Published in final edited form as:

J Child Fam Stud. 2014 July 1; 23(5): 837–843. doi:10.1007/s10826-013-9736-z.

Innovations in the Identification and Referral of Mothers at Risk for Depression: Development of a Peer-to-Peer Model

Mary Acri,

Department of Child and Adolescent Psychiatry, New York University School of Medicine, New York, NY 10016

S. Serene Olin,

Department of Child and Adolescent Psychiatry, New York University School of Medicine, New York, NY 10016

Geraldine Burton,

Department of Child and Adolescent Psychiatry, New York University School of Medicine, New York, NY 10016

Rachel J. Herman, and

New York State Psychiatric Institute, New York, NY

Kimberly E. Hoagwood

Department of Child and Adolescent Psychiatry, New York University School of Medicine, New York, NY 10016

Mary Acri: mary.acri@nyumc.org

Abstract

This paper describes a feasibility study of a peer-delivered prevention intervention to identify mothers at high risk for depression and facilitate engagement in mental health services for their emotional health. Sixteen family peer advocates and their supervisors partnered with academic researchers over a period of six months to develop a four-session intervention that focused on identifying symptoms of depression, providing education about depression and treatment, actively linking caregivers to treatment for their own emotional health, and assisting caregivers in becoming active participants in their mental health care. Collaborating with peers to develop the model enhanced its perceived relevance and utility, and resulted in an intervention that was complimentary to their roles and the mission of peer-delivered support services. Peer/professional partnerships may be beneficial for enhancing the feasibility and acceptability of research efforts; the impact of peers' participation in the current project and the need for future research to develop and study peer-delivered models is discussed.

Keywords

peer-to-peer; family support; family advocates

Introduction

Approximately 20% of women experience depression during their lifetime (Weissman et al., 1996), and low-income women, of which African American and Latina women are disproportionately represented, are at particularly high risk of onset (Cordian & O'Connell, 2001; Grote et al., 2007; Kessler, 2003; Knitzer, Theberge, & Johnson, 2008). A sizable number of women who suffer from depression are also mothers (Swartz et al., 2008), especially caregivers of youth with mental health needs (Bailey et al., 2007; Ferro et al., 2000; Swartz et al., 2008). In addition to the strain associated with managing their child's mental health needs, they commonly encounter stigma and blame by family, friends, their child's school and providers because of their child's difficulties. Their parenting responsibilities are compounded by challenges associated with navigating mental health, school, and other systems to meet their child's needs (Bailey et al., 2007; Yatchmenoff et al., 1998). Many lack needed social support and experience social isolation (Lee et al., 2009).

The mental health needs of mothers are commonly unmet, however (Miranda et al., 2003; Smith et al., 2004). Logistical barriers, such as lack of transportation, childcare, and insurance, and often more potent perceptual factors such as stigma, mistrust of providers and treatment, and fears of losing custody of their children or being viewed as a bad parent if they seek care, result in low rates of service use (Abrams, Dornig, & Curran, 2009; Swartz et al., 2008; Ward, Clark, & Heidrich, 2009). Low-income women, especially those who identify as belonging to an ethnic minority group, are particularly unlikely to seek mental health treatment because of these perceptual impediments (Anderson et al., 2006).

Left untreated, maternal depression is enormously costly to the family. Mothers with depression incur economic and social difficulties, morbidity, and premature mortality (Ballenger et al., 2001; Fawcett, 1993; Kessler, 2003). Their offspring experience academic, cognitive, behavioral, mental health, and/or peer-related difficulties at virtually every age from infancy through adolescence (Boyd et al., 2006; Hair et al., 2002; Hammen, Shih, & Brennan, 2004; Hay et al., 2001; Lewinsohn et al., 2008; Riley et al., 2009; Rishel et al., 2006; Weissman et al., 2004; Wright et al., 2000). For youth with mental health conditions, maternal depression is associated with less optimal therapeutic progress (Beauchaine, Webster-Stratton & Reid, 2005; Pilowsky et al., 2008). However, when maternal depression remits, youth and family outcomes, such as treatment response and parenting behaviors, improve (Brent et al., 1998; Foster et al., 2009; Pilowsky et al., 2008).

There have been several efforts within the prevention field to reduce the impact of maternal depression upon the family. Both the Preventive Intervention Project (Beardslee et al., 2007) Keeping Families Strong (Riley et al., 2008) target children eight years of age and older who are identified as being at high risk because of parental depression. A third program, the Protecting Families Program, targets the highest risk families; urban, school-aged youth from low-income communities whose mothers are in treatment for depression (Boyd et al., 2006).

These programs are associated with positive parental outcomes, including high satisfaction levels, enhanced knowledge about depression, and a change in attitudes about how to discuss depression with their child. These programs are not preventative for caregivers, however, as their aim is to prevent the onset of depression among children and adolescents by identifying families in which the caregiver is actively experiencing depression and receiving mental health care. In fact, there is a notable lack of programs that intervene prior to the onset of a depressive disorder, and with the exception of the Protecting Families Program (Boyd et al., 2006), none that are designed specifically for low-income, minority families.

The purpose of this study was to develop a preventive, peer-delivered screening and active referral intervention to identify low-income, ethnic minority mothers at risk for depression and facilitate engagement into mental health services for their own emotional health. Peers called family peer advocates, an emerging workforce across the country who provide support to families, have personal experience caring for a child with mental health problems and navigating service systems on their behalf (Hoagwood et al., 2010). In the healthcare field, peers provide outreach, address disparities to access, and facilitate engagement in treatment, particularly for stigmatizing conditions (Bernstein, Mutschler & Bernstein, 2000; Deering et al., 2009; Heisler, 2007).

Growing evidence suggests peers also capably administer screening instruments for psychosocial and mental health problems (Duggan et al., 2000; Mishina & Takayama, 2009; Pickstone, 2003). They also provide psychoeducation about mental health conditions and treatment (www.nami.org), and deliver empowerment strategies to enhance participation in health and mental health services (Alegria et al., 2008) with appropriate training and supervision. Yet these kinds of engagement and outreach strategies delivered by peers and targeting mothers with symptoms of depression have neither been developed nor examined.

The purpose of this paper is to present a feasibility study that describes the development of this intervention in active partnership with family peer advocates, with an emphasis on adapting clinical tools for use by a peer workforce. The impetus for this project came from three sources: (a) the high risk of depression among mothers of children with mental health needs in a low income and ethnically diverse population (Miranda et al., 2003), b) high rates of under detection and limited engagement in mental health services among this population (Abrams et al., 2009; Miranda et al., 2003; Smith et al., 2004); and, c) an identified need expressed by professional family peer advocates in New York City underscoring their concern about the growing number of mothers experiencing feelings of sadness and distress, and their need for skills and training to appropriately address these mothers' mental health needs (Cavaleri et al., 2010).

Method

Overview

In 2009, the authors received a one-year pilot grant to develop a stress-reducing protocol for female caregivers receiving services at five Family Resource Centers located throughout Manhattan, the Bronx, and Queens. Family Resource Centers are programs located within

highneed communities that provide free services, including emotional support, tangible assistance (e.g., respite services), workshops and seminars about educational services, parenting and self-care strategies, community referrals, education about mental health and services, and one-on-one advocacy (<http://www.mha-nyc.org>).

During the first six months of the project, the authors met with 12 family peer advocates to develop the intervention (see Cavaleri et al., 2010, for the procedure and a description of intervention). The remaining six months were dedicated to delivering the three-session protocol to 10 caregivers. At the end of the project, family peer advocates participated in a group interview about their experiences delivering the intervention. Analysis of the notes from the group interview indicated three themes: a) peers thought the intervention was useful and addressed a need among parents, b) it was perceived as acceptable to both caregivers and peers, and c) it was feasible to administer. However, they expressed concern that many of the mothers with whom they were working were also exhibiting sadness and distress but were not receiving services or treatment to assist them. Although they had an in-house referral line for mental health services, family peer advocates did not feel they had the training to identify mothers experiencing possible symptoms of depression, or how to engage them in care.

Procedure

In November 2010, two of the co-authors (Acri and Burton) presented the current project, called SEE (Screening, Education, and Empowerment), during a monthly meeting attended by family peer advocates and their supervisors, who are senior family peer advocates, from the Bronx, Queens, and Manhattan Family Resource Centers. The purpose SEE was to provide peers with the skills they needed to identify caregivers at risk for depression and actively facilitate their engagement in treatment for their emotional health.

Ten family peer advocates and six directors volunteered to participate in constructing the intervention. Consistent with our previous efforts, we were guided by a community collaboration model as described by McKay, Bell, and Blake (2010), which rationalizes power and shared decision-making among key stakeholders. Specifically, five principles of collaboration guided our work: (1) agreement and investment in shared goals; (2) equitable distribution of power, including fair involvement in decision making and opportunities to change aspects of the research process; (3) recognition of skills and expertise associated with both university training and community experience; (4) ongoing opportunities for communication based upon commitment to honest exchanges and willingness to raise concerns without blame and; (5) trust (McKay et al., 2010).

To build the intervention, we first gathered relevant literature, (i.e., commonly used screening tools in non-clinical settings, content about depression and treatment). Whenever available, we utilized peer-delivered content and strategies derived from the evidence, such as Alegria et al.'s (2008) *Right Question Project-Mental Health Intervention*, which is a peer derivative of professionally-delivered model, the Patient Activation Model. We then constructed a rough outline of each module, which included a sequence of tasks and sample language. Each module was subsequently vetted through two experienced family peer advocates and members of the research team to provide content and language consistent

with a peer approach (e.g., referring to caregivers as partners, adopting an egalitarian, collaborative approach between parties). Once their feedback was incorporated, drafts were presented to the larger group of family peer advocates during our bimonthly meetings. Feedback that arose during these meetings were incorporated into a final draft and sent electronically to the entire group for approval.

The New York State Psychiatric Institute Institutional Review Board approved this project, and family peer advocates provided informed consent to participate.

Results

Description of the Intervention

The intervention content was divided into four modules, each module lasting between 20-30 minutes, and provided sequentially during the parent's regularly scheduled meetings with her family peer advocate. Each module is dedicated to fulfilling a core objective: 1) screening to identify depression, 2) providing education about depression and treatment to enhance knowledge, clarify misperceptions and reduce stigma about mental illness and mental health professionals, 3) providing referrals and active follow-up to facilitate engagement in mental health care, including identifying and addressing barriers to service use, and 4) empowering the parent to be an active participant in her treatment. Each module and objective is described more fully below:

After introducing the intervention and clarifying the family peer advocate's role, the main objective of the initial session is to screen for depressive symptoms. The family peer advocates reviewed several standardized instruments for depression before agreeing on the Center for Epidemiological Studies Depression Scale (CES-D) (Radloff, 1977), because it was perceived as being easy to read, understand, and score. The family peer advocate then scores the instrument with the parent and contextualizes the results. In addition to interpreting the total sum, the family peer advocate is trained to identify and act upon "red flag items" that should be attended to irrespective of the total score. For example, if the parent said she was feeling depressed *most or all of the time*, the family peer advocate follows the protocol at their Family Resource Center, which requires contacting the on-call clinician to evaluate the parent's risk.

In module two, we adapted Swartz et al.'s (2007) psychoeducation-based engagement model to engage in a discussion about the mother's distress, any noticeable impact upon herself and family, and how she defines depression both individually and within her culture. This module also presents information about assessment and treatment resources. We emphasize evidence-based practices to address parents' knowledge about mental health and depression, attitudes, beliefs and expectancies about mental health and treatment services, which are all factors that might influence their willingness to consider utilization of care. The module ends with a take-home assignment-to consider three types of treatment the parent would consider for their emotional health.

After reviewing the assignment with the parent, the remainder of the third module focuses on connecting the parent to services for a complete assessment and, if needed, evidence-

based treatment. A university-based referral service, which offers full evaluations and provides free or low-cost evidence-based treatments, is presented to the parent. In addition, the family peer advocate clarifies the assessment and treatment process, and prepares the parent to call the referral source either with the family peer advocate or alone, and to prepare for her initial appointment. If the parent elects not to pursue the referral service, the family peer advocate leaves the door open for the parent to change her mind, either while receiving the Screening, Education, and Empowerment intervention or in their other work together.

Key to this module is a discussion about the potential obstacles to attending an initial appointment, including both concrete obstacles such as transportation and childcare, and perceptual factors such as mistrust and negative views about treatment and mental health providers. If the parent has had prior, negative experiences with mental health care, the family peer advocate is empathic, attempts to address any concerns, and states that they will be reviewing strategies to empower the parent to be an equal participant in their care. Referrals are also given for alternate supports such as parenting and support groups that are available through the Family Resource Centers or through their in-house referral network.

The final module focuses on actively facilitating use of clinical treatment by adapting Alegria et al.'s (2008) *Right Question Project-Mental Health Intervention* to assist caregivers in feeling comfortable asking providers for information about treatment and additional options, gaining knowledge about their treatment in order to make informed decisions about their care and get their needs met. If the parent does not elect to pursue treatment, we emphasize that the skills can be helpful for use with her child's providers, teachers, or other professionals with whom the family interacts. The module concludes with a review of the work that the parent and family peer advocate have undertaken together, and to emphasize that although the parent has graduated from SEE, she will still be working with the family peer advocate for the reasons she initiated services at the Family Resource Center.

Discussion

Peer-delivered services are becoming an important adjunct to the public child mental health care system (Annapolis Coalition on Behavioral Health Workforce, 2007; The Hogg Foundation for Mental Health, 2008). These peers often directly interact or work with mothers at high risk for depression, but feel unprepared to address their emotional health. The purpose of developing the Screening, Education, and Empowerment intervention was to respond to the needs of mothers of children with identified mental health needs by providing peers with the skills to identify and engage high-risk women in treatment for their own emotional health.

Developing SEE provided valuable knowledge about how to undertake a collaborative effort with persons from diverse professional backgrounds and perspectives. Part of the initial buy-in for the intervention was that it was perceived as being within the scope of services provided by family peer advocates: In New York State, family peer advocates aim to increase self-efficacy, develop natural supports, model self-advocacy skills, facilitate linkages to services and engage the family in the planning process in the mental health and

school systems. In these ways, the SEE is complimentary to the mission and aims of the work family peer advocates do.

Along these lines, following the theory-based community collaboration model (McKay et al., 2010) was helpful for tailoring the strategies in a way that would compliment the work family peer advocates already do, which resulted in enhancing the clinical strategies to reflect the collaborative, egalitarian spirit in which family peer advocates work with families and their focus on empowerment. Peers had an equal voice throughout all aspects of building the intervention, which equalized the power differential that often arises in professionally-delivered services. We believe this equalization of power resulted in a more feasible, relevant, and acceptable intervention for mothers. As a case in point, we originally planned to provide information about evidence-based practices delivered by clinically-trained mental health professionals. However, the family peer advocates informed our thinking about caregivers' reliance on alternative sources of support, including members of the clergy, parent support groups, members of their community, friends, and family.

These discussions refined our thinking about the purpose of the psychoeducation module. Its purpose became to help mothers make an educated decision about what supports and treatments they choose when experiencing distress or potential depression. As a result, we focused on helping caregivers evaluate the quality and appropriateness of alternative sources of support and the experience of providers (e.g. asking if the provider has a clinical or medical degree). We also stressed that services that have little evidence and/or are not specific to treating depression should be considered in addition to, not instead of, evidence-based treatments.

Lessons Learned: Adapting Strategies for Peer Delivery

The consensus among family peer advocates was that the intervention was pertinent to the work they do with families. Initial concerns that the family peer advocates would feel the strategies were outside of the scope of their roles, or too confusing, were unconfirmed: They believed the skills would be useful, relevant, and applicable. The major alterations we made were not to the skills, but to the language and ensuring that the collaborative underpinnings of the work that family peer advocates do emerged. We detail these modifications and accompanying lessons learned as follows:

First, building on the strength of family peer advocates experiences, and their ability to connect to parents via shared experiences, peers expressed an interest in bringing their story into the intervention. Therefore, in the first module, the family peer advocate shares her story either as a family peer advocate and/or a parent of a child with special needs, or with an interesting story that connects her experience with the parent's. Personal disclosure within the confines to being relevant to the parent's difficulties or feelings are shared throughout the remaining modules as applicable.

Second, family peer advocates wanted to make it explicit that they were not mental health professionals or providing a diagnosis. They felt to use clinical language, like depression, was potentially stigmatizing and undermined the spirit of the intervention-to identify mothers feeling distress and to encourage further evaluation. In response, we added text to

clarify the family peer advocate's role, and referred to the parent's feelings as "distress," "sadness," or "possible depression."

Lastly, family peer advocates felt some of the language and techniques were hierarchical; for instance, having the peer administer and score the CES-D was potentially disempowering and created an imbalance of power between peer and parent. Instead, peers wanted to emphasize the collaboration between parties, and sought to empower parents to be equal partners and take charge of their mental health. As a result, collaborative language was built into each module. For example, after describing the CES-D and its utility for identifying feelings of distress, the peer states, "Would you like to go through this checklist (the CES-D) together?" Even the space between family peer advocates and parents was constructed in a way to foster a partnership, as demonstrated by the peer sitting next to, rather than facing, parents, whenever possible.

While the intervention is promising, several limitations should be noted. First, the effectiveness of this model with respect to identification and engagement in care is unknown. Our current study, still in progress, will assess the feasibility, acceptability, fidelity, and impact on mothers.

Additionally, we cannot generalize our experience with the family peer advocates who participated in developing SEE to all peers. There is enormous variability in the skills, competencies, types of services, and ways in which family peer advocates deliver family support services across the country. Differences also exist in how they view their roles and the mission of family support. There is a huge research agenda to parse out the relevance, feasibility, acceptability and impact of various modes of family support, including models such as SEE.

Currently there are four categories of studies that would advance knowledge about family support services and the role of family peer advocates. First, studies are needed about models for training family peer advocates to deliver service interventions such as SEE with fidelity. Intervention studies in children's mental health support the premise that effective services are effective only insofar as those services are delivered with fidelity (Schoenwald, Henggeler, Brondino, & Rowland, 2000). Second, we know little about key structural, systemic and social-organizational factors that facilitate the integration of family peers into the service system. Studies are underway to examine strategies for improving the integration and role clarify of different team members (e.g. Glisson, 2002; Glisson et al., 2010) but this is still a largely unexamined area. Third, studies are needed to examine questions of effectiveness of different peer-delivered service models and the types of outcomes they generate. For example, do they produce outcomes similar to those delivered by professionals? Do they offer additive benefits? Finally, studies are needed about the economic impact of peer delivered services and the value added. Given the increased attention within healthcare plans to issues of accountability for quality and to paying for performance, studies examining the added value of augmenting the workforce with presumably less expensive staff who can target costly healthcare expenses, such as no-show rates, use of emergency rooms, hospitalizations, inconsistent adherence to standards of care, is of great significance.

While there is increasing momentum behind the idea of employing peers to fill mental health workforce shortages (Annapolis Coalition on Behavioral Health Workforce, 2007), the research agenda is complex and focused attention on this area is likely to generate policy-relevant and practical findings that can improve the quality of services for children and families.

As noted previously, the effects of maternal depression are costly and far-reaching; accordingly, efforts that promote the early identification of mothers at risk for depression and active referrals to treatment has the potential to benefit the mother, child and family. National efforts to increase the peer workforce, credential peers and recognize peer support as a billable service, coupled with a substantial growth in families seeking peer-delivered services (Hoagwood et al., 2010), suggests there is much potential for SEE to impact a significant number of high-risk families.

The next steps in this line of inquiry are to test the feasibility and acceptability of this intervention from the perspective of key stakeholders, including mothers and family peer advocates, and fidelity to the intervention. A larger-scale study that would examine direct outcomes of the intervention (caregiver attendance at mental health appointments, symptoms of depression) is forthcoming.

Acknowledgments

Supported by Grant No 1 R21 MH090146-01. We wish to thank Marlene Penn, Angela Mora and the Family Peer Advocates from the Mental Health Association of New York City for their support of and participation on the project.

References

- Abrams LS, Dornig K, Curran L. Barriers to service use for postpartum depression symptoms among low-income ethnic minority mothers in the United States. *Qualitative Health Research*. 2009; 19:535–551. [PubMed: 19299758]
- Alegria M, Polo A, Gao S, Santana L, Rothstein D, Jimenez A, Hunter ML, Mendieta F, Oddo V, Normand S. Evaluation of a patient activation and empowerment intervention in mental health care. *Medical Care*. 2008; 46:247–256. [PubMed: 18388839]
- Annapolis Coalition on Behavioral Health Workforce. Action plan on behavioral health workforce development. Washington, DC: Substance Abuse and Mental Health Services Administration, Publication No. 280-02-0302; 2007.
- Bailey DB, Golden RN, Roberts J, Ford A. Maternal depression and developmental Disability: Research critique. *Mental Retardation and Developmental Disabilities Research Reviews*. 2007; 13:321–329. [PubMed: 17979207]
- Ballenger JC, Davidson JRT, Lecrubier Y, Nutt DJ, Kirmayer LJ, Lepine J, et al. Consensus statement on transcultural issues in depression and anxiety from the international consensus group on depression and anxiety. *Journal of Clinical Psychiatry*. 2001; 62:47–55. [PubMed: 11434419]
- Beardslee WR, Wright EJ, Gladstone TRG, Forbes P. Long-term effects from a randomized trial of two public health preventive interventions for parental depression. *Journal of Family Psychology*. 2007; 21:703–713. [PubMed: 18179342]
- Beauchaine TP, Webster-Stratton C, Reid MJ. Mediators, moderators, and predictors of 1-year outcomes among children treated for early-onset conduct problems: A latent growth curve analysis. *Journal of Consulting and Clinical Psychology*. 2005; 73:371–388. [PubMed: 15982136]

- Bernstein J, Mutschler P, Bernstein E. Keeping mammography referral appointments: Motivation, health beliefs and access barriers experienced by older minority women. *Journal of Midwifery & Women's Health*. 2000; 45:308–313.
- Boyd RC, Diamond GS, Bourjolly JN. Developing a family-based depression prevention program in urban community mental health clinics: A qualitative investigation. *Family Process*. 2006; 45:187–203. [PubMed: 16768018]
- Brent DA, Kolko DJ, Birmaher B, Baugher M, Bridge J, Roth C, et al. Predictors of treatment efficacy in a clinical trial of three psychosocial treatments for adolescent depression. *Journal of the American Child and Adolescent Psychiatry*. 1998; 37:906–914.
- Cavaleri MA, Perez M, Burton G, Penn M, Beharie N, Hoagwood KE. Developing the support, teambuilding, and referral (STAR) intervention: A research/community partnership. *Child & Adolescent Mental Health*. 2010; 15:56–59.
- Chinman M, Lucksted A, Gresen R, Davis M, Losonczy M, Sussner B, Martone L. Early experiences of employing consumer-providers in the VA. *Psychiatric Services*. 2008; 59:1315–1321. [PubMed: 18971408]
- Chinman M, Young AS, Hassell J, et al. Toward the implementation of mental health consumer provider services. *Journal of Behavioral Health Services and Research*. 2006; 33:176–195. [PubMed: 16645906]
- Deering KN, Shannon K, Sinclair H, Parsad D, Gilbert E, Tyndall MW. Piloting a peer-driven model to increase access and adherence to antiretroviral therapy and HIV care among street-entrenched HIV-positive women in Vancouver. *AIDS Patient Care and STDs*. 2009; 23:603–609. [PubMed: 19591602]
- Duggan A, Windham A, McFarlane E, Fuddy L, Rohde C, Buchbinder S, et al. Hawaii's healthy start program of home visiting for at-risk families. *Pediatrics*. 2000; 105:250–259. [PubMed: 10617732]
- Fawcett J. The morbidity and mortality of clinical depression. *International Clinical Psychopharmacology*. 1993; 8:217–220. [PubMed: 8277138]
- Ferro T, Verdelli H, Pierre F, Weissman MM. Screening for depression in mothers bringing their offspring for evaluation or treatment of depression. *American Journal of Psychiatry*. 2000; 157:375–379. [PubMed: 10698812]
- Foster CW, Webster MC, Weissman MM, Pilowsky DJ, Wickramaratne PJ, Talati A, et al. Remission of maternal depression: Relations to family functioning and youth internalizing and externalizing symptoms. *Journal of Clinical Child & Adolescent Psychology*. 2009; 37(4):714–724. [PubMed: 18991123]
- Glisson C. The organizational context of children's mental health services. *Clinical Child & Family Psychology Review*. 2002; 5:233–253. [PubMed: 12495268]
- Glisson C, Schoenwald SK, Hemmelgarn AL, Green P, Dukes D, Armstrong KS, et al. Randomized Trial of MST and ARC in a two-level evidence-based treatment implementation strategy. *Journal of Consulting and Clinical Psychology*. 2010; 78:537–550. [PubMed: 20658810]
- Grote NK, Zuckoff A, Swartz H, Bledsoe SE, Geibel S. Engaging women who are depressed and economically disadvantaged in mental health treatment. *Social Work*. 2007; 52:295–308. [PubMed: 18232240]
- Hair EC, McGroder SM, Zaslow MJ, Ahluwalia SK, Moore KA. How do maternal risk factors affect children in low-income families? Further evidence of two-generational implications. *Journal of Prevention and Intervention in the Community*. 2002; 23:65–94.
- Hammen C, Shih JH, Brennan PA. Intergenerational transmission of depression: Test of an interpersonal stress model in a community sample. *Journal of Consulting and Clinical Psychology*. 2004; 72:511–522. [PubMed: 15279534]
- Hay D, Pawlby S, Sharp D, Asten P, Mills A, Kumar R. Intellectual problems shown by 11-year-old children whose mothers had postnatal depression. *Journal of Child Psychology and Psychiatry*. 2001; 42:871–889. [PubMed: 11693583]
- Heisler M. Overview of peer support models to improve diabetes self-management and clinical outcomes. *Diabetes Spectrum*. 2007; 20:214–221.

- Hinshaw SP. The stigmatization of mental illness in children and parents: Developmental issues, family concerns, and research needs. *Journal of Child Psychology and Psychiatry*. 2005; 46(7): 714–734. [PubMed: 15972067]
- Hoagwood KE, Cavaleri MA, Olin SS, Burns BJ, Slaton E, Gruttadaro D, et al. Family support in children's mental health: A review and synthesis. *Clinical Child & Family Psychology Review*. 2010; 13:1–45. [PubMed: 20012893]
- Hoagwood KE, Green E, Kelleher K, Schoenwald SK, Rolls- Reutz J, Landsverk J, et al. Family advocacy, support and education in children's mental health: Results of a national survey. *Administration and Policy in Mental Health and Mental Health Services Research*. 2008; 35:73–83. [PubMed: 17999176]
- Hogg Foundation for Mental Health. [May 1, 2012] Health care in Texas: Critical workforce shortages in mental health. 2008. from <http://www.hogg.utexas.edu/PDF/Workforce%20Interim%20Senate%20052308.pdf>
- Kessler RC. Epidemiology of women and depression. *Journal of Affective Disorders*. 2003; 74:5–13. [PubMed: 12646294]
- Knitzer, J.; Theberge, S.; Johnson, K. [January 5, 2010] Reducing maternal depression and its impact on young children. National Center for Children in Poverty, Project Thrive Issue Brief, 2, 1-25. 2008. from http://www.nccp.org/publications/pub_791.html
- Koroloff NM, Elliott DJ. Linking low-income families to children's mental health services: An outcome study. *Journal of Emotional and Behavioral Disorders*. 1996; 4:2–12.
- LaRocco-Cockburn A, Melville J, Bell M, Katon W. Depression screening attitudes and practices among obstetrician-gynecologists. *Obstetrics & Gynecology*. 2003; 101:892–898. [PubMed: 12738146]
- Lee CY, Anderson JR, Horowitz JL, August GJ. Family income and parenting: The role of parental depression and social support. *Family Relations*. 2009; 58:417–430.
- Leiferman JA, Dauber SE, Heisler K, Paulson JF. Primary care physicians' beliefs and practices toward maternal depression. *Journal of Women's Health*. 2008; 17:1143–1150.
- Lewinsohn PM, Roberts RE, Seeley JR, Pettit JW, Olin TM. Intergenerational transmission of internalizing problems: Effects of parental and grandparental major disorder on child behavior. *Journal of Clinical Child & Adolescent Psychology*. 2008; 37:640–650. [PubMed: 18645754]
- McKay, MM.; Bell, CC.; Blake, CA. Community-based collaborations: Designing, conducting, and sustaining prevention programs. In: Hoagwood, K.; Jensen, PS.; McKay, M.; Olin, S., editors. *Children's Mental Health Research: The Power of Partnerships*. Oxford University Press; 2010. p. 9-20.
- Miranda J, Chung JY, Green BL, Krupnick J, Siddique J, Revicki DA, et al. Treating depression in predominantly low-income young minority women: A randomized controlled trial. *Journal of the American Medical Association*. 2003; 290:57–65. [PubMed: 12837712]
- Mishina H, Takayama JI. Screening for maternal depression in primary care pediatrics. *Current Opinions in Pediatrics*. 2009; 21:789–793.
- National Alliance on Mental Illness. [January 24, 2012] from www.namismw.nami.org
- Pickstone C. A pilot study of paraprofessional screening of child language in community settings. *Child Language Teaching and Therapy*. 2003; 19:49–65.
- Pilowsky DJ, Wickramaratne P, Talati A, Tang M, Hughes CW, Garber J, et al. Children of depressed mothers 1 year after the initiation of maternal treatment: Findings from the STAR*D-child study. *American Journal of Psychiatry*. 2008; 165(9):1136–1147. [PubMed: 18558646]
- Radloff L. The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement*. 1977; 1:385–401.
- Riley AW, Coiro MJ, Broitman M, Colantuoni E, Hurley KM, Bandeen-Roche K, et al. Mental health of children of low-income depressed mothers: Influences of parenting, family environment, and raters. *Psychiatric Services*. 2009; 60(3):329–336. [PubMed: 19252045]
- Riley AW, Valdez CR, Barrueco S, Mills C, Beardslee W, Sandler I, et al. Development of a family-based program to reduce risk and promote resilience among Families affected by maternal depression: Theoretical basis and program description. *Clinical Child and Family Psychology Review*. 2008; 11:12–19. [PubMed: 18360775]

- Rishel CW, Greeno CG, Marcus SC, Sales E, Shear MK, Swartz HA, Anderson C. Impact of maternal mental health status on child mental health treatment outcome. *Community Mental Health Journal*. 2006; 42:1–12. [PubMed: 16429249]
- Schoenwald SK, Henggeler SW, Brondino MJ, Rowland MD. Multisystemic therapy: Monitoring treatment fidelity. *Family Process*. 2000; 39:83–103. [PubMed: 10742933]
- Smith MV, Rosenheck RA, Cavaleri MA, Howell H, Poschman K, Yonkers KA. Screening for and detection of depression, panic disorder and PTSD in public-sector obstetrical clinics. *Psychiatric Services*. 2004; 55:407–414. [PubMed: 15067153]
- Solomon P. Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal*. 2004; 27:392–401. [PubMed: 15222150]
- Swartz HA, Frank E, Zuckoff A, Cyranowski JM, Houck PR, Cheng Y, Fleming MAD, Grote NK, Brent DA, Shear MK. Brief interpersonal psychotherapy for depressed mothers whose children are receiving psychiatric treatment. *American Journal of Psychiatry*. 2008; 165:1155–1162. [PubMed: 18558645]
- Swartz HA, Zuckoff A, Grote NK, Spielvogel HN, Bledsoe SE, Shear MK, et al. Engaging depressed patients in psychotherapy: integrating techniques from motivational interviewing and ethnographic interviewing to improve treatment participation. *Professional Psychology, Research and Practice*. 2007; 38:430–439.
- Ward EC, Clark LO, Heidrich S. African American women's beliefs, coping behaviors, and barriers to seeking mental health services. *Qualitative Health Research*. 2009; 19:1589–1601. [PubMed: 19843967]
- Weissman MM, Bland RC, Canino GJ, Faravelli C, Greenwald S, Hwu HG, et al. Cross-national epidemiology of major depression and bipolar disorder. *Journal of the American Medical Association*. 1996; 276:293–299. [PubMed: 8656541]
- Weissman MM, Feder A, Pilosky DJ, Olfson M, Fuentes M, Blanco C, et al. Depressed mothers coming to primary care: Maternal reports of problems with their children. *Journal of Affective Disorders*. 2004; 78:93–100. [PubMed: 14706719]
- Wright CA, George TP, Burke R, Gelfand DM, Teti DM. Early maternal depression and children's adjustment to school. *Child Study Journal*. 2000; 30:153–168.
- Yatchmenoff DK, Koren PE, Friesen BJ, Gordon LJ, Kinney RF. Enrichment and stress in families caring for a child with a serious emotional disorder. *Journal of Child and Family Studies*. 1998; 7:129–145.