An Overview of Infant and Early Childhood Mental Health Consultation Practices Across Service Settings

ZERO TO THREE
Early connections last a lifetime

Introduction and Key Considerations

Infant and Early Childhood Mental Health Consultation (IECMHC) has been widely recognized since the late 1990s as a proven approach to increase quality outcomes related to the social, emotional, mental, and relational health of infants, toddlers, young children, and the adults who care for them. IECMHC is a prevention-based approach that pairs a consultant with adults who work with very young children in early childhood settings where they learn and grow, such as child care, preschool, home visiting (HV), early intervention (EI), child welfare (CW), pediatric settings.

This document is intended for those who are building, scaling, and supporting IECMH consultants, programs, and systems and is an invitation to expand the conceptualization of IECMHC from a service to a strategy that can be integrated into any and all parts of the early childhood system.

IECMHC equips caregivers to facilitate children's healthy social, emotional, mental, and relational development. It is not about "fixing kids," nor is it therapy. The overarching goal is to increase and deepen adults' reflective capacity to recognize, consistently respond to, and nurture the needs of the young children in their care. IECMHC is nationally recognized as a best practice by the Association of Maternal and Child Health Programs (AMCHP). In February 2026, IECMHC was named a best practice in the State Medicaid & CHIP Toolkit for Children's Behavioral Health Services and the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Requirements Toolkit by the Centers for Medicare & Medicaid Services (CMS).

Historically, IECMHC has most often been understood as a service delivered in child care settings. In recent years, however, the field has been evolving and expanding to include the many settings where infants, toddlers, and young children live and grow. This resource, *An Overview of Infant and Early Childhood Mental Health Consultation Practices Across Service Settings*, offers high-level descriptions of what IECMHC can look like in non-traditional settings. It is not intended to represent an exhaustive breakdown of the differences between these approaches.

To provide the highest quality IECMHC services, consultants must be sustainably supported, well trained, and highly competent. The foundation of consultation includes deep reflective capacity, authentic relationship skills, and an integrated knowledge of infant and early childhood mental health (IECMH). These competencies and skills can be developed through ongoing participation in IECMH-grounded Reflective Supervision and Consultation (RSC), thorough training, and theoretical and experiential preparation. RSC is a critical and foundational professional development support. Best practice calls for consultants to participate in consistent, ongoing RSC with a trusted and competent supervisor.

Regardless of the specific IECMHC model, framework, or setting, the mechanisms by which consultation is delivered may include:

- Identifying strengths and needs by gathering information through formal and informal observations, assessments, and discussions
- Co-creating goals and action planning
- Providing individual or group training
- Facilitating RSC for staff across the early childhood system

A common question is: "What is the relationship between IECMHC and RSC?" While a consultant could provide formal IECMH-based RSC as part of the menu of IECMHC services, it may not be a required element depending on the model or framework. Formal RSC is a standalone professional development support and can be accessed outside of IECMHC services. Availability of RSC varies by state.

RSC grounded in IECMH practices and principles is a critical element in providing high-quality IECMHC services. RSC is provided by an individual qualified and trained in reflective supervision to professionals working directly with infants, toddlers, young children, and families, or on their behalf in non-direct service roles such as supervisors, administrators and organizational and state leaders. In the context of IECMHC, best practice calls for consultants to *receive* consistent and ongoing RSC. Depending on the model or framework of IECMHC that consultants are providing, consultants may also *provide* RSC to those they work with such as child care providers, home visitors, EI providers and child welfare workers.

- RSC is based on the professional relationship between a reflective supervisor and supervisee in service of deepening one's own reflective capacity. The process expands self-awareness of one's own reactions to the work, attunes to one's own resources and areas for growth, explores implicit biases, and deepens understanding through the parallel process of topics such as IECMH, attachment, trauma, development, equity, and systems change.
- RSC may be provided to consultants individually or in a group setting. Sessions are typically one to two hours and may be scheduled weekly, biweekly, or monthly depending on the model and context.

- Consistent, ongoing RSC is considered best practice for consultants to receive at all stages of practice, regardless of endorsement status. Participation in RSC supports professional growth and ensures consultants personally experience the reflective process they bring to those they consult with, reflecting the parallel process central to IECMHC.
- RSC has been described as a mechanism to support consultants' exploration of their professional relationships and to deepen reflection on consultation practice, ensuring fidelity to models, frameworks, and program expectations.
- RSC is distinct from administrative and clinical supervisory roles, though by choice or necessity it may be provided by the same individual. Best practice encourages consultants to receive RSC from someone other than their direct administrative or clinical supervisor.

Guide to the Table

- The rows identify different settings in which IECMHC may be provided.
- The columns list specific considerations for a consultation system.
- Note: Regardless of setting, IECMHC services may be delivered virtually based on need and the availability of resources to support virtual service delivery.

	Service Settings (individual or group)	**Consultees** (who directly receives the service)	**Beneficiaries** (who benefits from the service)	**Mechanism for Growth/ Change**	**Focus on Suspension/ Expulsion**	**Evaluation Metrics**	**Setting Notes/ Exceptions**
CHILD CARE (home- and center-based)	In-person in the child care setting	Child care providers/teachers, directors, and caregivers/parents	Child care providers/ teachers, children, parents/families, and the child care environment as a whole (including the relationships between all involved). Children are *indirectly impacted* by the consultant.	The relationship between the consultant and the adults caring for the child(ren)	Prevention of suspension or expulsion from the child care setting is an important area of focus.	Changes in knowledge, behavior, and practices, including reflective capacity across the continuum of services — at the child care program level, the caregiver/ teacher and classroom/ environment level, and the parent/family and child level.	Observations and assessments from child care providers, the consultant, and families inform the understanding of needs and the direction of services.
HOME VISITING (HV)	Most often, in-person in the HV office	Home visitor/ HV team	Home visitors and the relationship between the home visitor, children, and family/ caregivers. Children and families are *indirectly impacted* by the consultant.	The relationship between the consultant and the home visitor(s)	Prevention of suspension or expulsion from a child care setting is not a main focus of HV consultation, though it may arise as part of the family's or home visitor's concerns.	Changes in knowledge, behavior, and practices, including the reflective capacity of the home visitor. Ways to measure associations between consultation with the home visitor and changes in the family's knowledge, behavior, and relationships need further research.	There can be times when the consultant is asked to meet with the home visitor and family in the family home to assess the need for additional mental health support. Any treatment provided would not be considered consultation. This part of the service needs clear parameters (one to two visits) and is not typical in this setting.
PART C/EARLY INTERVENTION (EI)	Most often in-person in the EI office	EI provider/team	EI providers and the relationship between the EI provider, children, and family/ caregivers. Children and families are i*ndirectly impacted* by the consultant.	The relationship between the consultant and EI provider(s)	Prevention of suspension or expulsion from a child care setting may not be a main focus of EI consultation but may arise as part of the family's or provider's concerns.	Changes in knowledge, behavior, and practices, including the reflective capacity of the EI provider. Ways to measure associations between consultation with the EI provider and changes in the family's knowledge, behavior, and relationships need further research.	There can be times when the consultant is asked to meet with the EI provider and family (in the family home) to assist with a needs assessment or mental health review (one to two visits). Note that EI social-emotional services identified on an IFSP are distinct from consultation.

	Service Settings (individual or group)	**Consultees** (who directly receives the service)	**Beneficiaries** (who benefits from the service)	**Mechanism for Growth/ Change**	**Focus on Suspension/ Expulsion**	**Evaluation Metrics**	**Setting Notes/ Exceptions**
CHILD WELFARE/ FOSTER CARE (CW/FC)	In-person at the CW/FC office	CW/FC staff, supervisors, or directors	CW/FC staff and the relationship between the CW/FC staff, children, family/ caregivers, foster parents, etc. Children and families are *indirectly impacted* by the consultant.	The relationship between the consultant and CW/FC worker(s)	Prevention of suspension or expulsion from a child care setting is not a main focus of consultation but may arise as part of caregiver or consultant concerns.	Changes in knowledge, behavior, and practices, including the reflective capacity of the CW/FC worker. Ways to measure associations between consultation with the CW/FC worker and changes in the family's knowledge, behavior, and relationships need further research.	The role of the consultant is not that of a therapist to any of the parties. The treating therapist of a child could be included in RSC groups or multidisciplinary team meetings. The intent is to support, explore, and embrace an IECMH perspective on the part of CW/FC staff in the provision of services to children and families.
PEDIATRICS AND PRIMARY CARE	In-person at the doctor's office, clinic, or exam room	Health care providers (pediatricians or medical staff) and/or families	Health care providers, and/or caregivers/ families. Children and families may be *directly or indirectly* impacted by the consultant depending on the model.	The relationship between the consultant and the health care provider(s), and/ or the relationship between the consultant and the family/ caregiver(s)	Prevention of suspension or expulsion from a child care setting is not a main focus of consultation but may arise as part of caregiver or consultant concerns.	Changes in knowledge, behavior, and practices, including the reflective capacity of the health care provider. Ways to measure associations between consultation with the health care provider and changes in the family's knowledge, behavior, and relationships need further research.	Consultation is distinct from behavioral health appointments that may take place via co-located mental health services in health care settings.
SUBSTANCE USE RESIDENTIAL TREATMENT FACILITIES	In-person at the facility	Staff at the facility and/or families/ caregivers	Primarily to facility staff. Children and families may be *directly or indirectly* impacted by the consultant depending on the model.	The relationship between the consultant and facility staff/team	Prevention of suspension or expulsion from a child care setting is not a main focus of consultation but may arise as part of caregiver or consultant concerns.	Changes in knowledge, behavior, and practices, including the reflective capacity of facility staff. Ways to measure associations between consultation and changes in the family's knowledge, behavior, and relationships need further research.	This setting is designed for adult needs, and staff may have little to no expertise or experience with the needs of infants and young children, which may run counter to the expectations of the program (e.g., bedtime, feedings, and needs for play and exploration). Staff may have limited knowledge of developmentally appropriate expectations.

	Service Settings (individual or group)	**Consultees** (who directly receives the service)	**Beneficiaries** (who benefits from the service)	**Mechanism for Growth/ Change**	**Focus on Suspension/ Expulsion**	**Evaluation Metrics**	**Setting Notes/ Exceptions**
HOMELESS SHELTERS	In-person at the shelter	Staff at the shelter and/or families/ caregivers	Primarily to shelter staff. Children and families may be *directly or indirectly* impacted by the consultant depending on the model.	The relationship between the consultant and shelter staff/team	Prevention of suspension or expulsion from a child care setting is not a main focus of consultation but may arise as part of caregiver or consultant concerns.	Changes in knowledge, behavior, and practices, including the reflective capacity of shelter staff. Ways to measure associations between consultation and changes in the family's knowledge, behavior, and relationships need further research.	This setting is designed for adult needs, and staff may have little to no expertise or experience with the needs of young children, which may run counter to the expectations of the program (e.g., bedtime, feedings, and needs for play and exploration). Staff may have limited knowledge of developmentally appropriate expectations.
CHILD ADVOCACY CENTERS (CAC) (Trauma and abuse, not legislative advocacy)	In-person at the CAC office	Staff at the CAC office and/or families/ caregivers	Primarily to CAC staff. Children and families may be *directly or indirectly* impacted by the consultant depending on the model.	The relationship between the consultant and CAC staff/team	Prevention of suspension or expulsion from a child care setting is not a main focus of consultation but may arise as part of caregiver or consultant concerns.	Changes in knowledge, behavior, and practices, including the reflective capacity of CAC staff. Ways to measure associations between consultation and changes in the family's knowledge, behavior, and relationships need further research.	The intent is to support, explore, and embrace an IECMH perspective on the part of CAC staff in the provision of services to children and families.

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