# Michigan Home Visiting Initiative Mental Health Consultation

EVALUATION REPORT

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*Prepared for Michigan Department of Health and Human Services*

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# Introduction

Infant and Early Childhood Mental Health Consultation (IECMHC) is a prevention-based service that pairs a mental health consultant with families and adults who work with infants and young children in the settings in which they learn and grow. The aim is to build adult capacity to strengthen and support the healthy social and emotional development of children early and before intervention is needed. It also builds the capacity of professionals to support adults who have experienced trauma, stress or who have experienced mental health issues themselves and are now parenting.

The Michigan Home Visiting Initiative (MHVI) had the opportunity to borrow lessons learned from national partners and colleagues implementing home visiting in regard to mental health consultation, to pilot IECMHC within MHVI programs funded through the Michigan Department of Health and Human Services Home Visiting Unit. The intent was not to permanently provide ongoing mental health consultation but to support growth and development of all layers of program staff to ensure sustainability and increase capacity of staff to address family mental health challenges.

The Michigan Public Health Institute (MPHI) provided evaluation consultation to MHVI for the IECMHC project. MPHI worked collaboratively with MHVI to develop an evaluation plan, and to develop, administer, and analyze: surveys, focus groups, and interviews.

# Evaluation Approach

The IECMHC evaluation followed the CDC Framework for Program Evaluation in Public Health (CDC, 1999). The evaluation was designed to provide information that is useful, feasible, sensitive, and accurate. The evaluation used the following six-step approach: 1) Engage stakeholders, 2) Describe the program, 3) Focus the evaluation design, 4) Gather credible evidence, 5) Justify conclusions, and 6) Ensure use and share lessons learned. The evaluation of the IECMHC pilot in Michigan was designed to provide MHVI information to track implementation, ensure the project was meeting its goals, and inform decision-making through recommendations. Table 1 describes the IECMHC project in Michigan, including project components and strategies, as well as expected outcomes.

**Table 1: MHVI IECMHC Project Description**

| Project Components | Project Strategies |
|---|---|
| Identification of mental health consultant | • Identify and hire a Master's prepared Mental Health professional, who is licensed or license eligible with a minimum of a Level II Infant Mental Health Endorsement |
| Consultation from mental health consultant | • Case conferences with mental health consultant<br>• Reflective supervision with mental health consultant for home visitors and/or program manager/supervisor<br>• Home visit consultations with mental health consultant, if needed |
| Staff training from mental health consultant | • Training on mental health topics<br>• Training on reflective supervision |

| IECMHC Project Outcomes | | |
|---|---|---|
| **Short-Term Outcomes** | **Intermediate Outcomes** | **Long-Term Outcomes** |
| • Increase in home visitor knowledge of mental health and mental health resources<br>• Increase in home visitor capacity to work with families who have mental health needs<br>• Increase in supervisor capacity to provide reflective supervision<br>• Increase in supervisor capacity to support home visitors working with families who have mental health needs | • Decreased stress and burnout for home visitors and supervisors<br>• Improved services to families with mental health needs<br>• Improved connection to mental health resources for families<br>• Improved client engagement | • Improved home visitor retention<br>• Improved client retention<br>• Improved social and emotional health of home visiting clients<br>• Increased capacity of caregivers to support healthy social and emotional development of their children |

## Evaluation Objectives

The IECMHC evaluation took a multi-level approach, focusing on 1) Implementation of IECMHC and 2) LIA staff outcomes. Consideration was given to including a third level of outcomes: family outcomes. However, given the preliminary results of the evaluation, it was determined that it was too soon to examine family outcomes, such as client retention. Some LIAs experienced delays in starting their consultation, and were only able to work with their consultant for a few months.

This evaluation was comprised of both a **process evaluation**, which examined the implementation of IECMHC, and an **outcome evaluation,** which examined what was accomplished as a result of implementing these project strategies. Table 2 provides a summary of the evaluation questions, indicators, and data sources. Surveys consisted of a combination of established instruments/scales and questions developed by MPHI. Established instruments/scales that were used are listed under the data sources column where applicable. All data sources are described in more detail in the next section (Methods).

**Table 2. IECMHC Process and Outcome Evaluation**

| Evaluation Question | Measure/Indicator | Data Source(s) |
|---|---|---|
| **Implementation of IECMHC** | | |
| How was IECMHC implemented in each of the LIAS? | - Consultation activities (e.g., case conference, reflective supervision, training)<br>- Time spent on activities | - LIA survey<br>- Consultant survey |

| Evaluation Question | Measure/Indicator | Data Source(s) |
|---|---|---|
| To what extent were the consultants able to work effectively with LIAs? | - Consultant qualifications<br>- Quality of relationship between consultant and LIA staff<br>- Clarity of the consultant's role<br>- Barriers and facilitators to effective consultation | - LIA survey<br>▪ Mental Health Services Survey (adapted)<br>- LIA staff focus groups<br>- Supervisor/manager interviews<br>- Consultant survey<br>▪ Mental Health Services Survey (adapted)<br>▪ Knowledge and Skills Inventory (adapted) |
| What were the successes, challenges, and lessons learned from implementing IECMHC? | - Successes<br>- Challenges<br>- Lessons learned | - LIA staff focus groups<br>- Supervisor/manager interviews |
| **LIA Staff Outcomes** | | |
| To what extent did IECMHC increase home visitor capacity to work with families with mental health needs? | - Knowledge of mental health<br>- Knowledge of mental health resources for families<br>- Competence and efficacy in working with families with mental health needs | - LIA survey<br>▪ Goal Achievement Scale (adapted)<br>▪ Teacher Opinion Survey (adapted)<br>- LIA staff focus groups<br>- Supervisor/manager interviews |
| To what extent did IECMHC contribute to improved services for families with mental health needs? | - Relationship with clients<br>- Strategies for working with families who have mental health needs | - LIA staff focus groups<br>- Supervisor/manager interviews |
| To what extent did IECMHC increase supervisor/manager capacity to support home visitors working with families with mental health needs? | - Reflective supervision skills<br>- Confidence in providing reflective supervision<br>- Confidence in providing support to staff | - LIA survey<br>▪ Reflective Supervision Rating Scale<br>- Supervisor/manager interviews |
| To what extent did IECMHC decrease home visitor and supervisor/manager stress and burnout? | - Job stress<br>- Program support of home visitors | - LIA survey<br>▪ Child Care Worker Job Stress Inventory (adapted)<br>- LIA staff focus groups<br>- Supervisor/manager interviews |

# METHODS

## Participants

Four LIAs participated in the evaluation study. Across the four sites, there were 14 supervisors and 23 home visitors. Five mental health consultants participated in the evaluation study (one LIA had two consultants).

## Instruments

This evaluation used multiple methods to respond to the process and outcome evaluation objectives, including an LIA Survey, Staff Focus Groups, and Supervisor Interviews/Focus Group.

### *LIA Survey:*

MPHI developed an LIA Survey that was administered online through Qualtrics to home visitors and supervisors/managers at each of the four participating LIAs. The survey combined established scales with questions developed by MPHI. The survey included questions about what activities the mental health consultant completed with the LIA, how much time the consultant spent with the LIA, the quality of the relationship with the consultant (Mental Health Services Survey – adapted), knowledge of mental health, knowledge of mental health resources for families, home visitor competence (Goal Achievement Scale) and efficacy (Teacher Opinion Survey – adapted) in working with families with mental health needs, reflective supervision (Reflective Supervision Rating Scale), and job stress (Child Care Worker Job Stress Inventory – adapted).

Change over time was measured in two ways. First, the Goal Achievement Scale asked respondents to report the extent to which competence (e.g., knowledge, attitude, skills) changed as a result of mental health consultation. Second, a retrospective pretest design was used, where respondents indicated their responses to The Teacher Opinion Survey and Child Care Worker Job Stress Inventory separately for two time points – before consultation and after consultation. There was a home visitor version and a supervisor/manager version of the survey in order to tailor the wording of questions to the respondent's role. A total of 19 home visitors completed the survey for a response rate of 83%. A total of 12 supervisors completed the survey for a response rate of 86%.

#### *Mental Health Services Survey*

The LIA Survey included questions from The Mental Health Services Survey (Green et al., 2006) that asked about the relationship between the staff and the consultant. These questions were adapted to fit the context of this evaluation. Example items included, "The MHC seems like another member of the staff, not like an outsider," and "Our program's MHC services have improved the quality of our home visits." The 14 item questionnaire is broken into two sections: work and interactions, and effectiveness, which both utilized a 5-point scale (1=Strongly disagree; 2=Disagree; 3=Neutral; 4=Agree; 5=Strongly agree).

#### *Goal Achievement Scale*

The Goal Achievement Scale (Alkon et al., 2003) measures teacher competencies on mental health activities and program goals. The scale was designed for teachers, and was adapted for use with home visitors and to include questions that asked about competency in regards to adult mental health (not

just children). Example items included, “Home visitors have an improved understanding of children’s social and emotional development” and “Home visitors feel more understood and supported.” Respondents were asked to indicate how they felt about each statement compared to before they worked with the mental health consultant. Each item on the 12-item scale was rated on a 3-point scale (1=Not at all; 2=Somewhat; or 3=Very much).

*Teacher Opinion Survey*

The Teacher Opinion Survey (Geller & Lynch, 2000) was designed to assess feelings of competence and confidence in managing challenging behaviors and ability to make a positive difference in the lives of children. The scale was adapted for use with home visitors and to include questions that asked about efficacy in regards to working with families/adults (not just children). Example items included, “I feel a sense of hopelessness about the future of the families I work with” and “On a typical day, I feel a sense of accomplishment as a home visitor.” Each of the 10 items were rated on a 5-point scale (1=Strongly disagree; 2=Disagree; 3=Neutral; 4=Agree; 5=Strongly agree) for before the consultation and after the consultation.

*Reflective Supervision Rating Scale*

The Reflective Supervision Rating Scale (Ash, 2010) was designed to assess fidelity and quality of reflective supervision. The 17-item scale consists of four subscales: reflective processes and skills, mentoring, supervision structure, and mentalization. There are two version of this measure, a supervisor/manager version and a staff version. Example items included, “My supervisor is both a teacher and a guide” and “During supervision, I allow supervisees to come to their own solutions.” Items were rated on a 4-point scale (1=Rarely; 2=Sometimes; 3=Usually; 4=Almost always).

*Child Care Worker Job Stress Inventory*

The Child Care Worker Job Stress Inventory (Curbow et al., 2001) measures perceived job stressors in three dimensions: job control, job resources, and job demands. Prior research has shown that teachers’ experiences of high job demands, low job resources, and lack of job control are associated with their feelings of burnout and exhaustion. The scale was adapted for use with home visitors, and only the subscales for job resources and job demands were included. Example items include, “I feel pressure from my family to do a different kind of work” and “I see that my work is making a difference with a family.” Each of the 19 items was rated on a 5-point scale (1=Never/Rarely; 2=Sometimes; 3=Often; 4=Usually; 5=Most of the time) for before the consultation and after the consultation.

*LIA Staff Focus Groups*

Focus groups were conducted in person with home visitors at each participating LIA. The focus group complemented the LIA surveys by providing in-depth information about working with a mental health consultant, and the impact this had on home visitors and their work with families. The focus groups asked about mental health consultation activities, the quality of the relationship between the consultant and the LIA, the clarity of the consultant’s role, barriers and facilitators to effective consultation, and successes, challenges, and lessons learned. The focus groups also asked about the impact of mental health consultation on: home visitor knowledge; competence and efficacy in working with families with mental health needs; relationships with clients; strategies for working with families who have mental

health needs; client engagement; job stress; and program support of home visitors. A total of 21 home visitors participated in the focus groups.

### *Supervisor/Manager Interviews/Focus Group*

Interviews were conducted in person and over the phone with LIA supervisors/managers from each participating LIA. The interviews complemented the LIA surveys by providing in-depth information about working with a mental health consultant, and mirrored many of the questions in the LIA Staff Focus Groups. The interviews asked about mental health consultation activities, the quality of the relationship between the supervisor/manager and the mental health consultant, the clarity of the consultant's role, barriers and facilitators to effective consultation, and successes, challenges, and lessons learned. The interviews also asked about the impact of mental health consultation on: the supervisor/manager's knowledge of mental health, confidence in providing reflective supervision, and competence in providing support to staff; staff competence and efficacy in working with families with mental health needs; strategies for working with families who have mental health needs; and job stress. Because one of the participating LIAs had multiple supervisors, the supervisors participated in a focus group. This focus group asked the exact same questions as the supervisor interviews. A total of 11 supervisors participated in an interview or focus group.

### *Consultant Survey*

MPHI developed a consultant survey that was administered online through Qualtrics to mental health consultants who worked with each of the four participating LIAs. The survey combined established scales with questions developed by MPHI. The survey included questions about what activities the mental health consultant completed with the LIA, how much time the consultant spent with the LIA, consultant qualifications (Knowledge and Skills Inventory – adapted), clarity of the consultant's role, and barriers and facilitators to effective consultation. All five consultants completed the survey for a response rate of 100%.

#### *Knowledge and Skills Inventory*

The Knowledge and Skills Inventory (Hepburn et al., 2007) measures consultant qualifications, skills, and experience in early childhood, mental health, intervention, and coaching/training. The scale was adapted to fit the context of this evaluation. Each of the 27 items was rated on a 5 point scale (1=Minimal; 3=Moderate; 5=Strong).

Table 3 provides a summary of data collection instruments for the evaluation.

**Table 3. IECMHC Evaluation Data Collection Summary**

| Data Source | Data Type | Respondent or Completed By | Administered By |
|---|---|---|---|
| **LIA Survey** | Quantitative | LIA staff and supervisors/managers | MPHI |
| **LIA Staff Focus Group** | Qualitative | LIA staff | MPHI |
| **Supervisor/Manager Interview** | Qualitative | LIA supervisors/managers | MPHI |
| **Consultant Survey** | Quantitative/Qualitative | Mental health consultants | MPHI |

## Analysis

Survey data was imported into SPSS for analysis. Descriptive statistics were calculated for all measures. Additionally, for the two measures that included a retrospective pretest (Teacher Concerns Inventory and Child Care Worker Job Stress Inventory), a Wilcoxon Signed Rank Test was used to assess whether there was statistically significant change from before the consultation to after the consultation. The Wilcoxon Signed Rank Test is the nonparametric alternative to the dependent samples t-test. Like the dependent samples t-test, the Wilcoxon test calculates the difference between the pretest score and the posttest score for each person, and determines if, overall, the difference is statistically significant (i.e., the difference is not zero). The main difference between the two tests is that the Wilcoxon test uses rank ordered differences and the direction of the difference (i.e., increase/decrease in score) instead of calculating the average difference. A non-parametric test was selected because the answer options for these scales are ordinal, and because of the small sample size, which contributed to a distribution of data that was non-normal.

All interviews and focus groups were transcribed verbatim by a professional transcription service. Analysis followed the methods of Taylor and Bogdan (1998). The members of the study team developed a coding scheme based on emerging ideas, themes, concepts, and propositions discovered through transcript analysis. Using the coding scheme, each interview transcript was coded independently by two study team members, using the qualitative software NVivo. Any coding discrepancies were discussed until a consensus was reached. Once the data from the interviews and focus groups had been coded, the study team reviewed the data to develop interpretations, findings, and conclusions through a process of memoing. The quotes presented below are representative of the codes from which they were taken. Because only one site had a male consultant, all pronouns in the quotes have been changed to "she/her" to protect the male consultant's identity.

# FINDINGS

## How is IECMHC implemented in each of the LIAS?

The main functions of the mental health consultants were case conferences, reflective supervision, and trainings. Three of the four programs did case conferences with their consultant. While the case conferences were similar in structure, they were experienced by the site staff differently at each site. At one site, the home visitors described the case conferences as reflective supervision, because the consultant guided them through reflection with the questions that were asked (e.g., how were you feeling? how do you think the client was feeling? what might make the client react that way?). As one participant described it, "So [consultant] does the ultimate reflective supervision. You don't even know you're being reflectively supervised." At the other two sites, the home visitors did not describe the case conferences as reflective supervision, but the supervisors described the consultant as bringing a reflective component to case conferences.

All four of the sites had the mental health consultant provide reflective supervision to the supervisor(s). One site focused their consultation on reflective supervision, specifically (this is the site that did not do case conferences with their consultant). In this site, the consultant also provided formal reflective supervision to the home visitors in group supervision.

In addition to case conferences and reflective supervision, the consultants at all four sites provided trainings. The trainings covered a variety of topics, and were tailored to the needs of the site. Training topics included attachment, borderline personality disorder, social and emotional development, signs and symptoms of mental illness, referral resources, medication and mental illness during pregnancy, and self-care. The site that focused on reflective supervision received extensive training in reflective supervision.

There were a couple additional elements that were provided by some of the mental health consultants. Three of the sites mentioned that the consultant began sessions with a period of meditation or mindfulness. Also, one consultant was from the same community as the home visiting site, and this consultant was able to provide a lot of information on how to best navigate the mental health resources in that community for clients who needed resources and services. The focus groups asked about whether the consultant worked directly with families, and all four sites reported that the consultant did not.

Each of the four sites started their consultation at a different time point, depending on how long it took them to identify and establish a contract with their consultant. The total length of the consultation ranged from five to eight months. Some sites had sessions with their consultant once a month, and some did twice a month. These sessions were usually two hours in length. In addition, one site did four full-day trainings on reflective supervision. Most of this time was spent in groups, and at the three sites where there was only one supervisor, the supervisor also met one-on-one with the consultant. While all of the sites mentioned that the home visitors could have reached out to the consultant for one-on-one consultation, they did not do so (with the exception of one home visitor who had a one-on-one session only because the other home visitors could not make it to the session). Three out of the four sites said

that the time they had with the consultant was not enough time, both in terms of the amount of hours per month they worked with the consultant, and the full length of time for the consultation. Two of the sites mentioned that they were continuing their work with the mental health consultant beyond the initial funding period. They both talked about how glad they were to continue the consultation.

## To what extent are the consultants able to work effectively with LIAs?

In the Consultant Survey, consultants were asked a series of questions about their qualifications, including their education and training background, certifications, and years of experience. In addition, the consultants were asked open-ended questions about additional experience and their philosophy, orientation, and framework for providing mental health services.

All five consultants reported having graduate degrees. All but one consultant reported that their graduate degree was in mental health. Two consultants reported having degrees in psychology, two reported graduate degrees in social work, and one reported a degree in counseling (one consultant reported two degrees) (Figure 1). In addition, one of the consultants reported a Graduate Certificate in Infant Mental Health.

**Figure 1 : Mental Health Degree Type (n=5)**

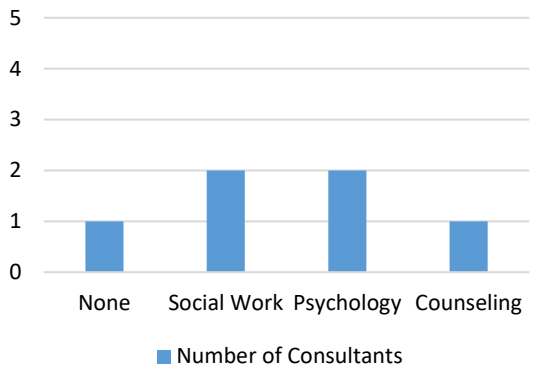
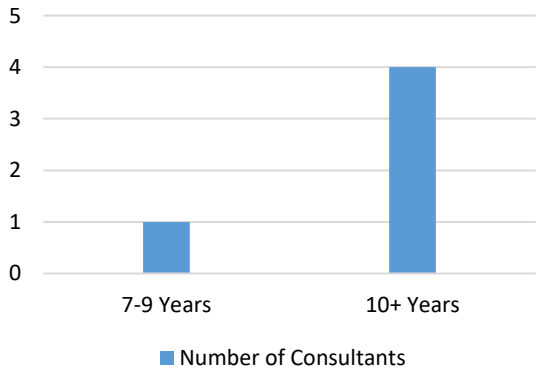



**Figure 2: Years of Experience (n=5)**




*One consultant reported having two degrees

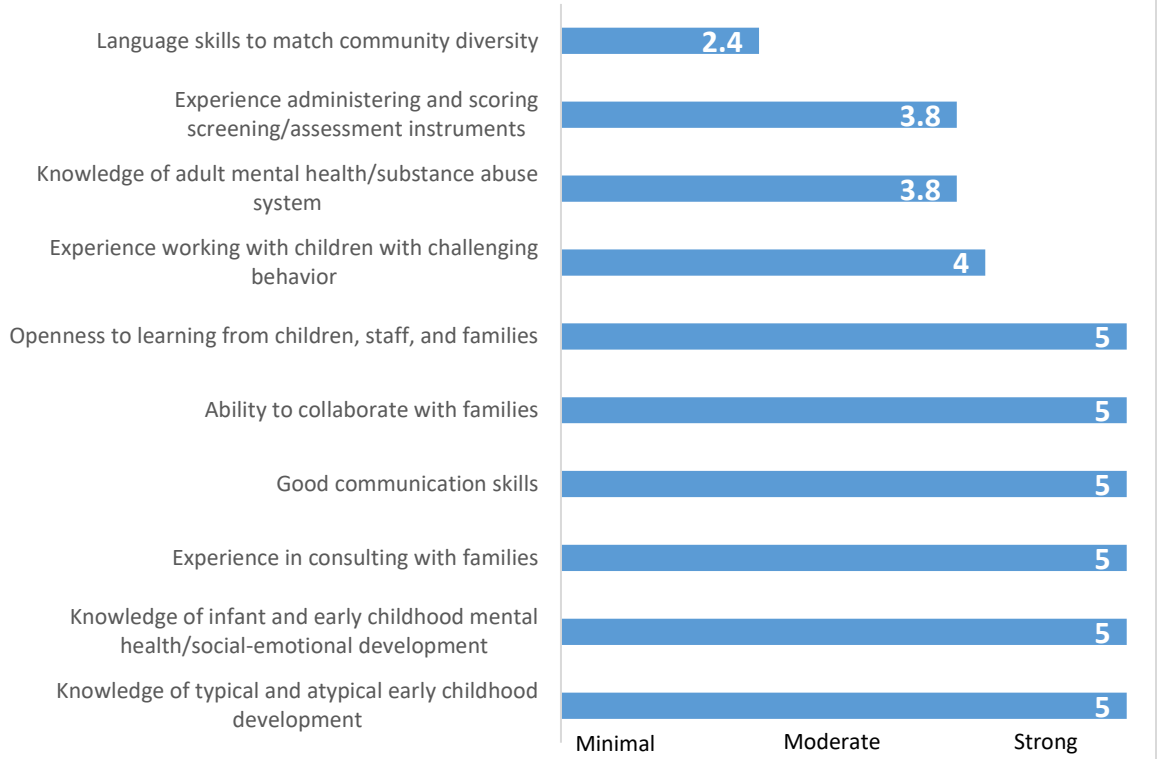
All five consultants reported that they were licensed mental health providers and that they have training in early childhood or infant mental health. Four of the consultants reported they had 10+ years of experience with mental health consulting and delivering mental health services to young children and adults, while one consultant had 7-9 years of experience (Figure 2). When asked about their philosophy, orientation, and framework, consultants talked about infant mental health, attachment theory, analytical psychology, relationship-based models, and reflection.

Consultants were also asked to rate their knowledge, skill, and experience on a variety of items, including childhood development, adult mental health, treatment approaches, community resources, diversity, and training on a 5-point scale (1=minimal; 3=moderate; 5=strong).[1] The lowest rated items by

[1] Means for each scale item from the LIA Survey and Consultant Survey can be found in the Appendix.

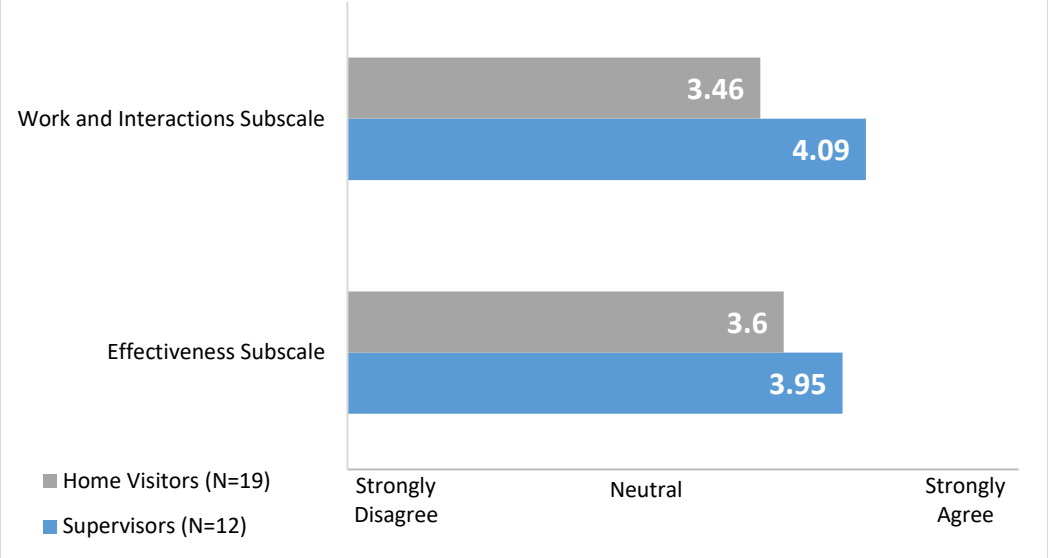
the consultants were language skills to match community diversity, experience working with children with challenging behavior, experience administering and scoring screening/assessment instruments, and knowledge of adult mental health/substance abuse system (Figure 3). Knowledge about language skills to match community diversity was rated between minimal and moderate, the lowest out of all items.

**Figure 3: Lowest and Highest Rated Items by Consultants (n=5)**




The LIA Survey asked home visitors and supervisors to rate their consultant from 1 (strongly disagree) to 5 (strongly agree) on how they interacted with the program and how effective they were through the Mental Health Services Survey subscales of "Work and Interactions" and "Effectiveness." The means for both the Work and Interactions Subscale and Consultation Effectiveness Subscale are shown in Figure 4. Within the Work and Interactions Subscale, the availability of Mental Health Consultants when they're needed was rated low. Consequently, both home visitors and supervisors didn't regularly go to the Mental Health Consultant when they needed help with particular children or families. Regarding the Effectiveness Subscale, items about improving the ability of staff were rated highly by both home visitors and supervisors. Feeling less stress and improved quality of home visits were also rated highly, which are related to improved ability. Interestingly, all items were rated more highly by supervisors than by home visitors, indicating that supervisors may have had a more positive experience with the consultant than their staff had.

**Figure 4: Mental Health Services Subscales**




Additional data about effectiveness were gathered through the interviews and focus groups. When asked what they hoped to gain from the mental health consultation, participants mentioned several program needs that they were looking to address. All four sites discussed how home visitors have complex cases, with clients who have high needs and/or mental illness such as depression, anxiety, schizophrenia, and bipolar disorder. They were looking for some help to understand and address these complicated cases. Some sites talked about how an outside person would be helpful, to have someone who is not familiar with the clients bring fresh perspective. In addition to these more general needs, there was some variability in what sites hoped to gain from the consultant. Two of the sites talked about improving reflective supervision and reflective practice for home visitors. One site hoped that the consultant would provide training on mental health topics, and help them craft specific strategies for working with complex cases. In the home visitor focus group at another site, participants mentioned that they hoped the consultant would help support the home visitors' own mental health, such as helping them process secondary trauma.

The participants provided a lot of information about what parts of the consultation were effective, and which were not. Aspects that were effective fell into three broad categories: the structure of the consultation, the qualities of the consultant, and the components of consultation provided.

In terms of structure, some participants mentioned liking the more structured approach to case conferences that differentiated them from more informal sharing with one another (e.g., venting about difficult situations). The case conferences with the consultant also provided an opportunity for others to learn about complex cases. Several of the participants also mentioned being happy with the flexibility that their consultant provided to meet their needs. For example, providing training on topics of their choosing, and providing information in multiple formats for different types of learners. One supervisor also made a point of saying that she really enjoyed having the ability to have one-on-one meetings with the consultant.

In regard to consultant qualities, sites discussed how they appreciated the expertise of their consultant, and the years of experience they brought to the site. One site felt that their consultant also held expertise in their community, which helped their consultant really understand the situations of the families they serve. Another site discussed how their consultant was clearly invested in them and in making their consultation experience positive.

There were several different components of the consultation that were seen as effective. Some participants thought the educational sessions were effective, providing information on specific topics. Some participants also thought it was effective to have a new perspective on their cases, and appreciated the validation that comes with having an outside person recognize the difficulty of the cases being shared. Also, several participants talked about the effectiveness of the support the consultant provided to the home visitors, helping them process the emotions of working with complicated client situations, and promoting self-care.

Participants also talked about aspects of the consultation that were not as effective. For example, one site thought the training provided was too general and discussion-based, rather than the didactic learning they wanted. One interesting finding of the focus groups was that many of the participants had difficulty recalling the topics of the trainings, which may indicate that they were not as impactful as they could have been. Another site did not like how the consultant started with a ten minute silent meditation at each session. Other critical feedback on effectiveness focused on the consultant's approach. The home visitors at one site were hoping the consultant would provide more concrete ideas and strategies for working with their families, and were not satisfied with the heavily reflective approach the consultant took. As one participant explained,

> *"Sometimes I felt like with [consultant] when we would try to like push to get a little bit more, she would like kind of just like smile and pop us back with a question. Do you know what I mean? And just like totally put it back in our hands. And like yeah, ultimately it's on us, but this is why we want this guidance and structure."*

The home visitors at this site also did not feel like the consultant led the case conferences with a clear direction, and were sometimes confused about what to take away from the sessions. This same site also did not think their consultant brought the level of expertise they needed. Another site did not see a clear value add from their consultation. They did not think the consultant changed the structure or quality of their case conferences. Several individuals at this site thought it might be more effective to work one-on-one with the consultant. This is the same site where several of the home visitors had hoped the consultant would help support the home visitors' own mental health.

Another area of effectiveness that the evaluation investigated was communication. When asked about communication with the mental health consultant, the participating sites described several ways in which communication went well. Three of the sites talked about how they felt comfortable with the consultant to communicate openly, and felt the consultant was relatable. One site also discussed how their consultant was very good at keeping the conversation on track. Two of the sites also mentioned appreciating that the consultant always remembered to check in on how things were going with the families that had been discussed in previous case conferences.

One of the sites did not think they had good communication with their consultant. They mentioned not feeling comfortable to open up to the consultant and speak freely. They also had a hard time following the direction of the consultant's questions. It felt like sometimes the questions the consultant asked took the case conference off topic, and sometimes the consultant asked the same question multiple times during the case conference, and they were not sure if this was because she wanted a different answer, or because she forgot that they answered the question already.

Previous research on IECMHC has shown that clarity of the consultant's role is an important factor in the success of consultation. When asked about this during the interviews and focus groups, all but one site thought the consultant's role was clear. One supervisor mentioned that the guidance for the funding was clear on what they could and could not do with the consultant. In two of the sites, the home visitors talked about how their supervisor explained to them what the purpose of the funding was, and what role the consultant would have, and that helped them feel clear. One site that had a lower satisfaction with their consultant said this was not an issue of clarity. They were clear on what the consultant's role would be, but they did not think that role was fulfilled.

The one site that did not think the consultant's role was clear talked about a few different ways in which there was a lack of clarity. To begin with, they did not know the full scope of what a mental health consultant could provide, which made it difficult to specify what that scope would be. The home visitors at this site also discussed how they were not clear on what the intended purpose of working with the mental health consultant was.

## What are the successes, challenges, and lessons learned from implementing IECMHC?

When asked whether the mental health consultation met their expectations, two of the four sites said it had exceeded their expectations. At one site, this was a product of the fact that they did not have specific expectations, and ended up being surprised that it was as useful as it was. In the other site, the way the consultation exceeded their expectations was that it supported them at a personal level that they were not expecting. As one home visitor explained, it helped them feel refreshed, "like a reset button."

Another way in which mental health consultation met expectations surrounded the function of case conferences. The consultant was able to help the home visitors work through complicated cases, and in one site, a home visitor commented that the consultant provided a good balance of reflection and advice, guiding the staff through reflecting on the situation, but offering suggestions if they were still stuck on what to do.

Three of the four sites also talked about ways in which the mental health consultation did not meet their expectations. This was different for each site. In one site, the supervisor thought the consultant had provided trainings that were too general, and not as useful. At another site, the supervisor would have liked to see a stronger bond between the consultant and the home visitors, and the home visitors wanted a consultant with more clinical experience to draw from, as well as a consultant that made suggestions for strategies they could use with their clients. At the third site, the home visitors had

expected the consultant to focus more on helping them manage stress and secondary trauma, perhaps in a one-on-one setting, and they did not think they had received that during the group case conferences. As one participant explained,

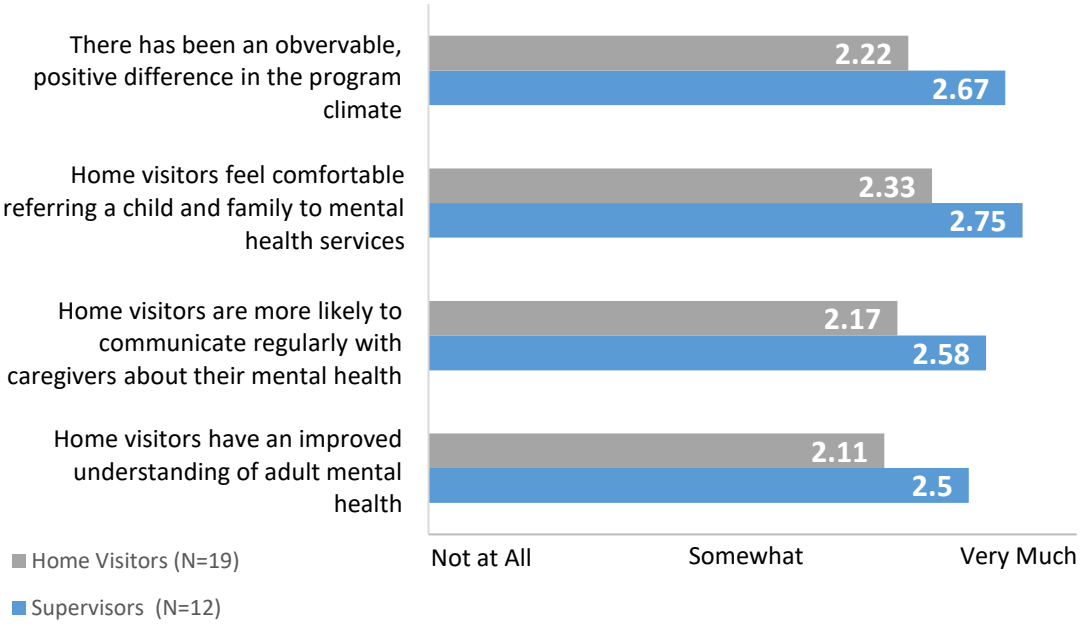
> *"I guess I pictured it prior to all this almost like a therapy session for us. (Some in agreement.) And I don't know if that would be any better or how that would look, but I think I was hoping for a little bit more like in-depth for us, yeah."*

When participants were asked what would have been helpful to know before the mental health consultation, several people discussed wishing they had known more about mental health consultants and the range of services they can provide. That would have helped them know better what to expect from the consultant. One of the supervisors also talked about how it was hard to find a consultant that had the required level three infant mental health certification, and who was available to provide consultation. The home visitors at one site explained that they would have liked to try a couple different consultants before one was selected to make sure the consultant was a good fit for the program. Only one site mentioned that it would have been helpful to provide a better explanation to the home visitors about what the consultant was going to provide prior to the consultation. However, in comparing the answers of supervisors and home visitors to questions about expectations, there were differences that indicated other sites may have needed to better inform their home visitors, as well.

## To what extent does IECMHC increase home visitor capacity to work with families with mental health needs?

In the LIA Survey, the Goal Achievement Scale measured the impact of the mental health consultation services on home visitors and the overall program climate on a 3-point scale (1=not at all; 2=somewhat; or 3=very much). On average, home visitors rated each of the items between 2.0 and 2.4. On the other hand, supervisors rated all but one item between 2.5 and 2.8. While these both fall within the range of "somewhat," the supervisors were much closer to "very much." Items with the largest discrepancy between home visitors and supervisors included home visitors having an improved understanding of adult mental health (2.11 and 2.50, respectively), home visitors are more likely to respond appropriately and effectively to families in distress (2.17 and 2.58, respectively), home visitors feel comfortable referring a child and family to mental health services (2.33 and 2.75 respectively), and there has been an observable, positive difference in program climate (2.22 and 2.67, respectively) (Figure 5). There are a few possible reasons for these differences. Similar to the ratings of consultant effectiveness, they may reflect different experiences with the consultant between supervisors and home visitors. They may also be the result of supervisors recognizing changes in their home visitors that the home visitors themselves do not see.

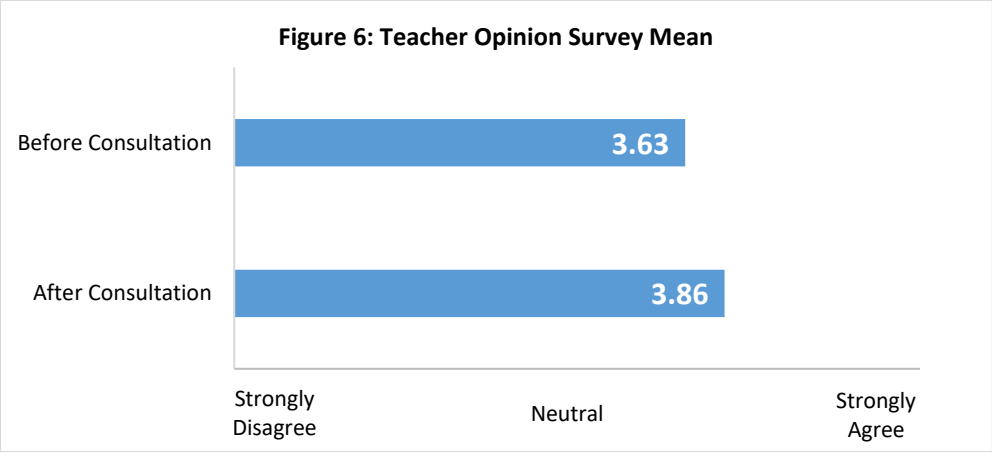
**Figure 5: Select Items from the Goal Achievement Scale**



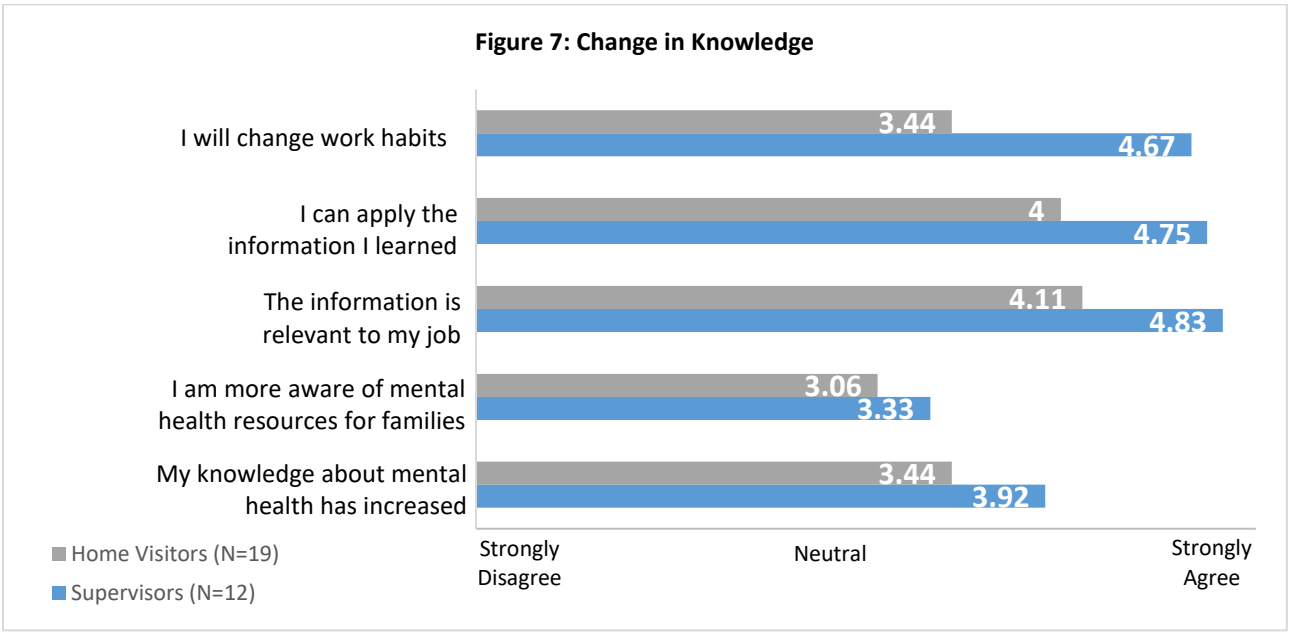

Home visitor self-efficacy was measured using the Teacher Opinion Survey on a scale from 1 (strongly disagree) to 5 (strongly agree). Home visitors, including supervisors who were home visitors at the time of the survey, were asked to think about the survey items both before and after their experience with the mental health consultant. Home visitors and home visitors/supervisors reported an overall increase in self-efficacy after working with the Mental Health Consultant (Figure 6). Before the consultation, survey items were ranked as neutral or agree, on average, with a combined mean of 3.63. After the consultation, the combined mean was 3.86. Survey items that saw the greatest change after consultation included:

- If I keep trying I can find some way to reach even the most challenging clients (**7.4% increase**).
- There are some families that I simply cannot have any influence on (**16.49 % decrease**).
- I feel a sense of hopelessness about the future of the families I work with (**17.49% decrease**).
- I have enough training to deal with almost any home visiting situation (**7.69% increase**).

The Wilcoxon Signed Rank Test indicated that the overall increase in self-efficacy was statistically significant, with a p- value <0.001.




Additional questions about changes in knowledge were included in the LIA Survey, rated from 1 (strongly disagree) to 5 (strongly agree). On average, home visitors were neutral about change in knowledge regarding mental health, awareness of mental health resources, and changes in work habits (Figure 7). However, home visitors agreed they felt changes in their knowledge about information being relevant to their job and applying the information they learned. Supervisors strongly agreed that their knowledge changed regarding information being relevant to their job, applying information that they learned, and changes in work habits. In addition, supervisors agreed that their knowledge about mental health had increased; however, they were neutral about being aware of mental health resources for families. There was a large difference between home visitors and supervisors for the item about changing work habits (3.44 and 4.67, respectively), which most likely reflects the fact that supervisors worked directly with the consultant around reflective supervision. Being more aware of mental health resources for families was the lowest rated item for both home visitors and supervisors (3.06 and 3.33, respectively). On the other hand, the highest rated item for both visitors and supervisors was information being relevant to their job (4.11 and 4.83, respectively).



Additional information about changes in home visitor capacity was collected through the interviews and focus groups. While most participants explained that they already had foundational mental health knowledge prior to the consultation, a number of participants commented on how the consultation services helped them better understand the importance of the mother-child relationship and how issues the parent is dealing with can impact the baby. For example, the consultant for one of the sites educated the staff on how a parent's adverse childhood experiences can affect their child and the parent-child bond, and provided ideas for how to intervene and mitigate that impact.

Participants also learned from the consultation process to be aware of when the focus was too one-sided in terms of emphasizing the parent, and to keep the baby in mind. When home visitors are working with adult clients who are experiencing mental health issues, it is easy to forget about how that is impacting the baby. As one supervisor explained,

> *"So I really felt like learning these skills helped us in ways to talk about it in supervision, or support each other, or ask more about keeping the baby in mind, so how was that parent who is struggling with severe depression and anxiety, how could that be impacting that relationship with the baby."*

In regard to mental health resources in their communities, three of the four sites indicated that they felt well-equipped with knowledge of available community mental health resources prior to the consultation. They felt that their knowledge exceeded that of the consultant they were working with, and that the consultant was not providing them with information that they did not already have at their disposal. However, in all three of these sites, the consultant was not from their community. The fourth site had a consultant who worked in their community and had extensive knowledge of mental health resources. Staff at this site commented that although they had a good understanding of available community resources, what the consultant was able to provide was strategies and processes for successfully accessing those resources, and the most current ways of going about contacting these resources. The staff at this site found this incredibly helpful, as they had run into barriers when trying to assist their clients in accessing mental health resources in the past.

Supervisor interviews and focus groups also asked whether there were things that home visitors were doing differently as a result of working with the mental health consultant. In general, supervisors reported that they had observed some changes in their staff since receiving the consultation services. Two of the site's supervisors discussed how staff are more confident in supporting families with mental health issues. One of the sites that did not think staff had increased their confidence explained that they had not been working with their consultant for very long, and there was a lack of clarity about the consultant's role. All four of the site's supervisors thought their staff were more reflective after the consultation. For example, one supervisor explained that her staff has worked on being aware of their feelings about working with their family prior to meeting with them for their appointment. Their consultant encouraged them to ask themselves how they are feeling before they get out of their car and walk to their client's door.

## To what extent does IECMHC contribute to improved services for families with mental health needs?

A theme shared by a number of supervisors and home visitors in the interviews and focus groups was that they felt the consultation had helped them learn how to be more comfortable with their clients, and how to give themselves permission to be transparent and "real" during home visits. This allowed them to be more present, more comfortable, more genuine, and raise issues with their clients that they may not have done in the past. A number of home visitors also indicated feeling more confident in their ability to identify and support families' mental health needs as a result of the consultation service. As one home visitor explained,

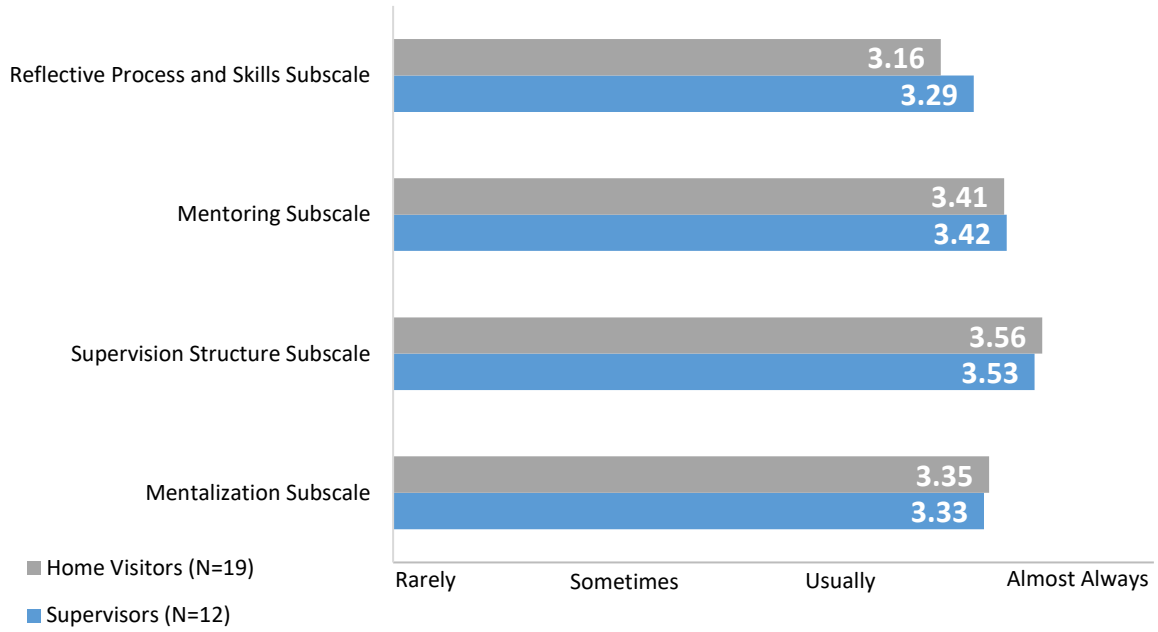
> *"So I think it gave me like a little bit of leverage to like have conversations that we hadn't been able to have before and that kind of thing. And even in regards to her parenting and stuff that like I didn't have to like walk on eggshells kind of."*

In terms of the home visitors' relationships with families, some home visitors stated that they believed the consultation had made a positive impact. When working with their clients, some home visitors became less focused on checking off boxes on a form during initial appointments, and instead prioritized developing rapport through active listening and letting the clients express themselves more freely and informally. Other home visitors learned that you don't have to go into a families' home and "fix everything"; that there is a lot of value and good that can come from just being present and available to listen. When asked whether these changes had an impact on client engagement, most participants said it was either too early to tell, or it was hard to tell what had caused a change in engagement. One notable exception to these findings was with the site that did not see the value add of having a consultant. The home visitors at that site indicated that they had not changed anything about the ways they work with families, and they did not feel more confident in supporting families with complex mental health needs.

## To what extent does IECMHC increase supervisor/manager capacity to support home visitors working with families with mental health needs?

The Reflective Supervision Rating Scale was used to assess supervisor and supervisee reflective processes and skills, mentoring, supervision structure, and mentalization on a 4-point scale (1=rarely; 2=sometimes; 3=usually; 4=almost always). Overall, both home visitors and supervisors rated the reflective supervision they were giving/receiving highly. The reflective process and skills subscale was ranked lowest for both home visitors and supervisors (mean of 3.16 and 3.29, respectively) (Figure 8). On the other hand, the Supervision Structure Subscale was ranked highest for both home visitors and supervisors (mean of 3.56 and 3.53, respectively). Items with the biggest difference between home visitors and supervisors included integrating emotion and reason into case analysis (3.05 and 3.42, respectively), setting the agenda for supervision together (3.11 and 3.42, respectively), having formed a trusting relationship (3.37 and 3.58, respectively), and the supervisor being both a teacher and guide (3.47 and 3.25, respectively).

**Figure 8: Reflective Supervision Rating Scale: Subscale Means**



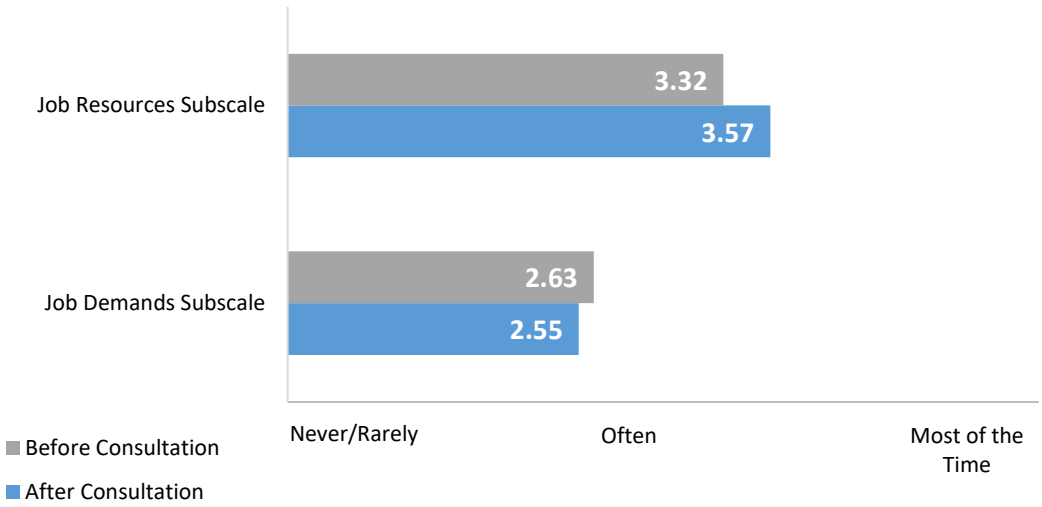

In the focus groups, supervisors from all four sites reported that working with the mental health consultant increased their knowledge of reflective supervision. At one site, a supervisor commented on how working with her consultant allowed her to give herself permission to be more patient with herself while working with her home visitors because there is no "perfect way to do it", and each home visitor was bringing something different to her, and there was no one, set approach she should try and follow. Supervisors from two other sites indicated that the consultation process gave them a clearer indication of the need to keep the administrative and reflective components of supervision separate as best they could so that staff could feel truly listened to during the reflective supervision piece. At the site that focused specifically on reflective supervision, supervisors discussed how the consultation provided an opportunity to see that what they had previously thought of as reflective supervision was more of a superficial exploration of the process, but wasn't reaching a deeper level.

Supervisors from all four sites talked about the changes they were aware of in their supervising approach as a result of the consultation services. They were more confident in supporting their home visitors, and more confident in supporting their home visitors working with families dealing with mental health issues. One supervisor talked about doing less talking in supervision and reflecting more on how her home visitors might be impacted by their client's situation. She also is now being more mindful of how questions in supervision are phrased, and how they may be received by her staff.

## To what extent does IECMHC decrease home visitor and supervisor/manager stress and burnout?

In the LIA Survey, the Job Stress Inventory measured job stress, in terms of job demands and job resources on a 5-point scale (1=never/rarely; 2=sometimes; 3=often; 4=usually; 5=most of the time). Home visitors, including supervisors who were home visitors at the time of the survey, were asked to think about the survey items both before and after their experience with the mental health consultant. Overall, they reported a decrease in job demands and an increase in job resources after working with the Mental Health Consultant, which indicates a decrease in job-related stress (Figure 9). Before the consultation, the combined mean of the job demands subscale was 2.63, and after the consultation, it was 2.55, indicating a decrease in job demands. Items on the job demands subscale with the largest decreases after consultation were home visitors being nice no matter how they felt (decreased 5.36%), and feeling pressure from family to do a different kind of work (decreased 6.52%). On the job resources subscale, the mean before consultation was 3.32, and after consultation it was 3.57, indicating an increase in resources. The item on the job resources subscale that increased the most after consultation was feeling respected for the work they do (increased by 8.58%). The Wilcoxon Signed Rank test indicated that the decrease in job demands and the increase in job resources were statistically significant with p-values of 0.046 and 0.002, respectively.

**Figure 9: Job Stress Inventory: Subscale Means (n=24)**




In the interviews and focus groups, the consensus among both supervisors and home visitors alike was that having the benefit of working with a skilled and knowledgeable mental health consultant had a positive impact on their ability to cope with stress. Comments focused on various aspects of the process, from the reflective nature of the feedback provided by consultants, to the new tools both supervisors and home visitors were able to bring into their respective roles, to actually feeling calmer and more capable of managing the demands of stressful work as a result of the consultation intervention. As one home visitor explained,

*"I also feel like—and this kind of goes back to what I said before, but not like having the pressure of not having to fix their problems, and to just be present and being there for them has made me feel less stressed, I guess."*

One notable exception was the home visitors at the site that did not see the value add of their consultant. At this site, the supervisor thought the one-on-ones she had with the consultant helped her stress levels, but the home visitors did not think the consultation had helped their stress. This was also the site where some of the home visitors had hoped the consultant would provide more support to the home visitors to deal with secondary trauma, and were disappointed when that was not what the consultation provided.

## Limitations

This evaluation had some limitations that are important to keep in mind when considering the findings. First of all, there were only four sites who participated in the mental health consultation and evaluation. There was a high response rate to the surveys and participation in the interviews and focus groups, which means the evaluation findings should represent well the processes and outcomes for the participating sites. However, caution should be used in applying the findings to make generalizations about mental health consultation in home visiting, in general. Another limitation is that one of the sites focused specifically on reflective supervision, while the other sites used a more traditional mental health consultation approach. One strategy the evaluation team used to address this difference was to look for differences in experiences and outcomes at this site in the qualitative data. These differences are noted in the findings.

## Discussion and Recommendations

Overall, looking at the survey data, the mental health consultation resulted in improvements in home visitor capacity and confidence to support families with complex mental health needs, and home visitors and supervisors experienced decreased stress and burnout. The interviews and focus groups provide a more nuanced picture of the impact of mental health consultation. The area where home visitors seemed to have experienced the most growth is in their ability to be more comfortable with their clients, and to give themselves permission to be transparent and "real" during home visits. Their work with the mental health consultant gave them permission to not have all of the answers, or to be okay with not knowing how a client might respond to something they say. Home visitors and supervisors also gained a deeper understanding of the parent-child relationship and how issues that the mother is experiencing (e.g., depression, anxiety) impact the infant. Home visitors also talked about how it was reaffirming to have an outside person recognize the difficulty of their cases. This may be linked to the finding from the Job Stress Inventory where home visitors reported an increase of nearly 9% for the item about feeling respected for the work they do.

*Recommendation:* Given the findings of the evaluation study, mental health consultation is recommended as a method for improving home visitor competence and confidence to support families

with complex mental health needs, and to decrease stress and burnout for home visitors and supervisors.

A key element that affected the quality of a site's experience with their mental health consultant was the extent to which the site had clear goals for the consultation, and how well the goals matched the skills and approach of the consultant. In both sites where the consultation did not go as well, what the consultant provided did not meet the expectations of the home visitors. Clear goals were also important for the training element of the consultation. When sites did not have a clear goal for the training provided by the consultant, or did not make that goal clear to the consultant, the trainings were not as useful.

*Recommendation*: When beginning a mental health consultation, home visiting programs should be clear about the purpose of the consultation, and what the supervisor and the staff hope to get out of the consultation. It is also important that supervisors build buy-in from their staff. Once clarity is established, ensure the consultant that is hired matches the goals for the consultation in terms of skill and approach, and that the goals are clearly communicated to the consultant.

In addition to the match between goals and consultant approach, there were a couple of consultant qualities that were highly valued by participating sites. First of all, there was a great deal of value in having a consultant that balanced reflection and problem solving, so that the consultant could help the staff reflect and come to their own solutions, but also provide helpful suggestions if they got stuck. This finding is also relevant for supervisors, as they develop their own skills in reflective supervision and work to find a balance of reflection and problem solving in their own style. Second, the site who had a consultant who was familiar with the mental health system in their community learned a lot about how to navigate that system. This may not be available in all communities, but is something for home visiting programs to consider when selecting a mental health consultant.

*Recommendation*: Some sites discussed how they were unsure of the full range of potential services that could be provided by a mental health consultant. This can make it difficult to develop goals for the consultation. For future efforts around mental health consultation with MHVI, it would be helpful to provide home visiting programs with resources on what they could gain from mental health consultation, or to facilitate connection and sharing with sites that have used consultants successfully (e.g., successful trainings, finding the right balance of reflection and problem solving, matching consultant activities to goals and expectations).

The evaluation findings indicate that mental health consultation had a positive impact on supervisors. Supervisors rated the mental health consultant more positively than home visitors did, and were more likely to report having gained knowledge and changed their practices as a result of the consultation. All of the supervisors said they had increased their understanding of reflective supervision through the consultation, and felt more confident providing supervision to their staff.

*Recommendation:* Given the success of the mental health consultant working directly with the supervisors on reflective supervision, this element should be repeated in future mental health consultation efforts.

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# APPENDIX: DATA TABLES

The following tables provide the means for each scale item from the LIA Survey and Consultant Survey.

## Consultant Knowledge and Skills Inventory

| Item | Mean |
|---|---|
| Knowledge of typical and atypical early childhood development. | 5 |
| Knowledge of infant and early childhood mental health/social-emotional development. | 5 |
| Knowledge of diverse mental health treatment/intervention approaches. | 4.2 |
| Knowledge of family support and adult service systems. | 4.6 |
| Knowledge of the adult mental health/substance abuse system. | 3.8 |
| Knowledge of adult mental health and wellness. | 4.8 |
| Knowledge of community resources. | 4.8 |
| Experience in consulting with families. | 5 |
| Good communication skills | 5 |
| Crisis intervention skills | 4.4 |
| Care management/care coordination skills | 4.6 |
| Understanding of diverse cultures | 4.6 |
| Experience administering and scoring screening/assessment instruments | 3.8 |
| Experience working with children with challenging behavior | 4.0 |
| Experience providing direct therapy to children, birth through five | 4.8 |
| Knowledge of adult learning principles | 4.4 |
| Experience providing training/education to adults | 4.6 |
| Ability to facilitate team meetings | 4.8 |
| Ability to integrate a 'wellness approach' to mental health that includes activities focused on promotion and prevention | 4.6 |
| Ability to collaborate with families | 5 |
| Experience in providing reflective supervision | 4.8 |
| Specialized expertise such as separation and loss, maternal depression, adolescent mothers, abuse and neglect, failure-to-thrive, trauma, sexual abuse, etc. | 4.4 |
| Resource referral and case management skills to facilitate systems and services access | 4.6 |
| Openness to learning from children, staff, and families | 5.0 |
| Language skills to match the community diversity | 2.4 |

(1=Minimal; 2; 3=Moderate; 4; 5=Strong)

## Mental Health Services Survey

| Item | Home Visitors (N=19) | Supervisors (N=12) |
|---|---|---|
| MHC Work and Interactions | | |
| I have a good relationship with the MHC(s) | 4.12 | 4.58 |
| The MHC(s) works as a partner with me to meet family's mental health needs. | 3.74 | 4.42 |
| The MHC(s) seems like another member of the staff, not like an outsider. | 3.32 | 4.1 |
| The MHC(s) has good relationships with families. | 2.95 | 3.45 |
| I regularly go to the MHC(s) when I need help with particular children or families. | 2.32 | 2.92 |
| The MHC(s) respects staff's knowledge and perspectives on family's issues. | 4.32 | 4.75 |
| The MHC(s) is "part of the team" trying to help families. | 3.53 | 4.58 |
| The MHC(s) is available when I need him/her. | 2.89 | 3.92 |
| The MHC (s) demonstrates an awareness of families' unique cultural characteristics and preferences | 3.95 | 4.58 |
| *Subscale Mean* | *3.46* | *4.09* |
| MHC Effectiveness | | |
| *Our program's MHC services have:* | | |
| Improved the quality of our home visits. | 3.78 | 4.42 |
| Improved our ability to help families with mental health needs. | 3.78 | 4.42 |
| Improved our ability to help families know how to cope with children's challenging behaviors. | 3.61 | 4.08 |
| Helped staff to feel less stress. | 3.67 | 4.5 |
| Our mental health consultation services and approach are in need of improvement. | 3.17 | 2.33 |
| *Subscale Mean* | *3.6* | *3.95* |

(1=Strongly disagree; 2=Disagree; 3=Neutral; 4=Agree; 5=Strongly agree

## Goal Achievement Scale

| Item | Home Visitors (N=19) | Supervisors (N=12) |
|---|---|---|
| Home visitors have an improved understanding of children's social and emotional development. | 2.28 | 2.42 |
| Home visitors have an improved understanding of adult mental health. | 2.11 | 2.50 |
| Home visitors are doing a better job of managing families' mental health needs. | 2.22 | 2.58 |
| Home visitors are more likely to respond appropriately and effectively to families in distress. | 2.22 | 2.67 |
| Home visitors are more likely to communicate regularly with caregivers about their mental health. | 2.17 | 2.58 |

| | | |
|---|---|---|
| Home visitors know how to refer a child and family for mental health services. | 2.28 | 2.67 |
| Home visitors feel comfortable referring a child and family to mental health services. | 2.33 | 2.75 |
| Home visitors feel more understood and supported. | 2.28 | 2.67 |
| Home visitors feel more competent and confident in their ability to respond to behavior that worries them | 2.28 | 2.67 |
| Home visitors are more likely to receive regular, supportive supervision | 2.39 | 2.58 |
| The supervisor is more responsive to home visitors' needs | 2.39 | 2.67 |
| There has been an observable, positive difference in the program climate. | 2.22 | 2.67 |

(1=Not at all; 2=Somewhat; 3=Very much)

## Teacher Opinion Survey

| Item | Before Consultation (N=24) | After Consultation (N=24) |
|---|---|---|
| I can help families learn skills that they need to cope with adversity in their lives. | 3.92 | 4.17 |
| If I keep trying I can find some way to reach even the most challenging families. | 3.92 | 4.21 |
| There are some families that I simply cannot have any influence on (reverse scored). | 3.20 | 3.67 |
| If some families are not doing as well as others, I believe that I should change my way of working with them. | 3.58 | 3.79 |
| I can help children develop skills to make successful choices later in life. | 3.92 | 4.04 |
| I feel a sense of hopelessness about the future of the families I work with (reverse scored). | 3.38 | 3.83 |
| I can imagine myself being a home visitor for several more years. | 3.63 | 3.67 |
| If a family was in distress, I feel pretty sure that I'd know how to respond effectively | 3.79 | 3.88 |
| I have enough training to deal with almost any home visiting situation. | 3.25 | 3.50 |
| On a typical day, I feel a sense of accomplishment as a home visitor. | 3.67 | 3.88 |
| *Scale Mean* | *3.63 (α = 0.71)* | *3.86 (α = 0.80)* |

(1=Strongly disagree; 2=Disagree; 3=Neutral; 4=Agree; 5=Strongly agree)

## Reflective Supervision Rating Scale

| Item | Home Visitors (N=19) | Supervisors (N=12) |
|---|---|---|
| **My supervisor/supervisee…** | | |
| **Reflective Process and Skills Subscale** | | |
| Shows me how to integrate/integrates emotion and reason into case analyses. | 3.05 | 3.42 |
| Has improved my ability/their ability to be reflective | 3.11 | 3.33 |
| Explores my/explains their thoughts and feelings about the supervisory process itself. | 3.16 | 3.0 |
| And I together set the agenda for supervision. | 3.11 | 3.42 |
| Thinks with me about how to improve my/their observation and listening skills | 3.11 | 3.17 |
| Encourages me to talk about emotions I have felt/talks about emotions they have felt while consulting and working with families. | 3.42 | 3.42 |
| *Subscale Mean* | *3.16 (α=0.94)* | *3.29 (α=0.93)* |
| **Mentoring Subscale** | | |
| And I have formed a trusting relationship. | 3.37 | 3.58 |
| Is engaged throughout the entire session | 3.68 | 3.5 |
| Is both a teacher and a guide/treats me as both a teacher and guide | 3.47 | 3.25 |
| Makes me feel/seems to feel nurtured, safe and supported during supervision. | 3.37 | 3.58 |
| Allows me time to come to my own solutions/comes to their own solutions during supervision. | 3.05 | 3.17 |
| Listens carefully for the emotional experiences that I am expressing/expresses emotional experiences. | 3.53 | 3.42 |
| *Mean* | *3.41 (α=0.96)* | *3.42 (α=0.93)* |
| **Supervision Structure Subscale** | | |
| And I have established a consistent supervision schedule | 3.74 | 3.67 |
| Questions encourage details about my practice to be shared and explored/shares and explores details about their practices within the supervision session. | 3.26 | 3.42 |
| Is engaged throughout the entire session | 3.68 | 3.50 |
| *Mean* | *3.56 (α=0.80)* | *3.53 (α=0.58)* |
| **Mentalization Subscale** | | |
| Listens carefully for the emotional experiences that I am expressing/expresses emotional experiences. | 3.53 | 3.42 |
| Encourages me to talk about emotions I have felt/talks about emotions they have felt while consulting and working with families. | 3.42 | 3.42 |
| Keeps families' and children's unique experiences in mind during supervision. | 3.37 | 3.50 |
| Wants to know how I feel/tells me how they feel about my/their consultation or practice experiences. | 3.37 | 3.25 |
| Helps me explore cultural considerations in my work/explores cultural considerations in their work. | 3.05 | 3.08 |
| *Mean* | *3.35 (α=0.93)* | *3.33 (α=0.92)* |

(1=Rarely; 2=Sometimes; 3=Usually; 4=Often)

## Child Care Worker Job Stress Inventory

| Item | Before Consultation | After Consultation |
|---|---|---|
| **Job Demands** | | |
| Clients are late or miss their appointments. | 2.04 | 1.96 |
| I feel there are major sources of stress in families' lives that I can't do anything about. | 2.83 | 2.75 |
| I feel I should be paid more for the work that I do. | 3.21 | 3.21 |
| I need to be nice no matter how I really feel. | 3.92 | 3.71 |
| I buy supplies for families out of my own money. | 2.58 | 2.52 |
| I have to work long hours. | 2.46 | 2.42 |
| I feel pressured from my family to do a different kind of work. | 1.38 | 1.29 |
| *Subscale Mean* | *2.63 (α = 0.39)* | *2.55 (α = 0.54)* |
| **Job Resources Scale** | | |
| I have fun with my clients. | 3.58 | 3.71 |
| I feel the satisfaction of knowing I am helping families. | 3.67 | 3.83 |
| I feel respected for the work that I do. | 3.38 | 3.67 |
| I know that the work I am doing is important. | 4.08 | 4.13 |
| I know that I am appreciated by my clients. | 3.29 | 3.21 |
| I get praise from my clients for the work that I do. | 2.33 | 2.38 |
| I feel like I am doing a "real" job. | 3.67 | 3.71 |
| I see that my work is making a difference with a family. | 3.29 | 3.38 |
| I know my clients are happy with me. | 3.63 | 3.67 |
| I feel like I become close to my clients. | 3.58 | 3.71 |
| I feel like I am teaching families skills they need. | 3.67 | 3.88 |
| *Subscale Mean* | *3.32 (α = 0.39)* | *3.57 (α = 0.54)* |

(1=Never/rarely; 2=Sometimes; 3=Often; 4=Usually; 5=Most of the time)