Baseline Individual and Organizational Readiness Assessment for Parental Mental Health Intervention Implementation among Florida MIECHV Program Staff

FLORIDA MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING INITIATIVE - 2017

Abimbola Michael-Asalu, Kimberly Hailey, Jennifer Delva, Esther Jean-Baptiste, Pamela Birriel, Oluwatosin Ajisope, Cynthia Horwitz, Oluyemisi Amoda, & Jennifer Marshall
UNIVERSITY OF SOUTH FLORIDA COLLEGE OF PUBLIC HEALTH, CHILES CENTER FOR HEALTHY MOTHERS & BABIES

INTRODUCTION

The Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) initiative supports evidence-based home visiting programs across the state with the aim of improving health and developmental outcomes for families living in at-risk communities. Home visitors provide education, social support, and linkage to community agencies for pregnant women and families with young children. These home visitors help to ameliorate family stress, offer resources and guidance, and identify and address risk factors associated with poor birth outcomes or child developmental issues.

Mental health issues can cause varying degrees of interference in thought processes and behaviors, leading to difficulties in coping with ordinary life experiences, and consequently negative effects on the family (Leinonen, Solantaus, & Punamäki, 2003; Reupert & Maybery, 2007). Parents with mental health issues may contribute to marital friction with increased risk of divorce, inability to develop or maintain positive relationships with children, poor judgment, and poor parenting practices. Depression is the most studied form of mental illness (Leinonen et al., 2003; Reupert & Maybery, 2007) and aside from the effect on the parents, children of mothers with depression are more likely to experience problems with school performance, peer relationships, substance abuse, psychological adjustment, and are at an increased risk of developing depression themselves (Leinonen et al., 2003; Reupert & Maybery, 2007). Parenting practices and interpersonal relationships improve when mental health issues are addressed (Smith, 2004). Prior research with the Florida MIECHV population found that about a quarter (24.6%) of 715 sample participants were at high risk for maternal depression based on the Edinburgh Depression Scale (score $\geq$ 10), with a mean score of 6.3 (SD 5.5) (Ross et al., 2015). The most significant factor associated with the depressive symptoms was perceived parental stress (OR: *1.26*, CI: *1.21-1.31*) (Ross et al., 2015).

The implementation of Parental Mental Health (PMH) intervention programs throughout Florida MIECHV sites are one focus of an initiative funded by a Federal Competitive Grant awarded to the Florida Association of Healthy Start Coalitions, Inc. from the 2016-2018 cycle. The PMH intervention aims to incorporate mental health service delivery into current home visiting services for Florida MIECHV participants. This initiative includes implementation of *Moving Beyond Depression* (Moving Beyond Depression, n.d.) in selected sites, and *Mothers and Babies Program* (Mothers and Babies, n.d.) statewide. The PMH-focused curricula, with topics such as prevention and psycho-social education, along with counseling and intensive therapy, support families experiencing depression or other mental health issues.

To assess the baseline individual and organizational readiness for PMH intervention implementation, all Florida MIECHV staff were provided with a "Parental Mental Health Implementation Readiness Survey" by the University of South Florida MIECHV Evaluation Team. The Florida MIECHV evaluation uses a mixed-methods approach to evaluate various activities of the program to inform program design, implementation, and policy as a part of the federal funding agreement. The PMH baseline survey serves as a reference to assess readiness across sites for future implementation, and to determine if improvements occurred after the PMH intervention programs were implemented in late spring of 2017.

METHODS

Quantitative

Diffusion of Innovation (DOI) Theory was introduced as the foundation for understanding adoption of PMH practice among staff within their organizations (MIECHV sites). The DOI theory describes how an innovation or new practice "diffuses" throughout a particular population. The adoption of innovation typically happens in five stages: initial knowledge of the innovation; persuasion to readily incorporate new knowledge into deciding whether or not to adopt the innovation; decision to adopt or reject the innovation; implementation of the innovation; and confirmation to agree or disagree with the decision made (see Figure 1).

DOI theory was used to measure both the individual and organizational readiness to employ PMH practices. The 56-item questionnaire assessed participant characteristics, knowledge, attitude, individual and organizational practices, and self-efficacy/effectiveness concerning PMH implementation. The survey was available both online through Qualtrics software, and hard- copy format distributed by members of the evaluation team during the 2016 annual site visits. Program staff not present at the time of site visits were invited to complete the survey online.

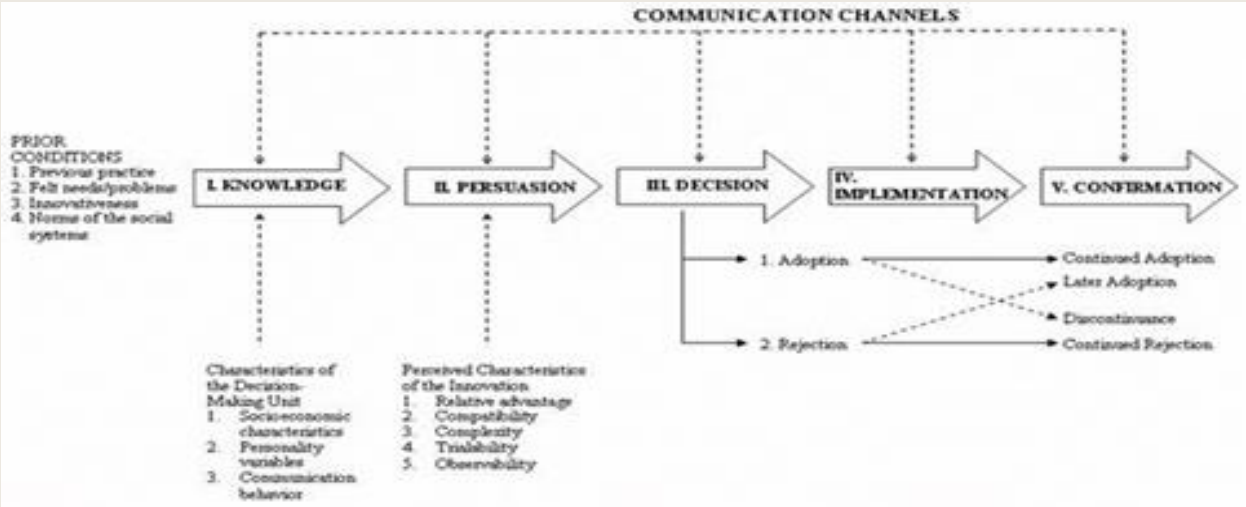

Figure 1. Diffusion of Innovation Stages of Adoption

Qualitative

To explore additional attitudes on the organizational processes of implementing a new program, focus groups were conducted with home visiting staff members in four sites. Several administrators, supervisors, and home visitors from Alachua, Duval, Hillsborough, and Miami-Dade counties participated in three focus groups, typically for an hour with members of the MIECHV Evaluation team. These group sessions aimed to explore the impact of the intervention on participants' mental health and parenting, as well as the participants' engagement, collaboration, and retention in the MIECHV home visitation program. The focus groups/conference calls were recorded, transcribed, and reviewed to identify major themes of the process of implementation, specifically the perceived challenges/barriers, successes, and expectations in the preliminary stages of the *Moving Beyond Depression* (MBD) intervention.

RESULTS

Quantitative

A total of 45 survey participants completed the survey or accessed it online. The participants included 29 home visitors (64.4%), 12 administrators/directors/supervisors (26.7%), and 'other' roles such as therapist, office operations manager, and program manager (8.9%). The majority of the survey participants were female (93.3, n=42), with most identifying as White (71.1%, n=32), versus Black (20.0%, n=9), Asian (4.4%, n=2), and 'other' (8.9%, n=4). Respondents also mostly identified as non-Hispanic (77.8%, n=35). The mean age of respondents was 42.3 years (range from 25 to 67 years), with the highest level of education ranging from Bachelor's degree (51.1%, n=23) to Master's/Doctoral/Professional degree (31.1%, n=14). About half of respondents were already familiar with the term "parental mental health" (56.1%, n=23).

Table 1: Characteristics of Florida Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program Staff, Participants of the Parental Mental Health Survey, 2016

PMH Survey Participants Characteristics	**Respondents (N=45)**
Characteristics	**N (%)**
AGE (Mean, SD)	42.3(11.05)
GENDER	
Female	42(93.3)
Male	2(4.4)
Prefer not to Answer	1(2.2)
RACE (N=47)	
White	32(68.1)
Black/African American	9(19.1)
Asian	2(4.3)
Other	4(8.5)
ETHNICITY	
Non-Hispanic	35(77.8)
Hispanic	10(22.2)
EDUCATION	
Some College	1(2.2)
Associate Degree	7(15.6)
Bachelor's Degree	23(51.1)
Masters/Doctoral/Professional Degree	14(31.1)
ROLE IN ORGANIZATION	
Administrator/Director	4(8.9)
Supervisor	8(17.8)
Home Visitor	29(64.4)
Others	4(8.9)
FAMILIARITY WITH THE TERM 'Parental Mental Health'	
Strongly Agree/Agree	21(56.8)
Neutral	12(32.4)
Strongly Disagree/Disagree	4(10.8)
WORK IN A PMH INTERVENTION SITE	
Yes	13(32.5)
No	27(67.5)

Abbreviations: SD = standard deviation; PMH = Parental Mental Health

INDIVIDUAL READINESS

In assessing readiness for PMH implementation, survey respondents were asked questions relating to their individual current PMH practices. Approximately one-third (30.0%, n=12) of respondents have been using PMH strategies for a while (more than 1 year), while 35.0% (n=14) reported that they "think it would be a good idea to begin" using PMH strategies. Six respondents (15.0%) planned to begin using PMH strategies as opposed to three (7.5%) who have recently started using PMH strategies.

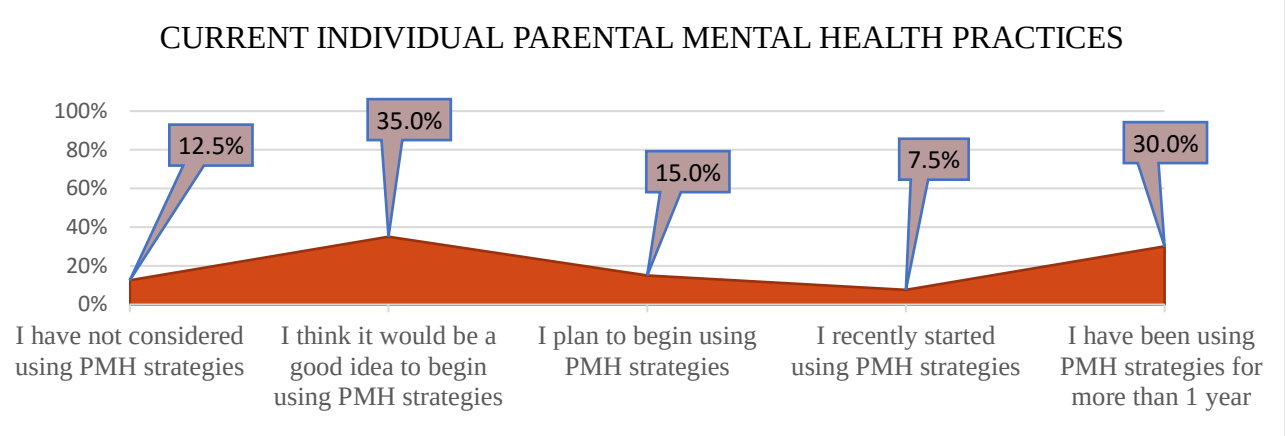

Figure 2: Description of current individual Parental Mental Health practices

Knowledge, Attitudes and Practices

While just over half (56.1%) of the survey participants were familiar with term 'parental mental health', most reported knowing the importance of involving an entire family in PMH programs/services (85%, n=34). Many respondents reported knowing what to do if a child needed mental health services (72.5%, n=29), and about half (48.8%, n=20) had observed how incorporating PMH improved practices for others in their field. Overall, participants (70%, n=28) were motivated to implement PMH programs/services. Similarly, majority of survey respondents perceive that PMH services were compatible with the services they currently provide (76.3%, n=29). A majority of staff felt that they play an important role in improving community's ability to address PMH by promoting PMH programs/services (67.5%, n=27).

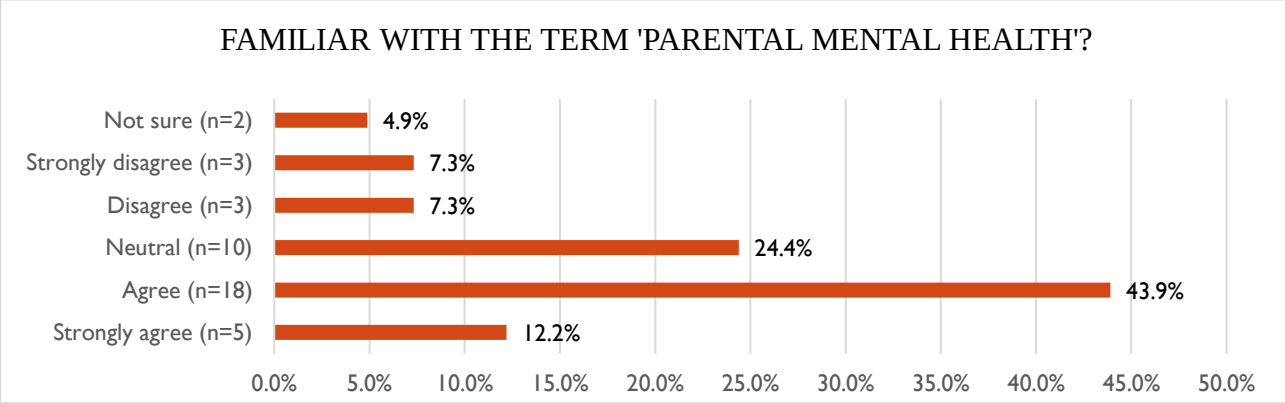

Figure 3: Participant familiarity with the term Parental Mental Health

About half of participants (50%, n=17) felt that incorporating PMH into their practice was something they could try out before fully committing, and less than half reported that their position allows enough time to implement PMH (46.2%, n=18). In terms of skill set and practices, while a little above half of the respondents strongly agreed/agreed to having confidence in their ability to implement PMH practices (53.7%, n=22), 17 participants (42.5%) find it easy to locate current local, state and national resources on PMH. About a quarter (26.8%, n=11) felt that their current PMH practices are effective. Less than half (48.8%, n=20) have the skills to assess PMH and connect those at risk to appropriate services.

Perceived Need

When asked if PMH was an important issue for the families with whom respondents worked, the vast majority indicated that they strongly agreed/ agreed (82.9%, n=34), while 7 respondents (17.1%) were either not sure or neutral. Participants strongly agreed/ agreed (75.7%, n=28) that incorporating PMH into current practices would improve the services they currently provide. No the participants disagreed on the importance of PMH or its ability to improve services provided.

Facilitators/Barriers

As previously mentioned, the majority of the respondents stated they play an important role in improving their community's ability to address PMH by promoting PMH programs/services. 73.2% (N=30) of participants indicated that it is not only important for someone in their position to engage in PMH practices, but also to advocate for PMH (80%, n=32), and to partner with others in the community who are interested in promoting PMH (82.5%, n=33). No barriers to implementing PMH were mentioned and just one individual (2.6%) agreed that it would be too complicated to incorporate PMH into his/her current practices.

ORGANIZATIONAL READINESS – MIECHV SITES

Following an assessment of individual PMH readiness, survey respondents were also asked questions related to their organization's PMH practices. About half of participants reported that their organization had been using PMH practices for more than 1 year (50%, n=16); other organizations planned to begin (21.9%, n=7), or thought it would be a good idea to begin (21.9%, n=7) using PMH strategies.

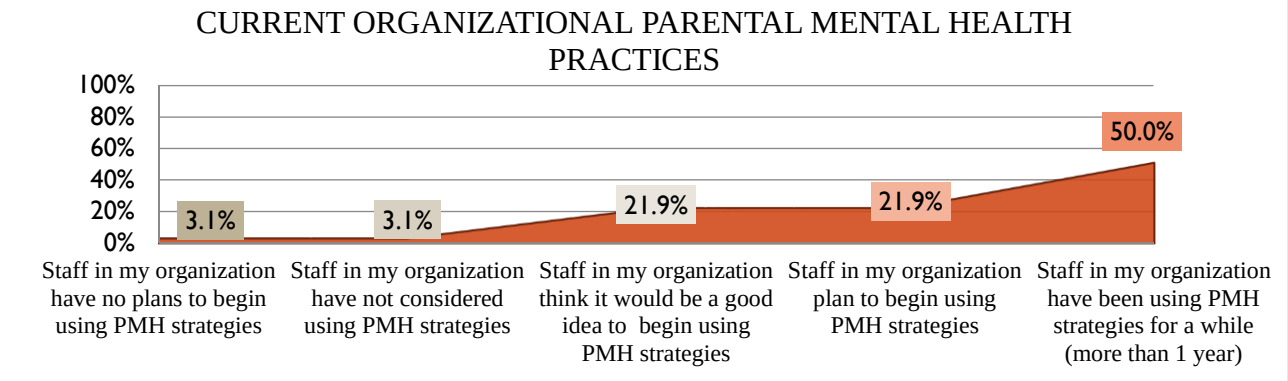

Figure 4: Description of current organizational practices of Parental Mental Health

Organizational Awareness and Attitudes

In terms of the MIECHV sites' awareness, necessity, and compatibility: almost half of participants (48.1%) strongly agree/agree that their organization was familiar with the term "Parental Mental Health"; the vast majority reported that incorporating PMH into the current practices of staff in their organization would improve the services currently provided (79.2%); PMH is compatible with services currently provided by their organization (82.6%).

Half of participants (50%) strongly disagreed/disagreed that it would be too complicated to incorporate PMH into current practices in their organization, similar to 57.9% reporting on their individual practice. Similarly, reports were mixed regarding the trialability of incorporating PMH in their organizations: 52.2% of participants strongly agreed/agreed, 43.5% were neutral/not sure, and 4.4% disagreed/strongly disagreed that incorporating PMH into their organization's current practices would be something they could try before fully committing. Most participants (69.6%) strongly agreed/agreed that incorporating PMH into their organization's current practices would be something that could be learned by watching others; that PMH is an important issue for families served in their organization (84%), and that staff in their organization should be trained to assess PMH and connect those at risk to appropriate services (85.2%).

Organizational Leadership, Capacity, and Interagency Linkage:

More than two-thirds (69.2%) of participants strongly agreed/agreed that their organization places importance on promoting or providing PMH programs/services in the community and partners with community members to promote PMH (61.5%). However, fewer than half of participants reported that key leaders in their organization are actively involved in PMH practices (46.2%). Participants also report their organization and that community organizations participate in joint planning and decision-making about PMH (42.2%).

Translation of these activities into practice is reported at a lower rate. As shown in the figures above, approximately half (51.8%) of survey participants reported that most members in their organization know where to go to find resources or information regarding PMH. A similar proportion reported that organizations in their community share information with each other (55.6%) and share money or personnel (23.1%) to implement and promote PMH.

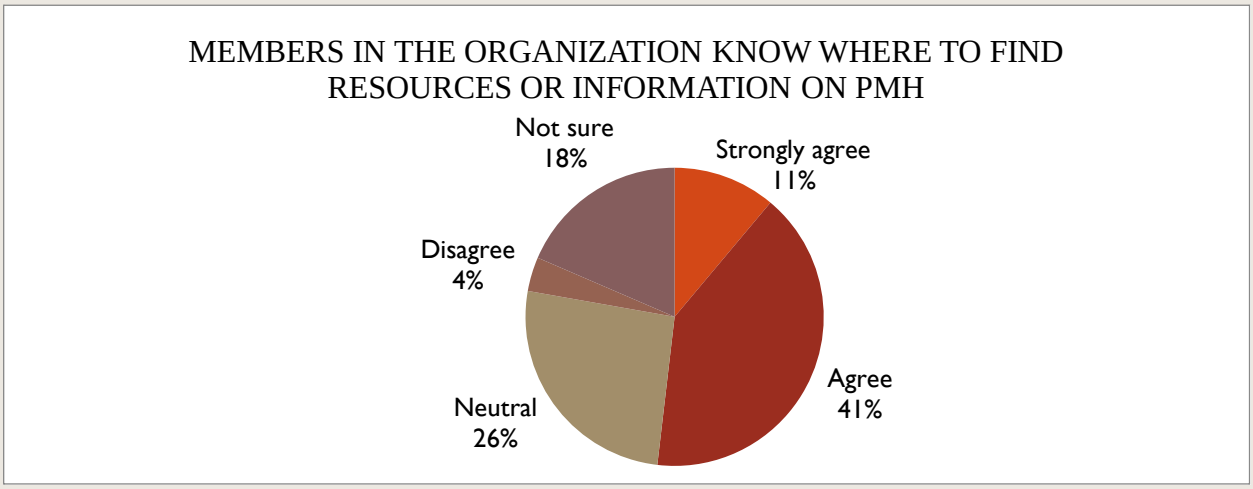

Figure 5: Participant perception of organizational awareness/ knowledge on resources for PMH

In terms of organizational capacity, 34.6% of participants strongly agreed/agreed that their organization has adequate funding; 46.2% strongly agreed/agreed that their organization has sufficient staff; 46.2% strongly agreed/agreed that their position permits enough time; and 33.3% of participants strongly agreed/agreed that their organization receives adequate technical assistance and support to educate staff on PMH practices.

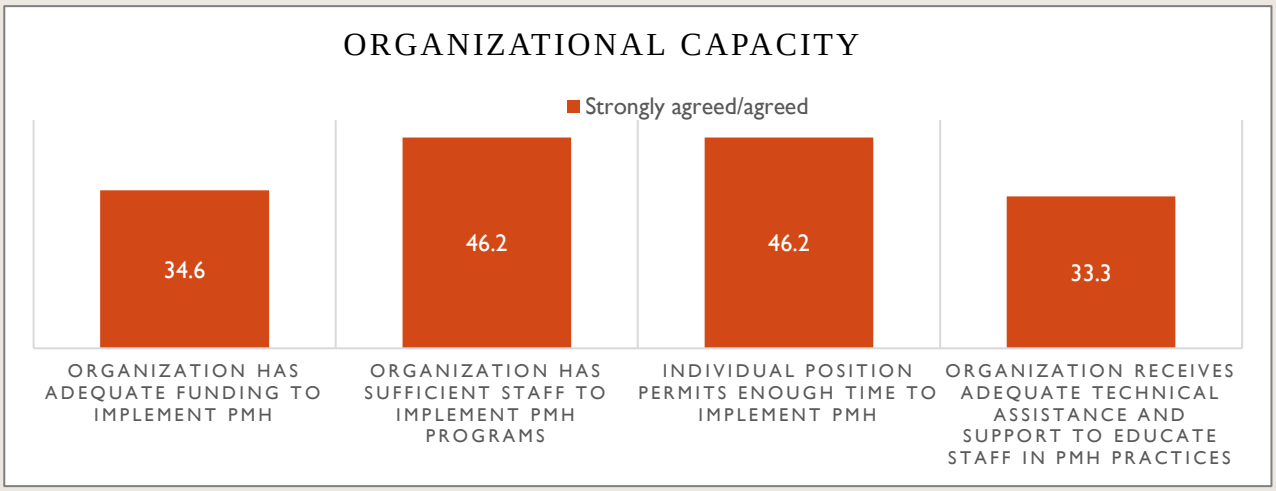

Figure 6: Participant perception of organizational capacity for implementing PMH practices

IMPLEMENTATION PROCESS

Qualitative Results

From the information gathered during the focus groups, the implementation process of *Moving Beyond Depression* has been a success so far. Many of the sites have referred parents to receive mental health services. The number of referrals across the four sites ranged from three to forty-seven referrals. Mental health providers, home visitors, care coordinators, data specialist, Healthy Start and Nurse Family Partnership program managers, and other stakeholders played an important role in ensuring the success of the implementation process. Although some sites experienced difficulties initially implementing the program, they were able to alleviate any further challenges by inviting a mental health provider to facilitate further staff training.

In addition to the involvement of a mental health provider, the launch of MBD can be directly linked to the level of engagement among current stakeholders. Staff members are encouraged to participate in scheduled meetings intended to evaluate the planning process demands, and discuss necessary adjustments. Participating in training sessions prior to and during program implementation, maintaining constant communication with various stakeholders, and sharing a communal understanding of the importance of the intervention provides a stable foundation for the current achievements of MBD.

Strengths

Acknowledgement of program significance

Stakeholders discussed that MBD recognized the limited, yet urgent need of mental health services for at-risk parents in our communities. Conducting in-depth screenings has identified more parents who are likely to benefit from receiving counseling services, thus, increasing program demand. The program has also been beneficial in targeting groups where previous programs' reach and interest were extremely limited. At a specific site, MBD received particular enthusiasm from the local Hispanic community; a group previously lacking engagement in mental health services.

Prior to the implementation of the MBD program, home visitors had to refer parents to different agencies, and then expected them to receive another referral to a mental health provider. MBD removes the additional step and allows home visitors to directly refer their clients to counseling services. For parents who are eligible, MBD has improved the timeliness of parents to receive services. For example, a stakeholder in one of the counties noted that a mother who scored 23 on the Edinburgh test received mental health services within forty-eight hours. In addition to the timely referral rates, meeting at the parents' home rather than having to schedule clinic visits was also a positive attribute of this program. Removing the barrier of having reliable transportation, as well as the promise of receiving needed services has influenced parents to participate and improves receptiveness to the program.

"The more we can get to the finish line, the better the overall results are going to be for the mom and the family." – Site B

"She's very new to it but she was really excited to have someone come to her. She doesn't have any other transportation than the bus and was just talking about how difficult it is to take the stroller and the car seat. They yelled at her the other day because she didn't have it broken down when they got there." Site B

"I've been pleasantly surprised of the engagement of our so-called Latin-Hispanic population that traditionally, this is taboo. As I recall, recent immigrants that I thought we were going to have more of a challenge, but it had not been, because have enjoyed being on the monthly calls with the therapists. " - Site A

Stakeholder communication

The level of stakeholder engagement and communication among all four sites greatly contributed to the successful attributes of MBD. In one of the implementation sites, a mother who scored high on the Edinburgh test, as a result of MBD and the high level of collaboration, discharged from Nurse-Family Partnerships after her last visit and easily transitioned into the Healthy Start and MBD program to begin mental health services. As reported from all sites, MBD makes it possible for home visitors, nurses, therapists, and other providers to be in constant communication with one another to form a relationship and provide the best coordination of care for the parent.

"I think that is a real testament of how close these programs have grown together and built relationships because I don't think that this would've happened before Moving Beyond Depression began in Florida." – Site A

"Amazing. Yes, it is a great story. It also really shows how sort of doing this with multiple programs that are all kind of connected is really a smart idea. If you think of people falling between the cracks, you kind of fill the cracks so she couldn't fall through them. So that's a nice story. Wow" Site C

"We have monthly phone calls to talk about how MBD is going, what we need to do better, what can we change, how can we do this differently and everyone is on the call together."
– Site A

Challenges

Parent eligibility issues

The process of referring parents who exhibit elevated risk factors of depression made it possible for many to receive counseling services but presented a challenge to others. Participants who had pre-existing conditions such as bipolar disorder, a history of substance use, or possibly exposure to intimate partner violence may be ineligible to receive services through the MBD program. Parents who score at or below the cut off level of 12 on the Edinburgh test are also ineligible. Stakeholders across sites discussed their concerns that if referred, MBD ineligible parents would then have to seek counseling services elsewhere, prolonging the process to receive services.

"Even when they are accepting referrals, it takes much longer for them to initiate that referral. By then, some of our girls are moved, have different phone numbers."- Site B

"History or current use of substance…they're already coming in with substance issues. So, they cannot be referred to your program. That's a barrier."- Site C

Waiting time

Multiple concerns were raised among stakeholders when the home visitor visitation requirement was discussed. To begin counseling services, parents must participate in a home visiting program for a minimum of one month. The home visitor enrollment requirement is an obstacle for parents to begin to receive services, especially for parents who can particularly benefit from treatment.

"Sometimes it's hard finding those clients that are 13 or above with no bipolar or the other qualifiers. I have lots of people I refer to [the therapist] but very few fit that criteria."- Site B

"The only problem that's coming up is having to wait for the home visitor to start meeting with a mom if the mom really needs services… therapy services, having to wait a month is a challenge for us. Just ethically, if we know she needs services and we have the referral, having to wait that month…"- Site A

One stakeholder noted that this waiting period runs the risk of parents moving or switching their contact information before connecting to needed services.

Parent retention issues

Some MBD sites experienced the challenge of low numbers of parents who complete the treatment plan in its entirety. Staff members reported several parents who start the program deciding to end treatment early due to a premature sense of resolution or completion, priority changes such as: enrolling in school or becoming employed, or a change in insurance. As in the case of many parents in a particular county, when a parent loses their Medicaid coverage, they are unable to complete services. Completion of the treatment is vital to ensure the well-being of the parent and the family. Another issue regarding program retention is the participants that are lost to follow-up. In one of the counties, housing was mentioned several times by home visitors as a dire problem. Lack of stable living situations in many MIECHV communities makes it difficult for home visitors to locate families after many calls are unreturned and doors unanswered. Unfortunately, many participants who initially show interest are not responsive to follow-up phone calls, texting, or drive-by attempt to begin the enrollment process.

"I had a client that was receiving TANF services and then she lost her Medicaid which happens a lot with our clients, and then she could no longer receive services through them."
- Site B

Privacy concerns

Stakeholders shared that parents who participate in the MBD program are initially hesitant to share information to someone besides their normal home visitor, with whom they have built trust and rapport. A stakeholder mentioned that while the relationship with the home visitor is stable enough to disclose personal information, the parent is cautious to share due to concerns of family members who may listen in. Parent resistance to being videotaped was also mentioned as a challenge.

"We describe them as they couch-surf a lot. So their housing is very unstable. So our nurses are having to try to sort of track them down, find out where they are."– Site C

"So that we have more moms consenting to be [video] taped, but they have been finding a lot of resistance from our client. I know that part of it is some of our clients – quite a few of them may be illegal immigrants or there are legal issues, things like that where they don't want to be taped…"– Site A

"With the home visitors but whenever I'll go to a home that is so crowded that sometimes they have issues that they don't want to share with all the family members. And it's really difficult because these are tiny home environments, crowded and most of the time that is like an impairment for the services to continue." – Site B

"…has the same issues with trying to find a client who maybe has decided that she wants services but then after you know several attempts of phone calls or texting or drive by, you can't find your client"– Site B

Impact on MIECHV

The impact of MBD on the home visiting program is positive. Home visitors mentioned that with the introduction of MBD to the parent, it strengthened an already established relationship. Despite the proposal of potentially removing the initial home visitation requirement and presenting the MBD and home visitation program as a team approach, enrollment in MIECHV would still be encouraged. Stakeholders in one of the participatory counties also noticed that those who received treatment had additional home visits and remained in the home visitation program longer than those who did not accept treatment.

"The first is that we found that mothers who were receiving the treatment through MBD had an additional 3.2 home visits during the treatment phase. We also found that among those mothers who completed the treatment, they stayed in the home visiting program in additional 4½ months over those who did not get the treatment." - Site A

"If they trust their nurse home visitor and their nurse home visitor is telling them about this wonderful counseling program that they would qualify for, would they be interested in finding out more about it and having our therapist come out to speak to them? They trust that we have their best interest at heart."- Site B

DISCUSSION

The evaluation of the implementation of PMH reveals that most staff responding to the Readiness Survey perceived PMH to be of great value and should be incorporated into current practices. Respondents also reported a general shift towards implementation, if they had not been already implementing PMH. However, over 40% of the participants did not agree with utilizing PMH, on the basis of not having enough knowledge about PMH practices and the importance of including the whole family in the program. Less than half of the participants felt that they could easily implement the program or connect clients in need of the program services to appropriate resources. While no barrier to program implementation was stated, having a professional role associated with PMH was identified as a facilitator among the survey participants. Upcoming state-wide training may increase awareness of parental mental health and more the resources available for families requiring mental health services.

After assessing staff perceptions of organizational readiness, more than half of the survey respondents did not believe that other members in their organizations were familiar with PMH.

"I think with this client's case, she was amazed that we could assist with therapy. That she could get that opportunity to have someone come into your house. She was really grateful. She's like, "Oh, you can do that? That's great." She was so excited. We already had our relationship built, but I think that that helped to strengthen it."– Site B

Additionally, half of the respondents believed that incorporating the program into the current practices at their organizations would be too complicated and were not sure they could test PMH before making a full commitment to PMH practices. Most of the organizations partner with community members to provide PMH services, but reported inadequate translation of the program into real-life practice. Problems with funding, staffing, time, and lack of technical assistance and support to educate staff were identified as barriers to implementation.

While most individual survey participants exhibit readiness to learn more about PMH and incorporate it into their current practices, these participants did not report the same level of readiness within their organizations. Using the DOI theory, most of the participants implied that there was necessary knowledge emphasized in the PMH programs, at both individual and organizational levels, and believed that it should be made a part of current practice. Although the majority of the individual participants have accepted the innovation and are ready for implementation, the organizations are still in the stage of making a decision to accept implementation of the program. From the baseline assessment, a large number of the individual participants viewed the program as compatible with current practice, not entirely difficult to implement, and are ready to try implementing the program while a few want to observe first.

To overcome some of the barriers encountered by organizations for program implementation, a plausible option could be towards enhancing community organization skills. Communities may have resources that can be built upon, reducing the amount of funding required (i.e. appropriate resource allocation), and members of the community may be willing to offer voluntary services when necessary. Training programs should also be organized for staff to increase content knowledge of PMH practices. These aforementioned recommendations ensure the utilization of best practices while working with families with parental mental health issues (Darlington & Feeney, 2008). Other factors that have the ability to influence program implementation include supporting organizational structures and promoting client readiness for service-delivery adjustments. Previous research provides adaptable measures to assess organizational and client readiness towards implementation of a new program (Chaudoir, Dugan & Barr, 2013). Organizational readiness can be measured using the Organizational Readiness for Implementing Change (ORIC) Framework, which assesses respondents' willingness and commitment to structural changes. This theory also considers how these factors affect implementation of innovation or if implementation can occur without or at various stages of organizational readiness (Shea et al., 2014).

There are increased risks associated with the rates of abuse and maltreatment of children living with parents who have a history of mental health issues (O'Donell et al., 2015). Hence, it is paramount to improve access to resources that will help enhance parental mental health practices. Through the current proposed efforts of PMH program implementation, state-level goals have emphasized: increased knowledge and awareness of the PMH practices, improved sustainability of the services provided, and increased access to resources that would facilitate optimal mental health among the families participating in the home visiting services.

Focus groups with sites illustrated how implementing a strong evidence-based mental health program such as MBD through the home visitation program facilitates access to mental health services. Although several sites have experienced low completion rates for this 18 session intervention, as well as difficulty with parent follow-up, and issues referring ineligible parents to

alternate services, the process identified more parents who may benefit from the intervention and improved the referral process for at-risk clients receiving those needed services. Staff report that parents express concern about their lack of privacy during counseling sessions and the long waiting time to initiate sessions, but are excited about the option to receive quality mental health services. In order to encourage participation in a parental mental health intervention, several staff members recommended presenting the home visitation program and MBD as an interdisciplinary- team approach. By removing the requirement of being in the home visitation program for a month, parents can receive mental health services in a shorter timeframe. With the continuance of stakeholder collaboration and addressing the concerns of the parents, MBD can have a positive impact on participant and infant mental health, parenting strategies, and commitment to the MIECHV home visiting program.

CONCLUSION

The Florida MIECHV program supports families experiencing higher risks by providing education, support, and referrals to optimize healthy physical, social and emotional development. Home visiting programs should incorporate interventions that meet the mental health and social-emotional needs of the populations they serve. Knowledge and attitude of program staff towards PMH implementation is generally favorable but gaps identified from this baseline survey should be addressed for proper implementation of PMH services such that the goal of improving health and developmental outcome is met. MIECHV should be strengthened in terms of funding, staffing, and adequate access to technical assistance made available to program staff. Challenges such as eligibility and time issues identified from the evaluation of the initial stages of PMH program intervention should also be addressed to ensure an efficient transition of the program from implementation to the confirmatory stage of adoption.

References

Chaudoir, S. R., Dugan, A. G., & Barr, C. H. (2013). Measuring factors affecting implementation of health innovations: a systematic review of structural, organizational, provider, patient, and innovation level measures. Implementation Science, 8(1), 1.

Darlington, Y., & Feeney, J. A. (2008). Collaboration between mental health and child protection services: Professionals' perceptions of best practice. *Children and Youth Services Review*, *30*(2), 187-198.

Leinonen, J. A., Solantaus, T. S., & Punamäki, R.-L. (2003). Parental mental health and children's adjustment: the quality of marital interaction and parenting as mediating factors. *Journal of Child Psychology and Psychiatry*, *44*(2), 227-241. doi: 10.1111/1469-7610.t01-1-00116

Mothers and Babies (n.d.). Research. Retrieved from http://www.mothersandbabiesprogram.org/research/efficacy/

Moving Beyond Depression (n.d.). Proven results. Retrieved from http://www.movingbeyonddepression.org/

O'Donnell, M., Maclean, M. J., Sims, S., Morgan, V. A., Leonard, H., & Stanley, F. J. (2015). Maternal mental health and risk of child protection involvement: mental health diagnoses associated with increased risk. Journal of epidemiology and community health, 69(12), 1175-1183.

Reupert, A., & Maybery, D. (2007). Families Affected by Parental Mental Illness: A Multiperspective Account of Issues and Interventions. American Journal of Orthopsychiatry, 77(3), 362-369. doi: 10.1037/0002-9432.77.3.362

Ross, K., Ramakrishnan, R., Michael-Asalu, A., Agu, N., Carter, J., Birriel, P., … Marshall, J. (2015). Florida maternal, infant, & early childhood home visiting program 2015 maternal depression analysis report. Retrieved from http://flmiechv.com/wp-content/uploads/Maternal-Depression-12-10-15.pdf

Shea, C. M., Jacobs, S. R., Esserman, D. A., Bruce, K., & Weiner, B. J. (2014). Organizational readiness for implementing change: a psychometric assessment of a new measure. Implementation Science : IS, 9, 7.

Smith, M. (2004). Parental mental health: disruptions to parenting and outcomes for children. *Child & Family Social Work, 9*(1), 3-11. doi: 10.1111/j.1365-2206.2004.00312.x

For further information on this report, please contact:

Jennifer Marshall, PhD, MPH
Assistant Professor, Lead Evaluator
University of South Florida, College of Public Health
Department of Community and Family Health
(813) 396-2672
http://miechv.health.usf.edu

This project is supported by the Health Resources and Service Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number D89MC28265, Affordable Care Act, Maternal, Infant and Early Childhood Home Visiting Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsement be inferred by HRSA, HHS, or the U.S. Government.