a large number of direct service providers from a range of sectors, including home visiting. Quarterly trainings on many topics, including Radical Hope, were followed by monthly, 90-minute small group mentorship discussions to deepen engagement with the training. The three mentors are reflective consultants in King County. Many participants of the BIPOC CoL now facilitate reflective practice at their own organizations and some take more active leadership roles in their agencies by bringing an infant-early childhood mental health focus to all levels of agency work.

Home visiting programs use reflective supervision and infant-early childhood mental health consultation to build home visitors' capacity to address diverse families' mental health needs

In addition to training, many home visiting programs offer regular reflective supervision and mental health consultation to their staff. In reflective supervision, home visitors "examine their thoughts, feelings and behaviors in their ongoing work with infants, toddlers and their families. [Reflective supervision] provides an

ongoing, regularly scheduled, and safe environment to do that reflection and...can lead to professional growth and improve practice.”⁷ Reflective supervision is usually provided by a supervisor within the home visitor’s program, and it is distinct from day-to-day job supervision. Infant-early childhood mental health (IECMH) consultation is delivered by a mental health professional who can support home visitors’ ability to understand and effectively address the mental health needs of the young children and family members they serve. Both reflective supervision and IECMH consultation may be delivered individually and in groups.

Almost all programs reported that they offer at least one of these supports regularly, and sometimes these were described in ways that show common features. One program’s mental health consultant talked about supporting reflective practice and another professional included discussion of cases and strategies to support families in group reflective supervision. Two of the main outcomes of these supports that programs identified are: 1) maintaining, reinforcing, and building home visitors’ skills and knowledge related to strategies for supporting families’ mental health and 2) addressing particular challenging cases and situations.

Qualifications, Training, and Support for Reflective Supervision and Consultation

Programs described a variety of efforts to ensure that the professionals delivering reflective supervision and IECMH consultation to home visitors have the competencies needed for this work. Several programs highlighted the value of ensuring that supervisors who provide reflective supervision have a background in infant-early childhood mental health and additional training on models, such as **Facilitating Attuned Interactions (FAN)**, that promote reflective practice and responding with empathy and sensitivity to parents’ cues. In **Louisiana’s state MIECHV program**, which offers IECMH consultation to all home visiting teams, all consultants received training from **Tulane University’s Institute for Infant and Early Childhood Mental Health** for 15 days over a five-month period, as well as individual clinical and reflective supervision at least one to two times a month. Consultants also benefit from monthly,

half-day statewide meetings that include a case presentation, as well as access to the state’s **Provider-to-Provider Consultation Line**.

Arizona’s **Smart Support** IECMH consultation program, which serves home visiting teams delivering evidence-based home visiting models, provides extensive pre- and in-service training and ongoing supports to consultants. All consultants are required to have a master’s degree in a license-eligible mental health discipline. New consultants participate in a two-week orientation, followed by a yearlong training period that covers the Smart Support consultation model, service delivery, reflective supervision, evaluation and database training, the **Pyramid Model**, and the **FAN** approach. Consultants participate in weekly hour-long sessions with their supervisor and attend monthly group supervision meetings, which blend discussion of administrative issues with reflection on consultation work. Consultants may also apply to the **Harris Infant and Early Childhood Mental Health Training Institute** at Southwest Human Development, with tuition covered by Smart Support. This two-year training consists of full-day sessions once a month that cover the principles and practices of infant mental health.

Enhanced Home Visiting (EHV) in Colorado offers group reflective consultation to home visiting supervisors each month. The consultant has an individual onboarding call with supervisors before they join a group and can also offer individual sessions on an as-needed basis. In the evaluation of EHV, supervisors underscored the value of group reflective consultation, especially its provision of support among peers sharing similar experiences and its help toward reducing isolation and managing the challenges experienced by supervising staff.

Consultant Connections with Home Visitors and Relevance of Support

Programs also emphasized the importance of having consultants who are able to forge close connections with home visitors. Both **South Puget Intertribal Planning Agency** and **Sisseton Wahpeton Oyate ILAUNCH**, which serve tribal communities with home visiting programs, spoke of the value of working with a consultant who has decades of experience working with tribal communities. In Colorado, **Enhanced**

Home Visiting (EHV), an initiative to improve the well-being and mental health of home visitors and supervisors, provides reflective consultation, workforce wellness, and infant-early childhood mental health training to MIECHV-funded programs across the state. An **evaluation** found that EHV supports helped increase home visitors' use of self-care practices and reduced family dropout. Sites have autonomy in hiring consultants, and one site that works with a substantial population of refugee families selected a consultant because she was already deeply engaged with the community.

In King County, Washington, **Best Start for Kids** began to require its mental health consultants who deliver group reflective consultation to participate in **Intergroup Dialogue**, a series of semi-structured, facilitated meetings for members of different social identity groups to help build critical self-awareness and social awareness and to better ground their approach to infant-early childhood mental health in the principles of social justice and equity. This requirement was a response to concerns from home visitors, identified in an evaluation, that the consultants were not always adept at addressing concerns related to implicit bias, microaggressions, and barriers produced by structural racism. In New Mexico, **Las Cumbres** convened a race and social justice group for home visitors, which offered a safe space to discuss their work. A clinician on the agency's behavioral health team hosted weekly meetings that approached topics such as suicide awareness, postpartum depression, homelessness, and awareness of resources for the community from an equity and social justice perspective. One outcome from this group was successful advocacy to raise compensation for bilingual home visitors. Las Cumbres also offers Spanish-language group supervision for its bilingual home visitors.

Programs reported on additional targeted supports for home visitors that promote effective interactions with families. In **Louisiana's state MIECHV program**, consultation requests are automatically made when parents screen positive for depression or anxiety or are known to have experienced trauma. To support home visitors' implementation of strategies identified with the consultant, the consultant has

regular meetings with the home visitors' supervisors to help reinforce their use. Arizona **Smart Support** consultants conduct pre- and post-home visit phone calls with each home visiting team, which are used to plan future home visits.

Home visiting programs employ multiple strategies to retain a skilled workforce with the capacity to support the mental health and well-being of children and families

Given the effort involved in recruiting, training, and supporting home visitors, home visiting programs emphasized the need to retain these skilled professionals. However, the work of home visiting can be extremely stressful, undervalued, and poorly compensated in relationship to the demands of the job, all of which contribute to high turnover.⁸

Home Visitor Well-Being

One retention strategy programs cite is offering supports for home visitor mental health and well-being. In addition to reflective supervision and IECMH consultation (discussed above), programs also mentioned that home visitors draw on skills learned in training intended to benefit families, such as Mothers and Babies, to address stress and anxiety in their own work and lives. In Colorado, **Enhanced Home Visiting** offers quarterly group consultation sessions explicitly designed to address and support home visitor wellness through a focus on secondary trauma and mindfulness. There are also full-day mindfulness retreats offered three times a year that address well-being, such as work-life balance and practical ways to deepen resilience during challenging times.

Professional Advancement Pathways

Another strategy home visiting programs use to retain home visitors is offering pathways to professional advancement, including support for obtaining formal credentials while placing a high value on lived experience. **Infant Mental Health Endorsement and Early Childhood Mental Health Endorsement** are credentials that recognize experiences that lead to competency and are evidence of a specialization in infant or early childhood mental health. In King County, Washington, the **Best Starts for Kids** initiative helped nearly 200 home visitors attain

endorsement at the Infant Family Associate level, which requires either a college degree or two years of experience and is more accessible to those home visitors who do not have the degrees required by higher levels of endorsement. To support home visitors with the endorsement process, BSK offered scholarships to cover the cost of endorsement and also helped them meet the endorsement training requirements through its infant-early childhood mental health trainings. Qualitative evaluation data from the endorsement process found that participants gained a view of themselves as professionals engaged in important work supporting infant-early childhood mental health. **Healthy Families Massachusetts** has worked with the Massachusetts Association for Infant Mental Health to help its home visitors earn endorsement. Following an extensive cross-walking of Healthy Families Massachusetts training offerings with the endorsement requirements, a cohort of 32 applied for endorsement in spring 2023, with 23 applying at the Infant Family Specialist level and 11 applying at the Infant Family Reflective Supervisor level.

In Illinois, **RefugeeOne**, a refugee and immigrant resettlement agency, offers home visiting using the **Baby TALK** model through a contract with the Chicago Department of Family Support Services (DFSS). The contract requires home visitors to have a Family Support Specialist credential, which includes earning a bachelor's degree within five years. DFSS supports RefugeeOne's home visiting workforce, all of whom are former refugees, in meeting these coursework and degree requirements by paying tuition and covering the cost of course supplies; without this subsidy, costs would be burdensome for home visitors who typically do not have higher education credentials when they are hired.

Home visiting programs use a variety of efforts to reach and enroll harder-to-reach families in the communities they serve

Programs emphasized the importance of reaching all eligible families in the communities they serve, especially those from underserved groups who may have greater difficulty in addressing parent and child mental health concerns. To do this, programs reported

building referral relationships with other trusted organizations in the community that already reach underserved populations, including places of worship, healthcare providers, early care and education providers, and WIC offices. Several programs noted that word of mouth from existing families is a primary source of referrals, especially among harder-to-reach populations, such as undocumented immigrants and families who speak a language other than English. Programs explained that families recruited in this way have high rates of retention. Some programs, such as **Community Action Inc. of Central Texas**, also offer incentives in the form of gift cards or car seats for families who enroll and remain involved in the program.

Family Recruitment

Programs discussed the importance of engaging in intentional approaches to family recruitment, including monitoring what is and is not successful. **Healthy Families Massachusetts** programs are required to conduct self-assessments every two years to determine if the families they serve are representative of their community catchment areas. A statewide technical assistance provider then works with programs to identify trends and develop strategies to address barriers, such as ensuring staff reflect the local population, translating materials into languages spoken in the community, and working with existing and potential referral sources to learn where programs can reach families. Healthy Families Massachusetts programs also consider the messaging they use to engage families, especially in response to family concerns about participation related to the broader political climate for immigrant families. A relationship with **Medical-Legal Partnerships**, which incorporate lawyers' expertise into medical and social service settings to address social determinants of health, provides education to home visitors on changes in local, state, and national legislation that may potentially impact families, including recent immigrants. This education allows home visitors to tailor and guide their interview questions during the relationship-building process, to help identify a family's strengths, challenges, and possible needs, including any concerns related to immigration. **Community Action Inc. of Central Texas (CAICT)**, which delivers **Parents as Teachers**, also noted a

hesitation to access home visiting services among non-citizen, Spanish-speaking families. To better engage these families, CAICT employs a dedicated outreach coordinator who is fluent in English and Spanish, involved in the Latino community, and serves on boards of local organizations.

Home visiting programs use shared cultural experiences and program flexibility to help home visitors build close relationships with the families they serve, promoting family retention and engagement

Programs reported that home visitors find topics related to mental health to be among the most challenging to discuss with families. When home visitors can establish close, trusting relationships with families, it is more likely that families will open up about sensitive issues and stay in the program long enough to receive and benefit from supports. In addition to the workforce recruitment strategies described in an earlier section, programs have adopted several strategies to facilitate the development of trusting relationships with families.

Cultural Relevance to Families

Some programs adapt the content of their models, in formal and informal ways, to increase their cultural relevance. In 2009, **Oklahoma SafeCare** adapted its materials for use with Spanish-speaking families served by **Latino Community Development Agency**. The adaptation incorporated feedback from families and included not only translation into Spanish, but also cultural and colloquial adaptations of materials. For example, the SafeCare health modules incorporate information on culturally defined illnesses experienced by families, such as *empacho* or *mal de ojo*, and discuss responses and remedies, including whether folk remedies may be beneficial or harmful. Families praised these modules, reporting the content changes “made them feel heard.”

The adaptation of **Mothers and Babies** into the Lakota and Dakota languages (described earlier) has proven popular with both families and home visitors. As part of the adaptation, the intervention helps families understand stressors that can affect the mother-baby relationship in the context of the

Lakota worldview encompassed in *Woop'e Sakowin* (Seven Sacred Laws), which reflects important cultural values—compassion, generosity, humility, fortitude, respect and honor, bravery, and wisdom.⁹ An artist incorporated Lakota colors and designs, all of which have specific meanings, into the Mothers and Babies materials. Home visitors have observed parents' positive responses to the adapted materials, including mothers' continued use of the mood journals that are part of the Mothers and Babies program after its completion.

Global Perinatal Services (GPS), a doula program in Washington State that serves immigrant and refugee families, encourages non-Western, culturally meaningful ways to support parents' bonding with their child. These include communicating with children in home languages other than English to encourage bilingualism and introducing children to food from parents' cultures and countries of origin. GPS also adapts screening tools if questions are not relevant to families (e.g., if a question asks about the use of spoons and the family's culture does not use spoons).

Flexibility of Model Delivery

Some programs also allow flexibility in the timing and dosage of model content, especially when it concerns sensitive topics, such as mental health, substance use, and domestic violence. This flexibility allows home visitors to first develop relationships with families, who are then more comfortable discussing their concerns. **Massachusetts Early Intervention Parenting Partnerships** used to screen for maternal depression, intimate partner violence, and substance use at the time of enrollment, but found that allowing up to 60 days to complete screenings gave home visitors additional time to first build trust.

In California, the Promotores, who are community health workers, have considerable latitude in the delivery of **El Sol Neighborhood Educational Center's Healthy Children, Resilient Families (HCRF)** model, which was developed in response to community needs in San Bernardino County. The Promotores work with families to determine the frequency of visits that works best to meet their needs, in contrast to some models that make a specified number of weekly visits a condition of enrollment.

The curriculum model is also flexible, which allows Promotores to respond to families' changing situations and needs, supporting them as they grow, as well as responding to any crises that may arise.

Home visiting programs use individualized and culturally tailored strategies to conduct child and parent screening related to mental health and support families' engagement in needed evaluations and interventions

The use of validated, formal screening tools can help home visitors identify potential mental health needs of children and families in home visiting programs. MIECHV- and TMIECHV-funded home visiting programs are required to report the percentage of family members who receive various screenings with validated tools, including depression screening for primary caregivers, a formal observation of child-parent interaction, and a child developmental screening. Many programs reported that home visitors face challenges in the accurate administration of these tools. Programs described strategies to ensure that they are able to use these formal tools with families to develop an understanding of mental health-related needs and to increase their receptivity to addressing them.

Explaining Screening Tools and Results

Programs emphasized the need to demystify screening tools and destigmatize the topics they address. **Community Action Inc. of Central Texas (CAICT)** created handouts for parents, on topics such as baby blues and parent stress, which can be helpful conversation starters. Each time home visitors conduct a depression screening with caregivers, they share an infographic developed by CAICT, which is available in both English and Spanish. The infographic was developed with parent feedback and covers the goal of screening, what results mean, and possible intervention options. Before discussing the results and next steps with the family, the home visitor meets with a supervisor to discuss the family's situation and experiences, available resources, and insurance status. They also practice the conversation the home visitor will have with the family, fine-tuning the best language to use and including the explanation that a positive result is not a diagnosis.

In Washington State, **Global Perinatal Services** described challenges in overcoming stigma experienced by the immigrant and refugee families they serve when there are concerns about possible child developmental delays or mental health needs. Doula administering screening tools are trained



to talk with families in a positive way about the screening process and the opportunity it provides to address any issues that are found. Home visitors for **Healthy Families Massachusetts**, introduce the **Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO)**, a caregiver-child observation tool, by emphasizing that it is part of the program for all families and helps families recognize what they are doing well and where they might want to build additional parenting skills.

Understanding Family Priorities

Programs also discussed the importance of working with families who have a positive screen, to explore how they understand and feel about the results and how they might address any of the concerns that are identified. In Missouri's **Nurses for Newborns**, nurses use their training in **Motivational Interviewing** to learn about families' attitudes toward the various needs they are screened for, which helps identify family priorities and engagement in developing a realistic plan (e.g., addressing housing if this is a high priority to a family).

Home visiting programs ensure access to needed mental health evaluations and interventions through their model design, referrals, and home visitor training

Many home visiting models employ curricula with activities and strategies for home visitors to use with families that address common difficulties related to parent stress or challenging child behavior. However, when home visitors identify possible mental health-related needs through formal screening tools and discussions with families that go beyond what their curriculum is capable of addressing, they must be able to support families' access to evaluation and appropriate interventions. (See box for more information on evidence-based infant-early childhood mental health (IECMH) interventions delivered by home visiting programs.)

Programs Incorporating Evidence-Based Mental Health Interventions

Some home visiting programs such as **Child First**, Michigan's **Infant Mental Health-Home Visiting**,

EVIDENCE-BASED INFANT-EARLY CHILDHOOD MENTAL HEALTH INTERVENTIONS

Attachment and Biobehavioral Catch-up: ABC is an evidence-based, 10-week, in-home dyadic parenting program designed for parents of children from ages 6 to 48 months who have experienced early adversity. ABC providers coach parents and other caregivers during in-person sessions using in-the-moment feedback and review of videos of caregiver-child interactions to support sensitive, nurturing parenting that helps children develop attachment, self-regulation, and coping skills. Coaches do not have to meet particular educational or background requirements to be trained on ABC.

Child-Parent Psychotherapy: CPP is for children from ages birth to 5 years who have experienced trauma or are at risk of insecure attachment or social-emotional problems. The goals of CPP are to help the parent understand normal development, the effects of trauma on the child, and the meaning of child behaviors, as well as to increase use of a responsive, nurturing style of interaction that helps build a positive, secure relationship between the parent and child. CPP is delivered by licensed mental health professionals.

Infant-Parent Psychotherapy: IPP offers parents the opportunity to express and understand their feelings from past or present trauma, loss, abuse, neglect, or depression that threaten to interrupt the development of secure, stable, and enduring parent-child relationships. IPP is delivered by master's-level, licensed mental health clinicians.

Moving Beyond Depression: MBD is an evidence-based cognitive behavioral therapy model delivered in-home to mothers over 15 weekly visits by master's-level clinicians. Modules cover mood identification, how to improve mood, what increases anxiety/symptoms, and what does and does not work.

and New York City's **Power of Two**, incorporate evidence-based mental health interventions as part of their formal models.

Child First targets families with children prenatal through age five who have social-emotional or developmental problems and are experiencing multiple adverse circumstances, including extreme poverty, homelessness, domestic violence, incarceration, maternal depression, and abuse and neglect. Families receive home visits twice a week during an initial period when a comprehensive assessment of family well-being and needs is conducted. Based on this comprehensive assessment, an individually tailored child and family plan is developed in collaboration with the family that reflects family strengths, goals, cultural background, and needs. Child First clinicians and care coordinators visit families weekly either together or individually over six to 12 months. Licensed mental health clinicians provide dyadic treatment using the evidence-based **Child-Parent Psychotherapy (CPP)** model.

Michigan's **Infant Mental Health-Home Visiting** is a statewide Medicaid-funded home visiting program for families facing multiple risks, including maternal depression, that threaten the parent-infant attachment and development of the infant. Visits are conducted weekly, or more often as needed, by a master's-level early childhood mental health professional who must be endorsed at Level 2 by the Michigan Association of Infant Mental Health, with Level 3 preferred. A major feature of the model is the delivery of dyadic **Infant-Parent Psychotherapy**, along with support for the family's material needs, emotional support, and developmental guidance.

In New York City, **Power of Two**, is a home visiting program delivering **Attachment and Biobehavioral Catch-up (ABC)** in combination with other family supports, with a focus on serving at-risk families including those involved in foster care. ABC, unlike CPP and IPP, may be delivered by non-clinicians trained in the model. In addition to ABC, Community Resource Specialists work with families to connect them to a range of resources to help address their concrete and mental health needs, which are identified through questionnaires during program intake.

Providing Access to Evidence-Based Mental Health Treatment as a Program Supplement

Some home visiting programs help families gain access to evidence-based treatment as a program add-on. Home visitors with **Nurse-Family Partnership** and **Parents as Teachers** in Louisiana can conduct joint visits with infant-early childhood mental health consultants from a state-funded consultation program when family needs call for this level of support. During these visits, the consultant may conduct assessments with the family and identify additional mental health services that might be helpful. These services include **Child-Parent Psychotherapy (CPP)**, which the consultant can deliver to the family outside of regular home visits. Up to 25 percent of a consultant's time may be spent on delivering CPP to families.

In Johnson County, Kansas, **Healthy Families Kansas** has a partnership with **Promise 1000**, which provides referrals and support to home visiting programs across more than 20 Kansas and Missouri counties in the Kansas City region. For mothers who have a positive maternal depression screen or who express a need for mental health supports, Promise 1000 offers free access to **Moving Beyond Depression (MBD)**. When a family accepts this service, the home visitor makes an initial warm handoff to the MBD clinician, who then delivers MBD to mothers on separate home visits. Families remain jointly enrolled in Healthy Families Kansas and MBD.

Ensuring Successful Referrals for Mental Health Treatment

Other home visiting programs refer families to mental health providers outside of the home-visiting program and must use strategies to encourage family engagement with these providers. Programs discussed the importance of developing comprehensive lists of local mental health service providers and establishing referral relationships with them. In some cases, home visiting programs are housed in larger agencies that offer mental health services. **RefugeeOne** in Chicago has several mental health and related resources that are available to families engaged in its **Baby TALK** home visiting program. These include trauma-informed clinical mental health services for adults that are provided by clinicians with experience serving refugees, as well as **Child-Parent Psychotherapy**.

In New Mexico, **Las Cumbres** can refer families in its **Confident Parenting** home visiting program to its agency's team of IECMH therapists.

Even without mental health supports in the program's agency, home visiting programs can support referrals through warm handoffs to mental health providers. Home visitors with **Oklahoma SafeCare** accompany families on visits to mental health care appointments and follow up with referrals on their behalf. Mental health consultants with Arizona **Smart Support** sometimes join home visitors on a visit to the family, serving as an "ambassador" of mental health who can help facilitate a referral to an outside mental health service provider.

Training Home Visitors on Mothers and Babies

Many programs described a number of barriers to connecting families with mental health supports in the community. These include a lack of mental health providers with experience in infant-early childhood mental health in the area, financial barriers for families who do not have health insurance, and the challenge of finding providers who speak their primary language if it is not English. To address these challenges to accessing mental health care, a number of states and programs have turned to training for home visitors on **Mothers and Babies**, an evidence-based intervention to prevent the onset of major depression and reduce depressive symptoms in pregnant and parenting people. (See Mothers and Babies box for more information.)

In Georgia, all MIECHV-funded home visiting programs have received training on Mothers and Babies. Programs have found this model works especially well for parents who are less inclined to accept referrals to external mental health services, in places with fewer mental health services available, and in Spanish-speaking communities with few bilingual mental health service providers. In home visiting programs delivered by the **Great Plains Tribal Leaders Health Board (GPTLHB)**, Mothers and Babies helps to fill a gap in the broader need for curricula and interventions for Native families that focus on mental health, especially given the scarcity of mental health services in communities served by GPTLHB. The Lakota and Dakota culturally adapted Mothers and Babies has proven extremely popular

with the GPTLHB home visitors who have been trained on the model; they report that its tools are helpful and easy to use, and that they benefit from using it in their own lives. GPTLHB home visitors initially implemented Mothers and Babies with women during the perinatal period, but quickly saw the value of using it with women who have children up to age five. Home visitors now offer it to all women, not just those with elevated depression screens, especially because stigma around discussing mental health means screening tools often fail to reliably identify those who would most benefit from Mothers and Babies.

Home visiting programs offer other critical services and supports that can reduce family stress and enhance the mental health and well-being of children and families

Families in home visiting programs who face mental health challenges commonly experience stressors related to unmet basic needs, such as housing and food, overall financial insecurity, and other adversities like social isolation. To address these needs, home visiting programs offer a range of supports that can have positive impacts on families' mental health.

Fostering Connections with Other Parents

Programs noted that many parents report feeling socially isolated and can struggle to engage in community activities. To supplement the one-on-one sessions between home visitors and parents, many programs offer parent support groups to help build peer connections. **South Puget Intertribal Planning Agency** offers the **Parents as Teachers** home visiting model, which includes a group connections component. Some home visitors who lead these sessions incorporate elements from the **Positive Indian Parenting** curriculum. These can include traditional activities, such as constructing cradleboards, beading, and making tea and salves with local herbs. **Global Perinatal Services** in Washington State offers weekly parenting support groups, one for mothers and one for fathers, facilitated by doulas who speak Oromo and English. **Massachusetts' Early Intervention Parenting Partnerships (EIPP)** offers group meetings for parents, which are held at libraries or community resource centers and include a meal, child care, and transportation. These sessions allow

parents to form connections with other families and develop social support networks. In response to asking parents what they want out of the sessions, EIPP has offered a group field trip to the local library, an infant massage class, and a family storytime.

Addressing Concrete Needs

Home visiting programs assist families with concrete needs by connecting them to public benefits and services, such as SNAP, WIC, and housing support. However, when families face situations that these services are not designed or able to address, home visiting programs may be able to step in, especially if they are permitted the flexibility to do so. During the COVID-19 pandemic, Texas home visiting programs receiving state Prevention and Early Intervention funds were able to offer gift cards to Walmart, Amazon, or grocery stores; individual items, such as cribs or playpens; and, in one case for a family with water access issues, plumbing parts that a plumber volunteered to install. Promotores community health workers with **El Sol Neighborhood Education Center** are able to drive families to appointments with doctors or therapists. Bilingual home visitors with **Healthy Families Kansas** initially did not provide translation for families in healthcare settings, many of which do not offer translation services, because they did not have medical translation training. However, because this service is so important, Healthy Families Kansas decided to authorize home visitors to translate during these visits if families signed a release form acknowledging the home visitor is not a trained medical translator.

Home visiting programs engage in continuous quality improvement (CQI) efforts and use data to better identify and address mental health needs of children and families

As discussed in the introduction, MIECHV- and TMIECHV-funded home visiting programs are required to report on performance indicators and engage in continuous quality improvement efforts. In addition, many home visiting models require programs to conduct ongoing monitoring to ensure fidelity of model delivery.

Providing an Equity Lens and Family Voice

In the context of identifying and addressing the mental health needs of the diverse children and families they serve, programs emphasized the importance of ensuring that collected data can be used to examine equity questions relating to both program implementation (e.g., family recruitment and retention) and outcomes (e.g., access to mental health services and improvements in maternal depression symptoms). **Healthy Families Massachusetts** regularly asks programs whether the community they serve is reflected in program staff and participants and whether, based on monitoring data, family outcomes are similar across race and ethnicity. They also conduct annual satisfaction surveys with families to ensure families feel their voices are heard.

Program respondents also stressed the value of parent engagement in CQI efforts. In Texas, program performance data from MIECHV-funded programs revealed low rates of maternal depression screening, which led to a yearlong CQI project that examined barriers related to training, engagement with families, tools, and services in the community. Parents were successfully engaged in this CQI process, which led to the selection of **Mothers and Babies** to strengthen programs' capacity to address parent mental health needs. Another example is **Community Action Inc. of Central Texas (CAICT)**, where parent representatives along with home visitors are part of three internal committees: CQI, recruitment, and group connections. One parent who was a member of the maternal depression CQI helped CAICT develop materials related to maternal depression screening and response that families could relate to and understand.

Research and Evaluation with Diverse Populations

Programs engaging in formal evaluation research, particularly in the context of establishing an evidence base to meet funding eligibility requirements, may face challenges if they serve a population that is more reluctant to participate in research or use a model tailored to the needs of the population they serve rather than one that is highly standardized. In Illinois, **RefugeeOne's Baby TALK** home visiting program conducted **a rigorous evaluation** using random assignment to treatment and control groups, and found significant positive impacts on children's

social-emotional and language development after families had participated for 12 months. The evaluation is notable for overcoming challenges related to the recruitment of refugee families into a research study and addressing ethical concerns about withholding services from refugee families by using a waitlist design. Recruitment strategies included communicating clearly that the participants have full autonomy to decide whether to participate and giving them time to make their decision.

The **Best Starts for Kids** initiative in King County, Washington aims to deliver culturally appropriate services that meet the needs of all King County families where they live through innovative approaches developed by community-led organizations. Because these organizations have faced linguistic, cultural, and organizational barriers to accessing government funding in the past, BSK has adopted several approaches to build community-led organizations' capacity. In addition to funding evidence-based and research-informed service models, BSK sets aside funds for community-designed models, which often do not have the capacity and funding for the randomized-controlled studies that meet the evidence requirements of some funding sources. With support from BKS, organizations that implement these community-designed models create "practice profiles," which include descriptions of the population to be served and core model components, as well as a theory of change, implementation plans, and methods for measuring performance.

Home visiting programs inform and benefit from systems-level supports

Many of the examples of home visiting program strategies discussed so far incorporate supports offered through broader state- and systems-level efforts. The organizations leading these efforts, such as state agencies or local initiatives, are often able to draw on sources of funding that are not available to individual home visiting programs, even to those programs that are implemented at scale. The organizations are also able to focus on the sustainability of supports, so that individual home visiting programs can rely on their availability as they engage in their own planning and CQI efforts.

The **Best Starts for Kids** initiative in King County, Washington is funded through a voter-passed tax levy that started in 2015 and was renewed in 2021 to extend through 2027. In addition to grants to community-based organizations and service providers, BSK offers an array of technical assistance and training supports. These include a set of workforce development activities to build grantees' capacity to support the infant and early childhood mental health of young children and families they serve, grounded in an understanding that mental health is inextricably linked to the broader struggle for social justice and racial equity. During the first levy, BSK's supports for infant-early childhood mental health comprised four strands: training, reflective practice, infant-early childhood mental health endorsement, and a **landscape analysis** that identified strengths, challenges, and opportunities in King County. As part of the second levy, infant-early childhood mental health efforts related to training and reflective practice will be sustained, with a continuing focus on BIPOC perspectives. These supports were highly informed by input from BSK's community organizations, including home visiting providers.

In Georgia, a state-funded Technical Assistance and Quality Team (TAQ) provides technical assistance, training, data system maintenance, performance monitoring, continuous quality improvement, and evaluation support to home visiting programs. As part of the state's **Mothers and Babies** training, made possible with MIECHV funding, train-the-trainer trainings were delivered to members of the state-level TAQ team and representatives from local home visiting programs. Training for home visitors is currently offered through on-demand online modules, which participants can take at their convenience. These modules are supplemented by a one-hour live in-person or online training on how to implement Mothers and Babies in the context of **Georgia Home Visiting**. The supplemental training covers when Mothers and Babies should be offered, what it looks like in practice, and required documentation. This training can be delivered by in-house trainers for home visiting programs or by members of the TAQ team. Based on feedback from home visiting program supervisors, the state is planning an annual meeting for program-level supervisors on supporting Mothers

and Babies' use by home visitors and is developing FAQs and other resource documents. The TAQ team also plans to solicit feedback from home visitors on how they are adapting Mothers and Babies and the model's materials to meet individual families' needs, and on what they are finding successful.

Louisiana's statewide mental health consultation program for home visiting is provided by 18 teams and is currently funded by the Title V Maternal and Child Health Services Block Grant. The state is responsible for hiring, training, and supervising the consultants.

Enhanced Home Visiting (EHV) in Colorado offers three strands of support statewide to **Parents as Teachers (PAT)** and **Home Instruction for Parents of Preschool Youngsters (HIPPI)** home visiting programs: reflective consultation, wellness for home visitors (described earlier), and infant-early childhood mental health endorsement and training. Originally funded by private foundations, the program is currently funded by MIECHV and two foundations. **An evaluation** found that the EHV supports increased home visitor knowledge and competence related to family mental health needs. Home visiting programs that accessed EHV supports also had higher rates of home visitor retention and better model fidelity at the end of three years in the program.



Recommendations

As shown in this report and summarized in the Key Strategies table, home visiting programs reported on a wide-ranging set of strategies for supporting infant-early childhood and parent mental health. These include not only screening, interventions, and infant-early childhood mental health consultation, but also approaches to workforce recruitment, training and ongoing support for home visitors, strategies for helping ensure families' access to and engagement with needed mental health services, culturally responsive adaptations to home-visiting models, and use of systems supports. Below are recommendations that build on the observations and insights of home visiting program and model representatives captured in the previous sections.

State, Tribal, and local home-visiting leaders should engage in multiple strategies to recruit and retain a diverse home visiting workforce with providers who come from the same communities as the families served by the programs.

Recruitment efforts might include partnerships with community organizations, community colleges, and faith-based institutions. Strategies to retain home visitors should include training that offers professional advancement and recognition, monetary incentives for home visitors with special skills (e.g., bilingual providers), and financial support for obtaining additional training, education and professional credentials.

States and Tribes should invest in and facilitate the delivery of cross-model training and supports for home visitors that increase their capacity to develop positive relationships with families and to identify and address family and infant-early childhood mental health needs.

These efforts should make training accessible to home visitors with varied backgrounds and levels of education. They should be accompanied by supports, such as reflective supervision, that allow home visitors to discuss applications of training and receive assistance with challenging cases. Because not all organizations that deliver home visiting programs are able to access or provide infant-early childhood

mental health (IECMH) trainings and supports, such as reflective supervision or mental health consultation, for their home visitors and supervisors, states and Tribes should consider developing the infrastructure to make these supports available across home visiting programs and models.

State, Tribal, and local home visiting leaders should assess and consider strengthening strategies they use to address parents' basic needs as a means of reducing parent stress, establishing supportive parent-provider relationships, and retaining families in programs.

These strategies might include helping parents access public benefits, providing transportation to medical and social service appointments, and responding to emergencies, such as threatened eviction. Home visiting programs can increase their capacity to help families address basic needs by establishing relationships with organizations that offer legal and public benefits assistance.

When selecting home visiting models and embedded mental health interventions, state, Tribal, and local home visiting leaders should consider including models and embedded mental health interventions that can be implemented by home visitors without college degrees.

These models and interventions create fewer barriers to recruiting home visitors who come from the same communities as families, and who may share life experiences with them. Healthy Families America, Baby TALK, and Attachment and Biobehavioral Catch-up (ABC) are examples of such home visiting models. An example of an embedded intervention is Mothers and Babies, a parent depression prevention intervention.

States, Tribal, and local home visiting leaders should work to ensure that when home visitors encounter family mental health needs requiring treatment from a mental health clinician, home visitors can support connections to affordable, culturally responsive services.

Maternal depression harms mothers and children's development,¹⁰ and it is also associated with lower

retention in home visiting.¹¹ Effective treatments are available,¹² and mothers who receive treatment remain enrolled in home visiting longer than those who do not.¹³ Home visiting programs can reduce barriers to mental health treatment by incorporating access into their program, through in-home supplemental treatment add-ons like Moving Beyond Depression (MBD) or close relationships with referral sources, and by facilitating warm handoffs to clinicians as a trusted partner.

States and Tribes that are implementing evidence-based models funded by MIECHV, TMIECHV, or the state should consider adaptations of program materials and content that retain program fidelity while increasing cultural responsiveness for different groups of families.

Families that experience programs with content and activities aligned with their traditions, values, and priorities may stay in programs longer and engage more fully with the program's supports, including those related to parent and infant-early childhood mental health. Families should be engaged in developing and assessing the value of these adaptations.

Federal and state policymakers should work to address two serious gaps in foundational supports for home visiting programs and the larger systems of mental health services available to families in these programs:

- 1. Increase funding for home visiting to allow fair and adequate compensation for home visitors.** Improved compensation is critical for home-visitors' well-being and retention, which in turn allows home visitors to develop the experience and skills needed to address early childhood and parent mental health needs.
- 2. Increase investments in the training of infant-early childhood and parent mental health specialists and clinicians and ensure reimbursement for their services.** These investments are urgently needed to increase the number of IECMH consultants, interventionists, and clinicians who can serve families and support home visitors in home visiting programs, as well as in other settings (e.g., pediatric clinics and early intervention programs).

Federal, state, Tribal, and local funders and philanthropy should invest in studies that examine the potential benefits of the IECMH and family mental health-related strategies described in this report.

There is a need for research that can show the extent to which these strategies individually or in combination contribute to desired outcomes, including supportive provider-parent relationships, family retention in programs, reductions in parent depression, enhanced parent-child relationships, and positive infant and early childhood social-emotional development. This research should be conducted with diverse groups of families and be used to inform the design of programs that contribute to equity in families' access to and full engagement with culturally responsive home visiting programs that promote family and child well-being.

Conclusion

Home visiting programs prioritize enrollment of low-income families, many of whom face financial insecurity and related adversities that increase parent stress and the likelihood of parent mental health and infant-early childhood problems.¹⁴ In 2021, programs delivering evidence-based and emerging home visiting models served approximately 300,00 families, with 86 percent of children served covered by public insurance.¹⁵ While this represents less than four percent of the families who might benefit, the 2022 reauthorization of MIECHV will increase federal funding and access to home visiting services.¹⁶ The expansion of Medicaid's and Children's Health Insurance Program's (CHIP) coverage of home visiting as a benefit for pregnant women and newborns would also increase access.¹⁷

Providing strong supports for family mental health can help home visiting programs meet other important program goals (See box on MIECHV program goals). MIECHV and TMIECHV programs, and many other home visiting models, strive to help parents pursue goals of family financial stability through increased parent education and earning potential, promote children's early development and school readiness, and prevent child maltreatment. Parent and child mental health are foundational to these outcomes. For example, parents' engagement in education and work might worsen stress and

depression without adequate mental health supports, which, in turn, could impede parents' pursuit of education and job-related goals.¹⁸ Parents' unaddressed mental health problems increase the chance of problems in the parent-child relationship,¹⁹ while child behavior difficulties that may result from impaired relationships increase the risk of maltreatment.²⁰ Expanding the use of culturally responsive, effective mental health supports for parents and their infants and young children in home-visiting programs is therefore integral to programs' capacity to help diverse families thrive in multiple areas that matter for young children's long-term well-being and development.

MIECHV PROGRAM GOALS

- **Improve:** maternal and child health
- **Prevent:** child abuse and neglect
- **Reduce:** crime and domestic violence
- **Increase:** family education level and earning potential
- **Promote:** children's development and readiness to participate in school
- **Connect:** families to needed community resources and supports

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