Home Visiting Community Advisory Board (HVCAB) –

Meeting Summary

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| **Meeting Type: Home Visiting Community Advisory Board (HVCAB) Date: 10/24/22** | **Minutes Completed By: Jen Ettinger** |
| **Video Conference Attendees: 29 attendees** |
| Marneda Bailey, Zakiya Bakari-Griffin, Noelle Bartkowski, Heidi Beck, Stephanie Cantres, Debbie Finch, Jennifer Fromme, Melissa Gonville, Kimberly Liprie, Kelly Ensslin, Jen Ettinger, Debbie Finch, Heather Hafer, Amy Harter, Christine Hoeflich Olley, Stephanie Martinez, Alana Moffa, Mary Moor, Nate’ Morris, Shelly Nix, Tara Oliver, Kirsten Olsen, Amber Shelton, Christine Stoops, Asia Summers, Kellie Turner, Janet Umble, Liset Villabos, Adriana Viveros-Sosa, Stephanie Wagner, and Kimberly York. Guest speakers: Delreen Schmidt-Lenz, Linda Delimata and Leslie McCallister |
| **Call to Order:**  |
| The meeting began with introductions. The minutes were approved with no corrections. |
| **Announcements:** |
| Help Me Grow Anniversary - a celebration on Nov. 9th to celebrate the 10th anniversary of Help Me Grow. The afternoon will include a community resource fair and a Books, Balls and Blocks event for kids. MIECHV Reauthorization – did pass the house, the initial bill passed unanimously so we are hopeful this bill will support funding in the formula award. Hoping for full reauthorization by the end of the year and will keep you posted. Not getting everything, we wanted but there are some increases and better than what we have now.  |
| **HVCAB Retreat Recap** |
| The Statewide Annual report and the Child Death Review Committee report also came up with specific recommendations for HV. What does this group hope to accomplish? What is our mission and priorities that will align with recommendations? Must be a realistic accomplishment that this group can oversee based on who is at the table. Must determine who *is not* at the table and focus who *should* be at the table to get the work done. A few things that came up in terms of priority:* Infrastructure meaning centralized outreach and resources.
* A Fatherhood position with more intentional collaboration.
* Increase in community voices, need families at the table to answer the questions ‘*why folks aren’t accepting home visiting’* and trying to understand that better.
* Professional development across the board, common standards in training across all programs without losing the individual Technical Assistance and support programs needed depending on the population we are working with.
* Increased communication with stakeholders. Thinking about ‘what does it sound like to consumers vs. providers, and to align community partners.
* Early childhood infant and mental health consultation and the infusion of that in home visiting.
* Are there the right mix of programs in our existing continuum of services? Is there an opportunity for universal, shorter duration programs? Could we establish different tiers of intensity based on the family needs?
* Thinking about other programs that may target different populations than the ones we currently have. Who should be in on this conversation?
* The ‘home visiting’ name may be holding back what the service is – possible name change? Nationally some states are getting away from the words ‘home visiting’ using different language.

Other additional feedback:* Who needs to be at the table with a focus on referral services, coming up with strategies to really engage families?
* Getting Unite US at the table because of their presence in the state, how can we get them to help us and meet the needs of our customers?
* When a baby is born in Delaware, all families would receive at least 1 visit. To be inclusive to all families and is recognized as a normal process rather than someone saying ‘oh you need help’ or seen as punitive.

Next Steps: * Breakdown and develop the vision/mission and what the workgroups should look like.
* Come back to the group and determine what do we want to work on to get this moving forward.
* Where do we have strategic partnerships? Some of this we can take on ourselves, but some we will need to involve other partners.
* Once all the information is gathered, determine if it falls in line with a particular topic. We can come back with something the group can react to.
* Development of Subcommittees – listing them and possibly providing a short explanation of each one for those newer folks that want to participate would like to join the topic that is true to the person’s passion.
* We want to be thoughtful about the mission of each subcommittee, so we aren’t duplicating efforts. Need to be intentional.
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| **Infant Mental Health Early Childhood Presentation** |
| * We have been talking about IMH and the infusion of it within HV. DE is one of few states that does not have the integration of IMH. What would the infrastructure look like in DE, since we are a small state with little capacity for those services. We do not have an Early Childhood Mental Health Association that we can tap into. What could we do in Delaware and what are those next steps?
* We received one on one consultation with our TA Leslie McAllister with MIECHV who included Linda Delimata who is overseeing work that is being done in Illinois around this topic. We invited them to come speak about their experience with ECIMH consultation in home visiting and what that looks like, giving us a background. Linda included Delreen Schmidt-Lenz, a mental health consultant working in Illinois to talk about her experience and what she does during a consultation.
* Infant Mental Health Consultants work with the actual providers, they do not work directly with families. They could have a clinical degree or certification. It can help with staff retention because are able to unpack some of their barriers that are getting in the way of them being successful at their job.
* What is infant early childhood mental health consultation? We work with the adults that are already working with the family. Work with the adults that are already there on a regular basis. They become part of the family and share in depth information and very personal and they don’t know what to do with that information.
* In consultation we team them with a consultant who is prepared to deal with mental health issues. It is their job to support that home visitor in thinking through what is going on and what is coming up for them. It’s not about fixing anyone and it’s not about therapy, it’s about helping those caregivers, so they can help those babies to grow in the healthiest way to including social and emotional health.
* There is no national model, but they do follow best practices. Best Practice says the consultant must be master’s prepared in the mental health field. Clinical license preferred, marriage and family, social work, PhD in clinical psychology. There is a minimum of 2 years’ experience, and they must receive reflective supervision. Additional training in trauma, maternal depression, substance use/misuse, risk and resiliency, systems, and in our state, we do a training at no cost to them.
* Consultants must have the support they need to do this work. The must understand how to work in home visiting. The Center for Excellence of Infant Early Childhood Mental Health has competencies and specialized training. In our state, we also have a credential and a certification on infant mental health.
* Illinois has a long history of IECMH in home visiting (2003). When the Children’s Mental Health Act was passed and really created the IECMH partnership even before MIECHV came in 2012. We had a consultation in HV programs through a request for proposal process in 2009 and then in 2012 the MIECHV grant included funds for IECMH consultation. It started small and increased each year. We are currently providing consultation to all the MIECHV communities.
* In Wisconsin, a Reflective Practice Project was established to provide training to program staff that were supervisors and some folks identified as ‘early career’ mental health consultants. Those consultants were backed up by more senior folks with experience in either early childhood mental health consultation or home visiting directly. Having those supports not only for the supervisors, but also the mental health consultants with their own reflective space, was a critical feature. We saw improvement in reflective capacity, not just learning the reflective capacity of front-line staff, but they were also using those skills to improve their reflective capacity with the parents.
* There is a need for someone at the state level to have the capacity to bring people together and bring those consultants together. Must be clear about what you want to accomplish – then who is going to be a part of that. What does the structure look like, will you have 1 person who finds the consultant and offers those services first? Would you do a pilot? How will you train? How will you know it’s working?

**Questions from group:*** ***When you made the move, how did you handle the reflective supervision piece with the consultant? Was it embedded in the contract?***  It was part of the contracting process that they still receive reflective supervision and be part of a reflective group. We called it *reflective learning group* for consultants in Illinois, which was a requirement. For Wisconsin, when I put together the project with my partner who was with is Project Launch – we were working in partnership with our other partner Wisconsin Alliance for Infant Mental Health. They served as a convening body and helped to identify consultants, unlike IL, WI capacity around mental health consultation is a lot lower, we didn’t have the history that IL did. The Association really helped us build that capacity and identify those senior consultants that helped us to support the early career consultants. (Leslie McCallister)
* ***Even though the contracts include that the consultant oversee the reflective supervision with you, who is your contract with?*** The contract is with Lurie Children’s Hospital in Chicago. The Dept of Human Services has a Department of Home Visiting now. They work so closely with me and are seen as a state partner now so when there are statewide home visiting meetings, I’m always a part of those so it’s really been something that has been embedded at a state level. Even though there are different contract and subcontracts, we all just really try to work together to support the home visiting programs. (Delreen Schmidt-Lenz)
* ***When you first started the implementation, were there concerns with the actual HV programs in your states that folks were asking, how are we going to do this? What will it cost? This is so far from what we do. Could you speak to that at all from a program perspective and what you encountered?*** Yes, we had a lot of questions, there were 35 MIECHV home visiting sites and they were broken into clusters, there were 5 clusters and we had funding to do 1 site in each of the clusters. We had enough funding to do all 35 sites, so state leadership picked the sites that we thought could use more support. We also did a reflective supervision group in each one so that all the supervisors were still getting reflective supervision. Some sites questioned why they were chosen and why they had to do it when others did not. We found despite the fact we did webinars and tried to prepare; it was not smooth going at first. (Linda Delimata)
* ***How are you able to assist with social determinants of health when you have a patient going through financial circumstances that could potentially trigger their mental health overall? Second, do you have interpreters for patients that do not speak the language?*** One of the things we found was that our work force was not diverse enough and we needed some time, effort, and energy into creating a more diverse work force. I think we have a way to go but it is much better. We do have consultants that are bilingual, not in all parts of the state. Having doulas to support client and having people that can have those tough conversations has helped. (Linda Delimata)

Contact information and Slides were provided. |
| **Next Meeting:** |
| Virtual meeting date of Jan 23, 9 – 11 a.m. Zoom meeting instructions will be sent prior to meeting. |
| **Adjournment:** |
| Meeting adjourned at 10:41 a.m. |