

Depression in Homeless Mothers: Addressing an Unrecognized Public Health Issue

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Homeless mothers experience disproportionately high rates of major depressive disorder compared with the general population. Stressed by their circumstances, these women struggle to protect their families. Children living with a depressed parent have poorer medical, mental health, and educational outcomes. Despite the adverse impact on children, depression among mothers experiencing homelessness remains unacknowledged, unrecognized, and untreated. This article reviews the evidence supporting preventive and therapeutic interventions with low-income and homeless mothers and children, and finds that few services have been adapted and evaluated for use in the homelessness service system. Based on the robust evidence describing positive outcomes in programs for low-income parents with depression, the authors propose guidelines for adapting and implementing services directly by programs serving homeless families. Once families are housed and urgent issues addressed, they recommend assessing all family members, routinely providing culturally competent parenting supports, trauma-informed services, and treatment for major depressive disorders. They also emphasize the critical importance of creating child-centered spaces and developmental services for the children. To ensure quality care, training must be available for the staff. Given the increasing numbers of homeless families and high rates of maternal depression and its negative impact on children, support for these programs should become a high public health priority.

Depression is a major public health problem, especially for low-income and homeless women. Approximately 12% of women from all socioeconomic groups are depressed. This percentage approaches 25% for those living in poverty and for ethnic and racial minorities (Grote, Zukoff, Swartz, Bledsoe, & Geibel, 2007; Kessler et al., 2003) and 40% to 60% for low-income mothers with young children and pregnant and parenting teens (Knitzer, Theberge, & Johnson, 2008). Lifetime rates of depression among mothers who are homeless range from 45% to 85% (Bassuk et al., 1996; Bassuk et al., 1998; Weinreb, Buckner, Williams, & Nicholson, 2006). Despite this picture, depression among mothers experiencing homelessness remains largely unacknowledged, unrecognized, and untreated.

Depression adds to a mother's difficulty parenting effectively and may compromise her children's growth, development, and school readiness (Knitzer et al., 2008). Depression may also interfere with early bonding between mother and child, leading to the development of attachment issues (NRC & IOM, 2009a). Studies indicate that

children living with depressed parents have poorer medical, socio-emotional, and educational outcomes compared with children with nondepressed parents (Center on the Developing Child at Harvard University, 2009; Knitzer et al., 2008; NRC & IOM, 2009a).

Extremely poor and homeless women have disproportionately high rates of depression that are compounded by their circumstances. They are extremely stressed as they struggle to survive while trying to protect their children. With limited education and job skills, their prospects of finding and maintaining homes and becoming self-sufficient are limited. Many mothers experiencing homelessness feel dejected, depressed, and sometimes, despairing—feelings that reflect their challenging situations. However, the analysis that “you'd be depressed, too” if you were living in these circumstances (Gowen, 2008) does not consider the complex psychobiological factors that contribute to developing a major depressive disorder.¹

¹Major depressive disorder is characterized by feeling down and blue all of the time, or having no energy, plus five out of nine associated symptoms drawn from biological domains (e.g. trouble eating, sleeping, or concentrating) and psychological domains (e.g. feeling hopeless, helpless, that life is not worth living, or suicidal). For diagnostic purposes, these symptoms must last 2 weeks or more and may be accompanied by functional impairments; they often last much longer. The symptoms cannot be caused by substance use, medical diagnosis, or bereavement. Dysthymia is a condition with fewer symptoms that lasts 2 years. In standard psychiatric practice, recognition of either diagnosis requires treatment (*DSM-IV*, 2000).

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In general, current interventions in the homelessness service system are targeted toward obtaining housing and connecting families to mainstream resources, which are essential and often challenging tasks. Family oriented services and parenting supports are infrequently provided, and evidence-based practices to address parental depression are rarely available. Providers sometimes view identifying mental health disorders as “pathologizing” the mothers, thereby blaming the victims. Distinctions are rarely made between depressive feelings, symptoms, and clinical disorders requiring treatment, nor are these disorders viewed as only one dimension of a person’s experience. Even when depression is identified, many homeless women are afraid that a clinical diagnosis will lead to further stigmatization, child welfare involvement, and loss of their children. For these reasons, most homeless programs serving families do not routinely assess mothers for clinical depression and related mental health issues. Depression itself can significantly interfere with obtaining the housing and services that families need. Lack of access to critical services limits the opportunity for mothers to become self-sufficient and fully support their children. For these reasons, prevention and treatment of depression must be part of any effective solution to family homelessness.

Depression has been extensively researched and is one of the best understood of the mental disorders; it has both effective talking and medication therapies with demonstrated positive outcomes. Recent developments of evidence-based treatment and prevention services for depression in adults, and specifically for parental depression, provide a knowledge base that can be adapted for use with families experiencing homelessness. In addition to addressing external factors, such as poverty, and housing and food insecurity, the solution must also include preventive and therapeutic interventions.

With implementation of the Affordable Care Act (ACA), greater possibilities now exist for developing preventive programs, conducting routine screening and assessment, promoting recovery, supporting parenting, and providing family-oriented treatment for mothers and children experiencing homelessness. A strong and growing evidence base indicates that providing parenting supports is essential for effective mental health treatment. Two recent National Research Council and Institute of Medicine (NRC & IOM, 2009a, 2009b) reports provide critical information about the combination of promising and evidence-based services needed to address depression in families, and how to reframe service provisions to recognize that a parent with depression is a parent first.

This article reviews the high rates of major depressive disorder in homeless mothers, discusses the relationship of depression to parenting and the impact on children, reviews current and promising treatment practices, and describes strategies for implementing preventive and therapeutic practices in programs serving these families.

Background

Depression in Low-Income and Homeless Mothers

The prevalence of major depressive disorder tends to be higher in low-income women and especially in women experiencing homelessness (Polshuck, Cerrito, Leshoure, Finocan-Kaag, & Kearney, 2013). Researchers have investigated whether poverty predicts maternal depression and negative outcomes among their children. A meta-analysis of 193 studies demonstrated that poverty seems to be

a broad-scale enhancer of risk in relation to depression in mothers, but when controlling for socioeconomic status, maternal depression alone predicted greater adverse outcomes among children (Goodman et al., 2011; Kiernan & Huerta, 2008; Nomura, Wickramaratne, Warner, Mufson, & Weissman, 2002; Reinherz, Giaconia, Hauf, Wasserman, & Paradis, 2000; Riley et al., 2009).

It is not surprising that homeless mothers have high rates of mental health issues given their experiences of extreme poverty, exposure to violence, and limited support networks (Bassuk et al., 1996; Smith, North, & Spitznagel, 1993; Vostanis, Tischler, Cumella, & Bellerby, 2001; Weinreb et al., 2006; Zima, Wells, Benjamin, & Duan, 1996). Lifetime and current prevalence rates of major depressive disorders are much higher than in the overall female population. The Worcester Family Research Project (WFRP; Bassuk et al., 1996) reported that the lifetime rate of major depressive disorders for sheltered homeless mothers (45%) was more than twice that of women aged 15–40 in the National Comorbidity Survey (Kessler et al., 1994). Ten years later, when researchers (Weinreb et al., 2006) compared the mental health statuses of homeless mothers in Worcester, Massachusetts over the previous decade, they reported that 85% of sheltered homeless mothers had experienced a major depressive episode at some point in their lives; this was a marked increase from the 1996 study. Although the samples were assessed with different measures [The Structured Clinical Interview for *DSM-IV* Axis I Disorders (SCID) vs. The Mini-International Neuropsychiatric Interview (M.I.N.I.; First, Spitzer, Gibbon, & Williams, 1996; Sheehan et al., 1998)], these instruments were validated against each other. The authors speculated that the higher rates of depression and very low rates of treatment might be because of welfare cuts, fewer affordable housing units, and limited numbers of federal housing vouchers (Weinreb et al., 2006). Since the Great Recession of 2007, cuts at the local and state levels have been deep, suggesting that depression rates may be even higher now.

Overall, a majority of people with clinical depression experience other mental health and substance-use issues (NRC & IOM, 2009a). This is true of many homeless mothers as well. The WFRP documented that 47% of homeless women had two or more lifetime disorders compared with 27% in the National Comorbidity Study (Kessler et al., 1994). Zima et al. (1996) reported that 72% of sheltered homeless mothers in their sample had lifetime mental health or substance-use disorders. Bassuk et al. (1996) documented that more than 25% of homeless mothers in the WFRP said they had made at least one suicide attempt during their lifetimes, generally before the age of 18 years, and often when they were trying to leave their nuclear family and establish themselves independently. More than half had made two or more attempts. Few studies have investigated the relationship between depression, other mental health disorders, and suicide attempts.

Despite high rates of mental health disorders, poor and ethnic minority individuals are less likely to receive treatment than Whites and middle class individuals (Miranda et al., 2006). Significant disparities have been found in the care of African American women compared with White women. Primary care physicians are less likely to detect and treat depression in minority women. Furthermore, many low-income mothers, regardless of their ethnicity, do not seek mental health treatment or they drop out of treatment early (Grote et al., 2007; Nicolaidis et al., 2010; Polshuck et al., 2013; U.S. Department of Health & Human Services, 2001). Kuehn, Pergamit, & Vericker (2011) reported that only 30% of low-income mothers who were severely depressed and had young children received care within the

year. Women who are poor, young, lack insurance, and are offered single modality treatment for depression were most likely to drop out of treatment (Edlund et al., 2002). Nicolaidis et al. (2010) conducted focus groups with low-income African American women with major depressive disorder and histories of violent victimization and found that these women had “a deep distrust of the health care system as a White system” (p. 1470), and that racism rather than their illness determined service utilization patterns. They recommended that whenever possible, African American providers or women who have had similar experiences provide care “as a bridge to a White health care system” (p. 1474).

Depression and Parenting

With few exceptions, researchers have documented that parents’ health and well-being significantly impacts their children’s growth and development (Shonkoff & Meisels, 2000; Shonkoff & Phillips, 2000). For example, mental health problems—particularly depression—interfere with parenting, and contribute to emotional and behavioral problems manifested by homeless children (NRC & IOM, 2009a; Perlman & Doyle, 2012). Depression is associated with poor parenting skills and child maladjustment (Perlman, Cowan, Gewirtz, Haskett, & Stokes, 2012). As Knitzer et al. (2008) concluded, “the lesson from research is clear: Adult depression is not only bad for adults, it is bad for children, especially young children” (p. 11). External factors associated with extreme poverty and homelessness compound this picture.

Although many families may be resilient and manifest fewer adverse effects related to their circumstances (Gewirtz, DeGarmo, Plowman, August, & Realmuto, 2009), according to the NRC and IOM study of 2009a, mothers with depression who were homeless displayed more limited parenting skills. They were more likely to be disengaged, lacked understanding of child development, provided inadequate structure, used harsh and inconsistent discipline strategies, communicated less well with their children, were less empathetic and warm, and were less likely to provide learning stimuli (Howard, Cartwright, & Barajas, 2009; Koblinsky, Morgan, & Anderson, 1997). They also had trouble establishing predictable routines (e.g., feeding and sleeping schedules) that are so vital to a young child’s development.

Parents living in shelters and other residential facilities face additional challenges. Many experience traumatic stress, particularly interpersonal violence, and many had adverse experiences and few positive role models as children (Bassuk et al., 1996; Perlman et al., 2012). As comprehensively described by Friedman (2000), once families entered shelter, privacy was limited and families were required to abide by various rules and restrictions, including how they interacted with their children. Parenting became public, with staff and other residents viewing parents’ interactions with children and often scrutinizing, criticizing, and sometimes undermining their parenting approaches (Friedman, 2000; Paquette & Bassuk, 2009). Understandably, family rituals and routines were frequently disrupted (Schultz-Krohn, 2004). Establishing predictable routines was critical, as doing so has been shown to be strongly related to positive health and mental health outcomes (Fiese, Wamboldt, & Anbar, 2005; Fiese, 2006).

Child Outcomes

Compared with children with parents who were not depressed, children with depressed parents had an array of adverse outcomes. Studies documented that maternal depression predicted fewer “well-baby” visits in children younger than 2 years. These children were more likely to be hospitalized and to have multiple acute health-care visits, especially to emergency rooms, regardless of their health status. Although studies of adolescents were far less frequent, the NRC and IOM (2009a) concluded “. . . depression, at least in mothers . . . is related to the use of child health-care services and adverse health-care outcomes in children, from infancy to adolescence” (p. 140).

Children with depressed parents were also more likely to have emotional and behavioral disorders, attachment issues, cognitive vulnerabilities, difficulties in interpersonal relationships, lack of school readiness, and poor school performance (Howard et al., 2009; Magnuson & Waldfogel, 2005; Zima et al., 1996; also see pp. 135–164 in NRC and IOM (2009a) for a complete review). Researchers documented higher levels of both internalizing and externalizing disorders in children beginning in the preschool years. Adolescents with depressed parents exhibited 2 to 4 times the rate of depression compared with children of nondepressed parents (IOM & NRC, 2009b).

Current Approaches to Prevention and Treatment

Studies have documented that when mothers are treated for depression (e.g., medication, psychotherapies, behavioral interventions), their children develop fewer emotional and behavioral problems (NRC & IOM 2009a; Weissman et al., 2006). However, in general, these treatments have not been adapted and implemented for use with mothers and children experiencing homelessness. Gewirtz, Hart-Shegos, & Medhanie, (2008) reported that “housing agencies lack infrastructure or expertise in children’s mental health” (p. 810) and did not screen or assess mothers experiencing homelessness for depression. Furthermore, homelessness programs were less successful accessing community-based services and were less likely to have clinical staff on site with expertise in mental health, parenting practices, and children’s issues.

More research is necessary. Overall, studies of depression “rarely measure outcomes that specifically affect parents, including parenting quality and impact of therapeutic treatments on children” nor have they examined effective delivery, especially in underserved populations (NRC & IOM, 2009a, p. 205). In fact, a recent critical review of the evidence base of programs targeted to homeless families and children indicated that no studies have sufficient evidence to be rated as having positive effects within the guidelines of the *What works? Clearinghouse standards for evidence-based practices* (Duran et al., 2011). “In most cases, this is because quality evidence that evaluates the program effects doesn’t exist (Herbers & Cutuli, in press, p. 2).

Assessment

Some programs serving low-income women are now screening for maternal depression (Howell et al., 2012; NRC & IOM, 2009a), and

administrators of other homelessness programs can learn from their experiences. Studies have shown that standardized tools are far more successful in identifying depression compared with informal inquiry, and that many of the current assessment instruments are brief. In addition, screening may vary with the setting. For example, the ABCD Program (Assuring Better Child Health and Development) administered by the National Academy for State Health Policy recommends screening mothers within the context of prenatal care or pediatric practice (Knitzer et al., 2008), whereas others have highlighted the importance of screening postpartum (Boyd, Le, & Somberg, 2005) and beyond. Challenges to implementing even brief screening programs for depression in settings serving low-income and high-risk families include resource and training limitations, challenges engaging mothers in ongoing treatment, and connecting mothers to community-based programs (NRC & IOM, 2009a).

Prevention and Treatment

The two recent NRC and IOM reports—one on prevention of emotional, behavioral, and mental health difficulties in children, youth, and families (2009b), and the other on parental depression (2009a)—resulted from a 3-year process in which two committees of independent scientists reviewed evidence and made recommendations about promising research and practice strategies. The reports proposed a developmental framework for creating and implementing various preventive interventions. Early in life, interventions such as prenatal or postnatal care are most important. For high-risk youth, home visitations from nurses and early childhood-center-based care such as Early Head Start provide a strong evidence base. As children move into school-age years, social skills training, academic support, and parenting skills trainings also had positive outcomes. For adolescents, there is strong evidence for preventing depression and substance use. Across all developmental periods, effective interventions address parenting skills, focus on specific family adversities, such as bereavement, divorce, and parental depression, and attempt to strengthen policies. Using a developmental framework, the NRC and IOM reported that specific preventive interventions had a strong evidence base for ameliorating parental depression and reducing its impact on children. Principles driving these interventions included

- Addressing the needs of children in families where parents were depressed.
- Strengthening parenting through psychoeducation or more complex parenting interventions.
- Providing treatment to parents when they had full-blown episodes of major depression.
- Assessing children to understand their needs.
- Using a variety of preventive and therapeutic strategies to assist children.

The NRC and IOM (2009b) emphasized that parenting can be supported through effective parenting programs that address depression and a wide array of other conditions, such as problem behaviors, substance use, and various adversities (e.g., loss and bereavement). NRC and IOM (2009a) documented the association of maternal depression with less effective parenting, and how this can contribute to a range of mental, emotional, and behavioral disorders in children. Since most mental health disorders have their roots in childhood and youth—with an estimated 14–20% affected in any given year—

prevention and treatment in both mothers and children is vital and effective (NRC & IOM, 2009b). High rates of major depressive disorder in mothers experiencing homelessness make it critical that evidence-based interventions be made available for these women (NRC & IOM, 2009a).

Additional promising programs and family-oriented best practices have emerged since publication of the NRC/IOM reports. Unless specifically indicated, the services described below have not been adapted for use with homeless families and children. For example, Compas et al. (2011) have developed a group/family-centered program that focuses on parenting skills, youth coping skills, and understanding parental depression. At 24-month follow-up, they found an increase in both parenting and coping skills as well as a significant decrease in episodes of major depression in the groups receiving the intervention. Clarke et al. (2001) adapted a cognitive-behavioral group treatment for depression in youth for use in a mental health setting. In a randomized trial at a single site, rates of major depression in youth who had parents with major depression, and who had a history or symptoms of depression, were significantly lower 15 months later (Clarke et al., 2001). Garber et al. (2009) replicated these findings in a four-site trial involving approximately 320 youths. At 9 months, researchers reported similar findings, although youth who had acutely depressed parents did not benefit as much from the intervention (Garber et al., 2009). Recently, these findings were again replicated (Beardslee et al., in press) among children whose parents received the intervention and who were not depressed; depression rates among youth were lower at 33 months. In the “usual care” subgroup, parents sustained positive changes in their behaviors and attitudes toward mental health issues.

Psychoeducational approaches that combine information about mental health and promote strong parenting practices have a robust evidence base for use with low-income families, but have not been specifically adapted or implemented for use with families and children experiencing homelessness. Beardslee et al. (1998) developed Family Talk—a family-centered, six-session intervention that included taking histories, providing psychoeducation, interviewing children about their worries, meeting with parents to plan family meetings, discussing concerns together, and following up. The goal of Family Talk is to increase self-understanding and create a shared understanding in families by helping them construct a coherent narrative of the events leading to parental depression. Various studies have demonstrated the effectiveness of this intervention. In a large-scale, randomized trial (Beardslee, Avery, Ayoub, & Watts, 2009; Beardslee et al., 2011), 100 families were followed for approximately 4.5 years. The main outcome for the children was better understanding of their parents’ depression and positive effects for both parents. These findings were replicated in a trial with African American families and again with Latino families (D’Angelo et al., 2009; Podorefsky, McDonald-McDowdell, & Beardslee, 2001). When the intervention was replicated in different cultural settings, it was positively transformed and strengthened by the process of adaptation (Beardslee, Ayoub, Avery, Watts, & O’Carroll, 2010). Family Talk has been used in Finland, Holland, Norway (Beardslee, Solantaus, Morgan, Gladstone, & Kowalenko, 2012), and more recently in Australia and Costa Rica (Beardslee et al., 2011). The principles of Family Talk were also integrated into a training and empowerment program for Head Start teachers (Beardslee et al., 2010).

The WE Care study (Nadeem, Lange, & Miranda, 2009) also focused on major depression in low-income women. Based on a

randomized control trial, the study documented that antidepressant medication (e.g., SSRIs) and cognitive-behavioral therapy (CBT) or interpersonal psychotherapy were shown to be effective with disadvantaged populations. A meta-analysis of six randomized trials of remission after antidepressant medication (i.e., paroxetine) or after CBT were approximately equivalent, averaging 46% compared with 24% for controls (Casacalenda, Perry, & Looper, 2002). In the WE Care study, 44% achieved remission with medication and 32% with CBT after 6 months (Miranda et al., 2003), suggesting that, in the short term, medication might be more effective. However, studies following patients over 12 months found that those who were treated with CBT were more likely to have a sustained response than those who had been treated only with medication. These outcomes suggest that CBT may be more effective in the long term (Miranda et al., 2006).

A randomized control trial (Miranda et al., 2006) of 1-year treatment outcomes in young, low-income minority women demonstrated that both medication and CBT decreased depression in more than half the sample; medication interventions had a somewhat stronger effect. Researchers attributed the slightly better outcomes for medication to the fact that they were only able to engage women in CBT for short periods. However, even minimal exposure of six sessions was useful in reducing depressive symptoms, although role functioning did not improve. Overall, the researchers reported difficulty engaging low-income women in their study into care. Despite assertive outreach that included childcare and transportation, only 36% of the women in the CBT cohort attended six or more sessions. Based on these findings, they recommended that brief, structured CBT interventions might be introduced in settings most comfortable for mothers, such as Head Start, church, or during the course of their county health-care visits (Miranda et al., 2006). They concluded that providing antidepressants or psychotherapy for low-income women decreased their suffering. "Antidepressant medications result in rapid decrease in depressive symptoms and both treatments achieve high rates of remission by 12 months" (Miranda et al., 2006, pp. 109–110).

Head Start and Early Head Start programs have also demonstrated that building a variety of services and supports for low-income families with depression can improve parenting practices and child outcomes in low-income families. Helpful services have included a combination of screening and assessment, postpartum interventions, home visiting (Ammerman, Putnam, Bosse, Teeters, & Van Ginkel, 2010), staff training (Beardslee et al., 2009), mental health consultation, and specific treatment services (Beeber, 2010; Duran et al., 2009). Researchers have emphasized the vital importance of also addressing nonspecific risk factors, such as poverty, exposure to violence, social isolation, and unemployment, that may contribute to the onset of depression (Beardslee et al., 2010; NRC & IOM, 2009a; Yoshikawa, Aber, & Beardslee, 2012). Developing nurturing environments in the schools and communities where these families reside, as well as policies that support these approaches, are also essential for their success (NRC & IOM, 2009b). Addressing the immediate needs of sheltered homeless families such as structural inequalities (e.g., housing, income) require different time frames and additional strategies.

Although the research on parenting practices in emergency shelters and transitional housing serving homeless families is extremely limited, various strength-based parenting approaches have recently emerged for use in these settings. Parenting Through Change (PTC) is a 14-week group program that targets skill development, problem

solving, limit setting, monitoring, and positive involvement (Forgatch & DeGarmo, 1999; Perlman et al., 2012) through role playing and active learning. Originally developed as a preventive intervention for children with behavioral problems, it has been shown to reduce children's difficulties as well as maternal depression over 9 years (Patterson, Forgatch, & DeGarmo, 2010). Perlman et al. (2012) have adapted and evaluated PTC in a domestic violence shelter and in 16 supportive housing agencies in Minnesota. Satisfaction and retention of parents in the program was high; program outcomes are currently being analyzed. Family Care Curriculum (FCC) is a strength-based, 6-week program currently being piloted in seven emergency and transitional housing agencies in the Northeast. FCC focuses on attachment issues, trauma-informed care, effective Black parenting, and self-care. It is based on the idea that when parents understand what their children "are thinking, feeling, and needing," parents will become more consistently sensitive and receptive to their children's needs leading to sustained behavioral change (Perlman et al., 2012, p. 406). Preliminary outcome results are encouraging.

A Framework for Effective Response

Because the high prevalence of depression in these families may help to undermine their ability to find and engage in programs and services, we encourage agencies to directly address depression by developing an integrated response. We strongly emphasize the critical importance of responding to the family's immediate and often urgent circumstances, including safety, permanent housing, food, income and benefits, employment, and acute medical issues; create "child-centered spaces" for learning and play; help families connect to a sustainable support network; and address mental health needs of both mothers and children. Fortunately, as we have discussed previously, there are numerous promising programs that have been used with low-income families and can be adapted for use with mothers and children who are homeless. In this section, we propose various principles of care and service strategies for agencies serving homeless families and children.

Principles of Care

Safe, affordable, permanent housing provides the foundation for stabilizing homeless families. Housing First, a program based on the principle that housing is a basic human right, houses families as quickly as possible and does not make permanent housing contingent on meeting various service requirements. Once families are stably housed, families are offered services, but their participation is not meant to affect their housing status.

Although housing is essential for all families, it is not sufficient for many. Once families and children are housed, the principles described later should guide the process of adapting and implementing various preventive and therapeutic practices to address depression in homeless mothers and their children.

First, care must be family centered. This involves understanding the needs of both parents and children, developing strategies for strengthening family functioning and cohesiveness, and enabling families to stay together, especially during the various transitions that characterize homelessness. Rather than waiting for difficulties to emerge in children whose parents are homeless and sometimes depressed, a preventive family preservation and strengthening approach

should be developed. Although our focus has been on parental depression, it should be emphasized that a family-focused approach is beneficial in helping parents master other adversities as well. This may require a paradigm shift in how services are delivered and how staff is trained and supported.

Second, programs should be based on strengths rather than deficits. The preventive interventions described earlier build on strengths that build resilience. Protective factors at the individual, family, caregiving-system, and community levels should be identified and supported. Connecting mothers and fathers to resources that will help them be more effective parents builds on a natural impulse and is an important strength-based intervention.

Third, all services should be adapted to meet the needs of parents from different cultures and backgrounds, and of different genders. Cultural issues and traditions often determine both the expression and experience of depression. Whenever possible, providers with similar experiences or from the same cultural background (e.g., African Americans) should be available to treat women with depression. In addition, treatment should address gender-specific issues. For example, women's self-esteem is largely defined by their affiliations with others and with their children. Solid relationships are a woman's capital, contribute to her psychological well-being, and must be heartily supported during treatment.

Fourth, all programs should assess and address the needs of children; programs should be responsive to their developmental needs. Such programs must also assess and address the needs of adult family members, including their roles as parents. Similarly, providers should evaluate each family as a unit. Without understanding family members' needs, it is hard to develop responsive service plans.

Fifth, all programs developed for depression should include both preventive and therapeutic components. Studies indicate that programs benefitting depressed parents and their children include center-based and development-oriented daycare or child care, as well as home visitation. Often these programs are enriched by outreach that increases the likelihood that depressed parents will engage in treatment. In addition, some of the promising prevention and intervention programs for low-income families in which parents are depressed might result in better outcomes, and are especially relevant for the subset of those families experiencing homelessness.

Finally, because of the high rates of traumatic stress and violent victimization in these families, all services should be trauma-informed. Trauma and depression are highly associated. Just as providers must understand the signs and symptoms of PTSD (e.g., triggers, hypervigilance, hyperarousal, numbing, dissociation), providers must also be aware of the signs of depression (e.g., persistent sadness, difficulty engaging, irritability, lack of energy). Mothers experiencing homelessness must be engaged in trusting relationships that promote choice, empowerment, and self-efficacy.

Service Strategies

Screen and assess all family members. All family members, including children, should be routinely screened or assessed using brief standardized measures. Contextual factors, such as housing, education, employment, as well as traumatic life stresses and co-occurring disorders, should be identified (e.g., PTSD, substance-use disorders). Children should be assessed for developmental delays as well as the presence of mental, emotional, and

behavioral disorders. Referral sources for those who test positive should be identified.

Address urgent issues. Urgent issues and basic needs (e.g., safety, domestic violence, medical issues) as well as nonspecific risk factors such as housing, employment, income, and educational issues should be addressed as part of a holistic approach to depression. In many programs, case managers routinely address these issues.

Engage family members in services. Whenever possible, "meet the family where they are" Often assertive outreach requiring patience and persistence is necessary to build a trusting relationship that will help support families' participation. Asking about the parents' concerns and addressing them is one of the most important ways to build rapport and alliances with the families.

Routinely provide parenting supports. Emphasize the importance of parental roles by supporting effective parenting (e.g., help parents to provide routines and positive discipline, teach them how to reassure their children, and help them understand their experiences). Ask parents how their children are doing and what they need for their children (e.g., health care, schooling, transportation). Support the parents in helping children understand what they have been through and help them make sense of their experience. Reassure them that the family unit will survive. View the provision of these support services as a way of taking care of the family unit and preventing depression in both mothers and children.

Ensure that all services are trauma-informed. Given the extremely high rates of traumatic stress and exposure to violence experienced by homeless mothers and the disproportionately high rates of PTSD, all services should be provided through the lens of trauma. Staff should be trained to understand the impact of sustained traumatic stress on relationships and behaviors, and encouraged to support consumer choice, empowerment, leveling of power differentials, and psychoeducation.

Provide treatment for full-blown depressive disorders. Use medication or talk therapies or both (e.g., CBT). Wherever possible, provide these services as part of the housing program. Try to ensure that training and clinical backup are available.

Establish relationships with community-based agencies. Collaborate with local agencies that are knowledgeable about homelessness and have the compassion, capacity, and motivation to provide family-centered care to mothers and children experiencing homelessness. Community agencies providing direct care (e.g., medications and talking therapies) for maternal depression should be identified and partnerships established. Referral routes should be clear so that waiting lists are not long and mothers are more likely to engage in treatment.

Address the needs of children. Agencies should formally assess all children and provide them with developmentally appropriate programs and "child-centered spaces" for children to play in, as well as areas for school-age children to do their homework. All services that address maternal depression should be family oriented, support effective parenting, and also focus on the children.

Programs should ensure that all staff are knowledgeable about developmental issues. Children who manifest serious emotional, behavioral, and developmental problems should be appropriately referred.

Provide ongoing training and support to staff.

Routine training should be provided in the following areas: homelessness and housing, child development, parenting, traumatic stress and its mental health consequences, depression, and substance use. Training should also help providers develop skills to implement evidence-based practices. Clinical supervision and consultation should be available to staff as necessary.

Develop a research and evaluation agenda. An ongoing research and evaluation agenda should point the way to better understanding the causes, correlates, and consequences of depression in homeless family members. Promising practices and model programs should be routinely monitored and evaluated. The research agenda should focus on the challenges of adapting evidence-based practices for low-income women for use in homeless service settings, and then identify the supports necessary for implementation. Of particular importance is identifying strategies that are strength-based and family-centered, have evidence bases demonstrating positive outcomes, and can eventually be taken to scale.

Conclusion

With the staggering increase in the number of homeless mothers and children, many more extremely poor women and children are at high risk of depression. In the 2010 school year, the number of homeless families reached an historic high—with a 13% increase from the previous year. Forty-four states reported a 20% increase in school-age children in 2010–2011. Now, one in 45—more than 1.6 million children—are homeless each year in the United States (National Center on Family Homelessness, 2011).

The passage of the ACA creates new opportunities for addressing prevention and treatment of maternal depression within a family-oriented context (Howell & Kenney, 2012). Medicaid provides broad coverage of various mental health problems, including depression. In addition, in 2014, many more low-income adults who live at up to 138% of the federal poverty level will be eligible for coverage. If all states agree to the option, 2.7 million currently uninsured parents would become eligible (Howell & Kenney, 2012). Mental health is one of the 10 essential services covered under the ACA. In addition, it strongly emphasizes preventive services that include parenting supports. Opportunities within the ACA are manifold, including primary care medical home demonstrations, health home state plans, SAMHSA-funded integrative service demonstration projects, and the Medicaid Pediatric Accountable Care Organization demonstrations.

Significant progress has been made in understanding parental depression and its impact on children, developing treatment and prevention approaches, and implementing them with diverse populations. The NRC and IOM (2009a, 2009b) reports have synthesized the evidence base for these interventions and have delineated a set of core principles that drive them. This article has provided a guide for adapting family-centered strategies to prevent and treat depression in homeless families and children. Given the growing problem of family homelessness, and the emerging opportunities for prevention and treatment of depression, the task of identifying and treating these mothers and developing strategies to address the needs of their

children should be a high public health priority. Otherwise, we stand to lose another generation of children and young mothers.

Keywords: homeless mothers; trauma; maternal depression; parenting skills; family centered care

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