

Opportunities and Challenges in Addressing Maternal Depression in Community Settings

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Depression in mothers is recognized as a major public health problem that is multigenerational in its impacts. Depression undermines parenting by interfering with attachment and im-



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peding the mother's ability to recognize and respond to child cues and needs, as well as create the nurturing and stimulating environment required for optimal child development. These problems are particularly deleterious for children for whom the first years of life are foundational and represent a sensitive period for emotional and behavioral development.¹ Low-income mothers are at great risk for major depressive disorder, with rates of diagnosis at least double that of their counterparts with greater social and financial resources.² The negative consequences of maternal depression for mothers and children are amplified in low-income families. Mothers in poverty are more likely to have a persistent course of depression, and for most, there are barriers to accessing treatment that are often insurmountable.³ As such, identifying and intervening with mothers at greatest risk is imperative.

The article by Silverstein and colleagues⁴ in this issue of *JAMA Psychiatry* describes a compelling approach to preventing depression in low-income mothers. The intervention, called problem-solving education (PSE), was delivered to mothers whose children were enrolled in Head Start. Mothers were identified based on elevated screening scores for depression administered as part of the Head Start program. Problem-solving education included 6 sessions that were manualized, delivered by lay interventionists, and tested in a real-world setting. In contrast to mothers in Head Start alone, those in the intervention group had trajectories reflecting fewer occurrences of elevated depressive symptoms over 12 months. Although measures of child functioning were not reported, it is noteworthy that children of mothers receiving PSE had less exposure to a primary caregiver with depression over this period in contrast to those in the comparison group. The study has several strengths: a rigorous randomized clinical trial design, a sampling strategy with minimal exclusion criteria to ensure a sample representative of Head Start, recruitment from multiple sites, and repeated measurement of depression over 1 year to permit a fine-grained characterization of depressive symptoms.

Deploying the PSE intervention in a Head Start program is novel and important. Embedding PSE in a nontraditional setting for providing mental health interventions has many advantages. First, implementation in the community reaches mothers who might otherwise not seek out mental health pre-

ventive services. Second, linking PSE to Head Start leverages the mother's strong relationship with and connection to Head Start. To the extent that mothers value Head Start and the educational experience that it offers their children, they are likely to be more willing to participate in an ancillary service focused on promoting their own emotional health. Third, providing a preventive mental health program in the context of Head Start implicitly appeals to parental altruism and maternal commitment to support their child's healthy growth and development. Although mothers may be reticent to seek out services for themselves, they may be open to participating in programs that they see as benefiting their children. Taken together, providing preventive mental health services alongside Head Start can increase engagement and reduce the stigma associated with mental health.

Concurrent provision of the PSE intervention and ongoing Head Start services also creates potential synergies. Each program may support the other and lead to greater retention and involvement. The curriculum of PSE is compatible with and complementary to parent services offered as part of Head Start, thereby mutually strengthening both programs. An example of this effect is found in a study of the concurrent delivery of in-home cognitive behavioral therapy (CBT) with mothers with depression in home visiting programs in which higher intensity of home visiting and psychotherapy was associated with improved depression outcomes.⁵ The potential for optimizing outcomes through the combined efforts of multiple programs is a particularly appealing aspect of offering mental health services in nontraditional settings, as they can maximize efficiencies and enhance cost-effectiveness.⁶

The current study is noteworthy in its attention to practicality and future dissemination. Too often, interventions designed in highly controlled settings are too complicated or involved to be readily disseminated, especially in the community. As a result, many evidence-based interventions cannot be adopted in sites that lack the needed infrastructure or resources. In the case of PSE, these concerns have been considered and addressed. The focus on prevention means that the intervention can be delivered by lay providers who do not require extensive mental health training, thereby increasing the pool of potential interventionists and decreasing training and support costs. Use of a manual standardizes the intervention. The intervention is brief and does not require mothers to commit to a lengthy service in which consistent participation would be challenging. All in all, the PSE intervention appears to be amenable to rapid scaling and deployment in other Head Start programs.

The current study also leaves some intriguing questions unanswered. Mothers with high levels of depression at baseline did not respond to PSE. It is possible that the level of severity is such that this group of mothers needed a more intensive and clinically focused intervention. But perhaps timing of the intervention is important. For many mothers, depressive symptoms fluctuate over time, and maybe PSE is only effective if introduced when symptom severity is lower and mothers are better able to respond to and benefit from intervention elements. If this is true, it suggests that flexibility is needed as to when mothers are offered PSE, and timing should be driven by maternal clinical presentation rather than other indices.

Although not the primary focus of the study, it is striking that mothers in both the PSE (24.5%) and usual service (29.1%) groups met criteria for a major depressive episode during the 12-month interval. These high rates reflect the risk status of the population but also reveal the limitations of the preventive program. These mothers may require a more intensive approach or treatment, and this is worthy of further study.

The lack of a significant difference between the 2 groups on a measure of problem-solving raises questions about the mechanism of change. Maybe PSE is impacting other known mechanisms and, as noted by the authors, behavioral activation is a likely candidate.⁷ This is an important topic for future research, as understanding mechanisms of change will accelerate the development of more effective interventions. Additional moderators of outcome warrant further investiga-

tion. Maternal experiences of violence and abuse are associated with depression⁸ and may have implications for response to the intervention. Psychiatric comorbidities, including substance use and anxiety disorders, may also lead to differential outcomes. Finally, although the 12-month follow-up in the current study is informative, it is important to document the durability of effects over a longer period.

The potential for addressing mental health issues in non-traditional community settings is an exciting direction for the field. Approaches will require close attention to the unique needs and challenges of low-income mothers and their families and novel models of intervention delivery. Recent examples include CBT treatment for mothers with depression that is delivered in the home and offered concurrently with early childhood home visiting programs,⁹ CBT-based groups to prevent depression that are also incorporated into home visiting programs,¹⁰ and an internet-facilitated CBT intervention for low-income mothers with depression.¹¹ The current study builds on and expands this line of work. There is a need to increase the types of settings that are leveraged to deliver mental health programs. Compelling options include pediatric primary care; the Women, Infants, and Children program; day care; and community institutions. Moving mental health services into the community holds promise to broaden the reach of evidence-based programs for mothers with or at-risk for depression and to guide the trajectories of children toward healthy emotional and behavioral development.¹²

ARTICLE INFORMATION

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