Early Childhood Mental Health Consultation and Early Childhood Positive Behavior Interventions & Supports in Home Visiting: Highlights from a Pilot Effort

Project Background

Beginning in 2012, Multnomah Project LAUNCH began funding an innovative service model, partnering Early Childhood Mental Health Consultation (EC MHC) and Early Childhood Positive Behavior Interventions & Supports (EC PBIS) with a Healthy Families America (HFA) home visiting program in Portland, Oregon.

EC MHC typically involves providing early learning classroom staff with consultation from a mental health professional to help prevent child behavior problems, strengthen staff skills, and improve overall quality of early childhood classroom environments.[1] EC PBIS is a model that provides early childhood teachers with strategies and tools with a tiered approach (universal promotion, secondary prevention, and tertiary intervention), to increasing positive behavior and decreasing negative behavior in the classroom.[2]

Although EC MHC and EC PBIS have developed a solid evidence base in early childhood classroom-based programs,[2, 3] and have been described as complementary frameworks,[4] less is known about the effects of either model with home visiting approaches, or how the EC PBIS model can be used to support the consultant's work with home visitors and high-risk families in home environments. This research brief provides highlights from a pilot demonstration of this model, including a description of the approach and preliminary outcomes, intended to contribute to the growing evidence base for mental health consultation in home visiting programs.[5, 6]

The rationale behind piloting EC MHC-EC PBIS in a HFA home visiting model grew out of recognition of the growing demands put on Healthy Families Oregon (HFO) home visitors to meet the needs of increasingly challenging and complex high-risk families.[7] Multnomah Project LAUNCH grant presented an opportunity to pilot the implementation of EC MHC-EC PBIS within a HFO home visiting program and work toward the overall goals of EC MHC in home visiting programs to strengthen home visiting program and staff skills and effectiveness in working with high-risk families, increase home visitors' job satisfaction and reduce job stress, and ultimately, to improve the quality of parent-child relationships and parent and child outcomes.[5]

The EC MHC-EC PBIS Model

HFO is an evidence-based home visiting program for high-risk parents with infants and young children. For this project, a mental health consultant (MHC) was paired with one home visiting team (2 supervisors, 9 home visitors, and a community health nurse) serving 342 children.

The MHC in this project is a Masters-level mental health clinician with expertise in infant-toddler mental health and family work. Working an average of 16 hours per week with the home visiting team, which has an approximate caseload of 15 families per home visitor, the MHC provides individual and group consultation and training; offers materials, resources, and tools; observes families on home visits; coaches home visitors; provides time-limited direct service supports with families; facilitates parenting groups; and participates in her own ongoing reflective group and individual supervision with mental health consultant colleagues and her supervisor.

Two different MHCs supported the home visiting team during the two years of this pilot.

A unique aspect of this model of consultation is the use of EC PBIS training and tools as part of the consultant's work. The Multnomah Project LAUNCH model introduced the use of EC PBIS with the HFO home visiting program, adapting EC PBIS training modules into a "Family Coaching" module and modifying the EC PBIS tool used to assess and strengthen overall organizational supports for EC PBIS, known as the "Benchmarks of Quality" assessment specifically for Home Visiting (BOQ-HV) and adapted for use with the HFO program.

Evidence of Effectiveness

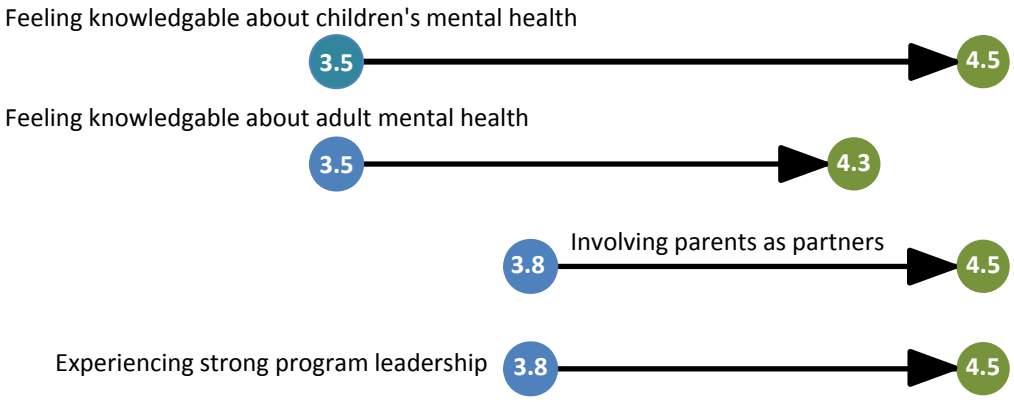
The consultant's work focused on strengthening home visiting program and staff capacity and effectiveness in working with high-risk families, increasing home visitors' job satisfaction and reducing job stress, ultimately to improve the quality of parent-child relationships and parent and child outcomes.[1]

Outcome measures collected through staff surveys at baseline and 24 months, focus groups with the home visiting team, and interviews with the MHC demonstrate areas of impact to-date.

> *"[MHC] has been a great educator around working with feelings on an adult level and a toddler level. She has helped me to acknowledge and discuss emotions with the families. With her help I feel like have grown in my work with families."*
>
> *- Home Visitor*

Staff Skills & Confidence[2]

Significant increases occurred in four domains between baseline and 24 months.



Staff Stress

Although staff did not report a significant difference in average ratings of work-related stress, variability in responses was dramatically reduced; the standard deviation at the 24 month follow-up was nearly half of that at baseline, showing responses more closely clustered around the average rating.

Furthermore, home visitors shared feedback in the focus groups suggesting that the MHC has supported them in this area, both in relation to job-related stress, but also more broadly.

[1] Child and family outcome data are not yet available.

[2] Statistically significant difference in mean rating on scale from 1 to 5 between baseline and 24 months (N=12); paired sample t-tests ($p < .05$).

"It's just her listening and having someone I could vent to that's not a supervisor or coworker and it's confidential. She gives me feedback about how to alleviate stress, and help with goals, even personal goals, like I'm hitting the gym now, and she's huge on self-care, which I love." – Home Visitor

Another home visitor drew the connection between building increased skills and confidence as a result of working with the MHC, which in turn, had an impact on reducing stress:

"When I first started home visiting, I was talking about and encouraging [children's] physical development. Now I feel like I have the tools and confidence to talk to families about the whole picture of emotional and physical states of everyone involved. Having better tools and confidence myself has made work less stressful." – Home Visitor

What Makes the Model Work?

Key Elements of EC MHC-EC PBIS Model

Providing individual consultation and support to staff on strategies to work with specific families, staff stress management, and general staff support, **and to supervisors** on EC PBIS implementation, training and screening processes, and structuring EC MHC services.

Providing limited direct service with families to complement the home visitor's work in specific areas, e.g., especially difficult routines or parent-child interactions, coping, and **providing referrals** to mental health services.

Facilitating reflective group supervision and training with staff to consult on cases each month, and providing group training on topics of interest, such as coaching families, stress management for staff, and using EC PBIS tools to promote positive child behavior.

Facilitating Incredible Years parenting classes for referred families to continue to build parenting and stress management skills and strengthen the parent-child relationship.

"We've gotten more structured with her, more topic specific. She's really good about listening to our needs and being responsive to what we say we need or want more of." – Home Visitor

Key Benefits

Individual coaching and consultation. This is helpful to home visitors for planning and debriefing home visits, coordinating services, increasing their confidence as family coaches, and for self-care/stress management.

Integrating EC PBIS tools and techniques into home visits. The MHC has shared EC PBIS tools with home visitors, who in turn, introduce these tools with families on home visits.

"I use Tucker the Turtle now almost on every visit, introducing kids to the puppet right away." – Home Visitor

Joining staff on home visits. This has allowed the MHC to "put a face" to a mental health agency in order to provide direct referrals for families between the home visiting program and mental health services, and/or provide short-term direct mental health services, coordinating with the home visitor.

Program-level support to assist the team in refining their screening and identification processes, both for parental depression and child development delays.

Reflective group supervision. These meetings grew out of the team's need to have regular dedicated time to engage in facilitated discussions about specific families and challenges. The team has appreciated being able to raise training topics of interest, and have dedicated time to debrief and strategize approaches in their work for specific families.

Aligning practice models. The MHC led an effort to adapt the infant-toddler EC PBIS training module for use in the HFO program model, highlighting areas of consistency between EC PBIS and HFO. This provides a foundational understanding of EC PBIS for home visiting participants, and describes strategies to promote social and emotional competencies with families and children.

Key Challenges

The biggest implementation challenge has been the amount of time needed to **establish relationships and trust** between the MHC and the home visiting team, assessing needs and strengths of the team, and clarifying how the MHC can support the home visiting program.

Earlier on in the process home visitors described not **understanding how the MHC fit into their work,** and it took nearly a year to establish expectations about how the MHC could best support the work of staff with families.

Supervisors described why some home visitors may have been more reluctant to work with the MHC and offered that some staff might be more protective of families and bringing additional service providers into the home or issues related to **stigma** around mental health services.

Having **limited time** to work with individual home visiting staff, supervisors, and families; provide group trainings and reflective group supervision; and facilitate periodic parenting groups has been challenging. The demand for the consultant's time outpaces her availability.

Another challenge presented by limited availability was related to the home visitors and MHC **staying connected and coordinated** in their strategies if they were conducting separate home visits for a limited duration. It has required more intentional efforts to ensure they continue to stay informed about and aligned with each other's work and the family's progress.

Finally, an ongoing challenge for the team has been related to the need for the MHC to have a dedicated, **physical space** in the building with the home visiting team for confidential conversations, either about specific families and challenges, or for personal support.

Lessons Learned

It took **considerable time to build trust** and positive relationships with home visiting supervisors and staff. The MHC spent much of the first year meeting with supervisors to clarify the MHC role and expectations; attending team meetings; providing materials, resources, and trainings; and joining home visitors to observe families during home visits and debrief with staff afterwards.

> *"The home visiting model is so successful because we're going into the environment where families are at, and the reason why mental health consultation in this model is so successful is that we're getting a mental health consultant into the home environment where families are at. It's a larger thing for families than we realize. There's a lot of barriers and that just breaks right through them when [MHC] can go into the home." – Home Visitor*

EC PBIS gave structure to the EC MHC and offered specific tools that could easily be used by home visitors with families. From the perspective of the MHC, being able to provide concrete tools and strategies that could be easily integrated during a home visit and with the HFO model, allowed her to quickly demonstrate ways she could support the team and meet their needs.

Home visitors also noted that the introduction of specific EC PBIS materials also helped build initial trust in the MHC, seeing the immediate and positive impact of using these tools with families.

Office hours were not as productive as being available on an as-needed basis by phone, text, and email. Initially, the MHC had set regular office hours to meet with home visiting staff, but learned quickly that home visitors were more likely to connect with the MHC on an "as needed" basis with emergent issues as they arose.

EC MHC-EC PBIS with home visiting programs benefits staff in multiple ways, from their professional development, knowledge, confidence, and work with families, as well as on a personal level, to better manage stress and strengthen self-care.

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Endnote

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