

2017-2020 COLORADO ENHANCED HOME VISITATION (EHV) PROJECT EVALUATION

Supported by The Community First Foundation

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ENHANCED HOME VISITATION (EHV) PROJECT EVALUATION REPORT 2017-2020

EXECUTIVE SUMMARY

Parent Possible promotes and supports evidence-based, high-quality programs focused on parents of children from pregnancy through kindergarten. Each program seeks to engage with parents where they are – inspiring parent involvement, facilitating school readiness, and strengthening opportunities for children to achieve their full potential.

Parent Possible served as the lead agency for the Enhanced Home Visitation (EHV) Project funded through the Community First Foundation. Beginning in October 2017, the three-year project aimed to improve the home visiting workforce by supporting the social/emotional well-being and behavioral health of home visitors, families, and children.

The Enhanced Home Visitation Project was designed to meet a key goal of Community First Foundation's Early Childhood Mental Health Wellness grantmaking strategy. The geographic focus of the initiative was the seven-county metro Denver area. Parent Possible worked in partnership with the Community Impact team at Community First Foundation to oversee evaluation, reporting, and coordination among the grantee home visiting programs.

Seven agencies with five home visiting programs committed to providing home visitors with mental health consultation throughout the project. In addition, program sites had the option of supporting home visitors with one or more of the following:

- Mindfulness/Trauma Informed Training and Consultation
- Colorado Foundations of Infant and Early Childhood Mental Health Courses
- Infant Mental Health Endorsement®

Parent Possible collected data throughout the three years of the EHV Project. Evaluation tools included a pre- and post- home visitor survey incorporating the Professional Quality of Life (ProQOL) measure, satisfaction surveys, reports from program site supervisors and Mental Health Consultants, and interviews and focus groups with participants. Data were analyzed to describe the impact of the EHV Project on home visitors and to examine changes in practices and home visitor protective factors. A parent-child observation tool was used to look at developmentally-appropriate parenting behaviors for families with home visitors participating in the project. This report includes details regarding the measures used for data collection, approaches taken, and findings for EHV participants. Key findings are highlighted below.

KEY FINDINGS



Results suggest a positive relationship between participation in the EHV Project and program fidelity, home visitor retention, family retention, and community partnerships



Home visitor attrition before the EHV Project began in 2016-17 was 26%. The participating programs had lower attrition each year during the project, ending 2019-2020 with only 2% attrition



After participating in the project, home visitors' knowledge/confidence increased in 10 of 12 topic areas. Four of the areas increased by 8 to 15 percentage points from pre- to post: support felt in helping young children with challenging behaviors, comfort addressing substance issues, comfort using strategies to help families manage a child's challenging behaviors, and knowledge of own strengths and areas of growth



Home visitors' level of burnout and secondary traumatic stress increased from pre to post; however, they reported feeling more equipped with strategies to be able to handle this stress



After participating in the project, home visitors report practicing more mindfulness and self-care activities and sharing similar strategies with families



Program sites utilized different aspects of the EHV Project to various levels, but all report extremely high satisfaction with the project and the support they received



82% of participants report their mental health consultant had "a lot" of positive influence on their life



70% of participants state that they have experienced "a lot" of positive change in their organizational culture as a result of the EHV Project



Data suggest families with a home visitor participating in the EHV Project could lead them to practice more developmentally-appropriate interactions with their children

OVERVIEW OF PARTICIPATING PROGRAMS



Parent Possible equips parents of young children with tools and information to be their child's most valuable teacher, trainer, and mentor in life. The organization promotes and oversees the delivery of three evidence-based parent engagement programs, providing access and support, ensuring efficacy and impact, and advocating and collaborating with early childhood partners across the state. Parent Possible is the state office for Parents as Teachers, Home Instruction for Parents of Preschool Youngsters and Vroom, working with program sites across urban and rural communities throughout Colorado to ensure quality program delivery and success. [For the EHV Project, Parent Possible served as the lead agency, providing coordination, oversight, training, reporting, and evaluation.](#)



Home Instruction for Parents of Preschool Youngsters (HIPPY) is an evidence-based home visiting program that helps parents prepare their 2, 3, 4, and 5-year old children for success in school and throughout life. Through the use of curriculum, story books, and other materials, parents strengthen their children's cognitive, literacy, social/emotional, and physical development. HIPPY strengthens both communities and families by empowering parents to play an active role in preparing their children for school. HIPPY utilizes a peer-delivered, home visitation model, with trained home visitors providing weekly visits to work one-on-one with parents of preschool-aged children. The program also provides monthly group meetings. [Two HIPPY program sites participated in the EHV Project.](#)



Parent Child Home Program (PCHP) (now called ParentChild+) is an early childhood program that promotes parent-child interaction and positive parenting to enhance children's cognitive and social-emotional development. The program strives to prepare children for academic success and strengthen families through intensive home visiting. Twice weekly home visits are designed to stimulate the parent-child verbal interaction, reading, and educational play critical to early childhood brain development. Each week the home visitors bring a new book or educational toy that remains with the families permanently. Using the book or toy, home visitors model for parents and children reading, conversation, and play activities that stimulate quality verbal interaction and age-appropriate developmental expectations. [One PCHP program site participated in the EHV Project only during Years 1 and 2 \(the site closed in May of 2019\).](#)



Parents as Teachers (PAT) is an evidence based early childhood program that includes home visits, group meetings, health and developmental screenings, and development of resource networks. Parent educators meet with parents monthly or bi-monthly and utilize the PAT curriculum to promote positive parent-child interaction from pregnancy through kindergarten. The curriculum is designed to increase parent knowledge of childhood development, improve parenting practices, provide early detection of developmental delays and health issues, prevent child abuse and neglect, and increase children’s school readiness and school success. [Five PAT program sites participated in the EHV Project.](#)



Promoting Safe and Stable Families (PSSF) is a family support program to improve the quality of care and services that help keep children safe, allow children to remain safely with their families, and ensure safe and timely permanency for children in foster care. The program provides advocacy, resources, and education for families with children birth to age 8. [One PSSF program site participated in the EHV Project.](#)



SafeCare is an evidence-based, parent-training curriculum for parents of children ages 0-5 who are at-risk for or have been reported for child neglect or physical abuse. SafeCare providers work with families in their homes to improve parents’ skills in three areas: (1) parent-infant/child interaction skills, (2) health care skills, and (3) home safety. SafeCare is typically conducted in weekly home visits lasting from 60-90 minutes each. The program typically lasts 18-20 weeks for each family. SafeCare can be conducted by itself or with other services. [One SafeCare program site participated in the EHV Project.](#)

PROGRAM SITE INFORMATION

Arapahoe County Early Childhood Council - Centennial, CO

www.acecc.org

County served: Arapahoe

Programs Offered: Parents as Teachers, Safe Care, and Promoting Safe and Stable Families

Number of Home Visitors: 10

Average Annual Caseload: 293 Families

Family Star - Denver, CO

www.familystar.net

County served: Denver

Program Offered: Parents as Teachers

Number of Home Visitors: 5

Average Annual Caseload: 86 Families

Jefferson County School District (JeffCo HIPPY)- Lakewood, CO

<https://www.jeffcopublicschools.org/cms/One.aspx?portalId=627965&pageId=926850>

County served: Jefferson

Program Offered: Home Instruction for Parents of Preschool Youngsters

Number of Home Visitors: 12

Average Annual Caseload: 177 Families

JeffCo Schools Foundation – Golden, CO (*Years 1-2 Only*)

<https://www.jeffcoschoolsfoundation.org/>

County served: Jefferson

Program Offered: Parent Child Home Program (PCHP)

Number of Home Visitors: 4

Average Annual Caseload: 50 Families

Metropolitan State University of Denver - Denver, CO

www.msudenver.edu/flp/

Counties served: Denver, Jefferson, Adams

Program Offered: Parents as Teachers

Number of Home Visitors: 3

Average Annual Caseload: 53 Families

Mountain Resource Center - Conifer, CO

www.mrcco.org

Counties served: Jefferson, Park, Clear Creek, Gilpin

Program Offered: Parents as Teachers

Number of Home Visitors: 4

Average Annual Caseload: 64 Families

Roots Family Center - Denver, CO

www.rootsfamilycenter.org

County served: Denver

Programs Offered: Parents as Teachers, Home Instruction for Parents of Preschool Youngsters

Number of Home Visitors: 7

Average Annual Caseload: 67 Families

PARTICIPANT INFORMATION & DEMOGRAPHICS

72 people received training or reflective supervision

 61 Home Visitors

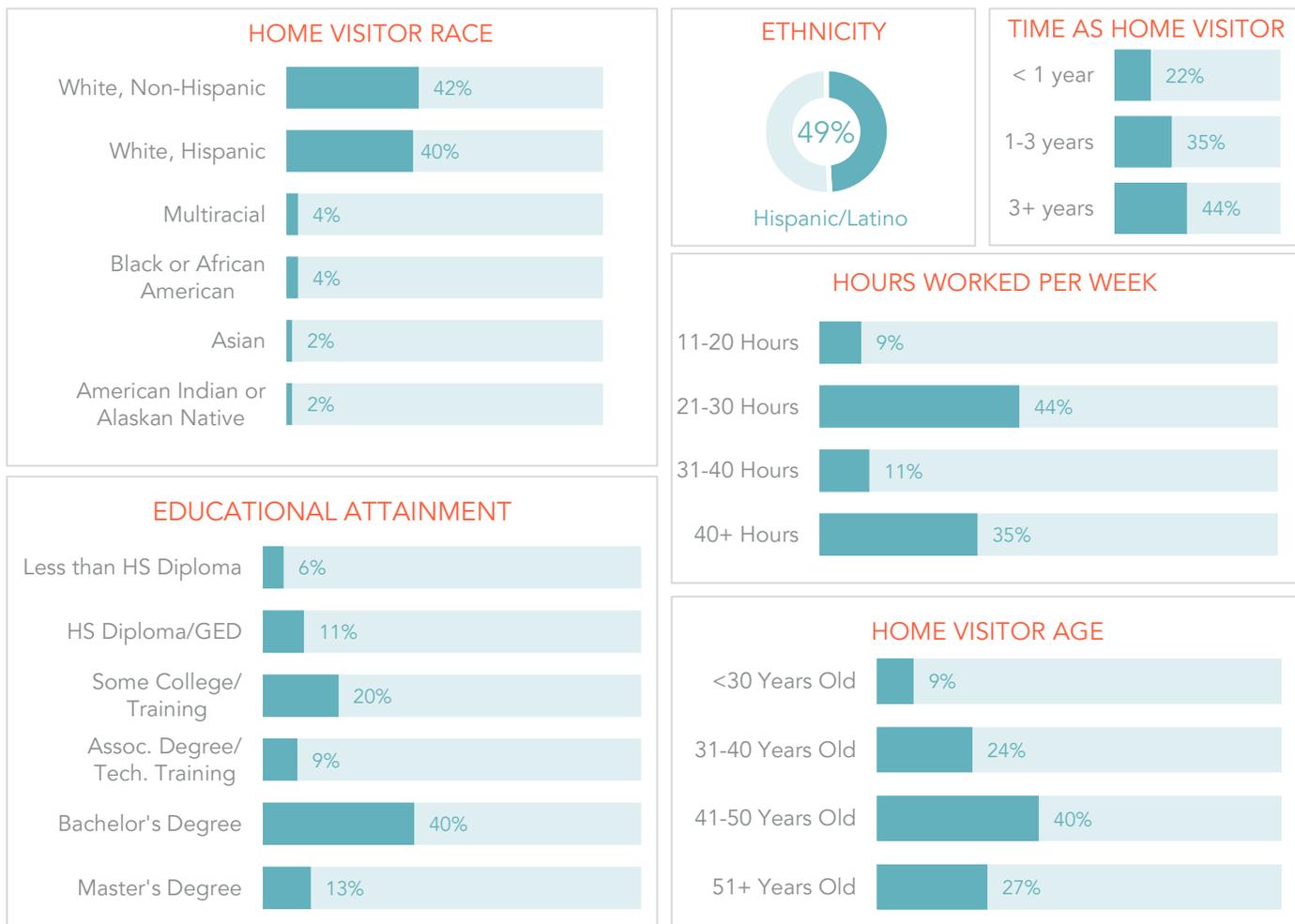
 11 Program Coordinators/Supervisors, Directors, Other Client-Facing Staff

90% of participating home visitors completed a pre- and post-survey.

 Average caseload was
15 Children per home visitor

Home Visitor Demographics

Based on self-report survey responses



PROJECT COMPONENTS

All program sites were required to participate in group reflective consultation with a qualified mental health consultant (MHC) and those MHCs were then required to attend group reflective consultation with a supervisory MHC. Beyond these two expectations, program sites had the option to participate in four other supportive practices described below. Not all sites completed each component of the project. For purposes of this report, Year 1 refers to activities occurring between December 1, 2017 and November 30, 2018, Year 2 refers to activities occurring between December 1, 2018 and November 30, 2019, and Year 3 refers to activities occurring between December 1, 2019 and September 30, 2020.

GROUP AND ONE-ON-ONE REFLECTIVE CONSULTATION

Licensed mental health consultants (MHCs) supported home visiting teams with individual and group-based reflective supervision sessions. The consultant helped home visitors to observe, assess, and support caregiver and young child relationships; increase self-awareness and reflective practices with families, including prevention and health promotion; increase confidence and competence around early childhood mental health; and make effective, timely, and appropriate referrals for additional mental health services. Appendix H includes a list of recommended qualifications sites took into consideration when hiring a mental health consultant to work with home visitors.

8 Mental Health Consultants participated over the course of the project.

One site contracted with two MHCs to meet the needs of both Spanish-speaking and English-speaking home visitors and two sites changed MHCs over the course of the project.

Mental Health Consultants conducted:

- Group reflective consultations with 72 participants (61 home visitors)
There were 320 hours of group reflective supervision sessions over three years, adding up to 1,526 hours of participant time.
- One-on-one consults
While this was a very popular part of the project for those who received it, not all sites participated in individual consults. In fact, only three of the sites used them regularly.
- Trainings and meetings
MHCs conducted 43 trainings and meetings over the three years, though most occurred during Years 1 and 2. Topics included information about what reflective supervision is, building structures for young children, and boundaries for the helping professional. Three sites used their MHC for training with one site alone accounting for over half of the MHC-conducted trainings completed. Four sites never used their MHC for training home visiting staff.

All of these ideas, thoughts, and practices have changed our practice because we lead with the thought that it's a parallel process....If we are good, we can take our best to the parents we work with and they in turn can be their best for their children.

-Site Director

The training that we receive around trauma response and parenting skills are constantly referenced in my work with families when they find themselves struggling. I love that I am able to suggest solutions from a place of knowledge on best practice because I have received this training.

-Home Visitor

Mental Health Consultation by the Numbers:



184 Group Reflective Consultations

13.2 Average Group Reflective Consultations Received per Home Visitor

21.7 Average Hours Spent in Group Reflective Consultations

	Year 1	Year 2	Year 3
184 Group Reflective Consultations	58 sessions	72 sessions	57 sessions
13.2 Average Group Reflective Consultations Received per Home Visitor	6.2 sessions	5.9 sessions	6.5 sessions
21.7 Average Hours Spent in Group Reflective Consultations	9.9 hours	9.6 hours	11.1 hours



341 One-on-One Consults

	Year 1	Year 2	Year 3
341 One-on-One Consults	102 sessions	120 sessions	119 sessions



85 Hours of Training

	Year 1	Year 2	Year 3
85 Hours of Training	49.5 hours	28 hours	7.7 ¹ hours

GROUP REFLECTIVE CONSULTATION FOR MENTAL HEALTH CONSULTANTS

Parent Possible contracted with Dr. Joy Browne to supervise the team of mental health consultants. This supervisory consultant coordinated monthly virtual group meetings to provide educational, supportive, and capacity building skills to mental health consultants working with home visitation program sites. Through reflective supervision, the supervisory mental health consultant collaborated, developed strategies, and promoted professional growth to strengthen and improve the mental health consultants' ability to provide reflective consultation to home visitors.

There were 35 consultations and 51 hours spent between the Supervisory Mental Health Consultant and the sites' Mental Health Consultants. Examples of topics discussed include boundaries, creating trust, encouraging effective reflection, the parallel process, managing transitions, supporting individuals with grief, stress, and additional challenges related to COVID-19.

I feel more validated in the challenges I've experienced with reflective consultation, more connected to others, and I've gained a lot of new skills related to communication, group management, and self-reflection which have helped me feel more clear and confident in my role.
- Mental Health Consultant

¹ Years 1 and 2 include hours an MHC at one site spent conducting CoAIMH's Foundations Course with home visitors. Other sites received Foundations Course training, however not from their assigned MHC.

ANNUAL RETREAT AND QUARTERLY CONSULTS

Parent Possible partnered with the Denver Children’s Advocacy Center (DCAC) to offer training and support around mindfulness and trauma-informed care. Six of the seven sites participated in this aspect of the EHV Project. The support from DCAC included four components.

- At the start of the project, DCAC assessed each program site for their level of trauma-sensitive readiness using questions from the Wisconsin Child Trust Fund “Trauma-Informed Organizational Self-Assessment”.
- Based on the assessment results, DCAC provided a half-day of individual consultation for each of the sites resulting in a plan developed by the program team and leadership to build a trauma-sensitive organization.
- On a quarterly basis, home visiting teams received a two-hour consultation from DCAC focused on secondary trauma and mindfulness.
- DCAC staff covered relevant topics such as child development, mindfulness, and trauma-informed care at an annual full-day training/retreat for all home visiting staff and hosted by Parent Possible.



The home visitors have taken strategies learned with DCAC trainings...and shared them with families. Specifically, they have discussed activities designed to lower stress as well as meditation techniques with parents.
-Site Coordinator

A total of three full-day retreats were held with over 40 participants each year. Topics covered at the retreats were determined based on site feedback. Year 1 was focused on trauma-informed care, including why exposure to violence in early years has such a disproportionate impact on development, how a child’s environment facilitates or inhibits brain development, and how home visitors can mitigate trauma and promote healing. Year 2 was related to the effects of attachment on development, building blocks of healthy attachment, caregiver affect management, and ways to strengthen attachment and attunement. Year 3 was about secondary trauma and its impact on caregivers as well as techniques for individual and organizational self-care.

ADDITIONAL TRAININGS

Program sites engaged in additional trainings related to trauma-informed care and supporting families’ mental and behavioral health provided by community organizations beyond Parent Possible and DCAC.

Training topics included signs of abuse and neglect, impact of trauma on the developing child, attachment, vicarious resilience, mindfulness for young children, postpartum depression, and reflective practice.



FOUNDATIONS COURSE WITH CoAIMH

Colorado Foundations was developed by the Colorado Association for Infant Mental Health (CoAIMH) to strengthen the capacity of the early childhood workforce by providing a continuum of high-quality, consistent infant and early childhood mental health supports to children and families. The eight-module course promotes a shared understanding and common language of infant and early childhood mental health principles to individuals across a broad array of disciplines. The curriculum content supports the competencies associated with the Infant Mental Health Endorsement®. More information on the Foundations Course can be found here: <http://coaimh.org/colorado-foundations/>

Parent Possible worked with CoAIMH to coordinate Colorado Foundations courses for home visitors in both English and Spanish. The EHV Project also provided financial and administrative support to sites to allow home visitors to complete the course.



26 participants completed the Colorado Foundations course during the project. Eleven of the participants completed the course in Spanish.

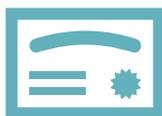
INFANT MENTAL HEALTH ENDORSEMENT

The Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health (IMH-E®) is an overlay onto a person's professional credentials that recognizes achievement of knowledge and training in the area of infant and early childhood mental health. The Endorsement identifies best practice competencies at multiple levels and across disciplines and offers a pathway for professional development in the infant, early childhood and family field. Each category of Endorsement has a set of educational, work, training and reflective supervision/consultation requirements. For all levels, specialized work experience with infants, toddlers and their families is required. More information about IMH-E® can be found here: <http://coaimh.org/endorsement-information/>

The consultant has shared very interesting topics with our team, and the support for the Child Mental Health certification has been fundamental.

-Home Visitor

The EHV Project provided financial and administrative support to sites to allow home visitors to complete the IMH-E® application process.



4 participants received their IMH-E® during the project and 14 are currently pursuing endorsement.

EVALUATION PLAN AND COMPONENTS

Parent Possible created the logic model and evaluation plan for this project in partnership with the Community First Foundation and with input from local experts in the field including Jordana Ash, LCSW, IMH-E®, then Director of Early Childhood Mental Health at the Colorado Department of Human Services, and Joy Browne, PhD, PCNS, IMH-E®, the founding President of the Colorado Association for Infant Mental Health. In addition, Parent Possible consulted with other evaluators working on similar projects in Colorado such as Project LAUNCH,² LAUNCH Together,³ and the Maternal, Infant, and Early Childhood Home Visiting Program⁴ and reviewed existing research on using mental health consultation in home visitation settings.

The initial evaluation plan was an ambitious look at how the EHV Project impacts the site, home visitors, and families involved. Because Parent Possible was dually charged with overseeing the project's implementation and evaluation, the evaluation plan includes items relating to output completion and participant satisfaction. Anticipated outcomes mirrored those found in the report *What Works?: A Study of Effective Early Childhood Mental Health Consultation Programs* by Georgetown University's University Center for Child and Human Development.⁵ To capture the data required, the evaluation team used tools created by others already working in the field and data already being collected by home visitors when available. A description of the data collection tools follows, and the full logic model and evaluation plan may be found in Appendix A and Appendix B, respectively.

HOME VISITOR SURVEY



The home visitor survey is a 59-item tool that asks home visitors about their confidence and knowledge around mental health, children's social/emotional development, and giving referrals, and included the Professional Quality of Life Measure (ProQOL) measuring compassion satisfaction, burnout, and secondary trauma.

The first part of the survey asked home visitors about their comfort using strategies to help families manage challenging behaviors, communicating with and involving parents regarding children's strengths and needs, addressing parental mental health issues, addressing substance use issues, and giving referrals for evaluations or more intensive services for young children. Questions were based on an existing survey used and shared by the evaluation team from Colorado's Project LAUNCH and adjusted to allow for pre/post comparisons. Based on results from the first two years of the project, a set of questions was added to the survey in the spring of 2020 asking how helpful the mental health consultant was in supporting each area assessed.

The second part of the survey consisted of the Professional Quality of Life (ProQOL) Measure developed by Dr. Beth Hudnall Stamm. The ProQOL is a 30-item scale commonly used to measure compassion fatigue and compassion satisfaction. It is intended for use as a screening tool for the positive and negative aspects of working within a helping profession. The ProQOL measures three areas:

- 1) Compassion Satisfaction-reflecting the pleasure and satisfaction from being a home visitor
- 2) Burnout-measures work-related hopelessness and not feeling effective
- 3) Secondary Trauma-measures work-related secondary exposure to very stressful or traumatically stressful events

² <https://healthysafechildren.org//sites/default/files/ColoradoGranteeProfile-508.pdf>

³ <https://earlymilestones.org/project/launch-together/>

⁴ https://create.piktochart.com/output/33907635-mental-health-consultation_interviews-summary_co-miechv

⁵ Duran, F. et al. (2009). *What Works?: A Study of Effective Early Childhood Mental Health Consultation Programs*. Washington, DC: Georgetown University Center for Child and Human Development.

Home visitors receive a raw score, a percentile rank, and a corresponding level (low, average, or high) for each area. Parent Possible emailed home visitors their individual scores after each survey period if they requested them. More information about the ProQOL measure can be found on the developer's website: <https://www.proqol.org/>

The survey was administered once when the project began in the fall of 2017 and then again each spring. If starting after the fall of 2017, new home visitors were asked to complete a pre-survey after three months in the role and then again each spring to align with all other respondents. The survey was available in both English and Spanish.

A total of 55 home visitors completed a valid pre- and post-survey. Most home visitors completed more than two surveys during the project: 20 home visitors completed 4 surveys and another 14 home visitors completed 3 surveys. Results in this report compare the first survey completed to the last survey completed by each home visitor and do not take into account the length of time between those surveys.

SITE ANNUAL REPORTS



The site annual reports ask site supervisors about staff turnover, program fidelity, program retention, improved linkages with other community resources, home visitor training, agency culture, and impacts of the EHV Project.

Sites submitted reports at the end of each project year. A total of 20 reports were completed, one per program site each year of the project. The questions contained in the report for 2019-2020 are included in Appendix E.

INTERVIEWS AND FOCUS GROUPS



While not initially part of the data collection plan, interviews and focus groups were conducted to gather qualitative data related to the EHV Project at the end of the second and third years. Conversations with program coordinators and supervisors, home visitors, and mental health consultants provided context to the quantitative data collected elsewhere and allowed for mid-project adjustments to better meet the needs of home visitors and program sites.

Parent Possible staff conducted 10 interviews over the phone at the end of the second year of the project, largely with site coordinators and mental health consultants. Two Parent Possible evaluation staff and one outside consultant conducted focus groups and interviews with 14 home visitors in the spring of 2020. Originally scheduled to take place in person at the Parent Possible Conference, focus groups with home visitors were ultimately conducted virtually via Zoom due to COVID-19. In response to participant interest and availability, three focus groups were held in English by Parent Possible staff while Robin Arnett, LCSW, conducted four interviews in Spanish. All focus group members and home visitors interviewed received a \$30 King Soopers gift card for their participation.

Interview questions related to the value of the work, challenges faced, lessons learned, and areas for improvement. Focus group questions can be found in Appendix G and the questions used for the interviews after Year 2 are in Appendix F.

MENTAL HEALTH CONSULTANT QUARTERLY REPORTS



Each site contracted with a mental health consultant (MHC) to provide some combination of group reflective consultation, individual reflective consultation, and group trainings on topics requested by site home visiting staff. Parent Possible asked MHCs to complete quarterly reports that included:

- Date, length, and attendance of group reflective consultation sessions and trainings
- One-on-one consult forms for each individual reflective consultation session conducted that included topics covered during the session, if specific skills and techniques were discussed, and follow-up information noting if the home visitor implemented the recommended skills and techniques

While MHCs were expected to submit complete reports each quarter, many data elements were missing in the reports received. This is likely due to the complexity of the data requested and the amount of data entry required. There is an accurate count of the number of group reflective consultation sessions, one-on-one consults, and trainings held, however, the details of those sessions are unknown in many cases. Results reported here are based on the data submitted by the MHCs.

SATISFACTION SURVEYS & TRAINING EVALUATIONS



Home visitors and mental health consultants completed a brief satisfaction survey semi-annually throughout the project to ensure their needs were being met and they were satisfied with the support received from the MHCs, Denver Children's Advocacy Center (DCAC), and Parent Possible. The survey was available in English and Spanish and conducted online via Survey Monkey.

The home visitor satisfaction survey changed slightly over time. The original version was based on a feedback survey created by Listen4Good, an initiative of the Fund for Shared Insight.⁶ Questions were added over time to tailor the responses to this project and the desired outcomes. The questions from the most recent satisfaction survey sent to home visitors are included in Appendix D.

Surveys were anonymous, making acting upon feedback challenging. Following a concerning response on one satisfaction survey early in the project, a question was added where home visitors could name their MHC and add a note about their concerns if they reported that their MHC "never" or "rarely" treated them with respect.

Home visitors and supervisors completed almost 300 satisfaction surveys over 6 collection periods during the project. Responses were overwhelmingly positive through the three years and continually demonstrated how valuable the time with MHCs was among participants.

We have had a longstanding relationship with our MH Consultant, so I have had the privilege of participating in group reflective sessions and individual sessions for over 3 years. My capacity to reflect on my work with her has grown by leaps and bounds and has positively impacted my work with families, agency staff at all levels as well as greatly enhanced my own personal wellbeing.
-Site Coordinator

Home visitors and site supervisors also completed evaluations of specific trainings related to the project. Parent Possible collected feedback from each annual retreat and training hosted while DCAC collected feedback following the quarterly consults and submitted those responses to Parent Possible for analysis. There are 105 satisfaction surveys between the three annual retreats and 166 satisfaction surveys from 34 separate DCAC trainings.

⁶ <https://www.fundforsharedinsight.org/listen4good/>

FAMILY-LEVEL METRICS AND DATA COLLECTION



There were three tools included in the original EHV Project Evaluation Plan to measure family/child level outcomes: the PICCOLO™, BSRA-3, and ASQ®:SE-2.

The PICCOLO™ (Parenting Interactions with Children: Checklist of Observations Linked to Outcomes) is a checklist of 29 observable developmentally supportive parenting behaviors in four domains (affection, responsiveness, encouragement, and teaching). It was developed for use with parents of children ages 10-47 months; however, it can be used for children up to 72 months old. Parent Possible uses the PICCOLO as part of the PAT and HIPPY statewide evaluation plan for families with children 10-72 months. Home visitors observe a ten-minute interaction between a parent and child and mark an item Absent (0), Barely (1) or Clearly (2). Score sheets are available in English and Spanish. The item scores are summed to get four domain scores and those are then summed for an overall PICCOLO score. Higher item and domain scores are strengths. For PAT program sites, the PICCOLO is administered within 90 days of enrollment or the child turning 10 months with subsequent assessments each fall. For HIPPY program sites, the PICCOLO is administered during Week 6 in the curriculum. More information on the PICCOLO can be found here <https://brookespublishing.com/product/piccolo/>

PAT families completed 1,172 PICCOLOs in 2018-19 and HIPPY families completed 542 in the same time period. Families at EHV Project sites comprised of 23 percent of the total PICCOLOs completed by HIPPY families and 15 percent of those completed by PAT families. PSSF and SafeCare did not complete any PICCOLO observations, and Jeffco PCHP data were not analyzed since the program is no longer in operation.

The Bracken School Readiness Assessment Third Edition (BSRA-3) is a validated assessment that measures preschool-aged children's skills in five areas: color recognition, letter recognition, numbers and counting, size comparisons, and shape recognition. The BSRA-3 is appropriate for children aged 36- to 83-months-old and is administered by asking children to point to pictures in response to home visitor questions. The BSRA-3 is part of Parent Possible's statewide evaluation plan for PAT and HIPPY. However, BSRA-3 scores were not analyzed for the purposes of this project as not all EHV program sites use this tool (SafeCare and PSSF do not, nor do PAT sites serving children under 36 months).



The Ages & Stages Questionnaires®: Social-Emotional, Second Edition (ASQ®:SE-2) is a parent-completed screening tool focused on social and emotional development for children aged 1-72 months. Again, as not all EHV program sites use this tool with families, any results collected were not analyzed for the EHV Project.

RESULTS AND DISCUSSION

Capturing the value and impact of enhanced home visitation on the participating sites, home visitors, and the families they served proved a difficult challenge. What follows is a glimpse into the change witnessed over three years of implementing this unique project. Like all evaluations, it is limited by what can be tracked and measured. It does not include the ripple effect felt by the families of home visitors less stressed from their work, the children who are more equipped with tools to manage their big feelings, the parents who better understand their child's development and are better able to support their growth as a result, or the coworkers outside of home visiting who are more mindful and present in their work. The words of home visitors and program supervisors give some idea of how their time spent on mindfulness work and with a mental health consultant impacted those around them and their work and may be found throughout the report.

Based on existing research, the evaluation plan included outputs and outcomes at the site, home visitor, and family level. Because the core of the intervention—i.e. the mental health consultation, the mindfulness consultation, and the annual retreats—centered around the home visitors themselves, it follows that the strongest impact was at the home visitor level. There was also change at the site level, though it is impossible to know if participation in the EHV project caused those improvements given the limits of this evaluation.

Not wanting to burden families with even more data collection than required, the evaluation plan looked to tools programs already used to capture family-level change. The proposed tools included a parent-child observation, a school readiness assessment, and a social-emotional developmental screening tool. In the end, only the parent-child observation tool was used by a sufficient number of sites and documented consistently enough to warrant analysis. We planned to collect data on reductions in challenging behavior from home visitor consult reports, however nearly all data were missing, and challenging behaviors were often not the subject of those sessions. Qualitative methods were added in Years 2 and 3 to gather insight into if and how home visitors changed the way they supported families due to the shortage of quantitative data available.

En lo personal como visitadora siento que esta herramienta que nos dan es de gran ayuda porque a veces uno no sabe como enfrentar el estres o preocupaciones desde de hacer visitas a las familias y el apoyo que nos dan de hablar con un experto de salud metal es excelente

[Translation] Personally as a [home] visitor, I feel that this tool they give us is of great help because sometimes you do not know how to cope with stress or concerns from making visits to families, and the support they provided us with talking to a mental health expert is excellent.

-Home Visitor

What follows are the results from data collected at the home visitor level, site level, and family level with each discussed in turn. For clarity and ease of reading, not every data point collected is included in this report. Reported results reflect the most relevant and meaningful outcomes observed throughout the three-year EHV Project.

Home Visitor-Level Results

As the primary focus of the project and evaluation, there is a lot to report about the home visitor experience in Enhanced Home Visitation. First and foremost, it is clear participating home visitors highly value their experience with the mental health consultants (MHCs) and their time spent learning about mindfulness, child development, and trauma-informed care.



Home visitors repeatedly shared how the EHV project allowed them to be more mindful in their work with families, create and uphold clear professional boundaries, and better handle the stresses that inevitably arose when working with families facing numerous challenges.



Home visitors completed up to six satisfaction surveys between the spring of 2018 and the fall of 2020. At the final satisfaction survey in August 2020, 100 percent of home visitors were pretty likely or extremely likely to recommend meeting with a mental health consultant to other home visitors. In addition, 83 percent and 79 percent reported that the MHC had “a lot” of positive influence on their life and work, respectively.



Satisfaction surveys were intentionally made anonymous to encourage honest responses and offered in English and Spanish. While we cannot determine if there were trends among certain sites, home visitors who completed the survey in Spanish were slightly less enthusiastic than those who completed the survey in English on a few items.

Respondents in Spanish and English were similarly satisfied with their support from Denver Children’s Advocacy Center and reported similar amounts of positive influence the MHCs had on life and work. Spanish-speaking home visitors all were “somewhat” likely to recommend meeting with an MHC, while

En lo personal este proyecto ha sido muy beneficioso para mi porque con las consultas he podido aprender mucho a saber manejar el estrés y como el cuidado personal es tan importante para llevar un vida balanceada emocionalmente para así poder apoyar mejor a mis familias del programa.

[Translation: Personally, this project has been very beneficial for me because with the consultations I have been able to learn a lot about how to handle stress and how personal care is so important to have an emotionally balanced life in order to better support my families in the program.]

-Home Visitor

61 percent of their English-speaking counterparts were “very” likely to recommend the practice. In addition, while 100 percent of English-survey takers reported their MHC “always” treated them with respect, only 73 percent of Spanish-survey takers reported the same. Twenty-seven percent of those who completed the survey in Spanish reported the MHC “usually” treated them with respect. Data reported above represent results from the survey in the fall of 2020 with a relatively small sample size, however similar trends existed throughout the project. Future research is necessary to determine the cause of these differences and why they continue to persist.

Given the strong support for the work and plentiful anecdotal evidence regarding the impact of the work collected on the satisfaction surveys and elsewhere, the quantitative results from the home visitor pre/post survey tell a different, more complicated story. The survey asked home visitors about their knowledge and confidence in 12 areas and then uses the Professional Quality of Life (ProQOL) measure to quantify the home visitor’s current levels of compassion satisfaction, burnout, and secondary traumatic stress. Nearly all participating home visitors completed multiple valid surveys with fifty-five home visitors submitting a pre and post survey over the course of the project. The average time between surveys was 17 months (ranging from 4 to 30 months). Thirty-five percent of pre- and post-surveys (n=19) were less than 10 months apart, 25 percent (n=15) were between 11 and 20 months apart, and the remaining 40 percent (n=22) were more than 20 months apart.

I feel that we as home visitors were so very lucky to have this project. Never in my wildest dreams would I have ever expected that we would encounter a pandemic, I feel that I was able to use the tools I received to help my parents last spring. I was able to help myself and in that being able to be strong enough to be a support to my parents.

-Home Visitor

Knowledge and Confidence

On average, home visitors entered the project with a high level of self-reported knowledge and confidence. Over 80 percent of home visitors rated their knowledge or confidence as a 4 or 5 out of 5 at pre-test when asked how comfortable they felt communicating with and involving parents regarding children's strengths and needs, how well they understood the social/emotional/developmental needs of children, and how comfortable they were giving referrals for evaluations or more intensive services for young children.

Confidence levels did vary by program with HIPPY home visitors tending to rate themselves as less knowledgeable or confident than PAT and other home visitors. For example, while 95 percent of PAT home visitors rated their comfort level communicating with and involving parents regarding children's strengths and needs as 4 or 5 out of 5, only 75 percent of HIPPY home visitors rated themselves this highly.

This difference in confidence between programs is likely due to the different experience and formal education among the home visitors. HIPPY programs are designed to recruit home visitors from the families they serve. This effective and empowering recruitment model often means that mothers join the workforce in a non-traditional way and bring experience to the role beyond formal education and prior paid positions. HIPPY home visitors make up 78 percent of the home visitors surveyed with a high school diploma or less and only 17 percent of those with a bachelor's or master's degree. In addition, 52 percent of HIPPY home visitors had been in their role for less than 6 months at pre-test. Given their unique background, it is arguably even more critical for HIPPY home visitors to receive the support and training provided by projects such as enhanced home visitation as they enter complex family systems and support wide-ranging child development needs.

Comparing results at the end of the project to when they began, home visitors increased their knowledge or confidence, on average, in 10 of the 12 areas assessed.

AREAS OF MOST COMFORT OR KNOWLEDGE ON POST-SURVEY

(Percent of Home Visitors Responding 4/5 or 5/5 at Post)

89%	Comfort communicating with and involving parents regarding children's strengths and needs
85%	Understanding the social/emotional/developmental needs of children
84%	Knowledge of own strengths and areas of growth as home visitor
84%	Comfort giving referrals for more intensive services for young children

GREATEST INCREASES FROM PRE TO POST-SURVEY

(Change in Percent of Home Visitors Responding 4/5 or 5/5 from Pre to Post)

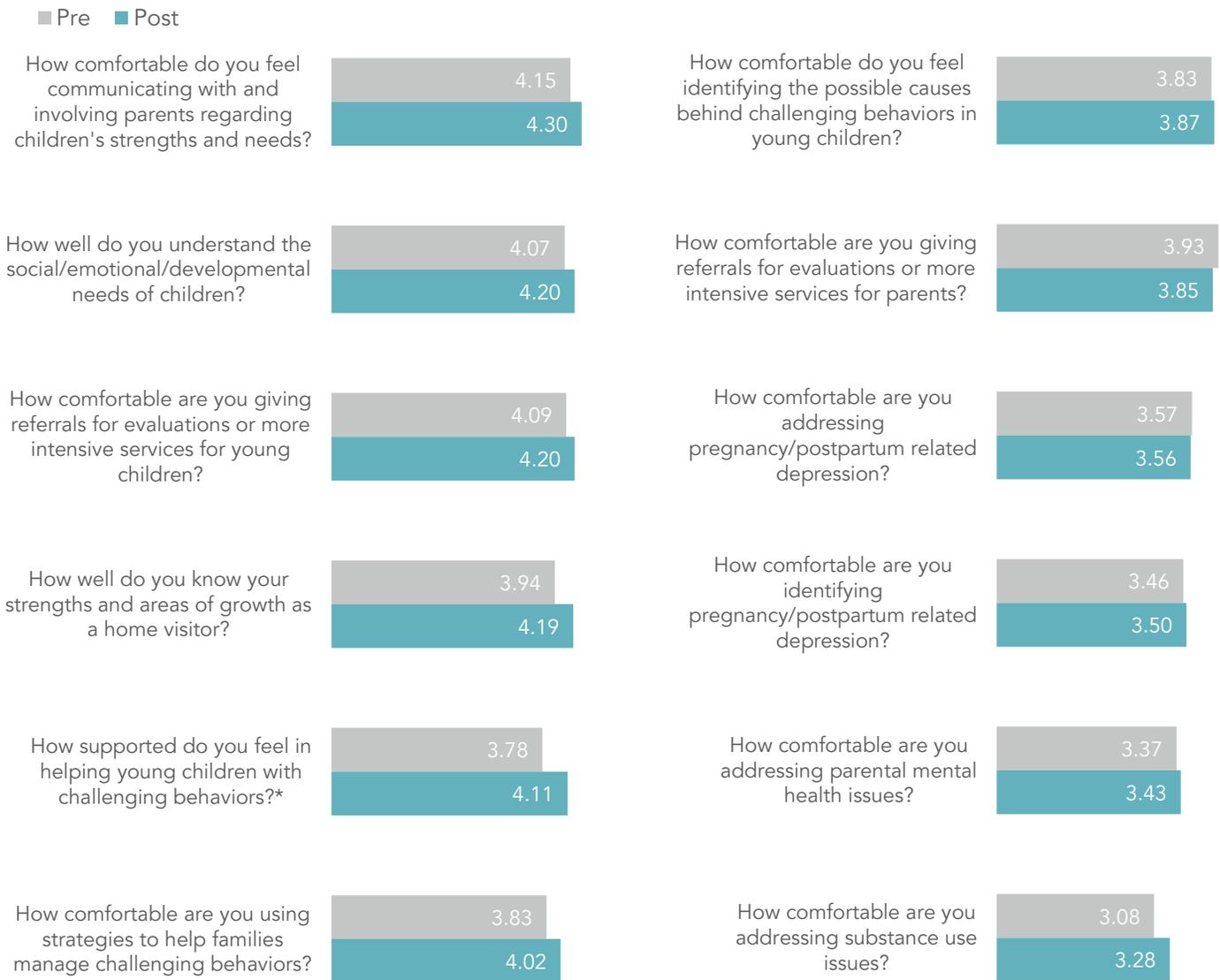
+15	Support felt in helping young children with challenging behaviors (61% to 76%)
+15	Comfort addressing substance use issues (36% to 51%)
+11	Comfort using strategies to help families manage a child's challenging behaviors (69% to 80%)
+8	Knowledge of own strengths and areas of growth as a home visitor (76% to 84%)

Being able to talk with the other home visitors and our [MHC], it really has given me a lot of knowledge on how to handle some situations and probably perspective as to 'maybe this is why this child behaves this way.'

-Focus Group Participant

There was statistically significant growth in only one area: how supported they felt in helping young children with challenging behaviors. Three other topics increased by 8 to 15 percentage points from pre- to post-survey—addressing substance issues, comfort using strategies to help families manage a child’s challenging behaviors, and knowledge of own strengths and areas of growth as a home visitor—though it was not statistically significant growth. Figure 1 shows the change in the average rating from the pre- to post-survey in each of the 12 areas assessed ordered by most to least confident or knowledgeable on the post-survey. All home visitors are reported in aggregate for this figure.

Figure 1: Average rating of home visitor knowledge/confidence in 12 areas at pre- and post-test



*=data statistically significant, $p < .05$

While there is modest growth in almost all areas on the survey, the decreases in two areas did not align with what we were hearing from home visitors and their supervisors in other spaces. Upon further examination, it was home visitors from one site that tended to rate themselves lower on the post-survey than on the pre-survey. It is unclear why this might be the case, though it could be because home visitors became more aware of how much knowledge and expertise exists in early childhood education and family support or simply that they practice certain skills less than other sites. As one focus group participant noted, "I think all of those things I feel competent on, but...when you did the survey, it was hard because if you don't practice it, then you don't know where your competence level is."

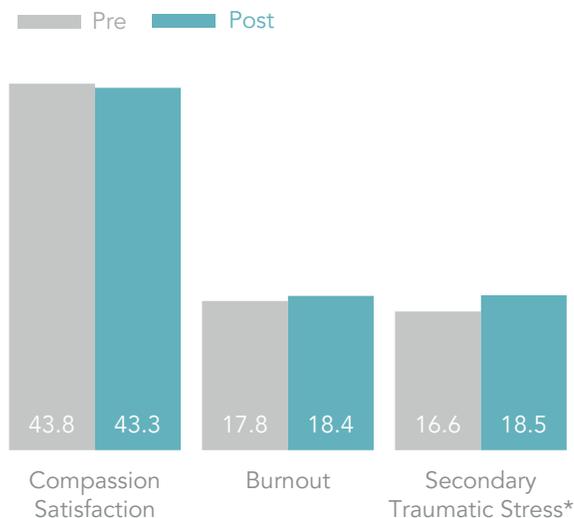
I get a lot of guidance from [the mental health consultant], which I really appreciate... I really use her guidance to let go of some of the things and kind of put a protective bubble over around myself that some of the stuff doesn't stick. But the second [most valuable thing about the project] is the guidance that we've gotten on mindfulness... It's helpful to build into the visits with our clients to help them deal with their stress or maybe start our visit off in a more quiet, calm way. I use it, learning from either [the mental health consultant] or the mindfulness consultant to let go of some of the stuff that's been building up. So I don't really feel like my job affects me in a negative way... when somebody is going through some sort of crisis, because I have so much support around me. I think that a critical piece to being a home visitor is having this program.

-Focus Group Participant

Compassion Satisfaction, Burnout, and Secondary Traumatic Stress

The home visitor survey included a 30-question tool called the Professional Quality of Life measure. The existing research suggested that enhanced home visitation could decrease the burnout and secondary traumatic stress felt by home visitors due to their work with families. Interestingly, each measure of the ProQOL went in the opposite direction of what we might expect given the stories and testimonies received through other data collection methods. What we found was that compassion satisfaction decreased slightly while both burnout and secondary traumatic stress increased slightly over the course of the project. Neither the change in compassion satisfaction nor the change in burnout was statistically significant, however the change in secondary traumatic stress between the pre-survey and post-survey was statistically significant in 2020. Figure 2 represents the average scores on the three ProQOL subscales at pre-test and post-test.

Figure 2: ProQOL results pre- and post-surveys



*=data statistically significant, $p < .05$

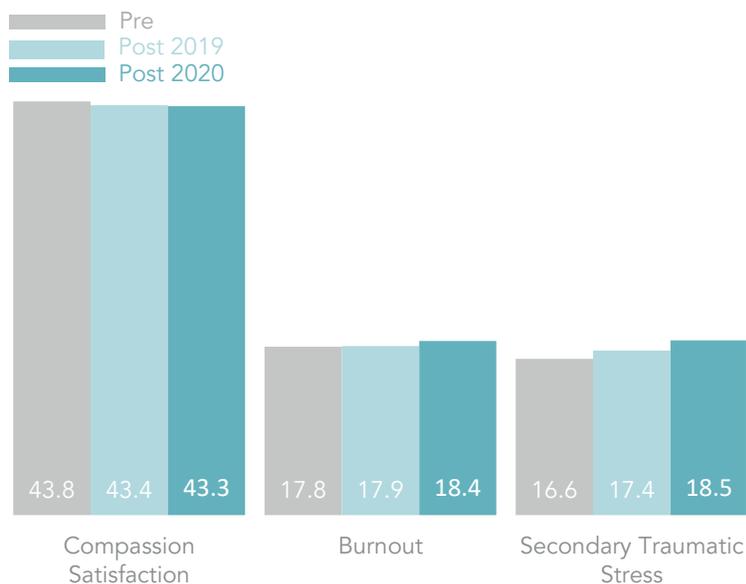
The post-survey in the spring of 2020 was conducted in April and May, shortly after Colorado’s Stay at Home orders began and most programs switched to remote programming. Focus group participants and annual site-level reports suggest that the COVID-19 pandemic caused a great deal of additional stress felt by home visitors and the families they serve. These extenuating circumstances most likely caused higher burnout and secondary traumatic stress scores for surveys collected during that time.

While COVID-19 and the Stay at Home orders likely affected the survey results for 2020, similar trends existed in the survey data collected in the spring of 2019. Figure 3 shows results from three time periods: the pre-survey, post-surveys collected in 2019, and post-surveys used in final analysis, largely collected in 2020. Compassion satisfaction and burnout saw very small changes between pre- and post-surveys completed in 2019, while secondary traumatic stress saw a slightly larger increase.

One potential explanation for the increased reporting of burnout and secondary traumatic stress is a newfound recognition of the burnout and secondary traumatic stress that was always present in the job. As a focus group participant noted, “Before the project we were doing, ‘this is just our job, this is just our everyday.’ We weren't really noticing it [stress and burnout], because we didn't realize what was inside us and what was inside our parents. And I think that we were just going with the motion. Then all of a sudden, when we get this project, you start to be aware of more, right? So your awareness is heightened....Now we know what we're looking for, what we're seeing. And now we are just now learning how to practice, to hold our stress, to handle our stress. And this hasn't come together yet.”

It is also possible that a small increase in burnout and secondary traumatic stress is a positive outcome. Home visitors potentially encountered many stressful and traumatic situations over the course of the project, and home visitors without the support of the EHV Project might have reported much higher levels of burnout and secondary trauma given the same experiences. Further research is necessary to determine the impact of enhanced home visitation in this regard.

Figure 3: ProQOL results from pre-surveys and post surveys completed in 2019 and 2020



The findings reported thus far—little change in confidence and knowledge and unexpected ProQOL results despite very high satisfaction with the project—inspired adaptations in the evaluation plan. In order to gain more insight into the context around the results, two elements were added for Year 3. First, there was an additional set of questions on the post-survey asking how helpful the mental health consultant was in the 12 areas assessed for confidence and knowledge. Second, a series of focus groups with home visitors were added in the spring of 2020 specifically to ask about the mixed survey results.

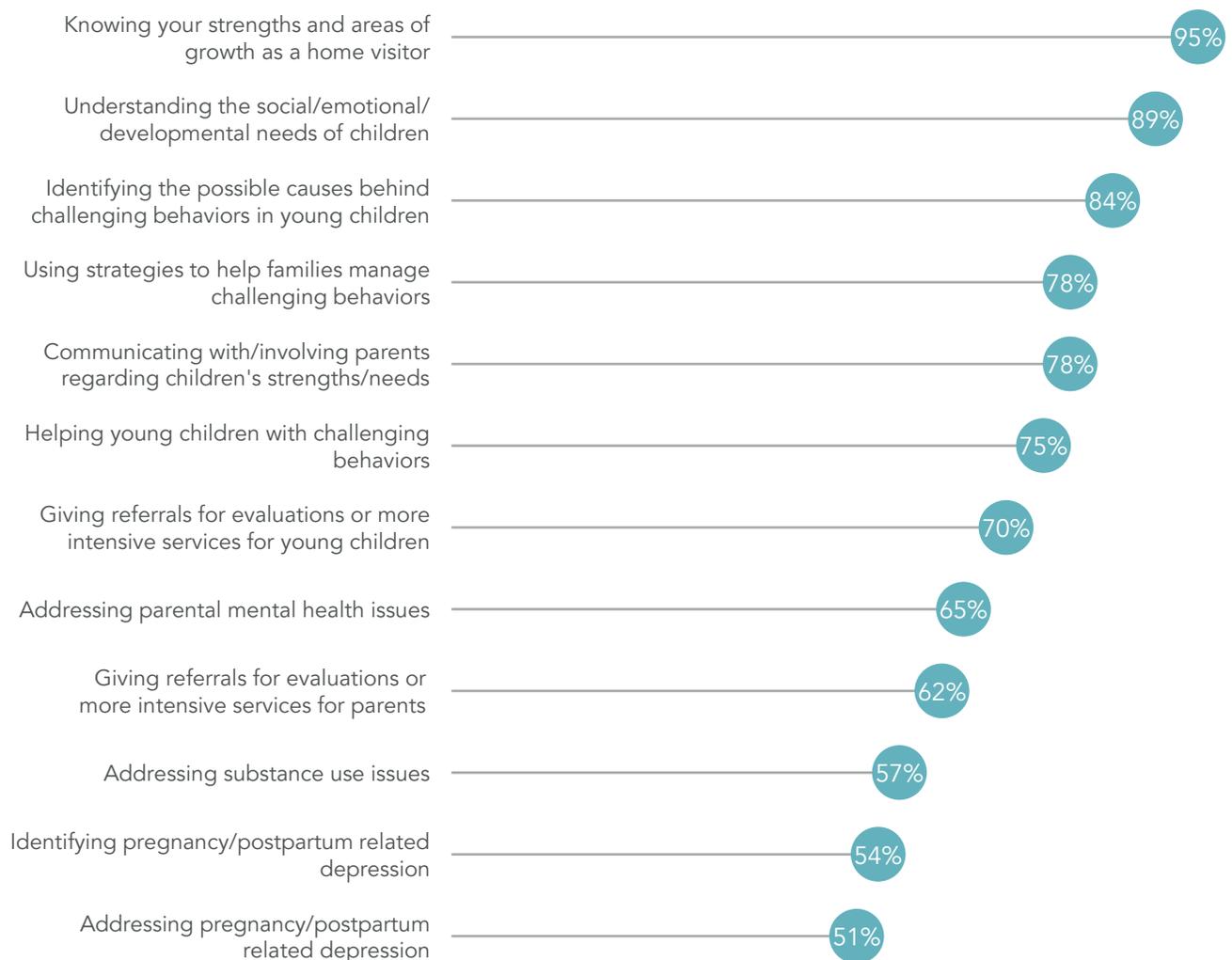
2020 Evaluation Plan Updates

Results from the additional questions on the survey and in the focus groups revealed two truths. First, on average, most home visitors report their mental health consultants do help them in the 12 areas assessed, though in some areas more than others. Second, the survey questions did not ask about the areas of work impacted most by the EHV Project—mindfulness and self-care.

To the first point, an additional set of 12 questions was added to the post-survey in the spring of 2020 to assess how much impact the MHCs were having on the areas in question. The hypothesis was that perhaps there are not large increases in confidence and knowledge because those are not the topics on which MHCs and home visitors are spending time. As Figure 4 demonstrates, the areas home visitors feel most and least confident largely follow the areas in which they rate their MHCs most and least helpful, respectively. These results suggest that survey questions did not always capture the actual subject matter—and therefore the full impact—of the project. Findings from the focus groups discussed below further support this idea.

Figure 4: Ratings of Mental Health Consultant helpfulness

Percentage of home visitors reporting their Mental Health Consultant was "Very" or "Extremely Helpful":



When asked about the home visitor survey results and what has changed that is not captured on the survey, home visitors noted that the survey did not ask about mindfulness or self-care practices and strategies. One focus group participant noted:

I feel like my knowledge has gone up. But not in the areas that you really ask about...[T]he mindfulness was...something that I felt like my knowledge went up in because [it was] making me more aware of my own mindfulness and how important it is. And then when I go in and see families, and they're maybe not in that space, to use some techniques, to maybe help, mainly get myself in a good spot so that...I can mirror that for them or something. So I do feel like [my knowledge has] gone up and I feel like my stress has gone down because I understand more what's going on with these particular families and their mental health piece.

In response to the question "Were there things that you were learning that we didn't ask about on the survey that we didn't capture very well?", another focus group participant said:

Yeah. I think a lot of it, how we use the mental health and [a website with all the home visitation group resources]... you guys kind of focused on the drug, the trauma, but there's always a little about stresses, different stresses, like the mental health. I use that so much with my parents, the breathing techniques, the child development, all those kinds of classes I used all the time with my parents. And we really didn't get asked a lot about the consultation and some of that training, I think.

Through these focus groups, the regular satisfaction surveys, and the site-level annual reports, it became clear that the mindfulness consultation and self-care strategies provided by MHCs and Jessica Gershwin from the Denver Children's Advocacy Center were some of the most meaningful parts of the EHV Project for participants and where participants grew the most in their professional lives.

While stress levels might plateau or increase due to external factors such as the global pandemic, climate change and natural disasters, loss of jobs, family death or illness, or a threat of deportation faced by families served or home visitors themselves, we suspect that the tools and strategies learned through mental health and mindfulness consultation mean home visitors are more resilient and better able to cope with those stressors. Stress and trauma will not disappear, but how home visitors handle the stress and trauma of families they serve can change. Further research on similar projects should examine the impact of mindfulness and self-care on home visitors and their work with a specific focus on professional resiliency.

Site-Level Findings

Existing research on impact at the site level supported the idea that enhanced home visitation could decrease home visitor turnover, increase the quality of services, and improve linkages to other mental-health related organizations in the community. Data were collected on these items on the site-level annual report. The first year's report for 2017-18 also asked sites to report on 2016-17 data to compare post-project data to pre-project data.

The EHV project has contributed greatly to the retention of families as we are now able to support them with greater knowledge in the area of children's mental health.

-Site Director

For home visitor retention, participating sites reported the number of home visitors employed each year and how many of those staff left throughout the year. Quality of services was measured in two ways—family retention and program fidelity—and community linkages were shared in narrative form as sites were asked about their relationship with mental-health focused agencies and programs, including if and how the relationship changed since the beginning of the Enhanced Home Visitation Project.

While this evaluation cannot prove a causal relationship between the EHV Project and site-level outcomes, results suggest a positive relationship between participation in enhanced home visitation and fidelity, home visitor retention, family retention, and community partnerships.

Before starting the EHV Project in the fall of 2017, PAT and HIPPY programs were meeting an average of 92 percent of fidelity measures.⁷ Fidelity across all programs improved each year over the course of the project, with 98 percent of fidelity measures being met in the 2019-2020 program year.

Home visitor attrition before the EHV Project began was 26 percent, meaning 26 percent of the home visitors employed over the course of the program year left their positions. There was not a clear downward trend in attrition the way fidelity increased each year, however the participating programs had lower attrition than 2016-17 each year during the project and ended 2019-2020 with only 2 percent attrition.

The EHV project has improved the program's retention of Parent Educators. No PE has left since the program started three years ago. This improved retention is due in large part to our work with the MHC and the workshops emphasizing stress management and self-care.

-Site Director

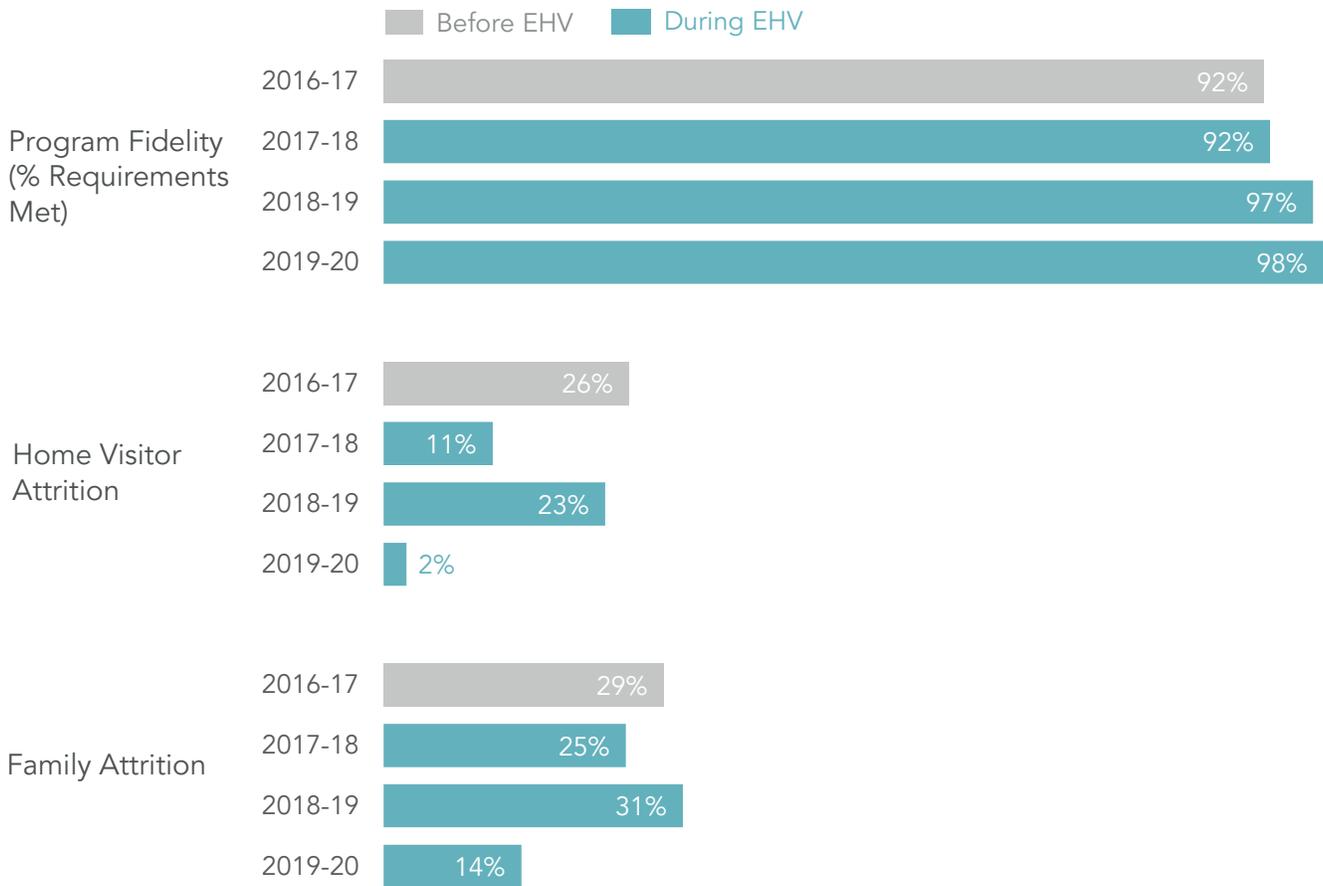
Lastly, family attrition also improved over the course of the EHV Project and largely followed the trends of home visitor attrition.⁸ Twenty-nine percent of families left before completing the PAT, HIPPY, or SafeCare programs in 2016-17 while that percentage decreased to only 14 percent of families exiting early in 2019-2020. The increase in family attrition in 2018-19 parallels the increase in home visitor results in the same year. Two program sites experienced unusually high staff attrition, which often results in losing the families assigned to those staff. These two sites account for half of the home visitors that left their positions in 2018-19 and nearly half of the families that exited early in the same year.

The following chart depicts the changes in program fidelity, home visitor attrition, and family attrition over time. The grey bars represent data from 2016-17, before the EHV Project began, and the three teal bars represent the three years of the EHV Project: 2017-18, 2018-19, and 2019-20.

⁷ Jeffco PCHP and the SafeCare and PSSF programs at Arapahoe County ECC did not report fidelity information on the annual reports.

⁸ Family retention data include families from PAT, HIPPY, and SafeCare. The PSSF Caseload is not reported due to the nature of the program and no reported data on families exiting before completion.

Figure 5: Site-Level Program Quality 2016-2020



Another theme of the annual reports is how reflective consultation establishes and builds team cohesion. Further supported by evidence gathered through surveys, interviews, and focus groups, spending time in group reflective consultation creates a stronger bond among home visiting team members and strengthens trust in the group. As one site notes:

The access to reflective supervision with a trained professional has brought our staff together in ways that we couldn't even imagine. Through these activities and increased knowledge and understanding about mental health, parent/child attachment and reflective practices, we as a staff have been able to understand ourselves, share our thoughts with our team, and develop a new and non-threatening way to understand mental health and share that same message with our families.

*Eso ayuda...sentirnos
más conectados y
entendernos más
[Translation] It [reflective
consultation] helps... we
feel more connected
and understand each
other more.*

-Home Visitor Interview



*I think both the consultation and the mindfulness time has been really valuable.
Sometimes it's the only time we have to really go over challenges that we're dealing
with and really be together and talk about those things.*

-Focus Group Participant



*Sobre todo, la forma de
comunicarnos. Comunicar las
situaciones que se presenta...por
ejemplo, si se presenta alguna
discusión... lo podemos hablar...
lo podemos expresar, y escuchar a
las partes y llegar a un acuerdo
[Translation] Above all, [our team
has changed] our way of
communicating. Communicating
about the situations that present
themselves...for example, if a
discussion comes up... We can
talk...we can express ourselves,
and listen to the parts, and come
to an agreement.*

-Home Visitor Interview

Family-Level Results

Despite multiple metrics for family-level change being included in the original evaluation plan, finding complete and relevant family-level quantitative data to analyze responsibly proved challenging. Programs do not all capture social-emotional development of the children served, nor do all the programs in the project measure children's school readiness. The COVID-19 pandemic also limited sites' ability to collect outcome data at the end of Year 3.

Despite these difficulties, PAT and HIPPY programs across Colorado completed a parent-child observation tool—the PICCOLO—in 2018-19 as part of those programs' existing funder requirements and evaluation plans. Home visitors could not complete the observations usually conducted in the spring during the 2019-2020 program year, thus results were examined from the prior year.

The PICCOLO (Parenting Interactions with Children: Checklist of Observations Linked to Outcomes) is a strengths-based measure of parenting interactions that predicts children's early social, cognitive, and language development. The PICCOLO measures four domains: affection, responsiveness, encouragement, and teaching. Based on research with diverse, low-income samples, the measure developers identified proficiency cutoffs of below average, average, and above average.

The results shown below compare PAT and HIPPY sites participating in the EHV Project to those not served through Community First Foundation's EHV Project. Non-EHV PAT and HIPPY sites in Colorado are not a perfect comparison group for a few reasons. Some of the non-EHV sites reported here do have access to a mental health consultant from other projects or funders, though they are not utilized to the same extent as those in the EHV Project in this report, nor do they participate in mindfulness consultation from Denver Children's Advocacy Center as most of the EHV Project sites do. All of the sites in the EHV Project are located in the Denver Metro area while non-EHV sites are spread throughout the state. We also do not consider the demographic characteristics of the families being observed in the current analysis, and families from EHV Project sites might differ in meaningful ways from families served by non-EHV Project sites.

I've also passed on some of the mindfulness activities to the families I work with, and I think they really were thankful for those. Especially during the COVID stuff...[The consultant] had given us some different videos and resources that we could give our families, and I know the families that I gave those to were really appreciative.
-Focus Group participant

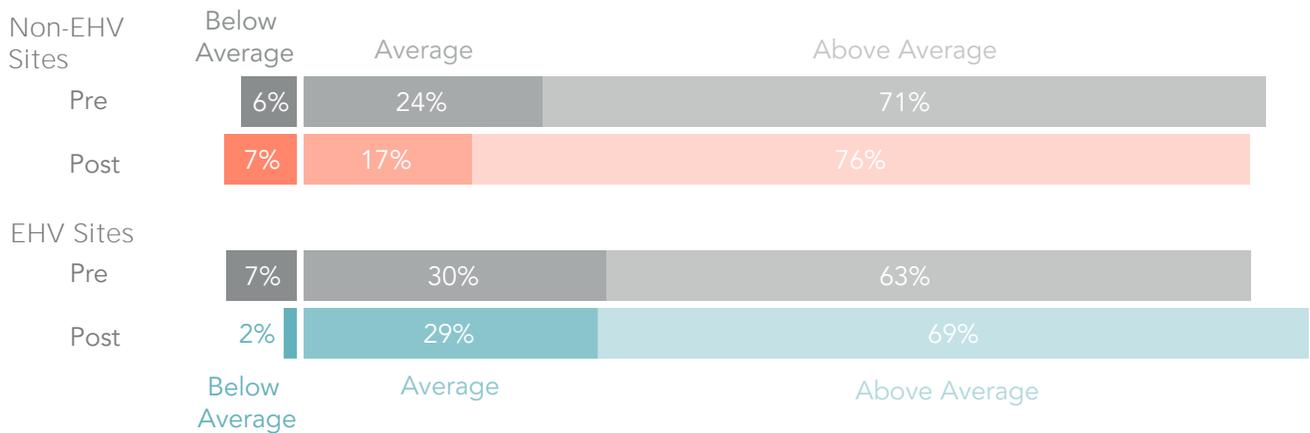
Keeping the limitations of this analysis in mind, data suggest participation in the EHV Project could lead families to practice more developmentally-appropriate interactions with their children even beyond the growth seen in non-EHV Project PAT and HIPPY sites. At pre-test, families at EHV- and non-EHV sites scored in the below average category at similar rates (HIPPY: 7 and 6 percent, respectively; PAT: 12 and 13 percent, respectively). When observed again at post-test, however, families at the EHV Project sites were less likely to score in the below average range (HIPPY: 2 vs. 7 percent, respectively; PAT: 3 vs. 5 percent, respectively).

When looking at the other end of the scale, families in non-EHV Project sites were more likely to exhibit above-average developmentally-appropriate behaviors when interacting with their children at both pre- and post-test. Even so, families at PAT and HIPPY sites participating in the EHV Project demonstrated a larger percent increase in the proportion scoring in the above-average range. Fifty-three percent more families displayed above-average developmentally-appropriate behaviors at post-test (from 38 to 59 percent), compared to a 26 percent increase among non-EHV site PAT families (from 53 to 67 percent). At HIPPY program sites, EHV-site families in the above average range increased by 10 percent (from 63 to 69 percent), while families from non-EHV HIPPY sites increased 7 percent (from 71 to 76 percent).

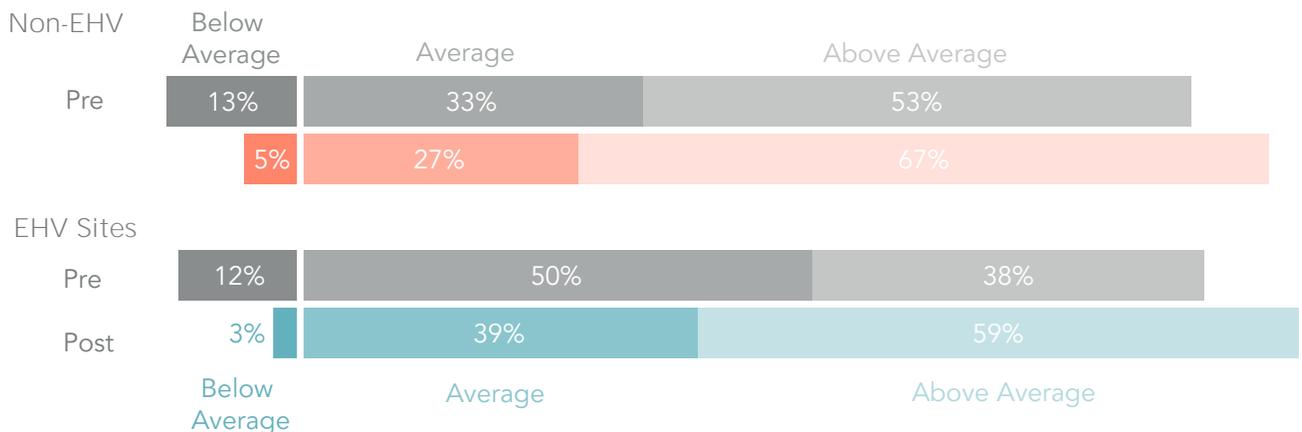
Figure 6 shows the results in more detail with grey bars representing the scores at pre-test for EHV and non-EHV sites, orange bars represent post-test scores at non-EHV sites, and teal bars represent post-test scores from the EHV sites included in this report.

Figure 6: PICCOLO scores from Colorado HIPPY and PAT programs in 2018-19, EHV Project-sites and non-EHV Project sites

HIPPY



PAT



These findings further support the notion that time with mindfulness and mental health consultants equip home visitors with tools and strategies they then share with families they serve. As one focus group participant noted, she has often used skills in how to interact with children in less stressful ways and self-regulation for parents. Another participant shared that one of the mothers she works with loves the new activities the home visitor brings from the trainings she receives. Assuming this is true for other home visitors as well, it naturally follows that parents benefit when home visitors receive on-going training around mindfulness, self-care, reflective practice, and trauma-informed care.



Home Visitors have reported that they feel more knowledgeable and skilled to respond and support families and their needs. Staff feel confident with the additional support, education and the opportunity to support their reflective process. We have shown an increase in identifying special needs, with all team members feeling supported with the process as well as an increase in access to mental health resources that families need.

-Site Director

Ver el crecimiento en los niños en diferentes áreas de desarrollo. como el notar que las familias se sienten mas confidentes y con herramientas que implementan con los niños en sus interacciones o en su día a día. Eso es muy satisfactorio y alentador el poder ver como hacemos una diferencia en la vida de esos niños y sus familias.

[Translation] To see the growth in children in different areas of development, such as noticing that families feel more confident and with tools that they implement with the children in their interactions or in their day-to-day lives—that is very satisfying and encouraging to see how we make a difference.

-Home visitor



CHALLENGES AND LESSONS LEARNED

Over the course of the three-year EHV project there were several challenges as well as lessons learned. Below are some of the top takeaways.

Establishing trust is key: It takes time for home visitors to understand the process as well as the benefit of meeting with a mental health consultant. It can take up to a year for participants to establish a strong relationship with their consultant and fully trust them and the reflective process. Being patient, flexible, and allowing enough space to develop this relationship is important. Consultants should be willing to meet with home visitors on their time and not expect the home visitors to accommodate a set schedule. Finding the right fit with the mental health consultant is critical to success. The consultant can have the necessary credentials, but if the team is not comfortable with them, they cannot communicate in the home visitors' native language, or if they are not available when needed, the capacity to be reflective cannot be fully developed.

Quantitative data don't tell the full story: The real value of the EHV project is not clearly articulated with quantitative data alone. By relying solely on pre/post survey and assessment results, the actual impact of the project can be overlooked. Focus groups and direct conversations with home visitors and supervisors led to many rich stories of impact and uncovered areas for continued improvement.

Importance of agency support: In order to be truly successful, all levels of leadership must be bought in to the value of enhanced home visitation. This requires a shift within the entire agency from the top down and changing practices, policies, and the overall culture. If supervisors and directors do not prioritize this work, it can be frustrating for home visitors and will make it difficult for them to fully embrace the process and realize the benefits.

Benefit of the supervisory consultant: The mental health consultants reported monthly meetings with a supervisory mental health consultant were extremely valuable. They were able to discuss themes and topics related to being an effective reflective consultant with others doing similar work. However, these sessions were difficult to coordinate given the schedules of the consultants and were an additional expense, since all consultants were paid for this time. If a supervisory consultant is not incorporated into future projects, having mental health consultants continue to receive reflective supervision as well as group consults through other avenues is still important.



Being intentional with training: In order to sustain the impacts of this project, it is important to include intentional training around early childhood mental health, reflective supervision, and other related topics for program site staff. It is also critical to consider the coordinators' and home visitors' background and level of experience and not assume they understand how to give or receive reflective supervision. Offering regular, comprehensive trainings for all levels, opportunities for exploring and sharing concerns and ideas within and between agencies, and ensuring all supervisors who provide reflective supervision are receiving it have been identified as key components moving forward.

Experience for Spanish-speaking home visitors: Several home visitors participating in this project were monolingual Spanish speakers and found components of this project not fully accessible. The sites with monolingual Spanish speakers had a harder time finding a bilingual mental health consultant. One of the teams had to split up English and Spanish speakers into separate groups, which potentially impacted the cohesion of the team and increases costs. The Foundations for Infant Mental Health

course was not made available in Spanish until year two of the project and fewer courses were offered over the course of the project than were offered in English. Parent Possible provided all surveys, emails and training materials in English and Spanish and hired interpreters for the full day retreat in Year 3, however some of the trainings were not fully accessible for all participants. Having translation and interpretation services for all meetings and ensuring all communication is available in English and Spanish should be prioritized moving forward.

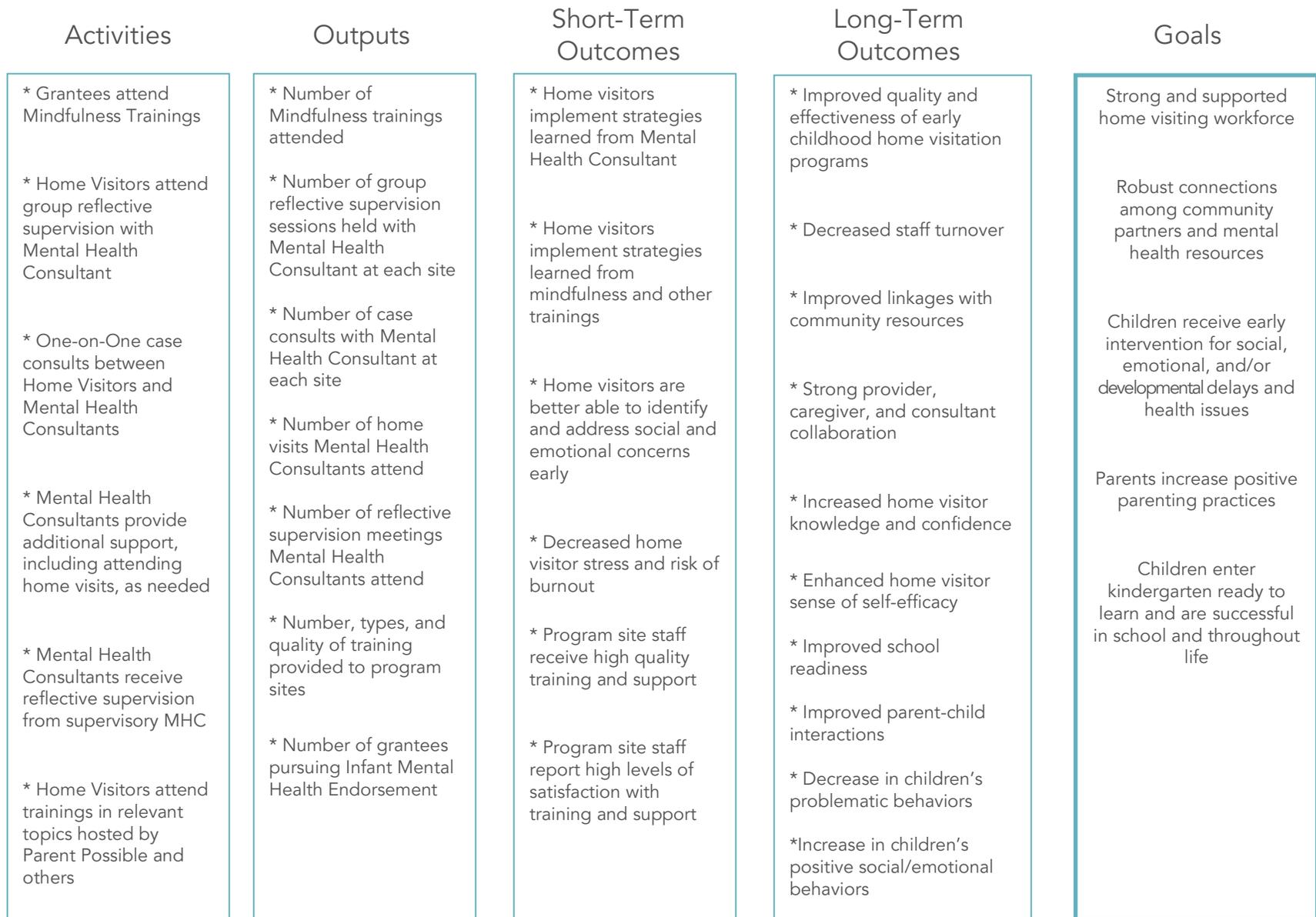
Confusion with complex funding structures: Several of the program sites had multiple funding sources supporting various components of enhanced home visitation (including LAUNCH and MIECHV in addition to EHV). This led to increased data burden as they were collecting program level and family level data for several funders. It also created some confusion around fiscal and programmatic reporting. While the intention of supporting sites who were in Launch communities was a good one, it complicated the project evaluation and expenditure reporting (i.e. determining which grant paid for what activity).

Difficulty collecting data: Communication and data collection from the mental health consultants and home visitors was challenging. Due to busy schedules, competing priorities, and home visitors not checking their email regularly, it often took multiple attempts to get necessary data and many of the forms were incomplete when returned. Attempting to collect data points across multiple program models was also challenging, especially the program models that Parent Possible does not oversee. Implementing use of the Basecamp site for coordinators and consultants in Year 2 was useful for communicating due dates and posting training materials but simplifying the forms and having a more streamlined way for participants to submit their data would be helpful.

COVID-19 Challenges: The biggest challenge in year 3 of the grant was navigating the COVID-19 pandemic. It impacted every level of programming—training, home visits, group meetings, recruitment, assessments/screenings, staff stress levels, working with families experiencing an extreme level of stress/trauma, increased need for services for families (e.g. rent, food, diapers, etc.), lack of child care for staff, site funding, technology for both staff and families, and the impact on the overall mental health of families and staff. It also impacted funding for several program sites. However, this challenging time has highlighted how committed and resilient home visitors are and how important this work is – especially the focus on self-care and coping strategies. It has also shown that using a virtual platform instead of in-person meetings is an effective and, according to some home visitors, a preferred way of receiving reflective consults.



APPENDIX A: LOGIC MODEL



APPENDIX B: EVALUATION PLAN

	Outcome	Indicator/	Tool/Measurement	Collection Period	Completed By
Site Level	Decreased turnover	Fewer HVs leave after implementing EHV	Annual Report	Annually, in July (ask at Pre for prior year)	Program Supervisor/Coordinator
	Increased quality of services	Improvement on program fidelity measures (or maintain if meeting all requirements)	Annual Report	Annually, in July (ask at Pre for prior year)	Program Supervisor/Coordinator
	Site Level Increased quality of services	Improved family retention over the course of the grant period	Annual Report	Annually, in July (ask at Pre for prior year)	Program Supervisor/Coordinator
	Improved linkages with community resources	Increased number and quality of relationships with mental health-focused agencies or programs	Annual Report	Annually, in July	Program Supervisor/Coordinator
	Satisfaction with services	Sites report high levels of satisfaction with Parent Possible and Joy Brown	Satisfaction survey sent separately	Every 6 months	Program Supervisor/Coordinator
		Consultants report high levels of satisfaction with Joy Brown	Satisfaction survey sent separately	Every 6 months	Consultant
Home Visitor	Increased knowledge	Number of home visitors pursuing ECMH Endorsement	Annual Report	Annually, in July (ask at Pre for baseline)	Program Supervisor/Coordinator
		Number of HVs and supervisors that attend trainings hosted by other agencies	Annual Report	Annually, in July	Program Supervisor/Coordinator
		Number of HVs and supervisors that attend trainings hosted by Parent Possible or DCAC	Sign in Sheet	After each training (DCAC or Parent Possible)	Parent Possible
		Number of HVs that report increased knowledge following trainings	Post-training survey	After each training (DCAC or Parent Possible)	Home Visitor
		Number of HVs that report increased knowledge	HV pre/post Survey	Pre: Fall 2017 or upon hire Post: Every Spring	Home Visitor

Home Visitor	Satisfaction with services	HVs report high levels of satisfaction with trainings	Post-training survey	After each training	Home Visitor
		HVs report high levels of satisfaction with consultant	HV satisfaction survey	Every 6 mo	Home Visitor
	Reduced Stress	HVs report reduction in stress since utilizing services of MHC	HV pre/post survey	Pre: Fall 2017 or upon hire Post: Every Spring	Home Visitor
	Enhanced sense of self-efficacy	HVs report increased confidence around supporting families facing certain issues	HV pre/post survey	Pre: Fall 2017 or upon hire Post: Every Spring	Home Visitor
	Implementation of techniques and strategies recommended by the consultant	HVs report using techniques/strategies learned from consultant	HV satisfaction survey	Every 6 mo	Home Visitor
		HVs report they used strategies or techniques provided by consultant in a one-on-one case consultation	One-on-One Case Consult Form (report total in Consultant Quarterly Report)	Consultant follow up with HV 4 weeks after individual case consult	Consultant
	Increased ability to identify and address social and emotional concerns early	Number of group reflective supervision sessions and one-on-one case consultations consultant holds with HVs	Consultant Quarterly Report	Quarterly	Consultant
	Strong provider, caregiver, consultant collaboration	HVs increase number of one-on-one case consults with consultant	Consultant Quarterly Report	Quarterly	Consultant
Family/Child	Improved interaction with child	Increased PICCOLO scores	PICCOLO	See PAT & HIPPIY guidance	Family/Home Visitor
	Improved school readiness	Children increase his/her percentile rank on Bracken	Bracken	See PAT & HIPPIY guidance	Family/Home Visitor
	Decreased problematic behaviors	HV reports child shows reduced problematic behavior following one on one consult with the consultant	One-on-One Case Consult Form (report total in Consultant Quarterly Report)	Consultant follow up with HV 4 weeks after individual case consult	Consultant
	Increased positive social/emotional behaviors	Decreased ASQ-SE scores for children in Monitor or Refer Categories	ASQ-SE-2, Annual Report	Annually, in July	Family/Home Visitor & Program Supervisor/Coordinator

APPENDIX C: HOME VISITOR PRE/POST SURVEY

Please rate the following questions regarding knowledge/confidence on a scale of 1 (Not at all) to 5 (very)

How well do you understand the social/emotional/developmental needs of children?

How comfortable do you feel identifying the possible causes behind challenging behaviors in young children?

How comfortable are you using strategies to help families manage challenging behaviors?

How comfortable do you feel communicating with and involving parents regarding children's strengths and needs?

How well do you know your strengths and areas of growth as a home visitor?

How supported do you feel in helping young children with challenging behaviors?

How comfortable are you identifying pregnancy/ postpartum related depression?

How comfortable are you addressing pregnancy/ postpartum related depression?

How comfortable are you addressing parental mental health issues?

How comfortable are you addressing substance use issues?

How comfortable are you giving referrals for evaluations or more intensive services for *young children*?

How comfortable are you giving referrals for evaluations or more intensive services for *parents*?

How helpful has your mental health consultant been in the following areas:

(Added Spring 2020; Options were: Not at all helpful, Slightly helpful, Moderately helpful, Very helpful, Extremely helpful)

Understanding the social/emotional/developmental needs of children

Identifying the possible causes behind challenging behaviors in young children

Using strategies to help families manage challenging behaviors

Communicating with and involving parents regarding children's strengths and needs

Knowing your strengths and areas of growth as a home visitor

Helping young children with challenging behaviors

Identifying pregnancy/postpartum related depression

Addressing pregnancy/postpartum related depression

Addressing parental mental health issues

Addressing substance use issues

Giving referrals for evaluations or more intensive services for young children

Giving referrals for evaluations or more intensive services for parents

When you help people you have direct contact with their lives. As you may have found, compassion for those you help can affect you in positive and negative ways. In this section are some questions about your experiences, both positive and negative as a Home Visitor. Consider each of the following questions about you and your current work situation.

Select the response that honestly reflects how frequently you have experienced these things in the past 30 days. (*Options were Never, Rarely, Sometimes, Often, Very Often*)

I am happy

I am preoccupied with more than one of my Home Visiting families

I get satisfaction from being able to help my Home Visiting families

I feel connected to others

I jump or am startled by unexpected sounds

I feel invigorated after working with my Home Visiting families

I find it difficult to separate my personal life from my life as a Home Visitor

I am not as productive at work because I am losing sleep over the traumatic experiences of my Home Visiting families

I think that I might have been affected by the traumatic stress of my Home Visiting families

I feel trapped by my job as a Home Visitor

Because of my job as a Home Visitor, I have felt "on edge" about various things

I like my work as a Home Visitor

I feel depressed because of the traumatic experiences of my Home Visiting families

I feel as though I am experiencing the trauma of some of my Home Visiting families

I have beliefs that sustain me

I am pleased with how I am able to keep up with home visiting techniques and protocols

I am the person I always wanted to be

My work makes me feel satisfied

I feel worn out because of my work

I have happy thoughts and feelings about my Home Visiting families and how I can help them

I feel overwhelmed because my casework seems endless

I believe I can make a difference through my work

I avoid certain activities or situations because they remind me of some of the frightening experiences of my Home Visiting families

I am proud of what I can do to help my Home Visiting families

As a result of my work as a Home Visitor, I have intrusive, frightening thoughts

I feel "bogged down" by the system

I have thoughts that I am a "success" in my work

I can't recall important parts of my work with trauma victims

I am a very caring person

I am happy that I chose to do this work

APPENDIX D: HOME VISITOR & SUPERVISOR SATISFACTION SURVEY

1. Please select your title below (if you are both a home visitor and a supervisor, please select supervisor):

1. Home Visitor
2. Supervisor

2. How beneficial have you found working with Denver Children's Advocacy Center to be? (This includes the full day retreat and the quarterly consultations)

1. Not at All
2. Barely
3. Somewhat
4. A Lot
5. N/A

3. How likely are you to recommend meeting with a Mental Health Consultant to other home visitors/programs?

1. Not Likely
2. A Little Likely
3. Somewhat Likely
4. Pretty Likely
5. Extremely Likely

4. How much of a positive influence has your Mental Health Consultant had on your work?

1. None
2. A Little
3. Some
4. A Lot
5. N/A

5. How much of a positive influence has your Mental Health consultant had on your life?

1. None
2. A Little
3. Some
4. A Lot
5. N/A

6. How much positive change have you experienced in your organizational culture as a result of this project?

1. None
2. A Little
3. Some
4. A Lot
5. N/A

7. How often does your Mental Health Consultant treat you with respect?

1. Never
2. Rarely
3. Sometimes
4. Usually
5. Always

8. Do you have any comments or concerns about your Mental Health Consultant?

9. What would improve your experience in the Enhanced Home Visitation Project?

10. Are you satisfied with the support and communication you receive from Parent Possible surrounding the Enhanced Home Visitation Project? Is there anything that we could improve upon?

11. We are hoping to secure additional funding for this project to continue and expand in future years. Please share any specific stories about the positive impact of this project on you, the families you serve or your organization.

(If responded "Never" or "Rarely" to Q7)

12. We are sorry to hear that you feel your Mental Health Consultant does not treat you with respect. We want to do everything that we can to ensure that you have a positive experience in this project. If you are comfortable sharing your Mental Health Consultant's name and your concerns below we will work to address them.

APPENDIX E: SITE ANNUAL REPORT 2019-2020

This is the final report of our original grant cycle, and we will use your responses to compile our own final report. Please be as detailed as possible so we are able to convey the true value of this project.

Person completing the report:

Agency name:

Staff turnover rate for 2019 – 2020 program year (July 1 – June 30)

How many home visitors were employed over the course of the year?

How many left their positions over the course of the year?

Fidelity

What percentage of fidelity requirements did your program meet in 2019 – 2020?

Please list any fidelity requirements that you did NOT meet in 2019 – 2020. If you would like to comment on why this was the case and how you plan to meet fidelity next year, please do so below.

Family retention for program year 2019 – 2020:

How many families did you serve in program year 2019 – 2020?

How many of those families exited (or left the program) before completing the program?

FOR PAT: families actively enrolled for at least 18 months are considered to have completed the program.

FOR HIPPY: families in Years 1 or 2 should complete 26 packets before completing the program.

Improved Linkages With Other Community Resources

Please list all relationships your organization had with mental-health focused agencies and programs this grant year (October 2019 – September 2020). Describe the length, nature, and quality of the partnership/relationship, including if and how the relationship has changed since the beginning of the Enhanced Home Visitation project (October 2017).

Infant Mental Health Endorsement®

How many home visitors are currently pursuing or already received their Infant Mental Health Endorsement®? Please list their names, the type of Endorsement, when they began the process, and completion or target completion date in the table below.

Name	Start Date	(Target) End Date	Type of Endorsement (select from dropdown)

Training

Did you and/or your home visitors attend any trainings relevant to this project (i.e. reflective supervision, PICCOLO, mental health first aid, etc.) outside of those hosted by Parent Possible or DCAC? If yes, please list the title, topic, and host of each training and how many home visitors attended.

General

Please describe at least one specific example of how this project has benefited your families, home visitors, and/or your organization as a whole.

How has the EHV project influenced or changed your agency's culture and/or approach to your mission?

How has COVID-19 impacted your EHV project?

Is there anything else you would like to share with us related to the Enhanced Home Visitation Project?

This can include challenges, successes, good stories or suggestions for this project moving forward.

APPENDIX F: INTERVIEW QUESTIONS

Mental Health Consultants

1. What is the value of having Mental Health Consultants working with home visitors?
2. What are the challenges of this project?
3. Have you noticed any changes in the team you're currently working with since the inception of the project? If so, please describe.
4. What would you change about this project?
5. If we received funding to implement Enhanced Home Visitation at all HIPPPY and PAT sites in the state – what do you think should be the priorities or focus of the work? What are your recommendations for how to do this on a large scale?
 - a. How many home visitors in group reflective supervision is too many? How many would be too few?
6. Is meeting with a supervisory Mental Health Consultant beneficial/necessary to the success of your work?
7. For sites in remote areas of the state we're considering group or individual consultations with a Mental Health Consultant by Zoom. What are your thoughts about this?
 - a. If you had to pick, which is most valuable for home visitors if it had to be done via video calls: individual or group reflective supervision?
8. How would you articulate successes of this project? Do you have any success stories you'd be willing to record for us to share with funders?
9. What elements need to be in place within an organization for successful implementation of MHC with home visitors? (What are the markers of an agency that will benefit most from MHC?)

Site Coordinators

1. What is the value of having the EHV funding?
2. Have you noticed any changes in the quality of your team's work/relationships as a result of this project?
3. What would you change about this project? What are the challenges?
4. If we received funding to implement Enhanced Home Visitation at all HIPPPY and PAT sites in the state – what do you think should be the priorities or focus of the work? What are your recommendations for how to do this on a larger scale?
5. For sites in remote areas of the state we're considering group or individual consultations with a Mental Health Consultant by Zoom. What are your thoughts about this?
6. How would you describe successes of this project? Do you have any success stories you'd be willing to record for us to share with funders?
7. What does support for EHV from organizational leadership look like for you? How has their support, or lack thereof, influenced the project's implementation?
8. Knowing all of the types of support a MHC might provide and you had a limited budget, how did you determine what the MHC would do with your home visitors (individual reflective supervision, group reflective supervision, trainings, visits with families, meetings with program supervisors, etc.)? Did that change throughout the project?

Home Visitors

1. Has meeting with a Mental Health Consultant been valuable for you? Why or why not?
2. Have you noticed any changes in the quality of you and/or your team's work/ relationships as a result of this project?
3. Have you been able to better support the families you work with as a result of this project? If yes, how?
4. Have you gotten your Infant Mental Health Endorsement? Foundations training? Why or why not? (What are the barriers?)
5. What would you change about this project? What are the challenges?
6. If we received funding to implement Enhanced Home Visitation at all HIPPIY and PAT sites in the state – what should be the priorities or focus of the work? What are your recommendations for how to do this on a larger scale?
7. For sites in remote areas of the state we're considering group or individual consultations with a Mental Health Consultant by Zoom. What are your thoughts about this?
8. How would you describe successes of this project? Do you have any success stories you'd be willing to record for us to share with funders?
9. Given all the elements of this project, which have been most useful to you: DCAC quarterly consults, group reflective supervision, individual reflective supervision, Foundations Course/IMHE, Annual Retreat with Parent Possible, other related trainings?

APPENDIX G: FOCUS GROUP QUESTIONS

Who is in the “room”?

Site and program, length of time as home visitor, parts of project they receive (group RC, individual RC with your Mental Health Consultant, DCAC consultation, annual retreat, Infant Mental health Endorsement/Foundation Course), ice breaker (favorite activity to stay grounded during quarantine)

Implementation:

1. How does the reflective consultation fit into your regular duties as a home visitor? Is it stressful to find time to do it?
2. What were the downsides of having EHV added to your programming (consultation, DCAC trainings, retreat, IMHE)?
3. What was the most valuable part of the project?
 - a. Follow up: How has that changed the way you work, serve, or live? (why is it the most valuable)

Survey Results:

1. We asked home visitors about their comfort level and confidence in certain areas at the beginning of the project and then each spring. We expected to see growth in many areas, but it turns out not much changed on paper. Specifically, HIPPY home visitors reported being most confident communicating with and involving parents regarding children's strengths and needs, knowing your strengths and areas of growth as a home visitor, and giving referrals for evaluations or more intensive services for young children. HIPPY home visitors reported being least comfortable addressing substance use issues, parental mental health issues, postpartum related depression, and identifying postpartum related depression.
 - a. Was this your experience? Do you have any thoughts about why this might be the case? Were we not asking about the right things?
2. Thinking about where you were when the project began, do you think you know more about:
 - a. Child development?
 - b. Problematic behaviors in children?
 - c. Mental health issues in children and parents?
 - d. Giving referrals to families?
 - e. Follow up: where did you learn about it? How was education provided? Was it in trainings, consultation, other sources?
3. Thinking about where you were when you first began this project, are there other areas that you learned about and grew that we have not talked about already?
4. Are there areas you wish you had more training or experience? Would you be interested in receiving those trainings from your MHC? (if no, why not?)
5. Part of the survey also includes the ProQOL—Professional Quality of Life Scale—that measures compassion satisfaction, burnout, and secondary traumatic stress. We were hoping that this project would reduce burnout and secondary traumatic stress among home visitors, and we have heard this is true in some stories shared by home visitors and supervisors. The survey results, however, show home visitors actually report being a more burnt out and having more secondary traumatic stress than they did when first taking the survey. Has this been your experience? If not, why do you think home visitors are more burnt out than when we first started?
6. How has COVID-19 impacted your burnout and secondary traumatic stress levels? Has your mental health consultant been helpful during this time? How so or why not?
7. Have you considered leaving your position as home visitor? Has participation in this project influenced your decision to stay (or leave)?

Benefit for families or beyond their direct work:

1. Have you noticed any changes in your organization or in your team?
2. Were you able to share what you learned with your families? What does that look like? What skills did you access the most?

Relationship with Mental Health Consultant:

1. How would you characterize your relationship with your MHC? What did you like about your MHC? How did they make you feel comfortable?
2. Did you switch MHC during the project? How did that influence the team dynamic/your experience?
3. For HIPPY:
 - a. how long does it take to form a truly trusting and respectful relationship with your mental health consultant?
 - b. Given how many HIPPY home visitors change each year, how would you help the relationship develop faster?
 - c. For Jeffco: how did your program handle having home visitors that needed support in both English and Spanish? How do you think Spanish-speaking home visitors' experiences differed than those who are more comfortable in English?

Looking forward:

What do home visitors in Colorado need to be able to do their jobs more effectively and with less burnout?

APPENDIX H: MENTAL HEATH CONSULTANT QUALIFICATIONS

1. Master's degree in psychology, social work, nursing, or counseling
2. Colorado License in a mental health field (strongly preferred, but not required)
3. Experience working with pregnant women, infants and young children (0-6)—either direct services or in a consultant role
4. Prior experience working with underserved populations, preferred
5. Currently endorsed, in the process of being endorsed, or intention to become endorsed at the Infant Mental Health Specialist (Level III) or Infant Mental Health Mentor (Level IV) with COAIMH <http://coaimh.org/endorsement-information/>
6. Prior training and experience in reflective practice/consultation/supervision preferred
7. Liability insurance is required either through the agency or through the Mental Health Consultant
8. Bilingual, preferred (or required depending on the site)