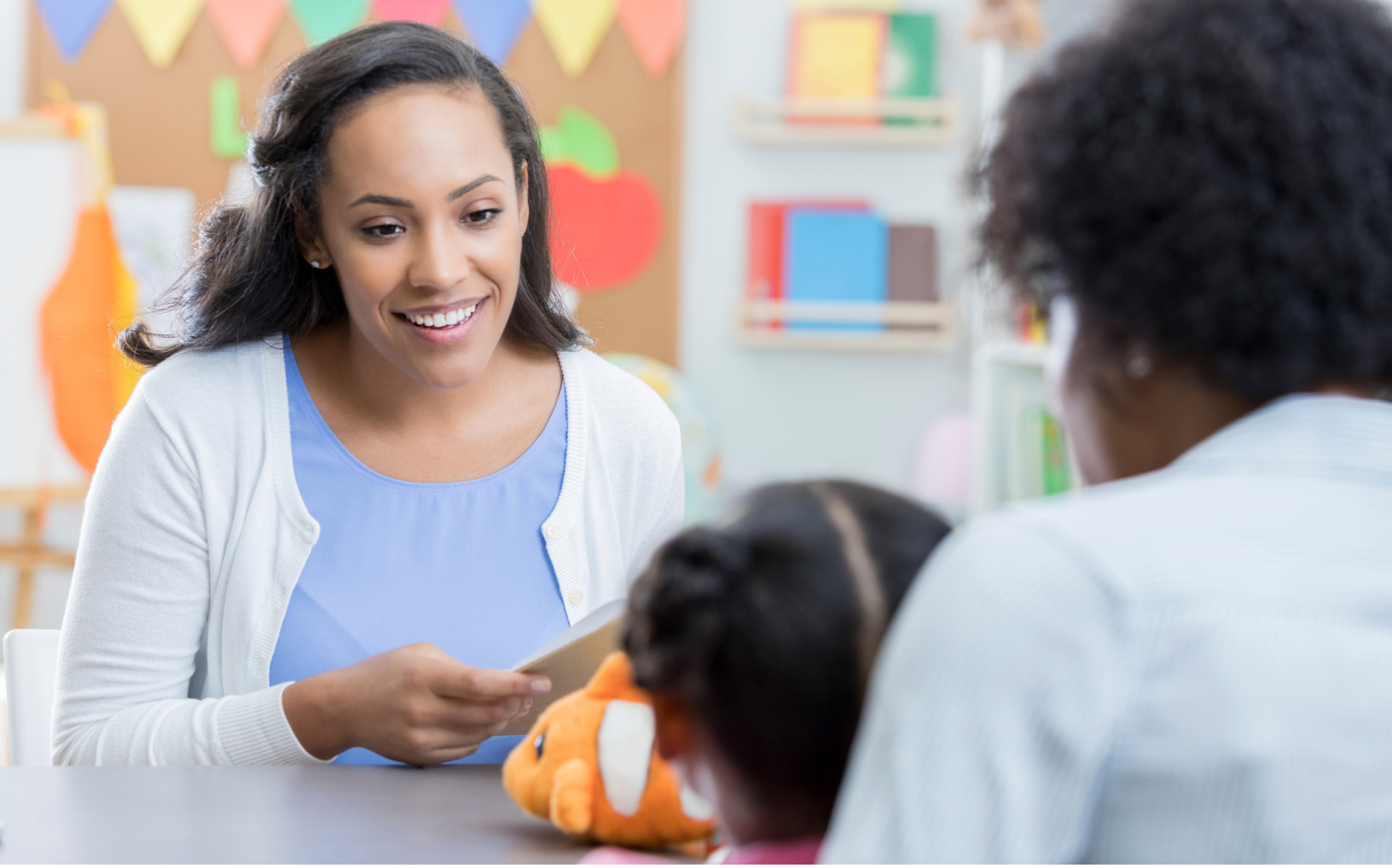

Evaluation of the Illinois Model of Infant and Early Childhood Mental Health Consultation Pilot

Report to the Illinois Children's Mental Health Partnership

Julie Spielberger • Tiffany Burkhardt • Carolyn Winje • Aida Pacheco-Applegate • Elissa Gitlow • Erin Carreon • Lee Ann Huang • Anna Herriott • Reiko Kakuyama-Villaber

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Executive Summary

Infant/Early Childhood Mental Health Consultation (IECMHC) is a relationship-based, collaborative support designed to improve the capacity of early childhood professionals to promote children's mental health (Cohen & Kaufmann, 2000). Social and emotional development is the foundation for success in learning and in life. It begins in children's early relationships with caregivers and is supported by strong partnerships among families, providers, programs, and systems. 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 social and emotional well-being and development of children and families.

A growing body of research has shown IECMHC to be an effective strategy for building the skills of early childhood staff and alleviating their job stress, as well as supporting children and families (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). In addition, considering mounting evidence that preschool children of color experience harsh discipline at disproportionately higher rates than other children (Gilliam, 2005; Giordano, 2019; Giordano, et al., 2020; U.S. Department of Education Office for Civil Rights 2016), there has been strong interest in the potential of IECMHC to mitigate inequitable expulsions and suspensions from early childhood programs. The evidence base for IECMHC has evolved and expanded across multiple early childhood settings, including public pre-K, community-based childcare, and home visiting programs. However, efforts are often fragmented and lack a clearly defined model of consultation.

This report describes the results of a 3-year pilot study of the Illinois Model of IECMHC. The study was part 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. That 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 and develop a plan to integrate consultation into early childhood systems throughout Illinois (Harris Foundation, 2016).

The Illinois IECMHC Model

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. In addition to identifying the goals and critical elements of the model (see Box ES-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 includes a common vision and funding commitment across diverse systems and communities and a workforce development strategy to ensure trained, highly qualified mental health consultants who can 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. (See Box ES-2 for types of consultation in the Illinois Model.) 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) administrators 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

Box ES-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 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, consultants provided services 10-12 hours/month, on average, over 15 months, then 6 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, or parental depression
- Co-facilitation of peer-support groups for program staff and/or caregivers
- Support for staff in meetings with parents

better outcomes. These outcomes include increased self-efficacy and reduced burnout and depression in staff and supervisors; positive social emotional development and better regulated behavior in children; and improved well-being and parenting practices in families.

The Illinois Model Pilot Study

The Illinois Model was piloted in three early childhood systems in four communities—Chicago urban, Chicago suburban, Peoria urban, and Peoria suburban/rural. The sample consisted of 23 early childhood programs, including center-based childcare and prekindergarten and home visiting programs. After matching, 15 programs were assigned to receive the Illinois Model of IECMHC.[1] The period of implementation varied somewhat between year-round programs and programs that closed during the summer. For year-round programs, the full implementation period was 21 months—15 months of intensive support and 6 months of intermittent support. The other eight programs, matched by type, served as a "business as usual" comparison group. Although some of the comparison programs received support from mental health consultants as part of their existing programs, none received services comparable to the Illinois Model.

Box ES-2. Types of Consultation in the Illinois Model

- ***Programmatic Consultation***: In collaboration with supervisors and directors, activities to assess and improve a program's structures, policies, procedures, professional development opportunities, philosophy, mission, and practices to better support the mental health of young children and families.
- ***Classroom and Home Consultation***: In collaboration with supervisors, staff, and parents, activities to assess and improve relationships, routines, and practices that affect the classroom or home climate.
- ***Child and Family Consultation***: In collaboration with families, staff, and other caregivers, activities to understand and respond effectively to an individual child's or family's mental health needs.

The goal of the evaluation was to assess both the implementation and effects of the Illinois Model pilot. The primary research questions were as follows:

(1) Was the Illinois Model of IECMHC implemented as intended? What factors affected its implementation?

(2) What were the effects of the intervention on staff and supervisors? Were there differences between staff in programs receiving the intervention and those in comparison programs in measured outcomes (reflective capacity, supervisor-staff relationships, burnout, depression, self-efficacy, and classroom and home visit environments)?

[1] Initially, there were 24 programs, 16 of which were in the intervention group, but one program withdrew from the pilot during the summer of 2019.

(3) What were the potential effects of the intervention on parent and child well-being and behavior? Were there differences between parents and children in programs receiving the intervention and those in comparison programs?

To address these questions, we used a mixed-methods, matched-comparison group design. During a three-month pre-implementation phase, mental health consultants were trained, and we collected baseline data. We collected additional data at three subsequent time points, approximately 6, 12, and 18 months after the start of implementation. The study drew from multiple sources of data: surveys and interviews with staff and supervisors, observations of classrooms and home visits, and assessments of children and families. Because the data were clustered and longitudinal, we analyzed the staff surveys, classroom observations, child assessments, and home visiting observations using linear mixed modeling, which accounts for missing data and the nonindependence of repeated measures in nested data (West et al., 2007).

Like most approaches to IECMHC, the Illinois Model both promoted use of specific strategies and had to be flexible and responsive to differences in programs in its implementation. Likewise, the evaluation design was rigorous but also had to be responsive to the community and program characteristics of the sample and variations in implementation. In addition to assessing the Illinois Model, this evaluation fills some important gaps in the literature. It provides more in-depth information about the process and challenges of implementing mental health consultation in early childhood systems, and a deeper understanding of the mechanism of change through which IECMHC impacts outcomes. In this report, we summarize our key findings by research question and discuss their implications for policy, practice, and further research.

Key Findings

Research Question 1: Was the Illinois Model of IECMHC implemented as intended? What factors affected its implementation?

Mental health consultants successfully implemented the Illinois Model based on structural and process indicators of fidelity. Despite a number of challenges with implementation, evaluation data on implementation dosage, adherence, and process indicate that the implementation of the Illinois Model was overall effective in both early childhood center-based programs and home visiting programs.

Structural indicators. We used two structural indicators to assess implementation. One was dosage, or the number of hours of consultation, and the other was adherence, or the extent to which consultants' activities were consistent with the model. Consultant logs indicated that all but two of the programs received at least 80% of their expected consultant goal hours. (One program did not because of a complete turnover in staff, and another had a structure that made it difficult for the consultant to meet as frequently with administrative staff as desired.) Although consultant activities varied, all intervention programs received the expected type of consultant

support. The most frequent activities were reflective supervision sessions with individual staff and their supervisors; reflective consultation with directors and supervisors; and reflective consultation with staff (without the supervisor present). There were differences between early childhood center-based programs and home visiting programs in types of activities. There also was considerable variability in activities among the programs in each group, reflecting the flexibility of the model to meet the characteristics and needs of individual programs.

Process indicators of fidelity. Qualitative interviews with program staff and consultants confirmed and added to the findings from the consultant logs. The interview data underscored the ways in which consultants adapted their work to fit the needs of the individual programs. While consultants spoke favorably of their training in the "Diversity-Informed Tenets for Work with Infants, Children, and Families" (Harris Foundation, 2016; Tenets Initiative, 2018), issues of diversity, equity, and inclusion were not a primary topic of consultation in most programs, reflecting an area for future growth in implementing IECMHC. The qualitative data also indicated similarities in the overarching needs of center-based early childhood and home visiting providers and how the Illinois Model can effectively support both types of programs.

Factors affecting implementation. As expected, it took time for consultants to build relationships with program supervisors and staff and develop processes for working together. Several factors impacted implementation. These included the ease or difficulty of scheduling meetings with staff and supervisors; stability or instability of staff at all levels (director, supervision, and staff); and extent to which leaders and staff understood IECMHC and their readiness to engage with the consultant. Indeed, one of the primary facilitators in successfully implementing the model was strong leadership support for consultation.

Research Question 2: What were the effects of the intervention on staff and supervisors? Were there differences between staff in programs receiving the intervention and those in comparison programs in measured outcomes?

Consistent with the theory of change for the Illinois Model, we found positive changes on two standardized measures of staff reflective capacity and a relationship between increased reflective capacity and decreased burnout in a subsample of staff. However, we did not see changes in standardized measures of staff-supervisor relationships (which were assessed quite favorably at baseline) or measures of burnout or depression (assessed low at baseline). Other factors, specifically, teacher position and race/ethnicity, appeared to have a stronger effect on these outcomes than the intervention did.

At the same time, there was evidence of an intervention effect on teachers' and home visitors' practices. Interview data confirmed this and revealed the following shifts in practice: 1) active listening and deeper exploration of issues; 2) the ability to think critically about one's reactions

and biases; 3) the ability to consider others' perspectives; and 4) the ability to establish or improve boundaries and be mindful of self-care.

Reflective capacity. Strengthening staff reflective capacity through reflective consultation is an important component of the Illinois Model of IECMHC. The intervention demonstrated positive effects on two measures of staff reflective capacity. The growth in staff reflective capacity was evident in both quantitative and qualitative data, whereas changes in supervisors were only apparent in the analysis of qualitative data, likely because of a small sample.

Being in the intervention group also significantly predicted lower emotional exhaustion, a component of burnout, at Time 3 for a subsample of staff, which was similar demographically to the larger sample. Growth in reflective process and collaboration predicted lower levels of emotional exhaustion, but the intervention was a stronger predictor. Thus, receiving the Illinois Model and building reflective capacity could mitigate staff burnout; however, we need additional research to better understand how consultation and improved reflective capacity can lead to lower burnout.

We also found group differences in burnout by race and ethnicity, indicating that these factors were bigger factors in burnout than the intervention. In particular, staff who identified themselves as White reported higher emotional exhaustion compared to all other racial and ethnic groups. Previous research has found that White providers tend to report higher burnout than Black and Hispanic providers (Salyers & Bond, 2001, in caseworkers; Garcia et al., 2020, in physicians). Although the reasons for these differences are unclear, it might reflect differences either in perceived burnout or in willingness to admit feelings of burnout.

We found that teacher role affected views of supervision and relationships with supervisors. Lead teachers in the intervention group had a more negative view of their supervisor's fidelity and delivery quality, efforts to build a bond or relationship with them, and efforts to support goals and tasks expected to benefit clients than lead teachers in the comparison group. One possible explanation for the difference is that after experiencing reflective conversations with the consultant, lead teachers in the intervention group realized that the supervision they received from their supervisor was not as reflective. Future research should further explore the effects of IECMHC on supervision and teachers' perceptions of supervision.

Teacher reflective capacity and child outcomes. Teachers with higher reflective capacity reported less teacher stress associated with children's behaviors; rated children's social and emotional strengths related to resilience greater; and rated children as having fewer problems with attention and emotion regulation than teachers with lower reflective capacity. Although directionality cannot be determined from these findings, strengthening reflective capacity might lead to lower teacher stress and shift teachers' perceptions of children to be more positive and strengths based. It is also possible that teachers' more positive views of children lead to less

stress and greater reflective capacity, as stress limits one's ability to be reflective (Ferguson, 2018). As Roffey (2012) noted, "How teachers feel makes a difference to their ability to respond effectively to the challenges they face" (p. 8).

Teacher depression and child outcomes. Although it is not clear whether IECMHC can affect measured depression in staff in the same way it can affect reflective capacity, depression is a variable that has been included in research on IECMHC (Silver & Zinsser, 2020). Greater reflective capacity was associated with teachers perceiving child behavior more positively, but teacher depression predicted more negative views of child behaviors and views of children's abilities to manage their behaviors. This association has a few possible explanations, as we cannot attribute causality: teacher depression could lead teachers to perceive child behavior more negatively; teacher depression could result in children exhibiting more behavioral concerns; or children's behavioral concerns and poor self-regulation skills could exacerbate teacher depression. Additional research could help to clarify this relationship.

Classroom climate. Observations in center-based classrooms showed that teachers in the intervention group were better able to manage children's behavior by enforcing clear, consistent, and developmentally appropriate rules of behavior and using proactive and positive behavior strategies over time than teachers in the comparison group. Teachers in the intervention group were also more likely to promote holistic development through a child-centered and individualized approach over time, although this finding was a trend that did not reach statistical significance.[2] These findings from the classroom observations suggest that center-based early childhood programs that received the intervention had a climate that better promoted mental health, particularly by responding to children in more positive, developmentally-appropriate ways, than programs who did not receive the intervention.

Equity in classrooms. Moreover, greater equity was observed in the classrooms of programs that were receiving the intervention than comparison programs. Diversity, equity, and inclusion is a core component of the Illinois Model. One core competency of the model is the consultant's ability to work effectively throughout diverse cultures and communities through cultural humility. These concepts were emphasized in consultant training before the initiative started and during the implementation of the model through ongoing training, supervision, and reflective learning opportunities, including workshops on the Diversity-Informed Tenets for Work with Infants, Children, & Families (Tenets Initiative, 2018). Thus, the finding that classrooms in the intervention group had higher ratings on equity is promising. However, it also underscores the

[2] Any finding reported as significant in this report is one with a *p* value of .05 or higher. Any finding reported as a trend or tendency is one with a *p*-value that approaches significance, i.e., is between .05 and .10.

need for further research on how the DEI core competency is reflected in home visiting and classroom practices and how to develop that competency.

Home visitor engagement. In the home visiting programs, we observed differences in the video-recorded observations of visits with staff who did and did not receive the intervention. Home visitors in the intervention group more frequently engaged in responsive behaviors during the home visit and elicited input on the content and activities of the home visit from parents than home visitors in the comparison group. In addition, there was a trend for home visitors in the intervention group to facilitate positive parent-child interactions and encourage the parent's leadership in the visit more often than home visitors in the comparison group. When we analyzed the home visit observation items that most aligned with the Illinois Model—essentially creating an IECMHC scale using the Home Visit Rating Scales-Adapted & Extended (HOVRS-A+; Roggman et al., 2010)—we found that home visitors who received the intervention tended to increase on this scale over time at a greater rate than those in the comparison group.

Research Question 3: What were the potential effects of the intervention on parent and child well-being and behavior? Were there differences between parents and children in programs receiving the intervention and those in comparison programs?

Child behavior. The evaluation did not assess children's behavior directly but relied on teachers' ratings. When teachers rated the severity of problems in children who they perceived to have behavioral problems on the Strengths & Difficulties Questionnaire, teachers in the intervention group tended to report less severe behavioral problems over time than teachers in the comparison group. Along with the classroom observation findings, this result supports the theory of change that mental health consultation for teachers can change both their practices to better support children's social and emotional development and their own perceptions of children's behavior. Because our measures were all teacher-reported, however, it is unclear whether these changes reflect actual change in children's behavior.

Contrary to some of the findings in the literature (e.g., Gilliam et al., 2016b), there were no racial or ethnic differences in teachers' assessments of children's behavior. However, consistent with the literature (e.g., LeBuffe & Naglieri, 2012), teachers rated girls significantly differently than boys on the child assessment measures, reporting more strengths and fewer challenges in girls compared to boys. The findings suggest that gender was the strongest influence on teachers' perceptions of children's behavior—stronger than race and stronger than mental health consultation. It may also suggest that another area of focus for mental health consultation is helping teachers better understand gender differences in children's development and behavior.

Family-level home visiting outcomes. Parents whose home visitors received the intervention tended to report higher satisfaction in their role as parents than parents whose home visitors

were in the comparison group. Features of the home visit were also associated with family-level outcomes. The home visitors' responsiveness to the family during home visits was associated with the parent's role satisfaction and parental report of a positive home environment. Home visitor practices to facilitate parent-child interactions were associated with the parent's report of the responsiveness and positivity in their interactions with their child. Consistent with the theory of change for the Illinois Model, home visitors' behaviors and aspects of the home visit predicted were also associated with parents' reports of positive interactions with their children.

Study Strengths and Limitations

This study makes important contributions to the growing body of IECMHC research literature. Several areas merit mention here.

- **Comprehensive, cross-system field study of both IECMHC implementation and outcomes**. This evaluation was the first to study the implementation of a new model of IECMHC in multiple early childhood systems, both school-based and community-based, using a matched-comparison group design. Although the variability in participating programs and consultants posed challenges for implementation, data collection, and analysis, it reflected the goal and commitment of the Leadership Team to examine implementation in the diverse communities and programs characteristic of Illinois.
- **IECMHC in home visiting**. One of the priorities of the Leadership Team was implementing the Illinois Model in home visiting programs. Few studies of IECMHC have included home visiting. We included six home visiting programs in the study and collected data from program supervisors, home visitors, and families, including recorded observations of home visits. We found positive effects of the intervention on home visitor practices. Specifically, home visitors who received IECMHC were more responsive to families and prioritized facilitating parent-child interactions during visits. In addition, implementation was somewhat easier in home visiting programs because their program structure included regular team meetings and supervision was more likely to incorporate reflection, in contrast to the program structure and supervision in early childhood center-based programs. On the other hand, home visiting programs in the study still experienced challenges in implementing the Illinois Model because of staff and director turnover and changes in funding and funders' requirements.
- **Innovative measures**. Many of the tools we used in this study were developed recently to measure constructs that are central to IECMHC but are also difficult to measure, such as reflective capacity and reflective supervision. First, to measure reflective capacity, we used the Provider Reflective Practice Assessment Scales (PRPAS; Heller, 2017). Although more research is needed to validate the tool, the PRPAS shows promise as a measure of change in reflective capacity. Second, we administered a standardized scale in the

surveys to measure reflective capacity, the Reflective Functioning Questionnaire (Fonagy et al., 2016). Third, we used the Reflective Supervision Rating Scale (Ash, 2010) to assess the content and structure of reflective supervision. For the classroom observations, we used the Climate of Healthy Interactions for Learning and Development (CHILD; Gilliam & Reyes, 2017), an observational assessment of the mental health climate of early care and education settings. The CHILD domains align very well with the aims and anticipated outcomes of IECMHC. Finally, based on the theory of change for the Illinois Model of IECMHC, the research team selected items from the HOVRS-A+ (Roggman et al., 2010) and created a new IECMHC scale for home visit observations.

- **Analytic approach**. We used linear mixed modeling (LMM) to account for the nested longitudinal data (e.g., children within classrooms within programs), missing values, and the many covariates. There were different numbers of staff and families per program, and the amount of time between data points was important to include, both of which LMM can address. Previous IECMHC evaluations that used a matched-comparison group design did not account for the clustered levels of the data (Conners-Burrow et al., 2012; Egeren et al., 2011; Gilliam, 2014). This is the first IECMHC evaluation to use both a matched-comparison group design and multilevel modeling.

As with every research study, our evaluation also had some limitations, which we discuss below. It is our hope that future research on IECMHC initiatives will consider these issues during the planning phase to ensure the strongest possible research designs.

- **Study timeline and scope**. Although the scope of the evaluation was a strength of the study, there were challenges associated with conducting both implementation and outcome studies at the same time. Ideally, an evaluation of a new model first should assess how the intervention is implemented and identify any barriers to implementation. An outcome study would occur only after there was evidence that the intervention or program was implemented as planned. This sequence would result in greater confidence that any observed outcomes could be attributed to a fully functional intervention, and any outcomes that were not observed were not due to implementation issues. However, we designed the evaluation to be responsive to the multiple information needs of the Leadership Team, prioritizing implementation and staff-level outcomes, but also examining the potential of the to affect children and families.

  There were not enough eligible programs in each setting, region, and community type to conduct a randomized control trial of the Illinois Model, which is typically considered the "gold standard" in evaluation design. We were able to use a matched-comparison group design to allow us to measure change that could be attributed to the intervention. Experts still consider the matched comparison group design to be a rigorous design

when it is not possible to randomly assign participants to study groups (e.g., Hanita et al., 2017). However, a limitation of this design is that we could not match programs on all potentially relevant program and staff characteristics before implementation started. The intervention and comparison groups were similar demographically at baseline, but they differed in staff education.

- **Comparison programs receiving consultation.** The programs in our comparison group were functioning as "business as usual," which means that they continued program operations as normal during the study. Several programs were receiving, or had access to, some form of mental health consultation during the study period. Although the consultation models were different from what the intervention programs were receiving, this may have masked measurable change of the Illinois Model on the intervention group in our analyses. We also lacked comprehensive information about the form and content of consultation in the comparison group, which limits our ability to explain differences or lack of differences in some of our outcome measures.
- **Variability in consultant relationships with programs.** There was considerable variability in the intervention programs' relationships with their mental health consultants. Some were familiar with the concept of mental health consultation or had an existing relationship with their assigned consultant prior to implementation, while others had never had a consultant before and had to develop relationships. As a result, the time it took to build relationships and trust between the consultant and the staff and the time to reach full implementation of the model varied across the programs. At the same time, this "limitation" also provided an opportunity to understand how the model will work once it is implemented more broadly.
- **Measure limitations.** Again, we selected a number of outcome measures developed over the past decade for use in evaluations of mental health consultation and related interventions. Although some measures have been used in diverse populations, one limitation is that others are still being tested and validated and may evolve further. Some measures do not have published psychometrics, and some might not have been sensitive enough to detect changes in staff and supervisor well-being and relationships that occurred because of the Illinois Model of IECMHC. For example, most staff reported low levels of burnout and positive relationships with supervisors, which meant that there was not a lot of room for improvement over time. Other researchers have suggested that baseline ratings may be artificially inflated, limiting ability to measure progress. For example, Heller and colleagues (2011) suggested that asking teachers to report on their own growth retrospectively after engaging in IECMHC might be more valid for some self-assessment measures than collecting self-report data at baseline.

- **Data collection challenges.** We collected data over three academic years, which caused some difficulty in terms of data quality and sample retention. Children moved classrooms and left programs. Some programs closed or had reduced programming during the summer; additionally, there was more turnover in program staff, including supervisors, than we were led to expect from the participating programs, which affected the ease of both program implementation and the evaluation. In particular, our sample of program supervisors was smaller than ideal, given how important the consultant-supervisor relationships are to the intervention.
- **Child assessments.** Unfortunately, we could not conduct the child assessments on a random sample of children. Instead, we asked teachers to select no more than eight children in their classroom whose parents had provided informed consent and who were likely to remain in the program the following year. Nonetheless, because the baseline data collection period was in the spring, transitions in staff and children during the summer resulted in a smaller sample of children who remained with the same teacher in the fall when the second data collection occurred.

Implications and Recommendations

This pilot study demonstrated several strengths of the Illinois Model. Establishing relationships and promoting infant and early childhood mental health through the parallel process (Johnston & Brinamen, 2006, 2012) are the foundation of the model. The model is preventive, aiming to support the well-being of children and families by building the capacity of the adults who care for and work with children, rather than only responding when challenges arise. The model uses reflective practice and a social justice framework to support and strengthen the early childhood care and education workforce. Its flexibility allows the approach to be implemented into different programs in different early childhood settings, each with its own set of challenges and needs. The study also resulted in several important findings relevant to practitioners, policymakers, and researchers interested in understanding what IECMHC can accomplish for program staff, families, and children. In the section below, we highlight some important considerations and implications of this research.

Practice Implications: The Illinois Model

Mental health professionals successfully implemented the Illinois Model in diverse settings, ranging from community-based childcare to school-based pre-K to home visiting programs. The consultants were well-trained and supported throughout the implementation, but they also varied in experience, understanding of the model, and prior relationships with the participating programs. Given all these variations, the model seems to have the right balance of structure and flexibility to be used in various settings by well-supported consultants from varied backgrounds. Implementation was facilitated by the infrastructure that was established by the Mental Health

Consultation Initiative, which encompassed more than this pilot study. Notably, the initiative has created a strong workforce development plan, started the development of a centralized data system, and obtained funding to continue to coordinate efforts to advance IECMHC across multiple early childhood systems.

Based on the results of the pilot study, our recommendations for the Illinois Model and its implementation fall into three main areas—program commitment to and readiness for implementation; flexibility of model; and workforce development, as follows.

Program Readiness and Commitment

- Ensure readiness of program staff to engage with consultant and establish structures for implementation. Complete a thorough readiness assessment prior to implementation to ensure all staff, not just directors and supervisors, understand the structure and process of the Illinois Model and are engaged from the beginning. Depending on their understanding, some programs might need more support to become ready to engage with the consultant. Indeed, the first several months of implementation might be labeled a readiness or preparatory phase of the Illinois Model.
- Establish minimum requirements and clear expectations for the consultation, including a regular schedule of meetings and space for the consultant.
- Continue to monitor implementation through data collection and periodic check-ins to make sure structures and schedules are working. Provide booster trainings every six months for staff and leadership in the model's approach or more often during times of staff transition.

Model Flexibility

- Maintain the flexibility of the Illinois Model's approach. Again, program administrators and staff will have varying levels of readiness, and some may need more support than others to fully engage with a consultant. Program structure, size, and staff needs will affect the monthly amount of consultation required. Our study findings suggest that 10-12 hours per month is appropriate for many larger programs, but smaller programs that do not have the schedules to allow for regular reflective supervision sessions may not have this much time. A consistent structure and schedule based on staff size might be more important than a specified number of hours. In addition, given the time it took some consultants to establish relationships with program staff at the beginning, more hours in the early months might help to solidify these relationships and ensure that staff and supervisors understand the Illinois Model's approach to consultation.
- Continue the consultation practices currently recommended by the Illinois Model while also monitoring their implementation to understand how they are working in different

programs. For example, the model advocates that consultants meet with staff and their supervisors together rather than individually. This helps to ensure good communication and relationships between supervisors and staff. Although some study participants, including a few consultants, resisted this idea at the beginning, over time they came to understand its value. Yet, some programs found it very difficult to coordinate schedules and put it into practice.

- Explore and be open to other means of communication with administrators and staff. The unfortunate arrival of the COVID-19 pandemic as the pilot was wrapping up forced some early childhood programs to experiment with the delivery of consultation services through virtual means.

Workforce Development

- Continue to monitor implementation with online data collection by consultants. Periodically share data with programs leaders and staff to help them understand the process and progress of regular consultation.
- Maintain ongoing supports and training for consultants. All consultants participating in this study appreciated the regular monthly supervision and ongoing opportunities to reflect and learn provided to them during the implementation. These supports were particularly important for less experienced consultants, with more seasoned consultants serving as mentors for less experienced consultants. Consultants highlighted the reflective learning groups, which provided regular opportunities to reflect with peers, as especially beneficial for a number of topics, for example, issues of diversity, equity, and inclusion (DEI).
- Relatedly, provide more in-depth training and support to help consultants implement the Diversity-Informed Tenets. This study found that consultants were familiar with and endorsed the Tenets because of training, but they varied in their skills and comfort in addressing them with program staff. Although our study did not focus in-depth on DEI, this area, which is so important to IECMHC, seemed difficult for many consultants to address. Consultants also reported that it was challenging to find the appropriate time and space for sensitive and uncomfortable conversations about DEI, particularly when program leaders did not recognize the relevance of these issues. These findings suggest a need for more intense training and, perhaps, more effective strategies and tools for consultants to use in implementing the Tenets, including how to initiate conversations related to DEI with program staff and administrators in order to support their growth in being culturally sensitive, aware, and humble.
- Try to match consultants and programs so that consultants have experience with the system in which they are working. We found that staff and supervisors appreciated

consultants who understood the content, funding requirements, and structures of the program they were serving.

Policy Implications

Illinois Inclusion Policy and IECMHC

The Illinois preschool expulsion ban legislation (Public Act 100-0105) was passed just prior to the start of the study. This law prohibits any program receiving funding from ISBE or licensed by DCFS from expelling children for behavioral reasons as of January 1, 2018. This legislation highlighted IECMHC as an important resource for staff in this legislation. If programs could no longer remove children, they need alternative solutions and resources to support them. This study adds to the growing body of evidence suggesting IECMHC is an effective support for early childhood program administrators and staff to develop new strategies for working with children who they perceive as having challenging behaviors.

Early Childhood Workforce

Research shows that young children and families benefit from high quality early childhood experiences, it is not easy for providers to achieve the level of quality necessary to support child development. The ability of early childhood center-based programs to meet the needs of children and their families depends, more than anything, on the professional development, knowledge, and skills of their staff. Over the past two decades, educational requirements for staff and program quality standards in publicly-funded programs, including Head Start, state pre-K, and home visiting, have become increasingly rigorous (Bernoteit et al. 2016), yet it has been difficult for the early childhood workforce to keep pace with new requirements. As a result, the workforce has widely varying qualifications, degrees, and credentials as well as compensation, which typically differ by funding stream.

Although IECMHC can support program staff facing these challenges, it is not enough to address all of the current issues and inequities in early childhood systems. IECMHC cannot be implemented successfully in a fragile system or fix systemic issues that contribute to staff stress, burnout, and turnover. For example, in community-based programs in this study, insufficient staff prevented consultants from facilitating reflective supervision because the supervisor had to serve as backup for a staff member. How can the Illinois Model make room to support programs with these kinds of barriers so that there is space for consultation rather than it feeling like an additional task on the list? Consultants showed themselves to be creative and adept at finding times to meet with supervisors and staff, but it was not easy. For IECMHC to be successful, staff must have time and space free of other responsibilities to meet with the consultant.

Research Implications

This study contributes to a growing body of research that has demonstrated positive effects of IECMHC for staff and families. However, we need additional research to determine whether the Illinois Model of IECMHC leads to reductions in disparities, as theorized, as well as longer-term outcomes such as staff professionalization, staff retention, improvements in behavioral regulation in children, and reductions in harsh disciplinary practices. We highlight some of our suggestions for additional research below.

- Conduct a follow-up study of program participants in this pilot to understand the sustained effects of consultation and structures put in place to keep consultation in place. The COVID-19 pandemic has changed service delivery, especially in school-based and home visiting programs. Evaluating the implementation and sustainability of IECMHC during challenging times like these is necessary. Early childhood programs likely need the support of mental health consultants now more than ever.
- Do more study of implementation, paying special attention to differences between programs in different early childhood systems to better understand adaptations that should be made for different program types and differences within the childcare or home visiting systems. There has been very little study of IECMHC in other early childhood systems such as family childcare, public health, and Early Intervention.[3]
- Explore the role of supervisors in IECMHC implementation and outcomes. 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. Based on interviews with supervisors and consultants in this study, there was clear benefit for supervisors. However, our sample was very small, and standardized measures did not find differences between the two groups of supervisors. Thus, we recommend more study of the role of supervisors in implementing IECMHC, the challenges they experience in their work, and the supports they need to work more effectively with frontline staff.
- To better understand outcomes of the Illinois Model for children and families, conduct an experimental or quasi-experimental study of the model with a longer study timeline and larger sample of children; for example, a study that follows different cohorts over time as they transition to kindergarten. The child and family outcome data suggest that the Illinois Model has the potential to affect children and families in the long run but more rigorous, longitudinal studies are needed to understand its impacts. Furthermore, future research should measure the rates of child expulsion and suspension at the

[3] A small pilot study of the Illinois Model in four public health settings in Illinois is nearing completion but otherwise, we are not aware of other published research on IECMHC in public health settings.

program level, if possible, to determine any impacts IECMHC may have on preventing expulsions and suspensions of young children.

- Examine how mental health consultation can improve the equity of early childhood settings for diverse populations. Classroom observations and staff surveys in this study revealed some differences by staff race and ethnicity. For example, White teachers had lower scores on staff-child interactions and equity in their classrooms. It would be helpful to further analyze data from this study and other studies using the same classroom observation measure (CHILD) to examine the role of teacher-children racial concordance and discordance (i.e., same vs. different racial identity) on the classroom climate.
- Work with other researchers to develop more sensitive measures of the changes expected from IECMHC to more clearly assess the outcomes and mechanisms of change of consultation, including reflective practice, supervisor-staff relationships, staff well-being, and ability to promote children's and families' social and emotional growth. The measures of reflective capacity used in this study are very promising, although the PRPAS takes time to administer and analyze. Furthermore, we need psychometric evidence for some measures to ensure reliability and validity, especially for use in evaluations of IECMHC. Finally, our results suggested several relationships between variables, for example, reflective capacity and burnout, reflective capacity and perceptions of children's behavior, and effects of staff role and staff race on outcomes. These relationships are ripe for further investigation.

Conclusion

Given the variations in implementation and the size of the samples in this evaluation, we find the outcomes for staff, children, and families to be promising. At the same time, the extent of changes in some of the outcomes (notably, reflective capacity and classroom practices) indicates that there is room for further growth in staff, for example, in their reflective capacity and the social-emotional climate in classrooms. In addition, we need more study of outcomes, especially for supervisors, children, and families. We were impressed that any of the changes in child and family measures were significant or trending towards significance, given the fact that these are more distal outcomes than staff outcomes.