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Evaluation of the Illinois Model of Infant and Early Childhood Mental Health Consultation Pilot in Public Health Departments

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Executive Summary

This report presents findings from a 15-month pilot of the Illinois Model of Infant and Early Childhood Mental Health Consultation (IECMHC) in four public health departments, funded by the Illinois Department of Public Health (IDPH). IECMHC is a relationship-based, collaborative support developed to promote children's mental health by improving the skills and knowledge of early childhood professionals (Cohen & Kaufmann, 2000). IECMHC consultants are trained mental health professionals who engage in a variety of promotion, prevention, and intervention activities to build the capacity of early childhood providers to foster the social and emotional well-being and development of children and families.

Growing evidence suggests that IECMHC is an effective strategy for improving a professional's ability to understand and respond appropriately to parents' and children's behaviors and feelings; it has also been shown to help staff manage their own emotions in their work (Albritton et al., 2019; Brennan et al., 2008, Conners-Burrow et al., 2012; Duran et al., 2009; Hepburn et al., 2013; Perry et al., 2010). Although IECMHC is likely to support professionals in a variety of child- and family-serving programs, most existing research comes from studies of implementation in center-based early childhood programs (pre-K and childcare) and, to a lesser extent, home visiting programs (Goodson et al., 2013; Lambarth & Green, 2019; Spielberger et al., 2021). Little is known about the feasibility or impacts of implementing mental health consultation in other settings, such as public health departments and programs.

The Illinois IECMHC Model

The Illinois Model was developed by a broad-based Leadership Team of public and private stakeholders. In addition to identifying the goals and critical elements of the model (see Box 1), the Leadership Team also established an infrastructure to embed IECMHC in multiple early childhood systems in the state for a sustained period. The infrastructure included a common vision and funding commitment across diverse systems and communities. It also incorporated a workforce development strategy to ensure that mental health consultants were well-prepared to work across a range of settings.

All approaches to IECMHC aim to help to develop the skills of early childhood professionals to work more effectively with children and families. However, the Illinois Model is distinct in the priority it gives to relationship-building, reflective practice, and program-focused consultation as the means to build staff skills. Relationships between consultants and staff are collaborative, ongoing, and proactive rather than episodic and reactive.

The theory of change for the Illinois Model assumes that if the approach is well-implemented and supported in multiple systems in diverse communities, then (1) supervisors and staff will improve their reflective capacity, relationships with supervisors and coworkers, and knowledge of young children's and parents' social and emotional health; and (2) families and children will have more positive engagement with providers and easier access to high quality mental health services. In turn, (3) providers, families, and children will experience better outcomes. These outcomes include: reduced burnout and depression and increased self-efficacy in staff and supervisors; positive social emotional development and better regulated behavior in children; and improved well-being and parenting practices in families.

Box 1. The Illinois Model

The Illinois Model of IECMHC is designed to be applicable to a range of family- and child-serving systems and programs. In addition to identifying best practices, the model makes recommendations for coordinating consultation practices across the state and implementing the necessary structures and supports to ensure a high quality, diverse consultant workforce. It specifies a consultant's qualifications, competencies, and activities. The competencies are:

- Knowledge of infant/early childhood development, mental health, and early care and education
- Ability to build relationships and partner with families, providers, programs, and systems
- Ability to work effectively throughout diverse cultures and communities
- Ability to effectively and sensitively gather information
- Ability to collaboratively develop a plan and measures of success
- Knowledge of community systems and resources and ability to develop partnerships
- Commitment to ethical behavior and reflective practice

The Illinois Model is multi-level, flexible, and tailored to meet the needs and goals of the consultee(s). Thus, in practice, consultation can differ in its format, frequency and dosage, and focus or target. For the IECMHC pilot in public health programs, consultants provided services 10-12 hours/month, on average, over 12 months, followed by a 3-month sustainability period of intermittent support. Activities varied but prioritized building relationships with staff and supervisors and increasing their reflective capacity.

Pilot Study of the Illinois Model in Public Health Departments

The purpose of this study was to understand the adaptations to the Illinois Model that would make it viable and ultimately sustainable in public health department programs. Implementation focused on staff in two child- and family-serving programs: Family Case Management (FCM) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). However, consultation services were available to other staff as well. We sought to answer the following research questions regarding implementation and impacts of the Illinois Model:

RQ1: How is the Illinois Model of IECMHC implemented? For example, what are the most frequent activities provided by consultants and to whom? Do consultants feel prepared for their work? Are FCM and WIC program staff ready to engage with the consultant?

RQ2: How does IECMHC affect FCM and WIC staff and supervisors? How does it increase their capacity to serve children and families? Is there evidence that FCM and WIC staff can engage families in a consultative, collaborative manner?

RQ3: Since the state is attempting to serve more high-risk populations and staff need more support to do so, how does IECMHC assist systems/agencies in serving all families?

The study used a mixed-methods design to examine the feasibility of implementing the Illinois Model in public health departments and assessing the potential impacts of the model on FCM and WIC staff. The study collected and triangulated quantitative and qualitative data from a variety of program staff, tracked consultants' activities, and looked at change over the duration of the intervention. Additionally, we sought to capture information about the organizational and community contexts for implementation.

Timeline and Context

The pilot of the Illinois Model of IECMHC took place in four public health departments over a 15-month period. Two health departments were in southern Illinois and two were in northern Illinois. The population served at each health department varied as to whether they served a largely rural, urban, or mix of both urban and rural populations. The pilot consisted of 12 months of intensive implementation of mental health consultation (3 hours/week for each site), followed by a 3-month intermittent support and sustainability period. The evaluation included three periods of data collection, starting with the collection of baseline data in July 2019 and followed by two post-implementation periods—January 2020 and July 2020.

It is important to note that in mid-March 2020, the COVID-19 pandemic forced the immediate closure of in-person services at agencies, health departments, and many early childhood programs in Illinois. This created considerable disruption to the regular operations of the four health departments in this study, not to mention unprecedented levels of unemployment and health crises among the families they served. Thus, this report also describes how public health staff and supervisors and the mental health consultants responded to changes in procedures required during the pandemic, for example, by holding meetings virtually instead of in person.

Key Findings

RQ1: How is the Illinois Model of IECMHC implemented? How are services delivered by the consultant and to whom? Do consultants feel prepared for their work? Are FCM and WIC program staff ready to engage with the consultant?

The Illinois Model was successfully implemented in all four health departments as measured by structural and process indicators of fidelity. From the consultant logs, we found that all four health departments received over 90% of their goal hours of consultation. We learned that the consultants spent about half of their time engaging in a practice termed "mindfully hanging out." This is an approach consultants took of respectfully getting to know the work that is being done and the people who are involved. It is integral to the development of relationships with staff and supervisors so they may move on to the more substantive reflective consultation activity.

Most of the consultation work was delivered in dyadic interactions involving the consultant and a staff member or supervisor. Although the approach favored by the Illinois Model is triadic (i.e., involving staff, supervisor, and consultant), it was rarely possible to find times when both a staff and supervisor were available to meet with the consultant. Initially, consultation was to occur on a "drop-in" basis with staff and supervisors seeking the consultant out during her predetermined consultation hours. However, the drop-in approach was not the best fit for all the health departments. Thus, two health departments decided to start scheduling staff in advance so each staff would have access to the consultant at least once a month.

The consultants were highly experienced; they felt prepared to provide mental health consultation in public health departments because of their previous consultation experience and the training in the Illinois Model, which they received before starting their work with the health departments. For the most part, supervisors voiced strong support for the implementation of consultation. However, it took time for them to understand the approach of the model and, in turn, encourage staff to engage with the consultant. As a result, staff were uncertain about its purpose and slow to take up the opportunity. From the consultants' perspective, the FCM and WIC staff were not quite ready to engage in consultation and could have benefited from additional orientation to consultation and the Illinois Model at the beginning. They also likely needed a longer period of implementation to benefit from consultation.

RQ2: How does IECMHC affect FCM and WIC staff and supervisors? How does it increase their capacity to serve children and families? Is there evidence that FCM and WIC staff can engage families in a consultative, collaborative manner?

Staff outcomes were relatively consistent over time on all constructs measured in the surveys. Staff's perception of the quality of reflective supervision and how well it met their needs did not change during the initiative on standardized measures. Reflective capacity, for the most part,

was high at baseline and remained consistent throughout the study. Self-efficacy and sense of competence in their work was relatively high and remained stable over time. Staff burnout and levels of depression were low at baseline and did not change over time.

At the same time, there was a relationship among reflective capacity, reflective supervision, and the Emotional Exhaustion subscale of the burnout measure. Specifically, increases in the quality of reflective supervision and in the Certainty subscale of the reflective capacity measure predicted a decrease on the Emotional Exhaustion subscale. Thus, strengthening the quality of reflective supervision and staff's reflective capacity predicted reductions in burnout.

There also was evidence in the qualitative data that staff who engaged with the consultants developed new capacities in understanding the perspectives of families and new ways to communicate with them. Likewise, supervisors who engaged with the consultants gained new ways of working with their staff and ways to encourage their reflection. Supervisors and staff appreciated the fact that consultants were available at designated times each week—and during the pandemic, available at these and other times by email and telephone—and willing to listen to and help them figure out how to manage their concerns.

RQ3: Since IDPH, like other state agencies, is attempting to serve more welfare-involved and other high-risk populations in public health programs and staff need more support to do so, how does IECMHC assist systems/agencies in serving more families, especially those with greater needs?

There was a significant increase in staffs' self-reported knowledge and strategies related to family well-being and child development from Time 2 to Time 3. This means that the growth in knowledge and skills that staff perceived in themselves occurred between winter of 2020 and summer of 2020, during the pandemic. As suggested above, consultants helped staff understand the perspectives of families and develop new ways to communicate with them. There was also evidence of a relationship among reflective capacity, reflective supervision, and the Emotional Exhaustion subscale of the burnout measure—suggesting the potential of IECMHC to strengthen the capacity of the public health workforce and system to work with high risk families. However, the implementation period was too short to fully develop their reflective capacity—a central goal of the Illinois Model—and to determine how the model can support staff and build the capacity of agencies and systems to serve more families in the state.

Study Contributions and Limitations

As a small, exploratory study, this pilot makes important contributions to the growing body of IECMHC research literature. This is one of the first efforts to incorporate a mental health consultant into multiple public health departments, and despite implementation challenges, it

was successful. Given the goals and scope of the study, there were a few limitations to be considered:

Short study and implementation period. Twelve months of intensive consultation was not long enough for a consultant to establish relationships with staff and supervisors and fully engage all of the staff in the consultation process. A longer study period likely would have allowed for the development of stronger relationships and more reflective practice.

Lack of a comparison group. A comparison group of health departments serving similar populations as the four in our study but not receiving any mental health consultation would have allowed us to learn more about the impact of consultation.

The pandemic health crisis. COVID-19 created a gap in continuity of relationships with the consultants and changed how consultants interacted with staff. The shift to virtual services came just after the midpoint of the initiative, just as the consultants seemed to be settling into a pattern with each health department. We do not know how consultation in these health departments would have proceeded without the pandemic.

Data on consultant activities. The consultant logs were an important source of valuable information for the evaluators, the consultants, and the implementation director. However, they need further refinement to make them more useful for consultants and evaluators, for example, so consultants can refer back to earlier entries in planning their work and so entries can provide a better analysis of how consultation is unfolding over time.

Implications and Recommendations

Given the novelty of the public health programs and systems for implementing the Illinois Model of IECMHC, the study yielded several lessons for implementation and research.

Recommendations for Practice: Implementing the Illinois Model

This study indicates that the Illinois Model can be adapted to public health departments. Compared to other child- and family-serving systems, the public health context limits the length of individual consultation sessions with staff and supervisors. However, regular team meetings and in-service training can provide opportunities to build reflective practice among staff and supervisors. Below we highlight a few areas of consideration for future implementation:

Implementation expectations

- Clarify expectations in advance with program leadership. Mental health consultation leadership should spend time with program leadership prior to implementation to ensure that program leadership understands what consultation is and what it entails. These discussions should include clear expectations for staff, supervisors, and leadership. They should also include expectations about the consultant's availability, schedule,

interaction and engagement with staff, regular attendance at team meetings, and other expectations.

- Focus on relationship-building, particularly at the beginning. Developing relationships and building trust is an essential part of the consultation model and should be emphasized especially in the early months of implementation.
- Highlight that issues of diversity, equity, and inclusion (DEI) are a central part of the model and will be addressed in implementation. These issues are important in public health departments in terms of serving families with diverse backgrounds and also affect staff relationships.

Length of implementation period

- Even without the interruption of the pandemic, the study suggests a need for a longer implementation period, for example, 18 months, to fully realize the benefits of consultation. Given the time it takes to develop relationships and for the consultant to understand the structure and staffing of the program, 18 months should be considered a minimum period of time for implementation to occur in a setting that has had little previous experience with consultation.

Logistical barriers

- Provide dedicated space for the consultant. Having a dedicated, private space for the consultant where staff know to find her helps facilitate drop-in sessions and relationship-building. In addition to being private and known to staff, it has to be reasonably accessible to staff during regular work hours.
- Consider more use of video conferencing. While the COVID-19 pandemic forced this strategy, the use of video conference for consultants and staff/supervisors to connect may be beneficial in other contexts. Some public health departments had staff located at several different locations, with supervisors not always in the same location as staff. Video conferencing could facilitate supervision sessions when individuals cannot physically be together—whether due to pandemic-related restrictions or to program structure.
- Encourage brief, 15-minute consultations. The Illinois Model promotes consultation sessions of sufficient length to allow for reflection, processing of concerns, and problem-solving. However, the typical length—15 minutes—of consultation in the public health departments was necessary for most of the consultants' individual sessions with staff. Although staff may not be able to set aside enough time for reflection, processing of concerns, and problem solving in a single session, multiple 15-minute sessions to accomplish all aspects of consultation can be beneficial.

Preparation and support of consultants for public health

- The two consultants in this study were very experienced with consultation in general

and the Illinois Model in particular, and thus, well prepared for implementing a new model in a new system. Their ongoing supervision and participation in reflective practice groups were essential supports. These lessons make clear the importance of continuing this structure. While it is important to orient consultants to public health programs and systems, we also learned that health departments vary in organization and culture. Thus, it will take time at the beginning for the consultant to get to know the individual health departments and programs in which they are providing consultation.

- Emphasize consultant documentation. Documenting consultant activities is very important for consultants and their supervisors to reflect on their work and to monitor how a new model is being implemented. We recognize how time consuming it can be and the fact that it can seem less important than time spent in direct service. However, it is essential to making sure consultants are not only ready for their work, but also for monitoring implementation and providing lessons for the field.

Recommendations for Research

This study was a pilot of the Illinois Model in public health departments. The variations in size, structures, and organization of public health departments presented challenges to implementation and reinforced the importance of a flexible model, as the Illinois Model is. We recommend additional implementation research with a larger sample and a longer study period—possibly with a small comparison group—to draw more lessons about implementation and its effects on staff and supervisors. It would also be useful to understand differences in staff needs and consultation activities in FCM and WIC programs. A few of the survey items suggest there are differences in the structures of these programs, which suggest differences in their work and might point to differences in what staff need from consultation, but our study was not able to follow up on these differences.

We also recommend more study of the role of supervisors in the implementation of consultation in public health. Supervisors are less likely to be a focus of research on IECMHC but are integral to supporting the efforts of consultants to improve the knowledge and skills of frontline staff. They also indicate that consultation can help them work more effectively with staff to address their concerns about families and to promote more collaboration within staff teams.

The analysis of impacts on supervisors and staff was limited in this study but they suggest a relationship between increased reflective practice and reduced burnout. These and other relationships are important topics for future research. At the same time, there is a need for more sensitive measures of the expected outcomes of mental health consultation such as relationships, reflective practice, and staff well-being.

Conclusion

This study and the small body of literature on efforts to implement mental health consultation and related services in public health systems show both the challenges and benefits of doing so. The challenges were largely logistical but also included an inadequate understanding of the purpose and processes of consultation. Staff and supervisors who engaged with the consultant reported several benefits, including professional development in a variety of topics helpful to their work, such as trauma, parental depression, children's mental health, and self-care. They also learned new communication strategies. Although the COVID-19 public health crisis changed the course of this pilot in many ways, it also showed how experienced consultants using the Illinois Model were able to adapt to a new environment. It appears that the model has considerable promise for use in public health programs and merits further study.

Introduction

Funded by the Illinois Department of Public Health (IDPH), this report presents findings from a pilot of the Illinois Model of Infant/Early Childhood Mental Health Consultation (IECMHC) in public health departments. IECMHC is a relationship-based, collaborative support designed to improve the capacity of professionals who work with children and families to promote children's mental health (Cohen & Kaufmann, 2000). It acknowledges the importance of strong partnerships among families, providers, programs, systems, and IECMHC professionals. Consultants are trained mental health professionals who engage in a variety of promotion, prevention, and intervention activities to build the capacity of early childhood providers to foster positive social and emotional well-being and development of children and families. A consultant's activities are wide-ranging and may focus on programs, smaller group settings (classrooms, homes, work teams), and individual cases (a child or parent).

A growing body of research suggests that IECMHC is an effective strategy for increasing a professional's ability to understand and respond appropriately to parents' and children's behaviors and feelings; it has also been shown to help staff manage their own emotions in their work (Albritton et al., 2019; Brennan et al., 2008, Conners-Burrow et al., 2012; Duran et al., 2009; Hepburn et al., 2013; Perry et al., 2010). Most of the evidence for IECMHC comes from studies of implementation in center-based early childhood programs (pre-K and childcare) and, to some extent, home visiting programs (Goodson et al., 2013; Lambarth & Green, 2019; Spielberger et al., 2021). To date, there have been limited efforts to implement or study mental health consultation in other settings, such as public health programs, using a clearly defined model of consultation.

Given the public health approach of focusing on health promotion and prevention, mental health consultation appears to be a natural fit for public health programs that serve children and families. These programs include Family Case Management (FCM) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). As one of the most successful nutrition assistance programs in the country, WIC can be an important gateway for many families to access mental health services (Illinois Department of Human Services [IDHS], 2020; IDPH, 2020b; Klawetter, 2017). The example most relevant to the current study is the Warm Connections program developed at the University of Colorado School of Medicine and implemented in WIC offices to help families access mental health support and services (Glaze et al., 2018; Klawetter, 2017; Klawetter & Frankel, 2018). If a family indicates a need or concern in a meeting with a WIC educator, the educator offers them a visit with a Warm Connections Specialist to process their concern. A meeting can range from 5 minutes (for example, helping a

family fill out a form) to as long as 1 or 2 hours (such as for discussing a behavior or developmental concern). The goal is to provide parents with some new understanding of their concern and capacity to manage it in the future. Specialists have their own designated space and do not require appointments so that they can be available as needed. The Warm Connections program also provides reflective support to WIC staff to prevent compassion fatigue and burnout, training on social and emotional development and well-being, support in depression screening, and help identifying appropriate referral sources in the community. A pilot study of the intervention found that it helps to increase parenting efficacy and reduce stress among low-income mothers. It also facilitates screening and follow-up of mothers with symptoms of depression (Glaze et al., 2018; Klawetter et al., 2020).

At the same time, efforts to implement screening and other mental health services in WIC offices are not without challenges (Coffman et al., 2019; Georgia Early Education Alliance for Ready Students, 2019; Klawetter & Frankel, 2018; Klawetter et al., 2020; Perry et al., 2015; Zuckerman et al., 2017). In a statewide sample of WIC providers, for instance, Zuckerman et al. (2017) found that developmental and behavioral concerns and conditions are a frequent topic of conversation among families and staff in WIC clinics. However, WIC staff did not feel they had adequate resources or strong connections to mental health care and other service providers to ensure that families received appropriate services to address developmental concerns. Perry et al. (2015) reported similar concerns among WIC staff about their own lack of mental health training and expertise when asked to implement depression screening as part of their services. WIC staff expressed worries about their inability to manage participants who might become highly emotional and about participants who do not follow-up on referrals to mental health services.

Thus, despite the apparent need, there still are few examples in the literature of implementation of mental health consultation or similar services for families or staff in WIC or other public health programs. The purpose of this exploratory study of the Illinois Model was to examine its implementation and early outcomes in four public health departments in different areas of the state. Although implementation was directed towards staff in two programs, FCM and WIC, consultation services were available to other staff as well. It was expected that the impact of consultation on staff would lead to families who were more engaged and receptive to the services, because the staff working with these families would have the capacity to engage and work with them more effectively.[1]

[1] IDPH Pilot Planning Meeting minutes, 01/31/2019

The Illinois Model

The Illinois Model of IECMHC (see Box 1) is designed to improve the skills of professionals who care for and work with young children and their parents in a range of early childhood settings and systems, including public health. This report describes the results of a 15-month pilot study of the Illinois Model of IECMHC in four public health departments. The study grew out of a 5-year comprehensive, coordinated, statewide initiative by the Illinois Children's Mental Health Partnership (ICMHP) to expand IECMHC across multiple systems and settings in Illinois. The Mental Health Consultation initiative began in 2014, after almost two decades of coalition building and advocacy for IECMHC, when a private foundation convened public and private stakeholders to examine early childhood mental health in the state. The coalition developed the *Plan to Integrate Early Childhood Mental Health into Child- and Family-Serving Systems, Prenatal through Age Five* (Harris Foundation, 2016).

A key goal of the plan was to implement a high-quality, consistent IECMHC approach to ensure that staff who work within any early childhood system can have regular access to reflective consultation and professional development about mental health issues, social and emotional development, and child and family well-being. A broad-based Leadership Team of public and private stakeholders led the effort to develop the Illinois Model and provided oversight and guidance to the pilot implementation and evaluation. Box 1 summarizes the goals and critical elements of the model.

Box 1. The Illinois Model

The Illinois Model of IECMHC is designed to be "universal," that is, applicable to a range of family- and child-serving systems and programs. In addition to identifying best practices, the model makes recommendations for coordinating consultation practices across the state and implementing the necessary structures and supports to ensure a high-quality, diverse consultant workforce. It specifies a consultant's qualifications, competencies, and activities. The competencies are the following:

- Knowledge of infant/early childhood development, mental health, and early care and education
- Ability to build relationships and partner with families, providers, programs, and systems
- Ability to work effectively throughout diverse cultures and communities
- Ability to effectively and sensitively gather information
- Ability to collaboratively develop a plan and measures of success
- Knowledge of community systems and resources and ability to develop partnerships
- Commitment to ethical behavior and reflective practice

The Illinois Model is multilevel, flexible, and tailored to meet the needs and goals of the consultee(s). Thus, in practice, consultation can differ in its format, frequency and dosage, and focus or target. For the IECMHC pilot, consultants provided services 10–12 hours/month, on average, over 12 months, followed by 3 months of intermittent support. Activities were both program- and case-focused but prioritized relationships with staff and supervisors and building their knowledge and skills. Activities varied but included:

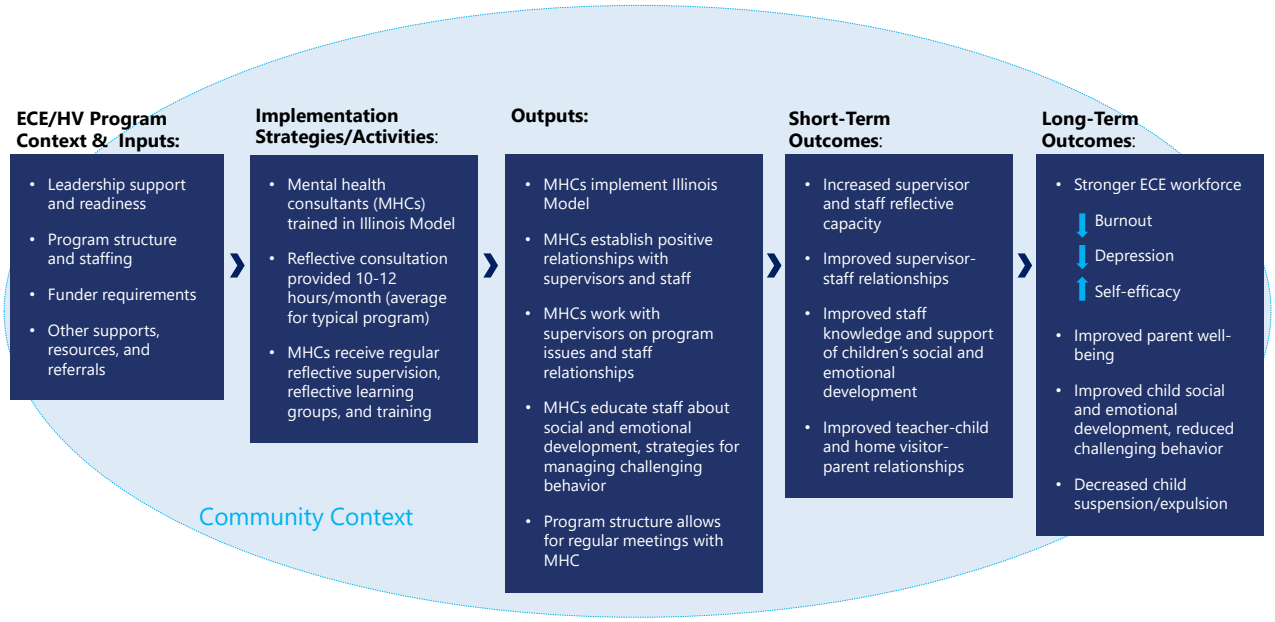
- Reflective consultation to individual staff or groups
- Support with observation, screening, and assessment of children
- Training on social and emotional development, the impact of trauma, and parental depression
- Co-facilitation of peer-support groups for program staff and/or caregivers
- Support for staff in meetings with parents

To further develop and implement the Illinois Model in broader systems beyond early childhood centers and home visiting programs, it is essential to understand the factors that influence the model's success, including organizational structure and relationships. There are many sources of variation, including the consultants' education, experience, and roles and activities at each program; organizational context; and how FCM, WIC, and other public health programs and clinic staff understand and use the consultants' support. This study will expand our current knowledge by providing more in-depth information about the process of implementing and embedding mental health consultation in public health departments and its potential effects.

Theory of Change

Figure 1 presents the current IECMHC Theory of Change Framework for the Illinois Model in public health departments. As suggested by the theory of change, there are several levels of outcomes expected from the implementation of the Illinois Model in these settings. This process study focuses on implementation and early outcomes at the system and program staff levels. Potential staff outcomes include an increase in self-efficacy and reduced job stress.

Figure 1. Theory of Change for Evaluation of Illinois Model of IECMHC in Public Health (PH) Departments



The assumption of the Illinois Model is that consultation delivered to public health supervisors and staff will improve staff knowledge of mental health and social-emotional well-being of families and children, and improve staff skills in engaging families. This will provide staff with a greater capacity to perform their duties, meet outcomes for children and families, and engage families in a consultative, supportive, and culturally appropriate manner. In turn, it is expected that improvements in staff well-being and relationships with families and children will lead to

families who are more engaged and receptive to health and nutrition services. Families who are more engaged can help staff identify issues to be addressed sooner, and lead to healthier parents and children long-term.

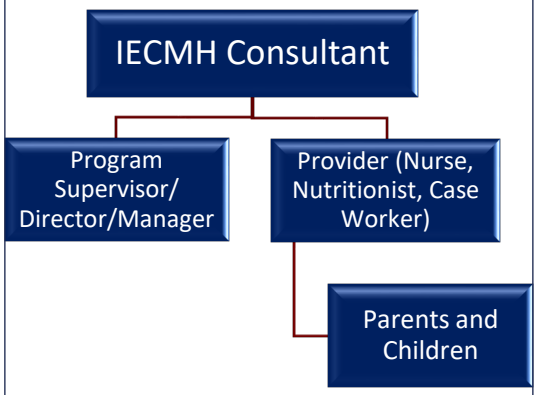
Mechanism of Change

The positive child and provider outcomes shown in previous IECMHC research and evaluations raise the question: What is the mechanism by which IECMHC achieves these outcomes? Although there is no definitive answer to this question, the literature suggests that one potential mechanism of change is the relationship between the consultant and the early childhood provider. Positive relationships between the consultant and early childhood staff have been called a "catalyst for success" for positive child, family, staff, and program outcomes. These consultant–staff collaborations are expected to improve relationships between program staff and the families with whom they work (Duran et al., 2009). Johnston and Brinamen (2006, 2012) describe the parallel process at work in consultation, explaining that the transformative power of the consultant–provider relationship allows the provider to develop new ways of interacting with children and other adults (see Box 2).

In a national survey of Head Start consultants, Green and colleagues (2006) found that the strongest predictor of perceived effectiveness of consultation was the quality of staff members' relationships with the consultant. Furthermore, providers who reported strong relationships with consultants were more likely to report having goals related to improved child and family well-being than staff who reported weaker relationships with consultants (Green et al., 2004). According to Allen and Green (2012), consultant reports of positive relationships with families, positive relationships with staff, and high levels of supervision and support are all associated with staff reports of positive relationships with the consultant. Moreover, the quality of the consultant–provider relationship was associated with staff wellness (Green et al., 2006).

Because the consultant–provider relationship may be the key to the effectiveness of IECMHC, some studies have explored which factors strengthen this relationship. Green and colleagues (2006) found that integrating the consultant into the program and having clearly delineated roles for consultants predicted a strong consultant–provider relationship. Duran et al. (2009) reported that consultant characteristics and the amount of time providers spend with consultants influence consultant–staff relationships.

Box 2. Conception of Parallel Process



Study Purpose and Research Questions

The purpose of this study was to better understand the adaptations to the Illinois Model that would make it viable and ultimately sustainable in public health departments and beyond. We address the following research questions (RQ) regarding implementation and impacts of the Illinois Model:

RQ1: How is the Illinois Model of IECMHC implemented? How are services delivered by the consultant (e.g., individual vs. group meetings, appointments vs. informal drop-ins) and to whom? Do consultants feel prepared for their work? Are FCM and WIC program staff ready to engage with the consultant?

RQ2: How does IECMHC affect FCM and WIC staff and supervisors? How does it increase their capacity to serve children and families? Is there evidence that FCM and WIC staff can engage families in a consultative, collaborative manner?[2]

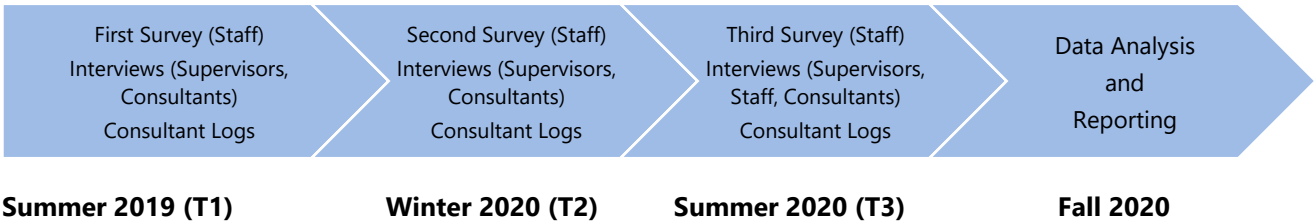
RQ3: Since IDPH, like other state agencies, is attempting to serve more welfare-involved and other high-risk populations in public health programs and staff need more support to do so, how does IECMHC assist systems/agencies in serving more families, especially those with greater needs?[3]

Timeline

The Illinois Model of IECMHC was implemented as a pilot in four public health departments over a 15-month period. Two health departments were in southern Illinois and two were in northern Illinois. The population served at each health department varied between largely rural, urban, or mix of both urban and rural populations. The pilot consisted of 12 months of intensive implementation of mental health consultation (3 hours/week for each health department), followed by a 3-month intermittent support and sustainability period. As shown in Figure 2, the evaluation included three periods of data collection. Data collection started with the collection of baseline data in July 2019, which was followed by two post implementation periods of data collection in January 2020 and July 2020.

[2] IDPH Pilot Planning Meeting minutes, 01/31/2019
[3] IDPH Pilot Planning Meeting minutes, 02/05/2019

Figure 2. Timeline for Pilot of Mental Health Consultation in Public Health Departments



Prior to implementation, the implementation team for the Illinois Model recruited four health departments. The implementation team and evaluators oriented the leaders and health department staff to the Illinois Model and the study. The implementation director selected two experienced mental health consultants who were trained in the Illinois Model to consult with the four health departments. We conducted baseline surveys with staff and interviews with supervisors and directors in July 2019 (baseline). We conducted two additional data collections at 6 and 12 months after the start of implementation (Time 2 and Time 3).

Context and Overview of this Report

In the next chapter, we describe the characteristics of the communities and programs that participated in the study and our research design and methodology. The following chapter presents our findings about implementation and potential outcomes of consultation. The final chapter summarizes all the findings and discusses their implications for future practice, policy, and research.

It is important to note that we began data collection for this study in July 2019 and completed it in September 2020. In mid-March 2020, the COVID-19 pandemic forced the immediate closure of in-person services at agencies, health care centers, and many early childhood programs in Illinois. This created considerable disruption to the regular operations of the four health departments participating in this study. It also created unprecedented levels of unemployment and health crises among the families served by the health departments. Further, the pandemic highlighted racial and other inequities in healthcare systems. Thus, this report also describes how public health staff and supervisors and the mental health consultants responded to changes in procedures required during the pandemic (for example, holding meetings virtually instead of in person).

Methods and Sample

The study used a mixed-methods design to examine the feasibility of implementing the Illinois Model in public health departments and to assess the potential impacts of the model on FCM and WIC staff. The study collected and triangulated quantitative and qualitative data from a variety of program staff, tracked consultants' activities, and looked at change over the duration of the intervention. The study also sought to capture information about organizational and community contexts for implementation.

Sample Recruitment and Description

The implementation team, in collaboration with IDPH, recruited four health departments to participate in the study. Two health departments were in the southern parts of Illinois and two were in the northern regions. IDPH and the implementation team selected health departments outside of Chicago and Cook County that represented some of the variety of health departments across the state in terms of location and size—for example, a large health department serving both urban and rural communities and a smaller but spread-out department in a rural setting. Health department leaders' interest in participating and their perceived need for the support of a mental health consultant were other factors in the selection. The structures of the FCM and WIC programs varied by public health department. All but one health department provided both programs; one provided only WIC. The staff across the public health departments indicated that while the two programs were independent programs, they shared many family cases and worked closely with one another.

Overview of Public Health Departments

The four public health departments participating in the pilot varied by geographical location and by the demographics of the population served (see Table 1. To maintain confidentiality, we refer to each health department by a letter rather than its name.). Public Health Department A is in an urban area. It primarily serves low-income families—33% of the population in the area live below the federal poverty level. About 5% of the population is under 5 years of age, and the majority (96%) of people living in this area are Black. The median household income (about $24,000) for this location is less than half of the state's median income ($65,886). The area lacks accessible public transportation, which is a barrier to families' access to the health department programs. In addition to FCM and WIC services, this health department offers community nursing, school-based health clinics, and administrative and STD/HIV services. The services are provided in three different locations across the community.

Public Health Department B serves a rural population that covers a wide geographic area. About 5% of its population is under the age of 5 years, and 85% of the population is non-Hispanic White. Seventeen percent of the population lives below the federal poverty level and the median household income is about $47,000. In addition to FCM and WIC, this public health department also offers Nursing, Health Education, and Environmental Health. They offer services in five different community locations. Given the relatively small population in a large geographical area, they have a small number of staff at each location.

Public Health Department C serves a largely rural population where the majority (82%) of the population is non-Hispanic White and about 6% of the population is under the age of 5 years. This location has about 12% of its population living below the federal poverty level and the median household income is about $49,000. Along with FCM and WIC services, Public Health Department C also offers their community a state-funded early childhood collaboration called All Our Kids Network, Healthy Families America home visiting services, Coordinated Intake and Family Connections, community-based doulas, and public health nursing. All the programs are in one location in the community.

Finally, Public Health Department D serves a mostly urban population, but also includes some smaller towns and more rural communities. This is the largest county in the study with a population of almost 300,000. Six percent of the population is under the age of 5 years, and 68% are non-Hispanic White. Eleven percent live below the federal poverty level and the median household income is about $54,000. They provide WIC, lead prevention programs, programs to improve birth outcomes, and HealthWorks. All services are offered at one location.

Table 1. Characteristics of Cities or Counties of Participating Health Departments

Characteristics	Illinois	Region of Health Department A	Region of Health Department B	Region of Health Department C	Region of Health Department D
Population	12,671,821	26,047	61,510	44,498	282,572
Under age 5 (%)	6	5	5	6	6
Race/Ethnicity (%)					
Non-Hispanic White	61	2	85	82	68
Black	15	96	9	10	14
Hispanic/Latino	18	1	3	4	14
Income					
Below federal poverty level (%)	12	33	17	12	16
Median household income	$65,886	$24,343	$46,955	$48,805	$54,489

Source: https://www.census.gov/quickfacts/ accessed February 26, 2020.

Data Collection Methods and Measures

The evaluation used four primary methods of data collection:

- surveys of FCM and WIC staff at baseline (before implementation) and 6 and 12 months after the start of the intensive intervention period
- semi-structured interviews with a small number of supervisors/directors and consultants at baseline and 6 and 12 months after the start of implementation
- semi-structured interviews with a small number of staff 12 months after the start of implementation
- consultant logs of activities, time spent, and recipients of consultation

The surveys gathered information about staff's experiences with mental health consultation, supervision, self-efficacy, job stress, burnout, reflective functioning, and relationships. They included both standardized measures and nonstandardized questions. We measured these constructs because they reflect the intended outcomes of the intervention. When appropriate, we selected measures that were used in our recent study of the implementation of the Illinois Model in early care and education (ECE) center-based and home visiting programs (Spielberger et al., 2021). The standardized measures are briefly described below.

- The *Reflective Functioning Questionnaire* (RFQ; Fonagy et al., 2016) measures the ability to understand and interpret one's own and others' behavior. It consists of 8 different items which are rescored to be used in two different subscales, each consisting of 6 items. The initial scale ranges from 1 ("Strongly disagree") to 7 ("Strongly agree"). Each of the 8 items is rescored into a scale ranging from 0 to 3. The 6 items in each subscale are averaged together so that the Certainty subscale would have a possible score range of 0–3 and the Uncertainty subscale would have a possible score ranging from 0 to 2.33. High reflective functioning is indicated by a high score on the Certainty subscale and a low score on the Uncertainty subscale.
- The *Maslach Burnout Inventory* (MBI)-Human Services (Maslach et al., 1996), contains 22 items measuring three facets of burnout in the following subscales: Emotional Exhaustion, Depersonalization, and Personal Accomplishment. The response scale, which is labeled at each point, ranges from 0 ("Never") to 6 ("Every day"). Subscale scores are sums of the item scores, resulting in possible scores ranging from 0 to 54 for Emotional Exhaustion (9 items), 0 to 30 for Depersonalization (5 items), and 0 to 48 for Personal Accomplishment (8 items).

- The *Patient Health Questionnaire* (PHQ; Kroenke et al., 2003) measure of depression consists of two items. The response scale ranges from 0 ("Not at all") to 3 ("Nearly every day"). The two items are summed, resulting in possible scores ranging from 0 to 6.
- The *Reflective Supervision Rating Scale* (RSRS; Ash, 2010) consists of 17 items to measure the quality of reflective supervision. The response scale, which is labeled at each point, ranges from 1 ("Rarely") to 3 ("Almost always"). The 17 items are summed, resulting in possible scores ranging from 17 to 51.
- The *Goal Achievement Scale* (GAS; Alkon et al., 2003) measures staff sense of competence about working with children and families. It contains 13 items (as a 14th item in the original version was not included in our study because it could not be asked at baseline). The response scale ranges from 0 ("Not at all") to 2 ("Very much"). The 13 items are summed, resulting in possible scores ranging from 0 to 26. With the authors' permission, we adapted the GAS to refer to working with parents and children, rather than only children.
- The *Teacher Opinion Scale* (TOS; Geller & Lynch, 1999) consists of 12 items to measure job self-efficacy. The response scale, which is labeled at each point, ranges from 1 ("Strongly disagree") to 5 ("Strongly agree"). The 12 items are summed, resulting in possible scores ranging from 12 to 60. With the authors' permission, we adapted the TOS to refer to working with parents, rather than working with children.
- The *Social and Emotional Development Inventory* (SEDI; Shivers, 2011 measures staff's perception of whether they gained knowledge and strategies related to children's social-emotional development over the course of the implementation. We administered this measure at Time 2 and Time 3.

Interviews with supervisors and consultants (at all three data collection points) and staff (Time 3 only) gathered more information about the organizational context for implementation and the factors that affect implementation. Staff, supervisors, and consultants discussed their perceptions of mental health services, barriers to accessing them, challenges engaging clients and making referrals and knowledge of screening tools. The consultant logs were similar to those used in a previous evaluation of the Illinois Model (Spielberger et al., 2021), but were modified to be appropriate for use by consultants in public health departments. Consultants reported dates of their service, number of hours, staff position, types of activities, and content of the consultation.

Although the implementation of the model and the evaluation focused on FCM and WIC staff, the consultant was available to all staff at each department. We needed to capture information about use of the consultant by staff not participating in other data collection activities. Thus, we initially proposed using brief encounter forms for staff members to record their interactions with

the consultant and satisfaction with their interactions. However, supervisors said this would be too burdensome for staff.

Sample Characteristics at Baseline

Staff Survey Sample

In July 2019, we sent baseline surveys to 70 staff; 47 (67%) responded. Of those 47 staff, 25 (53%) completed both the Time 2 and Time 3 surveys and were included in the subsequent analysis of change over time (see Table 2). Table A-1 in the Appendix presents the characteristics of the 47 staff who completed more than one survey at baseline by program affiliation.

Table 2. Baseline, Time 2, and Time 3 Data Collection Response Rates

Method	Source	Indicator	Baseline	Time 2	Time 3
Survey	Staff	Sent (*n*)	70	68	64
		Completed (*n*)	47	37	37
		% completed	67	54	58
	Supervisor	Requested (*n*)	14	13	8
		Completed (*n*)	14	10	8
		% completed	100	77	100
Interviews	Consultant	Requested (*n*)	2	2	3
		Completed (*n*)	2	2	3
		% completed	100	100	100
	Staff	Requested (*n*)	--	--	15
		Completed (*n*)	--	--	8
		% completed	--	--	53

Table 3 presents demographic characteristics of the frontline staff—those who completed all three surveys and those who did not, but for whom we have baseline demographic data. There was only one statistically significant difference between the two samples, the number of hours worked in a typical week. Those who completed all three surveys worked fewer hours (32 hours) in a typical week than those who did not complete all three surveys (37 hours).

Staff who responded to all three surveys all identified as female. Almost three-quarters (72%) self-identified as White, 12% as Black, and 4% as Hispanic. Almost two-thirds (64%) reported being 40 years of age or older. Almost half (48%) had earned a Bachelor's degree while just over one-quarter (28%) held an Associate's degree and about one-quarter (24%) had attended college but had not yet earned a degree. Our sample had about 8 years of experience, on average, in public health programs serving children and families at the time of the baseline survey. Staff reported working with about 36 families in a typical week and about 32 hours per

week, on average. Over half (56%) work primarily in the WIC program, while just over one-quarter (28%) work primarily in the FCM program, and the remaining 16% work in other programs with access to the mental health consultant.

Table 3. Demographic Characteristics of Baseline Staff Sample

Characteristic	**Completed all three surveys** (*N* =25)	**Did not complete all three surveys** (*n* = 23)	***p* value**	**Interviewed at Time 3** (*n*=7)
Gender (%)				
Female	100	96	0.292	100
Male	0	4		
Race/Ethnicity (%)				
Black	12	27	0.612	25
White	72	55		63
Latino(a)/Hispanic	4	9		0
Other/Multiple races/ethnicities	12	9		13
Age (%)				
20–29 years	16	30	0.649	0
30–39 years	20	26		25
40–49 years	20	13		13
50 or older	44	30		25
Education (%)				38
High school diploma/Some college	24	17	0.400	25
Associate's degree	28	26		25
Bachelor's degree	48	48		38
Master's degree	0	9		13
Years of Experience	(*N* = 25)	(*n* = 21)		
Mean (*SD*)	7.6 (*8.14*)	7.9 (*10.95*)	0.913	6.5 (*7.56*)
Range	0.09–30.80	0.13–31.54		0.09–20.21
Number of families served in typical week				
Mean (*SD*)	36.6 (*33.82*)	33.6 (*25.36*)	0.733	30.0 (*10.80*)
Range	3–170	0–100		20–50
Number of hours worked in typical week				
Mean (*SD*)	31.5 (*9.80*)	37.2 (*3.07*)	0.011*	33.4 (*4.83*)
Range	7–40	28–40		28–40
Health department (%)				
Health Department A	16	22	0.063^	38
Health Department B	28	30		25
Health Department C	40	9		25
Health Department D	16	39		13
Program type (%)				
FCM	28	26	0.477	38
WIC	56	44		50
Other	16	30		13

*$p < .05$, ^$p < .10$

Staff Interview Sample

At the third data collection point, we contacted a small number of staff at each of the participating health departments to see if they would be willing to talk to us about their experiences with the initiative. To make sure the staff we interviewed had actual experience with the consultant, we asked the consultants to give us the names of three staff with whom they had worked since the start of the study and three staff with whom they started working in the last 6 months of the study. We received names of 15 staff and contacted all of them; in July 2020, we completed interviews with seven of them. We interviewed at least one representative from each of the four health departments. All seven staff participating in the interviews identified as female. Their demographics and the program in which they worked were similar to the larger staff survey sample.

Administrator Interview Sample

Ten administrators—supervisors, program managers/directors, and executive directors—participated in at least two of the three interviews that were part of this study. Seven self-identified as White, two as Black, and one as other race/ethnicity. Eight of the 10 program leaders reported being 50 years of age or older and the rest were between 30 and 49 years of age. All 10 had a bachelor's degree or higher; five had a master's degree and one held a doctorate. On average, this sample had about 13 years of experience in their current position at the time of the baseline interview, worked full-time, and reported supervising about 14 people. Five of these informants were from Health Department D, two each from Health Departments A and C, and one from Health Department B. Four worked primarily in the WIC program, two in the FCM program, two oversaw both FCM and WIC programs, and two were in other programs with access to the mental health consultant.

Mental Health Consultants

Two mental health consultants were trained and hired to implement the pilot of the Illinois Model in the four public health departments, with each having responsibility for two departments. Both consultants were experienced; they had consulted in a variety of early childhood settings, including schools, home visiting, and Early Intervention. One had been a consultant/trainer for the Fussy Baby Network and Mothers & Babies Program. The other had worked previously in one of the public health departments in the study as a consultant for a home visiting program. This consultant had also worked in medical settings before, including a regional medical diagnostic network for a NICU. Otherwise, neither consultant had worked directly with WIC or other public health programs. Consultants recorded their activities with the health department staff and supervisors in a consultant log. We also interviewed the consultants

at the same three time points as the supervisors and interviewed the pilot implementation director at Time 3.

Data Analysis

Staff Survey

We analyzed the data obtained from the staff who completed all three surveys, which limited our sample of survey respondents to 25 staff. We tested for differences in mean scores over time using repeated measures analysis of variance (ANOVA), controlling for number of hours worked per week. We ran crosstabs with chi square analysis and one-way ANOVAs to see if there were any noteworthy differences by program (FCM, WIC, and "other") at each time point. We only found a few differences between the programs. When we found differences, we provide this information in table notes. Otherwise, given the small size of these subsamples, we only present results for the total sample in the report.

In addition, we conducted a correlational analysis with change scores from staff surveys using the difference in scores from baseline to Time 3. The purpose of the correlational analysis among the staff survey measures was to look for any associations between a reduction in burnout and reflective supervision, staff reflective functioning, and staff self-efficacy. We then conducted a hierarchical multiple regression to predict change in the Emotional Exhaustion subscale of the burnout measure. We entered the predictor variables, starting with the strongest association with burnout.

Consultant, Supervisor, and Staff Interviews

We imported the interview transcripts into Atlas.ti software for analysis. Two members of the research team analyzed the transcripts thematically using primarily descriptive coding (Saldaña, 2015) that aligned with the topics and questions in the interview guide. Two members of the qualitative research team developed an initial codebook based on the interview guide for each respondent group (staff, supervisors, and consultants). They and two other qualitative researchers divided the transcripts by respondent group and topics for initial coding of topics. The team met regularly (once a week or more often) to discuss coding decisions, create additional codes as needed, and ensure consistency of application of the codes. Once the interviews were coded, the coded material was exported to Excel to discern themes within and across respondent groups for analysis. Our analyses were largely guided by our research questions, though we allowed new topics or themes to emerge when relevant. We continued to hold regular research team discussions to assess the interpretation of narratives (in other words, construct validity). We also established the validity of themes and key findings by triangulating our data sources (such as consultant logs, surveys, and interviews).

Consultant Logs

We used the data from the consultant logs to analyze the extent to which the Illinois Model was implemented as intended. Our analysis of implementation considered both structural and process indicators. Structural indicators include dosage—the number of hours of consultation program staff received—and adherence—the alignment between the types of consultation provided and the activities recommended by the model. We also looked at the topics or issues raised in consultation and the level of the issue. In sum, we analyzed the logs in terms of the following three aspects of implementation:

- Dosage of, or exposure to, consultation: What was the total number of hours of consultation provided to each program?
- Alignment of activities to the model: In what types of activities and with whom did the consultant engage?
- Content and level of activity or issues raised in consultation: Was the content of consultation in line with expectations to be departmental-, programmatic- or individual-focused?

Dosage

In consultation with the Evaluation Team, we determined that consultants who were able to complete at least 80% of their expected hours would be considered to have satisfied the expected number of hours required by the Illinois Model. For all four health departments in this study, the expectation was that consultants would provide 10–12 hours each month; we used 10 hours as the standard for calculating the percentage of expected hours completed.

Alignment

In addition to dosage, it was also important to understand whether the consultants' activities were in line with the recommended practices identified by the Illinois Model developers. Since both consultants reported their hours and activities slightly differently within the structure of the consultant log, it was difficult to describe precisely how each consultant worked with each health department. To ensure the data were as complete and accurate as possible, we communicated with each consultant to fill in missing information on their hours and types of activities. This allowed us to be more consistent when categorizing activity descriptions and hours.

Content

In the analysis of the content of the consultant logs, we categorized the topics and activities covered in a consultation as one of three types, using the following definitions:

- Departmental consultation: Collaborates with health department senior administrators/directors to assess the program's structures, policies, procedures, professional development opportunities, philosophy, mission, and practices to better support the mental health of young children and families.
- Programmatic consultation [specific to FCM, WIC, other]: Collaborates with supervisors and staff, undertakes activities to assess a program's structures, policies, and procedures (staff relationships, routines, and practices) to better support the mental health of young children and families.
- Individual consultation: Collaborates with staff and families to understand and respond effectively to the mental health needs of an individual staff member, family, or child.

The analysis of the consultant logs involved three steps: (1) cleaning the data and resolving missing data, (2) identifying the type of consultation, and (3) categorizing the issues and identifying emerging themes. Some entries included multiple topics for a single day, and it was sometimes difficult to determine which topic(s) were most important.

Two researchers initially selected a set of sample excerpts from the logs and confirmed the applicability of these three themes to the log entries for all types of consultation activities (for example, team meeting, reflective consultation, and mindfully hanging out). One researcher assigned one of the three types of consultation to each log entry; a second researcher checked the assignment for consistency and accuracy. Conflicts were resolved through team discussion and consensus.

We decided some of the content categories based on the form of the activity (such as team meeting or community event) rather than the content, because that was the only information provided. For example, the research team assigned the programmatic level to general team meetings attended by the consultant, and the individual level to entries that addressed issues regarding specific people. Similarly, if the consultant participated in community events, we assigned those to the departmental level. To further identify the focus or theme of the consultation, the researchers revisited the logs and discussed potential issue categories.

Once primary content categories were developed, one researcher assigned a content category based on the main issues reported in the log (Category 1). Up to two additional categories were assigned if applicable. A second researcher checked the assignment for accuracy. Next, the researchers combined similar categories (such as "staffing and performance" and "administrative"). The researchers created several content categories that addressed forms or activities of the consultation (for example, training) rather than the content of the issues. For the categories that were linked to only one or two log entries, the researchers considered whether the category informed the focus or theme of the issues discussed at each level. Then they either kept the categories independent or combined them.

When the log contained a limited amount of information regarding the content of the issues raised, researchers considered additional information about the consultation in the logs. This included how the consultant responded to the needs of the staff/program and what competencies or plans of action were addressed. Using this information, researchers then determined the level and category/categories of the issues.

Chapter Summary

This purpose of this process study of the Illinois Model of IECMHC was to examine the feasibility of implementing the model in public health departments. As an exploratory study, it required a design and methods that responded to the community and program characteristics of the sample. Like most approaches to IECMHC, the form and content of consultation in the Illinois Model depends on the needs and goals of the program staff, the relationship between the consultant and staff, and other factors such as organizational context and how public health staff understood and used the consultants' support. This made studying implementation—and the fidelity of implementation—complicated. Although the model is based on prior research and tools developed by the field, the Illinois Model is unique—particularly in the extent to which it emphasizes the development of reflective capacity in staff and supervisors—and required a mix of quantitative and qualitative methods to evaluate both the implementation and the potential impacts of the model.

Findings: Implementation of the Illinois Model

> *Consultation is a capacity-building model. We work with staff and generally supervisors. We can work with them separately [but] prefer to work in concert, really supporting the capacity of the supervisor to support their staff. There are certain activities within that model of capacity building that we can do—individual consultations, problem solving, training, cofacilitation of groups, or sitting in with [staff's] individual meetings with families to then be able to reflect with staff or supervisors later about what's going on.*
>
> *~Mental Health Consultant*

This chapter addresses the first set of research questions about implementation:

- RQ1: How is the Illinois Model of IECMHC implemented? What are the most frequent activities provided by consultants and to whom? How are services delivered by the consultant? Do consultants feel prepared for their work? Are FCM and WIC program staff ready to engage with the consultant?

Understanding the fidelity of consultation and how services were delivered with the Illinois Model is critical before we attempt to examine its ability to achieve its intended outcomes (see, for example, Daro, 2010; Durlak, 2015; Fixen et al., 2009; Hansen, 2014). It is particularly important for this pilot because it is one of the first efforts to examine the feasibility of implementing mental health consultation in public health programs.

For assessing implementation, we were interested in both structural and process indicators. Primary structural indicators were *dosage*, or the number of hours of consultation delivered to a program, and *alignment* between the types of consultation provided and the activities recommended by the model. Data for these indicators came primarily from the consultant logs, an online database of consultant activities, recorded throughout the 12-month intensive implementation period and the 3-month sustainability period. The implementation structure required the mental health consultants to spend 10 to 12 hours each month, or an average of 3 hours each week, providing consultation.

Surveys and qualitative interviews offered additional information about how consultation was provided. Qualitative interviews with consultants were particularly helpful in describing the structure and approach to consultation, relationships with staff, and implementation challenges. Interviews with supervisors and staff provided their perspectives on the need for consultation in

public health departments, relationships with the consultants, and the potential benefits of consultation. In the following sections, we present our findings regarding implementation, with a focus on implementation fidelity, the content of consultation, and factors that shaped implementation. Although we analyzed the data for each group of informants separately, we triangulated or synthesized the information as much as possible for this report. Overall, the information from one informant group was consistent with or validated that of other informants.

Structure and Process of Implementation

Initially, both consultants expected to work with the health departments in ways that were like their work in other settings. They described meeting with a director or supervisor at the health department early on to develop a schedule of when the consultant would be at each health department. Given that staff schedules depend on when the public comes to them, they decided that a "drop-in" approach to consultation would be most beneficial. Typically, consultants would go to a designated area of the department close to the FCM and WIC staff and a director or supervisor emailed staff to let them know the consultant was in. Having a dedicated space near where program staff worked made it easy for staff to drop in or schedule private meetings with the consultant. Consultant meetings with individual staff usually were brief, lasting no more than 15 minutes. Aside from being the typical amount of time allotted to staff visits with their clients, these brief consultation windows made it easier for staff to meet with the consultant without disrupting the flow of work.

Schedules and Approaches to Consultation

During the first few months, consultants would *mindfully hang out* in each health department by spending time walking around the clinic office areas greeting staff and getting a sense of their schedules and activities. Initially, it was assumed that staff would drop-in when they knew the consultant was there. After a few months, however, it became evident that only a few staff were dropping in and engaging with the consultants, and a more fixed schedule of activities was needed.

Consultants also attended team meetings. At one health department, which had several locations in a largely rural area, the consultant emphasized the importance of her attendance at team meetings. The consultant said, "Because staff are so remote, everybody is all together for this team meeting experience, [so] my participating in the team meetings seems a lot more effective." In retrospect, she would have asked about attending team meetings sooner and incorporated some reflective consultation in those meetings, which might have facilitated her relationship-building with supervisors and staff. The number of meetings varied among the health departments depending on their meeting structures (for instance, at one site, the FCM and WIC teams met separately while at another they met together). These meetings were an

opportunity for consultants to provide training and to introduce staff to reflective practice. Staff who were not comfortable meeting individually with the consultant—perhaps because of stigma or a lack of perceived need for support—seemed to be more comfortable discussing topics of behavior and mental health in the group setting.

Meetings with supervisors and other administrators depended partly on their schedules and preference; usually, consultants were able to schedule regular check-ins or meetings with supervisors. On occasion, at departments with more than one location, supervisors were not available on the days the consultants were scheduled to be on site or were rarely at the same location as the consultant.

Although the drop-in model was designed with the structure of the health departments in mind, a consultant at one health department found the pace of staff engagement to be slow. Thus, that health department began requiring that all staff schedule 15-minute appointments with the consultant at least once a month. The consultant expressed enthusiasm for this idea, saying:

> *Sitting and waiting for people to come and see you didn't seem particularly effective. I think [scheduling] is a great idea, because it's just been frustrating thinking about why people aren't coming in. They're very busy, so when I walk around they've either got families or they're writing notes. There's just a lot to do. . . . If you don't set aside time for reflective work, it doesn't get done.*

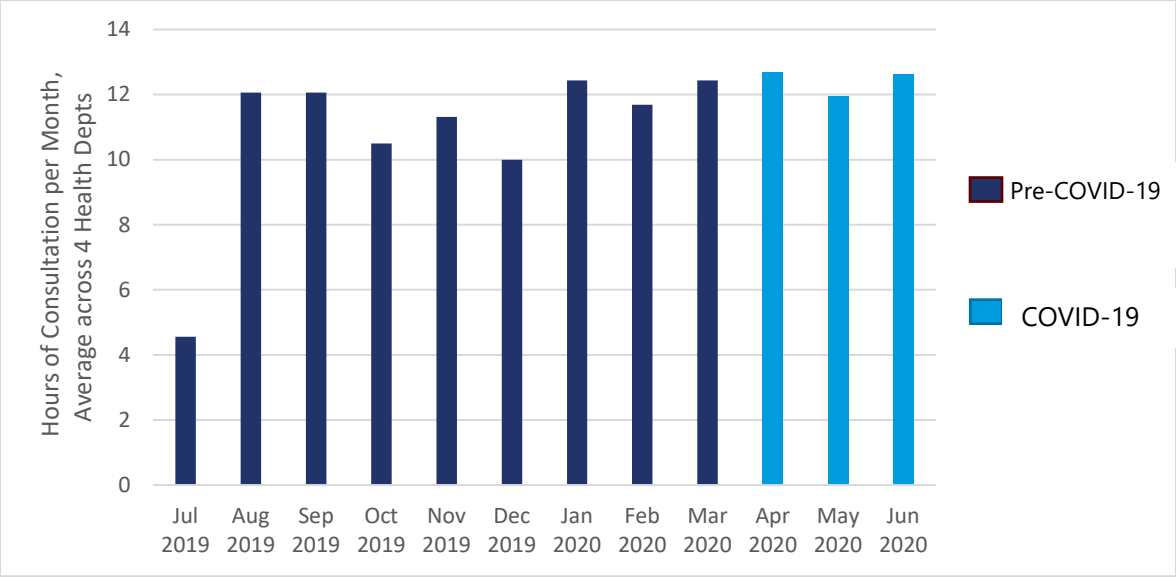
At another health department, supervisors suggested making consultation mandatory for staff, but the consultant explained that consultation must be voluntary. Instead, she encouraged the supervisors to use group meetings to bring up sensitive issues that might affect several staff.

Although it took several months to establish a structure and process for their work with staff and supervisors, by the time of our second data collection point in early 2020, relationships and procedures were becoming more established. However, shortly after the second data collection point—in mid-March 2020—the COVID-19 pandemic forced the immediate closure of in-person services at agencies, health care centers, early childhood programs, and businesses in Illinois. Public health departments also closed. Many public health staff were asked to modify the way they provided services to families or take on new tasks to meet their needs. This produced a sharp shift in the implementation of mental health consultation during the last 4 months of the initiative. As described later in this report, after the pandemic closed the departments to in-person services, consultants tried to continue their regular schedule of contacts with supervisors and staff. For example, consultants would schedule a virtual meeting room, reach out to their primary contact at the health departments, and then email everyone to remind them of their availability.

Dosage: Hours of Consultation

Analysis of the consultant logs showed that consultants consistently provided services to all four participating health departments throughout the intensive intervention phase of the pilot. Their services continued even after the governor issued a "stay at home" order effective March 21, 2020, in response to the pandemic. The goal was to provide 12 hours of consultation to each health department per month; all four received over 90% of their goal hours (range 91%-94%), as Figure 3 illustrates. Furthermore, two of the health departments included multiple locations, and the consultants were able to distribute their hours among the various program locations.

Figure 3. Average Monthly Hours of Consultation Provided to Four Health Departments during the Intensive Period



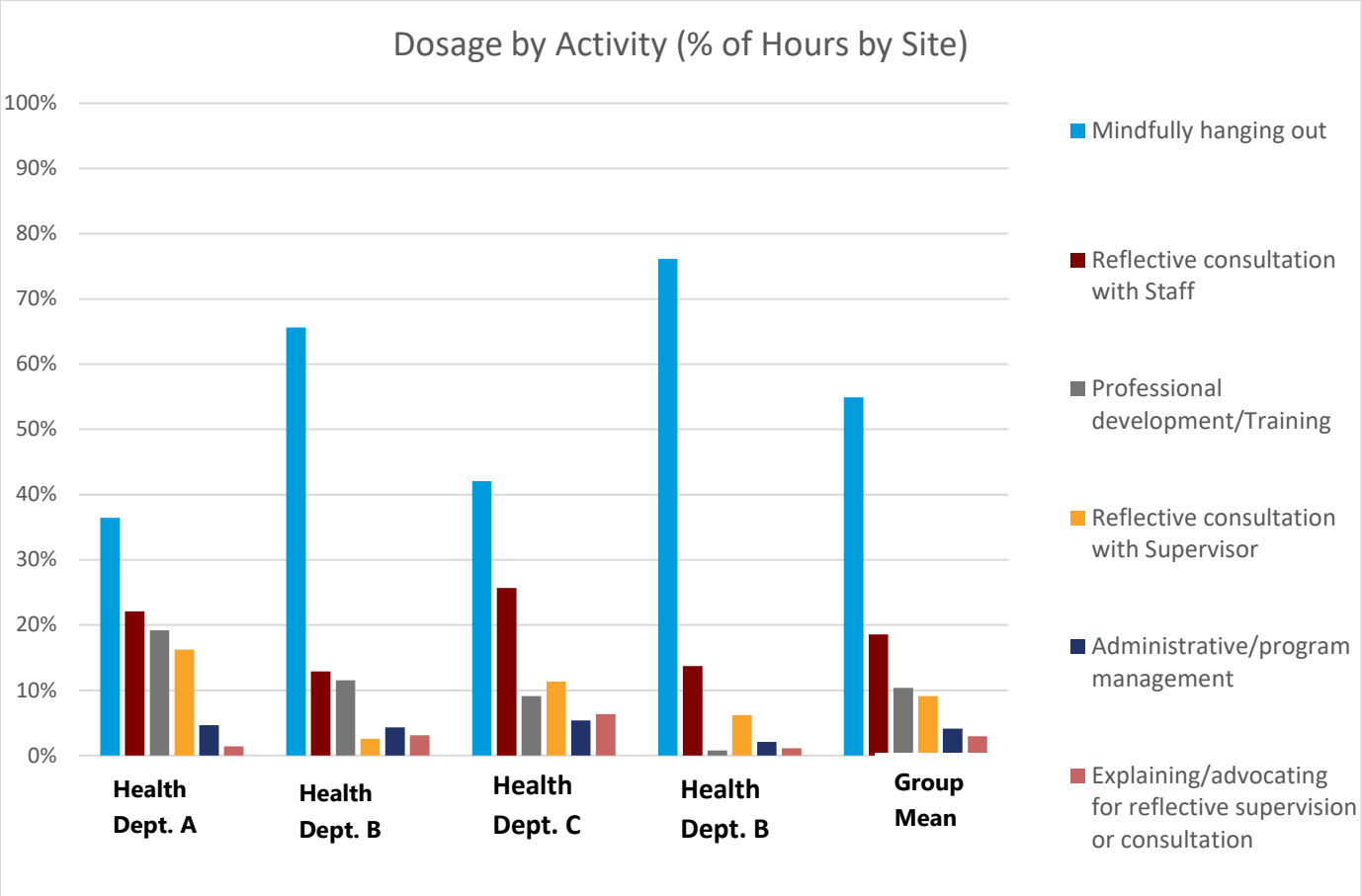
Adherence: Types of Consultant Activities

In addition, consultants delivered the expected services and engaged in activities aligned with the Illinois Model. As Figure 4 illustrates, the most common activity overall was "mindfully hanging out," which accounted for more than half of all consultation activities. The category of "mindfully hanging out" pertains to the intentional process of building relationships and establishing rapport with the staff and supervisors. Very few, if any, personnel in the four public health departments had worked with a mental health consultant prior to this initiative. The staff, supervisors, and consultants needed time to get to know one another and build trust.

Figure 4 also shows that some activities occurred more often at some health departments than others. For example, mindfully hanging out ranged from 36% to 76% of the activities among the four health departments. Professional development and trainings were about 10% of all consultation activities, ranging from just 1% of the consultation activities at one health

department to 19% at another. Administrative issues, such as staffing and recruitment of families, were 5% or less of the consultation activities at each health department. Advocating for reflective supervision and mental health consultation was the least common activity overall, but it was important to capture this activity because helping staff and administrators understand the importance of reflective capacity in improving their work was a necessary part of establishing consultation in the public health departments.

Figure 4. Consultation Activities by Health Department

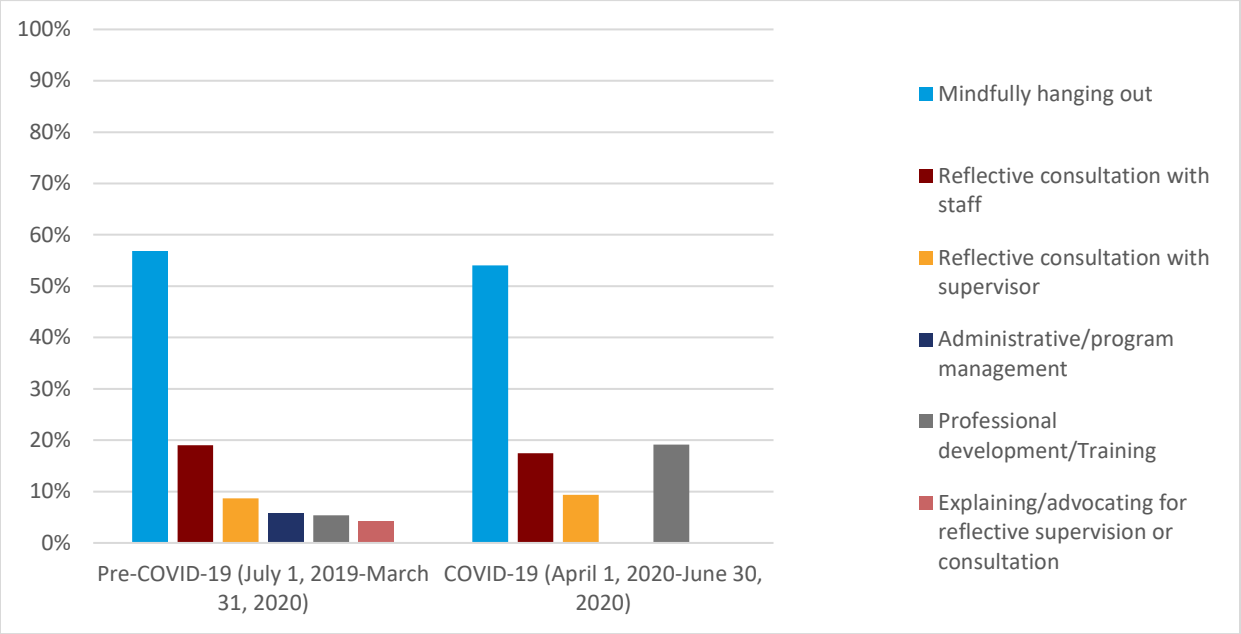


Reflective consultation with staff and supervisors is a core element of the Illinois Model. Consultants supported staff through reflective consultation, which accounted for about 19% of all consultation activities provided. Reflective consultation with supervisors occurred less frequently and comprised about 9% of activities. Reflective consultation with either staff or supervisors comprised 28% of all activities (combining reflective consultation with staff and reflective consultation with supervisors).

Consultants spent over half of their time mindfully hanging out both before and during the pandemic, as Figure 5 illustrates. Between April and June 2020, consultants were available virtually and continued to provide reflective consultation with staff and supervisors. The amount

of professional development and training increased during the pandemic when services were provided virtually. This may have been because it was needed more during this difficult time or because it was easier than scheduling individual meetings with staff virtually. By the time COVID-19 hit, consultants no longer spent time explaining and advocating for reflective supervision and reflective consultation, and they no longer dealt with administrative and program issues. Personal stressors tended to come up more often during the pandemic, which is understandable.

Figure 5. Types of Consultation Activities in Consultant Logs Pre-COVID-19 vs. COVID-19



Content and Process of Consultation

We analyzed data on the content and process of consultation from interviews with consultants and the consultant logs. The data confirmed that consultants were following the expectations of the Illinois Model in their implementation, despite the need to adapt the structure to the public health environment. Both consultants told us that the primary focus of consultation is "to support the staff who support the families so they can support their child's development." One consultant elaborated on this by describing three components of consultation:

> *One component is training and education of staff and supervisors and administrators. Another [is] helping supervisors and staff, to be more reflective on their personal experiences and their positions as well as their families or with their coworkers to build their reflective capacity. And the third component is that you are available to help on cases that may need some additional guidance on how to engage these families or address issues [like depression] that come up.*

In an effort to build relationships and foster reflective practice with supervisors and staff at each of the health departments, consultants initially planned to work in triads with supervisors and staff, or with supervisors and their own supervisor, as well as attend team meetings. The Illinois Model recommends this practice. However, the triadic approach proved difficult to establish. At two of the health departments, the supervisors and staff were not located in the same building and their schedules did not facilitate meeting with the consultant.

Both consultants acknowledged it was hard to find opportunities to establish reflective practice with the public health supervisors and staff. This was partly because of the short period of time available to meet with staff. However, supervisors' and staff unfamiliarity with the concept also made this difficult. As one consultant explained:

> *It's a little different [than] my experience with Early Intervention, for example, like I did more reflective practice work with the staff and the supervisor there, [so] the managers were involved more, hearing reflective questions, and learning about how to ask reflective questions. I haven't had that experience yet with the health departments. . . . And I'm not so sure that that's the right format for the health department. That's something I'm still thinking about.*

Thus, both consultants began to introduce reflective practice by incorporating "reflective questions and reflective practice" in group meetings and trainings. At the time of the baseline interviews, consultants reported that trainings and discussions addressed issues of trauma, depression, and self-regulation. For example, staff at one health department wanted guidance in how to talk with mothers about their depression if they scored high on the Edinburgh Postnatal Depression Scale, the depression screener used in the WIC program. Both consultants commented that while they presented the information to the full team, they were available and willing to discuss specific families or delve into the topics in more detail with one or two staff members at a time.

Over the course of the pilot, both consultants continued to present views about their role that were consistent with the Illinois Model. As one consultant explained, being a consultant to staff in a public health department is not that different from consulting in other early childhood settings. That is, she uses the same processes (consultative stance, reflective consultation), but the settings are different in terms of scheduling, logistics, and what they want from consultation.

As a capacity-building model, consultation aims to increase supervisors' ability to work effectively with their staff and for staff to work more effectively with families. According to one consultant, an important component of her work with staff was helping them recognize and manage the emotions that emerge in the course of their work. Such emotions may contribute to compassion fatigue or secondary trauma. If these emotions are not handled well, they can impact staff interactions with families. To differentiate their approach from other approaches to

mental health consultation, both consultants also noted that their role was not to formally interact with families or children. Rather, they supported staff in their work with families. Thus, they were willing to participate in a meeting with a staff member and a family and reflect with the staff later about the family. Based on the consultant logs, however, they did not do this during the pilot period. Rather, consultants interacted informally with families on just a handful of occasions, for example, attending a Facebook Live event or a Diaper Bag open house, and chatting with a parent and child while completing forms.

As supervisors became more familiar with the purpose of consultation and the consultants' knowledge, they asked consultants to provide trainings on specific topics that came up in discussions of staff cases at team meetings. After 6 months, staff began to request additional trainings. One consultant reflected during conversations with the research team that she was not sure if this shift was because staff knew she only had 6 months left or because they were more comfortable asking for help than before. "I'm wondering if maybe now they don't feel so much like an island so now they feel like they can ask for those things. Like they don't have to do things by themselves, they actually can get support."

From the perspectives of the consultants, mental health consultation is a useful and necessary support for public health staff and supervisors. They noted that although staff are very skilled, they have few opportunities for reflection. Although they have supervisors, they are not always in the same location, which makes regular contact difficult. If there are mental health professionals on staff, they are not there to meet with staff. Staff get support from their peers but depending on where peers are located and their schedules, there may be few staff in a building to call upon. As one of the consultants observed, supervisors and staff "have a lot of responsibility [and] are always busy and stretched thin."

Staff often are burdened more by the problems that they cannot help families with than the ones that they can. These difficult problems are the examples that are often brought to consultation as one of the consultants told us:

> *It's the families that come in and are dysregulated. It's engaging families. It's dealing with chronic mental health issues. I would say the issues are similar. . . . I've had staff say, "I don't know what to say when people are talking about things that aren't directly related to my work. How do I [respond]? I feel bad, I don't have the resources, I don't have the time, I don't have the know-how to talk about homelessness when that's not my issue, other than giving them a referral. It makes me feel bad because I can't do more." So that comes up a lot.*

Reinforcing the flexibility of the Illinois Model, both consultants described differences between health departments in terms of the people with whom they worked and the specific topics that

were addressed in consultation. In some cases, the consultants were focused on supervisors who did not have the support they needed; in other cases, they worked more frequently with staff.

Consultant Log Activities

Table 4 describes the types of consultation activities based on the descriptions of the main issues raised during mental health consultation sessions, as recorded by the mental health consultants in their logs. It should be noted that consultants usually recorded their activities by day rather than by amount of time, one of the logs' limitations. Typically, consultants spent 3 hours at a health department each week. During that time, a consultant could have met with a supervisor (for 15 minutes), attended a team meeting (for 1 hour), met separately with two staff (for 15 minutes each), and spent the remainder of her time being available to consult with other staff and preparing for an upcoming training. The logs might list her activities and the topics of consultation but rarely provided information about the amounts of time spent on each activity.

Table 4. Types of Consultation Activities in Consultant Logs for Four Public Health Departments

Activity/Category of Content[a]	Consultation Type (*n*)			Total	
	Departmental	Programmatic	Individual	*N*	%
Reflective consultation with staff	10	27	79	116	35
Mindfully hanging out	67	10	0	77	23
Reflective consultation with supervisor	14	42	8	64	19
Professional development/ Training	21	15	0	36	11
Administrative/Program management	20	3	1	24	7
Introducing/Explaining consultation	7	6	0	13	4
Total	139	103	88	330	100

[a] Another 15 log entries were categorized as "unclear" because of limited or no information.

We categorized most of the interactions between consultants and staff or supervisors as reflective consultation. The issues included in the "consultation with staff" category addressed staff members' concerns and perspectives and ranged from discussing changes in leadership to job duties, inter-staff conflict, parents' depression scores, and team meetings. Additionally, during the pandemic, issues included stress caused by working from home and anxiety related to COVID-19. Staff also brought more personal matters to the consultant as these issues could, in the words of one informant, "keep them from being open to the work, or present to it." The consultants recognized the importance of providing space for staff to address issues in their personal lives to help them become more effective employees. Consultants offered support to anyone who came to them with nonwork issues. While most staff-specific consultation activities

were between the consultant and staff member, about 19% of the log entries mentioned meeting with both a staff member and supervisor, as the Illinois Model recommends.

In the category of consultation with supervisors, we included work-focused issues that were primarily from the supervisor's perspective. Examples of topics in this category include planning of team meetings, changes in staffing/leadership, topics of upcoming trainings, staff issues, impact of a new electronic benefits system, and impact of COVID-19. Only a couple of supervisors brought personal issues to the consultant. Although the majority of these activities were between the consultant and supervisor, about 3% also included the supervisor's own supervisor.

Consultants offered and participated in professional development/trainings with the public health department staff. Some of these offerings were community events that the consultant supported; others were community events where they shared their knowledge with members of the community. Additionally, consultants provided in-service trainings to public health staff on screening tools, professional boundaries and self-care tools, early childhood trauma, mindfulness, burnout prevention, and other topics. In other situations, consultants wrote so-called social stories for staff to share with families or for staff to use themselves. For example, one story was entitled "Going to the WIC office for families with children on the Autism Spectrum" and "Preparing for Birth during Uncertain Times.").

Another category, administrative/program management, typically involved discussions with the consultant, supervisor or the director (65% of the time), but could also involve staff members. Issues raised in these conversations included agency changes (staffing, re-organization of departments) and modifications to the pilot program (changing schedules, adding additional locations).

The final category, introducing/explaining mental health consultation and the pilot, typically occurred at the start of the pilot program. These discussions most often involved explaining the purpose of mental health consultation, what the consultant would be doing, and other logistics, including where she would be located so that everyone could find her. At times, the consultant and consultees revisited the purpose and value of mental health consultation. These discussions were sometimes one-on-one conversations and at other times they occurred in a group setting.

Consultation in Public Health vs. ECE Center-based and Home Visiting Programs

One benefit of the Illinois Model is its flexibility to adapt to different program structures and staff needs. As shown in Table 5, the content of the consultation provided to the public health staff and supervisors was slightly different from what staff and supervisors in ECE and home visiting programs received (Spielberger et al., 2021). For example, the most frequent type of activity for all programs was reflective consultation with staff, either in a dyadic meeting with the consultant and staff member or a triadic meeting that also included the supervisor. Triadic

meetings rarely occurred in the public health departments (30% in ECE/home visiting and 35% in public health programs). The IDPH consultants reported "mindfully hanging out" as their second most frequent activity (23%), whereas the second most-often noted activity for ECE center-based and home visiting programs was observations. Public health consultants reported proportionately more professional development and training activities than reported by consultants in ECE center-based and home visiting programs; this might reflect the fact that there were fewer team meetings in ECE center-based programs or other opportunities to provide group trainings.

Table 5. Comparison of Consultation in Public Health and ECE Center-based and Home Visiting Programs

Public Health				**ECE Center-based & Home Visiting**		
Consultation Type	*N*	%		Consultation Type	*N*	%
Departmental consultation: Collaborates with Health Department senior administrators/directors, to assess the program's structures, policies, procedures, professional development opportunities, philosophy, mission, and practices to better support the mental health of young children and families.	139	42	~	**Programmatic consultation**: Assesses a program's structures, policies, procedures, professional development opportunities, philosophy, mission, and practices as they relate to supporting the mental health of young children and their families.	390	49
Programmatic consultation [*specific to FCM, WIC, other*]: Collaborates with supervisors and staff to assess a program's structures, policies, and procedures (staff relationships, routines, and practices) to better support the mental health of young children and families.	103	31	~	**Classroom and home consultation:** Collaborates with parents and staff to assess relationships, routines, and practices that impact the classroom or home climate.	233	29
Individual (case) consultation: Collaborates with staff and families to understand and respond effectively to the mental health needs of an individual staff member, family, or child.	88	27	~	**Individual child and family (case) consultation:** Collaborates with families, staff, and other caregivers to understand and respond effectively to a child's mental health needs. Assists caregivers and home visitors to understand and effectively respond to the mental health needs of a family. Consults with families, staff, and other caregivers about a particular child or family.	171	22
Total	330				794	

There were some content categories in the ECE center-based/home visiting logs that were not pertinent to the public health data, such as child behavior or family support. In addition, the public health consultants rarely recorded instances of family contacts, issues of trauma, or details about staffing and staff performance in the consultant logs. These differences between the two groups might indicate actual differences in the types of activities and issues in each setting. However, the differences might also reflect the way consultants scheduled and recorded their activities. As a result, we had to take a different approach to analyzing the data in the logs.

Consultants' Preparation for Their Role and Competencies

Given the novelty of implementing mental health consultation in public health departments, one of our research questions asked whether the consultants felt prepared for their work. As noted earlier, both consultants had extensive prior experience providing consultation to early childhood providers. Thus, although they acknowledged that providing consultation in a public health department was new, they felt well-prepared to do so by virtue of their prior experience, the initial orientation and training they received in the Illinois Model, and the ongoing monthly supervision they received from the implementation director. As one of the consultants explained, "I wouldn't say I felt prepared for a public health setting, [but] I felt prepared to do consultation. It's helpful [to have experience in a particular system] you're developing relationships in, but you're not really changing the model."

At the same time, the consultants recognized the importance of having well-grounded knowledge of the settings in which they provide consultation, preferably through direct experience for many years. Both consultants approached their work with a sense of humility and an openness to learning. One noted that such experience helps consultants "understand and empathize with the staff you're working with. You also learn that even if you have a lot of experience, you're going to encounter situations where you need the help of another." She added that less experienced consultants sometimes underestimate their lack of experience.

Both consultants indicated that their work was guided by the seven competencies in the Illinois Model (see Box 1 in the first chapter). They highlighted three competencies as being especially important for consultants in public health departments: knowledge of infant mental health, relationship building, and diversity, equity, and inclusion (DEI). With reference to DEI, one consultant told us, "There's a lot of issues around recognizing or even thinking about the cultural component to interaction." Both consultants reported that DEI issues were behind some of the challenges staff expressed about communicating with families and with other staff. Another highly relevant competency in public health departments, according to the consultants, is the ability to sensitively gather information and keep it confidential.

Implementation during the Pandemic

As mentioned, the unexpected closing of public health departments in March 2020 had an immediate effect on the structure and content of the consultants' activities. The consultants demonstrated the value of their experience and the adaptability of the Illinois Model as they shifted to providing all their services virtually. In most respects, the changes they made were in the structure and process of providing mental health consultation, although it took time for everyone to develop and get accustomed to the new procedures. For example, consultants participated in group meetings by video conference and met with individuals by phone. There also was more use of email and texting to communicate between meetings. In retrospect, consultants thought that being able to use email and text in the same way at the beginning of implementation might have facilitated communication and relationship building. The length of individual meetings were similar—typically 15 or 20 minutes—although some meetings lasted somewhat longer. Virtual trainings were now available to all staff, not just FCM and WIC staff (which had to be limited at some locations when done in person because conference rooms were small). With virtual trainings available, consultants might have reached more people during this time.

Due to the pandemic, the content of consultation sessions also shifted. Consultants continued to provide resources by email and trainings in mental health topics relevant to serving families (such as autism and bipolar disorder), but also increased trainings in self-care and professional values. Consultation sessions also focused more on managing emotions and other aspects of self-care than in the past. A few individual staff increased their contact with one of the consultants during this time. At one health department, a staff member was promoted and needed support as she navigated the transition to her new position. At another, a couple of staff increased the frequency of their contacts with one of the consultants because they were struggling to simultaneously fulfill their work responsibilities and manage their anxieties about the pandemic. It is possible that some of these changes might have occurred without the pandemic because staff understood better and were more comfortable with the purpose of consultation and how to engage with the consultant.

At the end of the initiative, when reflecting on the shifts that occurred in consultant activities, the consultants concluded that delivering consultation virtually can work. However, virtual consultation is most effective when leadership embraces and supports it and when there is a scheduled time to ensure it happens. Individual contacts with staff via email was effective in maintaining or developing relationships. But virtual consultation is also affected by the culture of the community. At one of the health departments, video conferencing and other virtual communication strategies were not used or were not as effective as in-person contacts. Similarly, consultants told us, although virtual is a way for people in isolated areas to get services, it depends on the services. One consultant noted, "Now, maybe it's different like if

you're seeking information, but with reflective consultation, I think it's such a personal intimate experience of talking to someone, I think that makes a difference if somebody is not comfortable virtually to navigate that."

Overall, the four health departments showed few differences in level of engagement with the consultant and support from the leadership. This was true during the 8 months before the closure of the health departments and the 4-month period when the offices were closed. Departments that were more or less engaged in consultation at the beginning continued to participate at a similar level during the final phase of implementation. Consultants continued to send emails reminding staff they were available and giving suggestions for mindfulness and other self-care activities. Thus, with few exceptions, the shift to working remotely did not change frequency of contact because most staff did not feel that they needed more support.

Experiences and Views of Supervisors and Staff

Staff Survey Respondents

Responses to the staff survey indicated a range of views about the need for support in working with families or children with challenging behaviors, emotional distress, family trauma, or other social emotional challenges. At all three time points, about a third of the survey respondents indicated that about half or more of their clients presented with mental health issues. When asked if children and families with challenging behaviors placed an added burden on responding staff, over two-thirds (between 64% and 79%) responded either "not at all" or "a little." There was a slight increase in the percentage of staff who responded that these challenging behaviors place "a medium amount" or "a great deal" of burden on them. At baseline, 21% indicated experiencing a medium amount or a great deal of burden, while 36% at Time 2 and 31% at Time 3 indicated this. The interview data suggest that the pandemic might be one factor in this increase.

As shown in Table 6, the survey also asked all responding staff if they had the opportunity to talk to a mental health consultant about these children or families. At baseline, as expected, most (72%) responded "no." At Time 2 and Time 3, two-thirds of the respondents said yes, they did have the opportunity to consult with a mental health consultant about these children and families.

Staff who reported having the opportunity to work with mental health consultants at each time point were asked additional questions about their experiences with the consultant. At Time 2, responding staff reported that they had worked with the consultant either "monthly" (35%) or "weekly" (47%). At Time 3, they were still consulting the consultant, but less frequently; 38% reported "monthly" consultation sessions and another 19% reported "weekly" sessions. This decline in frequency of meeting at Time 3 could be the result of the consultants working

remotely during the pandemic as well as the planned decrease in consultant support toward the end of the initiative.

Table 6. Staff Survey: Views of Mental Health Consultation and Needs over Time (*N* = 25)

Indicator	Baseline	Time 2	Time 3
Opportunity to consult with a mental health consultant about infant, child or parent behaviors or mental health concerns (%)[a]			(*n* = 24)
Yes	28	68	67
Frequency of opportunity to consult with a mental health consultant about infant, child, parent behavior/mental health (%)[b]	(*n* = 7)	(*n* = *17*)	(*n* = 16)
Never	43	6	0
Once or twice a year	14	6	25
Quarterly	14	6	19
Monthly	29	35	38
Weekly	0	47	19
Primary way you receive consultation now (%)	(*n* = 6)	(*n* = 17)	(*n* = 16)
Regular one-on-one consultation	0	42	19
Regular group consultation	0	6	25
Unscheduled consultation (e.g., drop in or call when needed)	100	52	56
How often do you receive regular one-on-one consultation (%)		(*n* = 7)	(*n* = 2)
Once a month	--	86	100
Once a week	--	14	0
How often do you receive regular group consultation (%)		(*n* = 1)	(*n* = 4)
Once a month	--	100	100
How valuable do you feel mental health consultation is to you?[c]			
Mean (*SD*)	2.4 (*1.13*)	2.4 (*1.27*)	2.9 (*1.20*)
Ease of making time to meet with the mental health consultant[d]			
Mean (*SD*)	1.9 (*1.07*)	1.8 (*1.51*)	2.2 (*1.11*)
What is the quality of the consultation?[e]	(*n* = 6)	(*n* = 16)	
Mean (*SD*)	2.2 (*1.33*)	3.1 (*1.03*)	3.1 (*0.81*)
How well does your consultation time meet your needs?[f]		(*n* = 15)	
Mean (*SD*)		2.8 (*1.21*)	3.3 (*0.68*)

Note: Sample sizes (noted in parentheses) varied by question (e.g., only staff who reported contact with the consultant answered questions about the amount of quality of consultation).

[a] Chi-square analysis found significant differences at Time 2 among FCM, WIC, and other programs (p = .034); a larger percentage (100%) of FCM staff reported accessing a consultant than WIC (67%) or other programs (25%).

[b] Chi-square analysis found significant differences at Time 2 among FCM, WIC, and other programs (p = .010); FCM staff were more likely to indicate accessing the consultant weekly than staff in other programs.

[c] Response scale: 0, "Not at all valuable"; 1, "A little"; 2, "Somewhat"; 3, "Moderately"; and 4, "Very valuable."

[d] Response scale: 0, "Not at all easy"; 1, "A little"; 2, "Somewhat"; 3, "Moderately"; and 4, "Very easy."

[e] Response scale: 0, "Poor"; 1, "Fair"; 2, "Good"; 3, "Very good"; and 4, "Excellent."

[f] Response scale: 0, "Not well at all," 1 "A little," 2 "Somewhat," 3 "Fairly well," and 4 "Very well."

Staff survey respondents indicated that they found consultation "somewhat" valuable at Time 2, which was about 6 months after the start of implementation. There was a modest, nonsignificant increase in their positive views 6 months later at Time 3, which was 4 months after the pandemic changed the way consultation was provided. At this time, staff described the consultation they

received as "moderately" valuable. Most survey respondents also felt that the amount of contact with the consultant was adequate and that it was "somewhat" easy to make the time to meet with the consultant. Finally, we also asked survey respondents about the quality of the consultant's work. At both Time 2 and Time 3, respondents were positive in their responses. They told us that the quality of the consultation they were receiving was "very good" and that the consultation met their needs "fairly well."

At Time 3, we asked three additional questions of staff about their views of consultation in the wake of the COVID-19 pandemic. Although a majority (56%) responded that the value of consultant was "similar to what it was before the pandemic," a sizeable percentage (44%) reported that it was "more valuable than it was before." When asked about the impact of COVID-19 on making time to meet the consultant, over half (56%) said "it was as easy as it was before," but more than a third (38%) found that "it was harder than it was before." It may have been harder because staff could no longer walk down the hall to talk to the consultant. While the consultants maintained their regular consultation hours during the pandemic, they were remote and conversations occurred via telephone or email, which altered the relationship. Finally, more than a third (38%) of the survey respondents reported that they preferred meeting with the consultant in person, while more than half (56%) reported that they were comfortable with both in-person and virtual consultation.

Director, Supervisor, and Staff Interview Informants

Based on the survey and consultant interviews, the level of engagement of program leaders and staff with consultation varied across the four health departments. However, the program leaders and staff who participated in interviews all expressed support for mental health consultation. (It should be noted that we selected the sample of staff interviewed at Time 3 from those who had had some regular contact with a consultant throughout the implementation period. There was less selection bias in the sample of supervisors and directors because we tried to interview anyone who might have some contact or familiarity with the initiative, regardless of their level of engagement with a consultant.)

Workforce Challenges and Needs for Consultation

In their baseline and Time 2 interviews, supervisors discussed challenges in their work environment. These challenges underscored the role of and need for mental health consultation in public health programs. These fell into two related categories: a need for support to ensure staff's own well-being and a need to strengthen their capacity to support the families in their programs. These two themes—supporting staff mental health and supporting families—go hand-in-hand. Staff who feel more equipped to support families and do their jobs more effectively may find their well-being improve; staff feeling more emotionally supported in their work with families may do their jobs more effectively.

Staff Well-being

Supervisors from most of the public health departments expressed concerns about their staff's well-being and potential burnout. Staff support families who may be dealing with stressful or traumatic circumstances; hearing about those situations can be overwhelming for staff, particularly when options for processing their emotions may be limited. One supervisor said:

> *I had one WIC staff person who came in and. . . was very upset by a story she heard. It was just a little overwhelming, she shared details of a family that was [in a difficult situation]. . . . I let her know it's okay if you need to go to our wellness clinic and talk to our EAP program if you find that you're becoming overwhelmed. . . . How do we deal with our day-in and day-out stories that we hear and how to manage those when they affect us personally?*

Another supervisor described how burnout can unfold and manifest in staff who work demanding jobs in a large public agency. The supervisor's description highlighted the need for support for both staff and supervisors. Supervisors could benefit from support with identifying staff burnout and managing demands in ways that work for everyone. The supervisor said:

> *My biggest concern is burnout. I know at every public agency we're always being asked to do more with less. I try my best to acknowledge people and be appreciative, but that only goes so far. Being able to make sure that staff are feeling like they're given a manageable amount. . . honestly, the workload is more than I think anyone would ever be able to do. And you wind up with a. . . triage situation where you realize you've got to pick the worst of the worst and handle that and work your way down. . . . When new complaints are always coming in, you're never caught up. . . that's kind of the nature of the job. We still have deliverables, we still have ends we need to meet. It's a tough thing to balance. . . . It's easy for me not being a field staff, but I worry that maybe sometimes I don't recognize the signs of burnout or unknowingly put too much on a staff member.*

Some supervisors spoke more explicitly about their expectations that working with a mental health consultant could help alleviate staff stress, resulting in professional and personal growth. Supervisors recognized that job stress could overwhelm and lead to burnout or other mental health issues. While this would negatively affect staff as individuals, it would also affect their professional role. When asked for their expectations for mental health consultation at their health department before implementation started, one of the supervisors said the consultant's role would be:

> *To assess my staff and us to work with the families we're working with and how to handle the issues. . . and also even if the staff feel overwhelmed with everything that is going on, or they [are feeling] depressed, you know, because they cannot successfully complete everything what they're supposed to. So, they're going to receive assistance to make them grow. That's what this is about, make them grow and be, then, capable of handling the situations, what they come across. And they can discuss those situations with the consultant and give them more guidance.*

Some supervisors mentioned turnover as a related concern. They suggested various reasons for staff departures, such as a desire for more income or different job responsibilities than what they were experiencing in public health. Although there were multiple reasons reported for staff leaving, the most common seemed to be income and better jobs. A supervisor explained that staff were generally satisfied with their jobs but sought better opportunities: "I think overall I don't see they are not satisfied. To many of them, this is a stepping stone; some stay with us for 1–2 years, some much longer. Many leave for further education and other positions in this or similar fields." For example, being a WIC nutritionist was viewed as a way to either become a registered dietician or take another role in nutrition education. At the same time, a supervisor at one of the four health departments noted that it was hard to recruit and retain public health staff and that the departure of a few staff in leadership roles within a short period of time "resulted in very low morale."

Supporting Parents and Families

Supervisors recognized that just as staff could benefit from support for their emotional responses to witnessing families' stress, so too would they benefit from more concrete ways to support overwhelmed families and those facing highly stressful situations. One supervisor explained:

> *I'm glad we're getting the opportunity [to receive the consultation] because I think it's definitely a need in our community and if we're going to prepare our workforce and our public health practitioners to be able to work in the population and fill this space, they're going to have to have more tools.*

Supervisors specifically talked about the need for staff to more effectively support parents and families dealing with mental health concerns and trauma. One supervisor noted high rates of mental health concerns in children in their community; the same supervisor discussed moving toward becoming a trauma-informed organization. Thus, staff are supporting families dealing with trauma and its accompanying mental health issues across all ages. A supervisor said:

> *I think for any of the staff here, to just be better prepared to deal with people who may or may not have psychological problems. . . . We're working real hard on becoming a trauma-informed organization. And I don't think all of our staff have quite figured out that people's trauma can affect how they react when they come here.*

The same supervisor talked about the need to support staff who are less experienced working with families and may require additional help in understanding families' diverse needs and backgrounds.

> *A lot of the WIC staff are very young and they've not dealt with the public a whole lot. And so they've been known to. . . say, "I think something's wrong with this person. They're not acting right and they're not talking right. And should we call the police." And every time I go over and check, I'm like, "No. This person's fine. They may act different than you do and they may respond different to questions than you would. But let's not label people as having a psychiatric illness just yet." A lot of the younger staff need to learn more about the diversity in people's worlds and attitudes and thoughts.*

Supporting Families during the Pandemic

In addition to their own well-being and workload, staff and supervisors were concerned about the disruptions in their ability to communicate with families created by the pandemic. Once in-person and hands-on support services were suspended, the health department staff were limited in how they could deliver necessary information and how they could support families. For example, breastfeeding practices were difficult to deliver virtually. As mentioned, the departments were forced to replace their in-person services with telephone check-in and curbside pickup, leaving very limited options for families to access face-to-face support at the program offices. During the interview, one WIC staff said, "I feel like I'm not able to get across all the information just being over the phone. . . ... And you can get more across face-to-face than over the phone."

A WIC staff member indicated that she tried to explain available services to families, often with the help of online platforms, including YouTube. She would often make referrals to Illinois Department of Human Services and provide breastfeeding information. She also made referrals to a licensed lactation consultant for mothers who had trouble latching or pumping. The staff would receive recommendations from the lactation consultant to provide mothers with further support for meeting their goals. Additionally, staff felt they could not provide as many concrete resources as they had in the past. As one family case manager explained: "It's mainly just doing everything over the phone, supporting them, but not able to offer the amount of resources

because all the resources [centers] are doing things differently, so that's been a big learning curve."

Staff were especially concerned about families who did not respond to telephone check-ins or who they knew tended to be isolated or affected by mental health issues. Many families reportedly adapted to new ways of receiving services by phone and by curbside pickup—partly because they had already established relationship with FCM and WIC staff but also because they no longer had to come into the office (often with children). On the other hand, some existing families as well as new families stayed away from the services during the pandemic.

Implementation Experiences

Staff and supervisor interview informants verified the findings from the consultant interviews and consultant logs about the structure and process of implementation. Their reports indicated that how the consultant worked with the four public health departments varied, based on their size and structure. For example, at two health departments, the consultant visited the same location on a weekly basis. Other programs had multiple office locations, and the consultant switched the locations each week to meet with all of the staff. According to staff interviews, most staff had contact with the consultant at least during the initial phase of the pilot. Staff and supervisor reports were like those of the consultants. For example, they mentioned that individual consultation with the staff commonly took place using, in the words of one informant, the "drop-in" approach, rather than scheduling appointments. Additionally, staff noted that the consultants provided in-service training to the programs or attended the monthly team meetings/supervision (or both). Several staff mentioned the consultants' involvement in group supervision throughout the year, which provided opportunities for staff to discuss family-level issues as a group.

Staff and supervisors mentioned addressing a variety of topics during individual and group consultation. Child development, mental health, and self-care strategies, particularly after the beginning of the COVID-19 pandemic, were common topics of in-service training. During individual consultation, staff often discussed relationships with supervisors and coworkers, concerns related to children/families, and self-care strategies. For example, a staff member reported meeting with a consultant to discuss the limited relationship and communication she had with her supervisor. Another staff member shared her need for more guidance from her supervisor about learning and professional development opportunities. Several staff reflected on mindfulness and meditation as a means for self-care: "[My consultant] always talked about mindfulness," "Self-care and a little meditation . . . . Take time for yourself," "To take a moment for myself. And to listen, rather than trying to solve and fix things, which many families need."

After the beginning of the pandemic and stay-at-home order in March, the staff continued to have access to consultation to discuss children and family cases and work-related challenges,

such as relationships with their supervisors and other sources of stress at work. During this time of drastic disruption of service delivery and communication with families and colleagues, the mental health consultation, training, and resources focused on strategies to adjust to these changes and maintain the work with the families to respond to their needs. The topics included the work environment (for example, remote work), the learning process in the new situation, family engagement and communication during the pandemic, and dealing with one's own stress. One health department held a webinar series focused on these topics, including responding to families' needs during the COVID-19 pandemic and promoting staff self-care. At this health department, the consultant also suggested WIC staff use a video chat program to communicate with families, which would allow them "face-to-face"—although not in-person—interaction. The supervisor approved this proposal, which enhanced the communication process between the staff and families.

Staff from WIC, FCM, and other public health programs provided numerous examples of strategies recommended by their consultants to respond to pandemic-related challenges, as illustrated from the following interview excerpts from three different informants:

> *I think in the Zoom meetings, [she talked about] how to relax, take a deep breath, [and helped] us understand where families may be coming from and the mental health issues that may be creeping up more.*
>
> *[The consultant] helped me work through better self-care, and how to get through being locked down and not being able to go do home visits, and all the anxiety surrounding COVID. She gave me a lot of tips on how to deal with that.*
>
> *[My concern] has been the lack of communication I have with my clients. . . . And I was talking to her about like, "How can I [get] them to communicate more since I can't actually see them face-to-face more so now and how to come across, you know, better with them just being able to do phone consultations?" It's just a lot different, and she's walked us through some different things with the different E-mails about different ways that we can help our clients during this time.*

After the COVID-19 pandemic began, staff and consultants frequently reflected on practices and strategies for navigating challenges surrounding the staff and families. For example, using video chatting with families as an alternative way to have home visits and in-person appointments, which helped to better understand and communicate family concerns than calling could. FCM staff in particular told us that consultants helped them understand the circumstances that families might be in and mental health issues that might be affecting them more due to the pandemic. They also mentioned learning new strategies from consultants for self-care and self-

regulation, including meditation and mindfulness approaches (such as taking a moment for oneself, how to relax and take a deep breath, and how to deal with anxiety).

A relatively new staff member also found support in just sharing her need for more guidance from her supervisor:

> *I would like some more guidance. Just because I can do my job doesn't mean I don't need help. But that's kind of overlooked sometimes. [The consultant] just listened to me, which I appreciated. And then, she [did] two things. First, she said, "What can you do? There's nothing wrong with saying, 'No. I need time, or I need to take this slow. You have a voice. You deserve just as much time and opportunity as everyone else." And so, she kind of encouraged my own voice [and] then she brought into perspective a lot the dynamics I have here in relation to my boss and co-workers and supervisor. And . . she gave me a little bit more insight into everything, which helped me understand it better and why it was happening the way it was happening. . . . I need a bigger-picture kind of thing sometimes.*

When asked for suggestions for improving the consultation approach and structure, staff said that they preferred talking with the consultants in person rather than by other means. However, staff appreciated the fact that consultants were available when in-person meetings were not possible. They were also pleased with the consultation period being 12 months. However, some staff suggested making the consultant available at least twice a week instead of once. This way there would be less of a gap and more continuity between sessions. Lastly, several staff noted that fitting consultation into their busy schedule was a challenge. They described advantages and disadvantages to prescheduling appointments. As one WIC staff member explained, a drop-in structure did not require staff to schedule consultation ahead of time and therefore allowed staff to see the consultant even if their work schedules were uncertain or inconsistent. On the other hand, scheduled time would ensure that each staff person has an allocated time for consultation.

Factors Affecting Implementation

From the perspective of the consultants, their ability to engage with staff and leadership to implement the model varied by public health department and other factors. At Time 2, consultants reported several factors that affected implementation related to program engagement. These included the readiness of the public health department to implement consultation, leadership support and engagement, understanding of the consultant's role, logistical matters such as scheduling, and staff reflective capacity. By Time 3, many of these

factors remained relevant, but leadership's willingness to remain engaged and supportive of consultation was particularly meaningful.

Program Readiness and Engagement

The consultants reported that the public health departments were generally oriented to the concept of mental health consultation and the approach of the Illinois Model at the beginning of implementation, but there was variation among the four health departments. For instance, a committed supervisor at one of the health departments who had been involved in the initial planning moved to a new position at the beginning of implementation. This meant communicating to staff about the purpose of consultation and implementation became difficult. At other departments, administrators showed a limited understanding about the purpose of consultation at the beginning, for example, mistaking consultation for therapy. Although their views changed over time, misunderstandings about mental health consultation slowed the implementation process.

One consultant reported that, initially, leadership at both health departments she was working at were invested in consultation. However, over time the involvement at one health department dropped off as supervisors became busy with other meetings and did not see the consultant regularly. Further, the consultant noted that she collaborated with WIC supervisors more often than others. One supervisor would not seek the consultant out, but if the consultant contacted her, the supervisor was responsive and would engage. This consultant talked about how helpful it was to have the support and engagement of at least one supervisor. This supervisor engaged the consultant in thinking about ideas; this type of interaction and supervisor support helped facilitate a smoother implementation.

Thus, consultants noted that support of supervisors and administrators differed across the four health departments, which affected the pace and success of implementation. In one instance, one of the consultant's last contacts with a supervisor was in March 2020, about the time of the state's stay at home order. At that point, the supervisor said there would be no more consultation because staff had to focus on the new electronic benefits transfer (EBT) system.[4] The consultant commented that her relationship with that supervisor was never strong and when the lockdown was put in place, it was almost an ideal excuse not to continue it. The consultant offered virtual trainings, but they basically were declined. She did continue to send resources to everyone about self-care.

Staff engagement was influenced by support and buy-in of supervisors and other leadership; consultants noted that the health departments differed in that regard, with staff at some health

[4] The new electronic benefits transfer (EBT) system for WIC was rolled out to health departments starting in September 2020. Prior to roll out, extensive training was provided to staff.

departments receiving a lot of support from supervisors, while others less so. By Time 3, a consultant commented that she thought staff at one health department in particular were highly committed to their work and the families they serve. However, they were working in a fairly closed system and staff did not feel they had the supervisory support to talk about or process their work.

Similarly, consultants reported a lack of support or interest from some supervisors and administrators. For example, a member of leadership had not contacted the consultant and was not responsive to her communication. According to the consultant, this lack of communication influenced staff engagement with consultation. Except for WIC, high-risk nursing, and home visiting programs, public health departments were not familiar with consultation. This lack of familiarity could contribute to lack of understanding and a reluctance to engage or develop trust. This underscores how not understanding roles, perhaps coupled with communication difficulties, could make it difficult to develop trust and thus make consultation challenging to implement.

Understanding the Consultant's Role

Both consultants talked about how health department staff and leadership's perception of the consultant's role—including confusion about it—impacted implementation. One consultant noted that it would have been important to check in a few months into implementation to see how things were going, and if everyone's understanding about consultation was consistent. She did not check in until 6 months into implementation and reported wishing she had done so sooner. The consultant also discussed how it would have been helpful for consultants to be present at the initial orientation held with each health department. She further said a more structured schedule should have been put in place from the beginning at one of the health departments, given limited staff availability for meetings.

The other consultant talked about how complicated their role could be, and how that complexity could lead to confusion. While consultants were not there to provide therapy or emotional healing to staff—a common misconception among the health department staff—they understood that staff's clinical issues could impact their work. Therefore, it was beneficial to address some of staff's more personal concerns along with other factors that could hinder their performance at work. However, it was sometimes hard for staff to understand the difference between therapy and consultation. Staff eventually came to realize the consultant's role in helping staff and supervisors develop their reflective capacity and new ways of interacting with families and children, but this took time. The consultant also noted that the limited frequency and time spent with staff (sometimes just once per month) made this understanding more difficult to develop.

Scheduling and Other Logistics

Both consultants also talked about how logistical challenges interfered with implementation. Particular challenges were scheduling and staff availability. One consultant noted that the medical clinic model of short appointments affected how consultation was provided. Although having a schedule was better than drop-in, "you have to go with the flow" and sometimes schedules had to shift. They recognized that participating in team meetings at the beginning of implementation and providing more structure for meeting with supervisors would have gotten implementation off to a stronger start.

The implementation director echoed the complexities related to scheduling and consultant availability, given the staff structure of the health department. Perceived benefits of a drop-in model could be a way to respond either to short-term crisis or longer-term emotional issues affecting work. However, the issues tended to be more focused on short-term problems than on building the capacity of staff. The director said:

> *The consultants had defined hours and they kept those defined hours and people who want to just stop in and talk with the consultant would do that. Many times that didn't happen and when it did, it was very quick. So we had to think through how helpful was that. It was helpful if there were crisis issues that people needed to address right then and there. I think it was helpful if someone was in a deep emotional issue that was keeping them from being comfortable doing their work, which of course happened during the pandemic. But it was more of crisis conversations than it was about building the capacity of staff and dealing with mental health and social and emotional needs of children.*

One consultant talked about how the clinics at a health department with multiple locations are only open for a limited number of hours and said that, because of the distances between the different locations, she could only go to one each week. This meant that she only had contact with individual staff about once a month; this did not seem sufficient to build relationships with the staff. Although using some virtual meetings might have made communication more frequent, this was also a health department in which staff seemed more comfortable with in-person meetings than ones requiring use of technology.

According to one consultant, having a dedicated space near where the program staff worked was critical to successful implementation. The space made it easy for them to drop in or schedule private meetings. At one health department, the consultant was initially put in a location on a different floor than most of the staff. This made it difficult for staff to remember the consultant was available and to drop in to talk with her. Later, she was relocated to be closer to the staff, which improved her visibility.

One consultant discussed challenges related to staff turnover and retention and how this affected implementation. Although this seemed to be an issue at just one of the health departments, not at all of them, it is still important to consider. New staff constantly joining a program can be disruptive to the remaining staff because of the need to orient and train the new staff. The consultant reported offering to discuss this issue with leadership, but they were not open to talking with her about it. Later, during the pandemic when the department had to curtail most in-person services, there sometimes was only one staff person in the office. That person needed to be responsive to families that came by, leaving no time to talk with the consultant (even virtually).

In January, one of the health departments asked their consultant to work at another location. In addition to serving a challenging client population, this department evidently had recurring issues with staff communication. Although the consultant thought she was making progress in building relationships with staff at the new site, it was hard to maintain the schedule of meetings. In this case, staff could have greatly benefitted from the consultant's support, but logistical challenges interfered and, ultimately, pandemic-related challenges exacerbated existing difficulties. The consultant said:

> *We tried to implement me to their team meetings. That was the goal because staff had different responsibilities, and we thought that'd be easiest. And then what happened is the team meeting kept getting changed because of other administrative duties that had to be priority. And then that wasn't cohesive with my schedule and then COVID happened.*

It took time—a good 6 months—for the health department staff to develop relationships with their consultant. According to the consultants and implementation director, relationships were beginning to take shape when the COVID-19 pandemic began and the health departments had to close their buildings. Staff were pulled away, and many could not make time for consultation. At the same time, staff needed to talk because they were anxious about what was happening. Although initially there was an increase in communication as people shared fears and concerns, people eventually focused their time on providing services to families in new formats.

By Time 3, of course, the pandemic and the way it impacted all facets of the consultants' work was a theme in their interviews, as well as in interviews with supervisors and staff. The pandemic, coupled with the pace of work, interfered with implementation. One consultant recalled:

> *I was invited to [a team meeting]. . . . And it seemed like what they really wanted was a training on conflict resolution. So we talked about it, and it really was about how you talk to people when they're stressed and perspective-taking. It was a very successful meeting and people were very forthcoming and several*

people, including the supervisor, said they want to continue this. And they never had me back because I think [COVID got] so overwhelming. But, at least there were these kinds of discussions going on across the agency.

Reflective Capacity

Given the importance of facilitating growth in reflective capacity in the Illinois Model, both consultants discussed why it was difficult to develop this capacity among staff. One reason was that some health departments did not make consultation a priority, and so, development of reflective capacity was not occurring. As one consultant noted, "There's just a lot to do. If you don't set aside time for reflective work, it doesn't get done." Both consultants discussed how staff at the health departments were contending with resource deficits in their work with families. Staff were more concerned with the immediate needs of the families they served; amid lack of health care and other resources, perhaps spending time on developing reflective capacity did not seem like a priority.

Another reason was a lack of knowledge and use of reflective supervision among health department staff. Reflective supervision is a concept and skill that requires a certain amount of work and a different way of thinking. Staff had not previously received reflective supervision at any of the health departments, so reflecting on one's work was not familiar to staff or to most supervisors. Moreover, according to one consultant, some staff seemed more naturally reflective, which made it easier for them to engage with the consultant in reflecting on their work.

Chapter Summary

With some adaptations, consultants were able to implement the Illinois Model of IECMHC in four public health departments. They were able to provide the expected dosage of services and supports and the kinds of activities that adhere to the model. That is, most activities were directed at developing the reflective capacity of staff and supervisors and had a programmatic rather than individual focus. Building relationships and establishing an effective structure and process for implementation took time, though; this was partly because the concepts of mental health consultation and reflective practice were so unfamiliar to most of the public health staff and administrators. The implementation team initially planned a drop-in model rather than scheduled appointments with staff and supervisors because that structure seemed to fit well with the structure of the health departments. In time, however, the consultants and supervisors at two of the health departments decided to schedule appointments for staff to meet with the consultants to make sure that staff took advantage of their support. Consultants did not always participate in team meetings at first, but it became apparent that this was an effective venue to get to know the staff and introduce them and their supervisors to reflective practice.

Several factors affected the implementation of the Illinois Model of IECMHC in the public health departments. Although the public health crisis stemming from the COVID-19 pandemic was particularly disruptive, the consultants experienced several other challenges that affected their ability to implement the model. The structures of public health programs, the fast pace of work and short appointments, and the unpredictability of community needs were all influential factors. Consultants also experienced variations in the commitment of agency and program leaders to consultation and staff readiness to work with the consultant.

Findings: Outcomes of the Illinois Model

This chapter addresses the second and third set of research questions about impacts:

- RQ2: How does mental health consultation affect FCM and WIC staff and supervisors? How does it increase their capacity to serve children and families? Is there evidence that FCM and WIC staff can engage families in a consultative, collaborative manner?
- RQ3: Since the state is attempting to serve more high-risk populations and staff need more support to do so, how does mental health consultation assist systems and agencies in serving all families?

The primary purpose of this exploratory study was to see whether it is feasible to implement the Illinois Model effectively in public health departments. At the same time, as reflected in the research questions, we were also interested in the effects it might have on public health staff and supervisors. Because program staff and supervisors receive the intervention directly, the theory of change for the model assumes that we will see changes in staff and supervisors—for example, their relationships with each other, reflective capacity, well-being, and knowledge of social and emotional development—before changes in families or children. (Changes in families or children are longer-term outcomes.) Thus, this chapter focuses on the effects of the pilot on supervisors and staff.

Staff–Supervisor Relationships

Program supervisors played an important role in implementing the Illinois Model. Their understanding of the model and support for making sure that consultants were able to connect with staff was critical for building relationships with the consultant and fully implementing the model. The online survey asked staff about the format and frequency of their supervision and its adequacy to meet their needs in four areas of their work. At baseline, just over one-third (36%) of staff reported receiving one-on-one supervision with their program supervisor on a regular basis, with a nonsignificant increase at Time 2 (44%) and Time 3 (48%; see Table 7). Of those who reported receiving one-on-one supervision in person at baseline, half of the respondents reported receiving one-on-one supervision for 30 minutes, and the other half for 60 minutes or more. At Time 2, most (90%) reported receiving one-on-one supervision for 30 minutes. At Time 3, when supervision had to be provided virtually, over half (58%) reported 30-minute one-on-one sessions and another 42% reported 60-minute one-on-one sessions with their program supervisor.

About half (56%, 55%, and 50% respectively) of staff at all three time points reported they typically received supervision in a group setting with an additional one-third or more (33%, 36%, and 42% respectively) at each time point reported receiving "unscheduled supervision."

Table 7. Supervision Received at Baseline, Time 2, and Time 3 (*N* = 25)

Indicator	Baseline	Time 2	Time 3
Do you meet one-on-one with your program supervisor on a regular basis (%)[a]	(*N* = 25)	(*N* = 25)	(*N* = 25)
Yes	36	44	48
How long do you typically meet one-on-one with your supervisor (%)	(*n*=8)	(*n*=10)	(*n*=12)
30 minutes	50	90	58
60 minutes or more	25	10	42
Primary way you receive supervision (%)[b]	(*n* = 9)	(*n* = 11)	(*n* = 12)
Regular one-on-one supervision	11	9	8
Regular group supervision	56	55	50
Unscheduled supervision (such as drop in or call with a question or concern)	33	36	42
Frequency of regular group supervision (%)	(*n* = 5)	(*n* = 6)	(*n* = 6)
Once or twice a month	60	83	67
Once a week	20	0	17
More than once a week	20	17	17
How well one-on-one supervision meets your needs in the following areas[c]	(*n* = 8)		
Professional Development	(*n* = 9)	(*n* = 11)	(*n* = 12)
Mean (*SD*)	3.2 (*1.39*)	2.9 (*0.83*)	2.8 (*1.29*)
Program/administrative issues	(*n* = 9)	(*n* = 11)	(*n* = 12)
Mean (*SD*)	3.2 (*1.39*)	3.0 (*1.00*)	2.7 (*1.23*)
Clinical issues	(*n* = 8)	(*n* = 11)	(*n* = 12)
Mean (*SD*)	3.0 (*1.60*)	2.6 (*1.12*)	2.4 (*1.56*)
Processing feelings/reactions to work with families	(*n* = 8)	(*n* = 11)	(*n* = 12)
Mean (*SD*)	2.8 (*1.58*)	2.6 (*1.37*)	2.5 (*1.62*)

Note: Sample sizes varied by question—for example, only staff who reported meeting with their supervisor with some regularity answered additional questions about their supervision—and are indicated for each item.

[a] Chi-square analysis indicated a significant difference in responses by program type at Baseline (p = .012);14% (1) FCM, 29% (4) WIC and 100% (4) other said "yes."

[b] Chi-square analysis indicated a significant difference in responses by program type at Baseline (p=.048) and at Time 2 (p = .026).

[c] Response scale: 0, "Not at all well"; 1, "A little"; 2, "Somewhat"; 3, "Fairly well"; and 4, "Very well."

For those survey respondents who receive one-on-one supervision, regardless of frequency, they said it met their needs "fairly well," although their responses tended to be lower at Time 3 than the previous two time points. These results were similar to the responses of staff in early

childhood care and education center-based and home visiting programs (Spielberger et al., 2021).

Reflective Supervision

Staff completed the Reflective Supervision Rating Scale (RSRS; Ash, 2010) at all three time points (see Table 8). The scores at all three time points remained fairly consistent, all around 38–39, a satisfactory score. Staff scores on the RSRS were not significantly different over time (p = .27). In the evaluation of ECE center-based and home visiting programs, the mean score on the RSRS by staff was similar, about 41, and also consistent over time. Given the findings reported above that how supervision was received and how well it met staff's needs did not change during the initiative, the relative consistency in the RSRS scores over time is not surprising.

Table 8. Reflective Supervision Rating Scale Scores over Time (n = 21)

RSRS Score	Baseline	Time 2	Time 3
Mean *(SD)*	39.2 (*9.44*)	37.8 (*10.89*)	38.7 (*10.46*)
Range	19–51	17–51	17–51

[a] Response scale: 1, "Rarely"; 2, "Sometimes"; and 3, "Almost always." Possible scores range from 17–51. Differences found at Time 2 among FCM, WIC, and other programs were significant at p = .053; WIC mean scores were higher (M = 42.6, SD = 8.93) than FCM mean scores (M = 30.3, SD = 9.85) and Other program means (M = 34.0, SD = 13.11)

Interviews with supervisors and staff confirmed findings from the staff survey about the nature of relationships between supervisors and staff before and during the implementation of the Illinois Model. That is, FCM and WIC staff and supervisors across all four public health departments reported generally positive relationships. However, supervision occurred on an as-needed basis rather than on a regular basis. Staff described their individual supervision as informal and unscheduled. "My door is always open," a supervisor said in her baseline interview. For example, a family case manager would request a meeting with her supervisor when she had an issue concerning a family on her caseload or a question about scheduling and work tasks. Another family case manager described the supervision she received as a "very open, constant conversation," albeit not regularly scheduled. Despite the lack of scheduled individual meetings with their supervisors, several staff said that they received adequate supervision and support and had a trusting relationship with their supervisor. One staff person said:

> *I can go to [my supervisor] whenever I feel necessary, and she leaves me to do my work and trusts me to do my work like it needs to be done. So she's not always on top of me about things. She knows I'm going to get my work done. And then, that's good that she trusts me enough to do that.*

In addition to receiving guidance from their supervisors about their family cases, they also felt comfortable sharing concerns about stress and workload. For example, a staff person in the WIC program indicated that she would call her supervisor or a coworker when she felt stressed at work. She also let her supervisor know when she needed help talking with frustrated parents:

> *When moms are angry or cussing, I feel stressed. I transfer angry calls to my supervisor. I also talk to the office manager, who is always in her office and share concerns around moms feeling frustrated. When they are frustrated, I'm also frustrated. But I like my job. The office manager and I discuss where else moms can get help, and we (interviewee and office manager) can work together.*

At another health department, a family case manager indicated that the supervisor was very aware of her concerns regarding a particular family on her caseload. The supervisor contacted the doctor to further address concerns and ensured that the family received appropriate services. "I feel like [my supervisor] knows if I'm generally concerned, she takes action." A WIC staff member at another health department said she regarded her supervisor as an expert and brought issues to her related to specific topics, like breastfeeding. Perhaps influenced by the mental health consultant, a supervisor from the same health department reported guiding another WIC staff person by "brainstorming strategies" together to address concerns about family cases as well as locating relevant resources that the staff could share with the families.

However, there also was evidence in the interviews of supervisors having limited interactions and relationships with their staff about families on their caseloads or other matters. Topics of discussion between the staff and supervisor were typically limited to program- or organizational-level issues, such as the new EBT system, technical questions, and program policy and procedures. The staff person and supervisor did not discuss as often staff's concerns and challenges related to families or children. Some staff reported sharing concerns related to families or children with their colleagues instead of their supervisors. One staff person felt that her supervisor had limited understanding about assisting families and chose to talk about her concerns and stress sources with her more knowledgeable colleagues. Another indicated that her program had recently hired a new supervisor, who was more focused on administrative duties (such as finance and grant writing) and not often available to discuss family cases.

A family case manager expressed that she needed more guidance as well as more learning opportunities because of evolving job responsibilities. One staff person mentioned that she has very little interaction with her supervisor, who she felt had limited appreciation and understanding about working with families, and she would rather seek help from the mental health consultant and her colleagues. Several family case managers would report issues or concerns related to families to their supervisor only if the issues were serious, such as possible domestic violence, severe depression, or child abuse.

At the end of the implementation period, there was little evidence of change in supervision over time. Staff and supervisor interviews at Time 3 mostly reported changes in supervision structures because of the COVID-19 pandemic rather than the goals, content, or approach of supervision. For example, one supervisor told us:

> *I'd say [the only change in supervision is] just physically how we do it. It's a lot more electronic communication and rather than having weekly meetings that we used to do in person—they were very routine—it's kind of as needed now. But I think as far as the big picture stuff we're still doing it the same way: what might have been in person before now is just an email but I think we're still able to provide the same level of supervision and then still cover the same basic accountability that I'm looking for and being able to get them the resources that they need. That hasn't changed too much.*

On the other hand, an exception was a supervisor who indicated that she had changed her approach to supervision as a result of her work with the consultant. The supervisor explained:

> *After talking to the consultant, I have changed some of the approaches I use in the clinic and how I talk to staff. Sometimes when I don't know why things are happening, I will just talk it out with [the consultant] and she will say, "Oh, you know, why do you think it happened? What do you think this is? Maybe did you think about it in this way?" and then it opens up a whole other way of me thinking about this situation so I'd say it has really been* ***helpful****.*

Staff Functioning and Well-being

Reflective Capacity

A primary goal of the Illinois Model is to improve the reflective capacity of staff and supervisors. Strengthening provider reflective capacity is also referred to as mentalization, or the ability to interpret one's own and others' mental states (Fonagy et al., 2016). Improving provider reflective capacity may strengthen the reflective capacity of the families served through infant-family services, such as nursing and social work (Heffron et al., 2016). To understand how the Illinois Model affected staff reflective capacity, we administered the Reflective Functioning Questionnaire (RFQ; Fonagy et al., 2016) at each time point.

The Certainty subscale assesses genuine mentalizing. A high score reflects a respondent's understanding of their own and other people's thoughts and feelings, while acknowledging that thoughts and feelings can be difficult to understand. A high score on the Uncertainty subscale reflects an almost complete lack of knowledge about mental states. Thus, high reflective capacity produces high Certainty and low Uncertainty scores. Staff scored fairly high (average scores were around 2 out of a possible 3) on the Certainty subscale at all three time points (see

Table 9) and fairly low (average scores were around 0) on the Uncertainty subscale. These scores suggest high reflective capacity for the sample followed over time. Staff scores on the RFQ were not significantly different over time for the Certainty (p = .87) or Uncertainty (p = .88) subscales. In a previous evaluation of the Illinois Model in early care and education programs and home visiting programs, the mean score on the RFQ Certainty subscale was similar, about 2, but it was a bit higher for Uncertainty, about 0.2 (Spielberger et al., 2021).

Table 9. Staff Survey Responses on Reflective Functioning Questionnaire (n = 24)

RFQ Subscale	Baseline	Time 2	Time 3
Certainty			
Mean (*SD*)	2.21 (*0.68*)	2.25 (*0.68*)	2.17 (*0.73*)
Range	0–3	0–3	0.67–3
Uncertainty			
Mean (*SD*)	0.17 (*0.39*)	0.10 (*0.18*)	0.09 (*0.18*)
Range	0–1.83	0–0.67	0–0.67

[a] Response scale: 1, "Strongly disagree"; … 7, "Strongly agree."

Staff Burnout

To assess whether working with a mental health consultant would impact staff engagement with their work, we measured burnout with the Maslach Burnout Inventory (MBI; Maslach et al., 1996). The measure has three subscales: Emotional Exhaustion (feeling emotionally overextended by one's work), Depersonalization (unfeeling and impersonal toward others), and Personal Accomplishment (feelings of competence and achievement in one's work).

Table 10 presents the staff scores for the three subscales on the MBI over time. On the Emotional Exhaustion subscale, the scores for staff were very low and remained very low over the course of the study. The mean scores ranged from 15.8 to 17.1 (possible range of 0 to 54). Staff scores on the Emotional Exhaustion subscale were not significantly different over time (p = .29). In the evaluation of the Illinois Model in early care and education programs and home visiting programs, the mean score on the Emotional Exhaustion subscale had a similar range, from 15.1 to 17.5 (Spielberger et al., 2021).

The Depersonalization subscale also had very low scores over time for staff with mean scores ranging from 2.8 to 3.5 (possible range of 0 to 30). Staff scores on the Depersonalization subscale were not significantly different over time (p = .98). In the evaluation of the Illinois Model in early care and education programs and home visiting programs, the mean score on the Depersonalization subscale ranged from 3.8 to 5.0 (Spielberger et al., 2021), which is a bit higher than in this study.

The Personal Accomplishment subscale had high average scores for staff—around 40 at each time point (possible range of 0 to 48)—so scores were not significantly different over time. In

the evaluation of the Illinois Model in early care and education programs and home visiting programs, the mean score on the Personal Accomplishment subscale ranged from 35.1 to 36.3 (Spielberger et al., 2021), which is a bit lower than in this study.

Table 10. Survey Respondent Scores on Maslach Burnout Inventory Subscales over Time (*N* = 25)

MBI Scale	Baseline	Time 2	Time 3
Emotional Exhaustion	(*n* = 24)	(*n* = 24)	(*n* = 24)
Mean (*SD*)	15.8 (*13.80*)	17.1 (*13.19*)	16.6 (*15.37*)
Range	0–41	0–47	0–47
Depersonalization	(*n* = 24)	(*n* = 24)	(*n* = 24)
Mean (*SD*)	2.8 (*4.95*)	3.5 (*4.39*)	3.4 (*5.00*)
Range	0–18	0–18	0–18
Personal Accomplishment	(*n* = 23)	(*n* = 23)	(*n* = 23)
Mean (*SD*)	40.4 (*5.27*)	40.7 (*3.38*)	40.0 (*5.81*)
Range	29.7–48	34–48	24–47

[a] Response scale: 0, "Never"; 1, "A few times a year or less"; 2, "Once a month or less"; 3, "A few times a month"; 4, "Once a week"; 5, "A few times a week"; and 6, every day."
Note: Score ranges are 0–54 for Emotional Exhaustion, 0–30 for Depersonalization, and 0–48 for Personal Accomplishment.

Self-efficacy

The staff survey included two measures of self-efficacy: The Teacher Opinion Scale (TOS; Geller & Lynch, 1999) and the Goal Achievement Scale (GAS; Alkon et al., 2003). We used a version that we adapted, with the authors' permission, to be more applicable to mental health consultation in home visiting and other programs that work more directly with parents than with children. The TOS consists of 12 items that measure early childhood providers' feelings of confidence in managing challenging behaviors and their ability to make a positive difference in the lives of children. As shown in Table 11 the TOS scores were consistently high over the course of the study, with no differences over time. In the evaluation of ECE center-based and home visiting programs, the mean scores on the TOS ranged from 46.2 to 47.6 (Spielberger et al., 2021).

Table 11. Staff Survey Responses on the Teacher Opinion Scale over Time (*n* = 22)

TOS Scale	Baseline	Time 2	Time 3
Mean (*SD*)	43.9 (*5.48*)	44.0 (*5.05*)	43.5 (*5.32*)
Range	35–55	37–58	31–56

[a] Response scale: 1, "Strongly disagree"; 2, "Disagree"; 3, "Neutral"; 4, "Agree"; and 5, "Strongly agree." Scores can range from 12 to 48.

The GAS measures staff sense of competence in their role relative to general mental health activities or program goals, including the ability to manage child behavior. Table 12 shows the GAS scores for staff over time. The scores were consistently positive over time (ranging from

20.0 to 20.4). Staff scores on the GAS were not significantly different over time (p = .86). In the evaluation of the Illinois Model in early care and education programs and home visiting programs, the mean score on the GAS was a bit higher, ranging from 22.1 to 23.1 (Spielberger et al., 2021). This might reflect the fact that staff in these programs interact more frequently and directly with children and families than the public health staff do.

Table 12. Staff Survey Responses on Goal Achievement Scale (n = 21)

GAS Scale	Baseline	Time 2	Time 3
Mean (*SD*)	20.0 (*3.56*)	20.2 (*4.84*)	20.4 (*4.71*)
Range	11–26	9–26	10–26

[a] Response scale: 0, "Not at all"; 1, "Somewhat"; and 2, "Very much."

Reflective Supervision, Reflective Capacity, and Burnout

The theory of change suggests that strengthening reflective supervision, staff reflective capacity, and staff self-efficacy may reduce burnout. To test this, we first ran a correlational analysis to look for any associations between an increase in reflective supervision (RSRS, baseline to Time 3 change score), staff reflective capacity (RFQ Certainty and Uncertainty subscales, baseline to Time 3 change scores), and staff self-efficacy (TOS and GAS, baseline to Time 3 change scores) with a reduction in burnout (MBI-Emotional Exhaustion, baseline to Time 3 change score). As Table 13 shows, increases in staff reflective capacity, quality of reflective supervision, and staff self-efficacy were associated with a decrease on the Emotional Exhaustion subscale of the burnout measure. In addition, improvement in the quality of reflective supervision was associated with improvement in reflective capacity (RFQ Certainty), self-efficacy (TOS) and competence in dealing with challenging child behaviors (GAS).

Table 13. Correlations among Staff Burnout, Reflective Capacity, Self-efficacy, and Reflective Supervision (n = 24)

Construct/measure	1	2	3	4	5
1. Emotional Exhaustion (MBI)					
2. Reflective Supervision (RSRS)	-.70***				
3. Reflective Capacity – Certainty (RFQ-C)	-.63**	.52*			
4. Reflective Capacity – Uncertainty (RFQ-U)	.06	-.25	-.42*		
5. Job Self-efficacy (TOS)	-.65**	.65**	.62**	-.32	
6. Competence Managing Child Behaviors (GAS)	-.48*	.52*	.54**	-.29	.38^

***p < .001, **p < .01, *p < .05, ^p < .10

Note: All Pearson's correlations were conducted using change scores between baseline and Time 3 for each variable.

To understand the relationships among these variables, we conducted regression analyses. We found that an increase in reflective supervision quality and increase in reflective capacity predicted a decrease in the Emotional Exhaustion subscale of the burnout measure. We ran a

hierarchical multiple regression to predict change in the Emotional Exhaustion subscale. We entered the predictor variables starting with the strongest association with burnout. All variables were each scale's change score from baseline to Time 3. The model with the best fit was one in which change in reflective supervision (RSRS) and the Certainty subscale of the reflective capacity measure (RFQ-C) predicted change in the Emotional Exhaustion subscale, $F(2, 19) = 8.89$, $p = .002$ (see Table 14). Increase in the quality of reflective supervision significantly predicted a decrease on staff's Emotional Exhaustion subscale. Adding change in the Certainty subscale of the reflective capacity measure significantly increased the amount of variance explained in the decrease on the Emotional Exhaustion subscale. Together, increases in reflective supervision and reflective capacity explained about 48% (43% adjusted) of the variance in decreases on the Emotional Exhaustion subscale. Thus, strengthening the quality of reflective supervision and staff's reflective capacity predicted reductions in burnout.

Table 14. Change in Reflective Supervision and Reflective Functioning Predicting Burnout (n = 24)

		ΔR^2	Final model β
Emotional Exhaustion			
Step 1	Reflective supervision	.334*	-.358^
Step 2	Reflective capacity certainty	.149*	-.445*
	Total R^2 = .483* (adjusted .429)		

*p < .05, ^p < .10
Note: All variables were the change score from baseline to Time 3.

Depression: Personal Health Questionnaire (PHQ)

The Personal Health Questionnaire (PHQ-2; Kroenke et al., 2003) is a two-item screening measure of depression. At each time point, staff scores on the two-item PHQ depression screen were low, indicating that they tended to have few depressive symptoms. Scores did not differ significantly over time. The mean scores from the public health staff sample were just slightly lower than the scores obtained in the evaluation of the Illinois Model in early care and education center-based and home visiting programs (Spielberger et al., 2021). The mean score on the PHQ-2 in that study ranged from 0.7 to 0.9 (see Table 15).

Table 15. Staff Survey Responses on Personal Health Questionnaire (N = 25)

PHQ Scale[a]	**Baseline**	**Time 2**	**Time 3**
Mean *(SD)*	0.64 (*1.11*)	0.88 (*1.36*)	0.56 (*1.04*)
Range	0–4	0–5	0–4

[a] Response scale: 0, "Not at all"; 1, "Several days"; 2, "More than half the days"; and 3, "Nearly every day."

Staff Knowledge of Social-Emotional Development

The survey included a measure of staff's perception of whether they gained knowledge and strategies related to child social-emotional development—a key component of IECMHC—over the course of implementation. The measure is an adapted version of the Social and Emotional Development Inventory (SEDI; Shivers, 2011). Staff were not given the measure in the baseline survey and were administered it at Time 2 and Time 3 as long as they responded that they were currently receiving mental health consultation. Table 16 presents responses representing staff self-assessment of knowledge and skills gained as a result of the intervention. The mean score at Time 2 was 3.1, or "neutral," but at Time 3, it increased to 3.6, closer to "agree." This was a significant increase in staff knowledge and strategies, $t(13) = 2.51$, $p = .026$.

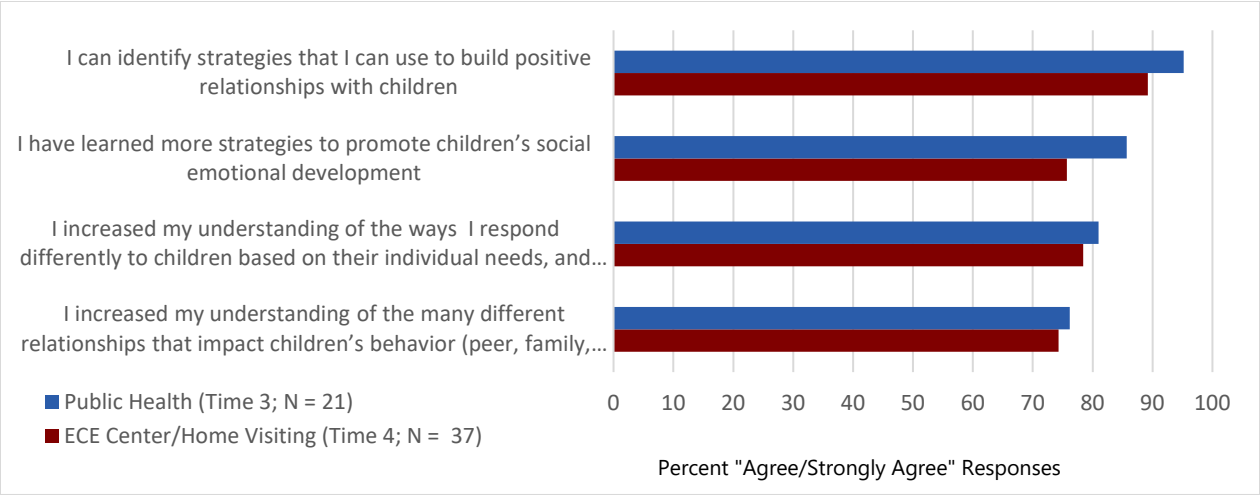
Table 16. Staff Survey Social and Emotional Development Inventory (n = 14)

SEDI Scale[a]	Time 2	Time 3
Mean (*SD*)	3.1 (0.60)	3.6 (0.85)
Range	1.88–4	1.38–5

Note: Measure was not included in baseline survey.
[a] Response scale: 1, "Strongly disagree"; 2, "Disagree"; 3, "Neutral"; 4, "Agree"; and 5 "Strongly agree."

We compared responses to selected items from the SEDI that seemed most applicable to both the public health departments and the ECE center-based and home visiting programs (Spielberger et al., 2021) at the final data collection point. These results, which are displayed in Figure 6, did not indicate any noteworthy differences between the two samples. Both groups of providers assessed themselves as gaining considerable knowledge of social and emotional development and new strategies for working effectively with families and children.

Figure 6. Comparing Staff Responses to SEDI at Last Data Collection Point in Public Health and ECE Center-based/Home Visiting Programs



The SEDI 5-point response scale ranged from "strongly disagree" to "strongly agree."

Views of Impacts from Interview Informants

Qualitative interviews provide additional perspectives on the impacts of consultation on supervisors and staff in public health programs. As noted earlier, both consultants reported variation among the four health departments in implementation and effects on staff related to differences in their location, size, and organization. Overall, however, both consultants felt that at the mid-point of the pilot, staff and supervisors were making modest progress in terms of understanding the purpose of consultation and using it as a resource, even though they were still developing the ability to reflect on their work and their relationships. Indeed, they expressed satisfaction with where staff and supervisors were in the process of developing reflective practice, given that they had little, if any, previous experience. As one consultant explained:

> *Again, it's a process. It's like being someplace and leaving and thinking, "Whew, this day went really well, this felt really well." I interacted with this person and that person, and that felt good. . . . I guess I'm feeling right now like we have done a lot of work in both places, and there's a sense that I'm going to show up every week and I'm available, and we might – at the very least I'm going to ask a few people how are things going, anything you've been thinking about or want to talk about. And so, I'm satisfied with that.*

The consultants were impressed with the skills of the staff and their ability to convey to the consultant what information they needed and then to implement the knowledge they gained into their work. They also noted that individuals who were willing to meet regularly with the consultant and put in more time during meetings seemed to benefit more than others. As an example, a consultant recalled a supervisor who did not limit her time with the consultant to the typical 15-minute block of time, but instead allowed for more time to reflect and process a concern she had:

> *It was really helpful that [the supervisor] was willing to put in that kind of time because I think that by her talking through it and us talking through like challenges in the program or things that she was going through with staff members or different things, she was able to gain reflective capacity. She was able to gain [knowledge of] how to ask reflective questions, like how to ask questions differently where staff was [able to] take a different perspective of the questions she was asking.*

Below we describe some of the themes that emerged from qualitative interviews with staff and supervisors about what they gained from consultation.

Growth in Understanding of Mental Health Consultation

Staff who participated in the pilot expressed understanding the role of a mental health consultant as someone who provided the staff with guidance for managing challenges with their families. Some WIC staff and family case managers also felt that the mental health consultants helped them with personal issues that affected their performance at work. For example, a WIC staff member commented that the consultant "helps me learn how to take a moment for myself, and to listen, rather than trying to solve and fix things, which many families need." A family case manager reported that the consultant "is there to support staff if they have challenges with a particular family. . . or if they are having issues in their own personal life that affect how they do their job."

Building Relationships and Trust with the Consultants

The interviews suggest that the support staff received from the consultants served as the main facilitator to promote the staff's trust and comfort in engaging with the consultation. Many staff developed relationships with the consultants and trusted that they would listen and provide guidance. For a lot of the staff, the consultants were available in several forms, including in person, email, phone, and text. WIC staff reflected that the consultant let staff know that she was always available, whether at the program or through email. One staff member noted that during the pandemic, the consultant "left each one of us with her business card and her email contact information. And she always let us know that if anything came up before she was able to speak with us, just to always [keep] in contact with her. And she had no issues with that." Other staff and supervisors commented that it was reassuring that the consultants were available by email or telephone as needed.

Staff reported positive relationships with the consultants. "She was above and beyond. . . I was able to talk to her for personal reasons and for professional reasons," one staff member said. "I feel like she was very open to that. And she was very understanding of everything." Another said it felt "very comfortable" meeting with the consultant, and "I could talk to her about anything."

Developing Strategies for Working with Families

In interviews, staff described difficulties they had communicating with parents with depression and anxiety, as well as parents who did not want to be educated about their or their child's development or nutrition. One WIC staff member tried to manage communication challenges by "[being] brave" and opening up to families to communicate her knowledge to them. Over the course of the pilot, this staff person felt that she had gained more knowledge about breastfeeding, as well as confidence passing along the information to mothers. When asked about negative feelings staff might experience at work, another WIC staff member indicated that she had learned to wait until families were open to sharing their issues and that she would try to

be understanding of the families. The staff member also mentioned that she tried to be a good listener and offer advice.

> *In a way, sometimes I can understand that some families don't want to hear what you have to say. . . . I try to be understanding with them, I guess. Sometimes it is kind of frustrating. You kind of expect it when it does happen, and you just brush it off, I guess. . . . In my earlier days in the WIC program, it might have bothered me a little bit more, but now, it's not as much because I just understand that there's going to be people like that. They just don't want to be educated or told that they're doing something that's not recommended. Now, I just understand that I have to wait until they're open. They're just not open right now to hearing about things.*

Increased Reflective Capacity

Supervisors from most of the public health departments highlighted increases in reflective capacity—for both themselves and staff—as a central benefit of having worked with their consultants. The consultants' process for developing reflection often began by asking questions that encouraged staff and supervisors to think differently about various situations. For example, questions encouraged staff to consider a family's context instead of jumping to conclusions. Supervisors subsequently observed that in their interactions with families, staff became more likely to change the way they approached families who were resistant to suggestions. These changes included giving them more information and more space to think about a recommendation. In the example below, the supervisor's reference to "a little drop of information" comes from a strategy of the Fussy Baby Network®s FAN approach (Gilkerson, 2015) that consultants used in their work with staff and encouraged them to use with their families.

> *I hear [the impact of consultation] differently from different staff. I think it has to do with how they hear what they've learned, and how they use that information. For example, I've got one employee who will always say, "So the mom was talking about this, but I know she wasn't ready to hear from me. . . . So she was talking to me about how she's planning to cosleep with the baby, and I knew that she wasn't ready to hear from me that's not best practice, that's not what we recommend." So [the staff] would leave like a little drop of information and say, "What do you know about that? Do you know about any dangers that might be associated with that?" So then the next time [she would] circle back to it. So I have a couple of employees that even use those phrases and document it that way; "I left a drop of information about this to get them to think about it, so that we could come back and talk about it again later." It's definitely been*

> *positive; I can say that. I think that the other part of it is just stopping and thinking and reflecting on stuff is a huge piece of it that's so important for working with families, so that we take a moment and take a pause.*

Supervisors also talked about how their own increased reflective capacity improved their interactions with their staff. Similar to how staff began interacting with families in more intentional and curious ways, supervisors reported that they, too, began considering context in their challenging interactions with staff. One supervisor said:

> *I have an issue and I go to [the consultant] about it and she'll say, "Why do you think they said this? What makes you think?". . . . She makes me ask myself these questions in which I come up with my own answers; she's not giving me the answers. So the next time when I'm in situations I started asking these questions and that actually has driven me to make better decisions and be more positive about certain situations. . . . Sometimes I don't like to write up people and I don't like them getting upset with me, you know, but I have to do my job. . . . So, you know, she says, "This is the better way to do it. Put it in this kind of context." So I have grown because she's made me think about it and asks me certain questions. Like, okay, if you ask this question why would you think this was a thing? What would you have done differently? And so it makes me want to ask these questions in different situations. . . where I have to do these confrontational talks and it just helps.*

Similarly, another supervisor talked about the growth she experienced, which resulted in her taking more time to respond. She said, "I think I've become less. . . proactive and more reflective. . . . I work real hard on trying not to instantaneously react and take some time, get a little more knowledge."

Most of the staff had a positive experience with the consultants—receiving reflective consultation and training on social and emotional development and mental health throughout the pilot—and believed that it was effective overall. One family case manager indicated, "We were all so sad when we realized the program was coming to an end." Although a few staff felt unsure if every staff person needed to use consultation in their program, most thought it was a very beneficial support and that there was an ongoing need for that kind of support. As a WIC staff member stated, "I think it's always good to have a consultant on hand, that we could reach out to somebody. I think it would be good for our agency."

Overall, the WIC staff and family case managers across the health departments hoped that the consultation would continue after the pilot. Most of the staff expressed positive views about the MHC pilot and believed that continuing the MHC program would benefit the programs and agencies. A WIC staff member commented, "It's nice having someone to talk to and bring up

issues." A family case manager said, "I would love [the consultant to continue to work with us]. I think that would be great for our programs and our staff." Another told us, "I think it can be beneficial for new staff and I think it can be beneficial for those in home visiting programs who work very intensively with families on a weekly basis."

At the same time, one staff member acknowledged being uncertain about the need for or value of consultation. This staff member had consistently worked in public health programs for several years. As an experienced professional, she was perhaps less open to consultation because she felt she already had resources and support for stress management and self-care. She explained, "I didn't feel a need for the mental health consultant. And I think over the years I learned to leave the job at the job, so I'm no longer taking it home with me. So, I think that makes a big difference too."

Chapter Summary

Qualitative data from interviews with consultants, supervisors, and staff all indicated that because of the pilot, there was modest growth in reflective capacity over time and increased skills in communicating and working with families. They also expressed an ongoing need for mental health consultation in their public health departments. Staff scores for items about their knowledge of strategies related to child social-emotional development on a self-assessment instrument used in the survey significantly increased. This scale was included in the survey at Time 2 and Time 3 (not at baseline), so the growth in knowledge and skills occurred between January and July of 2020, during the pandemic.

On the other hand, standardized measures of staff–supervisor relationships, reflective capacity, and staff well-being did not show change. Staff reported relatively consistent levels on all constructs we measured in the surveys. Staff members' perception of the quality of reflective supervision and how well it met their needs remained high over the course of the initiative. Reflective capacity was also rated high at baseline and remained consistent throughout the study. Staff burnout and depression started low at baseline and remained so throughout the initiative. Self-efficacy and sense of competence in their work was relatively high and remained stable.

We found relationships among some of the staff well-being variables. An increase in reflective supervision quality and increase in reflective capacity predicted a decrease on the Emotional Exhaustion subscale of the burnout measure. Thus, strengthening the quality of reflective supervision and staff's reflective capacity predicted reductions in burnout.

Discussion and Conclusions

The Illinois Model of IECMHC was designed to improve the skills of early childhood professionals who care for and work with young children and their parents in a range of systems and programs. The purpose of this study was to explore the feasibility of implementing the Illinois Model in public health programs and determine what adaptions to the model would make it more viable and sustainable in public health departments. Although the focus was on implementation, we also attempted to examine its potential effects on public health staff and supervisors. Because program staff and supervisors receive the intervention directly, the theory of change for the model assumes that we will see changes in supervisors and staff. For example, expected outcomes included improvements in reflective capacity and well-being, relationships between supervisors and staff, and knowledge of social and emotional development. The theory of change suggests we would see such differences in supervisors and staff before changes in families or children, which are longer-term outcomes. Another longer-term outcome expected from mental health consultation is a stronger, more effective workforce with an increased ability to serve families who face challenges that put them at risk.

To pilot this model, the implementation team and the Illinois Department of Public Health (IDPH) selected four unique public health departments that varied by geographical location and by the demographics of the population served. The purpose of the study was not to compare the four health departments but to look across them at the feasibility of implementing consultation in public health programs—especially FCM and WIC—and the factors that affect the success of consultation. Two health departments were in the southern parts of the state and two were in the northern regions; all were outside of Chicago and its surrounding county. One health department primarily served an urban area that lacks accessible public transportation, which poses a barrier to families' access to the health department programs. Another health department serves an urban population but also includes some smaller towns and more rural communities in its service area. The other two health departments serve a mostly rural population, one of which covers a geographically wide region of the state.

We used a longitudinal, repeated measures study design with three data collection points with both quantitative and qualitative measures for implementation process and outcomes. We surveyed a sample of staff of FCM, WIC, and other public health programs at three time points: baseline before implementation and then again at 6 months (Time 2) and 12 months (Time 3) after implementation. We also and interviewed a subsample of these staff once at the end of the 12-month implementation period. Additionally, we conducted semi-structured interviews with selected administrators, supervisors, and consultants at the same three time points. We

collected supplemental information from consultant logs, which consultants completed after each contact with the health departments for the 12-month intensive implementation period and a subsequent 3-month sustainability period.

Baseline interviews with consultants and supervisors allowed us to gain some understanding of the community and program contexts that were likely to affect implementation and impacts of the model. These factors included the needs and goals of the health department staff; the relationship between the consultant and health department staff; program goals, funding, and structure; the stability of staff and organizational leaders; and their readiness to work with a mental health consultant.

Below, we first summarize our key findings by research question and then discuss the contributions and limitations of the study. We conclude by discussing implications of the findings for the Illinois Model, practice and research.

Summary of Findings

RQ1: How is the Illinois Model of IECMHC implemented? How are services delivered by the consultant and to whom? Do consultants feel prepared for their work? Are FCM and WIC program staff ready to engage with the consultant?

The Illinois Model was successfully implemented in all four health departments as measured by structural and process indicators of fidelity. From the consultant logs, we found that all four health departments received over 90% of their goal hours of consultation. We learned that the consultants spent about half of their time engaging in a practice termed “mindfully hanging out,” which is integral to the development of relationships with staff and supervisors. “Mindfully hanging out” helps staff and supervisors move on to the more substantive reflective consultation activity.

Most of the consultation work that was part of the project was done in dyads—with the consultant and the staff or supervisor. Although this was not the approach favored by the Illinois Model, it was a necessary modification to the model based on the needs of the health departments. Initially, consultation was to occur on a “drop-in” basis with staff and supervisors seeking the consultant out during her predetermined consultation hours. At some health departments, however, only a few staff engaged with the consultant using the “drop-in” approach. Additionally, in some locations, the space where the consultant worked was too far from the FCM and WIC programs for anyone to "drop-in" on the consultant. Even after this logistical issue was addressed, however, the drop-in approach was not the best fit for all the health departments. Thus, two health departments decided to start scheduling staff in advance so each staff person would have access to the consultant at least once a month.

The consultants were highly experienced in consultation. Because of their previous experience and the training in the Illinois Model that they received before starting their work with the health departments, they felt prepared to provide mental health consultation. For the most part, supervisors voiced strong support for the implementation of consultation. However, it took them time to understand the approach of the model and, in turn, encourage staff to engage with the consultant. As a result, staff were uncertain about its purpose and slow to take up the opportunity. From the consultants' perspective, FCM and WIC staff members were not quite ready to engage in consultation and could have benefited from additional orientation to consultation and the Illinois Model.

RQ2: How does mental health consultation affect FCM and WIC staff and supervisors? How does it increase their capacity to serve children and families? Is there evidence that FCM and WIC staff can engage families in a consultative, collaborative manner?

Over the course of the study, staff members reported relatively consistent levels of all constructs we measured in the surveys. Their perception of the quality of reflective supervision and how well it met their needs also remained consistent on standardized measures. Reflective capacity was fairly high at baseline and remained so throughout the study. Staff burnout and levels of depression were low at baseline and also did not change over time. Self-efficacy and sense of competence in their work was relatively high and remained stable over time.

Additionally, we found a relationship among reflective capacity, reflective supervision, and the Emotional Exhaustion subscale of the burnout measure. Specifically, increases in the quality of reflective supervision and in the Certainty subscale of the reflective capacity measure predicted a decrease on the Emotional Exhaustion subscale of the burnout measure. Thus, strengthening the quality of reflective supervision and staff's reflective capacity predicted reductions in burnout.

At the same time, there was evidence in the qualitative data that staff who engaged with the consultants developed new capacities to understand the perspectives of families and new ways to communicate with them. Likewise, supervisors who engaged with the consultants gained new ways of working with their staff and ways to encourage reflection. Supervisors and staff appreciated the fact that consultants were available at designated times each week—and, during the pandemic, available at these and other times by email and telephone—and willing to listen to and help them figure out how to manage their concerns.

RQ3: Since IDPH, like other state agencies, is attempting to serve more welfare-involved and other high-risk populations in public health programs and staff need more support to do so, how does IECMHC assist systems/agencies in serving more families, especially those with greater needs?

As discussed in the report, consultants helped staff understand the perspectives of families and develop new ways to communicate with them. Staff valued their support and felt they benefited from it, even during the pandemic period. Additionally, supervisors also assisted in understanding the perspectives of their staff and developed new ways to communicate with them. We surmise that the knowledge gained by both staff and supervisors is evidenced in our survey results. That is, we found a significant increase in staff members' knowledge and strategies related to family well-being and child development from Time 2 to Time 3 and that increases in the quality of reflective supervision and in the Certainty subscale of the reflective capacity measure predicted a decrease on the Emotional Exhaustion subscale of the burnout measure. This suggests that the Illinois Model has promise for strengthening both the public health workforce and the public health system. However, the implementation period was too short to fully develop the reflective capacity of staff who received consultation and to determine how the model can build the capacity of agencies and systems to serve more families in the state.

Study Contributions and Limitations

As a small, exploratory study, this pilot makes important contributions to the growing body of IECMHC research literature. This is one of the first efforts to incorporate a mental health consultant into multiple public health departments. Despite implementation challenges, it was successful. The mixed methods used in the study, especially the qualitative interviews, provide considerable information about implementation experiences and the factors that helped and hindered implementation. The information from this study provides several lessons on ways to incorporate mental health consultation and screening of maternal depression and child development in public health programs—and both the challenges and benefits of doing so. Given the goals and scope of the study, there were a few limitations that should be considered:

- *Short study and implementation period.* As mentioned above, 12 months of intensive consultation was not long enough for a consultant to establish relationships with staff and supervisors and fully engage all of the staff in the consultation process. A longer study period likely would have allowed for stronger relationships and trust to develop and, in turn, accomplish more effective reflective practice.
- *Lack of a comparison group*. We did not have a comparison group of health departments serving similar populations as the four in our study, but not receiving any mental health consultation. If we had had this comparison group, we could have learned more about the impact of consultation.
- *The COVID-19 pandemic health crisis*. COVID-19 created a gap in continuity of relationships with the consultants and changed how consultation was provided. The shift

to virtual services came just after the midpoint of the initiative, just as the consultants settled into a pattern with each health department. The pilot timeline was essentially cut into two parts: pre-COVID and during COVID. (It also seemed to decrease staff and supervisors' availability to participate in the evaluation, given the smaller survey response rate at Times 2 and 3.) We can only infer how consultation in these health departments would have proceeded without the pandemic.

- *Data on consultant activities*. The consultant logs were a valuable source of information for the evaluators, the consultants, and their supervisors. However, they need further refinement to make them more useful for these groups. For example, consultants should be able to refer back to their earlier entries for monitoring and planning purposes. We had hoped to include brief encounter forms from staff and supervisors in the FCM, WIC and other departments engaging with the consultant to gather their perspectives, but we were advised that staff would not have time for this kind of documentation.

Implications and Recommendations

Given the novelty of the public health programs and systems for implementing the Illinois Model of IECMHC, the study yielded several lessons for implementation and research. We discuss these lessons in this section.

Recommendations for Practice: Implementing the Illinois Model

The findings of this study indicate that the Illinois Model can be adapted to public health departments. Compared to other child- and family-serving systems, the public health context limits the length of individual consultation sessions with staff and supervisors. However, regular team meetings and in-service training can provide opportunities to build reflective practice among staff and supervisors. Moreover, even brief, 15-minute consultations can provide some opportunity for questioning and reflection, with the understanding that topics can be discussed further at another time. As one of the consultants told us, the consistency of consultation is more important than the length of time.

Successful implementation depends on the preparation and commitment of health department staff, supervisors, and leadership. In this pilot, administrators, supervisors, and staff received an orientation to the model and the implementation process--sometimes multiple times. However, given the lack of experience with either mental health consultation or reflective practice in public health programs, this orientation was not sufficient. This was especially true in programs with leadership turnover. Both leadership and staff needed a better understanding of what consultation would entail in terms of structure and process. They also needed to understand the distinction between consultation and other mental health services.

Consultants should be involved in the orientation process provided to staff, supervisors, and administrators. This orientation should be comprehensive and offer staff concrete examples (e.g., through video presentations) of the consultant's role to help facilitate understanding and clarify expectations. Further, consultants and supervisors can provide regular refreshers and check-ins to ensure that consultation is being promoted in an ongoing and consistent way. The pilot showed the importance of intentionally promoting consultation at the health departments; consultants should regularly attend group meetings to learn more about public health programs but also to discuss and define the consultative process on a recurring basis.

Below we touch on a few areas of consideration for future implementation:

Implementation Expectations

- Clarify expectations in advance with health department leadership. Mental health consultation leadership should spend time with program leadership prior to implementation to ensure that program leadership understands what consultation is and what it entails. These discussions should include clear expectations for staff, supervisors, and leadership. They should also include expectations about the consultant's availability, schedule, interaction and engagement with staff, regular attendance at team meetings, and other expectations.
    - Focus on building relationships, particularly at the beginning. Developing relationships and building trust is an essential part of the consultation model and should be emphasized, especially in the early months of implementation.
    - Highlight that addressing issues of diversity, equity, and inclusion (DEI) are a central part of the model and will be part of implementation. These issues are important in public health departments in terms of serving families with diverse backgrounds. They also affect staff relationships. Staff and leadership's readiness to engage in DEI discussions could be assessed initially and the consultant can base their work around that assessment, but leadership should be aware of and on board with DEI work as a central component in consultation.

Length of Implementation Period

- Even without the interruption of the pandemic, the study suggests a need for a longer implementation period, for example, 18 months, to fully realize the benefits of consultation. Given the time it takes to develop relationships and for the consultant to understand the structure and staffing of the program, 18 months should be considered the minimum period of time for implementation to occur in a setting that

has had little previous experience with consultation.[5]

Logistical Barriers

- Provide dedicated space for the consultant. Having a dedicated, private space for the consultant where staff know to find her helps facilitate drop-in sessions and relationship building. In addition to being private and known to staff, the space has to be reasonably accessible to staff during regular work hours. Staff need to be able to stop by the consultant's space without disrupting the flow of the work being done around them in their absence.
- Consider more use of video conferencing. While the COVID-19 pandemic drove this implementation strategy, the use of video conferencing as way for consultants and staff/supervisors to connect may also be beneficial in other contexts. Some public health departments had staff located at several different locations, and supervisors were not always in the same location. Video conferencing could facilitate supervision sessions when individuals cannot physically be in the same space together—whether due to pandemic-related restrictions or to program structure.
- Encourage brief, 15-minute consultations. The Illinois Model promotes consultation sessions of sufficient length to allow for reflection, processing of concerns, and problem solving. However, the typical length of consultation in the public health departments—15 minutes—was necessary for most of the consultants' individual sessions with staff. Although staff may not be able to set aside enough time for reflection, processing of concerns, and problem solving in a single session, multiple 15-minute sessions to accomplish all aspects of consultation can be beneficial.

Preparation and Support of Consultants for Public Health Departments

- The two consultants were very experienced with consultation in general and the Illinois Model in particular and, thus, well prepared for implementing a new model in a new system. Their ongoing supervision and participation in reflective practice groups were essential supports. These lessons make clear the importance of continuing this structure. While orienting consultants to specific public health programs and systems also is necessary, we learned that each health department varies in organization and culture; so it will take time at the beginning for the consultant to get to know the individual health departments and programs in which they are providing consultation.
- Emphasize consultant documentation. Documentation of consultant activities is very

[5] In general, it is difficult to specify a time period for implementation given the variations in programs and staff. Our study of the Illinois Model in EC center-based and home visiting programs used a 15-month implementation period followed by a 6-month sustainability period, which did not seem long enough for a number of programs.

important. It allows consultants and their supervisors to reflect on their work and monitor how a new model is being implemented. We recognize documentation can be time consuming; it can seem less important than time spent in direct service. However, it is essential to make sure consultants are ready for their work and to monitor implementation and providing lessons for the field.

Recommendations for Research

The variations in size, structures, and organization of public health departments presented challenges to implementation and reinforced the importance of a flexible model (like the Illinois Model). We recommend additional implementation research with a larger sample and a longer study period—perhaps with a small comparison group—to draw more lessons about implementation and its effects on staff and supervisors. It would also be useful to understand differences in staff needs and consultation activities in FCM and WIC programs. Responses to a few of the survey items suggest differences in the structures of these programs. In turn, that suggests differences in their work and what staff need from consultation. Our study was not able to follow up on these differences.

We also recommend more study of the role of supervisors in the implementation of consultation in public health. Supervisors are less likely to be a focus of research on IECMHC but are integral to supporting the efforts of consultants to improve the knowledge and skills of frontline staff. They also indicate that consultation can help them work more effectively with staff to address their concerns about families and to promote more collaboration within staff teams.

The analysis of impacts on supervisors and staff was limited in this study but it suggests a relationship between increased reflective practice and reduced burnout. These and other relationships are important topics for future research. At the same time, there is a need for more sensitive measures of the expected outcomes of mental health consultation, such as relationships, reflective practice, and staff well-being. It is not clear whether the lack of change we observed over time in this study was the result of a short study and implementation period, a small sample, insufficient sensitivity of our measures, or a lack of impact of consultation on these constructs.

Conclusion

This study and the small body of literature on efforts to implement mental health consultation and other mental health services in public health systems show both the challenges and benefits of implementation. The challenges were largely logistical, but they also included an incomplete understanding of the purpose and processes of consultation. Staff and supervisors who engaged with the consultant reported several benefits, including professional development in a variety of topics helpful to their work, such as trauma, parental depression, children's mental health, and

self-care. Staff also learned new strategies for communicating with families while supervisors learned new strategies for communicating with staff. Although the COVID-19 public health crisis changed the course of this pilot in many ways, it also showed how experienced consultants using the Illinois Model were able to adapt to a new environment. Perhaps the fact that we did not find significant change over time in our standardized measures of staff relationships and well-being suggests consultants play a role in maintaining some stability with staff who seemed particularly affected by these changes. We can only speculate about this. However, it does appear that the model holds considerable promise to benefit staff and families in public health programs and merits further study.

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Appendix

Table A-1. Full Baseline Sample by Program Affiliation

Characteristic	**Baseline Sample** *N* = 47	**FCM program** *n* = 12 (26%)	**WIC program** *n* = 24 (51%)	**Other programs** *n* = 11 (23%)
Gender (%)				
Female	98	100	100	91
Male	2	0	0	9
Race/Ethnicity (%)				
Black	20	42	13	9
White	63	58	57	82
Latino(a)/Hispanic	7	0	13	0
Other	7	0	13	0
Multiple races/ethnicities	4	0	4	9
Age (%)				
Under 20 years	0	0	0	0
20–29 years	23	25	25	18
30–39 years	23	33	21	18
40–49 years	17	8	17	27
50–59 years	28	25	33	18
60 or older	9	8	4	18
Education (%)				
High school diploma	2	0	4	0
Some college/no degree	19	8	29	9
Associate's Degree	26	33	21	27
Bachelor's Degree	49	50	42	64
Master's Degree	4	8	4	0
Years of Experience				
Mean (*SD*)	7.7 (*9.42*)	5.4 (*7.88*)	9.2 (*10.74*)	7.1 (*7.72*)
Range	0.09–31.54	13–27.87	0.09–31.54	1.21–20.21
Number of families served/week				
Mean (*SD*)	35.7 (*29.63*)	33.8 (*12.27*)	42.6 (*37.27*)	21.7 (*20.00*)
Range	0–170	20–50	3–170	0–60
Number of hours worked/week				
Mean (*SD*)	34.2 (*7.93*)	33.5 (*9.22*)	33.2 (*8.60*)	37.3 (*3.44*)
Range	7–40	7–40	7–40	30–40
Health Department (%)				
Health Department A	19	25	25	0
Health Department B	28	25	25	36
Health Department C	26	33	29	9
Health Department D	28	17	21	55