

**EARLY CHILDHOOD MENTAL HEALTH CONSULTATION  
TO HOME VISITING PROGRAMS:**



**ADDRESSING THE UNMET MENTAL HEALTH NEEDS  
OF FAMILIES WITH YOUNG CHILDREN**



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# Background

Early childhood mental health is defined as the developing capacity of a child from birth to age five to: experience, regulate and express emotions; form close and secure interpersonal relationships; and, explore the environment and learn in the context of family, community and cultural expectations for young children.<sup>1</sup> Recent research indicates that between nine and fourteen percent of children under the age of six experience social, emotional and behavioral challenges (Smith, Stagman, Blank, Ong, & McDow, 2011). The prevalence of these challenges is even higher in families who are experiencing economic instability, domestic violence, substance abuse or other stressors. The number of risk factors is directly proportional to the potential for poor mental health outcomes for both the caregivers and young children, including negative impacts on the caregiver-child relationship. Without intervention, these challenges have life-long impacts on healthy development and learning. For families with young children, access to intervention in the current mental health environment can be challenging due to the multitude of barriers that exist between them and necessary services and supports. These barriers include: mental health stigma; a lack of awareness and understanding of infant and early childhood mental health; lack of an adequately trained workforce with specialization in early childhood mental health; intrusive paperwork and other administrative issues that decrease the “family friendliness” of the mental health system; and, funding policies that do not recognize the mental health needs of young children.

One strategy to address some of these barriers is Early Childhood Mental Health Consultation (ECMHC). ECMHC is defined as a process to enhance the capacity through training, reflective supervision, reflective group learning, or education of those that provide direct care to children and their families. The training or education might be case specific or more

generally oriented program consultation. The purpose of mental health consultation is to assist staff in understanding the social and emotional development of children; identifying and addressing the mental health needs of young children and their parents; enhancing strategies with specific issues or cases; identifying appropriate referral resources; and, increasing the capacity to link families to needed mental health services. The consultant can also assist providers to better partner with parents to promote the social and emotional development and mental health of their children. Early Childhood Mental Health Consultation aims to build the capacity of staff, families, programs and systems to prevent, identify, treat, and reduce the impact of mental health problems among infants and young children.

Service providers in each early childhood system – child care, early education, Early Intervention, and home visiting – are in a prime position to recognize the mental health needs of young children and families, strengthen a caregiver’s capacity to address the social emotional needs of the child, reduce mental health stigma, and create linkages to services when needed (Zero to Three Policy Center, 2004). However, early childhood providers do not always feel prepared to address these needs creating an opportunity for ECMHC as a key strategy for improving the mental health outcomes of young children and their families (Center for Prevention Research and Development, 2011).



<sup>1</sup> The Illinois Children’s Mental Health Partnership adapted this from a working definition developed by ZERO TO THREE: National Center for Infants, Toddlers and Families – Infant Mental Health Task Force.

# The Role of Consultation across the Early Childhood System in Illinois

By 2007, ECMHC was embedded in every early childhood system in Illinois except home visiting. Child care providers had access to ECMHC through Caregiver Connections, a Project administered by the Illinois Department of Human Services (DHS), building a formal network of consultants organized regionally to provide consultation to either center-based or home-based providers who care for children ages birth to five. Consultation to staff and programs within the Early Intervention system, which was designed to assess and connect services to infants and children with developmental delays, was also provided under the over

sight of DHS. Under the leadership of the Erickson Institute and funded by the Illinois State Board of Education, consultation was available to preschool settings across the state. Based upon accounts by DHS staff, home visiting programs reported a growing concern about the prevalence of young children who are experiencing problematic behaviors and mental health issues. Staff identified a critical need for consultation on the following topics: appropriate interventions regarding specific behavioral concerns; postpartum depression and parent’s mental health concerns; and social and emotional development in early childhood.



*One way to view mental health services for children is to follow the public health model of promotion, prevention, and intervention. This allows for interventions at a number of levels - universal, secondary, and tertiary. In early childhood these might include promotion of social and emotional skills at the universal level, targeted supports at the secondary level or prevention, and individual or intensive supports to children and their families at the tertiary level.*

# Home Visiting Models

There are a variety of home visiting models in Illinois funded by the Illinois Department of Human Services (DHS), the Illinois State Board of Education (ISBE), and federally through the U.S. Department of Health and Human Services.

**The Healthy Families Illinois (HFI)** model is a voluntary home visitation program that works with expectant and new parents who may be at risk for problems in parenting, including child abuse/neglect. Through intensive home visiting, HFI works to strengthen the parent/child relationship, promote positive parenting, and healthy child growth and development. Home visits are offered weekly for the first six months and may continue for up to five years, with the length and frequency determined by the needs of the family. Home visitors model positive parenting skills and provide information on child growth, development, and safety. The program also assists parents in identifying and meeting their own educational and/or employment goals. A variation of the HFI model is **Parents Too Soon - Healthy Families Illinois (PTS-HFI)**, administered by the Ounce of Prevention Fund (the Ounce), and providing services to first-time teen parents. A total of 50 HFI programs are funded throughout the state, serving 3,940 young children and parents in state fiscal year 2011 (Illinois Department of Human Services, 2011).

**Parents As Teachers (PAT)** is funded through the Illinois State Board of Education and is administered by the Ounce. Parent educators meet with parents in their home before and after pregnancy and work to ensure all children are fully ready to learn when they reach school age. **Parents Too Soon - Parents As Teachers (PTS-PAT)**, administered by the Ounce, provides parent educators to first-time teen parents with the goal of ensuring that all children will grow, learn, and develop to their full potential. The program approach is to provide child development information and parenting support through parent educators and

peer-parent groups (The Ounce of Prevention Fund, 2010). In fiscal year 2011, there were nine PTS-PAT sites in Illinois, serving 707 families and 803 children.

**The Nurse Family Partnership (NFP)** model targets first-time, low-income parents. NFP requires a client to be enrolled in the program early in her pregnancy and to receive a first home visit no later than the end of the woman's 28th week of pregnancy. Services are available until the child is two years old. NFP works with women and their partners to engage in good preventative health practices, to provide nurturing and competent care for their children, and to develop a plan for an economically-stable future. In fiscal year 2011, 483 families were served in five Illinois counties through NFP (Nurse-Family Partnership, 2012).

**Baby TALK**, administered by the Illinois State Board of Education, screens families, identifies their needs, and provides appropriate services working with a network of community providers. In 2013, there were 100 Baby TALK programs in Illinois (Baby TALK, 2013).

**Early Head Start** provides comprehensive educational, health, nutritional, and social services for pregnant women, infants, and toddlers up to age 3. The program is funded federally through the U.S. Department of Health and Human Services, Administration for Children and Families. There were 25 Early Head Start Programs in Illinois in 2013 (Illinois Head Start Association, 2013).

**Home Instruction for Parents of Preschool Youngsters (HIPPIY)** works with parents within their homes, and provides them with a set of curriculum, books, and materials to strengthen their children's cognitive skills, early literacy skills, and social/emotional and physical development. There were two HIPPIY program sites in Illinois in 2013 (HIPPIY USA, 2013).

Six communities in the state receive funding through the U.S. Department of Health and Human Services Administration to implement the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. MIECHV is designed to use an evidence-based home visiting model (Early Head Start-Home Based, Healthy Families, Parents as Teachers, and Nurse Family Partnership) and improve the coordination of services to improve outcomes for families who reside in at-risk communities (Illinois Department of

Human Services, 2013). All of these home visiting models provide information and support to young parents during pregnancy and early childhood. By supporting parents, children are safer, healthier, and more prepared for success in school and beyond. Home visitors work to provide parents with necessary knowledge and skills to better understand their child's development and appropriate expectations for behavior to reduce the incidence of child abuse and neglect (Daro, 2006).



## The Role of the Illinois Children's Mental Health Partnership and the Home Visiting Task Force

The Illinois Children's Mental Health Act of 2003 created the Illinois Children's Mental Health Partnership (ICMHP), and charged the ICMHP with developing and monitoring a comprehensive, multi-year Children's Mental Health (CMH) Plan. In developing the CMH Plan, one of many critical issues that emerged was the insufficient number of adequately trained providers available to meet the myriad of mental health needs of children and adolescents, particularly young children ages birth to five years. In response, the ICMHP identified mental health consultation as a key strategy for supporting and building the capacity of various early childhood providers (e.g., early childcare, primary care, mental health) to respond to the social/emotional/behavioral and mental health needs of young children.

The ICMHP collaborated with key stakeholders in the home visiting community to create a comprehensive approach to mental health consultation for home

visiting programs. These key partners include: Voices for Illinois Children (Voices), the Ounce, and the Illinois Department of Human Services, Division of Family and Community Services (DHS). Under the leadership of the ICMHP, this state-wide collaborative process has secured state and federal funds dedicated to providing high-quality mental health consultation and professional development to home visiting programs across Illinois. System-wide leaders created a model for Early Childhood Mental Health Consultation to home visiting programs, and continue to advocate for increased funding and support to expand implementation. The Early Learning Council of the Governor's Office has provided support and leadership to advance home visiting programs. Additional supports come from Voices, the Ounce, and DHS, who have worked collectively to leverage federal funds for home visiting, including supports for mental health consultation.

# The Early Childhood Home Visiting Consultation Project

Based on the successful outcomes of previous early childhood mental health consultation efforts, and in response to the identified needs of home visiting program staff, the ICMHP convened a leadership team to design, implement, and provide oversight of a home visiting consultation project entitled the Early Childhood

The goals of the ECHVC Project are to:

1. Increase capacity of early childhood home visiting programs to recognize and address the mental health needs of young children and parents in home visiting programs.
2. Develop a well-trained cadre of experienced Infant and Early Childhood Mental Health Consultants across Illinois in order to meet the needs of the field.
3. Sustain the work of infant/early childhood mental health by enhancing the understanding and competency of home visiting program supervisors to address ongoing family work through an early childhood mental health perspective.

## Key Components of the Early Childhood Home Visiting Consultation Project

### Infrastructure

**The Statewide Leadership Team:** The Leadership Team is comprised of representatives from the ICMHP, Voices, the Ounce, the Governor's Office of Early Childhood Development, and DHS. The Statewide Leadership Team designed the original ECHVC Project, and revises the Project annually based on experience and lessons learned. The Team monitors Project implementation for fidelity of practice, problem-solves implementation challenges, and identifies available federal and state funding. Members bring specific areas of expertise and experience (e.g., mental health, early childhood mental health, training and consultation, system implementation, and advocacy) which contributes to the Project's overall success. At the core of the Leadership Team is a Consultation Coordinator, who is responsible for managing the daily activities of the project, including support of Consultants and home visiting sites.

**The Consultation Coordinator:** The Consultation Coordinator is hired under a contract developed with Voices on behalf, and as the fiscal agent of, the ICMHP. The Coordinator: conducts quarterly face to face reflective supervision with all consultants from each cohort (between four and eight consultants per cohort); conducts quarterly reflective supervision with all consultants by phone; conducts monthly individual reflective supervision with each consultant; plans and organizes a yearly all sites training for the consultants, supervisors and home visiting staff; plans and leads regular meetings of the leadership team; conducts a quarterly call with each consultant and the site supervisor; attends quarterly learning groups (See p. 11); assures that sites complete quarterly progress reports and submit quarterly budget reports; and problem solves as necessary.

## Home Visiting Project Sites

**Site Selection:** Project sites are selected based on review of responses to a Request for Proposals (RFPs), in which sites identify:

- Level of Interest in this work and motivation to participate as a site
- Strong motivation and interest from program administrators
- Diversity of agency clientele and the community it serves
- Experience in accessing and using resources, networking, and collaborating with community agencies and organizations
- Lead staff members within the program who have demonstrated an interest in increasing their professional capacity to work with the mental health needs of young children and their families
- Program commitment and assurances to:
  1. work with an outside children's mental health consultant as described in the RFP and,
  2. participate in the evaluation process

Selected sites are awarded \$18,000 per year to develop a contract with an early childhood mental health consultant, making this an economical approach to addressing the mental health concerns of families with young children. The Project, based on available funding, extends over two years. At the end of the two year period the home visiting program supervisor will have developed the skills necessary to continue the work initiated by the consultant. It is the intention of the Leadership Team that every home visiting program in Illinois be able to access early childhood mental health consultation. Funding for consultation has been available annually from 2008 to 2012, with a new cohort of sites entering the Project each year. Cohorts have varied between four to eight sites. As of 2012, almost half of all HFI-PTS/PAT-PTS home visiting programs in Illinois have been funded. Each Cohort has been diverse, with sites from urban, rural, and small cities. Sites serve remote rural populations where transportation is a barrier to partici-

pation; urban African American populations; and immigrant, primarily Spanish speaking populations.

**Site based expectations:** Once awarded a contract, site supervisors and program managers attend an initial orientation during which the grant expectations are explained, previously funded sites describe their experience with consultation, current consultants describe how they work with sites, and training is provided regarding "how to choose a consultant." Sites are provided a draft consultant position description (See Appendix A). The orientation provides an opportunity to clarify for site supervisors the differences between supervision and consultation and assure their willingness to meet with the consultant a minimum of once a month, as well as make the home visiting staff available to meet with the consultant twice a month as a team and individually with the supervisor and consultant monthly.

After the initial orientation, sites recruit, interview, and select a consultant. The Consultation Coordinator serves as a resource during the process, providing names of potential consultants and helping sites prioritize the strengths and limitations of potential candidates. Funding levels generally permit the consultant to work 20 hours a month, with about a third of that time devoted to consultant training and support. As part of the initial meeting with the selected consultant, sites develop a schedule for the consultant to meet with the supervisor, the entire staff as a group (home visitors and doulas), and each staff member individually with the supervisor. The consultant and the supervisor also discuss how to introduce the consultant to the staff, engage their participation, and identify topics for training.

Each year site supervisors, program staff, and consultants attend an all-sites training on topics suggested by home visiting staff members. The all-sites training also offers home visiting program staff the rare opportunity to network with staff from other programs across the state. Travel to and from the training offers the site staff and the consultant an opportunity to reflect on what was learned and how to apply the information gathered.

## Home Visiting Project Sites *continued.*

**Ongoing support:** The Consultation Coordinator and the site consultant meet by phone with the site supervisor monthly during the first year and quarterly thereafter. In addition, the Consultation Coordinator will check in with sites periodically. The Consultation Coordinator is available to assist in the resolution of any misunderstandings or conflicts between the consultant and the site supervisor or staff. Annually, each cohort of site supervisors or program managers meet by phone to share experiences, make suggestions for program improvements, and evaluate the level of the support offered by the Leadership Team and the Consultation Coordinator. Finally, the Consultation Coordinator conducts a site visit annually, meeting with the supervisor and then the staff in order to develop a fuller understanding of each site's unique successes and challenges, while looking for themes that cross sites.

## Early Childhood Mental Health Consultants

The Early Childhood Mental Health Consultants hired by each site are expected to be seasoned professionals with a full range of skill sets that include: knowledge and understanding of adult mental illnesses and the mental health service system; infant and early childhood typical and atypical development; the role of a consultant; reflective supervision as a cornerstone to practice; crisis intervention; home visiting; and services available within other state-funded early childhood programs (e.g., pre-school, Headstart, and Early Intervention). The availability of skilled and trained consultants varies across the state depending on proximity to training institutions. The Consultation Coordinator works with sites to choose the best consultant for that particular site, but the hiring authority rests with the sites. Sites having ownership of the consultant decision increases rapid induction of the consultant into the site and acceptance by the supervisor and the staff.

The consultation approach used in the Project is one that is based on Infant Mental Health principles, focused on relationship-based, reflective practice. A programmatic approach to consultation support the goal of strengthening the home visiting system

in Illinois. The process of effective consultation relies on the strength of the relationship that develops between the consultant, program supervisor, and staff. Within the context of that relationship the consultant provides a space for reflection on the system, program, and practice challenges that exist for home visitors and doulas, in order to build the capacity of the home visiting program to address early childhood mental health needs.

### **Consultant Responsibilities:**

***Reflective Consultation with the program manager/supervisor:*** The consultant meets a minimum of monthly with the program supervisor/manager to provide an opportunity for reflection, problem solving, planning staff interactions, and imbedding the skills and knowledge that the consultant brings into the program. These meetings are used to develop an agreement between the consultant and the supervisor and to clarify the differences between consultation and supervision, reinforcing the supervisor's ongoing commitment to the consultation process. This is an essential step that helps to sustain the work of infant mental health by promoting the reflective practice within the supervisory activities.

***Reflective Consultation with individual staff:*** In a parallel process, the consultant and the supervisor meet with individual staff to provide reflective consultation as described previously. Home visiting staff may have very little prior training on mental health topics, and sometimes struggle with issues of boundaries and judgments regarding participant's life choices or parenting practices. A reflective mental health approach can assist the home visitors in thinking about the impacts of issues such as a history of abuse, or living with a parent with mental illness and how to address these issues within their role as a home visitor. Consultation helps staff gain confidence when raising mental health concerns, using the trusting relationship that they have established with a client to make a referral to mental health services and addressing how the parent's mental health issues impact the relationship with their infant or young child.

## Early Childhood Mental Health Consultants *continued*

**Group Reflective Consultation:** Similar to reflective consultation with individual staff, the consultant works with the supervisor and the staff as a whole twice a month. Often staff members present cases for discussion. The consultant helps the group to wonder aloud, thinking about the meaning of behaviors. The home visitors are encouraged to hold steady and observe with clients, as opposed to problem solving and finding a “solution.”

**Training:** The reflective approach is balanced with training that is content specific. The consultants develop “mini-trainings” on topics that staff members identify such as sensory integration, attachment, self regulation, attention deficit disorder, post partum depression, substance abuse, and sleep disturbance. The home visiting staff gain knowledge and skills that are re-enforced in supervision and the twice monthly meetings with the consultant.

**Home visits:** The consultant may accompany staff on home visits on an as needed basis. The supervisor and the consultant, as well as the staff as a group, thoroughly discuss the decision to have the

consultant attend a home visit, minimally addressing the following: how does the consultant’s presence increase the skills of the home visitor; what does it mean to the family to have the consultant present on a home visit; what does the home visitor hope to gain from the consultant; and, how will the observations of the consultant will be shared with the home visitor, the supervisor, the staff as a whole and/or the family. Before the consultant participates in the visit, the home visitor engages the family in a discussion about the purpose of the consultant’s participation in the home visit. Consent should be received from the family for the consultant visit. The supervisor, home visitor, and consultant discuss how the consultant will support and partner with the home visitor during the visit. They also discuss what happens after the visit, and plan for follow-up with the family.

**Co-facilitation of groups:** Consultants may co-facilitate groups offered to families with staff. This is an opportunity for staff to utilize the consultant’s early childhood mental health knowledge while providing group services for parents.

***Consultants and Program Supervisors alike report that training is more effective when it happens naturally. If a subject comes up during a case consultation, the consultant may spend some time relying upon their knowledge and experience to share information with the team. The consultant may return the next visit with additional information and materials, if appropriate.***

## Early Childhood Mental Health Consultation Has Positive Impacts on Children and Families

One home visitor was concerned that she was not as effective as she would like to be with a mom who was struggling with a baby and a toddler. Mom was frustrated by the toddler's behaviors, and the home visitor was concerned, questioning attachment and bonding between mom and toddler. The home visitor was looking for help in how to best support the mom. Counseling was recommended to help mom look at her connection to her child and any issues that might interfere, but mom did not have a positive view of counseling. After several consultations regarding this family the home visitor asked the consultant to join in the next visit. Mom was consulted and it was explained that the purpose was to help the home visitor better support mom.

During the visit it was clear to the consultant that attachment was not a concern. The child went to mom for comfort and security several times during the visit. Mom was comforting and soothing to the child. However, her words were harsh and critical. The home visitor and consultant were able to meet after the visit and discuss their observations, which was helpful to both. They explored the level of attachment between the child and the mother, looking for other explanations for the mother's critical stance toward the child.

After meeting the consultant and sharing some concerns with her, mom decided to seek counseling. She is now very active in the program, and the relationship between the home visitor and the mom has deepened. The home visitor is no longer concerned about mom and toddler attachment.



## Training and Support for the Early Childhood Mental Health Consultants

One goal of the ECHVC Project is to create a well-trained cadre of ECMH Consultants across Illinois. Professional development opportunities are integrated throughout the Project. Learning is conducted through peer sharing and opportunities for individual and group reflective consultation, and through organized training. The amount of time a consultant dedicates to support/training averages about 18 hours per quarter. Below is a description of each of the areas of professional development offered to consultants.

**Orientation:** At the onset of each Cohort of the Project, the consultants attend a three-day orientation. This orientation takes place before the consultant begins providing consultation services to the site. In order to tailor the orientation to the unique strengths and needs of each Cohort, the consultants complete the “Consultant Professional Development Planning Tool” (see Appendix B), designed to identify individual consultant’s professional development needs. The agenda for the three day training includes: an overview of the Project; role and expectations of Consultants; in-depth review and discussion of the Project components; and topic-based trainings based on the needs and interests identified in the Tool.

**Monthly calls:** Each month, the Consultation Coordinator has an individual one-hour call with each consultant. This call is designed for the Coordinator to provide reflective supervision with the consultant and discuss issues specific to that consultant and site.

**Group supervision:** Every quarter, there is an opportunity for the consultants and the Consultation Coordinator to gather by phone and in person. The Consultation Coordinator facilitates a one-hour call with the Consultants as a group. This call is designed to offer an opportunity for the consultants to discuss the challenges and strengths of their sites and provide each other with support, resources, and new perspectives. During the same quarter, the Consultation Coordinator and consultants gather for a three-hour meeting in person. Both of these meetings provide the consultants with the opportunity for learning – from other con-

sultants and from the larger project. The meetings model the reflective consultation that the consultants are expected to provide their sites through use of open-ended questions, wondering out loud, and personal reflection.

**Infant Mental Health Learning Group:** The Infant Mental Health Learning Group is a five-hour professional development opportunity that occurs quarterly. Facilitated by the Ounce as the statewide home visiting training resource, and attended by the Program Supervisors as well as the consultants, a specific topic is discussed and then one home visiting program presents a case for group discussion. This is another opportunity for sites to discuss how consultation has benefited their programs and share new strategies to address common challenges.

**Reflective Learning Group:** The Reflective Learning Groups (RLG) are cross-initiative gatherings for ECMH Consultants to reflect on their work. Peer-reflective learning groups are recognized by national leaders as one of the most significant, as well as cost effective, learning tools available to support consultants in their work with early child-care providers, teachers, early intervention staff, families and young children. In 2013, the RLGs met in nine locations across the state, for a two hour period each month, with approximately five consultants attending each group.

**Mental Health Consultant Retreat:** Mental Health Consultants are located in all areas of the state of Illinois, and sometimes are very isolated. In order to help network and build skills, the ICMHP provides a retreat for Mental Health Consultants at least every

## Training and Support *continued*

other year. This retreat allows for networking with others in the field, and to observe the scope of the work in Infant/Early Childhood Mental Health across the state.

### **Infant/Early Childhood Mental Health Credential:**

The Illinois Association for Infant Mental Health began offering a credential for Infant Early Childhood Mental Health specialists, including consultants,

in 2012. The credential is for professionals with at least five years experience with infants, toddlers, young children, and their families/ caregivers, and experience with reflective supervision. The process includes ten monthly three hour group reflective practice sessions, bimonthly individual reflective supervision sessions, and a final review including a comprehensive case study.



## Evaluation

The Program evaluation, conducted by the Center for Prevention Research and Development (CPRD, 2011) at the University of Illinois, explored “the extent to which the consultation process benefits the local providers and to identify the qualities, characteristics, and conditions that support or interfere with program benefits.” The evaluation included:

- Online surveys of home visitors, program managers, and consultants
- Focus groups conducted at each grant site
- Focus group of each cohort of consultants
- Telephone interviews with members of the Leadership Team

The evaluation was conducted with Cohort Two of the Project. The data collected provides a snapshot of the Project’s implementation, challenges, and successes. The evaluation conclusions have been used to make improvements to components of the Project Model.

The Center for Child and Human Development at Georgetown University conducted a national study of effective early childhood mental health consultation programs and identified three core program elements and two additional elements referred to as “catalysts for success” that are required for effective mental health consultation (Duran et al., 2009). The three core program elements are strong program infrastructure, highly qualified mental health consultants, and high quality services. The two additional “catalysts for success” are the quality of the relationships between consultants and local staff, and the readiness of providers for the early childhood mental health consultation process. These elements were assessed through the evaluation and each of these five elements were addressed by members of the Leadership Team, consultants, home visitors, and program supervisors.

## Strong Program Infrastructure

The commitment of the Leadership Team to this project has been evident from the beginning. There were statements throughout the evaluation of how the Leadership Team became aware of challenges and made adjustments to the model. One of the challenges was role clarification for consultants. Based on challenges the Partnership has faced in previous projects with defining the role of consultants in early childhood mental health, the Leadership Team spent significant time creating a clear definition of early childhood mental health consultation and defining the duties that fit this role. Time was also spent with each program site to ensure they had clear understanding of the role of the consultant. During the evaluation, 84% of staff reported understanding the role of the consultant. However, only 50% of the consultants indicated that their role was fully defined for them by the Leadership Team. Based on this finding, the Leadership Team extended the initial consultant training and allotted more time for focusing on the role of the consultant.

During the evaluation, there was recognition of the need for balance between the sites local autonomy and funder oversight and input. It has been clear throughout the project that open communication and shared responsibility between the Partnership and program sites are imperative to success of the project.

***“I am more impressed with this state program than I have been with any other in my 46 years as a nurse.”***

## Highly Qualified Mental Health Consultants

One of the goals of the ECHVC Project is to develop a well-trained cadre of experienced Infant and Early Childhood Mental Health Consultants. Through the surveys, home visiting staff and consultants were given a list of characteristics associated with consultant effectiveness. Home visiting staff were asked how well each characteristic describes their consultant. The consultants were asked how important each characteristic was to their role as a consultant

and how confident they feel about their skills and abilities in each of the areas.

Certain consultant characteristics were associated with positive outcomes, but the majority of consultants were described as having these characteristics, making the degree of impact impossible to assess.

The characteristics included:

- Supportive and encouraging
- “Down to earth” and approachable
- A good listener
- Respectful of staff skills
- Trustworthy
- Prior experience with early childhood mental health
- Understanding of the challenges faced by staff
- Collaborative
- Reflective
- Flexible
- Good leadership skills
- Motivating
- Models strategies
- Provides opportunities for practice

The majority of staff saw most consultants as having the full range of these qualities (with a range of 54-78%) adding credence to the Leadership Team’s assessment of the skill level of consultants and the focus the model has on consultant development and support. Consultants did not see themselves as self-confident as the staff survey indicated. In a number of areas the consultants felt they lacked skills that they perceived as important to their jobs: effective reflective supervision, prior consulting experience, experience with early childhood mental health, and motivating staff. The consultants’ lack of confidence became the rationale for the current level of support and training. Model revisions included having the consultants complete a self assessment at the beginning of their involvement with the Project, and individualizing the training for each consultant. The level of support and overall training has been titrated for

## Evaluation *continued*

more experienced consultants, or those with a longer history with the Project. Consultants with more experience have served as peer mentors to those with less experience.

***“Our mental health consultant provided very relevant information regarding infant mental health. Her extensive knowledge...helped us understand the children we worked with, as well as their family environment.”***

### **The Quality of the Relationships Between Consultants and Local Staff**

The Leadership Team, consultants, and staff all recognized the importance of the relationships between consultants and agency staff. A significant amount of the consultant’s time in the beginning of the Project was spent on developing a working relationship based on mutual respect and trust with the staff and supervisor. Staff highlighted how the consultation process is different, and better, than typical training because it is more one-on-one, focuses around discussion where the staff are viewed as experts of the families, and is based on a trusting relationship. Several of the home visiting staff also made the connection of how establishing a relationship with the consultant parallels the type of relationship needed with families in order to do the work effectively.

***“Consultants ended up providing a lot of direct training to the teams of staff in their first months...It gave them a feeling of connectedness with staff, and staff with them, that then led to something else later on...”***

### **High Quality Services**

In the focus groups and surveys, staff from every site placed a very high value on the consultation services.

Direct case consultation and reflective supervision were viewed as the most valued pieces and staff reported that these services were offered in “the right amount.” The longer the site was with the Project, the higher the rate of satisfaction. Nearly a third of staff (31%) surveyed indicated the overall quality of the Consultation Project and the resources it provided as “excellent” and another 46% rated the Project as “good;” not a single respondent rated overall quality as “poor.” Suggestions made by staff included that the role of the consultant be broadened to include more home-based support, more time with consultants, and the potential to focus on adolescent mental health issues (in instances where the parents are teens), as well as early childhood. The model has been adapted to include some of these recommendations. Staff members were asked what topics they requested trainings on and the responses were varied across sites. Staff felt that site determination of need was important, as opposed to a prescribed set of trainings. Staff reported that the consultants had a positive impact in the following areas: understanding behavior in the context of a relationship, focusing on the parent-child relationship, understanding the impacts of trauma, improving the quality of their intervention skills, improving staff assessment skills, and increased referrals to other agencies.

***“The consultant frequently ‘touches base’ to see how we’re doing, what’s going on in our personal lives...she’s very relational [and that is] very parallel to our work with families.”***

### **Provider Readiness for Early Childhood Mental Health Consultation**

In order to ensure proper implementation of the Project, home visiting sites need to be open and ready for mental health consultation. Sites are asked in the RFP to state their readiness at each level (director, supervisor, and staff) and to explain the need, and perceived benefits, for early childhood mental

health consultation within their agency and within the community. Sites are asked what their current level of understanding of early childhood mental health is, and what, if any, trainings or consultation they have received in the past. The answers to these questions are used by RFP reviewers to determine the level of readiness for each site.

On the surveys, staff and consultants were asked a series of questions regarding their perception of the site's readiness to adopt early childhood mental health consultation. Factors explored included:

- Perceived need
- Agency support
- Staff capacity
- Staff buy-in
- Awareness of ECMHC
- Readiness for implementation
- Perceived benefits

Staff and consultants largely expressed similar views of the ECHVC Project, and of the agencies and staff involved in the Project. The majority of respondents perceived a high level of need for: early childhood mental health services within the community; the agency fully supporting the Project; staff at the agency having the capacity and readiness to implement the Project; staff buy-in to be high; and, everyone involved to be aware of the Project's potential for powerful benefits to staff, consultants, and to families served. Given that each of these areas reflect "a readiness for change" and are essential elements to the implementation of the ECHVC Project, these findings are a positive reflection of the Project's success.

***"It's been very empowering  
for us as a staff."***

The Consultation Coordinator made site visits to the Home Visiting programs to find out how each program experiences consultation. The reports were very similar across sites.

Home Visitors reported:

- Increased understanding of infant/early childhood mental health
- Feeling supported
- Having a place to address cases with which they are struggling
- Learning new approaches to families

One Home Visitor stated, "I used to wonder what to say when someone brought up really tough issues. Now I hear my consultant's voice in my head and I use her words: 'Tell me more about that.'"

Another Home Visitor reported that she felt a lot more relaxed when dealing with mental health concerns because she realized she does not have to know what to say, but can instead just listen and help the mom reflect.

## Discussion

Based on the program evaluation and site visits conducted by the Consultation Coordinator, key challenges were identified. These challenges included sustainability of project goals, building the number of trained early childhood mental health consultants throughout Illinois, determining site readiness, clarifying the role of the consultant, and accessing mental health services.

### Sustainability

The parallel process demonstrated through the consultant's support of supervisors and staff is designed to maximize sustainability. This is not an expert model, but rather a facilitated process of individual growth through reflective consultation and skill development. The parallel process of consultation supports long-term sustainability through building the capacity of home visitor supervisors and staff. Skills are imbedded in the supervisor who will continue reflective supervision of home visitors and increase the capacity of staff to address infant mental health challenges. The Project model has been designed to empower staff, not create reliance on the consultant to solve their challenges. This works particularly well because there is a very low turnover rate in both supervisory and program staff.

A new component added to the model is to continue to support the work of the supervisor in reflective practice by scheduling quarterly meetings with the mental health consultant after the monthly consultation comes to an end.

### Identifying/Building the Consultant Pool

Trained early childhood mental health consultants are more frequently based in urban areas with early childhood training centers or university-based programs. Recruiting consultants in rural areas is a challenge. One current proposal is to partner experienced consultants with newer consultants, developing a mentorship relationship that will support a cadre of consultants across the state. Another related challenge is that agencies have at times identified a consultant with insufficient early childhood experience. The Project has added training components to assist these consultants develop necessary skill sets. Another possibility is to require those consultants to

spend some time observing early childhood programs and participate in additional “hands on” experiences that increase their experiential knowledge of infants and young children.

It has been a challenge to recruit Latino/a consultants, and sites who serve primarily Spanish-speaking immigrant populations have struggled when the consultant does not reflect their cultural background. Efforts are underway to intentionally recruit and mentor more Latino/a consultants.

### Identifying Site Readiness

While sites are selected through an RFP process, the Leadership Team has debated the role of site “readiness.” In the early stages of the pilot, it was important to assure some level of success so sites were selected primarily based on the quality of their proposal. Over time, it has become important to embed mental health consultation in all the home visiting models used in Illinois. This has led the leadership team to consider “readiness development” approaches to support identified sites prior to receiving consultation. A consultant may meet only with the supervisor to assure a full understanding of the role of consultation, arrive at shared goals, and prepare staff for the consultation experience.

### Understanding the Role of the Consultant

Every site, as part of the Project Orientation, received material and spent time discussing the role of the consultant. Despite these efforts, every consultant spent the initial months of the Project working with the site supervisor and staff to fully understand the role of consultation—often by modeling a reflective approach. Allowing sites sufficient time to embrace the potential of consultation needs to be considered in the Project design.

## Lack of Mental Health Resources for Referrals

The majority of sites have identified a lack of resources to refer families of young children who are experiencing mental health concerns. Several HFI sites are housed within larger mental health programs, but more are housed within county public

health offices or human service sites. A goal of the ICMHP is the development of adequately trained early childhood mental health providers to address this gap in services.



## Conclusion

The key components of the Early Childhood Home Visiting Consultation Project Model include a solid and diverse leadership team; an experienced Consultation Coordinator; home visiting program sites that are open and ready for consultation; seasoned consultants with key skills and knowledge; and, ongoing training and support for consultants and sites. The model has been adjusted since its inception based on feedback from program sites and consultants. The ICMHP continues in its goal of building a well-trained cadre of infant and early childhood mental health consultants by identifying potential consultants and providing trainings and retreats for existing consultants. Through the evaluation and site visits, home visiting staff and supervisors have given overall positive feedback on the Project, including increased understanding of infant and early childhood mental health and how to address mental health concerns with families. The leadership team would like to see the ECHVC Project Model taken to scale and implemented in every home visiting program in the state and seen as an integral part of home visiting.

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## Appendix A: Role of the Consultant

For the purposes of this project, consultants will be expected to provide programmatic consultation to their assigned site. The main goal of programmatic consultation is to introduce capacity building and problem solving interventions using a collaborative approach with the provider. The consultant is not there to “fix the child or the parent-child relationship” or to address communication issues between staff and supervisors. Rather, they are there to assist staff and supervisors to understand and incorporate the infant mental health perspective, including reflective capacity, into their work with the families in order to enhance and improve their own roles, skills, and experience. The work relies heavily on the relationship-based and strengths-based approach. The following is a list of activities that illustrate this concept:

- Direct case consultation with the staff team about specific cases and issues that are present in the program.
- Trainings on topics, primarily related to infant mental health and staff stress and renewal that have been previously identified by staff.
- Observation and consultation on in-home visits both with individual staff and the larger team.
- Co-facilitation of clinical parenting support groups, infant/parent support groups, and play therapy groups with staff. This will include follow-up review and supervision with staff after group meetings.
- Reflective consultation with the program supervisor. This will benefit the supervisor in their own work and will also inform them as to how to provide reflective supervision to staff themselves.
- Consultant may join reflective consultation meetings with the supervisor and staff member.

## Appendix B: Consultant Professional Development Planning Tool

Please use the following scale to respond to each of the categories in the assessment:

1. I don't think this is relevant to my work right now
2. I think this is relevant to my work, but have minimal knowledge about or experience with the topic; however, I do not see this as a priority for learning at this time
3. I think this is important and I would participate in opportunities to learn about this topic
4. I think this is important, have some knowledge regarding the content area or experience with the identified skill set, but still want to learn more
5. I think it's important, have studied the topic, and have competencies.

### Child Development Knowledge

#### *Typical Child Development*

1. General knowledge of infant and child development (birth to 5 years of age) in all areas—motor, cognitive, language/communication, social/emotional.
2. In-depth knowledge of infant and child social-emotional development.
3. Familiarity with current research on brain/neurological development
4. Understanding how relationships impact development.
5. Knowledge and understanding of attachment theory and how early parent-child (caregiver-child) attachment relationships mediate and influence development.
6. Working knowledge of infant and early childhood mental health enabling me to help others consider how a child's internal and external experiences influence her behavior and relationships.

#### *Atypical Child Development*

7. Basic knowledge of biological, psychological and social features of atypical development.
8. Knowledge of “red flags”—potential indicators of atypical development.
9. Familiarity with current research on brain/neurological development and its connection to sensory processing, autism spectrum disorders and impact of environmental factors such as exposure to violence and fetal exposure to drugs.

#### *Direct Practice*

10. Ability to “join with” people in their natural environments by stepping into their setting, build a trusting relationship and developing empathic awareness of their situation.
11. Ability to develop targeted and individualized strategies that reflect the culture, skills, strengths, and needs of the provider.
12. Ability to assess the development of young children based on observational methods.
13. Ability to assess the development of young children using standardized screening and/or assessment tools for children birth through 5 and use the findings appropriately.
14. Capacity to use strengths-based practices.
15. Working knowledge of systems theory and how to apply it to my work.
16. Ability to build strong, healthy relationships in order to facilitate the communication between family members and/or other caregiver/professional on behalf of furthering the growth and development of a child
17. Ability to participate in a consensus-building process toward a plan or decision which honors minority opinions, in order to motivate parents or providers to try new strategies.
18. Ability to help programs integrate infant and early childhood mental health into their daily practices and assess ongoing progress.

### ***Reflective Work***

19. Ability to step back from the immediate experience to sort through my own thoughts and feelings about what I am observing and doing with children, families, others in the situation.
20. Ability to consider one's own history and experience (as a child, parent, student, etc) as influencing one's perspectives/ beliefs, values, actions and interactions. Ability to consider one's meaning to the provider.
21. Capacity to use self-assessment, reflective practice and continued study to inform my work with children, families, other systems.
22. Ability to use critical thinking skills to ask questions and make interpretations as a way to help build understanding in myself and with others.
23. Ability to assist administrators or directors in developing reflective capacities in their supervision work with staff

### **Background and Contextual Knowledge**

24. Knowledge of child-serving systems and how to work with them on behalf of a child and family.
25. Familiarity with community resources available to support children and families, including those with special needs.
26. Understanding the way in which an organization's culture informs their philosophy of and practices with children and their families.
27. Knowledge of Protective Factors—what they are and how to promote them as a means to prevent child abuse and neglect and support healthy development.
28. Knowledge of risk factors—biological, psychological, social, environmental
29. Knowledge and understanding of the impact of poverty and other social marginalization on families and their children's growth and development.

### **Background and Contextual Knowledge *continued***

30. Knowledge and understanding of how traumatic experience in the home or community affects children's capacity for growth and development and their families' functioning.
31. Working knowledge of adult mental health which enables you to consider how an adult's external and internal experiences influence their behavior and relationships, especially in relation to their children.

### **Regulation and Policies**

32. Knowledge of standards of ethics in your profession.
33. Ability to analyze the ethical issues of a situation while acknowledging and tolerating the ambiguity of subsequent decisions.
34. Working knowledge of the federal, state and local laws and regulations governing the rights of families and their young children with and without special needs.
35. Familiarity with regulations and rights applicable to immigrant children and their families.
36. Knowledge of the limits of my training and experience, ability to express these limits clearly and engage collateral resources as needed.

### **Consultation and Direct Practice Experiences**

How long (years) have you been in direct practice with children under the age of 5?

Has your work included home visits previously?

Have you been a consultant before?



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