

HV IMPACT WEBINAR - INFANT AND EARLY CHILDHOOD MENTAL HEALTH CONSULTATION IN HOME VISITING

12/15/2019

>> Hello, and welcome to HV-ImpACT webinar on Infant and Early Childhood Mental Health Consultation in Home Visiting Supporting MIECHV Awardees to Create and Refine Systems. I'm Karen Cairone, I'm the Universal Technical Assistance Manager for HV-ImpACT, and we're really excited to have you here with us today.

I'm going to go through and give a bit of an overview of the room if you haven't been on one of our webinars before. You can see over to the left-hand side is a chatbox box that we'll be using for comments, questions, and as a place to introduce yourself as you come into the room. We will also make sure if you're hearing any kind of background noise that you keep your computer speakers muted. If you're hearing an echo and any other technical support questions, you can go right into the technical support box beneath the slides and ask questions of our technical support staff, and they will reach out and make sure they help you get connected. You'll see a file share pod in the middle of the screen at the bottom. This has the PDF of the slides that you'll be seeing today, so you can feel free to grab that file at any time that makes sense for you.

We also have an evaluation link in the bottom left-hand corner, which I'll talk about in just a minute. And I want to just let you know that we have a recording of this webinar that will be provided on HRSA's website shortly after the webinar finishes. So if you have colleagues who were not able to attend today, or you want to share this with others, that you can be able to make this resource available at that time.

We do really value your feedback, so if you have to leave our webinar early today, we would ask that you would take a few minutes to complete the evaluation and let us know what worked well for you, as well as any suggestions that you have to make improvements for future webinars. We really do value the input that you give to our resources.

Today on our call, our objectives will be to go through several different things in this hour. We have quite a few presenters on the line with us. First, we'll learn about the federal investment in Infant and Early Childhood Mental Health Consultation Technical Assistance from HRSA's HV-ImpACT and also from SAMSHA's Center of Excellence. We'll then explore how they develop and they refine different layers of support for IECMHC within the MIECHV system. We'll describe some of the clinical and ethical considerations for providing IECMHC within home visiting. We'll then delve into MIECHV awardee

successes from Iowa, Louisiana and Illinois to gain actionable strategies for your own work within MIECHV. Today, we'll hear from Iowa on getting started with the work. We'll hear from Louisiana on structuring support for their home visiting staff through IECMHC and, finally we'll hear from Illinois on adopting high-level systems-building strategies.

Our presenters for today's call, we have with us Dr. Elaine Fitzgerald Lewis from HV-ImpACT. We have Lauren Rabinowitz, who is with us from the Center for Excellence. We have Dr. Paula Zeanah, who is with us from Tulane. We have P.J. West, who is with us from the state of Iowa. We have Dr. Sarah Hinshaw-Fuselier, who is with us from Louisiana. And then finally from Illinois, we have Lesley Schwartz and Delreen Schmidt-Lenz, who will be presenting on behalf of their MIECHV awardee.

Before we really jumped into the slides, what I'd like to do is to get a sense of folks that are on this call representing a state or territory awardee for MIECHV. If you could go over to the chat feature on the left, and it's OK if you have several folks from your program who type in a different number, but what I would love for you to do is to type in your state or territory abbreviation along with one of these four numbers. If you're not yet embarking in this work, if you would type 1, if you're just getting started on the work a 2, if you're well-along or continuing to evolve the work a 3. And if you feel your state or territory is very established in this work, if you would type a 4 into the chat, that would be great. This just gives us a little bit of a sense of where your fellow awardees are in this work right now and also some ideas of who you might be able to connect with as you look at some of the numbers popping up into the chat box and see numbers similar to your own, or maybe a number that's a little higher than your own that you might be able to connect with as a possible peer-sharing or a mentor situation. So continue to do that, please, as you represent different states and territories and as you're continuing to do that, I am going to turn it over at this time to our first presenter, Dr. Elaine Fitzgerald Lewis. Elaine, go ahead.

>> Good afternoon and good morning to some of you. Thank you so much, Karen, and all of you for taking the time to join us today.

As Karen mentioned, I will give you an overview very briefly about the work that we can offer you through HV-ImpACT. HV-ImpACT provides an array of universal products to support MIECHV awardee with infant Early Childhood Mental Health Consultation needs. As many of you know, there is currently a community of practice aimed to support awardees at different stages of implementing policies around using Infant Early Childhood Mental Health Consultation with in-home visiting programs, including core competencies, model involvement, cultural considerations, addressing ACES and trauma-informed

approaches, as well as around financing and sustaining funding. In addition, we are also developing issue briefs and tip sheets that will be made available to all of you in the upcoming months.

Secondly, individualized TA is also available to all of you, and we use the same system that you have been doing already to request TA to work with your HV-ImpACT TA Specialist and Project Officer. Your regional TA Specialist will respond to any inquiries that you have, meet you where you're at and offer support and consultation to assess what your TA need is, provide one-on-one TA and engage internal subject matter experts as well as support you around questions, figuring out where you're at and what you need to support you around your integration of early -- Infant and Early Childhood Mental Health Consultation into yourhHome visiting programs. Your TA Specialist can also work with you to develop strategies around funding and engaging stakeholders and supporting your understanding of what the landscape is both locally and in your state. So please do consider if this is a priority for you to include it as part of your annual TA Priorities Scan, and do not hesitate to reach out to your TA Specialist, now, even if you're in the process of completing that scan.

Your HV-ImpACT TA Specialist again will meet you wherever you're at and support you around coordination and engagement with resources that we have internally as well as with the Center of Excellence. So it's really exciting to have Lauren here, and you'll hear more about how we're looking to partner and coordinate with the Center of Excellence. Given the tremendous importance there is in supporting the social emotional growth and development of infants and toddlers, we are very excited to see the support and resources committed to HRSA's Maternal and Child Health Bureau and from SAMSHA and HV-ImpACT will continue to work together in partnership with the Center of Excellence to leverage these resources and align our activities so that we can support all of you in your work.

So with that, I'd actually like to turn it over to Lauren now, who will share more about the Center of Excellence. Lauren.

>> Thank you so much, Elaine. And thank you to HV-ImpACT and to HRSA for inviting the Center of Excellence to be part of this webinar. My name is Lauren Rabinowitz and I am extra happy to be here today. Some of you may know me from my time as a TA Specialist with HV-ImpACT. So I'm so glad and honored to be able to have a few minutes to spend today talking with you all about the Center of Excellence. We believe so strongly in the fit between mental health consultation and home visiting, who both focus on the layered challenges children and families face and have such complementary philosophies.

This second round of the Center of Excellence for Infant and Early Childhood Mental Health Consultation, better known as the COE, launched in September of this year. The first Center of Excellence focused largely on early childhood education settings and home visiting. This center will continue in these areas and also explore other settings where consultation is expanding, such as child welfare and early intervention.

As you see on the slide. Our mission, as a center, is to grow, advance, and impact the field. We are so eager to have the opportunity to continue the work of the first Center of Excellence to promote this evidence-based practice because we believe so strongly in the potential to improve outcomes for -- that this is such an important strategy to improve outcomes for young children, families, and caregivers. And given all of you that are on the call today, I know this is a shared vision and passion.

We at the Center of Excellence are delighted to be able to partner with HV-ImpACT in providing resources and knowledge to the MIECHV community. So I'm going to talk now just briefly about the main foci of our center, which you can briefly see on the slide. I'm going to go over these in just a quick, brief -- brief recap, but we'd be really happy to talk with folks later on if there are additional questions.

So the first of our main core approaches is to create a comprehensive national clearinghouse of everything needed to be a mental health consultant and to build a mental health consultation program. So part of this clearinghouse is going to include mapping mental health consultation efforts across the country to learn more about where consultation is happening geographically and by setting. Another really exciting effort is the creation of a data hub where we will be analyzing data from programs with completed evaluations to help us get closer to answering the really important questions about dosage and efficacy of mental health consultation.

The second part of our approach is a focus on professional development, specifically for consultants, where we will be creating a range of online, self-directed learning and training resources. For example, right now, we are in the process of creating foundational modules which aligned with the National Mental Health Consultation Competencies completed under the first COE. We will also be holding communities of practice and something called an ECHO model of training, which is basically a virtual training for mental health consultants in lower-resourced areas.

And lastly, we will be offering technical assistance for mental health consultation programs using what we are calling a concierge model. And this means that we are able to be responsive to mental health consultation programs in any stage of implementation, from those just starting out to those with many

years of experience. And as Elaine said, we plan to work really closely with HV-ImpACT to make sure that you, as awardees, are getting your TA needs met.

So here on this slide, you can see a little bit about the five cost-cutting areas of mental health consultation, as we have defined them. And these look really similar to how the first Center of Excellence defined the main cross-cutting content areas. Just want to highlight that these will be embedded in each of the three approaches that I just discussed: the clearinghouse, the technical assistance, and professional development. I have, at the bottom of this slide, the URL and the email address to get in touch with our new center. So please take a moment when you have time to visit our website and look around. It's evolving. New information and updates are going to be forthcoming. You also will see a button on that website to join our virtual community and to connect with us. So we look forward to working with you all in lots of different ways. So thank you so much again for the time. And I'll turn back to you, Karen.

>> Thank you so much, both Elaine and Lauren, for sharing about the federal investment in TA around Infant and Early Childhood Mental Health Consultation. I do want to say Lauren used the term complementary philosophies and I thought that was a really great way to sum up how these two centers plan to work well together. So thank you both for being here today and for sharing. If there are any questions, please go ahead over to the chat feature and type them in for our presenters and we will address them as we go through the session.

So at this point, I would like to turn it over to our next presenter. This will be turned over to Dr. Paula Zeanah. And just to tell you a little bit more about her, she is an endowed chair in nursing at the College of Nursing and Allied Health Professionals. She is also the Director of Research at the Picard Center for Child Development at the University of Louisiana at Lafayette. And we are so happy to have her here with us presenting today on behalf of her work. So I'll turn it over to you at this point, Dr. Zeanah.

>> Thank you. This-I am Dr. Zeanah, and I'm very happy to have the opportunity to talk with you today briefly about the importance of Infant and Early Childhood Mental Health Consultation in home visiting. I had the opportunity to do work a lot in this area in Louisiana for a number of years. So it's an area that's near and dear to my heart.

Today, I'm going to highlight some of the practical and ethical issues for consideration as part of this discussion. As home visiting programs have grown and evolved, the mental health and trauma experiences of clients and how those experiences impact client engagement and programs, client self-care and the client's ability to provide safe and consistent and responsive care to the infant have

become more and more apparent. By virtue of being in the home, home visitors are uncovering the mental health needs of caregivers and families that may not be recognized by traditional systems; thus, home visiting really provides the possibility of offering support that may not be available elsewhere. However, the complexity of the cases often stretches the skills and knowledge of visitors who usually are not trained as mental health providers. And home visiting programs typically do not have extensive resources to guide home visitors and their work with clients who have significant mental health issues. Nevertheless, home visiting services are being viewed as an important avenue for providing supportive ways to support clients with mental health needs.

In this slide, the idea here is to show that mental health issues are prevalent and very varied. This is a quote from a home visitor that I spoke with a number of years ago. And most of the research has focused on depression, and there is a growing literature on the prevalence of anxiety and trauma, but you can see from this slide there are a number of other related mental health issues, mental health diagnoses and conditions that impact-that come to light in home visiting. We also know that there's often co-morbidity. For example, a study done by Robert Ammerman in Ohio found that of 37% of home visiting clients who met the criteria for major depression, 37% also had a co-morbid post-traumatic stress disorder diagnosis. We don't have a true epidemiology of the range of mental health conditions that occur in home visiting. We know that home -- that emergency situations, for example, occur and that there are occasionally more severe mental health conditions like schizophrenia and psychosis. Those may be fairly rare, but as we take on more clients with higher levels of need, we might expect to see more significant mental health conditions in the caseloads that we're serving.

This slide comes from the Institute of Medicine's report on the prevention of child mental health problems and demonstrates a range of possible mental health services. Although home visiting programs are not mental health services per se, they were developed to provide health promotion, prevention, and early intervention. But a home visitor's caseload potentially can include clients across the full range of intensity of need, from no specific mental health needs to being in treatment for a diagnosed disorder to being involved in or recently released from a substance abuse or child protection or inpatient mental health treatment program. Alternatively, a home visitor may never encounter a psychiatric emergency or someone with more severe mental health problems. So the individual home visitors' experience of working with clients with mental health needs is quite varied, and that's in some ways what makes it more difficult for them to acquire the skills that they need.

I want to be clear that the home visitor is not expected to provide a diagnosis or to provide treatment, but because the clients can have symptoms that cross all of these different situations, it impacts the work of the home visitor. In a nutshell, the home visitor has to be prepared for a whole range of actions, including at the left-hand side of your screen. Providing health promotion, education and prevention is probably part of their usual toolkit in terms of providing education and general guidance. Many home visiting programs provide early identification through and early intervention through screening and referral. Those are all typically part of what home visiting programs are set up to do.

But for clients who have moderate or more significant symptoms, then it becomes a little bit less clear. And oftentimes some visitors will work to do something like improving functioning through things like enhancing stress management or so forth, or collaborating with mental health providers. They may, in fact, be involved in crises, suicide, homicidal or violent situations and so forth, where the home visitor has to identify and provide acute response, whether it's just calling 9-1-1 or having -- figuring out what to do with a child and so forth. And for those who are who are serving clients, been in treatment for substance abuse or child protection or whatever, there may be a need for increased monitoring, for more intensive collaboration with providers, or facilitating the client's reintegration or transition back into a home visiting program. So that's a lot -- a lot, a full range of activities that the home visitor might be involved in.

Of course, home visitors provide lots of education around positive parenting and child development, but maternal mental health issues impact not just the mother but the developing fetus, her ability to provide care for the child. The child's development, as well as her relationships with others around her. And when there are significant parent-infant or parent-child relationship problems, or when a child has a significant behavioral or emotional or developmental issue, it is often not clear for the home visitor what -- you know, who or what to focus on.

Screening and referral remain important, but if resources are not available, or if the client can't or doesn't want to take advantage of those resources, the home visitor is left with a dilemma of what to do. And of course, the clients' preferences and priorities also play a role here, as well as family and cultural beliefs.

So I'm taking a deep breath here, because that's a lot, but I want to just kind of in a nutshell go through some of the general activities that home visitors, you know, explicitly or implicitly are expected to do. Again, they often screen for a variety of risks for parents and the child. They take that information, they try to prioritize it and individualize it for that specific family. They try to engage the client to address the

problem, whether it's going to a referral or whatever, and they do that within the context of what the client wants and desires and what resources are available. They try to provide some kind of strength-based or evidence-based approaches to address those specific symptoms or behaviors or concerns that become apparent.

They try to track and monitor and respond to progress, whether it's improving or not, deciding when and how to engage family members and support of others in the care of that child or family, working in communication, in collaboration with communities, services, all of that in the realm of trying to address the needs of the client. Meanwhile, we also want our home visitors to identify and deal with their own personal experiences and beliefs and reactions and stress that they feel in reaction to these highly charged and often very complex situations. And besides that, we want them to continue to deliver all the rest of their program activities and keep to the goals and keep up with their busy caseloads. I get out of breath just talking about all that. So I think I think we're asking them to do a lot, and, therefore, we want to have the Infant and Early Childhood Mental Health consultants to really help out with this daunting task that home visitors have.

Infant and Early Childhood Mental Health Consultation involves a partnership between the professional consultant with early infant and infant mental health experience and home visiting programs, with the idea to enhance the capacity of home visitors to identify and appropriately address the unmet mental health needs of children and families.

There are a number of ways to do that, and you're going to hear about some of those shortly. But basically, the consultant is going to be called upon to provide a wide range of support and guidance to home visitors in their work with clients and in their response and reaction to the complex situations they face. When considering incorporation of an early- Infant and Early Childhood Mental Health consultant, it's important for the home visiting program to determine the type of support that's needed and what's available. Are you addressing specific types of populations? Rural, urban, all those kinds of things. What kinds of resources are available?

By virtue of training experience, it is important that the Infant and Early Childhood Mental Health consultant have strong clinical skills and experience in working in the home or with the home visiting population, and especially that he or she is able to recognize how mental health conditions impact parent-infant relationships and the early social emotional development of the child.

Consultation skills are particularly important when providing guidance and support to professionals who have a different set of knowledge and training and skills and priorities. They may be -- you may need to

develop policies and procedures around billing and funding and documentation and confidentiality and referrals and so forth as you develop your program.

But I also want to emphasize that it's really important that the Infant and Early Childhood Mental Health consultant become very knowledgeable about the program that you are offering and as well as the home visitors' role and skills and activities so that he or she can be most effective in providing the support that they need.

Along those lines, I just want to also comment that while we often focus on the expertise the consultants bring to the home visitors and teams, it's also important to recognize that the home visitors have a significant amount of expertise in their work. They do amazing work with clients across a whole range of needs, and they often have a very nuanced understanding or knowledge of what's possible within families.

Home visitor perspectives can open the door to new understandings of how mental health issues are experienced and dealt with by clients from a variety of social and cultural and economic situations.

In this slide, I want to just point out that the role of the Infant and Early Childhood Mental Health consultant could cross all these different levels that are shown on this slide. Most frequently, we talk about the support that's provided at the client home visitor level, whether that's developing skills or supporting the relationship between the two or providing education to the home visitor. But the consultant may also very much may be involved in providing team support by participating in team meetings, supporting the supervisor, supporting reflective practice, helping to develop policies and procedures and so forth. Also, it's important to remember that teams really vary their home visiting experience, so a brand new team will have different needs than a team that's been involved in the community for a long, long time. But certainly the Infant and Early Childhood Mental Health consultant is also looked to to provide support and help develop the resources in the community by identifying them, supporting collaboration, helping to integrate the home visiting program within the community, and advocating for the needs of the program, and so forth.

And finally, some infant mental health consultants may actually work at the inter-agency level, at the big system level, early childhood comprehensive systems that some states are involved in and so forth. So there can be involvement across all of these, across all of these dimensions.

I want to spend just one slide talking a little bit about ethical considerations, because when working in an interdisciplinary, integrative setting, ethical issues can emerge, as there can be differences in how

and what kinds of services are perceived as warranted or needed. For example, while an overall goal might be to improve the developmental outcomes of infants, the approach may vary by profession based on their expertise and priorities. An early education professional may want to focus on early learning, while a nurse may focus on health-related issues.

Similarly, all disciplines, especially those who serve children and families, have ethical guidelines which guide their professional behavior. They are not all exactly the same, although most of them do address the issues that are listed here on this slide. In home visiting, the ethical considerations that seem to most frequently emerge are around establishing trust and boundaries and safety and relationships, especially within the context of mental health concerns.

But again, there may be differences of emphasis. For example, in a high-risk situation, a nurse may emphasize the health implications of the situation, and a social worker may emphasize the justice or the social justice implications. These are generalities, of course, but the point is that ethical issues may emerge from either clinical or professional concerns. So awareness and attention to ethics is an additional consideration in the work of many early childhood mental health consultants.

You know, there's a growing literature, of course, on the positive effects of Infant and Early Childhood Mental Health Consultation in home visiting, and I'm not going to talk about those today, but I do want to emphasize that home visitors really do value the support, as can be seen here with these representative statements from home visitors, again, words that I've heard from people that I've worked with over the years. Infant and Early Childhood Mental Health consultants are becoming recognized as an essential contributor to successful home visiting and home visitor satisfaction. And the guidance for how to incorporate a consultant into perinatal infant and early childhood programs is growing rapidly, as you can tell from this webinar and so forth.

So I'm going to stop at this point. I look forward to the awardee presentations, as they describe their approaches to this essential support for home visitors.

>> Thank you so much, Paula. And her references are here and they will be in this slide deck if you want to see more information about where her research and some of the different studies that she cited while she was speaking.

At this point, I'd like to turn it over to P.J. West from Iowa. P.J.

>> Good afternoon, everyone. P.J. West here in Iowa, and just so much great information that I wish I would have had before we got started in the state of Iowa. But this afternoon, I'm going to share with you a little bit about our process, where we're headed next and some lessons learned. So here in Iowa, we're a little over 14 months into the process, and I feel like I can still consider us in the infant stage, as we're truly just getting started with our MIECHV mental health consultation work. The idea of adding mental health consultation into the contracts of our MIECHV Local Implementing Agencies was really generated by that feedback that we continuously received from our local family support staff, as they told us they needed more in regard to mental health issues and how prevalent they are. They needed more than just training, and this seemed to be a really great way to get started. There were areas across our own state and across the nation that were focusing on that mental health consultation work and offering that support to direct line staff as they in turn supported families. We decided that we could put a little bit of money towards this project, towards our MIECHV Local Implementing Agency. So we wrote into our annual request for application that each home visiting contractor would be funded up to a little over 10,000 dollars to provide that mental health consultation and education to our MIECHV home visitors and supervisors.

We wanted that to be by a qualified licensed mental health provider. And we stated that consultation could include technical assistance, training, case review, and other guidance as needed. We definitely wanted to point out that no mental health services would be provided to enrolled families with MIECHV funds. Of course, our Local Implementing Agencies knew that, but when you're writing it, you need to put that in as well.

We also included mental health consultation within the goals and objectives for our Local Implementing Agencies and our contracts, and we simply stated that MIECHV home visitors and supervisors would increase their skills and competence to support children and families with mental illness, including, but not limited to, mental health consultation and education for the home visitors and supervisors from a licensed mental health professional.

So what happened next? Lots of exciting things, if you ask me, but the applications came in from our Local Implementing Agencies and it was evident that we needed to do more. Our local contractors needed more. They needed more information about what is mental health consultation. We also needed someone on our own MIECHV team to coordinate with the local programs around mental health consultation, including how to find someone to fit that niche. Some local programs weren't even sure

what mental health consultation was or how to find someone to provide those services. And I was able to say that I wasn't, nor am I still, an expert in mental health consultation.

But I could coordinate conversation and facilitate that conversation. So I was excited to take on this project and have been very passionate about it since the beginning. I reached out to our Local Implementing Agencies and worked with them on how they were going to secure a consultant. Again, some knew a little some new a lot and some didn't know anything about the process. Really, what we found was communication through this process was key, asking lots of questions and diving in and digging around and figuring it out. I reached out to a key person in our state who had been doing some work on infant and early childhood mental health and I was so excited. There was a committee working to build a process for mental health consultation in our state. So a gal by the name of Rhonda Reirden-Nelson with the Department of Public Health was able to provide me with so much insight and information on what mental health consultation is. She talked to me about what it isn't and pointed me in the right direction and how to help our local programs know what to look for and how to hire the right person for the role. The Iowa Early Childhood Mental Health Committee had developed a draft document that explained the best practices in finding a mental health consultation and the distinctive roles and responsibilities of a consultant. This draft document sort of became my bible and it was a great resource for me as I was learning about the process, but also to our Local Implementing Agencies as they were securing a person to provide consultation and helping their family support staff understand the process as well.

So through that process, I was also connected with Linda Delimata, who had done extensive work with the Illinois Children's Mental Health Partnership and was providing technical assistance to Iowa at that time. I was lucky enough to meet with her and learn about the work that she had been involved in in Illinois and was able to lean on her expertise. She is truly the person who helped me see that I didn't have to be an expert in mental health consultation to facilitate conversation among our local programs and the mental health consultants. So with the help of those two ladies, we provided a day-long orientation via Zoom, since everyone's from different parts of the state, for our mental health consultants. It was an opportunity to lay the groundwork for the MIECHV mental health consultation process, but also for the consultants to get to know one another and to build those relationships. We learned so much through the day and one thing that stood out was that the consultants needed more time to network with one another. They were working alone, a lot of time in isolation. And from that

conversation, we set up monthly MIECHV mental health consultation check-in calls. They were provided at the same time and same day each month.

Not all consultants can attend each time, but they're always open and everyone is welcome. It's comparable to a parallel process to working with families. It takes time to build trusting relationships. And once that happened during these monthly check-in calls, the calls changed. And although I set up the calls and I kind of organized the agenda, the calls are now the mental health consultation calls. They take the lead. They decide where the conversation goes and what they need. One of the consultants on the last call said, "This is the best conversation I've had all week," and our calls are at noon on Friday.

So what's next? Where are we now? What's next and some of the lessons learned? I continue to check in with our Local Implementing Agencies often on how the process is going from their perspective. They have learned a lot and have a lot of lessons learned along the way. We were lucky enough to spotlight one of the Local Implementing Agencies on our last monthly MIECHV contractor call. There were a lot of questions raised from other areas about how they were making it work. We have also written mental health consultation into our upcoming request for proposal. It's such an important project and we want to see it continue and to support it toward the best of our abilities. Of course, we're still learning, as are our consultants and the Local Implementing Agencies.

Something we learned very early on, and I mentioned this already, is that intentional planning is key to move this process ahead. Originally, we wrote a small paragraph about mental health consultation into our request for application. It wasn't enough. Our local programs needed more. They needed information about what mental health consultation is, how it works. And as I explained, we certainly provided more right after that.

Having someone to coordinate the process with local programs and with the consultants themselves is important. We learned this after the fact as well. Having someone to check in with consultants and the local programs to facilitate conversation and connect the work that is happening across the state with Infant and Early Childhood Mental Health Consultation as we continue to build that process is so important. Training and supporting staff is a key to success. Understanding what mental health consultation is, who is a mental health consultant has been so important. It's also been really important, as we heard in an earlier slide, is to help the consultants understand what home visiting is because they not may not necessarily know. So I hope that you've been able to hear some of that passion and excitement about the projects here in Iowa. It's such a really neat time to be a family support worker in

our state and have access to mental health consultation to assist family support workers in supporting families. That's what I have today. Thank you.

>> P.J., thank you so much. You did have a question come in while you were presenting. The question asked, "Are you talking about Infant and Early Childhood Mental Health Consultation or general mental health focusing on the family, not specifically on the parent child relationship?" Could you address that question?

>> Yes, I am. I had put myself on me, so I apologize. I think it's a combination of those things. So we are - - we provide funds to our Local Implementing Agencies to go out and secure a mental health consultant, and we want them to have that early childhood knowledge base to provide those supports to our family support staff who in turn support families. So we're not providing any services to families, but supporting the family support staff with that.

>> Great. Thank you so much for addressing that and thank you for your presentation. All right. At this point, I would like to turn it over to our next presenter. We are going to hear from Dr. Sarah Hinshaw-Fuselier, and she's going to tell us about Louisiana's MIECHV efforts.

>> Hi. So in Louisiana, we've been working with infant mental health in home visiting for many years. So I'm going to just walk you through a little bit of our process and content regarding infant early childhood mental health in home visiting. So back when we began home visiting in the state in '99 or 2000, infant early childhood mental health was incorporated from the beginning, and that is actually thanks to the work of Paula Zeanah who just presented to you a few minutes ago and our program developed sort of organically and slowly over the years so that by about 2011, half of our team in Louisiana had an infant mental health specialist, was what we call it at the time.

So in the beginning, the consultants were spending about half of their time providing direct therapeutic services to families in their homes, families who were participating in home visiting, and about half of their time working with the home visitors, largely around the issues that they were facing with the families who were receiving mental health treatment. So our first evaluation, when we had about half of the teams with an infant mental health specialist on them, some of the things we found were that regardless of whether families were seeing the consultant for therapy, those teams had effects and those are the participants stayed in the program longer in the home visiting program longer, and that those teams made more community referrals.

So we kept chugging along and Paula moved on to other things, and I stepped in and we had to switch our focus because of funding issues. And so in 2016, we received a Targeted Innovation Award and we really focused at that point on the goal was to develop and retain a highly-skilled home visiting workforce, and we wanted to do that through mental health consultation, so Infant and Early Childhood Mental Health Consultation focused specifically in three areas: parent-child relationships, trauma-informed care, and diversity-informed practice. So we expanded our consultant workforce so that all of our then 18 teams across the state had a half-time infant and early childhood mental health clinician, so all licensed mental health professionals supporting that team and embedded with that team. And what we did over the two years of the Innovation Award was really focus on how to structure both the consultation that was provided and the training that was provided to the home visiting workforce. And so during that time, we had an evaluation, which I will talk about momentarily, but I want to just kind of show you and walk you through a little bit about what our model looks like for Infant and Early Childhood Mental Health Consultation in Louisiana.

We have four basic parts to our program, the first being consultation. So again, licensed mental health professionals are providing individual consultation to all of our home visitors. They meet with all of the home visitors at least once a month. So a home visiting team typically has about eight home visitors and a supervisor. And as I said a minute ago, we have a half-time consultant embedded with each team. So they'll meet at least monthly with each home visitor, and then as needed. They can certainly meet more if there are needs for that. We have some automatic requests for consultation criteria, including elevated depression scores, elevated anxiety scores and known history of trauma. The consultants also attend case conferences, so they're bringing that mental health voice to group discussions. And then they can also provide joint visits with the home visitors. So if there are questions that aren't maybe getting answered in consultation, the home visitor and the clinician can go together to visit the family to further assess maybe what -- and try to develop a better understanding of what's going on and what the needs are of the family, sometimes provide some psycho education for the family and help really facilitate linkage to community resources that are available. So that's the consultation piece. Also, our consultants provide monthly in-services in those three areas of focus that I mentioned earlier. So we developed those at the statewide level so that the content is consistent across the teams and we can kind of vet the information that way.

And then we provide the materials to our consultants at the teams. We review it together in a team meeting, so I haven't really focused on the support for the consultants in this presentation, but we have

a number of supports for those consultants. And one of those things that we do is a monthly meeting. And so we review with them the presentation that they will make. And we've really developed kind of a more workshop type of format where the didactics are less, so we have maybe 10 to 15 minutes of didactics at the most, but we integrate that with some kind of interactive learning activity and discussion so that what we find is that there's this real kind of synergy between the training and the consultation, so that a home visitor might hear about something in a training and then think about through discussion how it applies to her client and then take that maybe to consultation individually with the consultants and really kind of having a nice real back and forth there in the learning process and skill development.

So we also work with resource and referral and networking with community mental health providers and really trying to help connect teams and families with services that do exist. We have a real problem in Louisiana, as in many places around the country, with having enough providers, particularly who can provide dyadic treatment and be thinking about perinatal and infant and early childhood mental health issues, but we do want to connect them with what is available.

So those three elements were part of our targeted innovation work. As I said, we had been providing direct services. We stopped due to funding issues. When we got to the end of the Targeted Innovation Award, we did go back to providing evidence-based practice with families, so you'll see that up in the right corner there. And we're actually fortunate to be part of another grant through the National Child Traumatic Stress Network so that our consultants are now getting rostered in child-parent psychotherapy. So our focus right now is on identified trauma and providing evidence-based therapies to families in the home. That's a small percentage of what we do. It's about 25% of what our consultants do. So that's our model.

And then let me briefly run you through our evaluation. We have an external evaluator who provided the top things you see there. So they did some focus groups with teams. They did interviews with key personnel, and they distributed a survey at the beginning and the end of our work to look at self-efficacy amongst the home visitors. And so that was really focused on how home visitors perceive their competence and confidence in providing services and working with families who have mental health needs.

And then we have ongoing internal monitoring where we're looking at how much consultation is being provided, how many joint visits are being provided, and looking at the evaluation of our in-services to see: is knowledge increasing, how satisfied, how relevant is the material? A

And then lastly, just to give you some highlights from our evaluation, some results, we saw a statistically significant increase from beginning to end. So we had that pre and post survey as I said. Now it's about fifteen months apart, and the home visitors reported feeling more confident, more competent in navigating mental health concerns with clients. They reported a better understanding of clients who have mental health needs and a deeper understanding and awareness of where mental health issues come from and the impact of mental health on client behavior. They also demonstrated a statistically significant increase in knowledge in those three content areas, as well as perceived knowledge gain in the content areas and in their awareness of the resources in the community. So we saw a big increase in the amount of consultation we were doing and the joint assessments and then continued perception of support to the team, and, interestingly, reporting better self-care practices amongst the home visitors. And I'm sorry, I think I went a little over, but there we go.

>> No, that was perfect. Thank you, Sarah. If there are any additional questions, or anyone has any comments about work they're doing, please head over to the chat and share with us as well. At this time, I'd like to turn it over to our Illinois team. We have Lesley Schwartz and Delreen Schmidt-Lenz, who are going to present on behalf of Illinois. And I'll turn it to you first, Lesley.

>> Great. Thank you. So Illinois really started focusing on mental health in early childhood back in 2003. Our Illinois Children's Mental Health Act created the Illinois Children's Mental Health Partnership, and the partnership was charged with developing and monitoring a comprehensive, multi-year children's mental health plan for the state. And in developing this plan, a critical issue emerged. In Illinois, like many other parts of the country, there were insufficient numbers of providers available and adequately trained to meet the mental health needs of children, particularly young children ages zero to five.

So to begin addressing this need, the partnership identified mental health consultation as a key strategy for supporting and building the capacity of a variety of providers, including child care and pre-school staff, medical and mental health workers, and home visitors, which, of course, is our focus today.

So since its inception, Illinois MIECHV has supported Infant and Early Childhood Mental Health Consultation in its home visiting programs. And thanks to the groundwork laid by the Children's Mental Health Act and the Partnership, we were lucky enough to have some level of pre-existing infrastructure, including a well-trained consultant workforce to draw from, and other factors that contributed to our success of embedding consultation in MIECHV include the way that we funded and offered it. So we actually funded consultation and continue to do so at the state level. So the state contracts with the Partnership, who then provides consultants to our programs. So this didn't require home visiting

programs to build it into their own budgets. We managed the fiscal side of it, which made it easier for programs to engage in consultation without having to worry about how they were going to pay for it or what line items they might have to reduce to afford it.

Secondly, we didn't mandate consultation. It was voluntary. This was important to the consultant leadership at the time, who felt it was important for programs to want to engage in consultation voluntarily. And this also mirrors families' participation in home visiting. Over time, we have gotten 100% engagement in all of our programs.

Another factor to the success was the flexibility of the consultation model. Consultation was offered in various group settings, so a combinations of program staff and supervisors and administrators, consultations with groups of home visitors within the MIECHV community, consultation with groups of supervisors. We also expanded it to offer it to our coordinated intake staff in the community as well. So all of this really built a culture of reflective practice throughout the community.

Finally, we invested in the further development of the consultation workforce by supporting reflective practice groups for the actual consultants themselves and by cross-training them in our intimate partner violence curriculum, which is Healthy Moms, Happy Babies in our depression and substance abuse screenings and programs like Mothers and Babies to address maternal depression. In turn, the consultants could then offer these trainings to our home visiting programs, which was a great way for them to get in the door and start building relationships with programs. Now I will pass over to Delreen to talk about more strategies.

>> Thank you. So in Illinois, we have identified four systems building strategies for Infant and Early Childhood Mental Health Consultation. The first strategy is continuously communicating to professionals who work with children and families the expectation that Infant and Early Childhood Mental Health Consultation is a role within the field of home visiting while simultaneously communicating what consultation is and what it isn't. And Dr. Zeanah referenced that when she spoke earlier. The second strategy Illinois has is espousing that a foundational principle of infant and early childhood consultation is to build capacity of not only the home visitors and families, but of supervisors and the consultants themselves, all while maintaining that capacity is built with attunement. In Illinois, we are fortunate to have a strong connection with Dr. Linda Gilkerson at Erikson Institute and her framework of facilitating attuned interactions or the FAN. In fact, all of the MIECHV consultants have had extensive training in the FAN and are becoming Train the Trainers so they can promote engagement and attunement with programs and also programs can then promote that with families. The third system building strategy is

ensuring that Infant and Early Childhood Mental Health Consultation and consultants continuously remain curious about the lens they bring into their work, which is carried out by opportunities for reflective supervision that is regular, collaborative, and built into the deliverables of the work.

This strategy really connects with the three building blocks of reflective supervision, which I'm sure many of us know that are referenced by Zero to Three and these three building blocks include reflection, collaboration, and regularity of reflective supervision.

And finally, strategy number four is embracing and valuing that Infant and Early Childhood Mental Health Consultation will make a difference in the lives of professional communities, parents and caregivers, and children. The impact of Infant and Early Childhood Mental Health Consultation in the 13 MIECHV communities in Illinois is synonymous with the infant mental health concept of the parallel process of holding, which is on the next slide.

So this parallel process of holding is that consultants must maintain a self-actualized, regulated professional presence to themselves so that consultants can hold consultees, which include administrators, supervisors, direct practitioners in their work within the MIECHV communities and families so that families can learn to hold themselves and their children, and ultimately children can internalize this holding within their MIECHV communities and family systems and replicate this holding for generations to come. This parallel process ultimately coalesces with the design created for MIECHV home visiting by HRSA, which is an improvement of outcomes for pregnant women and families, particularly those considered at-risk.

Ok. And finally, looking ahead. So the Illinois Children's Mental Health Partnership is working closely with numerous public and private stakeholders to implement a multi-year Infant and Early Childhood Mental Health Consultation Initiative with the goal of developing and testing a universal, effective, and sustainable mental health consultation model in our state. As part of this initiative, a standardized training for consultants has been developed and tested. A statewide online consultant registry is under development, and an evaluation plan is being implemented. Additionally, we are working towards making consultation a core component of home visiting across the state, and one way we are pushing this agenda is by including it in the cost modeling we've recently completed for home visiting as part of the early childhood strategic planning and our preschool development grants.

>> Thank you so much for your presentation, Lesley and Delreen. We did have a question that came in from Allison Pinto. She asked, "Is there a statewide rate for paying MCFs?" I believe this question was for Sarah during her presentation, and I know she's having a little bit of issue with her visuals. So Sarah,

I'm going to read the question to you again and also, please, Iowa and Illinois, feel free to jump in with responses if you also have responses. So the question is: Is there a statewide rate per paying MCFs?"

>> So this is Sarah. In Louisiana our consultants are salaried because they're half-time embedded with each team, so it's not kind of a fee for service type of model, but I believe that Illinois might have a different answer to that question.

>> I was just going to say in Illinois yes, there is an actual fee for service rate for mental health consultation through MIECHV and then also for the other mental health consultation programs in Illinois.

>> Ok, great. Thank you for answering that question. I do want to alert you that we pulled up some polls, if you will take an action step based on this webinar. Also, if you do plan to take an action step, if you could let us know what that is. And if you don't plan take an action step, what would have helped you better be able to do that? We really want these webinars to be action-oriented so that you can come and get great strategies and leave and take them back to the work that you do. And we want to continue to improve the work.

So we have a webinar coming up in February and we'll want to be able to make any improvements or suggestions that you have here. So please type in the action steps that you took away from this webinar. If you have a moment, please write down one thing you learned or one thing you still need so that we can be able to connect to and help you with resources that might meet that need.

I do want to alert you to the slide in the corner that says "Visiting HRSA's website" is where all of our resources that have been published thus far are found, and we do have some new resources coming up soon, and we'll be very eager to get them out to you. You can save the date for our next webinar on February 11th from 3 to 4 p.m. Eastern. We'll be talking about supporting systems-level approaches to working with priority MIECHV populations, including families who are homeless, have immigrant status, are incarcerated, and more.

And then finally, if you have not had a chance to complete the evaluation, please do so. It should pop up on your screen when we wrap the webinar today. I just want to say one more thank you to all of our presenters for being here today for all of the time that they spent to think about what would be most important for MIECHV awardees this year. And thank you all for attending. And we will keep the polls open for another minute. So please feel free to write in some information in the poll. And with that, I hope you all have a wonderful day. Thank you.