

# Early Childhood Mental Health Consultation in Homeless Shelters

## Qualities of a Trauma-Informed Consultation Practice

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### Abstract

This article describes the conceptual approach to, and practical aspects of, the Infant-Parent Program's (IPP) decade-long experience providing early childhood mental health consultation in homeless shelters serving infants, young children, and their families. Illustrated by case examples, the authors discuss the characteristics of the consultant's stance, practices, and role with parents and shelter providers developed in response to the need of mitigating the impact of trauma related to homelessness in young children.

The experience of homelessness, marked by sudden changes, threats to safety, unstable relationships, and layers of loss, is traumatic for both children and adults and can heighten the vulnerability of infants and young children (Grant et al., 2007). Families of color are at a higher risk due to the disproportionately high number impacted by homelessness (U.S. Department of Housing and Urban Development, 2017). The very process of competing for scarce housing resources can further expose these families to implicit bias and systemic discrimination. When adults are impacted by acute stressors and trauma, their capacity to attend and respond to the needs of young children may be compromised as their own need for internal regulation, safety, and protection can be at odds with their desire to meet those same needs for their child.

In providing shelter for homeless and traumatized families, it is a profound challenge to meet the variety, depth, and intensity of the needs. The focus on finding housing is necessarily prioritized over addressing mental and physical health issues, substance use/abuse, domestic violence, unemployment, discrimination, and other debilitating experiences. Meanwhile, the needs of infants and young children often recede to the background, or when attended to, their distress is typically understood and responded to as distinct from their caregiving circumstances. In their critical role of securing stable housing, shelter programs are placed in the untenable position of having to prioritize this goal over the myriad needs families are facing.

Nearly a decade and a half ago, aiming to mitigate the vulnerabilities homeless families face in the extreme housing shortage in San Francisco, the Infant-Parent Program (IPP) began providing early childhood mental health consultation (ECMHC) to homeless shelters. Bringing consultation, originally established for early childhood education sites, to shelter settings can enhance the staff's capacity to integrate all members of the family into a more comprehensive housing plan; one in

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which adult's and children's concerns may be understood in the context of their relationship to one another. Consultants aim to help staff build empathy for parents and children, whose behaviors often reflect the immense stress and pressure they are experiencing, by supporting staff to consider and understand the needs of infants and young children and how they can provide containment, consistency, and safety during a time of significant upheaval.

Case examples highlight the ways that families and staff in homeless shelters can benefit from a relationship-focused, developmental, and trauma-informed approach to ECMHC. The examples begin by describing possible opportunities for the consultant to bring infants' and young children's needs to the forefront. The authors then outline the ways the consultants address the needs for self- and co-regulation during acute and ongoing crisis and set the stage for reflective exploration of the family's needs and the staff's own experience.

## Hearing the Voices of the Most Vulnerable

*Claudia, in her fifth month of pregnancy, arrives at the Mother Teresa Emergency Shelter with her 3-year-old Carlos in tow. Carlos and his mother had to leave their previous shelter because of her angry outburst with the staff. He has a rare autoimmune disorder that requires regular blood transfusions. Restrained throughout the painful procedure, Carlos screams, kicks, and curses. During free play or when the clamor and chaos of shelter life scares him, Carlos tries to manage his fear by asserting himself, grabbing toys, hitting, and sometimes pulling other children's hair. This is what he saw his dad do to his mom when they lived together. Even though things at home were often scary, he misses his dad and wishes he was there to cheer his mommy up when she feels so sad that she can't get out of bed.*

*The consultant, who comes to the shelter every week, heard a lot about Carlos' family. Desiree, the case manager, shared*

*her deep concern for Claudia's depression and anger issues and asked if the consultant could provide therapy and help Claudia to be able to follow through on the resources and referrals needed to secure stable housing. The children's program staff, meanwhile, were struggling to support Carlos and attributed his aggressive behavior to negative traits.*

*Although the consultant had only two chances to meet with Claudia, she quickly began to understand her struggles as a parent, both feeling powerless to bring relief to Carlos' pain and suffering and feeling lost in the face of his intense tantrums. Claudia also shared her hesitation to follow up with housing referrals as most of them were far away from where Carlos receives medical care. When the consultant inquired about Claudia's pregnancy, she shared how little internal capacity she had for caring and providing for another child.*

*With Claudia's permission, the consultant shared with staff the ways in which her worries regarding Carlos' medical care were contributing to her difficulty following up on housing referrals. Having a greater understanding of these stressors prompted the case managers to think with Claudia about partnering with Carlos' medical team to provide documentation for the family's need to be prioritized and housed closer to care. Learning that Claudia was feeling overwhelmed about her pregnancy led staff to help plan for her baby's arrival by referring her to the consultant's infant massage class.*

*Equally important, the consultant was in a position to represent to the children's services staff the ways in which Carlos' behaviors reflected his fear and insecurity given his difficult medical treatments, the family's history of intimate partner violence, and his loss of his father and repeated uprooting. With this understanding, staff was able to shift their perception of Carlos from an aggressive and defiant child to a child expressing an intense need for safety, trust, and predictability. Together with the consultant, the staff identified ways to support Carlos during free play time by narrating his experience and providing opportunities to engage in smaller groups with increased adult interaction. Having the staff hold the family's needs in mind helped Claudia to be more engaged and follow through on necessary steps needed to secure housing and allowed Carlos to develop a greater sense of security with the staff and with the free play routine.*

For many working in shelter programs, holding in mind the seemingly competing needs of parents and children in systems burdened with the responsibility of housing families is a significant challenge. With many programs structured in ways that have staff working with either parents or with children, the mental health consultant is, at times, one of the few people in a position to create opportunities for bridging this divide by representing various voices, especially that of the child.

In the case with Carlos and his family, staff's negatively skewed perceptions of this little boy were primarily informed by their struggles with him during the program's free play time. The

consultant recognized that this was due, in part, to the strong pressure on shelter staff to focus on the need for housing which necessarily gives primacy to adults and their experience. Under this immense expectation, the equally urgent needs of infants and young children, and their interconnectedness to the needs of their caregivers, must compete for attention. The consultant's presence, relational focus, and knowledge of how trauma impacts early development assisted shelter staff in integrating both the child's and parent's experience in the context of case and crisis management and housing planning.

In addition to the external obstacles, internal and interpersonal barriers can also hinder adults' capacities to hold in mind the perspective of the child (Johnston & Brinamen, 2006). It may be difficult or painful for staff to consider the ways in which trauma or adverse experiences impacts the young child. Staff may also hold complicated feelings toward parents as they learn more about the families' history. Holding a trauma-informed perspective, the consultant understands staff's avoidance or overprotectiveness as a way to manage the pain of seeing an already vulnerable child's suffering. Maintaining a nonjudgmental, inclusive stance (see Box 1), the consultant seeks to establish a safe space in which staff are able to consider the experiences of both adults and children while acknowledging and collectively holding the feelings evoked in response to the families' vulnerabilities.

### Entering From the Adult's Perspective

In many shelter programs, case managers hold the mighty task of supporting families in securing stable housing while assessing and identifying obstacles to this endeavor. Meeting with parents regularly, case managers learn a great deal about the adult's experience and may only learn about the child or infant's needs when they are immediate and pressing or, as in Carlos' case, may influence decisions related to housing. Case managers are often well-versed and highly skilled in working

#### Box 1. Consultative Stance

The consultative stance, developed by Johnston and Brinamen (2006), identifies 10 elements of the consultant's way of being that are central to supporting the co-creation of a relationship-based collaboration with consultees and stand as the most significant facilitator to positive change.

1. Mutuality of endeavor.
2. Avoiding the position of the expert.
3. Wondering instead of knowing.
4. Understanding another's subjective experience.
5. Considering all levels of influence.
6. Hearing and representing all voices—especially the child's.
7. The centrality of relationships.
8. Parallel process as an organizing principle.
9. Patience.
10. Holding hope.



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It may be difficult or painful for staff to consider the ways in which trauma or adverse experiences impacts the young child.

with adults, however they typically have limited experience with or knowledge of early development. Understandably, when engaging their mental health consultant, case managers initiate requests related to the mental health needs of their adult clients. Holding in mind that these adults are also parents and that how they are responded to will impact their capacity to attend to their children, the consultant looks for opportunities to introduce and amplify the children's voices.

The request for the consultant to address Claudia's depression came from a deep concern that if this mother didn't engage with the housing referrals offered, it might risk her and her children's safety and well-being. Although starting with providing such direct services to families is typically not how early childhood mental health consultants would lead in other settings, responding to the case manager's request was an important opportunity to both deepen the partnership with staff and to bring the child's and the parent's needs into focus. Understanding the immense pressures Desiree felt with the task of helping Claudia's family secure stable housing gave the consultant more empathy for the case manager's difficult position and for her request to provide brief therapy for the mother. In addition to supporting the case managers, responding to the direct needs of adults presents a portal for representing their parental role which, in turn, can lead to opportunities to consider the interconnected needs of the child. When shelter staff was able to hold Carlos' emotional and medical needs in mind, Claudia felt better understood by staff and was more engaged in the steps needed to secure housing.

While responding to the request to focus on particular families' immediate needs, the consultant looks for opportunities to expand her purview. Enhancing the shelter staff's and program's capacity to appreciate, attend to, and organize around the needs of parents and young children is a primary aim of ECMHC. Simultaneously, by consulting with parents and

providing direct services, such as infant massage, peer-centered playgroups, or child–parent workshops (see Box 2), consultants imbue an infant and early childhood mental health perspective throughout the shelter milieu.

### Entering From the Child’s Perspective

Because of the distinction of roles within many of these programs, children’s experiences are often attended to by the children’s services staff. This team is tasked with developing and offering activities for children from birth to 18 years old, celebrating birthdays, and working closely with the parents around referrals to child care, community resources, and treatment for their children. This staff and the case managers work diligently to attend to the needs of all family members during their stay. However, given the complexities of holding the competing needs of children and adults side-by-side, it is common that communication fails or becomes conflictual between the two services, one representing the child’s experience, the other the adult’s. The consultant supports shelter staff to consider the impact of parents’ experiences on their children as well as children’s experiences on their parents and encourages communication between the case managers and children services staff.

The consultant works closely with the children’s services staff to think about the unique impact of homelessness on children and their relationships. Carlos is only 3 years old, but he has already experienced the loss of contact with his father. Significant disruptions of primary relationships are common and traumatic in children’s lives while homeless. In addition to enhancing staff’s capacity to provide consistency and continuity in their programming for children, the consultant works with staff to implement institutional rituals that support children’s experiences. For example, through a goodbye protocol, space is created for children to say goodbye to peers and staff when they exit the shelter. When possible, staff prepares a gift basket for exiting families and provides opportunities for children to draw pictures or make goodbye books before leaving.

Trauma tends to fragment experiences both in individuals and in institutions. Using fragmentation as a way to cope, coupled with the pain of witnessing the suffering of people, especially the young and most vulnerable, influences how staff respond to families. In shelters where families’ lives are organized around overwhelming experiences, incorporating a trauma-informed approach to ECMHC is an essential ingredient to enhance the voices of the youngest and maintain effective collaboration with staff.

### Trauma-Focused Early Childhood Consultation Practice

*When the consultant arrived at the Harrison Family Shelter for her regularly scheduled meetings, the first thing that caught her attention was a police car parked out front. As she walked in, she found three case*

## Box 2. Direct Services Enhancing Early Childhood Mental Health Consultation

In our consultation with shelter programs, the development and provision of direct clinical services has proven to be an essential element in establishing and building rapport. In addition, it affords the opportunity for the consultant and staff to appreciate, address, and attend together to the unique relationships between parents and children in their program. This offering of early intervention and direct mental health services often and intentionally takes place early in the timeline of the developing consultative relationship with the shelter staff. Holding in mind the need and value of providing definitive and concrete assistance within systems plagued by trauma, the consultant seeks to intervene in ways that address the pervasive sense of urgency, respond to need for co-regulation, and maintain a focus on the needs of infants and young children. The following are examples of the ways consultants have developed direct interventions in these programs:

#### Infant Massage

Mental health consultants with specialized training offer infant massage to families in the shelters as a way of supporting the infant–parent relationship and providing opportunities for playful co-regulation. Various experiences of touch are explored for both parents and babies as the consultant facilitates reflection and attunement to the cues the babies give in response to the massage. The consultant weaves in discussion on the infant’s sensory integration and development, incorporating this into the massage practice. Infant massage strokes are taught over the course of several sessions from less to more sensitive body areas so that parents may practice incrementally as both parents and babies ease into this new experience of being with one another.

#### Child–Parent Workshop

A relationally focused child–parent playgroup was developed by the mental health consultant, in collaboration with the staff at a long-term housing program, as a way to offer a more experiential opportunity for families to meet the program requirement of attending regular workshops during their time in the program. The consultant and staff collaborate to offer activities for parents and their infants, toddlers, and preschoolers and build connections with the other families at the program. Together, they support the child–parent dyads with co-regulation, sharing mutually enjoyable moments of connection, and building curiosity about infants’ and children’s experiences. Despite their resistance toward mandatory events, families often described this open space as a moment of respite in their hectic lives.

#### Therapeutic Playgroup

In a shelter where there is an established child care center embedded within the program, the mental health consultant collaborated with staff to develop a therapeutic playgroup for those children of greatest concern. Cofacilitated with a member of the child care staff familiar to the children, this playgroup offered a weekly space where children were able to engage in exploration, develop age-appropriate play, and use the language of play to make sense of their experiences, all within the context of safe, predictable adult relationships. The consultant provides a model for engaging children and expanding on their play themes and ideas. Recognizing that this venue can evoke powerful feelings for the shelter staff who facilitate the group, the consultant meets regularly with the staff member to provide a space where they can reflect on the feelings, responses, and reactions which inevitably arise.

managers in the hallway, looking concerned and worried and talking through what needed to be done in that moment. Having met with the case managers weekly for the past year, the consultant knew that they cared deeply for the families in their program, where they often faced unpredictable and unsettling events. She quickly learned that Shawn and Kylie, two young parents who recently arrived with their 2-year-old daughter, Madison, had a loud physical argument in the hallway. Right before the consultant arrived, Kylie had thrown Shawn's belongings out into the hallway and locked herself in the apartment with Madison.

The consultant knew from her experience with this staff that during times of crisis, they sought out concrete ideas and expertise from her, and there was no time or tolerance for reflecting. She came to see these actions as necessary to re-establishing a sense of equilibrium and self-regulation within the staff. Listening to staff express their concerns and pressing questions, the consultant joined their problem solving in ways that supported their sense of agency and their own ways of knowing and led the team to identify steps ensuring the safety of the family and other residents. She intentionally worked to maintain her own sense of mindfulness and calm so that her presence offered an opportunity for co-regulation for the agitated staff who had witnessed the family's fight. Having a concrete plan of actions to respond to the urgency of the situation further supported the three case managers in regaining their sense of equilibrium.

With the staff feeling confident that the immediate safety concerns had been addressed, the consultant was able to engage them in considering Madison's experience, positing that she might feel confused and afraid. Knowing that the child was physically safe allowed the case managers to engage in reflecting on Madison's emotional needs in that moment. It became clear to them that they needed to help the parents have time and space to recover from their argument without the child witnessing more fighting. With the consultant's support, they considered how to best approach Shawn and Kylie, explaining their concerns for Madison and how they could support her in that moment. Together with the parents, the case managers were able to identify trusted adults in the program who could bring Madison to the program's playroom, offering Madison and the family time for respite.

The following week, when the consultant returned to the site, staff had more time and capacity to reflect, sharing their ongoing concerns about the family, particularly Madison's needs. Staff shared how the crisis with this family amplified their own feelings of stress and responsibility, and they reflected together on how their nearly insurmountable task of helping families find permanent housing in the Bay Area often left them feeling ineffective. The consultant felt deeply for the staff's experience. She, too, often had feelings of futility in her position. Only after validating their concerns and expressing her respectful appreciation for staff's efforts,



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Mental health consultants with specialized training offer infant massage to families in the shelters as a way of supporting the infant–parent relationship and providing opportunities for playful co-regulation.

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*did she find an opening to offer hope and reconnection to their values by highlighting the profound impact of their efforts on the families they serve.*

The consultant enters the shelters with the awareness that all families in these settings are impacted by acute trauma. Infants and young children, like Madison, whose development is dependent on their caregivers' emotional availability, are especially vulnerable and deeply impacted by their parents' compromised capacity to attune, attend, and protect due to their extremely high stress levels. The persistent, overwhelming experiences families face while navigating homelessness can leave infants, children, parents, and program staff with little opportunity to access calm states, with many oscillating between feelings of panic and exhaustion. The early childhood mental health consultant who values slowing down, wondering but not knowing, and avoiding taking the position of the sole expert in order to invite reflection (Brinamen, Taranta, & Johnston, 2012; Johnston & Brinamen, 2006), finds herself in a bind. Staff and families in states of acute crisis may deem these qualities unhelpful or even more dysregulating when quick, definite action is needed. The consultant has learned through many cycles of rupture and repair in the relationship with the staff that, in settings where the level of worry is intolerable and risks of safety call for immediate action, supporting regulation of the nervous system is necessary before reflective exploration becomes possible.

As Madison's vignette illustrates, many living and working in shelter programs experience continual moments of disruption and dysregulation. Strung together, staff in these programs experience the commotion as crisis and, in turn, feel a tremendous sense of urgency. Coupled with an acute awareness of what families have already lost and what is at risk in the moment, this urgency pushes staff toward immediate action in their effort to relieve suffering. In offering ECMHC to shelters, it has been essential to both respond and to reflect upon this sense of urgency and to be willing to understand

and partner with staff around their pressing concerns while inviting reflection in an effort to support informed action rather than reaction.

Under immense pressure in the midst of ongoing crisis, this sense of urgency becomes the norm, rather than the exception, leaving staff with little tolerance for exploration. Thus, even at times when there is not an immediate safety concern, the consultant's invitation to talk and reflect before taking action is perceived as unhelpful and potentially further dysregulating. With this awareness, the consultant working in trauma-infused settings assesses the level of activation in staff and chooses the most fitting response from her therapeutic repertoire. With a careful balance of maintaining her own state of emotional regulation and responding to staff's concrete needs, the consultant supports staff to modulate their own sense of urgency and return to a balanced state without compromising necessary action.

The consultant aims to support staff's capacity to regulate their own arousal not only through "what we do" and how quickly we do it but, also through "how we are" (Pawl & St. John, 1998). Engaging in active problem solving, offering expertise when it enhances quick decision making, and providing direct therapeutic services to families are settling to staff. These responses address the urgent need for relief, enhance staff's sense of effectiveness, and convey an understanding and appreciation for the pace and pressures of life in shelter settings. However, it is equally important that these actions are provided in the context of the consultant's regulating presence. With the intention to leverage the human capacity to co-regulate through relationships, the consultant aims to bring an attuned, emotionally balanced, and supportive presence to staff and families in the midst of heightened stress and crisis. The mental health consultant patiently waits for a port of entry to gently invite, acknowledge, normalize, and help contain feelings evoked in staff by their exposure to and empathy for the families' pain and suffering. In this way, staff are supported in their capacity to return to a state that is neither too alarmed nor too exhausted, which allows for natural opportunities to arise for reflecting and making meaning of the events and one's own experience in response to them. In these moments, the consultant shifts her approach to support reflection by stepping away from the role of an expert, wondering instead of knowing, and exploring multiple perspectives, including the staff's own experience (see Box 3). Strengthening adults' capacities to regulate their own arousal is central to supporting their ability to attune and respond to the parallel needs of the infants and young children residing in these settings.

Just like staff, the consultant is not exempt from being impacted by witnessing the traumatic experiences and injustices infants, young children, and their families are exposed to while on the journey toward housing stability. Maintaining a nonjudgmental, nonreactive container for family's and staff's intense or confusing emotional experience requires the consultant to be in touch with her own reactions and feelings without being overwhelmed by them (Pawl &

### Box 3. The Impact of Consultation—Quotes From Shelter Staff

The following comments from case managers and children's services staff illustrate the various ways ECMHC has expanded their capacities of holding the infant-caregiver relationship in mind, considering multiple perspectives, and practicing self-regulation, while supporting the families at their shelter program.

*"Consultation has been very useful to me in building relationships with families who do not express their needs. Through talking with the consultant, I am able to get a different perspective on how to best approach these families and their children."*

*"Consultation has been hugely beneficial for me; my experience there would have been very different without it. Sessions helped me clarify my thinking about what had occurred in my sessions with the children that week. I am a fairly emotional person and often took the clients' struggles and hardships very much to heart, so going over events helped me enormously to process and let go of experiences I was finding particularly difficult."*

*"As the Children's Activities Program coordinator, my job would be impossible to do if it wasn't for the reflective processing that enabled me to help and support the families and children with their needs. The reflective processing allowed me to be mindful about the children's developmental, social, and emotional needs. For instance, the consultant helped us understand the importance of 'tummy time' in babies' development and helped us facilitate an ongoing class for parents who had limited time and energy or didn't know of the benefits of babies playing while lying on their tummy."*

St. John, 1998). Through regular reflective supervision, the consultant is supported by the very process she brings to the staff and families at the shelter. This additional layer of support is a crucial part of consultation that enhances the consultant's capacity of presence, empathy, regulation, and reflective capacity. Reflective supervision also provides a place where the consultant explores her own implicit bias and position on the social map and how it influences her practice and relationship with staff and families.

### Conclusion and Lessons Learned

In shelter settings where pressing adult needs are prioritized in order to overcome insurmountable obstacles for successful housing, ECMHC brings infants and young children's voices into focus with the hope that both the child's and parent's needs can be addressed in the context of their housing decisions. The consultant is positioned to hold the child and the parent's experience jointly and looks for opportunities to bring the child-caregiver relationship to the forefront of awareness. This is achieved partly by addressing adults' needs directly while highlighting their role as parents and by helping staff to consider the meaning of children's behavior in the

context of their caregiver's stress, trauma, and compromised capacity to provide attuned caregiving.

Advocating for the voice of the young child in shelter settings must be embedded in a trauma-informed consultation practice. With the understanding of the impact of ongoing elevated stress on one's capacity to regulate strong feelings and internal sensations, the consultant swiftly but carefully assesses the level of urgency and regulation in her consultee and adjusts her interventions accordingly. While maintaining her own regulated presence, the consultant takes a more directive stance when modulating dysregulated states during crisis or crisis-like situations. It is the combination of leading with expert opinion and direct therapeutic contact with parents and their children along with providing co-regulation through the consultant's own calm and responsive presence that supports the consultee to modulate her own arousal. When the sense of urgency settles, the consultant switches to a more open stance that promotes exploration and reflection leading to a better understanding of the child and parent's experience and opening space for reflecting on staff's own experience. Adjusting the stance in these ways supports addressing the impact of trauma and leads to increased capacities for staff to self-regulate, reflect, and hold multiple perspectives in mind, which in turn allows them to enhance the same capacities in parents helping them to be more available to their children.

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