Center of Excellence for Infant and Early Childhood Mental Health Consultation

Considerations for Addressing Capacity and Dosage in IECMHC

THE CENTER OF EXCELLENCE FOR
Infant and Early Childhood
Mental Health Consultation

Contents

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How to Use This Document

This document is designed to assist your planning team in thinking through the logistics of preparing your workforce to run the program—which includes thinking carefully about your capacity and dosage.[1]

- The "Questions" column states the overarching question to answer.
- The "Data Points" column challenges your team to consider some hard numbers to help guide your decisions. (It is okay if final decisions have not been reached on the numbers, but having a general idea of what you want them to be will be useful.)
- The "Notes" column provides clarification about the overarching question and helpful examples.

[1] *Capacity* refers to the number of sites served; *dosage* refers to the frequency and duration of visits.

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Program Capacity Considerations

Questions	Data Points	Notes
Looking at your program's vision and theory of change, how does your model impact your program's capacity?	Our program hopes to serve: _____ sites _____ children and/or families Our program hopes to stay in each site for _____ months /_____ years *(fill in and circle one)*	Capacity considerations must take into account depth versus breadth of services. If your program has a vision or theory of change that centers on the provision of long-term, sustained MHC[2] services at each site, your program capacity will be different from a program model that has a vision for shorter-term, on-call MHC services. For example, if you plan to stay in a center long term, one of your first goals will be to build relationships, and significant time will be allowed for this. In a short-term model, relationship building is still important, but less time will be allocated for it. Alternatively, your vision may support working with each center for a set period of time (e.g., six months), which would provide more flexibility to serve additional sites but less long-term intervention. While there is variability in dosage across established IECMHC programs, understanding how your agency's specific vision and theory of change will set the frame for your program's capacity is an important starting point. For several examples of capacity expectations within programs serving early care and education and home visiting visit *Appendix A* in this document.

[2] Abbreviations used in this document: IECMHC (Infant and Early Childhood Mental Health Consultation), MHC (mental health consultation), ECE (early care and education), IMH (infant mental health).

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What are the expectations of your funders regarding how many programs need to be served?	We hope to serve _____ programs annually.	Funders may have expectations of the number of programs or children to be served through IECMHC in the course of the program year. Remember, a program may have more than one site, so it is important to consider both program size and number of sites when thinking about capacity.
What are the expectations (e.g., needs; level of interest, awareness, and/or readiness) of the programs that will receive MHC services?	Have the program directors, or administrators heard of MHC? ☐ Yes ☐ No Have other programs in the area used MHC? ☐ Yes ☐ No	Are the home visitors or childcare centers with whom your consultants will work interested in long-term or short-term support? Are they open to sharing their experiences with a consultant? How will your services be marketed to your intended audience? What information do you have, if any, about the program's experience working with mental health supportive services? The answers to these types of questions (regarding the initiation phase and the resources necessary for successful implementation) will assist you in determining capacity and dosage specifics.

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What are the sizes and locations of the sites that will receive MHC services?	Site 1 location:_ Early Care and Education: Program 1: ____ Number of classrooms: _ Number of teachers: ___ Program 2: ____ Size: ___ Number of classrooms: _ Number of teachers: ___ [add additional programs as warranted] Home Visiting: Program 1: Number of Home Visitors:_____ Number of Families Served by HVs:_____ Program 2: Number of Home Visitors:_____ Number of Families Served by HVs:_____	There are many considerations for providing consultation in different types of communities. Providing consultation in rural or remote settings often requires additional or significant transportation time, thus reducing the overall number of sites that can be served by a single consultant. Providing consultation in urban settings may offer greater proximity to the ECE and home visiting programs, but other challenges may emerge. For example, in San Francisco's ECMHC program, consultation in urban settings brings with it significant parking and traffic challenges that result in high levels of stress for consultants and added costs to the ECMHC program. For all potential communities, it is important to understand the specific needs and challenges and their impact on capacity. Larger programs will often need more consultant time than smaller ones. For example, in the Louisiana ECMHC program, childcare centers with eight or more classrooms are visited weekly, while centers with seven or fewer classrooms are visited every other week. This determination was based on the median childcare center size and consultants' ability to meet the needs of larger centers balanced with the desire to serve a breadth of programs. In Illinois' MHC program, a mental health consultant typically provides 18 hours of IECMHC per home visiting site per month. This includes 12 hours of direct consultation to home visitors per month and an additional 8 hours for the consultants to receive support, complete reporting requirements, and maintain professional licensure or endorsement. This may vary based on the number of home visitors a site has.

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Questions	Data Points	Notes
What is known about the level of need of the staff and families in the programs set to receive MHC services?	Average number of years of experience of staff: _____ Can the population served by the program be considered high risk? ☐ Yes ☐ No Are children regularly suspended or expelled from the program? ☐ Yes ☐ No	Programs with higher levels of need will often require more time and resources. If programs are located in areas with few resources and/or are in more isolated communities, MHC may become a primary support for families and staff, and the program may require more time with its mental health consultant. Additionally, if the program is serving a high-risk community (which can be defined by a variety of sociodemographic factors), the mental health consultant may have an increased need to provide referral services to other community-based programs and services.
Do the sites receive MHC services as part of a larger organization (such as Head Start or a school district)?	Do the sites currently receive any MHC services? ☐ Yes ☐ No If yes, from where? _____	Working with larger systems often requires additional administrative support and MHC time in order to coordinate services within and across the systems. For example, if a child in a program receives Early Intervention services through the county, it would be important for the MHC provider, the ECE providers, and, ideally, the parent to be aware of the services, the treatment plans, and the goals of services. MHC services can be greatly enhanced when they are coordinated with other service providers.

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What are the supervision and training needs of your IECMHC program?	Who will provide reflective supervision? _____ How often and in what duration will group reflective supervision be offered (e.g. biweekly for 1 hour): _____ How often and in what duration will 1:1 reflective supervision be offered:_____ What are the training needs of the consultants? _____ How often will you provide intentional training for MHC's?_____	When launching a new IECMHC program, staff often have significant training and supervision needs, as they learn and practice this specialized mental health service. Capacity may be lower in a program's first years to accommodate the time needed to train and supervise new staff. Once staff have been trained in the basics of MHC, the need for ongoing supervision and professional development will decrease but still continues. While the overall time assigned to these activities may decrease in subsequent years, it is important to ensure that time for training and supervision is protected and built in to your agency's plans for program capacity. Training: Having a training plan that can easily be replicated for new staff is useful and will save time during inevitable staff turnover. Visit the CoE toolkit section on Workforce Development for more information on critical training topics for MHC's. Reflective Supervision: Reflective supervision is a type of workplace management, oversight, or direction that supports the consultant's developing skills in regard to reflective capacity. Reflective capacity helps the consultant explore thoughts, feelings, actions, and reactions that are evoked in the work of IECMHC. At a minimum, consultants should receive 2 hours of reflective supervision monthly via group and/or 1:1 interaction with a seasoned supervisor. For more information and a video snapshot of reflective supervision in action visit the National Center on Early Childhood Health and Wellness Mental Health Consultation Tool:

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Questions	Data Points	Notes
What are the supervision and training needs of your IECMHC program? (continued)		*Reflective Practice Lesson:* https://eclkc.ohs.acf.hhs.gov/hslc/tta-system/health/mental-health/ec-mental-health-consultation/mh-consultation-tool For more information on defining reflective supervision, see the Michigan Association for Infant Mental Health's *Best Practice Guidelines for Reflective Supervision/Consultation:* *http://mi-aimh.org/wp-content/uploads/2016/03/BPGRSC-20160428-NP-FE.pdf*
How will your agency support the administrative needs of the IECMHC field-based staff?	Will the agency be able to provide the following to *all* consultants? Wi-Fi device: ☐ Yes ☐ No Laptop: ☐ Yes ☐ No Cell phone: ☐ Yes ☐ No Transportation: ☐ Yes ☐ No Administrative Supervision: ☐ Yes ☐ No	Laptops, cell phones, and satellite offices all make a significant impact on how mental health consultants are able to perform their work while out in the field. These accommodations can help staff work more effectively and efficiently, which may increase an agency's capacity to serve more programs. In addition, consistent access to a supervisor for clinical and administrative concerns provides important supports for mental health consultants in the field, which allows them to offer quality services without becoming overwhelmed. For example, many program sites do not have Internet access. This can be a significant challenge for a mental health consultant who is attempting to complete paperwork, communicate with other staff, research resources, and complete other tasks requiring Internet connectivity. Administrative supervision is critical to maintaining program quality and fidelity. Administrative supervision relates to the oversight of federal, state and agency regulations, program policies, rules and procedures.

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How will your agency support the administrative needs of the IECMHC field-based staff? (continued)		A person who provides administrative supervision typically is involved in hiring consultants, training them, overseeing paperwork and deadlines, explaining program policy and rules, monitoring consultant productivity and fidelity and evaluating success. At a minimum, consultants should receive 2 hours of administrative supervision monthly via 1:1 or group staff meetings.

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Individual Capacity (i.e., Caseload) Considerations

Questions	Data Points	Notes
What are your program's dosage expectations?	How often do you expect the mental health consultant to work with a site? ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other: _____ Will all sites receive the same amount of consultation services? ☐ Yes ☐ No	Funding, vision, populations served, geographic region, and additional factors will affect the dosage of services provided. In addition, such considerations as a high prevalence of historical or current trauma, the developmental stage(s) of the children, any specific learning needs of the staff, and available program resources can have a profound effect on dosage considerations. The general parameters for dosage listed below are minimum standards based on a dialogue and survey with seasoned IECMHC leaders of rigorously evaluated programs or who have decades of experience in implementing quality IECMHC services within ECE and home visiting programs. These minimums should be considered within the context of your unique community and family parameters. **Early Care and Education—Child-/Family-Focused Consultation** Consultants provide onsite IECMHC to ECE providers *at least* every other week. Consultants are onsite for *at least* three hours per visit. Note: While the visit length is generally between three and six hours, the actual amount is highly dependent on the size of the program served, the number of child-/family-centered referrals, and the level of support warranted. For example, an early childhood program with four to eight classrooms would

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What are your program's dosage expectations? (continued)		most likely warrant a five- to six-hour visit. IECMHC usually lasts 6–12 months, unless the program has a tiered model or no identified end date (consultants can stay with centers indefinitely). Again, this is highly dependent on the level of support warranted and the wants and needs of the family and providers. **Home Visiting** Reflective consultation with a group of providers (i.e., group reflective supervision) is provided *at least* monthly for two to four hours by a *qualified reflective supervisor* (someone who has an IMH endorsement, is a master's-prepared mental health provider, has experience providing reflective supervision, etc.). One-to-one reflective case consultation is offered to providers (e.g., home visitors) *at least* every other week for 60–90 minutes by a qualified reflective supervisor (see above).
Where are sites located, and how much driving will mental health consultants need to do?	Site 1 address: _ Site 2 address: _ Site 3 address: _ Approximate time to get from site to site: _____	IECMHC services are often field-based, requiring consultants to travel to sites. Reducing the amount of travel time and/or the number of sites visited per day can help reduce consultant burnout and support quality services. It is also helpful to consider whether the consultant has a "home base"—a place to complete paperwork, make phone calls, and attend to other administrative tasks.

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What are the language needs of the staff and families at the sites? Are there particular cultural or community needs that should be considered?	Number of languages spoken at the program: _____ Are staff able to communicate in all languages spoken? ☐ Yes ☐ No Identified cultural and community needs: _____ _____ _____ _____ Are there known resources to address any of these needs? ☐ Yes ☐ No	It is important to consider the added dimensions of providing IECMHC services in a language other than English. When additional community resources are scarce, consultants often feel more responsibility to the staff and families. They may also feel a sense of isolation and may need additional supports if they are the only mental health consultants on their team working with a particular community and/or providing services in a particular language. When considering consultant caseloads, it may not always be possible to distribute programs with specific language or community needs to different consultants. In these cases, consider how your program might develop specific strategies for supporting your consultants, such as integrating and making room for consultants' experiences in training and supervision, providing reflective supervision with a supervisor who speaks the same language that the consultant uses in his or her work, and providing opportunities for consultants who serve rural regions to come together regularly, either in person or via video-conferencing.

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What is the level of experience and background of your MHC staff? How will the supervision and training needs of your staff impact their caseloads?	Staff Member 1 Degree: _____ Years of experience with MHC: _ Other mental health experience: _____ _____ Staff Member 2 Degree: _____ Years of experience with MHC: _ Other mental health experience: _____ _____ Staff Member 3 Degree: _____ Years of experience with MHC: _ Other mental health experience: _____ _____	When considering consultant capacity, newly trained consultants should be given time to slowly increase their caseloads to full capacity. Even seasoned clinicians who are new to consultation will need time to "ramp up" and hone their skills as a mental health consultant. For specific information on hiring, training, and supervising consultants please go to the Workforce development section of toolbox.

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What do you know about the level of need at the sites? The level of trauma in the community and at the site? The percentage of children with special needs?	Site 1: Known level of need factors: ____ _____ Site 2: Known level of need factors: ____ _____ Site 3: Known level of need factors: ____ _____	Understanding the level of need at the various sites can help you assign a balanced caseload to your MHC staff. For example, assigning only sites that have a high level of trauma to the same consultant may lead to burnout and/or staff turnover, or a decrease in the quality of services. When possible, consultant caseloads should be balanced across size, need, and location. It is also important to consider the level of need of the staff. If a site is known to have particular staffing challenges, this should be factored into caseload balancing.

Appendix A: IECMHC Caseload, Frequency and Duration Snapshots

Early Childhood Consultation Partnership (ECCP) – Connecticut

Geographic area served: Statewide; mostly urban (51%), but also suburban and rural areas.

Setting Served: Public and private child care centers/preschool programs; Early Head Start and Head Start programs; licensed family child care homes; foster care settings and intermediate safe homes; kinship care homes (for those raising children of their kin); substance abuse residential facilities; community resource centers.

Ages served: Birth to 5.

Annual numbers served: (FY2008) 2,301 individual children, 224 ECE centers, 1,869 teaching staff members trained.

Caseload: On average, consultants balance 4 to 5 child-focused cases with program/classroom-wide consultation to three child care settings at any given time.

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Frequency/Duration: ECCP offers both child/family-centered and programmatic consultation across three levels of services that build upon each other in a stepwise fashion (i.e., Child-Specific Consultation is a component of Core Classroom Consultation and both are components of Intensive Site Consultation).

- Child-Specific Consultation, up to 9 hours of consultation, lasts approximately one month
- Core Classroom Consultation (i.e., classroom-focused), 4 to 6 hours a week for up to 14 weeks
- Intensive Site Consultation (i.e., program-wide focus), up to 6 hours a week for up to 5 months

For more information, visit the Early Childhood Consultation Partnership website at: http://www.eccpct.com/

Early Intervention Program (EIP) Instituto Familiar De La Raza (IFR) – San Francisco, CA

Geographic area served: Urban; primarily San Francisco's Mission District and Excelsior District, as well as the Outer Mission area that is on the south edge of the city.

Setting Served: Early Head Start and Head Start programs; a private non-profit early care and education program (only one, which serves a number of homeless children); public-funded early care and education programs that are part of the San Francisco Unified School District; licensed family child care providers; and family resource centers.

Staffing: EIP's staff is comprised of an Early Intervention Coordinator, three Senior Mental Health Specialists, and six Mental Health Specialists (i.e., mental health consultants).

Ages Served: Birth through 5.

Annual Numbers Served: 20 family child care homes, 31 classrooms at 15 early childhood centers, over 740 children. All EIP staff are full-time and employed by IFR, although funding for their positions comes from various sources.

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Caseload: On average, three sites per consultant (approximately 44 children per site), although the ratio is higher if one or more of the sites is a family child care home, which averages only six children per program

Frequency/Duration: Consultants spend approximately 6-8 hours per week at each center-based program—up to 16 hours for large centers—and two hours a week for family child care homes; frequency and duration varies with need; there is no time limitation.

For more Information visit the website at: http://ifrsf.org/programs/early-intervention-and-school-based-program/

Maternal, Infant, and Early Childhood Home Visiting Consultation Project- Illinois

Geographic area served: Not available

Setting Served: Home Visiting

Ages served: Birth to 5.

Annual numbers served: 13 communities, 26 sites receiving Maternal and Infant Home Visiting Funding (MIECHV)

Caseload: 1 FTE could serve up to 6 HV programs

Frequency/Duration: 18 hours of IECMHC per home visiting site per month as optimal for an IECMH consultant to provide the indicated and necessary services. This includes 12 hours of direct consultation to home visitors per month and an additional 8 hours for the consultant to receive support, complete reporting requirements, and maintain professional licensure or endorsement.

For more information on this approach see the Illinois Program Guide: http://icmhp.org/wordpress/wp-content/uploads/2016/01/EarlyChildhoodConsultHomeVisitProg.pdf

Or visit the website at: http://www.icmhp.org/

For additional snapshots of capacity, duration and frequency visit What Works: A Study of Effective Early Childhood Mental Health Consultation Programs, Duran et al. (2009). Section 2. Study Sites in Brief: http://gucchdtacenter.georgetown.edu/publications/ECMHCStudy_Report.pdf

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