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Infant and Early Childhood Mental Health Consultation

Michigan's Model for Infant and Early Childhood Mental Health Consultation in Home Visiting

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Adapted from Delimata, L. & Mackrain, M, 2011

MDHHS
Michigan Department of Health & Human Services

Michigan's Model for Infant and Early Childhood Mental Health Consultation in Home Visiting

For more information visit: https://michiganiecmhc.org/iecmhc-in-home-visiting/ or email MDHHS-IECMHC@michigan.gov

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Background and Acknowledgments

Background

In 2021, the development of Michigan's Infant and Early Childhood Mental Health Consultation (IECMHC) in Home Visiting model was made possible through an intentional partnership between the Michigan Department of Health and Human Services' Public Health Administration, Home Visiting Section, and the Bureau of Children's Coordinated Health Policy and Supports (the Bureau). Leaders in the Home Visiting Section had identified a growing need to address the relational and social–emotional challenges families were facing in home visiting programs—particularly as home visitors increasingly supported families navigating complex trauma, maternal depression, substance use, and other stressors. At the same time, the Bureau had a strong history of investing in IECMHC across child care and early education settings.

Recognizing their complementary strengths, the two groups came together to maximize impact: public health leaders contributed their deep connections to home visiting and maternal and child health, while the Bureau brought established infrastructure, workforce development, and reflective practice supports in IECMHC. This collaboration laid the foundation for Michigan's model of consultation in home visiting.

The Family First Prevention Services Act (FFPSA) provided a timely and flexible funding mechanism to bring this partnership to life to support mental health within home visiting. FFPSA allows states to use federal resources to expand evidence-based prevention services for families at risk of child welfare involvement. By directing a portion of FFPSA funds toward IECMHC in home visiting, MDHHS advanced a preventive, upstream strategy that helps stabilize families, supports parent–child relationships, and reduces the need for more intensive interventions. This use of FFPSA funding positioned IECMHC not as an add-on service, but as a core prevention strategy within Michigan's child welfare continuum.

Through this approach, the Public Health Administration's Home Visiting Section leads the integration with home visiting programs, ensuring that consultation activities are responsive to model requirements and maternal and child health outcomes. Meanwhile, the Bureau provides consultation infrastructure and reflective supervision to the consultant workforce. The result is a sustainable cross-agency initiative that strengthens the capacity of home visiting programs, supports the well-being of families, and aligns with state and federal priorities for prevention and early intervention.

Drawing on cross-system conversations, lessons learned from other states (including Illinois and Delaware), and Michigan's own history of providing IECMHC within early care and education, the state created an initial service model for IECMHC in the home visiting context (Delimata & Mackrain, 2021). Implementation began in select home visiting programs, with consultants providing reflective consultation to supervisors and home visiting staff, testing a flexible menu of activities, and entering consultation data into a statewide system. Feedback from supervisors, home visitors, and ongoing input from Michigan's consultants and program leaders has informed this adapted 2025 version of Michigan's IECMHC in Home Visiting model.

Current Model Summary

Michigan's Home Visiting model continues to support a relationship-based, prevention-oriented support for supervisors and home visitors. It provides structured opportunities for reflection, skill building, and consultation while keeping families at the center. Core components include:

- Reflective consultation with supervisors to embed reflection into leadership and sustain a reflective culture.
- Case and group consultation with home visitors to support staff in exploring emotions, perspectives, and strategies related to their work with families.
- Training on infant and early childhood mental health and related topics, woven into reflective conversations and responsive to program needs.
- Joint home visits, when appropriate, with family consent, to strengthen home visitor skills in real time.
- Participation in statewide data tracking, reflective supervision, and communities of practice to ensure fidelity and shared learning.

The model emphasizes that IECMHC is not direct therapy for families, but an indirect, capacity-building support that enhances the effectiveness of home visiting programs and improves outcomes for Michigan's youngest children and their families. For more on what IECMHC in Home visiting "is and Is Not" see the *Model Handout* section of this guide.

Critical enhancements to this model include deepening the detail around system leadership and funding structure, the consultant role, infrastructure and accountability, service delivery, and consultant qualifications and supports. Additionally, new tools and templates have been added to the model to enhance implementation. These changes provide a clear framework for consistency and fidelity to the model, while also allowing flexibility to meet the unique needs of diverse communities and individuals.

Acknowledgments

This revised model reflects the dedication and insight of many partners whose contributions were invaluable. Special thanks to:

- Community mental health agencies, partners, and consultants, who piloted the approach and shared invaluable insights including;
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- The families served by Michigan's home visiting programs, whose experiences underscore the importance of strengthening relational health in the earliest years.

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This model represents a collaborative effort across systems, disciplines, and communities. By investing in reflective practice and mental health consultation, Michigan honors the work of home visiting supervisors and home visitors and affirms the central role of parent–child relationships in building strong, resilient families.

Mary Mackrain

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Part 1:

INTRODUCTION TO INFANT AND EARLY CHILDHOOD MENTAL HEALTH CONSULTATION IN HOME VISITING

The Importance of Early Relationships and Defining Infant and Early Childhood Mental Health

Every family deserves the support they need to experience healthy, nurturing relationships. Yet many families face significant challenges—such as social, racial, cultural, and economic inequities—that can place stress on parents, caregivers, and their children. These stressors often affect relational health, or the ability to feel emotionally connected and supported in close relationships.

Early relational health is "the state of emotional well-being that grows from the positive emotional connection between babies and toddlers and their parents and caregivers when they experience strong, positive, and nurturing relationships with each other" (Center for the Study of Social Policy). When caregivers and children experience consistent, loving, back-and-forth interactions, they develop the emotional foundation needed to buffer stress, heal from adversity, and thrive. Additionally, these early relationships impact the well-being of caregivers. When caregivers experience warm, responsive connections with their young children, they often feel more confident, capable, and fulfilled in their parenting role. These positive interactions can buffer caregiver stress, promote mental health, and strengthen a sense of hope and resilience. Just as children thrive in the context of secure relationships, caregivers, too, are nurtured and sustained by the bonds they build with their infants and toddlers.

However, structural racism, gaps in supportive policies, and systems that are difficult to navigate too often make it hard for families to access help that meets their needs (Nurture Connections, 2022).

For babies and young children, these nurturing early relationships are the building blocks of infant and early childhood mental health (IECMH). IECMH refers to the developing capacity of children from birth to age five to:

- experience, regulate, and express emotions;
- form secure and trusting relationships with caregivers and others; and
- explore and learn within the context of family, community, and culture (Zero to Three).

This definition highlights that IECMH is not just the absence of problems—it is about the presence of strong, supportive relationships that fuel every aspect of a young child's growth. Healthy social-emotional development in early childhood shapes later outcomes in learning, resilience, and overall well-being. Research shows that children who experience warm, responsive, and consistent care are more likely to form secure attachments, succeed in school, and manage life's challenges (Connell & Prinz, 2002; Pianta et al., 1997). Conversely, when these supports are absent, children are at higher risk for difficulties such as anxiety, depression, and other long-term health concerns.

National data remind us of the scale of these challenges. From 2016 to 2021, the prevalence of mental, behavioral, and developmental disorders (MBDDs) among children ages 3–17 rose from 25.3% to 27.7%—with notable increases in anxiety, depression, learning disabilities, developmental delays, and speech or language disorders (Center for Disease Control and Prevention). The risks increase when families face multiple adversities, such as poverty, caregiver stress, or exposure to trauma. The more risk factors a child or caregiver faces, the greater the potential for poor mental health outcomes and strain on the caregiver–child relationship.

Without timely support, these early challenges can have lifelong consequences for children's health, relationships, and learning. Unfortunately, many families encounter barriers when seeking help for their young child. These barriers include stigma around mental health, lack of awareness of IECMH, a shortage of trained providers with expertise in early childhood, complicated paperwork and system navigation, and funding policies that do not adequately recognize the unique mental health needs of very young children.

Infant and Early Childhood Mental Health Consultation (IECMHC) is one important strategy to address these barriers. By bringing mental health expertise into the settings where young children and families learn and grow, IECMHC strengthens the capacity of caregivers, teachers, and home visitors to support children's social and emotional well-being, ultimately helping to build strong relationships and healthier futures.

Infant and Early Childhood Mental Health Consultation in Home Visiting

In Michigan, Infant and Early Childhood Mental Health Consultation (IECMHC) in home visiting is defined as a collaborative process that strengthens the capacity of those who provide direct care to infants, young children, and their families. Consultants do this through training, reflective supervision, reflective group learning, case consultation, and, at times, joint visits or crisis response with home visitors as critical issues arise. The focus is always on building the capacity of staff, families, programs, and systems to prevent, identify, respond to, and reduce the impact of mental health challenges among young children and their caregivers.

IECMHC is a prevention-based, indirect support for home visiting programs. It is not:

- A direct mental health service or treatment (such as therapy or counseling for families)
- A service that requires diagnosis
- A helpline staffed by a mental health professional
- A one-time training series without follow-up or ongoing support
- A coaching service tied only to a single curriculum, assessment, or model

By integrating an IECMH consultant's perspective into home visiting, mental health knowledge becomes a normal and expected part of family support, helping reduce the stigma often associated with mental health. At the state and local levels, consultants help home visiting programs strengthen their partnerships with early childhood and mental health systems, connect with stakeholders, and link families to a wider range of services. This integration creates both immediate and long-term benefits.

Benefits of IECMHC in Home Visiting

- Increased capacity of home visitors to recognize needs, respond effectively, and connect families with mental health supports
- More complete and accurate social-emotional and developmental screening practices
- Reduced stress and turnover among home visitors
- Improved caregiver–child relationships, interactions, and overall family engagement
- Enhanced social and emotional well-being for both children and their caregivers
- Easier access to mental health providers for home visitors, supporting smoother referrals and stronger care coordination
- Increased access for families to community providers, with consultants helping navigate referrals and transitions to treatment or support
- Stronger team relationships within home visiting programs and improved collaboration with other service providers

Examples of how consultants support home visiting programs include:

- Strengthening policies and procedures for supporting and linking families to mental health services
- Building home visitor confidence and skills in recognizing, interpreting, and responding to children's and families' mental health needs
- Assisting home visitors in supporting families to create emotionally safe, nurturing home environments that promote children's learning and growth
- Providing regular opportunities for supervisors and home visitors to reflect on their work, process strong emotions, and build resilience in the face of complex family needs

Home visiting providers—and other early childhood professionals—are in a unique position to notice mental health needs early, strengthen caregivers' ability to meet their child's social and emotional needs, and connect families to services when needed (Zero to Three Policy Center, 2004). Yet, providers often report that they do not feel adequately prepared to address these challenges. For this reason, IECMHC is a critical strategy in Michigan for improving the social-emotional and mental health outcomes of infants, toddlers, and their families (Center for Prevention Research and Development, 2011).

Evidence-Based Home Visiting Models in Michigan

It is important for IECMH consultants in home visiting to be familiar with the evidence-based home visiting models used across Michigan. Each model has unique activities and requirements that shape how home visitors work with families and what they bring to reflective consultation. By understanding these models, consultants can better appreciate the demands on home visitors and the supports—such as observation, curiosity, and responsivity—that each model is designed to cultivate.

Most home visiting models include key elements such as reflective supervision for home visitors, regular team meetings, and time for professional development. These requirements directly enhance the capacity of IECMH consultants to provide meaningful and effective consultation. Programs may choose to implement a single model, or, depending on workforce, funding, and other resources, they may match families with the model that best meets their needs.

Because consultation is always shaped by program context, seeing the models side by side helps consultants understand both the commonalities and the unique features they will encounter in practice. In Michigan, several models currently receive IECMHC support. These are outlined in Table 1 below.

Table 1. Snapshot of Model Types

Model	Who is Eligible	Focused Population for the Model	Program Description	Visit Frequency
Family Spirit	American Indian/ Alaska Native families from pregnancy through age 3	◆ American Indian/Alaska Native families (primarily, but adaptable to others) ◆ Expectant and new mothers (especially adolescents and young adults) ◆ Families with limited access to culturally relevant health care and parenting education ◆ Those facing intergenerational trauma, poverty, or behavioral health risks	Evidence-based home visiting program led by paraprofessionals focusing on American Indian/Alaska Native families, addressing parenting, substance use, and life skills.	Weekly during pregnancy and infancy; less frequent as child grows
Healthy Families America	Families with children under age 5, especially those at risk for adverse childhood experiences	◆ Expectant families or families with a newborn under 3 months old ◆ Families identified with high stress or risk factors, such as: • Low income • History of trauma or adverse childhood experiences (ACEs) • Young or single parents • Limited social support	Strength-based model providing family support and parenting education with services beginning prenatally or at birth.	At least weekly in early stages, tapering based on family needs

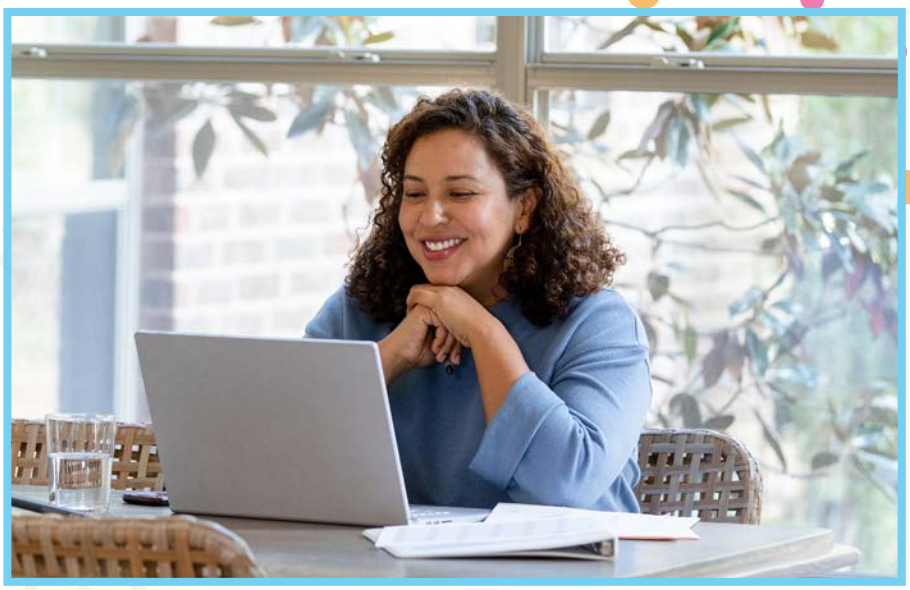
Model	Who is Eligible	Focused Population for the Model	Program Description	Visit Frequency
Nurse-Family Partnership	First-time, low-income mothers, beginning early in pregnancy	First-time mothers who are: ◆ Low-income ◆ Pregnant (must enroll before 28 weeks gestation) ◆ Often young (many participants are teen mothers) ◆ Services are provided from early pregnancy through the child's second birthday	Nurse-led program that empowers first-time mothers to create better futures for themselves and their babies.	Weekly or bi-weekly visits starting in pregnancy through child's second birthday
Parents as Teachers	Families with children prenatal to kindergarten entry	Expectant parents through kindergarten entry (ages 0–5) Universal model that can be adapted for: ◆ Families at risk for developmental delays ◆ Families with low income or education ◆ Families seeking school readiness support	Parent education model supporting parents in promoting early development and school readiness.	Typically monthly, but can be more frequent depending on family needs

Summary

Part 1 highlights the central role of early relationships in shaping infant and early childhood mental health (IECMH) and underscores the importance of integrating Infant and Early Childhood Mental Health Consultation (IECMHC) into Michigan's home visiting programs. Strong, nurturing caregiver–child interactions provide the foundation for children's social, emotional, and cognitive development while also supporting caregiver well-being. Yet many families face barriers—such as inequities, stigma, and limited access to specialized services—that can compromise these relationships. IECMHC offers a preventive, capacity-building strategy that strengthens the skills and confidence of home visitors and supervisors, reduces staff stress, and improves outcomes for children and families. By understanding the evidence-based home visiting models used across Michigan, consultants are better able to tailor their support, promote reflective practice, and foster healthier, more resilient families and communities.

The reflective questions below are designed to help you pause, think, and connect the content of Part 1 to your own role and experiences. You can use them in several ways:

- **Individually:** Take time after reading to jot down your responses. Consider how your answers highlight your strengths and where you may want to grow.
- **With a Supervisor or Mentor:** Share your reflections in supervision or consultation to deepen learning and receive support.
- **With a Team:** Use the questions to spark conversation during staff or peer group meetings, noticing similarities and differences in perspectives.



Reflective Questions

For Consultants

- How do I or will I communicate the difference between consultation and direct mental health treatment when working with home visitors or families?
- In what ways am I modeling curiosity, observation, and responsivity in my consultation practice?
- How do I create a reflective space that honors both the challenges and the strengths that home visitors bring from their program model?
- What strategies do I use to stay grounded and supported when navigating complex family or program needs?

For Supervisors Supporting Consultants

- How do I help consultants feel supported in clarifying their role and avoiding role confusion?
- What structures (e.g., reflective supervision, peer consultation) do I provide to ensure consultants sustain their own reflective practice?
- In what ways do I foster and parallel the collaboration needed between consultants, supervisors, and home visitors to strengthen team relationships?

Next Steps:

Watch our Michigan videos to learn more about IECMHC and see the services in action!

https://michiganiecmhc.org/iecmhc-in-home-visiting/

Part 2:

MICHIGAN'S INFRASTRUCTURE AND CONTRACTUAL OBLIGATIONS FOR INFANT AND EARLY CHILDHOOD MENTAL HEALTH CONSULTATION

State Leadership

Developing a clear, sound, and systematic infrastructure for the delivery and support of IECMHC programming statewide helps MDHHS ensure services are well organized, high-quality, stable, and accessible. As stated in From Neurons to Neighborhoods (Shonkoff & Phillips, 2000), early childhood policies and procedures are often fragmented, with complex and confusing points of entry. This makes it difficult not only for those providing services but more importantly for the key stakeholders—families—to understand what is being provided and how to access those services (Mackrain et al., 2011). In Michigan, IECMHC in Home Visiting state-level grant management is provided by a partnership between MDHHS Bureau of Children's Coordinated Health Policy and Supports (implementation oversight) and Administration for Public Health, Home Visiting Section (fiduciary and partner).

Oversight of contracts is administered by MDHHS staff, specifically the Early Childhood Coordinator. The Early Childhood Coordinator is an avid champion for early childhood mental health at the state level and is actively involved in negotiating and managing contracts, budgets and quarterly reporting and works collaboratively with the other state-level staff. Two state-level consultants—an IECMHC in Home Visiting Program Director and an IECMHC in Home Visiting Reflective Supervisor, collaboratively with the Early Childhood Coordinator to provide day-to-day monitoring, direction and reflective support to the current cadre of consultants.

Figure 1. State Leadership

Supervision and Accountability Roles

Consultants supporting home visiting programs are either (1) a provider that is part of a Community Mental Health Service Provider Agency that contracts directly with MDHHS to provide the services locally, or (2) individual consultants who are contracted through the Michigan Public Health Institute (MPHI) on behalf of MDHHS.

Community Mental Health Service Providers (CMHSPs)

CMHSP's are responsible for providing administrative and reflective supervision support to consultants as part of the contract requirements. This includes a requirement that they complete accurate quarterly reports for MDHHS within the Electronic Grants Administration and management system (egrams) system. Egrams is a password-protected, web-based system used by MDHHS to manage its outgoing grant agreements. Accurate completion of quarterly reports should include careful review of the consultants recent data and discussion with the direct IECMHC supervisor and consultant about each required outcome as the Bureau uses egrams to monitor and manage contracts.

Consultants are required to attend several T/TA supports (annual retreat, monthly Community of Practice sessions, and virtual quarterly meetings with the Project Director and Reflective Supervision Lead). Contact the Program Coordinator to ensure you have the dates in your calendar.

Additionally, CMHSP's are required to provide a minimum of two hours of Reflective Supervision monthly for the IECMH consultant. If a consultant is in a combined role, such as infant mental health clinician and an IECMHC, it is important that the Reflective Supervisor assures the home visiting consultation is explored regularly. Consultants working through a CMHSP can also get additional Reflective Supervision and/or Case Consultation through the state-level Reflective Director/Lead. For the first six months of consultation, the consultant will meet with state-level Reflective Director/Lead monthly and thereafter monthly consultation is optional.

Individual Consultants

Consultants who work through the Michigan Public Health Institute are responsible for completing quarterly reports to MPHI by the dates specified in their contracts. Additionally, consultants enter required and accurate data into the IECMHC data system at least monthly and attend required support (e.g., annual retreat, monthly Community of Practice and quarterly meetings with the Project Director and Reflective Director/Lead). Additionally, if consultants do not have Reflective Supervision access, they will meet for a minimum of two hours with the state-level Reflective Director/Lead to meet contract obligations. Consultants can also request this consultative support as needed.

Accountability

CMHSP administrators and consultants are accountable for bringing barriers and any implementation issues to the state director in a timely manner to ensure quality of services to home visiting recipients. In the case where the state director sees areas for growth or improvement, ideas will be discussed at quarterly meetings or in individual discussions between meetings in partnership with the consultation/program team to ensure timely resolution. In the case that improvement plans are not adhered to and services are either not meeting fidelity or contract obligations, a program may be put on a corrective action plan.

Staffing Guidelines

Qualifications and competencies of home visitors and supervisors

To meet fidelity to Michigan's Department of Health and Human Services model and to provide the level of services necessary, an IECMH consultant must have qualifications, education, skills, attributes, and experience to adequately provide supports to the home visiting programs. These include:

Qualifications of an IECMH consultant in Home Visiting

Infant Mental Health Endorsement as an Infant Family Reflective Supervisor (IFRS), Early Childhood Family Reflective Supervisor (ECFRS), Infant Mental Health Specialist (IMHS) or Early Childhood Mental Health Specialist (ECMHS). IMHS or ECMHS preferred. Applicants who have not become endorsed in one of the categories listed above, will have a grace period of 12 months to become endorsed. See Appendix A for MI-AIMS's IMH Competencies.

- An advanced degree in mental health such as Social Work, Counseling, Psychology, Marriage and Family Therapy, and Psychiatry; also Nursing or Child Development (specifically infant/early childhood) with additional education in infant and early childhood mental health required
- A minimum of 2-5 years' experience in areas related to infant and early childhood development or child and family related experience, and providing mental health services
- Receipt of 1-3 years of Reflective Supervision in a 1:1 or group setting
- A demonstrated ability to engage in reflective practice and maintain a consultative stance with a minimum of 1 year of providing reflective consultation preferred.

IECMH consultant skills and attributes:

Infant and early childhood mental health consultants can come from a variety of disciplines—for example, infant mental health, psychology, social work, or counseling (Kaufman, et al., 2013). Typically, IECMH consultants will hold a minimum of a master's degree in a related field and possess content knowledge of infant and early childhood mental health, child development, and relationship-and evidence-based practices. In addition, consultants will seek to have knowledge of and understand:

- Early childhood programs and community resources
- Knowledge of home visiting programs
- Understanding of the consultative stance
- Culture and cultural influences
- Implicit bias and equity considerations such as access to care
- Adult learning principles
- Specialized knowledge and skills related to the position, including understanding early childhood development, family systems, the impact of stress and trauma on family functioning, family mental health, substance misuse, the impact of domestic and community violence on mental well-being, and the relationship between adult mental illness and infant social and emotional development.

Since IECMHC builds the capacity of adults to recognize and understand the powerful influences of relationships and environments on young children's development, it's important for IECMH consultants to be able to build positive relationships with providers, program staff, and families (Duran, et al., 2009). Some ideal consultant attributes, as outlined in Duran et al. (2009), include:

- Respectful, values others' opinions
- Open-minded/non-judgmental, accept people for who they are
- Reflective
- Flexible, will adjust schedules and modify strategies as needed
- Approachable/easy to talk to
- Good listener
- Trustworthy
- Compassionate/empathetic
- Team player
- Reliable/dependable
- Self-motivated
- Positive/upbeat
- Patient, recognizes that change takes time
- Persistent, does not give up if there is resistance to change
- Loves children, shares the "children come first" mentality
- Warm/people person

Along with these skills, attributes and qualifications, it is equally important to understand the consultant's role in Michigan's home visiting programs—how consultants partner with home visitors, what supports they provide, and how their work strengthens both staff and family well-being

The Roles of IECMH Consultants and Home Visitors

Home visiting programs are designed to strengthen families and support the healthy development of very young children. To do this well, both the home visitor and the IECMH consultant play distinct but complementary roles.

Home Visitors

Home visitors focus on the caregiver–child relationship, knowing that responsive, nurturing interactions are the foundation for children's growth. Their work spans multiple systems—including public health, child welfare, early education, and infant mental health—and they come from diverse training backgrounds such as nursing, early childhood, and human services.

In practice, home visitors:

- Build trusting, multi-generational relationships with families.
- Support parenting practices, child health and development, and family goals.
- Conduct screenings for maternal depression, substance use, intimate partner violence, and child development.

Because they are often not trained in mental health, home visitors can feel uncertain or overwhelmed when families face complex challenges. This is where the **IECMH consultant** steps in.

IECMH Consultants

Consultants do not work directly with families. Instead, they partner with home visitors to build their capacity to recognize and respond to mental health needs. Through reflective consultation, professional development, and case-specific guidance, consultants provide an added layer of support that strengthens both home visitors and the families they serve.

Consultants help home visitors:

- Think through next steps when screenings raise concerns.
- Process their own reactions and maintain objectivity.
- Slow down, reflect on family stories, and plan thoughtful, effective responses.

Working Together

The partnership between home visitors and consultants ensures that programs are better equipped to address the complex realities families face. Home visitors bring the deep, ongoing relationships with families, while consultants bring expertise in infant, child, and adult mental health. Together, they create a powerful support system that promotes resilience, healthy development, and well-being for both children and caregivers.

To get a deeper look at what the partnerships and day to day work of consultants looks like, review the Daily Experiences with a Mental Health Consultation in Home Visiting Stories in Appendix B.

These stories were authored by Michigan consultants in 2025.

Workforce Development and Supports

A strong and well-supported workforce is the foundation of effective IECMHC in home visiting. Consultants need clear structures for reflective supervision, ongoing training, and connection to peers and statewide resources. They also benefit from intentional links to other programs and community services that strengthen the support available to families. By investing in supervision, training, evaluation, and continuous quality improvement, Michigan ensures that consultants have the tools, guidance, and relationships they need to sustain this complex work and deliver meaningful impact for children, families, and programs.

Reflective Supervision for the IECMH Consultant

Reflective supervision is foundational to Michigan's IECMHC work. It has been a cornerstone and a requirement of our IECMHC programming since its inception in child care in the mid-1990s. The official requirement for the MDHHS Michigan Model in Home Visiting is that each consultant receives 1:1 reflective supervision for two hours (at a minimum) monthly. Best practice recommends between 4-6 hours per month with both individual and group supervision, provided by the agency supervisor or contracted Reflective Consultant. IECMH consultants need an Infant Mental Health Endorsement as an Infant Family Reflective Supervisor (IFRS), Early Childhood Family Reflective Supervisor (ECFRS), Infant Mental Health Specialist (IMHS) or Early Childhood Mental Health Specialist (ECMHS).

Reflective supervision provides consultants with a safe space to explore their own emotions, concerns, and reactions while providing consultation. Through this process, the consultant will gain insights into their practice, hone their skills, and develop a more profound sense of self-awareness.

Reflective supervision is distinct due to the shared exploration of the parallel process. That is, attention to all relationships is essential, including the ones between the consultant and supervisor, between the consultant and home visitor, and between home visitors and the families that they support. It is critical to understand how each of these relationships affects the others. Finally, there is often greater emphasis on the supervisor/consultant's ability to listen and wait, allowing the supervisee to discover solutions, concepts, and perceptions on his/her own without interruption from the supervisor/consultant. Development of a trusting relationship is paramount for supervision to be impactful and supportive. (MI-AIMH)

The primary objectives of reflective supervision include the following:

- Form a trusting relationship between consultant and supervisor
- Establish consistent and predictable meetings and times
- Ask questions that encourage details about the infant, parent, and emerging relationship
- Remain emotionally present
- Teach/guide
- Nurture/support
- Apply the integration of emotion and reason
- Explore the parallel process and allow time for personal reflection
- Attend to how reactions to the content affect the process
- Support building reflective capacity

Training requirements

At the onset of engaging in IECMHC, all consultants are required to participate in an onboarding process that includes;

- **A kickoff meeting with the state consultants to review contract obligations and to begin establishing rapport.**
- **A multi-session onboarding of the curriculum with the Reflective Supervision Director**
- **A 1:1 orientation to the state database**
- **A virtual or in person meet and greet with the home visiting program supervisory team**
- **Shadowing of a seasoned consultant (optional)**

The consultants will work directly with the state consultant team to arrange dates for all of the above.

Please see our *Consultation Onboarding Checklist* in the Model Handouts Section. Consultants can use this checklist to make sure requirements are met and their entry into the role is clear, consistent, and supportive.

Once services begin, the consultant will attend a minimum of 90% of the monthly community of practice calls to engage in reflective peer to peer dialogue about the work of IECMHC.

Annually each consultant will complete the Michigan IECMH Consultant Self-Assessment Survey of their practices and competencies to help the state team direct T/TA support that meet the needs of the consultant team. A sample of this survey can be found in Appendix C.

Where possible, CEUs and IMH endorsement competencies will be tied to specialized training provided.

Lastly, consultants are required to attend an annual team retreat when offered. This is an opportunity for deep reflection about the work as well as an opportunity for training and coaching directly related to gaps and priorities uncovered in the annual surveys and through requested needs of the active consultant pool.

How to link to other programs

Home Visitors support families who often require extensive supports and services beyond what the home visiting program is capable of providing. Consultants will support program staff in exploring how to make connections with community resources that may support the population served.

Consultants are encouraged to be familiar with programs that are available to infants, young children and their families and to provide guidance to home visitors on making connections as needed. Some of the possible supports would be:

At times, the consultant will offer guidance to home visitors as they access mental health resources for families and children by:

- Offering consultation around challenging family dynamics, trauma, or caregiver stress.
- Helping home visitors support families navigate transitions between home visiting and other services (e.g., from home visiting to infant mental health home-based services).

Data Collection and Evaluation

Key performance indicators and outcome measures

Monitoring and evaluation are vital to determining the success and impact of mental health consultation in Michigan. Monitoring is an ongoing process that looks at the degree to which the program and practices are being implemented as intended. Program delivery should be monitored at multiple levels: program, consultant, and home visitor.

Data variables and periodicity are outlined below. Consultants will use the MDHHS IECMHC online system to report variables monthly. Consultant can use an optional excel tracker to log their data for entry into the system. This example tracker is in the Model Handout Section of this guide.

Data Variables to be reported include –

Demographics at time of entry of the HV program: Consultants enter these for each HV program (case)

- **Program name** (typed in)
- **# of home visitors in program**: Consultant types in number
- **# of families served by program**: Consultant types in number
- **Demographics of HV program**: Geographic region, population race/ethnicity, HV model type, ages served: Drop down choices

Ongoing Activity:

Consultant Activity	Data Variables
Consultant Education and Skills (not an activity)	**Master's Degree** (Yes/No) **Licensure** (Yes/No) **Years of experience** **Attainment and retention of IMH endorsement** (yes/no; levels 1, 2, 3, 4, or "in progress" in a dropdown)
Joint Visit with Home Visitor	This activity will require a consultation log to track each joint visit per family (e.g., Smith family and Jones family have separate logs with separate entries for joint visits; but all under the same home visiting agency that a consultant is working with). Within each joint visit log that is populated (specific to one family), consultants can record: ◆ **Intake/consent form completion date** for each family (completed once per family at the onset of services): select date ◆ **# of coaching minutes** (log minutes over time) - Per home visit with that family ◆ **Strategies used within each joint visit** (check all that apply): Observation, Planning meeting, Assessment, Referral linkage, Other (please identify) ◆ **Reason for each joint visit** - from a dropdown list of reasons: Caregiver mental health concerns, Child social/emotional/behavioral concerns, Other (please list) ◆ **Case closure date** (completed once per family at end of services): select date

Consultant Activity	Data Variables
Reflective Consultation with the HV program manager/supervisor	**Date agreement signed** - select date **# of sessions** - in log format like current contact log where they track it over time; track same as above (+ amount of time, 15 min increments in a dropdown) **Focus of each session**: open ended box (eventually create dropdown once we know common themes)
Reflective case consultation with home visitors (1:1 or group)	Log format to measure **number of sessions by type** (select 1:1 or group for each log entry, questions populate based on selection) **# of HVs attending (monthly)** - dropdown with options 1-20 ◆ **Only for entries where "group" was selected **Topics addressed (monthly)** - from a dropdown box of options ◆ For entries where either 1:1 or group was selected ◆ Options are select all that apply • Parent - HV relationship • Parent-child relationship • Family stressors (e.g., trauma, finances, homelessness) • HV stress/emotional experiences • Programmatic topics (e.g., relationship issues with peers, etc.) • Other: type in
Specialized Mental Health Training	**# of trainings** - consultants can add one entry per training ◆ Log format **# of attendees per training** - dropdown with options 1-20 **Topic addressed** within each training: select all that apply ◆ Maternal/Paternal Depression ◆ Home visitor well-being ◆ Pregnancy & early parenthood ◆ Infant/young child development & behavior ◆ Family relationships & dynamics ◆ Attachment, separation, trauma, grief, and loss ◆ Disorders of infancy and early childhood ◆ Mental & behavioral disorders in adults ◆ Cultural competence ◆ MH Screening & assessment ◆ Intervention/treatment planning ◆ Developmental guidance ◆ Substance Misuse ◆ Other

Annual Program Survey

An annual survey will be sent out electronically by the Administration for Public Health to supervisors and home visitors who are recipients of IECMHC. This survey will help consultants learn more about the impact of consultation work on home visitor and supervisors feelings of confidence and changes to competency in supporting the mental health of infants, young children and families. Results will be shared with the consultant team and will help to drive improvement year to year.

Use of data for quality improvement

The state team will review aggregate and individual consultant data quarterly to

- Look for patterns in service delivery (e.g., underserved regions or programs).
- Identify barriers (e.g., low engagement, high turnover, missed reflective supervision).
- Track changes over time to monitor growth or challenges.

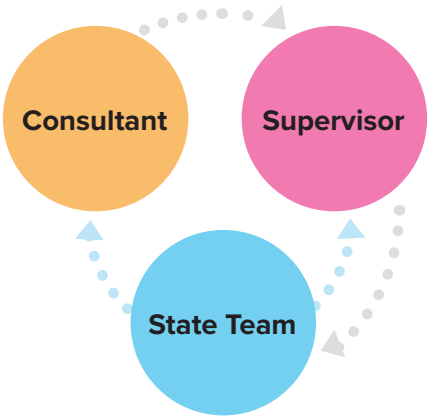
Data results are used to create a learning environment together with consultants and supervisors and to

- Ensure data is used to inform, not penalize.
- Highlight what's working and where additional resources or support are needed.
- Use data in reflective ways: e.g., "What does this tell us about our system's capacity or stress?"

Feedback loops for program adjustments

The state consultants have feedback loops to provide regular, responsive and reflective communication about the quality of IECMHC work.

Loop Level	Example Practice
Consultant to Supervisor	Monthly reflective supervision incorporating review of consultation data.
Supervisor to State Team	Quarterly check-ins with data highlights, challenges, and promising practices.
State Team to Consultants/ Supervisors	Data reports that share insights and trends at a COP or annual retreat and in quarterly team check ins.



Implementation Integrity

Implementation integrity refers to ensuring that Michigan's IECMHC in Home Visiting model is delivered as intended, with fidelity while still allowing room for flexibility to meet the unique needs of programs and communities. Maintaining integrity strengthens the quality, consistency, and credibility of the model across the state.

Key elements of implementation integrity include:

- **Clarity of Roles:** Consultants, supervisors, and home visitors understand their distinct roles and responsibilities within the consultation process.
- **Core Components:** Reflective consultation with supervisors, group and case consultation with home visitors, training, joint visits (when appropriate), and participation in statewide data systems are all implemented consistently.
- **Reflective Practice:** Consultants model reflective practice and ensure that it is woven into supervision, staff meetings, and consultation activities.
- **Ongoing Support:** Home visiting staff receive regular, predictable opportunities for consultation, not just one-time training or crisis response.
- **Data and Feedback:** Consultation activities are documented in the statewide system, and input from supervisors, home visitors, and families is used to guide continuous quality improvement.

Implementation integrity is not about rigid adherence, but about staying true to the core values and practices of the model while honoring the unique context of each program. It ensures that consultation is experienced as a reliable, supportive, and effective partnership for staff, families, and communities. For about fidelity see Part 3 of this guide which covers the core services consultants will provide to home visiting programs.

Summary

Part 2 outlines the infrastructure that supports Michigan's IECMHC in Home Visiting model, ensuring that consultation is consistent, high-quality, and sustainable. State leadership provides clear roles for contracting, program oversight, and reflective supervision, while both community mental health agencies and individual consultants share accountability for meeting requirements and reporting data. Consultants are expected to hold advanced qualifications and endorsement, engage in reflective practice, and build strong, collaborative relationships with home visitors and supervisors. Workforce supports—such as reflective supervision, onboarding, training, and communities of practice—help consultants sustain this complex work. Data collection and evaluation processes track fidelity, outcomes, and quality improvement, while implementation integrity ensures the model remains true to its core values across diverse communities. Together, these structures create a reliable system that supports consultants, strengthens home visiting programs, and promotes positive outcomes for families.

Reflective Questions

For Consultants

- How do I see my role fitting within Michigan's larger IECMHC infrastructure?
- In what ways does reflective supervision support my ability to sustain this work, and what more might I need?
- How do I use data—not just to report requirements—but to reflect on patterns in my practice and the needs of the programs I serve?
- How do I balance fidelity to the Michigan model with the unique needs of each program or community?

For Supervisors Supporting Consultants

- How do I ensure that consultants I support have consistent access to reflective supervision, training, and peer learning opportunities?
- What structures do I have in place to monitor fidelity while still honoring flexibility at the program level?
- In what ways do I create space for consultants to raise challenges and barriers without fear of judgment?
- How do I use evaluation data to inform workforce development and system improvements?

Resources to Dig Deeper

- **Center of Excellence for Infant and Early Childhood Mental Health Consultation.**
  (Georgetown University)
  https://www.iecmhc.org
  Comprehensive resources on IECMHC implementation, including workforce development, infrastructure, and fidelity tools.
- **Duran, F., Hepburn, K., Irvine, M., Kaufmann, R., Anthony, B., Horen, N., & Perry, D. (2009).**
  What Works? A Study of Effective Early Childhood Mental Health Consultation Programs.
  Washington, DC: Georgetown University Center for Child and Human Development.
  A foundational study highlighting effective program structures and workforce practices.

Part 3:

IMPLEMENTING INFANT AND EARLY CHILDHOOD MENTAL HEALTH CONSULTATION IN HOME VISITING IN MICHIGAN

This section offers practical guidance on how Infant and Early Childhood Mental Health Consultation (IECMHC) is carried out within Michigan's home visiting programs. It outlines the core elements of reflective consultation, describes the different ways consultants can partner with supervisors and home visitors, and provides strategies for entering and sustaining relationships with programs. The goal is to show how consultation can be integrated into the day-to-day work of home visiting in ways that are predictable, collaborative, and grounded in reflective practice.

Reflective Consultation

Through the parallel process a consultant supports an infant and their family without ever sharing space with them. This is done indirectly by supporting the program leads and/or home visitor who then supports the family. The consultant does this by meeting regularly with the program leads and home visiting staff to provide an opportunity for reflection on their experiences with infants and families. This is an opportunity for team members to reflect on their feelings and thoughts about a certain infant and their family or evocative topics. The consultant holds space for that experience and wonders about alternative perspectives, diversity and cultural considerations.

Outlined below are reflection, collaboration, and predictability/regularity—three essential elements of the supportive relationship the IECMH consultant offers to the home visiting staff.

Reflection

is the ability to step back and consider the work from multiple perspectives. This is what the consultant is aiming to foster through Reflective Consultation. This is done by supporting the home visitor/supervisor in exploring their own thoughts, feelings and observations about interactions with the family. The consultant should introduce alternative perspectives through direct questions, wondering and expressing their own observations.

Collaboration

refers to the participation needed between consultant and home visitor or supervisor for the consultation relationship to flourish. This is an integral part of each element of the service the consultant provides to the program but is especially important to Reflective Consultation. This might look like the consultant joining already scheduled meetings or establishing a new meeting time based on what works. The consultant and the home visitor or supervisor are working together to build the program's reflective capacity; this is a partnership.

Predictability/regularity

refers to the routines and frequency of services the consultant provides to create a space where there is adequate interpersonal safety to allow home visitors/ supervisor to engage authentically. This allows consultants and home visitors/supervisors to explore strengths, weaknesses and underlying problems in the work. Consultants establish predictability by having a consistent schedule for meetings agreed by the consultant, home visitor and supervisor. It is important for consultants to be mindful about making changes to established meetings and do this only when no other options are available. Regularity in meetings is important for staff to know they will have a consistent time for Reflective Consultation, not on an as needed/drop-in basis. Predictability also refers to the consultant running meetings with the same structure each time. This allows home visitors/supervisors to know what to expect from the consultant and what their role in the meeting will be.

The IECMH Consultant may provide Reflective Consultation in a variety of settings including:

- One-on-one session with the program manager/supervisor
- Sessions including program manager/supervisor with an individual home visitor
- Group sessions with several home visitors, or with the full team of home visitors, managers, and supervisors
- One-on-one with an individual home visitor

Each of the approaches are explained in more detail below.

Reflective Consultation One-on-One with Program Manager/Supervisor:

Consultant will use skills and strategies discussed in the Reflective Consultation overview when meeting with the supervisor/manager. It is imperative to build this relationship as much as possible before beginning consultation with staff. The consultant should be mindful of supporting the supervisor in reflecting on their thoughts and feelings related to the work, families and staff. The one-on-one Reflective Consultation meetings are essential to building the relationship with the supervisor, clarifying the differences between consultation and supervision, planning for group reflective meetings and reinforcing the supervisor's ongoing commitment to the consultation process. Consultants should think of the relationship with the supervisor as a partnership for supporting the reflective capacity of the program. This is an essential step that helps to sustain the work by promoting reflective practice within supervisory activities.

Common areas a consultant might hold space for during one-on-one meetings include:

- administrative and direct service aspects of the supervisor's role
- problem solving
- exploring staff interactions
- other specific skills and knowledge that the consultant brings that would best meet the needs of the program

The consultant can provide capacity development for the supervisor in areas such as Reflective Supervision (that they would offer to their own staff), leadership, trauma-informed practices, and implicit bias. Examples of reflective questions to use with supervisors can be found in the Appendices. Following Reflective Consultation with a supervisor, it is important for the consultant to reflect on what topics were the focus of the meeting. Common focuses of such meetings that are found in the IECMHC database include:

- team relationships
- supervisor/supervisee relationships
- supervisor experiences affecting the work
- supervisor stressors
- cultural humility/implicit bias
- adult mental health
- linkage to supports for home visiting
- trauma/loss/grief
- boundaries
- decision making
- community stressors

It is also important to reflect on what follow-up (mainly by the consultant) is needed prior to the next meeting. Examples might be revisiting the topic, looking for a community resource, or gathering written resources for the supervisor.

Reflective Consultation/Reflective Supervision with Program Manager/Supervisor and Home Visitor Together:

One option for the IECMH providing support is that the supervisor and consultant work together to provide Reflective Consultation (something the IECMH consultant offers) to the individual home visitor. This option is helpful in developing or enhancing the skill and confidence of supervisors who may have less experience in providing Reflective Supervision (something the supervisor must provide to his or her home visitors). The supervisor may lead Reflective Supervision sessions with the consultant providing support, or the consultant may lead Reflective Consultation sessions with the supervisor providing support. Either may join in already scheduled session to reduce the burden of additional meetings for the supervisor and home visitor to attend. Whether the supervisor or consultant leads the session, this option gives the opportunity for the consultant and supervisor to reflect outside of these support sessions about their thoughts and questions for the home visitor, points in which they felt stuck, common themes that are observed, or missed opportunities to explore a topic further.

Reflective Consultation with an Individual Home Visitor

As the process of Reflective Consultation with individual staff begins, there should be conversation between the consultant, program manager/supervisor, and home visitor to establish clear boundaries and expectations around this work. Careful consideration should be given to define the difference in relationships between the consultant/home visitor and the supervisor/home visitor. The consultant's Reflective Consultation with individual home visitors should be supportive of the supervisor's work with the home visitor as well as supportive of the supervisor's growth of their own Reflective Supervision skills. There should be discussion around the difference between administrative supervision and Reflective Supervision, and a clear expectation about what time and space is held for Reflective Supervision.

Since it is not always feasible or desired by supervisors to participate in each of the Reflective Consultation sessions with the consultant and home visitors, there is the option for the consultant to provide Reflective Consultation individually with the home visitor, without the supervisor in attendance. This option requires further discussion between the consultant, supervisor, and home visitor regarding times in which topics may need to be addressed with the program supervisor and ways in which the consultant and supervisor can support the home visitor with consistency and good boundaries between all three parties. In this scenario, a consultant will find times during reflective case consultation when they must say, "I'd like for us to share this information with your supervisor." The consultant and home visitor can discuss who will share that information and how, as well as the importance of ensuring that certain important information, such as pertinent client information, is consistently communicated with the supervisor.

Similar to the topics discussed during group Reflective Consultation, individual sessions with home visitors should focus on the home visitor's understanding of the family dynamics, needs, and strengths of families they are working with. They should also explore feelings that are elicited in the home visitor in the context of their relationships with the families. This is also an opportunity for further exploration and discussion around how the home visitor can proceed with a family if they are feeling stuck, as well as supporting and enhancing their understanding of factors impacting the family, such as mental illness, substance abuse, poverty, interpersonal violence, and more. Further, there should always be emphasis on the ways in which diversity (e.g., race, ethnicity, religion, sexuality, worldview, socioeconomic status, etc.) impacts all the relationships between consultant, supervisor, home visitor, and family

Reflective Consultation with a Group of Home Visitors or the Full Team

Like Reflective Consultation with individual staff, the consultant works with the supervisor and the staff. Sessions can occur regularly, typically monthly. Pragmatic factors to consider when starting a group include the number of participants (typically 8-10 participants), whether it will be in person or virtually, and the duration of the group session. If the groups occur virtually, participants should ensure they have a private space, typically keep cameras on, and each join on their own device. Consultant should work with the staff and supervisor to establish the group shared agreements as they initiate this reflective work. The agreement should be a living document that is reviewed when there are new members and/or annually to ensure that they meet the needs of the group. Examples of shared agreements to consider can be found in the Appendices.

The consultant will explore ways to deepen reflection, while holding the reflection space as a way of being vulnerable within the group in mind. One way to facilitate growth in reflective ability is to suggest journaling. Often staff members present cases for discussion (referred to as Case Consultation). The parallel process also applies to this type of Reflective Consultation. The consultant helps the group to wonder aloud, thinking about the meaning of behaviors. The home visitors are encouraged to hold steady, observe, and wonder with their colleagues like they would with their clients (parents/families), as opposed to problem solving and finding a "solution." The consultant may use reflective questions to promote discussion and reflection. Concerns that arise during the group sessions may be further explored in individual sessions. Visit the Appendices for a resource on how to enhance reflective functioning.

Activities and Techniques Applied During Reflective Consultation

Personal reflection:

There are many different topics that arise when reflecting with the consultant. Some of the topics are based on what is surfacing for the consultee during the time together. The consultee will spend time prior to the meeting thinking about what she or he might want to talk about during the consultation. This is a safe place where the individual can reflect on any concern, question, thought, fear, wondering, or feeling that arises during their work. The consultant can listen, think through this together with the consultee, and help them strategize.

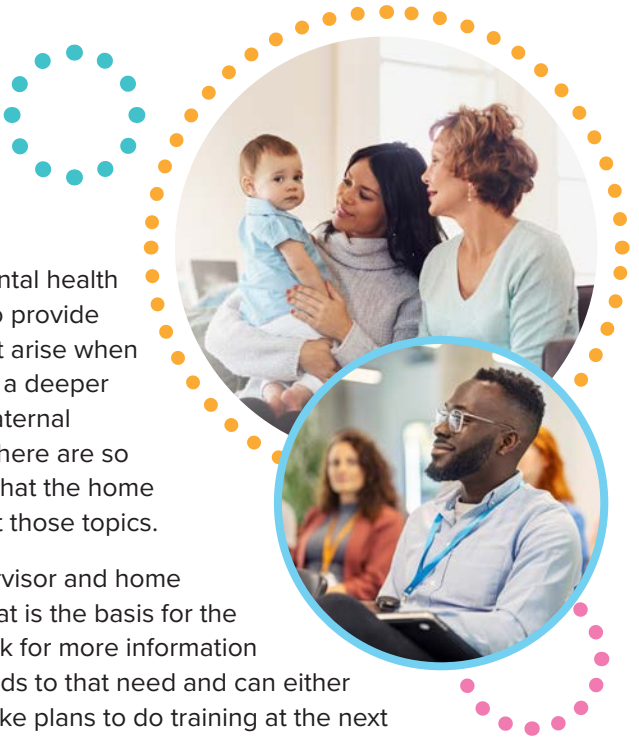
Case Consultation:

Similar to Reflective Consultation, Case Consultation can be done with supervisors/program managers, individual home visitors, and groups. There is often a natural flow between Case Consultation and Reflective Consultation with a portion of conversations focused on consideration of the work with an identified family (i.e., Case Consultation) and the home visitor or supervisor's thoughts and feelings related to the work with the family (i.e., Reflective Consultation). Like with Reflective Consultation, there is a parallel process of the consultant supporting the supervisor/program manager and/or home visitor as they support the parent/caregiver as the parent/caregiver supports the child.

Tasks of Case Consultation might include:

- A supervisor or home visitor presenting the details of a family they are working with
- Discussion of the family's pertinent history
- Discussion of pertinent cultural factors
- Strengths and challenges for the family
- Questions the supervisor or home visitor have about how to work with the family
- Strategies the home visitor could try using with the family
- Informal, in-the-moment mental health training by the consultant

While specialized mental health training often happens in pre-planned meetings where the consultant prepares training on a specific topic for the program, Case Consultation provides an additional opportunity for the consultant to expand the home visiting staff's understanding of the complex factors that impact the child and family, including cultural factors, attachment relationships, substance misuse, and mental illness. Home visiting staff are encouraged to consider the deeper meaning of behavior and how the family's personal beliefs and experiences contribute to their current strengths and challenges. While Reflective Consultation avoids focus on "solutions," Case Consultation can include concrete ideas and strategies the home visitor can try using with the family. Visit the Appendices for more resources on Case Consultation.



Specialized training:

IECMH consultants have knowledge of infant and early childhood mental health and social and emotional development that uniquely qualifies them to provide support to home visitors as they navigate mental health concerns that arise when working with families. At times, consultants may be prompted to offer a deeper understanding of additional mental health-related issues including maternal depression, substance use, and intimate partner violence. However, there are so many other aspects that arise while doing the work of home visiting, that the home visitors can ask the IECMH consultant to help share information about those topics.

The topics of the training will most often come directly from the supervisor and home visitors. They mention the concerns that they are dealing with, and that is the basis for the training opportunities. As a home visitor presents a case, they may ask for more information on whatever is causing concern for that family. The consultant responds to that need and can either provide support on that topic right then during the consultation or make plans to do training at the next team meeting. This type of training is natural, comes from the home visitors, and is based on what they are experiencing. The information shared is directly in response to the cases the home visitor supports, and questions and ideas can be part of the training. This is very informal but also meets the needs of the program. As consultants support program staff in the use of screening tools it is important to note that the training is not about the screening tool, but how to interpret the tool and what actions may be appropriate after reviewing the information gathered by using the screener. In addition, a more formal request can be made for a general training that will benefit the program. For example, if a program supervisor is concerned that some of the home visitors need information on self-care, as they are experiencing vicarious trauma, they might ask the consultant for a group presentation on that topic and follow up at future team meetings.

Some training opportunities are more formal and are based on the requirements of the training model. There are also resources available to consultants such as power points and handouts on various topics for discussion and/or training. There is also a Community of Practice where consultants meet regularly and can share resources and ideas on training topics.

Joint home visits:

Consultation in home visiting typically takes place with a consultant providing a safe space for home visitors and supervisors to explore cases, reactions and emotions, strategize how to best support a family, and review the progress made with new strategies. Joint home visits are not usually needed, as the home visitor is able to share and guide the process. However, there are circumstances where it might be beneficial to join in a visit with the home visitor. Careful consideration should be given to including the consultant in a visit, as adding another person to a visit will change the dynamics.

Factors to consider when determining if a joint home visit is appropriate:

- The request for a joint home visit will come from the home visitor and the supervisor. They spend time together processing how to best support the family; and they bring this case to consultation with the IECMHC. After several attempts to work through the issues that have caused the home visitor to have concern, and the IECMH consultant has been involved, they make a request for consultation on a joint home visit.
- What are the main concerns with this family? What is the issue that is concerning enough to ask the consultant to accompany the home visitor? What has already been tried? What were the results of those attempts?

If the home visitor, supervisor and consultant together make the decision that it is time to suggest a joint home visit to the family, the following steps are taken:

- The home visitor discusses the option with the family and determines if the family would be receptive to having the IECMH consultant present at a visit.
- The family is informed that the IECMH consultant would be in attendance to observe the home visitor, and to support her/him in working with the family. They are not there as a mental health provider who works directly with the family, but instead to assist the home visitor.
- The program will have a confidentiality form, and a consent for the IECMH consultant to be a part of a joint home visit. These forms should be signed as the home visitor prepares the family for the joint visit.
- During the joint home visit the consultant is mainly an observer, but in a way that is comfortable for the family. The consultant is aware of the main concerns of this case and is observing to be able to have more understanding of the family during consultation.
- After the visit, the consultant meets with the home visitor and potentially the supervisor. They will discuss the home visit, the perceptions of all that were present during that visit and reflect on the interactions and the concern that prompted the visit. If possible, strategies will be determined to help support the family.
- The consultant completes the documentation of the consultation.
- The team solidifies a plan for follow-up to check in and determine additional needs.

Crisis Support

There are situations that impact home visiting programs that are unexpected and particularly distressing for staff, such as the death of a client or colleague, natural disasters, community violence, or a personal traumatic event. Just as mental health consultants support home visiting staff through challenging day-to-day work, consultants can provide additional support via phone, email, video chat, or in person outside of the regularly scheduled appointments as their schedule and availability allow. It is important to note that mental health consultants are not able to guarantee availability at unplanned times like is the case with emergency hotlines/crisis programs, but the consultant can discuss the crisis with those impacted as soon as they are able. The consultant may assist with the emotional processing and debriefing with individuals or groups of staff and provide a safe, supportive space for staff within the context of their relationships. The consultant can also determine if additional support is needed and encourage use of the agency Employee Assistance Program (EAP) or community therapist. Program supervisors and staff should always follow agency policies and protocol first, but communicating the distressing event with the consultant afterward will allow the program supervisor and consultant to discuss how the consultant can be most supportive. In providing this support through crises, the consultant's relationships with program staff can be deepened as the staff experience further trust in the consultant's ability to hold them through distressing times. Additionally, the reflective and consultative work that the consultant and staff engage in can be considered with the shared understanding of how the distressing event may impact them personally and professionally.

Fidelity Process Steps and Best Practice Tips for Entering a Home Visiting Program and Ongoing Services

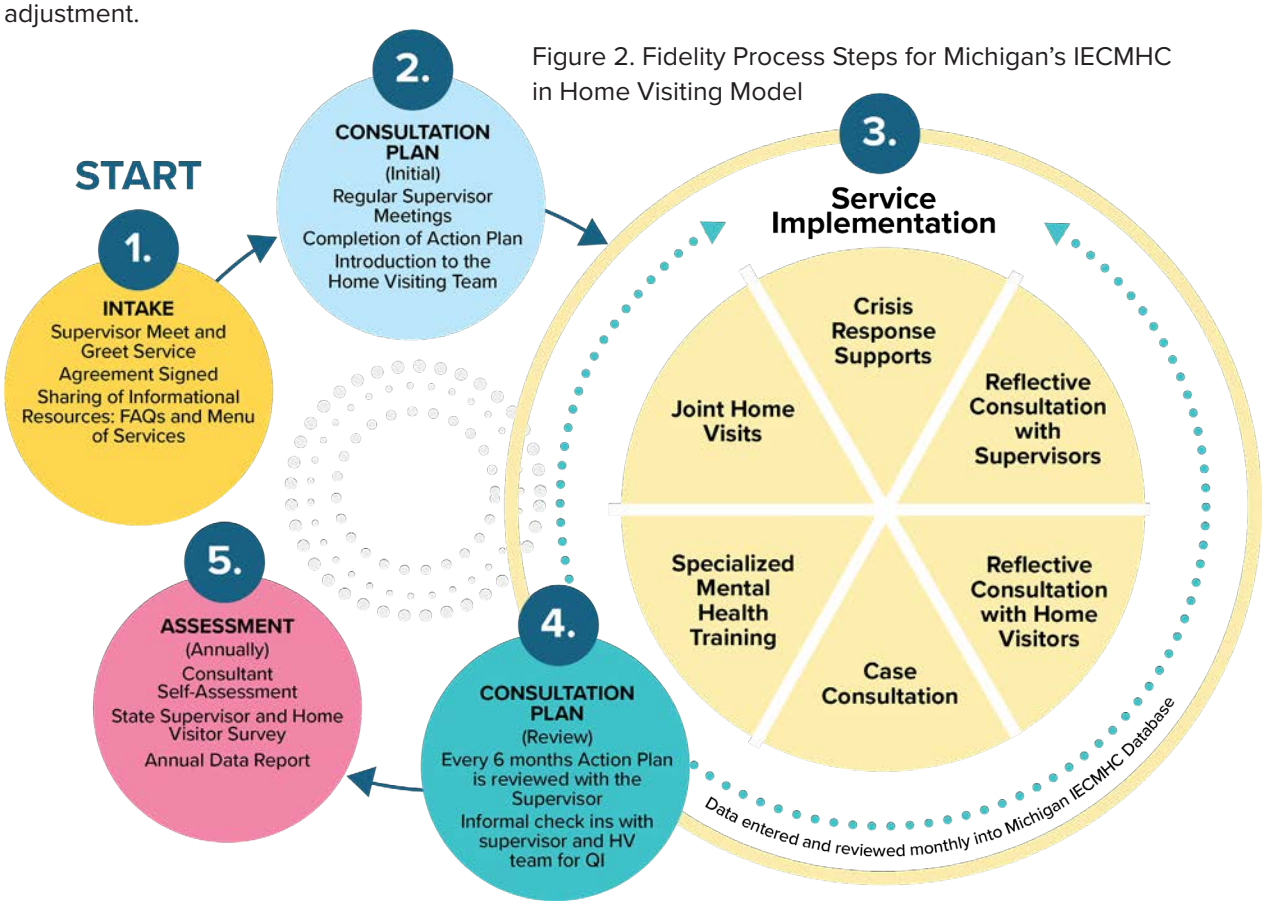
Maintaining fidelity to Michigan's IECMHC in Home Visiting Model is essential for ensuring that consultation services are delivered as intended and have the greatest impact. Fidelity is not only about how consultants begin their work with a new home visiting program, but also about how they sustain high-quality practices over time. It encompasses the consultant's approach to relationship-building, the integration of consultation into existing program structures, the use of reflective practices, and the commitment to continuous feedback and improvement.

In simple terms, *fidelity means staying true to the core practices of the model while adapting thoughtfully to each program's unique needs and culture*. It helps make sure the consultation experience is consistent, reliable, and effective, no matter where it takes place or who is involved.

This section offers guidance on the early and ongoing steps consultants can take to uphold fidelity, beginning with how they enter a new home visiting setting and extending through ongoing collaboration, action planning, reflective consultation, and feedback loops. By approaching this work with curiosity, humility, and respect for program culture, consultants can build the foundation for strong, trusting partnerships that support both staff and families.

Figure 2: Fidelity Process Steps for Michigan's IECMHC in Home Visiting Model outlines the key phases and practices that help consultants and home visiting programs stay aligned with the model. These steps illustrate how fidelity is woven throughout the consultation relationship—from initial engagement, to action planning with supervisors, to building relationships with the full team, to continuous reflection and adjustment.

Figure 2. Fidelity Process Steps for Michigan's IECMHC in Home Visiting Model



Steps for Entering a New Program

1. Pre-Entry Preparation

The MDHHS state coordinator will set up a meeting with the new consultant prior to their engaging with their home visiting programs. The coordinator may invite state home visitor leads to join as well to give deeper insight into the program(s).

In this meeting, the team will discuss and review helpful background information:

- The home visiting model(s) in use (e.g., HFA, PAT, NFP)
- Funder requirements for the home visiting program
- Demographics of the families served
- Any prior experience with IECMHC
- The agency's mission and values

2. Getting Connected with the Home Visiting Program Leads

After the initial preparatory meeting with the state IECMHC coordinator, the

IECMHC coordinator and state home visiting lead will set up an initial one-hour meet

and greet with the home visiting program leads, typically the program administrator and supervisor(s).

During this meeting, several objectives will be met:

- Engage in an icebreaker to get to know one another (IECMHC Coordinator)
- Provide a brief Introduction of IECMHC to the home visiting program (IECMHC Coordinator)
- Learn about team structure: Understand roles of home visitors, supervisors, and other support staff (home visiting program leads)
- Build rapport, learn about the home visiting programs goals for consultation, and identify priorities (home visiting program leads)
- Share how the consultant may meet some of these needs and their individual approach to partnering (IECMHC consultant)
- Clarify the consultation role, aligning with home visiting leaders on scope, expectations, and boundaries of consultation (non-clinical, relationship-based, reflective, and capacity-building) (the whole team)

The IECMH consultant will share the following resources as follow up by the next business day:

- IECMHC in Home Visiting FAQs
- IECMHC Services Menu 1-Pager
- Service Agreement form (see Model Handouts Section for these handouts)

3. Consultant Initiated Contact with HV Program Lead(s)

Taking time to meet with leadership and supervisors first will help build rapport, learn more about the leaders' goals for consultation, and identify priorities together as partners.

In the first few meetings with the supervisors/leads, the consultant will want to take time to address questions from the prior meeting with the state team and review the services agreement and get it signed. This should include careful reflection on each person's role, review of services available, confidentiality and privacy standards, duration/frequency of services and ethical considerations. Once this piece is done it is time to get to know more about the program and each other.

The consultant can use wondering and curiosity to learn about the program's readiness for IECMHC, for example exploring:

- The backbone organizations support of IECMHC
- Team understanding and expectations of IECMHC
- Capacity and infrastructure for supporting IECMHC (for example is there time built into home visitors' schedules to attend consultation?)
- Culture of openness and psychological safety (for example, is there a culture of trust where staff feel safe discussing challenges, biases, and emotions? How does the team handle stress, conflict, or differences in perspective?)
- Existing supports and gaps (for example, are other supports in place for workforce well-being? What are the program's biggest pain points (e.g., secondary trauma, high caseloads, family crises?)
- Fit of IECMHC with program priorities (for example, is the program undergoing other major changes or initiatives that could influence readiness (i.e., an audit)?)
- Experience with Reflective Supervision
- The supervisor's way of being and preferences for connecting

Consultants can share a bit more about their style of working and discuss together what a partnership looks like between a consultant and a supervisor on behalf of IECMHC. The consultant will also want to use meeting times with the supervisor to ensure there is a clear understanding of what IECMHC is and why it is important.

Remember, it is okay and recommended that the consultant spend the time needed with the supervisor to build a partnership around IECMHC and a clear understanding of the benefits, processes and how it might work best for the program before starting services.

Once a rapport and understanding of IECMHC has grown with the supervisor, it is time to begin developing a draft action plan for services.

It's important to create an action plan with the home visiting (HV) supervisor for IECMHC because it strengthens alignment, clarity, and accountability across the consultation relationship. A few key reasons:

Shared Understanding and Priorities

The supervisor sets the tone for the HV team. Developing an action plan together ensures the consultant's role, goals, and activities are clear, and that they connect directly to the program's priorities. This helps avoid role confusion and builds buy-in from both leadership and staff.

Integration into the Program

An action plan makes IECMHC part of the "fabric" of the HV program rather than a separate add-on. When the supervisor is actively involved, consultation goals can be woven into reflective supervision, staff meetings, and professional development, making implementation more effective.

Tracking Progress and Accountability

A written action plan serves as a roadmap for both the consultant and supervisor. It outlines concrete steps, timelines, and responsibilities, which allows progress monitoring, adjustment when needed, and accountability for follow-through.

Responsiveness to Emerging Needs

Home visiting programs often face new challenges (e.g., staff turnover, family crises, policy shifts). An action plan developed with the supervisor allows for flexibility—helping consultant and program leadership revisit priorities and adapt as circumstances change.

Building Trust and Partnership

Creating the plan collaboratively fosters mutual respect. It signals to staff that the consultant and supervisor are working side by side, which models the type of relational partnership IECMHC is built on.

At this juncture of action plan building it is important that the consultant and supervisor think about logistics and how IECMHC might fit into already occurring schedules and events of the home visiting program.

When the supervisor and consultant align on scheduling ahead of time, it ensures that consultation is introduced as a well-organized, predictable support rather than something last-minute or disruptive. This not only helps home visitors see the process as intentional and valued by leadership, but it also models the kind of stability and planning that IECMHC promotes for families and children.

The IECMH consultant can use the following resources as they build understanding and rapport with the supervisor:

- The Michigan Model for IECMHC in Home Visiting
- What IECMHC is and Is Not
- Reflective Supervision/Consultation Vs Therapy
- IECMHC Services Menu-1 Pager
- Michigan's IECMHC in Home Visiting Videos: https://michiganiecmhc.org/iecmhc-in-home-visiting/
- Sample Action Plan (*Can be adapted but the creation of an action plan is required)

4. Building Relationships with the Full Team

After initial meetings with leadership, the consultant should be introduced to the broader home visiting team. This may happen at a staff meeting, reflective group, or informal gathering. Early introductions help staff understand the consultant's role, clarify boundaries (e.g., not providing therapy, but offering reflective support), and begin to build trust. Consultants can share a brief overview of IECMHC, answer questions, and emphasize their commitment to partnership and

support. It will be important that the consultant and the supervisor prepare together for this orientation and enter as partners to build will and trust. It is also important that HVs know that the consultant is not taking over the role of the supervisor.

The consultant and supervisor may plan to host several meetings with the home visitors to ensure questions are answered and that understanding of what IECMHC is fully explored.

The IECMH consultant and supervisor can use the following resources as they build understanding and trust with the home visiting team:

- The Michigan Model for IECMHC in Home Visiting
- What IECMHC is and Is Not
- IECMHC in Home Visiting FAQs
- Reflective Supervision/Consultation Vs Therapy
- IECMHC Services Menu-1 Pager
- Michigan's IECMHC in Home Visiting Videos: https://michiganiecmhc.org/iecmhc-in-home-visiting/
- Drafted Action Plan (Consultants and supervisors may agree to have home visitors weigh in on the plan to give their feedback for improvement)

5. Beginning Reflective Consultation

Once rapport has been established, the consultant can begin offering training and reflective consultation sessions as agreed upon in the Action plan. It is often helpful to start with the supervisor to model reflective practice and reinforce the supervisor's role. Over time, the consultant may expand to group, individual and case consultations, depending on the program's readiness and needs. Additionally, to build rapport sometimes a supervisor and the home visiting team agree to address training needs that the program has. This allows the team time to get to know each other.

Although there is flexibility in how a consultant gets started and what IECMHC activities the program implements, quality typically entails a minimum of 8-10 hours of consultation per month per program. Ideally every home visiting program served would be getting all aspects of IECMHC if they do not already have them in place. Part of fidelity is reviewing the action plan every 6-months with the supervisor to ensure what you are doing together is working and meeting expectations.

This also provides a time to explore further integration of IECMHC into programs.

6. Ongoing Feedback and Adjustment

As consultation begins, it is important to create feedback loops. Regular informal check-ins with supervisors and staff help the consultant understand what is working well and what may need to be adjusted. This supports alignment, reduces misunderstandings about the consultant's role, and strengthens the overall partnership.

While the services outlined above describe how IECMHC ideally functions within home visiting, it is equally important to recognize the real-world challenges and circumstances that can shape implementation. The following section highlights common barriers and considerations consultants may encounter, along with strategies and support to navigate them.

Special Challenges and Considerations of the Model

While this manual lays out in detail the components of consultation with home visiting programs, it is important to explicitly state that this describes the optimal framework. For implementation purposes the manual should be used to guide program consultation closer to the ideal model. Not all programs and consultants start at the same place or are ready for the same pace of incorporating all the consultant-offered services. Below are common challenges consultants have found along with things to consider when implementing the model in the real world. It is also important to note the supports available to consultants to discuss challenges and considerations. Those supports include Reflective Supervision, IECMHC Community of Practice monthly meetings, and connecting with the network of other consultants through email. These supports are outlined in this guide in Part 2.

Below are common topics that may pose challenges for IECMH consultants:

Initial Engagement

It is typical for consultants to struggle with initial engagement from the program. Emails go unread or not responded to, meetings are scheduled then cancelled at the last minute, and it may be a battle to join the program's already scheduled meetings. It is common for the initial engagement to take multiple attempts. Consistency in reaching out and offering support helps to establish the start of a trusting relationship with the consultant. It is important to be aware of personal implicit bias and how this might be affecting engagement. This is particularly important when the culture and or race of the consultant is different from the majority of the program's families they are supporting.

Entering the Program

Entering a program can often be overwhelming for the staff, supervisor and consultant. It is very common for consultants to identify the support needed that they could offer, and the program is not ready to accept that service. Starting where the program is at with whatever service they identify as the desired service is typically the best approach. Once a relationship is established, the consultant learns more about the program and the staff learn the consultant's style, additional support is more readily accepted. This brings up a unique challenge to the consultant where they may start to question their competency and skills. Feeling frustrated and discouraged by the roadblocks that are often inevitable can lead to the consultant wondering if they are cut out for the work. This is a normal part of the process for consultants and is an excellent topic to bring to Reflective Supervision or Community of Practice meetings.

Organizational Culture

It is important for consultants to be mindful of the organizational culture and how this impacts the work. If the culture of the agency is one of mistrust, it might be a challenge to provide consultation that focuses on sharing vulnerabilities. Safety is another organizational barrier that can impact consultation. Consider the staff's overall feeling of physical, emotional, and psychological safety in the organization as a whole and also in the actual space consultation is being provided.

Ethnic, Religious, and Racial Culture

These are other areas that consultants will need to be mindful in considering. An example of this is consultants working with Tribal communities may find the process to be less linear than with traditional groups. At times consultants might wonder about the purpose of a meeting or role they might play with a new Tribal group. Sharing stories and experiences as a way to build a better understanding of the community is often common for this culture. It can appear to someone outside of the community that nothing was accomplished in the meeting as a specific agenda or topic was not worked on. Remaining open and curious about another group's norms and traditions is the first step of being culturally aware.

Geographical Locations

Consultants need to be sensitive to cultural norms around geographical locations. A very practical way this shows up is when location of the consultant and program are geographically far apart and the travel time to meet in person outweighs the benefit. In this scenario, virtual is the best option for meeting. Another consideration would be if the consultant lives in a different geographical location (rural vs. city) than the program location. It will be important for the consultant to be aware of the various community dynamics of the program location that might differ from their own community.

Staffing

Investment in consultation services and team management styles will vary from program to program. It is a challenge for some consultants where staff and supervisor's investment are mismatched. This is an important area of reflection and consideration, as pacing that is too fast or slow can interfere with how the support is accepted. Triangulation is another area for consultants to be aware. Staff can, at times, use the things discussed during consultation to challenge a supervisor's knowledge and authority. Staffing changes should be expected in programs. This can range from staff coming and going from the team, supervisors leaving, and changes in administration that shift the organization's commitment to consultation.

Navigation of change

Another area for consultants to reflect on in their work with home visiting programs is *change*. Change is a constant in various ways within the agency, program, services wanted and even plans for meetings. It is common for staff, supervisors and administrators to leave abruptly without much notice. This can create a challenge for the consultant as they may or may not be notified of the change. Another scenario that has occurred at times is programs starting off with virtual meetings due to geographical means and then deciding they want local, in-person meetings. Not all consultants are able to accommodate this request and that should be discussed with the State Coordinator to determine next steps for supporting the program.

Role confusion

Consultant's roles can often be misunderstood. It is common for there to be confusion around the difference between the Reflective Supervision provided by the program supervisor to the IECMH consultant, and the Reflective Consultation provided by the consultant to the home visitor and other members of the team. Staff and families may expect that the consultant will diagnose and/or provide mental health treatment. It is important to clarify that this is not the role of the consultant and support the staff in connecting the family to an appropriate mental health clinician for treatment. Often with programs that are new to being in a reflective space, Reflective Consultation can be confused with therapy. Consultants will need to be aware of this experience and provide education on the difference between Reflective Consultation and therapy. See Appendices for a handout on the difference between Reflective Supervision and therapy.

Change in IECMH Consultant

At times, there may not be a strong match—or "goodness of fit"—between a consultant and the program they are supporting. This mismatch can arise for a variety of reasons, including differences in communication styles, expectations, or approaches to reflective practice. It is important to recognize that this does not necessarily reflect a shortcoming on the part of the consultant or the program, but rather a natural part of the consultation process. When goodness of fit concerns emerge, the consultant should engage in open dialogue with their reflective supervisor and state coordinator to explore adjustments that may strengthen the partnership. If challenges persist, it may be appropriate to consider a change in consultant to ensure that the program receives the support it needs and that the consultant is positioned for success. Addressing these situations thoughtfully and transparently helps to maintain trust and demonstrates a commitment to the well-being of both staff and families. This process would include the consultant in all steps of the decision-making process.

Conclusion

Michigan's Infant and Early Childhood Mental Health Consultation (IECMHC) in Home Visiting model reflects years of collaboration, learning, and commitment to supporting families where they are. Grounded in reflective practice and relationship-based approaches, the model strengthens the capacity of supervisors and home visitors to meet the complex needs of infants, young children, and their caregivers.

By investing in workforce development, data-driven quality improvement, and implementation integrity, Michigan has built a sustainable framework that ensures consultation is consistent, supportive, and responsive across diverse communities. At its core, this work honors the central role of relationships—between consultants, supervisors, home visitors, and families—in promoting resilience and healthy development.

As the model continues to evolve, ongoing reflection, adaptation, and partnership will be essential. Together, we can sustain a system where every family is supported, every consultant is equipped, and every child has the opportunity to thrive.

A Closing Note to Consultants

Your presence and reflective stance are the heart of this work. By showing up with curiosity, humility, and consistency, you strengthen home visitors and supervisors as they support families through complex challenges. You won't always have every answer, but your ability to hold space, listen deeply, and walk alongside others makes a lasting difference. Thank you for bringing your skills and compassion to this role—your commitment helps ensure Michigan's youngest children grow within safe, nurturing, and connected relationships.

Model Handouts

- What IECMHC in Home Visiting "Is and Is Not"
- Consultant Onboarding Checklist
- IECMHC in Home Visiting FAQs
- Reflective Supervision/Consultation versus Therapy
- Reflective Supervisor Questions
- Supporting Reflective Functioning in Home Visitors
- Supporting Reflective Functioning in Groups
- Shared Agreements for Groups
- Case Consultation Form
- IECMHC Services Menu 1-Pager
- Sample Service Agreement form
- Sample Action Plan

Infant and Early Childhood Mental Health Consultation in Home Visiting

What It Is and Is Not

	IECMHC in Home Visiting IS	IECMHC in Home Visiting IS NOT
Focus/Goal	Indirect and prevention focused—helping home visiting supervisors and staff improve their responses to family and children's social-emotional needs as well as their own	A way to diagnose and provide direct therapy or treatment for children, families, or staff.
Who it Helps	A prevention-based support to home visiting supervisors and home visitors	For children or caregivers or staff who need direct mental health treatment.
Where it Happens	Provided within the home visiting program during one-on-one reflective supervision sessions or group sessions	An outside service that occurs in a clinic, private office, or hospital.
How it Happens	Ongoing, reliable, and predictable 1:1 and Group support from a mental health consultant that occurs through training and reflective support, on average 8-10 hours a month	A quick-fix or on-call only.
How it Works	A way to help home visitors understand infant and early childhood mental health.	A replacement for home visitor activities like depression screening or providing direct services
How Information is Shared	Private and confidential	A way to gather specific information to report what families or staff share.
The Consultant Stance	Supportive and respectful of different cultures and strengths, understanding unique scenarios and evolving circumstances.	Judgmental or punitive in its approach.
Purpose	A way to help home visitors reflect and improve their work with each other and with families.	Therapy, counseling, medical treatment, or a direct service provided to families.
Approach	A team effort that follows the needs of home visiting supervisors and the home visitors	Directed by the consultant.
Core Activities	A mix of training, group, and 1:1 reflective support using infant mental health principles to build the capacity and skills of the home visiting team	1:1 therapy with home visiting staff or families enrolled in a home visiting program.
Flexibility	Flexible—Consultants adjust to challenges and unexpected needs of the home visiting program.	Strict and the same for every situation.

Michigan's Infant and Early Childhood Mental Health Consultation (IECMHC) in Home Visiting: Consultant Onboarding Checklist

Purpose

This checklist provides a structured and comprehensive introduction to the role of Infant and Early Childhood Mental Health Consultation (IECMHC) within home visiting programs. By following these steps, new consultants will gain the necessary training, resources, and support to begin consultation services confidently and effectively. Timelines for completion will vary by consultant.

Week 1-3: Orientation & Training

- ☐ **Meet with the IECMHC State Project Coordinator (Coordinator)**
  - Review **contractual obligations and role expectations.**
  - Discuss **scope of work and consultation activities**.
  - Learn about the **home visiting model** I will be supporting.
- ☐ **Review the Michigan Model of IECMHC in Home Visiting through Ongoing Check-In Meetings**
  - Read and reflect on each section.
  - Discuss any questions or areas for clarification with the Coordinator, and/or the Reflective Supervision Lead.
- ☐ **Learn about the Evidence-Based Home Visiting Model you will be Supporting**
  - Review resources from the Coordinator that explain the foundational components of the home visiting model(s) that you will be supporting.
  - Discuss any questions or areas for clarification with the Coordinator.
- ☐ **Complete Reflective Supervision/Coaching Training and Coaching**
  - Gain an understanding of Michigan's approach to Reflective Supervision/Consultation.
  - Attend a live training or watch recorded sessions.
  - Review key takeaways with the Consultant Coordinator.
- ☐ **Watch IECMHC Consultation Videos**
  - Review Michigan IECMHC home visiting consultation videos.
  - Discuss insights with your supervisor.
- ☐ **Review webinar on How Programs Prepare for Consultation in DE and read the guide.**
  - Gain insight into how home visiting programs engage with consultants.

Week 3-4: Ongoing Support & Mentorship

- **Attend Key Meetings & Team Supports**
  - Join the Community of Practice (COP) meetings for Michigan IECMHC consultants.
  - Use this space to **reflect, strategize, and learn from peers**.
- **Engage in Reflective Supervision**
  - Meet with the State Reflective Supervisor Lead for monthly reflective supervision for a minimum of 6 months.
  - Use these sessions to explore consultation challenges and self-reflection.
  - Ensure you are getting regular reflective and administrative supervision within your agency if you are connected to a Community Mental Health Service Provider Agency.
- **Shadow an Experienced IECMHC Consultant**
  - Observe real-life consultation sessions (in-person or virtual).
  - Discuss observations with an experienced consultant.
  - Ensure consent is obtained from the home visiting program before shadowing.

Week 3-4: Documentation & Assessment

- **Learn How to Track Activities & Submit Reports**
  - Use Michigan's tracking and reporting tools.
  - Conduct monthly quality checks for the first 3 months with the Coordinator.
  - Discuss consulta**tion impact and areas for improvement** in team meetings.
- **Complete the IECMHC Annual Self-Assessment**
  - Evaluate strengths and identify areas for professional growth.
  - Use results to plan f**uture training and technical assistance**.

Michigan's Frequently Asked Questions about IECMHC in Home Visiting

1. **What is IECMHC?**
   A prevention-based approach that pairs a mental health consultant with adults who work with infants and young children in the different settings where they learn and grow, such as childcare, preschool, home visiting, early intervention and their home. Mental health consultation is not about "fixing kids." Nor is it therapy. Mental health consultation equips caregivers to facilitate children's healthy social and emotional development."
   Center of Excellence on IECMHC

2. **How will a consultant help our program?**
   IECMHC Consultants provide an opportunity for reflection with administrators, supervisors, and staff. This allows staff to think through their work with a mental health prepared person, go deeper into the situation, explore options, and produce the strategies needed to take the next steps. This is a collaboration, with all involved sharing their thoughts. It is NOT an expert giving advice.

3. **How long will we get consultation? A year?**
   The current plan in Michigan is to offer IECMHC to home visiting programs on an ongoing basis, although the amount of time allocated to each program may change based on the needs of the program.

4. **How many hours will a consultant work with our program each month?**
   The number of hours for each program is based on the size of the program, the activities of consultation that they will incorporate into their routine, and the needs of the families. This might also be flexible as situations change and the need for consultation fluctuates.

5. **How much does it cost?**
   The cost of a consultant will currently be funded through *the state.* However, the cost of receiving consultation includes the time that is set aside to meet with the consultant. It is important to safeguard that time, and for it to be consistent.

6. **Where do I find a consultant?**
   The state of Michigan has invested in the recruitment, training, and ongoing support of IECMHC consultants. The consultants have been selected for the home visiting programs that are receiving this opportunity. If you are not a part of that process and are interested in being considered for the services of IECMHC in home visiting, please contact Kate Rood at

7. **What are the qualifications of a consultant?**
   In the state of Michigan, a consultant must have these qualifications or meet requirements within 1 year of hire:
   - Infant Mental Health Endorsement Level II, Level III Preferred
   - Master's Degree in social work or Mental Health Field
   - Three years of experience providing child and family mental health services to those with children under the age of six

8. **What will a consultant do?**
   Some activities of consultation include:
   - Reflective consultation with administrators, supervisors, and home visitors.
   - Reflective supports individually, with supervisor and home visitor, or in groups
   - Case consultation
   - Training on topics related to mental health
   - Supports during referrals
   - Joining in on home visits with home visitors

9. **Is consultation individual or done in a group?**
   There are many ways that consultation can be delivered. The supervisor and the consultant will meet and determine how to move forward, with input from the home visitors. You may have both options of team or individual supports, or may choose to start with one and then bring in another.

10. **What do I need to do to prepare to work with a consultant?**
    The most important thing is to work with your consultant to determine a schedule that is favorable for both the program and the consultant. Then, try to save that time for the meetings with the consultant and do not allow other meetings to interfere. It will also help to think about what you might want to discuss with the consultant in your meetings. You bring to the reflective session the issues you would like to discuss. Being prepared to share these with the consultant helps prepare you for the time together.

11. **Can the consultant meet with the families I have on my caseload?**
    The consultant works with the home visitors and reflects on the work with families. Together they think through each situation, reflect deeply on what might be happening and how to best meet the needs of that family. They talk through strategies and supports, and it helps the home visitor plan and develop an approach. However, there may be times when the home visitor would ask the consultant to join in one of their visits to the family. The purpose is NOT to provide mental health services to the family, but instead to observe and then process the observations with the home visitor as they strategize supports to that family.

12. **Can the consultant provide therapy for our staff?**
    Consultants reflect with staff, help to think through situations that arise, support the ongoing relationships home visitors develop with families, etc. However, they do not provide therapy. Consultation is focused on the work that home visitors provide to families, and many times it impacts the staff, and they need to process those situations.

13. **Will the consultant do any trainings?**
    Yes, as you spend time with your consultant you may see that things arise while talking though some case consultation that you may want to learn more about. You can ask your consultant to provide some training on that topic. Those would typically involve mental health topics such as attachment, dysregulation, maternal depression, etc. It helps to have an ongoing relationship with a consultant as they can do this over time and connect the information to the work that is already happening with families.

14. **Do we have to use the word mental health? Can we just say social and emotional development?**
    The term mental health does carry some stigma, but we are not talking about mental illness. We are talking about helping young children develop healthy social and emotional skills in order to promote positive mental health. The more the term is used in a promotional/preventive manner the more likely it will be to remove that stigma.

15. **What documentation do we need to complete for consultation?**
    There is no extra documentation required for the programs. If the supervisor typically keeps notes from meetings, those notes would be sufficient to include general activities of consultation. The consultant will be taking notes to remind them of conversations that took place and may need to be addressed later, and to help with their own documentation.

16. **Do we need consent forms?**
    Your program will typically have consent forms for many different activities. A form that can be completed at intake that indicates that programs process information and situations with an IECMHC consultant may be the most efficient way to obtain consent. Additional consent would be necessary if the consultant would have contact with families.

17. **How do we maintain confidentiality?**
    Your consultant is a part of your team, and you can talk openly about issues and cases. The consultant maintains confidentiality and does not share the information you disclose except with their own reflective support. You may also include a statement of confidentiality in your agreements with your consultant.

18. **Is consultation available only in person, or can we use a virtual platform?**
    Consultation is here to support you. Scheduling can be difficult with very busy jobs, and at times it seems that virtual meetings might be the best way to deliver that support. These decisions are made between the programs and the consultant, hoping to find what works best for everyone.

19. **This is a lot to add to our already exiting programs. I am not sure how to make this happen.**
    Home Visiting programs have already established regular meetings that a consultant may join, instead of creating a new one. For example, programs typically have team meetings twice a month at minimum. Your consultant may join in one of the meetings to support and reflect with your team. There may be other meetings that are added, like a regular meeting between the supervisor and the consultant.

20. **How do we begin to feel confident in sharing with a consultant**? It is possible that some home visitors might not be comfortable sharing with a consultant. It takes time to develop a trusting relationship, and the first few months of consultation will offer time to begin building that trust. The hope is that at some point the home visitor will begin to feel comfortable opening up with the consultant present.

For more information or questions email: MDHHS-IECMHC@michigan.gov

Similarities and Differences Between Reflective Supervision and Therapy

Similarities between reflective supervision and therapy:

- Pull from the same emotional experiences of the home visitor.
- Value the exploration of thoughts, emotions and reactions
- Aim to enhance insight and awareness.
- Recognize how trauma and relational patterns show up in work and in relationships.
- Support emotional regulation through co-regulation.

Differences between reflective supervision and therapy:

Reflective Supervision	Therapy
"Let's think about how this moment is affecting you in your role."	"Let's explore where this feeling comes from and how it's shaped your life."
Reflective supervision is a collaborative, supportive relationship that helps you explore your work, your emotional responses to the work, and your role in a thoughtful, nonjudgmental space. • Focuses on your professional role and experiences in your work • Explores your thoughts, feelings, and reactions related to caregiving and helping relationships • Personal history is discussed only as it impacts your professional functioning • Aims to strengthen your reflective capacity, reduce burnout, and improve your work with families • Confidential within a professional framework, often within a program or agency • RS is not therapy—it does not include diagnosis or treatment	Therapy (or counseling) is a private, clinical relationship designed to help you heal from psychological distress, process life experiences, and improve your overall mental and emotional well-being. • Focuses on your whole self—your personal life, mental health, and relationships • Explores past and present experiences to promote healing and growth • May include a diagnosis, treatment plan, or medication support • Provides a space to work through anxiety, depression, trauma, identity, loss, and more • Held in a confidential relationship with a licensed mental health professional • Therapy is a strength, not a weakness—it's a space for healing and personal empowerment
Reflective supervision supports the emotional labor of helping work. It provides a space to make sense of what's happening inside you as you support others. • Name emotions stirred by client visits, team dynamics, or systemic pressures • Explore your reactions to challenging situations or families • Notice how your own history or values show up in your work • Reflect on moral distress, grief, or uncertainty connected to your role • Build the ability to pause, regulate, and respond instead of react • Strengthen your resilience, empathy, and professional presence	Therapy offers a deeper, more personal exploration of your emotional and mental health. It supports healing and growth across your life—not just your work. • Process grief, trauma, relationship struggles, or identity questions • Work through patterns from childhood or past experiences • Receive help for anxiety, depression, or burnout • Learn strategies to improve coping, self-esteem, and emotional regulation • Explore your values, goals, and sense of self • Receive nonjudgmental support during life transitions or crises

Reflective Supervision Questions

It is important to consider the supervisor's current skills in reflective supervision and use questions to support capacity building. Questions are broken into categories to help support growing supervisor's capacity in specific areas of reflection.

Thinking

- Think about those you support in your work. Do you align with one team member more than another? Does this staff feel seen, heard and understood by you? Do other team members feel seen, heard and understood by you?
- Who supports me in the work?
- How did you learn to take care of yourself? How does that show up in your work?
- Think about a staff member you are supporting. What are they teaching you? What are you learning about yourself? How might parallel process, goodness of fit, attunement or brace spaces be at play?
- What is a part of your professional role that is required of you that you find hard to lean into?
- How do you think the staff is feeling in this moment? What is that based on?
- How might culture and diversity come into play in this relationship/interaction?
- What was that reflective supervision like for you?

Feeling

- What practices support you to settle into a reflective space, to receive and offer connection?
- What do you need to feel brave in this space or in the space with supervisees?
- Tell me about a time when you left work feeling renewed? Describe a picture of what that looked like? What happened to make you feel that way?
- How does it feel for you to sit in the reflective space with your supervisees?
- Reflect on a challenging interaction with a staff that elicited feelings of frustration, disappointment, anger or other discomfort for you. Reflect on the bodily sensations that accompany these emotions.
- Describe your feelings while sitting with a staff during a reflective space this month? What might influence this for you? Does this staff remind you of anyone?
- When was a time when you felt strained to find compassion/empathy for this staff?
- What hot buttons are pressed for you? What feelings are being evoked?

Responding

- How do you communicate the felt experience of hope within a relationship?
- What is a message you tell yourself about discomfort in the work in order to stay present in the moment?
- What makes this situation/staff/family especially hard for you?
- What might happen when you don't agree with how a staff handled something in a visit?
- What might other people notice when you are regulated, overwhelmed, frustrated, etc.?

Some questions adapted from Advancing Equity Through Reflection and Relationships: Reflective Supervision Prompt Cards from MIAIMH produced by Kelsi Robertson and Victoria Sargent.

Supporting Reflective Functioning in Home Visitors

Levels of RF	Home Visitor Experience	What the Consultant Might Notice	Consultant Strategies
Pre-RF	· Unaware of their own emotional responses. · May describe families in behavioral and judgmental terms. · Lacks curiosity about inner experiences – both their own and the family's.	· Avoids discussing feelings or relational impact. · Focuses primarily on logistics, tasks, or problems. · Descriptions generally lack nuance, for example, "They always..." or "She just won't listen."	· Create emotional safety and establish trust. · Reflect back emotional content gently. · Model curiosity about internal experiences. · Focus on the home visitor's internal state.
Low RF	· Aware of some emotions but unsure how they relate to their behavior. · Limited ability to consider the parent's or child's perspectives. · May blame self/others or feel stuck in a negative dynamic.	· Uses some feeling language but still focuses on fixing or outcomes. · Starts wondering about the parent's motives with less judgment or confusion. · May say, "I don't know what else to do. Nothing works."	· Reinforce and validate emerging self-awareness. · Help connect emotions and thoughts to behaviors and outcomes. · Begin exploring the parent's and child's mental states gently. · Frame struggles as relational, not individual failings.
Moderate RF	· Articulates own emotional responses with insight. · Curious about the inner world of both parent and child. · Uses reflection to uniquely adapt their approach based on parent/child/family need.	· Expresses empathy and shows interest in meaning-making. · Begins connecting their responses to relational patterns. · Can hold complexity and consider multiple perspectives. · Connects the past with current behavior.	· Deepen reflection on emotional experience and parallel process. · Encourage thinking about long-term relational patterns. · Explore the nuances of the home visitor's thought, feelings and behaviors on relationships.
High RF	· Use reflection in real time with families. · Regulates their own emotions while staying empathically attuned. · Integrates reflective capacity into ongoing work and decision-making.	· Uses sophisticated, balanced interpretations. · Remains open and curious, even in emotionally challenging situations. · Acknowledges strong emotions without becoming overwhelmed. · Can understand when there has been a rupture and strategies for repair.	· Foster ongoing growth through deep, collaborative reflection. · Offer opportunities to reflect on larger patterns across families. · Support exploration of the meaning and purpose in the work. · Support connection between past and present experiences.

Shared Agreements for Groups

In group reflective consultation, shared agreements are essential to create a safe, respectful, and effective environment for learning, sharing, and growing. These agreements help to establish expectations and guidelines for how participants will interact with each other. Here are some common shared agreements for group reflective supervision:

1. **Confidentiality**
    - What is shared within the group stays within the group.
    - Personal or professional information should not be shared outside of the supervision group without consent.
    - The space the group occurs in (in person or virtual) should be private in nature.
2. **Respectful Listening**
    - Each participant is encouraged to listen actively and attentively without interrupting.
    - Validate and acknowledge each other's perspectives before responding.
3. **Non-judgmental Approach**
    - Participants are encouraged to share openly without fear of judgment or criticism.
    - Focus on being supportive rather than giving advice unless requested.
4. **Respect for Different Perspectives**
    - Appreciate the diversity of experiences and viewpoints within the group.
    - Understand that each person may approach challenges differently.
5. **Constructive Feedback**
    - Offer feedback that is supportive, specific, and actionable.
    - When giving feedback, focus on behaviors and actions rather than personal attributes.
6. **Confidentiality of Case Information**
    - Be mindful of anonymity and confidentiality when discussing cases, ensuring identifying details are discreetly and sensitively disclosed. There may be times when dual relationships or conflict when home visitors may need to excuse themselves from the discussion of the case.
7. **Openness and Honesty**
    - Be open to sharing challenges, difficulties, and successes.
    - Practice honesty in offering reflections and feedback.

8. **Commitment to the Process**
    - Attend regularly and be present in the sessions.
    - Participate actively and give your full attention to the group discussions.
9. **Accountability**
    - Hold each other accountable for maintaining these agreements.
    - Agree to address issues of disagreement or discomfort in a respectful manner.
10. **Time Management**
    - Respect the time of each participant by staying within the agreed-upon schedule.
    - Be mindful of each person's opportunity to share.
11. **Emotional Safety**
    - Acknowledge and support each other's emotional responses during discussions.
    - Foster an environment where everyone feels emotionally safe to express themselves.
12. **Reflective Practice**
    - Focus on self-awareness and self-reflection during the discussions.
    - Encourage growth through reflecting on both strengths and areas for improvement.
13. **Facilitating Discussion**
    - If you need to encourage participation of all home visitor, consider ways to facilitate this, "two before me"
14. **Technology Management**
    - Explore expectations to address the use of technology during group. May consider that they need to be turned off, turned on silent, or put away.

These agreements can be customized based on the group's specific needs and goals. Establishing and revisiting these agreements regularly ensures that all participants feel respected and supported throughout the reflective supervision process.

Case Consultation Form

1. What would you like the group to help you think about (questions, concerns, etc.)?

2. Background Information to Present

- Demographics: Age & gender of infant, racial and cultural background of the family.
- Family Composition: Information about the primary caregivers, siblings, and extended family members. Who is participating in home visits?
- Living Situation
- Primary Language
- Length of time working with family
- Most recent screenings/assessments completed and results (Edinburgh, ASQ, etc..)
- How does the primary caregiver describe the baby? What are their concerns?

3. Reflections to consider when presenting case

- What is it like being a home visitor with this family?
- How do you feel when you are in the family's home?
- What do you wonder about this family?
- What are your thoughts about the family?
- Who do you find yourself identifying with or paying the most attention to during the HV? (baby, mother, father, sibling, grandparent, other caregiver)
- What does the infant/toddler/preschooler need from the caregiver?
- Is there any racial difference and how do you and the family experience it?
- What connections do you see between the suggestions offered and the underlying issues such as substance misuse, development, attachment, etc.

4. Reflections to consider for the group participants

As you listen, pay attention to how it feels in your body and brain. RC can be a good time to consider those connections for yourself. When you have a question, ask yourself if it is supporting the reflection of the person presenting or if it is a curiosity question.

- What do you see going well in the case?
- What feelings come up for you or what thoughts do you have as you hear about the case?
- What are you left wondering?
- What supportive ideas can you offer?
- As you listen to the consultant and presenter what connections do you see between the suggestions offered and the underlying issues such as substance misuse, development, attachment, etc.

IECMHC in Michigan: Snapshot of Activities

Menu of Possible Activities	What is typical: Nothing is required but all is possible!
Reflective Supervision with the Supervisor: The consultant can meet with the program supervisor/manager to provide an opportunity for reflection, problem-solving, planning staff interactions, and embedding the skills and knowledge that the consultant brings into the program. These meetings help develop an agreement between the consultant and the supervisor and 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 by promoting reflective practice within the supervisory activities.	1 time per month for 1 hour – 90 minutes
1:1 Case Consultation with Home Visitor: In a parallel process, the consultant (and the supervisor) meet with individual staff to provide reflective case consultation as described previously. A reflective mental health approach can assist 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 parent/family to make a referral to and addressing how the parent's mental health issues impact the relationship with their infant or young child as appropriate.	1 time per month, per home individual for 1 hour on an as needed basis- for example if someone is dealing with a hard situation case consultation might be more frequent for a period of time.
Group Consultation with the Home Visiting team: Like reflective consultation with individual staff, the consultant can work with the team monthly. Often staff members present cases for discussion. The consultant helps the group to wonder aloud, thinking about the meaning of behaviors. The participants are encouraged to hold steady, observe, and wonder with their clients (parents/families), as opposed to problem solving and finding a "solution".	1 time per month for 1-2 hours
IECMH Training: The reflective approach is balanced with training that is content specific. The IECMH consultant brings training on topics that staff members identify such as attachment, self-regulation, substance abuse impact, and regulation. Typically, this training happens organically and informally in conversations. Some training may happen more formally on a given topic as requested by the supervisor or the team. The staff gain knowledge and skills. The consultant then reinforces this information in supervision and during ongoing meetings.	Provide training informally as topics come up or more formally as requested by the program
Joint Visits: The consultant may accompany staff on home visits on an as needed basis. The supervisor and the consultant, 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 what happens after the visit, and plan for the home visitor's follow-up with the family.	As needed

For more information contact: Mary Mackrain, Coordinator at mackrainm@michigan.gov

To watch a short video on what IECMHC and a longer video of IECMHC in Action go here:
https://michiganiecmhc.org/iecmhc-in-home-visiting/

IECMHC in Home Visiting: Service Agreement Form

Purpose

The IECMH Consultant provides prevention-based, capacity-building support to strengthen home visitors' ability to recognize, understand, and respond to the social–emotional and mental health needs of young children, caregivers, and themselves. Services are reflective, collaborative, and non-clinical in nature.

Scope of Services

The Consultant agrees to provide:

- Reflective Consultation with supervisors, home visitors, and/or teams on a regular basis (minimum monthly).
- Case Consultation to support home visitors' work with children and families.
- Specialized Training/Professional Development on mental health–related topics as needed.
- Joint Home Visits, only when critical and requested by supervisor and home visitor.
- Programmatic Consultation to support administrators in strengthening policy and practice.

Roles and Responsibilities

The Consultant will:

- Maintain fidelity to the MDHHS IECMHC Model.
- Uphold confidentiality and ethical standards.
- Participate in required reflective supervision and state/community of practice activities.
- Submit required documentation and data in a timely manner.

The Provider/Program will:

- Ensure home visitors and supervisors have scheduled time for consultation.
- Participate in developing and reviewing a consultation plan annually.
- Communicate program needs, changes, or challenges that may impact consultation.
- Collaborate with the Consultant to support a reflective and safe environment.

Agreement Terms

- Duration: This agreement is effective from _____ to _____.
- Frequency: Consultation will occur at least monthly (additional sessions as jointly determined).
- Confidentiality: The Consultant will not provide direct clinical treatment; all discussions are consultative and confidential, except when safety concerns arise.

Signatures:

Michigan IECMHC in Home Visiting: Example Action Plan Template

This template is intended to help Infant and Early Childhood Mental Health Consultants and home visiting program supervisors and home visitors to develop a shared plan for integrating reflective consultation into ongoing work.

Date: Leads:

Does the plan include home visitor input?

Date for Follow Up Check in:

Goal Area	Planned Activities	Timeline	Responsible Party	Scheduling/ Logistics Details

Sample Action Plan:

Date: 5/2/2025

Leads: Janet Smith/Consultant and Susan Myers/Supervisor

Does the plan include home visitor input? Yes, HVs gave feedback in a team meeting on 5/1/2025 and via a survey

Date for Follow Up Check in: 8/1/2025

Goal Area	Planned Activities	Timeline	Responsible Party	Scheduling/Logistics Details
Build relationship with program leadership	Schedule and conduct introductory 1:1 meetings with supervisor to clarify roles, expectations, and consultation structure	Month 1	Consultant, Supervisor	Mondays at 2:00 PM

Establish reflective consultation with supervisor	Hold monthly 1:1 reflective meetings with supervisor to support reflective practice and program planning	Ongoing	Consultant	Fridays 9:00 AM every other week
Provide group reflective consultation for home visitors	Facilitate monthly reflective groups using shared agreements and rotating case examples	Begin Month 2, ongoing	Consultant, Supervisor	Integrate into 3rd Monthly staff meeting, Wednesday 2-3:30 PM
Individual RC to home visitors	Discuss and develop process for individual reflective sessions; schedule as appropriate	Begin Month 3	Consultant, Supervisor	Consultant joins already scheduled sessions
Support staff during critical incidents	Determine communication protocol for distressing events; provide follow-up support	As needed	Consultant, Supervisor	TBD
Identify training needs and deliver content	Gather input from staff/supervisor on training topics; deliver tailored in-service or just-in-time training	Quarterly or as needed	Consultant	Consultant attends 2 staff meetings per month to gather information (January September)

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Michigan Association for Infant Mental Health (MI-AIMH) includes resources on how to access Reflective Supervision within your CMH, as well as detailed information to ensure the consultant meets the reflective competencies recommended by MI-AIMH.

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Appendices

Appendix A: MI-AIMH Competencies

Appendix B: Daily Experiences with a Mental Health Consultant in Home Visiting

Appendix C: IECMHC Consultant Self-Assessment Survey

Alliance for the Advancement of Infant Mental Health

Michigan Association for Infant Mental Health
Learning and growing together.

Infant Mental Health Consultant[1] Competencies

General Guidelines

The Michigan Association for Infant Mental Health (MI-AIMH) recommends that each consultant who is hired to provide reflective supervision or consultation to an individual or group on behalf of the promotion of infant mental health be:

- Knowledgeable about the community in which the individual/group provides service
- Fully informed and respectful of agency policies, regulations, protocols and rules that govern the individual's or group's services, as well as program standards and specific components of those services
- Knowledgeable and respectful of leadership roles within the agency
- Able to establish positive working relationships with agency personnel

MI-AIMH recommends that each consultant is knowledgeable about:

- Early development, from pregnancy through labor/delivery and the first 3 years of life, typical and atypical, complex and in multiple domains
- Attachment theory and the importance of early relationships to development
- Families, their importance to each child's development, their differences, cultural norms and values
- Developmental competence and psychopathology, identification of strengths and risks
- Situations specific to risk: prematurity, birth of a baby with special needs, the death of an infant, adolescent parenthood, mental illness, alcohol and drug abuse, child abuse and neglect, domestic violence, homelessness, trauma, poverty, grief and loss
- Assessment approaches, sensitive to understanding the infant or toddler within the context of each caregiving relationship, and assessment "tools"
- Service or intervention models, techniques and principles appropriate to the program
- Principles and practices promoting infant mental health
- Relationship-based services
- Reflective practice

MI-AIMH recommends that each consultant demonstrate the following skills:

[1] For the purposes of this document, the term "consultant" refers to the provider of reflective supervision/consultation.

- Ability to meet regularly and consistently as agreed upon by the individual/group
- Ability to create a place where individual/group feels safe in describing and exploring their experiences, thoughts and feelings about the work with infants, very young children and families
- Ability to enter into and sustain trusting relationships with individual/group
- Ability to model and encourage nurturing behavior
- Ability to provide meaningful support, being careful to enhance competency and self-worth
- Ability to provide developmental guidance as appropriate, following individual/group's lead
- Ability to reduce sense of isolation or loneliness that often accompanies work with infants, toddlers and families referred for services
- Ability to observe, listen, wonder and respond
- Ability to pay attention to the emotional state of each individual/group
- Ability to facilitate the expression of thoughts and feelings awakened by the work, talk about them, contain them, and offer comfort and support
- Ability to have and express empathy in response to the experiences, thoughts and feelings shared individually and within the group; nurture empathy in others
- Ability to attend to both the content (that is, what is happening with a particular infant or toddler and family, program or center) and the process underlying these events, including the feelings evoked by both the content and the process
- Ability to give the individual/group the opportunity to experience his/her feelings consciously, and to understand them in the light of the infant or toddler's development, parent-child relationship needs, parental history and current challenges
- Ability to ask questions that encourage reflective practice
- Ability to help individual/group to explore the parallel process, using feelings to inform understanding of the infant, the parent, the early developing relationship and self
- Willingness to seek additional expertise when the consultant recognizes concerns that may be beyond the consultant's scope of practice

Of additional importance, MI-AIMH recommends that each consultant follow the "Best Practice Guidelines for Reflective Supervision/Consultation" specifically:

- Remains culturally aware and sensitive to each individual/group
- Recognizes and responds to individual/group's thoughts, feelings of vulnerability and confusion, as well as strengths
- Encourages the exploration of thoughts, feelings and strengths, as appropriate to the individual/group
- Remains open, emotionally available and curious
- Regularly examines own thoughts, feelings, strengths and issues of concern with a trusted supervisor/mentor

Infant and Early Childhood Mental Health Consultation

MDHHS
Michigan Department of Health & Human Services

CONSULTATION IN ACTION

Daily Experiences with a Mental Health Consultant in Home Visiting

A Series of Real Life Daily Experiences Illustrating Consultation in Action

Edited by Linda Delimata and Mary Mackrain

Acknowledgments

This resource has been shaped and enriched by the incredible leadership of Linda Delimata. Her deep wisdom, historical perspective, and unwavering passion for this vital work have left an indelible mark, making this resource stronger and more impactful.

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Above all, we extend our deepest gratitude to the families, children, and home visiting program staff. Your voices, experiences, and daily efforts continue to teach us, inspire us, and guide us in our mission to better understand and support infant and early childhood mental health.

Mary Mackrain, PhD, IMH-E, Infant Mental Health Mentor, Michigan Department of Health and Human Services

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Introduction, Intended Users, and Purpose of This Resource

Supporting the mental health and well-being of infants, young children, their families is both a profound responsibility and an opportunity to create lasting impact. Infant and Early Childhood Mental Health Consultation (IECMHC) plays a vital role in strengthening home visiting programs by fostering relationships, building capacity, and promoting positive developmental outcomes.

Infant and Early Childhood Mental Health Consultation (IECMHC) in Home Visiting provides a collaborative, relationship-based intervention that pairs a masters prepared mental health consultant into home visiting programs to **strengthen the capacity of home visitors** and their supervisors by providing guidance, reflective practice, and mental health-informed strategies to help them navigate complex family dynamics, trauma, and early relational health challenges.

This resource is designed to offer a real-world glimpse into the work of early childhood mental health consultants (IECMHCs), providing insights into the complexities, challenges, and triumphs of this essential practice.

These stories capture the nuances of IECMHC—highlighting the importance of reflective practice, deep listening, and adaptive problem-solving. While every interaction is unique, the foundational principles remain the same: relationships, trust, and a commitment to the well-being of infants, young children and the adults that care for them..

Intended Users

This resource is intended for:

- **Early Childhood Mental Health (ECMH) Consultants** – Those providing mental health consultation within home visiting settings, helping to enhance the knowledge and skills of home visitors while supporting families.
- **Home Visiting Supervisors and Administrators** – Leaders overseeing home visiting programs who seek to integrate IECMHC practices to strengthen services.
- **Technical Assistance and Training Providers** – Professionals responsible for supporting home visiting staff in understanding and implementing IECMHC strategies.

Although not written specifically for families or home visitors, this resource acknowledges their critical role in the IECMHC process. Consultants and supervisors may find value in using this resource to enhance conversations with families and home visitors, ensuring that all voices are heard and respected.

Purpose of This Resource

The purpose of this resource is to:

Illustrate the IECMHC process in home visiting settings

Through authentic, real-life scenarios, this resource provides a window into the daily work of IECMHCs.

Support professional reflection and learning

By highlighting best practices and challenges, it encourages IECMHCs to refine their approach and deepen their impact.

Facilitate meaningful dialogue

Home visiting supervisors and IECMHCs can use these vignettes as discussion tools to explore strategies, decision-making, and relationship-building in their work.

Promote high-quality IECMHC practices

This resource serves as a guide for embedding IECMHC principles into home visiting programs, ensuring that all young children and families receive the support they need.

How to Use This Resource

The vignettes and discussion prompts included here can be used in various ways, including:

- **Training for New IECMHCs** – Providing real-world scenarios to help consultants navigate common challenges in home visiting settings.
- **Self-Reflection and Professional Growth** – Encouraging IECMHCs to explore their own experiences and refine their consultation practices.
- **Team Discussions and Supervision** – Offering a structured way for supervisors and consultants to engage in conversations about best practices and collaborative strategies.

By engaging with this resource, readers will gain deeper insight into the power of IECMHC within home visiting programs, fostering stronger partnerships and better outcomes for infants, young children, and families.

Table of Contents

Story 1:

ENTERING INTO THE WORK

I had been working as a home-based infant mental health therapist for several years when I applied for a new position in IIECMHC home visiting that was offered through my agency. I had been interested in mental health consultation for a while, so I was excited to get the job and start training.

In preparing to enter the field, I first needed to increase my understanding of mental health consultation and how it differs from therapy or reflective supervision, the latter being something I participate in regularly as a clinical home visitor. Reflective supervision and mental health consultation share similarities: discussing cases, offering support and ideas, meeting consistently. I understood that mental health consultation is NOT about me acting as a therapist to the home visitors, nor is it me acting as a therapist to the families they work with.

I learned to look at the home visitors in IECMHC as if they were the families I worked with in my home visiting role. I would be there to support the home visitors rather than the families they worked with. Some of the ways I would be connecting with the home visitors would be:

- helping them identify emotions and thoughts they experienced when working with families;
- validating and holding their emotions and thoughts to lighten their emotional load;
- encouraging them to examine how their own cultural lens may impact how they experience the families; and
- sharing resources to help them expand their skills and knowledge to better support the families they work with.

I wondered about how much to inquire about families, versus the home visitors' own experiences working with families. What could I offer and when should I hold back? I was fortunate to have a practice group consultation with interns at my agency but fell exactly into what I'd feared: asking question after question about the families and not enough about the home visitors' experiences.

Reflection:

That experience with the interns heightened my anxiety about my new role, but it also gave me some important feedback about forming new relationships. This experience helped me learn to pause during future consultations and not ask question after question about the parent and family and instead redirect my focus to the home visitors who were sharing their experiences.

As I moved deeper into the work, I was assigned three organizations and reached out to each supervisor by email to set up a virtual meeting. During this first meeting, we discussed my new role – a role that was also new to their organizations – and how I could support their programs. In turn, I learned about their programs: how many home visitors each program had, how many families each home visitor served, how often the group met, their supervision requirements, and how their funding worked.

Reflection

I was a bit overwhelmed and wondered how I was going to keep each program straight. In fact, it was a few email exchanges before I was able to remember names of supervisors and link them to the correct program. There was just so much information to take in!

When the supervisors each shared that regular reflective supervision was a requirement for their home visitors, I was surprised, and I found myself wondering how to convince them that I could add to that. In these situations, I wished for more experience in the job so I could be a louder cheerleader for IECMHC and leave them feeling excited about our work together. In each case, we left the virtual call with an agreement that the supervisors would call me when they needed me.

Reflection

Supervisors often asked, "What is it that you DO?" How could I convince them that I could be useful to the program when I still wasn't sure what our work together would look like? I hoped the shared inexperience with IECMHC could be something to connect on, but instead I worried that I came off as unsure of myself.

Forming relationships is at the heart of IECMHC. After my initial meetings with the supervisors, I waited to hear from them. I still hadn't met any home visitors and wondered how and when these programs would reach out. I knew I needed consistent communication with the home visitors and supervisors to establish the rapport and trust necessary for a successful collaboration.

For months, I would reach out and get either no response, or a response that they didn't have any work for me yet. I wondered about the reasons they weren't responding: did I not explain the services? Was I not clear enough? Are they not really interested in services, but required to get them? I hesitated to reach out too often because I didn't want to begin our relationship by badgering them, but I worried that I was failing at my job.

I began reflective supervision specific to IIECMHC and was grateful for a space to reflect on my own efforts and feelings around my slow start to this work. I also shared my insecurities and anxiety about not really knowing how to do the job. I blamed imposter syndrome (feeling like I didn't belong!), but my wise reflective supervisor reminded me, "It's not imposter syndrome if you don't actually know how to do it yet." I carried that idea with me as I continued to attempt to connect with these programs.

Reflection

I am passionate about connecting with people, and I know it to be one of my professional and personal strengths. No one would ever describe me as shy! So why was I so hesitant to reach out to these supervisors, knowing that we shared the same goal of supporting and strengthening families and home visitors? Yet, my inner critic loudly reminded me of my inexperience, and my insecurity made it difficult to gauge the level of interest of these organizations.

A few months into my new position, I was excited to have my first in-person meeting with one of the home visiting supervisors. Margaret was kind, warm, and welcoming, which made me forget my worries that she wasn't interested in services. We talked about how her home visitors were doing, the struggles they currently faced with their families, and how supported *she* felt in supporting *them*. Because it had been more than a month since our initial meeting, I reviewed the services I could provide, shared the key components of IECMHC (e.g., capacity building, supporting home visitors in addressing the complex needs of their families, and integrating IECMHC into the overall program). She shared with me some of the logistical challenges such as finding space to meet and coordinating schedules. Despite sharing some challenges, Margaret struck me as interested in the work and open to this new experience. I left feeling energized and hopeful that *finally* I could really get started in the work.

A few weeks later, I still was not in consistent communication with all three organizations, and I had yet to meet any of the home visitors I would be working with. I continued to check in with a reflective supervisor and peers in the IECMHC program about my progress. I was assured that because of the newness of this position, the slow start was not unusual, and they offered support and encouragement.

Margaret soon invited me to sit in on a team meeting (which I needed to do virtually because of my own schedule constraints) to meet the home visitors and learn more about their work with families. Again, I was welcomed warmly and found it easy to engage with the team. Margaret asked some questions about things we had already discussed so that I could clarify for the team around what kind of concerns they could bring me: Doing paperwork? No. Setting boundaries within a home visit? Yes. I left that meeting hopeful that I was about to start doing the work of a mental health consultant.

It was a couple of months before I met Margaret's team in person, and then three months after that before Margaret reached out and said, "I have a home visitor who is having some challenges with a family. She would like to present a case to you and get feedback." I was thrilled to be asked for my services rather than reaching out again to try to engage. After so many months and such buildup in my mind, I was anxious walking into the group meeting. I listened intently as the home visitor shared the challenges she was having with a particular family, along with her feeling of being stuck. I asked some clarifying questions, explored some of the home visitor's feelings and then found myself wanting to ask more questions about the mother of this family. I was grateful for the awareness to pause in that moment and recall the practice consultation I did with the interns at my agency. I refocused and continued exploring the home visitor's experiences with the family.

Reflection:

I had spent a lot of time waiting to start the work including checking in by phone and email, joining virtual meetings, waiting patiently during staff turnovers, and reflecting on what I could do differently to engage the programs. It wasn't until I walked out of that first one-on-one support meeting that I realized I had already been doing the work. All the build up to my first official consultation was crucial for relationship building—at the heart of any successful interaction in IIECMHC.

Reflection Questions:

1. One of the barriers this consultant faced was inconsistent contact with the program supervisors. How would you balance being proactive in reaching out with respecting the organization's readiness for engagement?
2. How did you (or would you plan to) work through your own insecurities starting out in the role?
3. How does reflective supervision support your growth and understanding of your new role?
4. The consultant kept waiting for specific moments to feel like she was succeeding in her role. Reflect on a moment when you felt successful in your new role. What contributed to that success?

Story 2:

CONNECTING WITH THE SUPERVISOR

The beginning of a consultative relationship is a time of excitement, uncertainty, and a myriad of other emotions. Each time I begin connecting with a new person or group, I get to know *myself* in a new way too. Before I start, I wonder what I will discover in this new relationship. What will it be like for this person to reflect on their work? How might I support them in doing this work? What will these relationships evoke what I already know and am a bit tired of encountering? What will be a surprise that I will then take to my own reflective supervisor?

I felt all these wonderings swirling around when I sent my first email to Rachel, the supervisor of a home visiting program I was beginning IECMH consultation with. In the email, I introduced myself and explained who I was and what I could offer to her and the home visiting program she supervised. I provided several dates and times that I was available to meet and get to know one another and answer any questions she had. Soon, we had our first appointment scheduled.

In our first meeting, I found that Rachel had been with the agency for about eight months. She had no home visiting experience and worried that staff were not taking her seriously because of this. When I asked what was driving this feeling, she told me that of the six home visitors she supervises, two of them often dismissed suggestions she made.

Rachel was questioning if moving to this position had been the right decision for her. We talked about what made her select early childhood home visiting for this new job. After a few moments, she responded that she had worked for daycare centers for about 15 years and had been a director of a large center for seven years. The center had been sold, and the new owners raised the rates, and several families who had been with the center for a long time could no longer afford to send their children there. This was very upsetting as she knew how important the services were for the families. She said that no matter how many conversations she had with the new owners, they just wouldn't listen to her. Rachel laughed ruefully, "Before this job, my bosses didn't listen to me. Now I have staff who don't listen to me. It makes me question if I really know anything at all." I replied, "It can be really upsetting when you doubt yourself." She made a small noise and looked away.

Sensing that she wanted to shift to a different topic, I asked if it would be okay for me to go through a short slide deck presentation that contained information on how I would be able to support her and the home visitors. After explaining the information, we decided to meet three more times over the next five weeks while she worked with the home visitors to get a regular group consultation schedule in place.

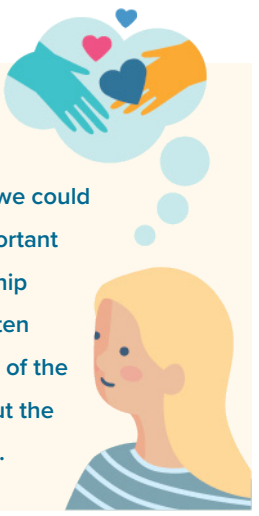
Reflection:

After our meeting, I thought back on the time Rachel and I had spent together. When I begin to work with a new home visiting program, I like to get to know the supervisor and have a good relationship prior to starting with the home visitors. When I understand the supervisor's experiences, it helps me to have a beginning understanding of the dynamics in the program and what they are experiencing.

With Rachel, my impression was that her hopes of being able to help families were an important part of her decision to move into home visiting. I appreciated how she spoke of the vulnerable families she had worked with at the daycare and her desire to help them. This same compassion for the daycare families showed up when she described the families participating in her current home visiting program. She was less forthcoming about her experiences with her staff, so I was curious to know what her experiences were with them.

At the beginning of our second meeting, Rachel said she had time to think about the information from our first meeting. *"It sounds like therapy in disguise,"* she said. And so, we spent about half of our meeting talking about the differences. I explained that reflective consultation with an IECMH consultant is an opportunity to reflect on her work and her emotional responses. Hopefully, she will experience professional growth as a result. Therapy, on the other hand, focuses on personal issues, mental health concerns, and emotional challenges with the goal of promoting personal growth and resolving psychological problems. I summed up that reflective supervision focuses on discussing work-related experiences and challenges, such as feelings related to the staff, the families they support, and the pressures she may experience in the workplace. I assured her that she wouldn't be pressed to discuss anything that felt uncomfortable. We spent the rest of the session coming to agreements on what the consultation would look like, and what boundaries she felt comfortable with.

The third meeting happened after multiple cancellations and rescheduling attempts. Rachel began the meeting by apologizing for the challenges of getting together for this meeting. One staff member had gone out on short-term leave, and another took a new job. As a result, she now had half a caseload to oversee, was trying to hire new staff, and also had her usual supervisory tasks to manage. I reflected that it sounded like there were a lot of demands on her and wondered how she felt about trying to keep so many balls in the air. She quickly responded, *"It's fine. At my last job, I had to fill in all the time at the last minute and do everything else. I just work a few extra hours a week to get everything done. My wife understands and is supportive. So, I'm good."* I asked her how she would like to use our time together. *"I know you said I should bring things that I would like to talk about, but I'm just not sure what that would be,"* she said. I responded, *"Well, has one of the staff or families you are supporting taken up a lot of brain space lately?"* She grimaced. *"Maybe the situation that is making you frown?"* I asked. We went on to discuss a mom and a five-month-old baby she was supporting who were living in a camper parked behind a friend's house. She had many concerns about this family. When I inquired how she felt about what she was experiencing when she was there, she would instead tell me another concern. After deflecting my reflection questions a few times, it seemed to me that she needed to have someone deeply empathize with her overwhelm. And so, that is how we spent the rest of our time.



Reflection:

Later, as I considered the meeting, I was pleased that Rachel had expressed her concerns, and we could address them directly. Given how she was questioning herself about what she knows, it felt important that we spend our time carefully addressing her concerns and being clear on what our relationship would entail. I found myself curious about how she would manage being vulnerable since we often don't end reflective tome together with solutions or answers, but rather a deeper understanding of the connection of our emotional experience to the work. I wondered if she might feel uncertain about the process and worry if she is doing it "right" or fear being judged or criticized about how she feels.

When I met with my own reflective supervisor, I discussed my experiences with Rachel. After listening carefully to my account, my reflective supervisor noted that it seemed Rachel didn't trust our relationship yet and needed more time to view our relationship as a safe space. I expressed my worry that if Rachel was unable to feel safe with me, she might also be passing on that "lack of having a safe space" feeling amongst her staff. What if she struggled to encourage staff to come to group consultation and be present and reflect? Without trust, it would be challenging for reflective consultation to have the hoped-for impact. She reminded me that sometimes we must show up for a long time and be predictable and consistent to be able to build trust.

The fourth supervision session happened as scheduled. Personally, I was quite happy to be staying on schedule so we could, hopefully, keep progressing. Rachel asked to talk about the first group consultation that was scheduled for later that week and wanted to know how the group should be prepared. I explained it would be like our first meeting. We would spend some time getting to know each other, and I would explain how reflective consultation is unique and what they can expect in future meetings. I asked if she had any concerns or anything she thought I should be aware of. She didn't have any, so we moved on to her concerns for the day. She told me about some of the challenges the home visitors were having accessing resources for families and how frustrating it was for the families, the home visitors, and her. She said, *"We have good stuff happen. I don't want you to think it's all bad, but it's just so hard that many of the families have so little and no matter how hard we try, we can't get them what they need. We can give them diapers or food or a gas card, but what they really need is housing and safety."* I empathized with the heavy emotional load she carries as she holds the many stories and layers that come with knowing the struggles of so many people.

Reflection:

After the meeting, I noted that Rachel was more willing to be vulnerable in our time together. A few times when I asked feeling questions, she was able to talk about them in a distanced way. Given her newness to the work, I wondered if being too vulnerable might lead her to be too overwhelmed. Insight and understanding aren't always welcome when there isn't a strategy to manage them. I reflected on previous reflective consultation relationships and considered the ways I had invited the person to deepen their understanding of themselves and how I felt privileged to witness their journey.

Although Rachel and I are only four consultation meetings into our relationship, I have hope that with time, the willingness to be vulnerable and reflect more deeply will come. In the meantime, I will continue to show up and extend the invitation.

Reflection Questions:

1. What have you learned about your own strengths and areas of growth through reflective consultation?
2. How do you handle uncertainty and vulnerability in professional interactions?
3. How do you create a safe space for others to share their thoughts and feelings?
4. How do you show empathy when a person is feeling overwhelmed?
5. How do you balance offering support with allowing the other person to find their own solutions?
6. What boundaries are important to establish in a reflective consultation relationship?

Story 3:

REFLECTING TOGETHER WITH A HOME VISITOR AND SUPERVISOR

In my role providing reflective consultation as an IECMH consultant, I was invited to join a supervisor and home visitor for their regularly scheduled reflective supervision sessions. As I drove to their offices that first morning, I wondered how my being there would affect the dynamic. I always hope that I can find ways to join staff together in their processes and their rhythms, similarly to how a home visitor joins alongside a dyad (parent and child).

Reflection:

Big or small, humans have a fundamental need to feel they are understood and cared for by others, and to be able to express their own natural intuition to care. These needs present differently and often motivate individuals to seek out relationships with those around them. I'm wondering what this looks like for the supervisor and home visitor and how this gets communicated during their time together. I'm wondering about the ways this will be described by the home visitor in her work with a family.

As I positioned myself in a chair in the supervisor's office for the start of that day's reflective consultation session, I remembered some advice given to me by a previous reflective supervisor – find ways to keep your eyes, ears, and heart as open as possible and try to experience moments.

Home visiting is hard and can sometimes feel overwhelming and unmanageable calling on us to seek and find answers. I don't always have a clear strategy to offer during consultation and am feeling concerned about expectations for our time together, and for me. The concern and uneasiness I felt led me to use a curious, yet containing, beginning approach. I started with: *"Thank you for inviting me to join you this morning. I recognize you've been meeting together for quite some time and as we talk about your experiences with families, I'm wondering what might be most helpful. We've all been supported in all kinds of ways, and I am hoping we can take some time to talk about how you're hoping to spend our time together today."*

The home visitor smiled in response and the supervisor shared how they typically move through their time. While there were several familiar aspects mentioned (describing a home visit, discussing thoughts and feelings and considering responses), it was difficult for me to get a feel for and a picture in my mind about the process the supervisor was describing. I reminded myself of the importance of being a "participant" in what happens.

The home visitor shared a concern first: *"I was thinking I would talk about a family I've been working with for about five months now. I cannot*

figure out what the mother wants from me, from the program. I thought we were off to a good start and although she keeps our visits, it's like the same visit each time I go. You know what I mean?"

The home visitor looked at both her supervisor and me while she spoke, yet her final question ended while making eye contact with me. While there was a "we're all in this together" feel to our time together, it also felt important to remember that I was new to their existing relationship. This was a nice "parallel process" reminder about how a home visitor can feel when beginning to work with a new family. So, I looked back as the home visitor asked this question and instead of replying, I held silent. Home visitor: *"I thought the mom was invested in us, that she cared about helping her child."*

Supervisor: *"What makes you think she's no longer invested?"*

Home visitor: *"She's on her phone sometimes and when she's not, it's as if nothing I say matters. Her son is two years old, and he gets so excited when I arrive. When he starts running around or doesn't listen to her, she gets pretty upset and ignores him...not just his behavior. I don't know what to say in these moments because when I've tried to take guesses about his behavior, she just looks away and says, 'He does it all the time.'"*

I feel as if it is the right time to share one of my wonderings: *"In these moments, I wonder if it feels like you're both being ignored?" I ask.* I wasn't sure how my question was going to be experienced and felt uncertain about what the home visitor and supervisor might offer in response. It was quiet in the room.

Reflection:

Was my timing okay? I thought to myself. This relational work we do holds onto the idea that we enhance social and emotional wellbeing and strengthen relationships when we respond in emotionally supportive ways and help support the reflective capacity of adults. Knowing this was my intention in asking this question brought me comfort.

Home visitor: *"Yes! And this feels different from our first few visits. I don't know what changed. We had long conversations about family goals and how we could work together toward these goals. She said it sounded nice and I thought we were on a good path forward. Now it feels like we're still standing in the same place...maybe even steps backward. I don't want to feel like she's wasting my time, but if she's not going to work with me, what's the point? I wish she'd just tell me if she's still interested or not."*

Supervisor: *"Every family is different. It can be a hard part of this work to not know what a family needs to feel comfortable and come to trust us."*

The home visitor went on to share a recent home visit and the way she noticed the child's fussiness. It didn't take long for the fussiness to become a full-blown cry. The home visitor's instincts and inner voice were screaming "Do something!" She described wanting to scoop up the child to hold him, to comfort him. Instead, she watched as the mother looked away and walked past him to pick up a piece of paper from the table.

Home visitor: *"I left angry and sad, not to mention concerned. I cried when I got into my car, and I'm worried about what happens when I'm not there*."

I was drawn in by several things, including the idea that we were developing our reflective relationship as she was developing her relationship with the family. The dance between this mother and child produced an urgency and vulnerability in this

home visitor and it was important for me to consider my responses to help set a pace and even slow quickening steps. This home visitor understood that responsive care requires listening to what children are communicating through their cries. I wanted my responses to mirror this type of listening for the home visitor and her supervisor, both separately and together. *"It sounds like you find yourself walking into the unknowns of their relationship. I can hear in your voice how much this mother's way of interacting with her son upsets you and you found a way to hold onto your strong reaction to rescue him during this moment of distress. Am I reading this right?"* I asked.

Supervisor: *"Sometimes when we feel upset or anxious, it can make our work with a family's struggle feel even harder. It sounds like you're learning even more about yourself as a home visitor as you're learning about this family."*

While glancing at her hands, the home visitor smiled and relaxed her shoulders.

Home visitor: *"I suppose I am."*

Reflection:

I couldn't help but consider the parallels between what sounded like a vulnerable mom and her home visitor who had also been working so hard.

Every home visitor enters into this work for their own reasons and with their own skills and strengths that allow them to remain engaged and supportive during a family's struggles. My hope was that the responses she received allowed her to safely explore her own emotional responses and that this awareness helped her further recognize her own strengths and successes within difficult moments. I also hoped for an opportunity to reflect with the supervisor about this interaction. I wanted to get a chance to discuss how effective it was for this home visitor when there was enough time, space, and attention given to her need, as well as what she noticed they were able to do well together in this and other reflective supervision sessions.

Reflection Questions:

1. What do you think is happening for this home visitor when working with the family?
2. What do you think is happening for the family when working with the home visitor?
3. What did this interaction bring up for you in your role providing consultation?
4. Think about relationships that have helped shape you in your work. What is something about the relationship or person that allowed for you to safely explore your own emotional responses and increase awareness?

Story 4:

CASE CONSULTATION

In the group case consultation this month, it was Janelle's turn to present (as the group of home visitors had decided to each present on a scheduled rotation). After everyone was settled in, Janelle, a white woman in her 20's, began with background information. She shared, *"Olivia is a first-time mom with a six-month-old baby girl, Amelia. She lives with her boyfriend, Carter, at his grandma's house and has since she was 18. She is 20, and he is 27. Everyone in the immediate family is white. Carter was removed from his parents and placed in foster care when he was little and then went to his grandma who adopted him. Carter is very loyal to his grandma. Sometimes they quarrel but what I see between them is positive overall. Olivia feels like when she and the grandma have a conflict, Carter always takes his grandma's side. And when she and Carter have a conflict, the grandma takes his side. This was a big part of the conversation last time we met, as Olivia and the grandma have very different ideas about how to care for Amelia. She feels like they gang up on her and she has no say, but honestly, I agree with Carter and the grandma, so I have to make sure that she doesn't feel like I'm taking their side. It's hard, though."*

"I can see how that might be hard to figure out how to navigate that," I said. *"Can you tell me a bit about what the conflicts are about?"*

"Well," Janelle begins, *"a big one is responding when Amelia cries. I have been there when Carter is at work and the grandma is out. Olivia puts Amelia in her bouncer and leaves her. When she starts crying, Olivia will wiggle it with her foot or give Amelia a pacifier but doesn't pick her up until she is shrieking crying and then as soon as she is settled down a little bit, Olivia puts her back in, and it starts all over again. But when Carter or the grandma are there, if Amelia starts fussing, they try to figure out what is wrong and pick her up quickly, and she settles down right away. Olivia gets frustrated and tells them Amelia can't always have everything she wants the minute she wants it, and she needs to learn patience."*

"What do you make of that?" I inquire.

"It could be a couple of things," Janelle shares, *"Olivia didn't have a good childhood. She and her mom watched a lot of TV. When her mom had a boyfriend, there was often emotional abuse, sometimes sexual abuse, and physical violence. She didn't get a lot of food to eat. She met Carter when she was 15. I don't understand exactly how they met. It's confusing, but a friend of a friend of a friend kind of thing. He felt bad for her because he was abused and neglected by his parents, so he and his friend group "adopted" her. They made sure she had places to stay because of all the violence with her mom's boyfriend. When she was 18, the grandma told her she could move in, as Olivia spent a lot of time there, mostly, it seems, to eat and shower. After she moved in, she and Carter started dating. Anyway, that's a long story, but I think she gets jealous when Carter or the grandma pay attention to Amelia. She really didn't have the experience of someone paying attention to her like that. Knowing what she needed and doing something about it. Sometimes, it seems like she does things purposefully to irritate Amelia, and then when Carter tells her to stop or solves the problem, she gets mad that Carter isn't supporting her way of doing things."*

"That's a lot. I can see how it might be hard to support her when you see that Amelia is so upset and can be soothed when her needs are met. Are there any other factors that you think contribute to Olivia's reluctance to help Amelia when she's upset?" I inquired.

Janelle responded, *"Well, to me, Olivia seems depressed. When she was pregnant, she was tired sometimes but still spent a lot of time running around with friends. She and Carter are the only ones in the friend group with a baby. Carter works a lot and regularly hangs out with friends, but it doesn't seem like she's invited now. I haven't really asked her about that. Maybe I should. Anyway, her mom isn't interested in being part of the baby's life. Olivia has invited her over many times, and she says she doesn't have a way to get there or doesn't show up. Her mother has never met Amelia. I can't imagine being a grandma and not trying to meet my grandchild!"*

I reply, *"Yeah, that's rough. I'm hearing that you have concerns about how Olivia treats Amelia, Olivia's possible depression, and you're concerned that she doesn't have a lot of social connections. Is there anything else? What do you find challenging in the home visit?"*

Janelle replies, *"As you know, I am always prepared and have a plan for her to do things with Amelia, but it's nearly impossible to do anything, as she only wants to talk about what is happening in her life. I have brought all sorts of things for us to do with Amelia, but we haven't done any of them. I can barely get the developmental screenings done. I have some concerns about Amelia's development, but Olivia blows me off and says she's able to do all sorts of things that a six-month-old can't do, like talking in sentences. It's like she thinks if I'm not worried about Olivia, then it's okay to ignore her when I'm there."*

Reflection:

As I consider what will help Janelle in this situation, I think about what she is bringing into the relationship with Olivia and Amelia. She is a new home visitor and is anxious about doing the "right" things in the work. She can get preoccupied with providing information and going down the checklist, which means sometimes she isn't able to hold space for just having a relationship with the families she is supporting. Because of this gap, I think this is the place to start before moving into strategies. Consultation involves supporting professional development and finding ways to help the home visitors be successful in all aspects of the work. I note that in this program the home visitor can work with both parents and focus could be on being more active in engaging Carter and potential biases around father's involvement in home visits. Another home visitor might need help understanding how to support Olivia in getting mental health treatment. If there were cultural considerations, the conversation might start there. For the consultant, understanding how the home visitor approaches the work is important, as that shapes how they will move the conversation forward.

I say, *"Janelle, the struggle you are having often happens in home visiting. There is a mismatch between what you are offering and what Olivia is wanting out of the visits. How would you feel about discussing this as a group?"*

After she agrees, I ask the group, *"How do the rest of you manage that type of situation? You show up with a plan that goes with the curriculum, and the family wants something different."*

"When I hear you talking about this family," Zan says, *"it reminds me of so many families I have had. For me, I try to get one small thing in per visit. I'll listen to the parent and talk about their feelings, then I'll slip something in. And then I leave materials with them and hope they look at it. I just hope that me being there listening is the thing that will help them get some relief from stress so they can parent better."*

Rebecca chimes in, *"I get frustrated in those situations too. Sometimes it helps to figure out why they want to be in the program. What does she want? Maybe it's really Carter who wants her to participate and she does to keep him happy."*

"Rebecca, those are great observations. Janelle, why do you think Olivia wants services?" I ask.

Janelle was able to come up with some reasons why Olivia might want services. Central to the conversation was consideration of what Olivia needed from the relationship with Janelle. The group was able to identify ways Janelle could connect with Olivia between appointments so Olivia would know that she doesn't just hold a place in Janelle's calendar but also in her mind when she isn't there. The group went on to connect other needs they noted to the curriculum and gave ideas on how Janelle might use it to strengthen the relationship.

Before we ended the group, I asked, *"Janelle, we talked about a lot of things that might help in your work with Olivia. Is there anything you wished we would have discussed but didn't?"*

She replies, *"I don't think so. I didn't really know what I needed. I just remembered that in the past you said that we should bring families that take up a lot of our brain space, and so that's how I decided to talk about Olivia and Amelia. Hopefully, I can help them with all the ideas that everyone gave."*

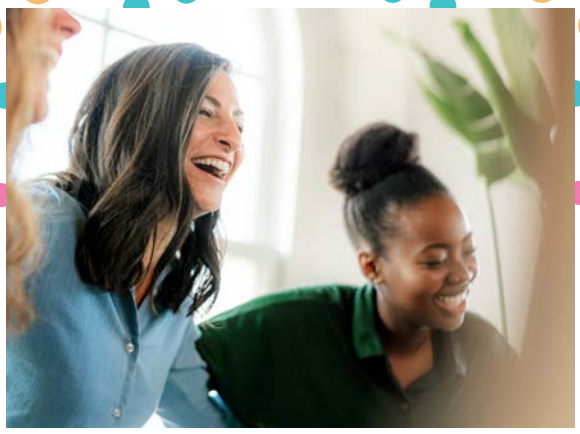
Reflection:

After the meeting, I spent time reflecting. I really appreciated the group's ability to encourage Janelle, give her ideas, and challenge her in considering Olivia's motivations in a different light. As for me, I recognized in Janelle similarities in how I struggled as a new home visitor in having enthusiasm for the program and a tendency to get frustrated when families weren't participating in a way that I thought they "should" and how that led to further frustration for both me and the families. Through the years, I found families with complex needs can't be reduced to a few neatly packed interventions but rather require a variety of skills on the part of the home visitor. And in turn it requires the consultant to be able to analyze and consider the needs of the home visitor and the family. In the early stage of my career, the consultant for the program I worked in was able to identify the emotional toll this friction was having on my life and the possibility for burnout if my skills stayed the same. The consultation provided me with emotional support and empowered me to handle challenging situations more effectively, which I think led to better results for the families I supported.

As an IECMH home visiting consultant, I sometimes find it challenging to plan and stay focused on how the home visitors and I will use our shared time together. When we are reflecting together, the focus is on how the home visitor is experiencing the work. Whereas, during case consultation, there is a greater emphasis on developing skills that will support the home visitor in being more effective in their work. Consequently, there is a lot of focus on how the family is experiencing both the intervention and the home visitor. The collaboration between the consultant and home visitor in reflective and case consultation hopefully provides a safe place where the home visitor can feel supported in areas of vulnerability. And then take the felt sense of safety to the families they support.

Reflection Questions:

1. How do you create a supportive and non-judgmental space for home visitors to share their challenges and successes?
2. How might the direction of the case consultation have changed if there was a cultural difference between the home visitor and the family? Or if Carter and the grandma had a different cultural background than Olivia?
3. There is a balance between providing guidance and encouraging home visitors to develop their own problem-solving skills. What would the potential pitfalls of leaning too far in either direction be for Janelle?
4. In this vignette, the consultant gets Janelle's consent on the discussion focus when asking, "How would you feel about discussing this as a group?" How does this build a collaborative relationship? What ways do you use language to build collaboration? Are there ways your language might disempower the consultee?
5. How do you manage your own biases and assumptions when providing consultation to home visitors?
6. How do you ensure that the consultation aligns with the home visitor's professional development needs while also addressing the needs of the families they support?



Story 5:

GROUP CONSULTATION

As I entered the room where we held group meetings, the supervisor was also walking in with the rest of the group of home visitors – seven in total. We all exchange greetings and the group quickly gather around the large table to begin. Today's presenter, Mandy, starts her presentation by sharing a song on her phone as our "mindfulness moment" to prepare and set the tone for reflection.

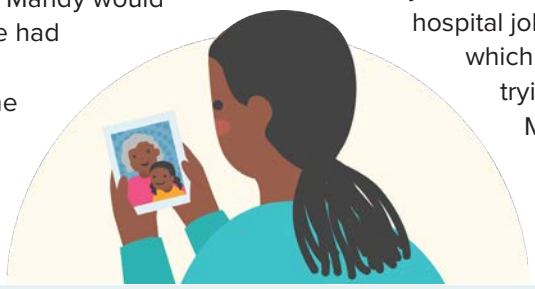
After we listen to the sorrowful song, Mandy says that she chose to share this particular song about a lost relationship as it reflects how she is feeling about one of her families. She said she has been struggling with these home visits because the mother is so withdrawn and the connection between the 8-month-old and mom and their secure attachment is in jeopardy.

After listening to the song, Mandy launched into her experience with baby Izzy (her nickname for Isabella) and her mother, Yolanda. She described having been able to begin home visits with Yolanda prenatally, when she was about 7 months pregnant. Mandy described the 26-year-old mother as looking low and subdued from the start, and it took some effort to allow her to open up to Mandy about her life. During their early visits, Mandy admired aloud her cozy apartment. The furniture was sparce and well-used, but Yolanda had some nice touches that warmed up the living room. Yolanda smiled slightly and thanked her for the compliment, adding that it was something she had put some effort into. Later Mandy would learn that some of the furniture had been her grandma's, who had passed away shortly before she became pregnant. This was the grandmother who had raised Yolanda most of her life.

Yolanda began to tear up when she explained how she was raised. She had so loved her grandma and had been fiercely protected and cared for by her after her own mother had died. Yolanda was only five. It would be several months before she would tell Mandy that her mother was killed in an auto accident. Her father had left them earlier in her life and was rarely mentioned. Mandy felt so much sadness in this young pregnant woman yet sensed that she had thrived while growing up in the loving care of her grandma and grandpa. They had even helped her to go to community college for two years, but then her grandpa passed away, and money was stretched too far to continue.

Mom-to-be Yolanda initially seemed quite reserved in her happiness about her pregnancy, but Mandy noted signed of hope as well. Yolanda had been in a relationship with Terence for over a year, beginning when she was living with her grandma and working in a medical office. Her grandma was at first pleased that Yolanda was dating him. As the relationship progressed, and Terence withheld his support and his feelings from Yolanda, her grandma expressed concerns. The couple stayed together though, and they became pregnant about three months after Yolanda's grandma's death.

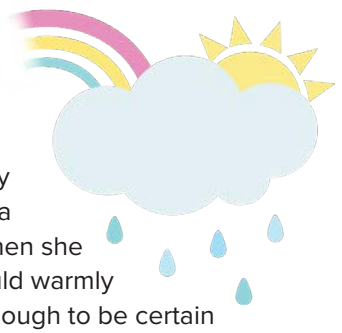
On the third visit with Yolanda, when she had shared her grandma's reservation about Terence, Mandy also learned that Terence had left his hospital job and returned to school, which was several hours away, trying to qualify for a special Med Tech program. He had



not been forthcoming about his plans before she became pregnant and decided to go despite Yolanda's pregnancy. That he had left so suddenly after the news and after her grandma's passing had really shaken up Yolanda. He was calling her often and seemed concerned about how she was feeling both physically and emotionally, but he had only been home to see her once since leaving. Terence was trying to sort things out and come to terms with becoming a father, convinced he needed to commit to becoming a good breadwinner, and this was the time to advance toward a profession, hopefully in the medical arena. Of course, Yolanda was feeling quite abandoned, awakening some buried yearnings about losing her father as well.

The pregnancy had progressed quite well, despite the circumstances. Yolanda had been quite steady in seeking pregnancy care and getting to her prenatal appointments. Mandy helped her see how competently she had been preparing for her baby, and initially felt she was a helpful sounding board for the birth plan as well as Yolanda's maternity leave planning. Terence would come back some weekends and fortunately was able to get there in time for the delivery. Mandy said at the time she would describe the couple as consciously trying to become both a sturdier couple and "good enough" parents.

Yolanda came to trust and look forward to Mandy's weekly visits (twice weekly for the first months after baby Izzy's birth) but Mandy described becoming more aware of how hard she had to work to prepare herself for these visits, because of the strength of Yolanda's sadness and grief that would occasionally present itself. It felt like, at times, she could not do enough to brighten the day of this fragile mom and baby, and she felt less competent than in her work with other families. Mandy had not yet experienced the death of anyone close to her. She had no children. She had a steady significant other who had not committed to their relationship long term. Sitting in the grief with Yolanda had become almost unbearable. Especially on the days Izzy had that blank look, when she seemed very uncertain of her mother's response to her bids for attention and would turn her head away if Yolanda came close or would begin to pick her up. Her smiles were few and fleeting. Sometimes there were more smiles between them, and Izzy would light up when her mama came to her or would glow when she heard her name, and they could warmly interact for a while. But not enough to be certain of a loving relationship evolving as mom and baby both deserved.



After sharing the family's situation and her reflections and experiences, Mandy then turned to her colleagues. She seemed uncomfortable and began to cry as she explained her wish to better support this family. Obviously, she cared a lot about this mother and her baby girl! She stopped talking, looked around the table at her teammates and saw they also had welled up with tears. This led to a round of supportive and tender validation from everyone there, starting with her supervisor. I waited a bit and felt the release and relief that enveloped us all as Mandy heard the tender words. Mandy heard and felt considerable acknowledgment of her feelings. It was also soon evident that everyone in the room was familiar with these evolving, heavy emotions stemming from home visiting work that also, often, reflected some of their own lived experiences.

Once the support from her colleagues died down, I thanked Mandy for her honesty about the challenging and surprising feelings that she uncovered within herself. And I applauded her courage to open up her heart and share it with us all. I added that her willingness to open up with us was likely what also helped Yolanda open up to her. I offered a few words about the parallel processes at work within the evolving relationships between Mandy, Izzy, Yolanda, and Terence as well. I wondered aloud how Mandy's deep emotion around this family and some of her own personal connections was bringing things up for others in the room.

Bravely centering on the swirling emotions that charged the room in the past minutes, Mandy's colleagues started sharing their stories that connected to Yolanda's case and shared their occasional feelings of self-doubt. The home visitors

in the room shared details around feeling guilty for having an easier life than their families; sitting in grief with families; experiencing families facing post-partum depression; and more.

This open sharing reenergized Mandy to share more about some successes she had recently had with Yolanda and Izzy.

Mandy shared that she had recently searched for some easy basic activities to entice Yolanda to come down on the floor to try some floor time with Izzy. She considered various options including drawing on the program curriculum, using the Edinburgh PPD Scale as a tool, and even changing the time of the visit so mom and baby could both be more rested and open to shared play time. She paused, stating she hadn't had much luck yet.

So, I wondered aloud if this might be just the opportunity to ask if Yolanda might now be interested in learning a few favorite games and songs that many babies love, and which might be fun to try with Izzy. Mandy brightened with that reframing and seemed hopeful. She also explained that she wanted to learn more about the feelings Yolanda was having related to the baby and find a way to talk more about Yolanda's depression. Mandy realized Yolanda was trying to do so much on her own, and it might be time to ask more of Terence.

I applauded that Mandy was identifying several important avenues to help mom and baby and to impact their attachment relationship. We opened the discussion to the group about the ways they had found to gently but effectively have more conversation that could remove the stigma or reluctance about addressing mental health and potentially seeking treatment. Others had examples of their approach from a place of empathy, directness, and unhesitating support. All also reinforced the idea of making sure to do an activity, with mom taking the lead directly, inviting Izzy into the fun.

One home visitor described her work as trying to bring fun and joy into their interactions together, with her role being more of a "play coach." She came to understand that this mom needed help to learn or re-learn to play and include her son. She felt Mom's mood had been so low that she failed to pick up on her baby's cues of readiness for fun and connection. As the home visitor pointed out her child's interest and delight during play, Mom, in turn, became more conscious about her own smiles and noticed that her son responded with anticipation and joy. "Joy begets more joy!" the home visitor shared.

Another practitioner said she was more successful when she simply stated to a mom that she was concerned about the deep sadness she sensed from her, wondering how she might help, followed by allowing a quiet couple of minutes for those compassionate words to sink in. This mother began to cry and shared that she felt so distant from her little daughter and then felt guilty for feeling distant. The home visitor provided a time and space—and ears and heart— for this new parent to believe the realness of her home visitor's worry about her own well-being as well as her baby's.

Finally, with only a few minutes remaining for this group, the newest member posed a question to Mandy. The home visitor had been wondering how Yolanda's family's culture, differing from Mandy's, might play any role in their interactions. This new home visitor shared that she had grown up in a family who was very reluctant to ask for help because they had repeatedly encountered service providers who let them down and were not genuine in their wish to offer support. As a person of color, she had learned to be careful before trusting another's intentions and to be protective, of herself and of her family and friends, in this world where racism is still an unfortunate reality. She has also quickly brought up the value of considering cultural influences both as part of contributing to a family's strength and sometimes creating unexpected difficulties that need tending.

This led to Mandy realizing aloud that she had only a surface sense of the differences between her own upbringing and Yolanda's. Mandy stated she was always drawn to children and the helping professions, but she often struggles with the intensity of the poverty she has seen up close in

some of the homes she visits. She sometimes just wants to sob after those visits for the scarcity of support and basics like food, diapers, and laundry soap. She also regularly mourns the lack of caring that those situations reveal about our larger culture.

Mandy then shared that she also admires the strength and determination that she has seen in parents who have had to find resources in unexpected and more challenging ways. And recognizes that most parents share the same dream— that their children are healthy and happy and know in their hearts and souls that they are loved and valued by both their families and in their larger communities and that they have ample opportunities to create happy, healthy, productive lives for themselves. Mandy shared that this new home visitor's wondering aloud about culture and connection would keep her grounded as she continued the work.

In the last minutes of this group reflective, I asked Mandy what she was thinking would be her next steps in returning to Yolanda's and Izzy's. As we listened to her, we heard a thoughtful plan emerging that was incorporating many ideas from today's group. I noted that her plan also mirrored the caring and thoughtful way these remarkably capable and sensitive colleagues held her. She will be tender and caring with Yolanda in part because Mandy asked for help and received TLC for herself. That, in turn, will help Yolanda to be able to be responsive, gentle, and caring with Izzy. I thanked Mandy for bringing baby Izzy and family to us today and for sharing the story of her work with them so honestly. I thanked the group for their receptive listening and wonderful reflections that will help us all to do better work with many other struggling babies and families.

Reflection:

This is such important work, and it is often so difficult, as is the work of parenting. I say my goodbyes with gratitude for the many individuals who have chosen the work of supporting families and young children. It is also a privilege to have the opportunity to help create a space to pause and reflect upon home visitors' very busy days. These opportunities help them find both community and connection that can sustain their vibrant efforts to return time and again as a steadying force for so many vulnerable homes with parents who want to offer safe, loving relationships and care for their infants and children and who deserve a strong supportive community with caring relationships to help assure a better future for the whole family.

Reflection Questions:

1. What led to Mandy being able to be vulnerable in this group reflection?
2. How was the parallel process helpful with this team?
3. What topics emerged during this group reflection that you, as the consultant, might bring back at another time for further training, reflection, resource-sharing, and discussion?
4. How might the culture of the family influence the interactions between the parent and the home visitor?

Story 6:

TRAINING

I had been working with an agency for about 9 months and had yet to provide a specialized mental health training. I had initially offered this component of the IECMHC model to the supervisor of the agency to deliver concrete training to the home visiting program. I explained that this type of training could meet the supervisor's need for his or her staff to be trained, while also meeting the home visitor's specific needs for knowledge and skills to aid their work with families. I felt that offering this type of support would be a great starting point for building rapport and trust, and eventually reflective relationships, with the supervisor as well as with each member of the home visiting team. But as often goes with the best laid plans, my intended training sessions were delayed by busy holiday schedules and an unexpected loss of the supervisor who resigned from her position.

The home visitors had a period of uncertainty as they processed what it meant for them to be without a supervisor and wondered who would become the new supervisor. I had established monthly case consultations already and felt that the home visiting team benefited from our time spent together. We used a portion of that time to process their thoughts and feelings about the changes in their program, and we spent time as we had done before, discussing some of their successes and challenges in working with their families. I was able to weave in mental health concepts through our case consultations, encouraging them to broaden their understanding of what may be going on for families, think critically about their interactions with their clients, and reflect on what thoughts and feelings were elicited in them through the work they were doing.

After the supervisor resigned, I had also begun individual sessions for the home visitors in the spirit of providing extra support during a period of chaos within the agency and to guide them through some of the questions they had about their work during the time that they were without a supervisor. The group case consultations were going well, but I noticed a pattern with some of the home visitors that they did not always follow through with their individual sessions with me.

Once things began to settle within the agency environment, I revisited the idea of providing training sessions with the new supervisor. She agreed that the timing felt right, and we decided to ask the home visitors to brainstorm some training topics that would be of interest to them. As a group, we decided that the first training I would provide was on building rapport with families. The home visitors explained that sometimes it can be hard to get families to engage in the program. They may call and leave voicemails several times, text and get minimal response, and might even have some families not show up. A theme that I had noticed with this group of home visitors was also that they lacked confidence in themselves.

Throughout our case consultations, they would express thoughts and feelings such as, "What do I even have to offer this family? I feel like I don't know what I'm even supposed to do with them." A couple of the home visitors had been with the agency for under a year and had previously been working in classrooms. We would talk often about how the work that they did in classrooms was very structured and often with tangible results at the end. Their work in home visiting felt very foreign to them. They often questioned whether they knew how to mentor parents and if the things they were doing with families would ever lead to noticeable results.

I also observed that during case consultations, the home visitors had plenty of good ideas of what to do with families and how to do the work. The staff who had been in the role longer were often able to share stories about their experiences, things that they tried that worked, and how to approach families when things were not working very well. The home visitors were very skilled in bouncing ideas off one another and sharing community resources that might help families.

Reflection:

I thought about what the home visitors were telling me they wanted training on and what I had observed as an area of potential development. I wondered how I might shape a training on building rapport with families to also provide the home visitors a boost in their confidence and foster their ability to trust in their judgment and skill too. I was also sensitive to coming across as the "expert." I hoped to continue developing collaborative and supportive relationships, and I considered the idea that it would benefit the home visitors most to be able to think critically and open-mindedly about their families, rather than depending on my suggestions alone.

As I prepared for the training, I jotted down all my thoughts on how to build rapport and engagement. I noted what I had learned about human attachment styles and entering relationships with those who may not easily trust others, especially not home visitors who arrive wearing a badge to talk about their child's developmental delays or prenatal drug exposure. I also noted what I had learned from my own experiences as a home visitor. I recall knocking on doors where there would be no answer that day, feeling partially relieved (Do I have the skills to have supported the family if they had been home?), partially concerned (Are they okay? Did I do something wrong?), and knowing I'd have to try again. My thoughts were based upon my understanding of the complexities of what vulnerable families may be facing – things like socioeconomic challenges, cognitive deficits, generational trauma, or addiction to substances. And so, I organized a few categories of things I wanted to discuss with the home visitors.

I typed out my notes with categories: Challenges to Building Rapport (with the two subtopics of challenges on the parents' part and the home visitors' part), Thoughts Elicited in the Home Visitor, Feelings Elicited in the Home Visitor, and Strategies to Build Rapport. Under each category I wrote a few of the ideas that readily came to mind. For challenges to building rapport, I thought of examples such as parents' distrust of the home visitor or mental illness or home visitors' burnout or lack of sensitivity to the family's cultural practices. I wrote how home visitors may feel concerned, angry, worried and how they might be thinking things like "Why bother?" or "How will I get my paperwork done in time if they won't meet with me?" And I listed several strategies to try, such as being predictable and consistent, using the relationship to demonstrate healthy boundaries, and how to gently "notice" with families their patterns of disengagement.

Perhaps the most important part of my planning was to leave bulleted blank spaces under each category for home visitors to add their own ideas. And add they did! The home visiting

team had many wonderful additions and lots of rich discussion on challenges they've had and what they have found that works. Colleagues collaborated, they realized their past successes, and I supported their thoughtful discussion. As we talked, they added onto the outline that I had created, so that in the end, we had an abundance of ideas about what potentially gets in the way of building rapport, what the home visitors think and feel when there are challenges to building rapport and engaging families, and plenty of strategies to try to overcome such challenges.

As I discussed strategies for engaging families, I stressed the importance of setting consistent appointments and following through predictability. I said that the consistency and predictability lend to building trust in new relationships. When a home visitor and family schedule to meet every Wednesday at 10:00 and the home visitor arrives every Wednesday at 10:00, they demonstrate they are reliable, trust-worthy, and that they can be counted on to follow-through. I also told the home visitors that when they have that consistent, predictable meeting scheduled and the family no-shows, they then have the opportunity to kindly but firmly discuss. For example, saying, "We set our appointments for every Wednesday at 10:00, but I've noticed the last two weeks when I've arrived, you haven't been here at those times. Can we talk about what might help you to attend our appointments?"

Reflection:

I drove away after giving my training, reflecting on how it went. I had accomplished my goal of taking on confidence-building and a collaborative stance. I emphasized how much the home visitors knew and could add to the topic themselves in hopes of them feeling more confident about what they have to offer families they work with. I had inserted a bit of education on attachment patterns, being open to thinking about the complexities of what the families face, and some self-reflective discussion about what types of thoughts and feelings are elicited in the home visitors in these moments.

After spending some time reflecting, I had a major revelation. I was not setting consistent, predictable times to meet each month for individual reflective supervision with the home visitors. And I was experiencing challenges in building the rapport too. Group reflective was going well, but the individual sessions I had started in the last couple of months where home visitors felt a bit more vulnerable with me were not. I was waiting 15 minutes on zoom calls that the home visitors forgot about and having them not respond to my emails to schedule that month's supervision until the month was nearly over and their schedules were full. It probably felt similar to their challenges in building relationships with some of their clients.

On my next visit to the agency, I humbly explained to the supervisor and home visitors about my realization that I, too, needed to demonstrate my consistency and predictability to build their trust in our relationship. I then suggested that we switch to having standing appointments for our individual sessions each month.

Since we made that adjustment, I have found better consistency in our meeting together. I incorrectly assumed that the home visitors had enough trust in me from our group work together, but the trust that we had established in that group setting didn't necessarily translate to the individual sessions for all the home visitors. I also didn't account for how much uncertainty and unpredictability had arisen within their agency, which really required me to be even more consistent, structured, and predictable in my interactions with them.

Though this definitely started as a bit of a "miss" in my work with the home visitors, it was also an opportunity for me to demonstrate other qualities they can expect in their relationship with me – self-reflection, repairing of misses in our relationship, and the ability to open myself up humbly and vulnerably to admit a mistake and grow from it. My hope is that their felt experience with me will also translate to their work with their families.

Reflection Questions:

1. How do you handle situations that require you to be flexible with your plans and shift how you meet the needs of consultees?
2. When has there been a time in your work that you were developing newer skills and lacking confidence in yourself?
3. What types of feelings are elicited in you when you have challenges in building rapport and engagement with consultees?
4. What could you look for that would help you gauge the level of trust, safety, and security you and a consultee have established in your relationship?
5. When have you noticed a "miss" or a disruption in one of your relationships, and how have you made repair? Or, if you did not make repairs, how did that impact the relationship?

Story 7:

JOINING IN A HOME VISIT

Today I am going to the program site to meet with Sarah and her supervisor Karen. We have been discussing a case for 6 months, and I can see that Sarah is becoming frustrated because she feels that she is not helping this young mom as much as she feels she needs to. Desiree has an obvious affection for Michael, and makes sure that he is clean and fed. She brings him to all his doctor's appointments and gets immunizations on time. But Michael is not reaching his developmental milestones and seems content to sit in his baby seat and just watch what is happening around him. He is 9 months old and has not made much effort to sit up or begin to crawl.

During our past discussions, Sarah had shared that Desiree was eager to talk with her, and that they shared information easily back and forth. But Sarah also shared that she rarely noticed Desiree holding the baby or talking directly to him. At times, when the Desiree was on the phone, she would give Michael a toy to hold when he began to fuss but would not address him.

During our reflection time, Sarah, Karen and I would discuss what strategies Sarah was trying. Sarah shared that she had made some suggestions and given Desiree information on the importance of bonding with her baby. On every visit, Sarah would ask what mom and baby did together, but the responses Desiree gave were mainly about what she did for the baby, not what they did together.

Since Sarah felt like she wasn't making much progress, during one of her reflective supervision sessions, she, her supervisor, and I brainstormed another approach. The new approach was that Sarah would ask Desiree to demonstrate various routines, in hopes that they could discuss the routines together and Sarah might bring up opportunities for interaction. When she visited the next week, Sarah asked Desiree to show her how Michael prefers to be fed. Mom took the bottle and propped it up on a pillow while the baby lay in the crib. Michael did, indeed, take the entire bottle. Then, when Desiree demonstrated feeding baby food, Michael sat in the baby seat while she fed him spoons of food, all while talking with Sarah.

Sarah started sharing with Desiree how important it is to talk to her baby during all activities, and whenever he seems alert. She explained how babies learn and the importance of their bonding and interactions. Desiree seemed interested and said she would try those things.

Sarah left feeling like they finally got to the topic that would help the bonding between the Desiree and her baby, and that this would be a turning point in the baby's social and emotional development.

When Sarah returned the next time, Michael was neat and clean yet lying on a blanket on the floor. While Desiree interacted with Sarah, she did not reach out to interact with Michael. Sarah asked about bonding and interactions, and Desiree said things were going well. Sarah showed her a video of a mom and baby interacting, and how the baby mimicked what mom was doing. Desiree said she enjoyed the video and thanked Sarah for showing it to her.

When I met with Sarah and her supervisor the following week it was clear that Sarah was frustrated. She is an incredibly talented home visitor and usually has a good sense of what each family might need and how to help make that happen. Sarah was feeling like this mom was either not understanding what Sarah was asking her to do, or that she felt she was already doing these things. Sarah mentioned to Karen and me several times that she wanted to transfer this case to a different home visitor who she felt might be able to better help this mom.

Hearing Sarah's frustration, I asked, *"How can I best support you?"* After thinking about this for a while she told me that she me to join her on a home visit and give her feedback about my impressions of the relationship between Desiree and Michael.

I asked Sarah for some time to reflect on her request, and that I would get back to her soon.

The next week, I met with Sarah and Karen again. I mentioned that it is rare that I would join a home visit. I said that Desiree, like many parents, might not be welcoming of a mental health consultant joining. I also shared that I may not see what Sarah has been talking about as one person added to a visit often changes the way families interact with the home visitor.

Sarah decided to present this idea to the mom at the next visit, and to explain the role of the IIECMHC consultant as someone that supports Sarah as she provides home visiting support to families.

To Sarah's delight, Desiree agreed to have me join in the next home visit. Sarah obtained written consent for me to accompany her.

Reflection:

I reflected on what might be my purpose in attending the visit with Sarah, and how best to support her. I am not there to be an expert, but instead to help Sarah process and think through her work and any emotions that surface while doing that work. I wondered if there is more at play than Sarah's concern for the bond between the mom and her son, but also if Sarah was struggling with confidence in her abilities as a home visitor.

Sarah and I met one more time before the scheduled joint home visit. We revisited the concerns Sarah had previously talked about, and then Sarah wondered aloud if mom could be experiencing some depression that interfered with her nurturing of the baby. She completed a depression screening, but it did not show any major concerns. "Honestly," she said, "I just need your eyes on this."

When we arrived at Desiree's home the following week, she greeted us at the door, and Sarah made an introduction. The baby was content in a bouncy chair positioned on the floor next to a comfortable chair. Mom returned to that chair while Sarah and I sat on the couch. Sarah began complimenting Desiree on how lovely everything looked, and how Michael was clean and appeared to be eating well. Sarah asked if she had any questions or concerns. She did not.

Then Sarah started asking Mom about the things that she did to have fun with the baby. Mom was pleasant, and talked about the routines such as bath time, eating, napping, etc. Sarah asked her

asked about other activities, like playing peek a boo, or reading a book, etc. I noticed that Desiree seemed a bit confused but smiled and said that those things went fine.

I also noticed that Desiree was focused on what Sarah said, and how to answer her. Desiree waited to hear Sarah say something approving, and then she would relax. During that entire conversation, the only one who interacted with the baby was Sarah. At one point the baby became a bit restless, beginning to fuss. Desiree gave him a toy, and he started to play with the toy. She did not talk to him during that interaction.

I felt a little uncomfortable during the visit as I did not want to interfere and was just observing. It was awkward, however, with me just sitting there so I did join in. Mom answered any question I asked but turned her attention back to Sarah right afterward.

When the visit concluded we went back to our car to head back home. Sarah was eager to get feedback. Instead of feedback I wanted to ask her some questions. I asked if this visit was similar to others? She said it was. Mom was always polite; she kept the baby clean and helped him remain content with objects.

I asked, *"What was your experience in that session? What did you see? What did you hear? What are your thoughts about this visit?"*

Sarah said that Desiree is always willing to try whatever Sarah asks her to do. In fact, she likes to have suggestions. Mom appears to want to please Sarah and waits to hear that Sarah thinks she is doing well. Sarah even noted that after Desiree answered my questions, she looked to Sarah for approval.

I asked if she had seen mom connecting with anyone besides the baby? She said that she had not. Mom is very young, seventeen, but she lives with her grandmother who is not at the visits. *"I wonder how mom would react if you found her a different home visitor?"* I asked. Sarah thought about this and said that it might not be the best approach. If she changed home visitors it might take some time to build a relationship with the new home visitor, or she might not want another home visitor.

We then spent some time thinking through approaches to help the bond between Desiree and Michael. We talked about the nurturing and support Sarah was providing to mom, and how mom seemed receptive to this type of relationship and these back-and-forth interactions. Sarah used that observation to come up with three or four relationship-based strategies that she might want to try.

Afterward Sarah told me that this visit was just what she needed. She felt like she was stuck, and needed me to just observe, and help her think about the next steps. After wrapping up our meeting, we made plans to meet in a few weeks to review how things were going. I thanked her for asking me to join her on the visit, and she said she was grateful I was there. By digging deeper into what is happening in Sarah's and Desiree's relationship, and seeing how mom wants to do what Sarah thinks is helpful, Sarah was able to get "unstuck" and has a plan for moving forward.

Reflection:

Now that I was alone, I needed to think about this visit, and my role. I don't do many visits, so I wondered if it was what Sarah really needed. I also wondered if Sarah needed more answers. I did not give any answers, just asked questions. Sarah was able to come to her own conclusions by answering the questions and reflecting on her answers. Was this enough? Before the visit, I felt like Sarah was hoping I would tell her my ideas about how she should work with this mom. Yet Sarah is really the person who knows this mom; I don't have a relationship with Desiree. I find that when attending a joint home visit, I need to remind myself to be quiet, to reflect, and to support the home visitor as they work with the family.

Reflection Questions:

1. At what point in reading about Sarah's experience with this family did you think it might be time for a joint visit?
2. When would your presence on a home visit cross over from supporting the home visitor to attempting to provide intervention? In other words, how difficult is it to remain an observer, and not to offer advice?
3. How does the term "mental health consultant" impact your introduction to families?

For more information on IECMHC in Home Visiting in Michigan visit: https://michiganiecmhc.org/

For questions regarding the use or development of this resource contact:
Mary Mackrain at mackrainm@michigan.gov

Infant and Early Childhood Mental Health Consultation

MDHHS Michigan Department of Health & Human Services

Infant and Early Childhood Mental Health Consultation

Instructions: Rate yourself honestly and reflect on areas where you can celebrate your strengths and where you might grow. We understand that being an IECMH Consultant provides space for continual learning and insight. Our program will use the results of this survey as a tool for planning and providing professional development and support. The results will not be used in annual reviews or to judge any individual. Your results will be shared with you directly and discussed together with your Reflective Supervisor. The IECMHC team results will be shared in an aggregate report that unidentifiable, showing how we are using the information to guide our support of the team. Please remember it is okay not to be an expert in everything! We expect to grow and learn together.

Section I: Personal Reflection on the Role of an IECMHC Consultant.

For each statement, rate your current readiness on a scale of 1 to 5, where: 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree. Circle or place an 'X' in the column to mark your answer.

Personal Reflection on the Role of an IECMH Consultant	Disagree	Disagree	Neutral	Agree	Agree
where the resources are stored.	(1)	(2)	(3)	(1)	(3)
peers.	(1)	(2)	(3)	(1)	(3)

Section I Score: _____

Fill in the following 2 questions related to the Role of an IECMH Consultant:

1. How do my personal experiences, biases, and emotions influence my work?_____
_____
_____

2. How do I embody the consultative stance? _____
_____

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Section II: Knowledge & Skill Assessment

For each statement, choose an answer from three options where: 1 = No, 3 = Somewhat, 5 = Yes. Circle or place an 'X' in the column to mark your answer.

topics:			

Section IIa Score: _____

For each statement, rate your knowledge and skill level on a scale of 1 to 5, where: 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree. Circle or place an 'X' in the column to mark your answer.

-	Disagree	-		-	Agree

I create a space for home visitors to reflect on their challenges and successes.	(1)	(2)	(3)	(4)	(5)
I effectively balance offering expertise with empowering Supervisors and Home Visitors to discover their own solutions.	(1)	(2)	(3)	(4)	(5)
I help home visitors strengthen their ability to support families.	(1)	(2)	(3)	(4)	(5)
I provide guidance in a collaborative, non-directive way.	(1)	(2)	(3)	(4)	(5)
I am reliable and predictable in keeping my appointments 90% of the time.	(1)	(2)	(3)	(4)	(5)
I understand and practice fidelity to the DC IECMHC in Home Visiting Model that the program is using.	(1)	(2)	(3)	(4)	(5)
I understand the goals, activities, population served, and reporting/deliverable requirements of the home visiting program, as these factors may impact IECMHC service delivery, schedules, reflective capacity, and the stress levels of the team, among other things.	(1)	(2)	(3)	(4)	(5)

Section IIb Score: _____

Fill in the following 5 questions related to Knowledge & Skill Assessment:

1. How do I create a space for home visitors to reflect on their challenges and successes? _____
_____

2. How do I provide guidance in a collaborative, non-directive way? _____
_____

3. If I am unable to keep my appointment, what is getting in the way? _____
_____

4. What about maintaining fidelity to the MI IECMHC in Home Visiting Model do I find challenging? _____
_____

5. What additional information do I need to understand the goals, activities, population served, and reporting/deliverable requirements of the home visiting program, and their impact on IECMHC service delivery, schedules, reflective capacity, and the stress levels of the team?
_____
_____

Section III: Competency Expertise

For each IECMHC Competency, rate your level of confidence on a scale of 1 to 5, where: 1 = I need help in this area, 2 = I need some new training to strengthen my knowledge in this area, 3 = I am moderately comfortable in this area, 4 = I am confident supporting this area but have not trained others in this, 5 = I am confident in this area and have trained on this. Circle or place an 'X' in the column to mark your answer.

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IECMHC Competencies	I need help in this area	I need some new training to strengthen my knowledge in this area	I am moderately comfortable in this area	I am confident supporting this area but have not trained others in this	I am confident in this area and have trained on this.
Prenatal, Infant and Child Development and Behavior ○ Typical and atypical development from Prenatal to age five ○ Developmental screening and assessment tools ○ Understanding temperament, emotional regulation, and social interactions	(1)	(2)	(3)	(4)	(5)
Systems and Policy Knowledge ○ Understanding early childhood systems (e.g., home visiting and its link to childcare, pediatric care, Part C, etc.) ○ Advocacy and policy efforts to support IECMH ○ Navigating funding, regulations, and workforce development in IECMHC	(1)	(2)	(3)	(4)	(5)
Adult Learning Theory ○ Knowledge of principles of adult learning, including the need for self-directed learning, application to real-world applications, and hands-on learning ○ Ability to design learning experiences that respect adults' prior knowledge and experiences ○ Builds relationships with an understanding of how family, culture, and community share trust and security	(1)	(2)	(3)	(4)	(5)
Foundations of Infant and Early Childhood Mental Health ○ Understanding early brain development and attachment ○ Recognizing the impact of early relationships on development ○ The role of toxic stress, trauma, and resilience in early childhood	(1)	(2)	(3)	(4)	(5)
Reflective/Relationship-Based Practice ○ Supporting secure attachments between children and caregivers ○ Strengthening relationships among children, families, and professionals ○ Applying reflective practice in consultation work	(1)	(2)	(3)	(4)	(5)
Ethics and Professionalism in IECMHC ○ Ethical considerations in mental health consultation ○ Confidentiality and boundaries in early childhood settings ○ Self-care and managing secondary traumatic stress for consultants	(1)	(2)	(3)	(4)	(5)
Equity, Diversity, and Cultural Humility ○ Understanding the role of culture, identity, and systemic inequities ○ Culturally responsive and trauma-informed approaches ○ Promoting inclusion and anti-bias practices in early childhood settings	(1)	(2)	(3)	(4)	(5)

○ Establishing and maintaining effective consultative relationships ○ Collaborating with early care providers, educators, and families ○ Identifying and addressing systemic barriers to social-emotional health	(1)	(2)	(3)	(4)	(5)
○ Partnering with families to support children's mental health ○ Recognizing and addressing caregiver stress and trauma ○ Effective communication and strengths-based approaches with families	(1)	(2)	(3)	(4)	(5)
○ Strategies to foster emotional literacy and self-regulation in young children ○ Promoting positive behavior and social skills ○ Preventing and addressing challenging behaviors	(1)	(2)	(3)	(4)	(5)
○ Understanding the effects of Adverse Childhood Experiences (ACEs) ○ Supporting resilience and healing from trauma ○ Trauma-informed consultation and intervention strategies	(1)	(2)	(3)	(4)	(5)

Section III Score: _____

Section IV: Program Integration & Collaboration

For each statement, rate your skills on a scale of 1 to 5, where: 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree. Circle or place an 'X' in the column to mark your answer.

Program Integration & Collaboration	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I easily build trust and rapport with home visiting teams.	(1)	(2)	(3)	(4)	(5)
I set clear expectations about what IECMHC is and is not.	(1)	(2)	(3)	(4)	(5)
I coordinate effectively with other mental health, early childhood, and family support programs.	(1)	(2)	(3)	(4)	(5)

Section IV Score: _____

Fill in the following 5 questions related to Program Integration and Collaboration:

1. What trust and rapport building practices help me the most? List them here: _____
_____
2. How do I set clear expectations about what IECMHC is and is not? _____
_____
3. What are some program collaborations I might expand (e.g. Part C, mental health, etc.)? List here: _____

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Section V: Data and Assessment, Ethical & Professional Considerations and Self-Care

For each statement, choose an answer where: 1 = No, and 5 = Yes. If no, then fill in the text box with what gets in the way or what additional information is needed.

	No	what	Yes	If no or somewhat: What is needed?
continuous quality improvement processes.	(1)		(5)	
information is needed?	(1)		(5)	

Section V Score: _____

Section VI: Identifying Strengths & Growth Areas

Fill in the following 5 questions.

1. What are my greatest strengths as an IECMH Consultant? _____

2. How do I manage my own stress and well-being in my work? _____

3. What areas do I want to improve in the coming year? _____

4. What professional development opportunities (trainings, mentorship, tools, research) would help me grow? _____

5. What challenges have I encountered in my consultation work, and how have I addressed them? _____

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Scoring and Interpretation

Record your scores from the sections above:

Section I	
Section IIa	
Section IIb	
Section III	
Section IV	
Section V	
Total	

Meet with your Reflective Supervisor and Interpret Your Quantitative Results:

- **240 – 300: High Confidence and Skill Level:** You demonstrate a strong level of readiness and are prepared to tackle challenges effectively.
- **180 – 239: Moderate Confidence and Skill Level:** You have a solid understanding and foundation. Ongoing skill development will further enhance your confidence and abilities.
- **120 – 179: Low Confidence and Skill Level:** You are in the initial stages of developing readiness. Engaging in reflective practices, seeking support, and additional training will be beneficial for further growth.
- **Below 120**: **Minimal Confidence and Skill Level:** There is significant opportunity for learning and development. With continued training, experience, and reflective supervision, your knowledge of infant mental health and IECMHC will expand and strengthen over time.
- **Additionally**- use your open ended answers and conclusions in Section VI to celebrate strengths and build annual goals.