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Relationship-based Systems Change:

Illinois' Model for Promoting Social-Emotional Development in Part C Early Intervention

Linda Gilkerson and Carolyn Cochran Kopel

Executive summary: This article describes the rationale, philosophy, and implementation of a relationship-based model for promoting social-emotional (SE) development in Part C early intervention (EI). The goal is to support SE development for all children in EI and to more effectively → continued

→ from the cover identify and serve children who demonstrate SE difficulties and their families. The comprehensive approach provides relationship-based training, the addition of a social-emotional specialist to EI entry points; reflective consultation for managers; reflective supervision and case consultation for service coordinators; and professional development and networking for providers. Evaluation results indicate that this is a cost-effective approach that produces positive changes in staff knowledge, practice, and role satisfaction and increases the early identification of SE concerns and the provision of appropriate services. The Illinois Bureau of Early Intervention is funding the rollout of the pilot model statewide.

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Carolyn Cochran Kopel, M.S.W., is special assistant to the secretary of the Illinois Department of Human Services and has served the state in a variety of human services planning and management roles. She began the state's elder abuse program, successfully managed the downsizing of state-operated developmental disabilities facilities, and was part of the team that achieved national recognition for the child welfare accomplishments at the Illinois Department of Children and Family Services. Recently, Kopel refocused the zero-to-three early intervention program and was a leader in the Children's Mental Health Task Force, which successfully advocated legislation to create a statewide comprehensive prevention, early intervention, and treatment system of mental health for children.

A version of this paper will be printed in *Infants and Young Children*. Please do not reproduce.

The SE Planning Committee is cochaired by Carolyn Cochran Kopel, Illinois Department of Human Services, and Linda Gilkerson, Erikson Institute. Funding is provided by the Illinois Early Intervention Bureau, Janet Gully, bureau chief. CFC managers were Carol Harvey, April Leopold, and Delores Nickel. SE specialists are Sonja Hall, Mary Marovich, and Nancy Segall. Mary Claire Heffron serves as the national consultant, Tina Taylor Ritzler as the evaluation coordinator, Lynn Liston as the Illinois Association for Infant Mental Health representative, and Therese Wehman as the Illinois Interagency Council on Early Intervention representative.

Relationship-based Systems Change: Illinois' Model for Promoting Social-Emotional Development in Part C Early Intervention

THIS IS A SUCCESS STORY — a story of systems change in early intervention (EI) brought about by the collaborative, compassionate efforts of state agency leaders, a committed state interagency council, thoughtful advocates and university partners, and most importantly, the tireless efforts of EI managers, service coordinators, and providers. The change was not mandated; the outcome was not prescribed. Rather, this initiative was synergistic, the result of mutual trust, generative planning, and careful attention to parallel process. At each level the nature and quality of relationships was of paramount importance.

The story begins on a home visit by the newly appointed associate secretary of the Illinois Department of Human Services (IDHS), a visit that provided the associate secretary, just placed in charge of the EI system, with a chance to see EI first-hand. During the visit, the mother of a young boy adopted from another country was obviously distressed. At night, she said, she took the stones in front of the house and scrubbed them. She was afraid to let her toddler feed himself in the house because he was so messy, and she said it was too hot to put the highchair outside. She felt depressed, overwhelmed. She had no experience with children and was glad when the therapists showed her how to play with her son. Outside, after the review, the young service coordinator and therapists recognized that the mother needed more help—emotional help—but thought she already had too many interventions and couldn't handle any more services. Perhaps even more revealing, they said: "We don't know how to talk to her about it."

A series of nearly simultaneous events helped further focus the associate secretary's attention on the potential of EI. Two advocacy organizations, the Ounce of Prevention Fund and Voices for Illinois Children, met with her to discuss the importance of the earliest years and to offer to partner with the state agency to problem-solve. At the Illinois Association for Infant Mental Health (IAIMH) annual conference, Douglas Davies[1] presented a clinical case study, illustrated with video, that showed that very young children do comprehend and remember violence and fear around them. Davies' presentation also showed how important dealing with the parents' concerns were to a young child's ability to resume healthy emotional development. Finally, two university partners,

[1] Davies, D. (2001, October). Infant mental health practice with toddlers and their families. Keynote at the Illinois Association for Infant Mental Health, 20th Annual Conference, Chicago.

Erikson Institute and University of Illinois–Chicago, shared the findings of the Unmet Needs Project, a statewide research, coalition-building, and policy initiative that identified social-emotional development as the primary unmet need of infants, toddlers, and families in EI. All of these experiences created the context in which a subsequent set of recommendations from a state advisory subcommittee could be taken to heart.

Piloting Change

The Illinois EI system serves more than 15,000 infants and toddlers each year who have disabilities due to developmental delay, who have mental or physical conditions that typically result in developmental delay, or who are at risk of substantial developmental delay. The system includes 25 Child and Family Connections (CFC) offices that serve as points of entry to EI in local service areas. Each CFC office is staffed with a manager, service coordinators, one or more parent liaisons, and a local interagency coordinator. The service coordinators conduct intake interviews, coordinate evaluations for eligibility, develop the Individual Family Service Plan (IFSP) with the family and providers, help families choose service providers, and provide ongoing service coordination and transition support. EI service providers are professionals who have been credentialed through the EI system in their specific disciplines. At present, the majority of service providers are independent, rather than program-based. While staff members and providers have their own areas of responsibility, they must work together in teams to develop IFSPs, and they are strongly encouraged to work in teams to provide services.

As a result of the advocacy efforts , the EI eligibility category for mental or physical conditions was expanded to include social-emotional (SE) disorders (e.g., attachment or relationship disorders). IDHS also established a social-emotional subcommittee of the special advisory committee on early childhood development to provide recommendations on how EI could address the SE needs of families, including how the new EI eligibility category could be implemented. The subcommittee drew upon the work the Unmet Needs Project, whose survey of families in EI uncovered two primary categories of need for SE support: emotional support for families, including parent-to-parent support, and assistance with children's behavioral problems.[2] Among the findings were the following:

[2] Cutler, A., & Gilkerson, L. (2002). Unmet Needs Project: A research, coalition-building, and policy initiative on the unmet needs of infants, toddlers, and families (Final report). Chicago: University of Illinois–Chicago and Erikson Institute.

- Families were highly stressed: "Your life's not your own anymore." "You're in a spin cycle." Parents were overwhelmed by the time and energy needed for their child's services and the stress of managing work on top of family responsibilities. The resulting tension spilled over into their marriage and their relationship with their child.
- Parents needed emotional support in their everyday encounters with EI: "Nobody asks: 'How are you?' when they call." "There needs to be someone out there saying: 'You know what? You're doing a good job.' 'You are okay,' telling you, 'Don't lose your dream for your kids.'"
- Parents wanted access to professional counseling, someone trained to know how to help after the parent says, "I'm fine." "If our children have specific therapies, we also have the need for support."
- Parents wanted support from other parents. Some missed the parent groups that once had been part of their EI experience; others just wanted informal contact.
- Parents wanted help with their children's behavior problems (e.g., sleep, head banging, tantrums, crying, hitting, risk-taking). Parents were exhausted, distressed, and frustrated by unhelpful recommendations and wanted help from professionals experienced with behavior problems in children with special needs.

The Unmet Needs Project also surveyed providers regarding their readiness to address SE needs. The providers validated the parents' concerns and expanded the picture to include the unmet training needs of professionals both within the CFC offices and in the community. Approximately 70 percent of the programs and 100 percent of the CFCs surveyed felt unprepared to fully address the SE and mental-health needs of children and families. (Substantiating their self-assessment, the CFCs identified only 9 percent of the children at intake as having SE concerns, while providers saw 24 percent of children as having these concerns.) Although the EI system rated itself as inadequately prepared, other community services surveyed (e.g., child care, public health, prevention programs) relied on EI as the primary resource for SE and mental-health referrals.

With the gap between capacity and need evident, elements of a possible solution began to emerge. Birth-to-three programs that had specially trained staff or consultants to help with SE and mental-health concerns reported that they were more prepared to meet these needs than programs without this

expertise. Further, many programs that did not have specially trained staff or consultation reported that they would like such assistance. When asked what one addition would most help address SE needs across service settings, respondents agreed: more training and staff and/or consultants with mental health expertise and knowledge of infancy.

Considering these findings, the subcommittee recommended an extensive list of changes to the advisory committee. Given the scope of the recommendations, a state agency representative suggested that the process begin with a pilot. In response, the associate secretary convened a small group of those who had been involved to develop such a pilot and identified the CFCs as the cornerstone of the EI effort. The initial idea was to add a consultant to the CFCs who could provide support for and consult on the SE and mental-health needs of children and families. This model allowed the consultant to be paid as a staff member of the CFC rather than as a fee-for-service provider, thus enabling the consultant to provide support to the CFC staff and consult on cases without being a part of any child's service plan.

Three CFC areas serving more than 1,600 children were chosen as pilot sites: Chicago South, serving 529 children; Joliet, with 789 children; and Bloomington, with 343 children. The pilot planning committee included the CFC managers and the consultants, SE specialists, who were identified for each site, as well as representatives of IDHS, Illinois Interagency Council on Early Intervention (IICEI), IAIMH, Ounce of Prevention Fund, and Voices for Illinois Children, along with an evaluation coordinator. The subcommittee chair and EI bureau staff led the pilot committee.

Goals

The SE pilot was designed as a capacity-building effort to increase the ability of the EI system to:

- Provide emotional support to all families in EI
- Work more closely with each family around the social-emotional development of their child
- Provide SE screening as a part of intake and, when needed, specialized assessment and intervention to address SE, behavioral, and mental-health concerns

The SE pilot was funded to strengthen the system to meet the needs of families already in EI and therefore provide a stronger foundation upon which to build services for newly eligible infants and families with more complex SE and mental-health needs.

Philosophy

Guided by the vision of the Illinois Interagency Council on Early Intervention and the state's commitment to meaningful early intervention for infants and families, the SE pilot embraced the philosophy of relationship-based early intervention.[3] The core principles of a relationship approach—the centrality of all relationships, particularly the parent-child relationship; attention to the social-emotional world of the child and the family; and the importance placed on the process of intervention—addressed the unmet needs identified by families and complemented the state's focus on developing functional outcomes.

[3] Weston, D. R., Ivins, B., Heffron, M. C., & Sweet, N. (1997). Applied developmental theory: Formulating the centrality of relationships in early intervention: An organizational perspective. *Infants and Young Children*, *9*(3), 1–12.

The emphasis on parallel process—how relationships affect relationships at all levels—became a hallmark of the SE initiative. Thus, the pilot was designed with the awareness that each element of this multilayered process would shape the quality of activity in the next layer: the quality of relationships and collaboration in the planning committee would affect the quality of relationships and collaboration at the CFC level, which would affect the quality of relationships among providers and families, which would bring about changes in practice that ultimately affect children and families.

The considerable benefits and challenges of building a relationship-based community agency have been well described.[4] The SE pilot ventured into new territory: attempting to build a relationship-based service system based upon the principle of parallel process. The planning committee took its role seriously in modeling the process of relationship-based work and developed a respectful, collaborative process that has guided the effort at each stage. Regularity of contact was maintained through monthly conference calls and quarterly meetings; a safe environment was cultivated to encourage the free exchange of ideas and mutual support; and development of all components, including training, outreach, service delivery, and evaluation, was a joint effort. A national consultant on relationship-based EI[5] worked closely with the committee to design and provide training in relationship-based EI, offering consultation at quarterly meetings, and providing assistance in developing training resources.

[4] Bertacchi, J. (1996). Relationship-based organizations. *Zero to Three*, *17*(2), 1, 3–7 Norman-Murch, T. (Ed.). (1999). Reflective practice in relationship-based organizations. *Zero to Three*, *20*(1).

[5] Heffron, M. C. (2000). Clarifying concepts of infant mental health—Promotion, relationship-based preventative intervention, and treatment. Infants and Young Children, 12(4), 14–21.

Table 1: Ten Elements of Illinois' Social-Emotional (SE) Component

1.	**Social-emotional specialist at entry point to early intervention**
2.	**Training in relationship-based early intervention**
3.	**Reflective consultation for leadership**
4.	**Reflective supervision for service coordinators**
5.	**Social-emotional screening at intake for all children**
6.	**Integrated assessment and intervention planning**
7.	**Regular case consultation**
8.	**Bimonthly integrated provider work groups**
9.	**Parent-to-parent support minigrants**
10.	**Social-emotional specialist network**

The concept of parallel process was something new to the state staff members working on the pilot project. They noticed that the meetings had a different flavor. Everyone seemed to look forward to them because they were enjoyable, helpful, and positive. The focus was on successes and learning. CFC managers are one of the most stressed subgroups in the EI system, and the meetings supported them. It was easy to see that the relationships and respectful process within the group influenced everyone's behavior.

Core Elements

Table 1 presents the ten core elements of the SE pilot.[6] The model includes (1) the addition of an SE specialist for ongoing consultation and support; (2) training in relationship-based early intervention—the guiding framework; (3) reflective consultation for leadership; (4) reflective supervision for staff; (5) addition of the Ages and Stages: SE Screening (ASQ:SE)[7] at intake for all children, leading to (6) more integrated assessment and intervention planning addressing SE development as an integral part of EI; (7) individual and group case consultation to build skill and understanding; (8) integrated provider work groups to support teaming and relationship-based practice; (9) mini-grants to increase options for parent-to-parent support; and (10) an SE specialist network for peer consultation and program development. The elements were conceived of as

[6] Gilkerson, L. & Ritzler, T. (in press). The role of reflective process in infusing relationship-based practice in an early intervention system. In K. Finello (Ed.), *Handbook of Training and Practice in Infant and Preschool Mental Health*. New York: Jossey-Bass.

[7] Squires, J., Bricker, D., & Twombly, E. (2003). *Ages and Stages Questionnaire: Social Emotional (ASQ:SE)*. Baltimore: Brookes.

complementary processes working together to shift the culture of EI toward relationship-based practice. Each element is described in more detail below.

SE Specialist

Central to the model was the addition of an SE specialist to the CFC. Funded by the EI bureau and hired by the CFC, the SE specialist provides professional development, clinical consultation, and systems support to infuse relationship-based, reflective practice throughout the early intervention process. Primary responsibilities of the SE specialist include reflective consultation to the manager, individual and group case consultation, bimonthly provider meetings, and coordination of pilot components, including overseeing the implementation of SE screening and specialized assessment. SE specialists have extensive clinical expertise in EI and/or infant mental health and skill in reflective supervision, clinical consultation, and group process. Personal qualities vital to the role include being a good listener, personable, willing to adapt to the program, and skilled at handling conflict and negative emotions, exemplifying high professional standards, and accepting and being effective at guiding people at different developmental levels. The specialist is a trusted ally for the manager, offering complementary skills and knowledge which, together with the manager's leadership, helps build the CFC's capacity to put a relationship-based, reflective approach into practice.

Relationship-based training in early intervention

To launch the social-emotional pilot, all CFC participants—the manager, SE specialist, service coordinators, parent liaisons, and a group of 10 to 15 providers for each CFC who agreed to participate in the pilot year—attended a two-day training developed by the national consultant and planning team to provide a shared framework for relationship-based practice. The training defined social-emotional wellness, presented the paradigm shift from a developmental to a relational approach[8], and reviewed outcomes from a relationship perspective (e.g., quality of parent-child relationship, parent's understanding of child, parent's confidence and satisfaction, child's adaptive capacities). Emphasis was placed on the practitioner's capacity to (1) listen carefully and demonstrate concern and empathy; (2) ask questions that promote reflection; (3) observe, highlight, and foster the parent-child relationship; and (4) understand the professional use of self (e.g., being aware of one's own feelings and desires to help, thinking about one's impact on the parent and child, being aware of social and cultural differences, being aware of the parent's history of relationships.[9] While

[8] See note 3, page 6, in margin.

training provided the foundation for relationship-based work, the internalization of training was supported through the ongoing opportunities for consultation, reflective supervision, and professional development described below.

[9] Heffron, M. C. (2004, April). Strategies for relationship-based EI. (Handout at Social/ Emotional Training, Tinley Park, IL).

Reflective Consultation for the Manager

The CFC manager's role is complex and multifaceted: part administrator, supervisor, crisis manager, data expert, and senior clinician. The manager is ultimately responsible to the early intervention bureau for the CFC meeting explicit performance criteria. For successful implementation, leadership must not only endorse but also model a relationship approach. Reflective consultation was included as a central component of the pilot to provide the essential support to the manager. The specialist met weekly with the manager to (1) offer support for the difficult demands of the manager's role, (2) provide the manager with the first-hand experience of reflective supervision to prepare her to provide reflective supervision for staff, and (3) jointly plan and monitor all components of the pilot.

Reflective Supervision for Staff

Service coordinators traditionally carry high caseloads, work on their own in the field, and are under the pressure of tight deadlines with much paperwork to complete. They, too, are evaluated based on specific performance criteria. Supervision, if present, is focused on case monitoring, inadvertently modeling the task-oriented approach that parents had described in the Unmet Needs study. To support staff in working from a relationship perspective, the manager introduced reflective supervision on a monthly basis either in individual or group sessions. The goal was to provide the service coordinators, parent liaisons, and local interagency coordinators with a safe environment where emotions could be explored, problems shared, and new perspectives on the work generated. Reflective supervision cultivated parallel process: the empathy and help offered by the manager fosters the empathy and support that the service coordinator offers families.

Social-Emotional Screening

In the pilot, the relationship-based approach for families began at the first contact with the service coordinator. While the coordinator has many tasks to complete, the quality of the initial interaction with the family at intake sets the family's expectations for what is to come. Thus, intake was designed to offer families the opportunity to share their concerns about their child with an atten-

tive, supportive service coordinator. The addition of the ASQ:SE to the intake opens the dialogue about SE needs, allows parents' concerns to be shared earlier, and helps the service coordinator feel more knowledgeable and connected to the family and child right away.

Integrated Assessment and Intervention Planning

After the intake, the SE specialist consults with the service coordinators regarding the intake interviews and the ASQ:SE findings. What are the parents' concerns? What special expertise might be needed to answer parents' questions? What disciplines should be included in the assessment? How might the family be involved in the assessment? These consultations with the specialist offer ongoing opportunities for the service coordinator to ask questions, share observations, and deepen the service coordinators' capacity to understand their impact on the families and, in turn, the families' impact on them.

Case Consultation

Monthly case consultation sessions were added to offer service coordinators another opportunity to develop understanding and skills in relationship-based EI. The consultants and managers and/or assistant managers lead small group sessions using a guided process that helps service coordinators, parent liaisons, and, in some settings, providers consider their work with each child and family from multiple perspectives, including that of the child's social-emotional development in the context of family relationships, the family's readiness and needs, and the service coordinators' felt experience of working with the child and family.

Integrated Provider Work Groups

As noted, EI providers in Illinois primarily work independently, with little opportunity for ongoing networking, team building, or professional development with a consistent group of peers. The pilot offered providers the opportunity to meet as a group every other month with the specialist and manager for mini-trainings, case consultation, and informal peer consultation. Further, the providers are encouraged to call the specialist for consultation and support on an individual basis.

Parent-to-Parent Grants

To expand support for families, each CFC was provided with a $3,000 mini-grant. The sites used the mini-grants in different ways: to develop a parent

newsletter, create parent-to-parent linkages through a parent liaison, hold a family day, attend a parent-to-parent support seminar, and hold parent support meetings where families could safely process feelings and build supportive relationships with other families.

SE Specialist Network

To ensure that attention was paid to relationships at all levels, the SE specialists met together to provide peer consultation and support. The trust and mutual respect built in these sessions allowed the consultants to freely share materials, resources, and training ideas and to support each other in the new role.

Outcomes

The evaluation of the pilot examined three questions:

- Were the SE components implemented in the pilot sites?
- How did participants perceive the benefits and challenges of the pilot?
- What changes in knowledge and practice resulted from the pilot?

The implementation of SE components was documented through review of site implementation plans, monthly activity sheets, and monthly logs for consultation and supervision. Pre- and post-questionnaires assessed the impact of the training on knowledge and skill, related to relationship-based practice. Mid- and end-of-pilot questionnaires were used to document the perceived benefits on a 5-point scale, challenges, and changes in practice. Focus groups with parents were held at two sites; individual interviews were held at the third site. The analysis of the focus group data is underway. Additionally, an IFSP review is planned.

Implementation of Core Elements

Table 2 shows the pre- and post-availability of the core program components. Each site implemented the required components within the first four months of the pilot. While the sites differed somewhat, typically reflective consultation, reflective supervision, and the ASQ:SE were implemented first, followed by case consultation and the bimonthly integrated work groups. A distance consultation model was used for one site. The specialist held weekly phone consultation with the manager and consulted on-site each month with the service coordinators and providers. Although the site was successful in implementing the components, both the manager and specialist agreed that an on-site specialist

Table 2: Baseline and End-of-Pilot Availability of Pilot Components

Pilot Component	Baseline	End-of-Pilot
Reflective Consultation	Not regularly available to the CFC manager	Available weekly to 100% of managers
Reflective Supervision	64% of SCs have no or occasional supervision	100% of SCs have supervision available monthly
Case Consultation	31% of SCs have no opportunity for group case consultation 68% report receiving inadequate support	100% of SCs have group case consultation available monthly
ASQ: SE Screening	Not provided at CFC 9% identified, only most severe	80% of children screened 82% passed screening 18% did not pass screening 22% received specialty assessment
Integrated Provider Workgroup	Not provided at CFC	At 2 sites bimonthly At 1 site monthly

would have been preferable. Below, we describe the benefits and challenges of the core components.

Reflective Consultation

Prior to the pilot, none of the CFC managers had experienced reflective consultation. During the pilot, 100 percent of the managers received reflective consultation on a weekly basis. The sessions averaged 49 minutes, and were held consistently over the 12 months, missed only for vacations and maternity leave, or shortened for urgent administrative concerns.

Managers used reflective consultation as planned: to support them in their leadership role, to build their capacity to provide reflective supervision, and to infuse the CFC with a relationship-based perspective. In terms of management challenges, consultation focused on helping the managers learn about "sympathetic conflict resolution," particularly in relationship to staff-staff conflicts and staff-management issues. Managers also planned for or debriefed from reflective supervision sessions with the service coordinators. The managers learned to ask questions that elicit reflection and to understand and experience reflective supervision as parallel process (e.g., the holding environment of consultation fostered their capacity to create a safe supervisory environment for staff, which in turn

supported staff to listen and respond supportively to families). In weekly reflective consultation, the specialists and the managers assessed how the pilot was going and provided mutual support and problem solving. While the planning committee served as the foundation for developing the pilot, the weekly reflective consultation sessions served as the foundation for its implementation in the field.

As a result of reflective consultation, managers reported that they could handle staff issues better. A greater understanding of their own "triggers" in interactions allowed them to be less reactive and use more proactive approaches to problem solving. With greater ability to reflect, they were more able to step back and see issues from the staff's perspective and then to build more on staff strengths. Specialists' observations confirmed the managers' greater ease in dealing with conflict, greater ability to create and enforce a safe atmosphere in individual and in group interactions, and, most importantly, greater ability to model relationship-based strategies in their daily encounters with staff.

Reflective consultation was highly rated by the managers both at the midpoint and at the end (4.00 at mid; 4.67 at end). In fact, the managers rated reflective consultation as the most beneficial of all the pilot components. Managers valued the structured time set aside to consult with the SE specialist: "The mandatory carving of time from the schedule has forced me to stop and reflect upon the multitude of issues that occur on a daily basis." At midpoint, managers reported a positive impact on their handling of staff issues, including understanding staff better, being better able to support and build on staff strengths, and being better able to develop proactive steps to problem solving. Reports from the SE specialists confirmed that the managers were more reflective and skilled in their roles. The specialists reported that the managers exhibited greater ease when dealing with conflict, demonstrated increased ability to consider multiple perspectives, modeled use of relationship-based strategies in their daily encounters, and grew in their ability to create and enforce a safe atmosphere in individual and in group interactions. At the end of the pilot year, managers reported that the positive benefit of consultation continued in their work with their staff and had extended to their work in the system as a whole.

Reflective Supervision

Monthly supervision was also successfully implemented in each site. Prior to the pilot, 64 percent of the service coordinators had no supervision or were supervised only occasionally. After the pilot, 100 percent of service coordinators, parent liaisons, and local interagency coordinators received reflective supervi-

sion. Individual supervision was implemented in two sites, small group supervision in one site. Regularity of monthly contact was maintained over 12 months in two of the three sites. In the third site, the largest, the manager was unable to maintain her goal of monthly individual supervision because of the demands of her job and the high number of service coordinators. A bimonthly schedule was instituted, with the opportunity for service coordinators to ask for a session in between. On average, the sessions lasted for 78 minutes; the time for individual and group supervision was not significantly different.

Service coordinators primarily used supervision to talk about their concerns regarding complex, emotionally charged situations with families. Like the managers, they learned to use the safety of supervision to share and own their feelings and at times to learn to work appropriately in spite of their own affect. Supervision also offered the opportunity to talk about the stresses of the role, share the overwhelmed feelings related to caseloads, and process their relationships with providers, where they often felt unvalued and not respected. With increased skill in sympathetic conflict resolution gained through reflective consultation, the managers helped service coordinators move toward more open dialogue and effective conflict resolution with providers.

Both service coordinators and managers reported that supervision helped them understand each other better and communicate more openly. Managers created an environment where service coordinators felt they could express feelings without worry and receive help with the emotional side of their work with families. The structured time was conducive to reflection and helped the service coordinators feel there was a support system for them. While the service coordinators used supervision to address difficult situations and generally felt supported in the sessions, the perceived level of benefit was moderate (2.96 at mid; 3.22 at end). The level of benefit was not affected by the format for supervision (group or individual); however, it was affected by the frequency of supervision. Benefit was rated highest in the site with the most supervisory time, and lowest in the site with the least supervisory time.

We have speculated about what might account for the moderate rating for reflective supervision when many service coordinators were actively engaged in the process, and managers and specialists rated the value of supervision to the service coordinators highly, reaching 4.33 at the final evaluation. The low intensity of monthly or bimonthly schedules may well have dampened the effect of supervision, since perceived benefit was related to the amount time in supervi-

sion. Some service coordinators felt discomfort that supervision was needed at all; it seemed like a sign that they weren't doing their job well enough, rather than an indication that they were trying to do it better. Others felt that it was redundant, that support already existed from peers and colleagues. Some resented the time required for supervision, especially with the high caseload demands. The collective wisdom of specialists and managers was that accepting and benefiting from reflective supervision takes time. Some service coordinators gravitate to the opportunity; others take longer to experience supervision as supportive and to know how to use it. The trajectory of benefit is positive, but gradual. Patience, steadfast adherence to supervision schedules, and trusting that the process will work are key.

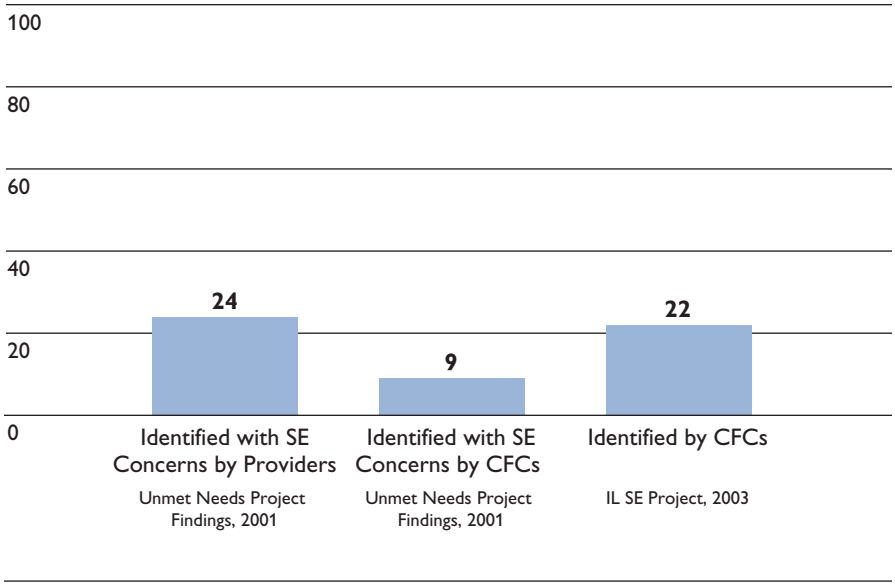
Case Consultation

Prior to the pilot, 31 percent of the CFC staff had access to consultation about SE concerns. After the pilot, access increased to 100 percent for the service coordinators and the providers in the bimonthly groups. Case consultation played a unique role in the pilot process. This was the one forum in which all aspects of relationship-based intervention were considered simultaneously: the child's health and development; the family constellation, structure, and process; parent-child relationship; cultural beliefs and practices; and the subjective experience of the interactions for the child, the family, and the professionals.

At the midpoint, managers, SE specialists, and service coordinators reported low to moderate benefits of group case consultation. However, by the end of the pilot year, we observed a significant increase in service coordinators' perceptions of the benefit of case consultation (2.42 at mid; 3.19 at end). Specialists also reported higher benefit ratings for the service coordinators at the end of the pilot (3.33 at mid; 4.33 at end). Specialists attribute the increases, in part, to the addition of a structured process for the case consultation discussions.

Service coordinators benefited from discussing difficult family situations and received support from the group. Representing the vast majority of service coordinators' sentiments, one coordinator reported: "It [group case consultation] really helps … when I have a complicated case. I can look to the consultation for help with ideas, support, suggestions, and I enjoy hearing others' outlooks on things that can benefit me." At the end of the pilot, specialists observed that in case consultation, service coordinators were demonstrating improved observational skills, increased emotional self-awareness, increased empathy for parents, and increased self-confidence in their work.

Figure 1: Percentage of Infants and Toddlers Identified with Social-Emotional Issues



In contrast, managers generally reported a decrease in the benefit of case consultation over time (3.33 at mid; 2.67 at end): "Some [service coordinators] have been able to benefit more than others." One manager reported, "Some staff are still looking at case consultation at a surface level and not realizing full gain from the process. The majority of staff have started the case consultation process and taken time to step back, analyze, and make informed choices." Another manager felt that case consultation "has caused some confusion, because many felt this process was already happening informally." In general, the managers reported that case consultation provided an important venue for service coordinators to consult formally with their peers and supervisors regarding the social-emotional needs of families: "It has helped them get to know each other."

SE Screening, Specialized Assessment, and Intervention Planning

Prior to the pilot, CFCs were not screening for SE development. Each pilot site was successful in implementing SE screening, reaching 80 to 90 percent of the children entering early intervention. Service coordinators report that the screening took about 15 minutes. Averaging the screening results over 12 months, 82 percent of the children passed the ASQ:SE at intake and 18 percent did not pass. Specialty assessments for SE development were provided for 22 percent of the

children at intake. Prior to the pilot, the CFCs identified only 9 percent of the children at intake who had SE concerns, while 24 percent of the children in EI were reported to have SE concerns by the providers.[10] The pilot CFCs succeeded in closing this gap by identifying nearly the same percentage of children with SE concerns assessed at intake (22 percent) as were reported to eventually have SE concerns (24 percent) prior to pilot (see figure 1).

[10] See note 2, page 3 in margin).

Specialty assessments were primarily carried out by developmental therapists (76 percent); social workers and psychologists conducted 13 percent of the SE evaluations. While 22 percent of the children were assessed for SE concerns, only 8 percent were eligible for EI only for SE reasons. For most children in EI, SE concerns accompanied other developmental concerns. Approximately half of the children who did not pass the ASQ:SE received SE services from a mental health professional (e.g., social worker or psychologist); the other half received SE support from a non–mental-health professional (e.g., developmental therapist, occupational therapist). A pre- and post-examination of IFSPs is planned to determine if the pilot affected the parental concerns identified and the outcomes and strategies for all children in EI, as well as for those children identified as presenting SE concerns.

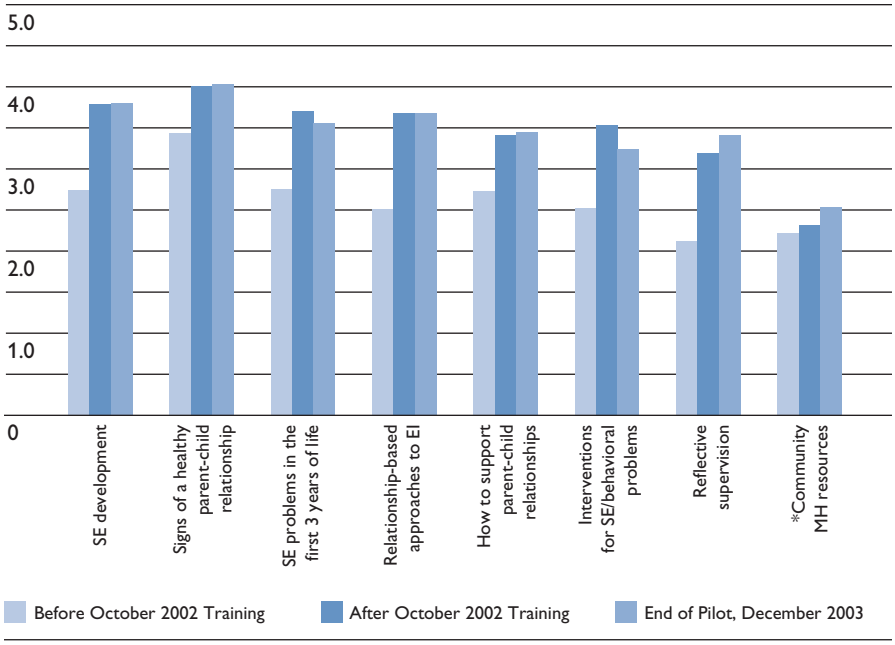
Overall, the service coordinators rated the addition of the ASQ:SE as the most beneficial part of the pilot (3.5). They felt it was easy to implement, did not take too much time, and that families liked answering the questions. More importantly, it provided a forum for them to connect with the families—to listen more deeply to parents as they talked about their child and his needs and their wishes and concerns. One manager mused that before the pilot, when she reviewed caseloads with the service coordinators, they could not remember who the families were without looking in the file. Post-pilot, the service coordinators knew the families better and felt more connected, more quickly.

Changes in Knowledge, Practice, and Role Satisfaction

Knowledge of Social-Emotional Development

All the participants (managers, service coordinators, parent liaisons, providers) in the initial two-day training increased their knowledge of SE development in the eight areas assessed. The service coordinators evidenced the greatest gains; the social workers reported the least change. The only area that did not show an increase for the service coordinators was knowledge of mental-health resources. At the end of the pilot, the service coordinators maintained the higher

Figure 2: Changes in Knowledge of Service Coordinators



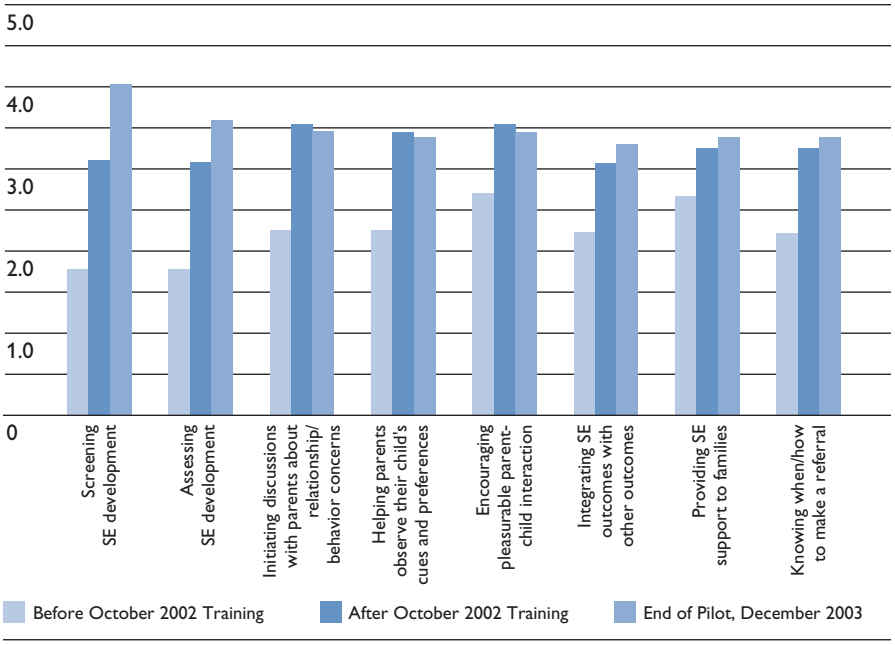
levels of knowledge in all areas measured. In addition, we observed a significant increase in knowledge of community mental health resources (see figure 2).

Comfort and Skill

All the participants showed changes in comfort and skill in relationship-based practice. Once again, the service coordinators showed the greatest change. The increases were apparent on all areas measured, including initiating discussions with parents about relationship and behavioral concerns, integrating SE outcomes with other outcomes, providing SE support to families, and knowing when and how to make a mental health referral. The service coordinators' skills in SE screening continued to increase after the post-training as a result of additional practice with the ASQ:SE and ongoing consultation with the specialist.

The two-day training was followed by regular opportunities for reflective supervision and consultation for manager, service coordinators, and providers to deepen their understanding of relationship-based work and grow in its practice. At the end of the pilot year, the knowledge, comfort, and skill levels stayed at the higher levels reported at post-training, suggesting that the reflective processes put in place were successful in consolidating and sustaining the learning over time (see figures 2 and 3). That is, the culture was beginning to shift toward relationship-based practice.

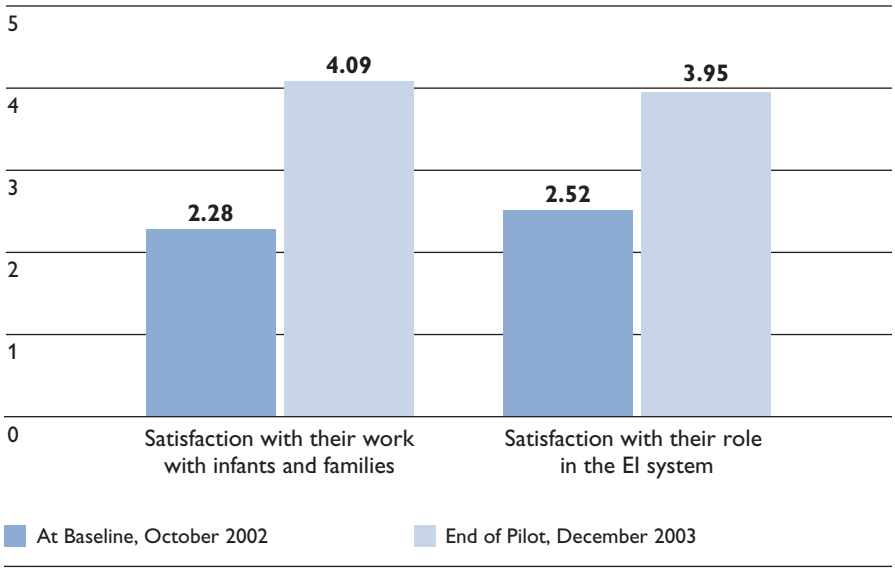
Figure 3: Changes in Comfort and Skill of Service Coordinators



Practice

Changes in practice were reported across all key groups. Mid-pilot evaluations revealed that 100 percent of the managers reported changes in their practice such that they "understand that all work is relationship-based." Ninety-two percent of the pilot providers reported changes in practice, including increased self-awareness with families; greater awareness of how intervention strategies impact the parent-child relationship, positively or negatively; and greater capacity to listen longer before formulating a response, even an internal one. Fifty-seven percent of the service coordinators reported that they were doing things differently, including an increased capacity to see the bigger picture, look at the family as a whole, and focus on strengths. While a little over half of the service coordinators reported that they were doing something different, 100 percent of the managers and 92 percent of the providers reported that service coordinators had changed. At the end of the pilot, 100 percent of managers continued to report changes in their practice, as did 62 percent of service coordinators and the majority of providers. Over time, fewer providers reported changes in practice, indicating either a consolidation of skills or a plateau in the acquisition of relationship-based practice.

Figure 4: Reported Changes in Role Satisfaction for Service Coordinators



Role Satisfaction

A valued outcome for the EI lead agency was for service coordinators to experience greater satisfaction in their work. The service coordinator position is entry-level, with high stress, low satisfaction, and high turnover. At the end of the pilot, we observed a significant increase in service coordinators' reports of their satisfaction with their work with infants and families (2.28 at mid; 4.09 at end) and with their role in the early intervention system (2.52 at mid; 3.95 at end; see figure 4). Because there was no control group, we can only speculate that the changes resulted primarily from the pilot. This hypothesis is supported by the fact that during the pilot year, there were no other major changes in the CFC operations; and caseloads, a primary stressor, did not decrease during that period. The striking increase in role satisfaction stands in contrast to the more muted ratings (around 3 on a 5-point scale) of the benefits of the individual pilot components. We assume that the model works synergistically; that each component is essential and contributes to the whole—to creating an enriched working and learning environment that potentially affects all members of the setting. The fact that new service coordinators who joined the CFC during the pilot year also showed the same high levels of satisfaction at the end point appears to support the concept of a culture change toward a more positive environment benefiting all members of the system.

The Rollout: Statewide Implementation

Based on the mid-evaluation findings, the pilot sites developed a set of recommendations for statewide expansion. These were presented to the IICEI and the lead agency and were timed to coincide with the budgeting process. After careful review and additional discussion, the IICEI and the EI bureau heartily approved the components and recommendations for statewide rollout. The SE pilot met the staff's, managers', and families' needs, the advocates' interests, and the state's goals for provision of meaningful and effective early intervention.

A phased rollout plan to occur over three years was adopted. Although the annual price tag, when expanded to every CFC, will total about $1.5 million (compared to total annual program cost of about $115 million), the state and the IICEI considered this money well spent in light of the benefits. In large part due to the collaborative, creative planning process, CFC managers supported the SE program changes to a much greater extent than they had previous changes in the system, which had been implemented top-down. Prior to the pilot, the state had achieved progress through performance contracting, but the changes were primarily in quantitative performance, e.g., increased CFC compliance with required timelines and procedures. The SE pilot project accomplished the next step, moving the system, including providers, to higher levels of qualitative performance. The pilot provided support at each level of the system so that individuals could be their best self and work toward goals for infants and families which everyone could support.

Typically in a pilot, a model is developed and then the state takes over its implementation. In the SE pilot, the rollout continued the collaborative, generative process. To determine which six CFCs would be in the first wave of new sites, the planning committee drafted a self-assessment for the remaining CFCs to complete. This gave the managers some control over the timing of their entry. With the state staff's concurrence, sites were selected based on their interest, willingness, and the individual factors each expressed. The first wave of six new sites was welcomed into the planning committee 16 months after the pilot began. With assistance from their mentor sites and cochairs, the new sites began to identify a specialist, recruit providers for the integrated work groups, and prepare the service coordinators. The mentor sites developed new components for the two-day training, based on the processes they had developed and the lessons learned. Each new site was brought into the SE effort with the recognition that it will become a mentor site to another site in the next wave. Through

mentoring, managers and specialists share not only their successes, but also their own doubts, issues, and problems, and how they worked through them. Compliance is not the goal of peer mentoring. Rather, the relationship is characterized by encouragement, resource sharing, and honesty. The cochairs of the rollout provide overall leadership, chair the monthly calls, plan the quarterly meetings, and provide support with problem solving. The national consultant continues to participate by telephone in quarterly meetings and on-site in the training sessions, which are now are led jointly by the mentor specialists and managers. The immediate goal of the planning committee is to develop a resource manual, the Illinois Guide to Social-Emotional Development in Early Intervention, to accompany the training for the remaining 16 sites. A long-range goal is to develop a module on relationship-based EI required for all credentialed providers.

Lessons Learned

Reflecting on the experience, the process, and the outcomes, we have identified a number of lessons learned:

- It is critical for key policymakers to spend time observing early intervention services in practice to appreciate the needs of the children and their families, and the ability of the system to meet their needs.
- Key policymakers need a vivid understanding of the social and emotional development of young children and the benefits possible from intervening. Seeing is believing when it comes to infant mental health. Video is invaluable in showing emotional suffering and emotional healing for infants, toddlers, and their families.
- Systems accept the need for change more readily when their members have been involved in the definition of the problem and the design. The involved members become cheerleaders for the change within their peer group, and success generates success.
- Change that grows from consensus or from research and parent statements is unifying and more likely to succeed than change mandated by a law, rule, or audit finding.
- A small group of committed persons can be a powerful catalyst for systems change when there is a strong relationship and a joint problem solving orientation. Advocate organizations can play a vital role when the

approach is collaborative. Likewise, universities can play a central role. Because academic institutions stand outside the system and are charged with studying change, faculty can bring an involved neutrality that allows for evaluation and reflection.

- The integration of theory and practice in mental health and disability was central to this effort. Our national consultant, Mary Claire Heffron, brought a depth of clinical experience in both fields and both service systems. As our effort and others move forward, we must design ways to engage community mental health professionals in mutually enriching, collaborative roles with EI providers. This will require an openness on all sides to look at issues from multiple perspectives and a recognition that supporting SE development is part of everyone's role.
- Seeds of change are more likely to take root when the needs of multiple levels/players in the system are met (i.e., families, service coordinators, managers, providers, advocates, state policymakers).
- EI changes can only be made with hands-on involvement from the state interagency council, as well as consistency with the council's direction and principles.
- Statewide change is a balance between common expectations (all sites will have all components) and accommodations to specific local needs and strengths.
- Changes are more readily embraced by policymakers when the costs can be minimized and phased in.
- Infusing a relationship approach within a system requires more than training; it requires adding an enduring expert (in this case, the SE specialist) to be a permanent part of the system, and it requires the implementation of regular reflective consultation and supervisory experiences for the leadership and the staff.
- Parallel process can guide systems change. Whether at the systems, program, or family/child level, the same principle applies: do unto others as you would have them do unto others.[11]

Now, fast forward to a monthly call with the managers and specialists from the three mentor and six new sites. The sites have participated in the two-day training; almost all the specialists are on board (they are now called SE consultants); ASQ:SE, consultation, and supervision are beginning, and more

[11] Pawl, J. H., & St. John, M. (1998). *How you are is as important as what you do …: In making a positive difference for infants, toddlers, and their families.* Washington, DC: Zero to Three, p. 7.

providers than expected have signed up for the integrated provider work groups. Two site updates reflect the promise of the pilot that is being actualized in the rollout. The first update illustrates one way that all families are reached through the SE initiative.

An SE consultant shares that at the first intake call, the service coordinators in one service area now reassure parents that providers will work with the parents and child together during the home visits and that the provider is there to support the parents and address their concerns about their child. This represents a powerful change in parent and provider expectations, and creates new frames for EI that truly support the parent-child relationship.

The second update illustrates how, when staff are well-trained and thoughtfully supported, EI can respond to significant SE concerns. A manager shares this moving update:

"We just had a new family come on board. The service coordinator and providers sensed that something was not right during the intake conversation and assessment. And they were able to talk about it. The service coordinator asked the mother if she would like to talk more with someone about her worries and concerns, an invitation that the mother welcomed. The service coordinator arranged for a social worker to visit within the next few days. The social worker, new to EI, had just completed the two-day training and joined the bimonthly provider groups. On the visit, the social worker and the mother made a plan for the mother to be hospitalized to begin to receive help for significant mental-health concerns. After she returned home, tragically, in an unrelated event, her baby died. The social worker and the other team members became a circle of support for the mother, helping her to make arrangements for her child and supporting her in her grief.

"Now," the manager reflected, "we are focusing on how to support the service coordinator and team as they support the mom."

Relationship-based EI provides a safe and nurturing experience where families receive emotional support and information that truly address their concerns. Because relationship-based EI asks that staff not only hold the hope, but also the pain, this vision for EI includes addressing the well-being of those who do this most important work and providing them with opportunities for reflection and growth. This is the goal in Illinois and a vision for early intervention in all settings.

Herr Research Center at Erikson Institute

The Herr Research Center, established in 1997 with a gift from the Herr family, is the hub of research activities at Erikson Institute. Its mission is the development of knowledge from applied research that contributes to a significant improvement in the quality, effectiveness, and equity of education and services for children and families. The center provides technical assistance and funding for the development and implementation of a wide variety of research projects, promotes the dissemination of research findings, and sponsors conferences and seminars.

Dedicated to addressing the interests and needs of an increasingly diverse society, center-supported research initiatives work with populations that vary in age, race, and ethnicity, with a primary focus on programs and populations in disadvantaged communities. The center is committed to providing a sound and useful base of information to guide the understanding of complex social issues such as changing family and societal needs and families in stress as well as the nature and efficacy of services for children and families.

Current research projects

Caregiving Consensus Groups with Latina Mothers
Children and Violence Project
Computer Training for Early Childhood Teachers Project
Doula Support for Young Mothers Project (in collaboration with the Department of Psychology at the University of Chicago)
Erikson Arts Project
Faculty Development Project on the Brain
Fathers and Families
Fussy Baby Network
The Helping Relationship in Early Childhood Interventions Project
Bridging: A Diagnostic Assessment for Teaching and Learning in Early Childhood Classrooms
Project Match
Reggio Emilia Project
Schools Project
Teacher Attitudes About Play
The Unmet Needs Project

Publications available from the Herr Research Center

Applied Research in Child Development Number 1, After School Programs
Applied Research in Child Development Number 2, Father Care
Applied Research in Child Development Number 3, Welfare Reform
Applied Research in Child Development Number 4, Assessment
Applied Research in Child Development Number 5, Arts Integration
Applied Research in Child Development Number 6, Parent Support and Education
"Lessons from Beyond the Service World," Judith S. Musick, Ph.D.
"Harder Than You Think: Determining What Works, for Whom, and Why in Early Childhood Interventions," Jon Korfmacher, Ph.D.
"Child Assessment at the Preprimary Level: Expert Opinion and State Trends," Carol Horton, Ph.D., and Barbara T. Bowman, M.A.
"'Does not.' 'Does too.' Thinking About Play in the Early Childhood Classroom," Joan Brooks McLane, Ph.D.

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