Key Driver Diagram + Change Ideas: Caregiver Depression SFY20 CQI Learning Collaborative

Primary Drivers	Secondary Drivers		Change Ideas
1 Competent, skilled, and trauma-informed workforce to address caregiver depression	**1.**	Comprehensive, ongoing training for HVs and HV supervisors on mental health and trauma-informed practice	❑ Training/education of home visitors on caregiver depression symptoms, impact, and treatment ❑ Training/education for home visitors in supporting families in trying to access care for mental health Model Specific Training/Resources ❑ Training and integration of Facilitating Attuned Interactions (FAN)
	2.	Ongoing, quality reflective supervision and clinical mental health consultation for HVs and Supervisors	❑ Reflective supervision that supports home visitors in supporting caregiver mental health, as well as trauma and ACEs ❑ Regularly integrate conversations about mental health during staff meetings (highlight ideas and experiences from home visitors) ❑ Case consultation with community mental health partners or infant mental health consultants
	3.	Support home visitor well-being through trauma-informed organizational practices, policies, and systems of support	❑ Regularly provide staff/team opportunity to engage in self-care practices (individual and community), incorporated into the workday ❑ Identify resources within the community; make strong connections and form partnerships with community agencies that offer treatment and supports for families who have experienced or are experiencing trauma. ❑ Training to address ACES and trauma – NEAR@Home
	4.	Emotionally and physically safe environment for staff and caregivers	❑ Comprehensive policy and procedures to support staff safety in the office and when conducting home visits ❑ Create an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff resilience ❑ Support home visitors to develop and implement a self-care/safety plan ❑ Home Visitor works collaboratively with caregiver to identify and support their strengths, goals, values, priorities, and parenting, while honoring each family' race, language, culture, family configuration, and approach to parenting
2 Standardized, reliable, processes for caregiver	**1.**	Timely and comprehensive training for HVs on depression screening, mental health conversations, referral, and follow-up	❑ Training and implementation support to administer the PHQ-9 depressions screening tool ❑ Home visitors have opportunities to role play and observe conducting depression screenings ❑ Home visitors utilize a script/talking points (adapted to each caregiver's specific context as needed) when asking sensitive questions, providing education, or introducing educational materials

depression screening and response	2.	Communicate results of screening to clients in a timely, accurate, empathic and sensitive manner	❑ Home visitors have opportunities to role play and observe discussing screening results with clients – including strategies to address stigma, culture, etc. ❑ Utilize talking points/script for communicating and explaining screening results ❑ Support and training to apply empathic communication strategies for difficult conversations (e.g. non-violent communication, motivational interviewing)
	3.	Appropriate periodicity to capture vulnerable windows	❑ Introduce follow-up screening 3-6 months following initial screening postpartum or first screening after enrollment ❑ Implement a reminder system for rescreens ❑ Talking points and strategies for re-introducing PHQ-9 screening
	4.	Timely and reliable depression screening	❑ Policy and protocol for administering depression screening, including the timing and frequency (the periodicity) of screening, communicating results, and referral processes ❑ Utilize talking points/script for administering depression screening and discussing mental health with families
3 Standardized and individually tailored process for referral, treatment, follow-up and education on mental health	1.	Sensitive and appropriate information, resources, and options to support caregiver mental health	❑ Protocol for referral and linkage to service for mothers who screen positive (internal and/or external services) ❑ In-house, evidence-based preventative support (e.g. Mothers and Babies curriculum) ❑ Create and formalize policies and processes that allow for flexibility and shared decision-making with caregivers
	2.	Crisis Response Protocol	❑ Policy and protocol for mental health crisis response and follow-up ❑ Training staff in policy and protocols for urgent and non-urgent care in maternal depression referrals and resources (e.g. role play, practice crisis protocol)
	3.	Culturally responsive, universal education for all families on mental health	❑ Policy and protocol for providing universal education on mental health for all families ❑ Provide universal opportunities for families to learn about and address wellness and mental health (e.g. introduce mindful self-regulation (MSR) strategies, wellness activities, stress management strategies – during home visits, or for families to practice at home)
	4.	Reliable processes for follow-up and ongoing mental health support for caregiver	❑ Standardizing a 'check-in' process using motivational interviewing (MI) for caregivers with positive screens for depression ❑ Create a wellness/safety plan with caregiver
	5.	Integration of infant mental health education and focus on the impact of mental health on attachment and child development	❑ Provide opportunities for group socialization, which promotes protective factors that can strengthen families and support children's optimal social and emotional development ❑ Activities to promote attachment and parent-child interaction

4 Community partnership and linkage to services	1.	Identification of and partnerships with available mental health services/resources in the community	❑ Develop partnerships between home visiting program and referral agencies, spelling out roles and responsibilities, communication processes, procedures for cross-referral, and training. This may or may not include an MOU. ❑ Create and maintain a list of available, appropriate community resources, including a variety of mental health care options (therapists, community behavioral health, primary care, support groups, etc.)
	2.	Effective partnerships with local, community-based mental health programs - involving cross-training, information sharing, and technical assistance	❑ Establish/strengthen partnerships with mental health agencies and community partners to address issues such as: making a referral, making first contact, creating a shared understanding of how to approach the work, ensuring confidentiality, documenting and keeping records, managing information, meeting expectations, and sharing information ❑ Create a standardized process for referring caregivers with mental health concerns, and clarify the relationship between the home visitor and the mental health partner ❑ Establish regular communication with a partner organization/community resource (e.g., monthly/quarterly meetings) to ensure coordination and relationship building ❑ Partner with a mental health specialist to case conference clients experiencing issues with mental health