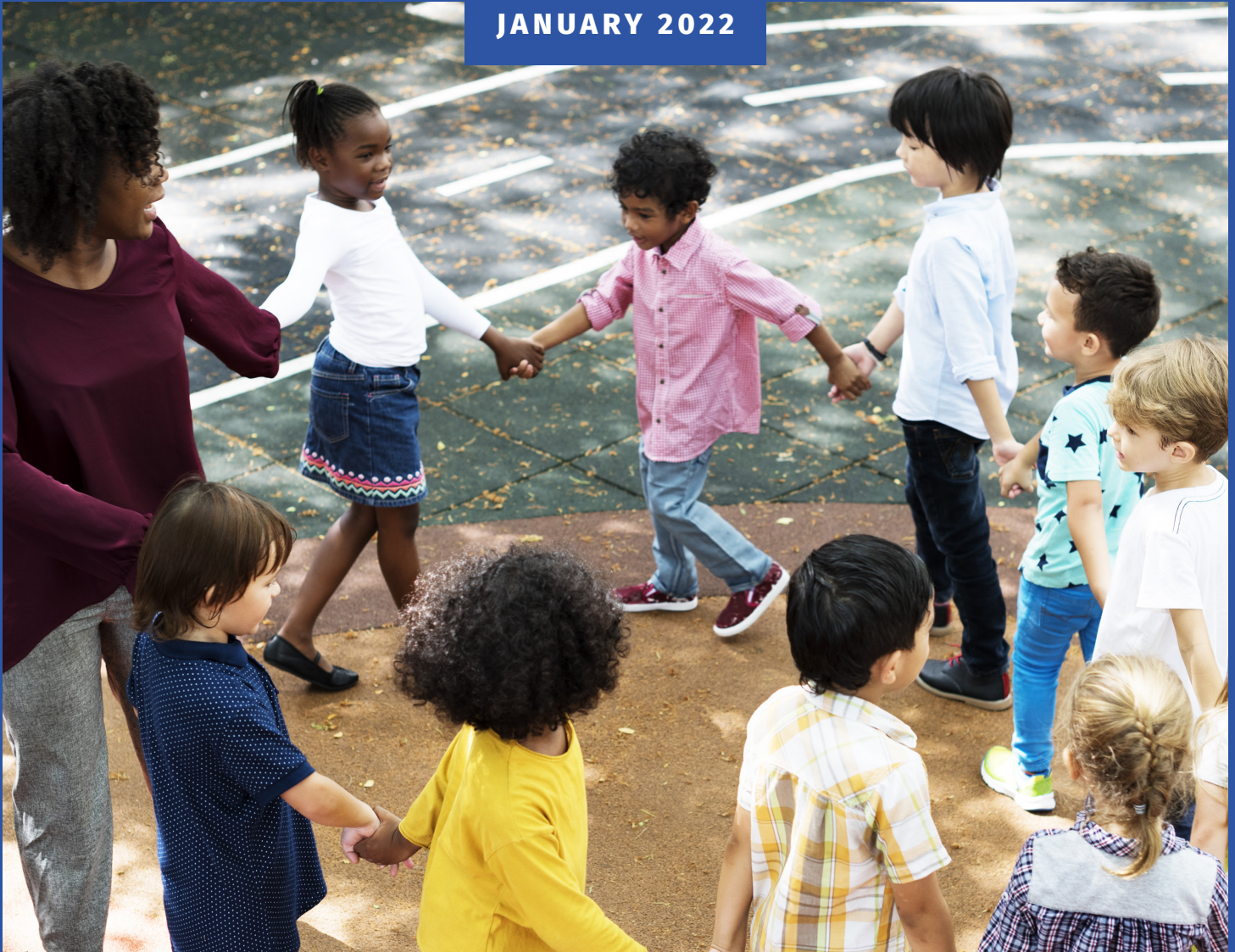


Centering Racial Equity

Design Considerations for Oregon's Statewide Infant and Early Childhood Mental Health Consultation (IECMHC) Program

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Selected Terminology and Definitions¹

Anti-bias A person, policy, or approach which works to actively prevent and oppose the unfair treatment of people based on race, ethnicity, language, sex, gender, socioeconomic status, disability, immigration status etc.

Anti-racist A person, policy, or approach which works to promote anti-racist ideals through active efforts to change embedded organizational policies, procedures, rules, behaviors etc. that have historically resulted in continued unfair treatment to some people and unfair or harmful treatment to others based on race.

Bias A subjective opinion, preference, prejudice, or inclination, often formed without reasonable justification, that influences the ability of an individual or group to evaluate a situation objectively or accurately. Biases can be either explicit or implicit. Explicit biases are the attitudes and beliefs we have about a person or group on a conscious level, while implicit biases are formed and held without our conscious knowledge.

BIPOC Black, Indigenous, and People of Color. The term is used to highlight the specific injustices and differential experiences affecting Black and Indigenous groups and demonstrate solidarity between communities of color.²

Culturally specific services Programs and services that are designed by or adapted for members of the community served; reflect the values, beliefs, practices and worldviews of the community served; provided in the preferred language of the community served; and are led and staffed by people who reflect the communities served.

Culturally responsive A person, policy, or approach which includes the knowledge and skills to be able to work with, serve, respect, and understand the social, cultural, and linguistic needs of children and families from minoritized communities. A *culturally responsive approach* is one that is responsive to, and inclusive of, community cultural practices, values, and beliefs in their work.

ECE Leadership Representatives in leadership positions in Oregon early care and education (ECE) programs (e.g., directors) that receive Infant and Early Childhood Mental Health Consultation.

ECE Programs Early care and education programs is an umbrella term that includes child care and education programs for children 0-5 years old. In Oregon, this can include public and private programs, home-based and center-based programs, and child care and preschool programs.

ECE Providers Early care and education providers implement direct early care and education services. Providers include lead teachers, assistant teachers, and aids in early care and education programs.

EI/ECSE Early Intervention/Early Childhood Special Education is a child- and family-focused intervention to support the developmental and educational needs of children ages birth to five. Oregon's EI/ECSE program provides a free screening and/or evaluation for children ages birth to five. EI/ECSE programs ensure that children who qualify for special education receive a Free and Appropriate Public Education (FAPE) as required in the Individuals with Disabilities Act (IDEA).

Equity Working toward fair outcomes for people or groups by treating them in ways that address their unique advantages or barriers. Equity means that all young children and their families should have access to the resources and opportunities they need to reach their full, healthy potential. To achieve this goal, program administrators and policymakers need to be aware of and understand potential disparities in access to care and outcomes, and to then address these disparities.

IECMHC Infant and Early Childhood Mental Health Consultation involves providing training and coaching to child care and early care and education providers that helps promote healthy social-emotional development, and which builds on child, family and provider strengths to ensure inclusive, supportive care for all children. IECMHC is a prevention based approach that pairs a mental health consultant with adults who work with infants and young children in the different settings where they learn and grow, such as child-care, preschool, home visiting, and early intervention.

Minoritized This term is used in place of the traditionally used "minority." Using minoritized amplifies the reality that some groups acquire minority status through the beliefs and social processes enacted on them by other groups who place them in the "minority." This allows for a more accurate representation of minoritized groups, which frames them within the structural context of their historical relationships with dominant power and access to social and economic assets due to race, ethnicity, language, sex, gender, socioeconomic status, disability, immigration status, etc. (Dowd & Bensimon, 2015; Gillborn, 2005; Harper, 2012).

Mental Health Leadership Representatives in leadership positions in Oregon organizations that house, organize, and support Infant and Early Childhood Mental Health Consultation programming.

¹ The following resources were consulted when creating these definitions: [OHSU Inclusive Language Guide](#) and [Center of Excellence Equity Statement](#)

² For more information about the use of the term BIPOC, refer to this page: [Why we use BIPOC](#)

Executive Summary

Purpose and Goals of Current Project

In Fall 2020, the Oregon Early Learning Division (ELD) contracted with Portland State University's Center for Improvement of Child and Family Services (CCF) to develop a foundational document that would guide development and implementation of a model for providing statewide Infant and Early Childhood Mental Health Consultation (IECMHC) services. IECMHC had previously been identified as an important component of the state's broader effort to address the growing problem of preschool suspension and expulsion.

Because of the well-documented disparities in rates of early learning suspension and expulsion for children of color (Burton et al., 2020; Meek & Gilliam, 2016; U.S. Department of Education, 2016), PSU's charge from the ELD was to gather information that **prioritized and centered the needs, experiences, and strengths of children, families, and early child care and education (ECE) providers of color**. Rather than replicating an existing model that may not have been developed for, by, or with Black, Indigenous and People of Color (BIPOC) communities, the ELD saw this as an opportunity to create a system grounded in racial equity. Leading with race acknowledges inequities based on race within and across other dimensions of identity, such as income, gender, ability, and geography. We know that a system based on an understanding of the intersectional aspects of marginalization, and one that centers those most impacted by inequities, is more likely to meet the needs of *all* children (Ake & Menendian, 2019; Powell et al., 2009).

The full report summarizes information collected from key systems stakeholders, particularly those representing minoritized communities, and provides detailed recommendations for implementing an equity-focused system of IECMHC in Oregon. This summary brings forward the central design considerations and offers a framework for moving forward. A key lesson from the data collection process is that there is no one prescribed or clearly evidence-based way to implement effective IECMHC. Likewise, IECMHC is considered by experts in the field to be a nuanced, long-term, holistic approach to transforming mindsets, relationships, and environments. The intervention is aimed at multiple levels—the program itself, individual classrooms and staff, and, when necessary, specific children. While IECMHC has been shown to be effective in improving crucial outcomes such as suspension and expulsion, it is also not intended to be a child-level, quick-fix. It is as much about building the knowledge, practices and capacity of ECE providers and programs, in order to prevent future suspensions and expulsions, as it is about preventing specific children from being expelled. Indeed, if implemented with only short-term, child-level outcomes in mind, the model may well lose its potency and transformative capacity. In particular, it is unlikely to uncover or begin to address the root causes of preschool suspension and expulsion and at worst, it could reinforce the tendency already present to pathologize BIPOC children and families.

Pragmatically, it is also important to keep in mind that while legislation passed in Oregon's 2021 legislative session that provided a significant investment in this new model, these resources are insufficient to provide IECMHC services to all ECE providers across

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We need to create pathways for more people of color to get to this field of mental health consultation. That's the only way that we are going to increase culturally specific or culturally responsive services for the children, the families, and the [ECE] providers that are serving those children and families... I think the state has the responsibility to create those pathways to increase the number of consultants that are consultants of color that are coming from those same backgrounds of the families and the children that we are serving, and the [ECE] providers that are serving those families on a daily basis.

”

the state. Given this reality, it is recommended that this report be read as outlining a **vision for phasing in a high-quality, equity-centered IECMHC system over time**. The need for services is pressing, yet the risk of rushing to implement, and potentially spreading resources too thin, is also real. It is recommended that **available funds be used intentionally and thoughtfully to lay a strong foundation for progressive expansion**, given the lessons learned from other states and the experiences and perspectives shared by key stakeholders in Oregon.

Creating a truly innovative system that disrupts assumptions about and patterns of interacting with BIPOC and other minoritized communities will require deeply reflective and creative work. Accordingly, ELD IECMHC program and administrative staff should be selected in part based on their **curiosity, learning orientation, and demonstrated reflective capacity**—mirroring the basic IECMHC competencies. A crucial first step will be articulating and building shared understanding around the core values that will be used to guide model refinement and implementation. The hope is that the design considerations offered in this report will serve as key touchstones in the process of creating policies and structures, negotiating complex decisions, and building/strengthening relationships. Most importantly, perhaps, continuing to dialogue with ECE providers, families and communities will be fundamental to understanding and supporting flexibility and responsiveness to local contexts, histories and needs. All of this will no doubt require time and resources; done right the first time, it will be well-worth the investment and likely prove both more efficient and effective in the long-term.

Oregon has garnered national attention as the first state to explicitly center racial equity in its statewide IECMHC system design process. BIPOC respondents in Oregon who shared their perspectives for this report expressed both support for the approach and a level of skepticism that it will actually come to pass. The state has a unique opportunity to defy those expectations by authentically listening to, learning from, and partnering with minoritized communities to keep children in safe, stable early learning environments and interrupt the preschool-to-prison pipeline. In doing so, Oregon would also serve as a valuable model and innovation lab for other states contemplating similar initiatives.

Summary of Key Design Considerations

In moving forward, we offer the following high-level summary of design considerations. These are not meant to provide a detailed implementation plan, but instead to serve as foundational guiding principles for building an anti-racist, equity-focused IECMHC system.

1 **Ensure that the model uses an equity-based, holistic approach** rooted in principles of racial equity and prevention to support the capacity of ECE providers and programs to meet the social/emotional needs of young children. Consultants need to be trained and able to address racism and implicit bias in addition to providing support for social-emotional well-being at the individual child, family, classroom, and program level.

2 **Ensure a flexible model** that can individualize consultation activities based on needs, strengths, and community context, but which is guided by foundational principles for ensuring a high-quality, equity based approach.

3 **Provide sufficient on-site/classroom time and limit caseloads** so that consultants and ECE providers can build the authentic, trusting relationships that are needed for their work together. Respondents repeatedly emphasized the importance of having consultants consistently present in a program or classroom, and of being able to spend time “on site” to build the trusting relationships with staff, families and children that are critical to effective consultation. Providing IECMHC in this way has the added benefit of being seen as normative rather than as “fixing” children or ECE providers. To support these foundational relationships, it was strongly recommended that **caseloads be limited** and **duration of services** be prioritized. National experts generally agreed that 6-months would be the minimum time period required for working intensively to address some limited kinds of child-specific issues, but continued to emphasize the importance of consultants building long-term relationships with ECE providers to prevent future crises. For longer-term capacity building, as well as the critical equity and anti-racist work with ECE providers, at least one year of involvement was recommended.

4 **Ensure equitable access** to consultants based on ECE provider needs and supported by a culturally responsive communication plan and systems that prioritize consultation for smaller programs that do not have access to IECMHC services. This might include moving away from a simple, “first come, first served” model of accepting referrals that is likely to be skewed toward those with the most resources and power. Moreover, avoid stigma and unintended barriers to accessing the services by renaming “Early Childhood Mental Health Consultation” and creating more welcoming language to brand and communicate about its program.

5 **Create formal templates for outlining services, roles, and expectations for IECMHCs and ECE providers, and include equity work as an expected component.** Respondents agreed that formal agreements between programs and consultants were essential to supporting realistic expectations and effective relationships. Several suggested using a template to clearly lay out goals of the consultation, roles and responsibilities of consultants and ECE providers, types of activities the consultant and ECE provider will engage in, and the timeline and process for both beginning and ending the consultation. Many respondents noted that it was important to specifically include in the agreement elements of the work related to implicit bias and racial equity; the Center of Excellence likewise now recommends setting those expectations up front.

6 **Develop, hire, and retain qualified BIPOC IECMHCs**, who are (1) grounded in a shared history, culture, and language; (2) better positioned to overcome mistrust; and (3) have a deeper understanding and skills for navigating issues related to mental health within BIPOC communities. Ensure consultants have specialized knowledge across multiple disciplines and bodies of knowledge, including the research regarding disproportionate suspension/expulsion and implicit bias in ECE settings, and consider using the Center of Excellence’s IECMHC consultation competencies³ as a basis for education, training, and hiring. To address the severe shortage of BIPOC consultants, respondents recommended creative problem-solving at multiple levels, ranging from short-term to long-term, and from individual workarounds to coordinated systems-level change. Intentionally and explicitly centering and promoting equity within the state program, from the individual to the system level, was seen as foundational to supporting BIPOC consultants, as was increasing BIPOC representation at the supervisory and administrative levels. White consultants currently in the field should be provided with required training related to equity and interrupting oppression, and supported to do their own work to understand community and historical contexts, White privilege, power, and their own identities and potential biases.

3 <http://www.iecmhc.org/documents/IECMHC-competencies.pdf>

7

Ensure that addressing implicit bias and racism is a core part of IECMHC services.

The vast majority of experts interviewed agreed that a key role for consultants is to actively and intentionally address implicit and explicit bias as a root cause of disproportionality in suspension and expulsion rates. The state should develop and implement accountability strategies for ensuring that all IECMHCs and supervisors are housed in regional organizations that demonstrate robust support and commitment to ongoing equity transformation at the organizational and programmatic level.

8

Allocate sufficient funds from the outset in building state infrastructure for program administration and contracting, technical support and workforce development, systems alignment and coordination, and data systems and evaluation. Specifically:

- **Create statewide systems to support implementation** that can reduce workload and improve service quality, while allowing sufficient local flexibility to meet community-driven needs.
 - **Establish state and local level structures for cross-system coordination**, such as regular meetings between cross-agency TA and quality improvement ECE providers at the state, regional, and program level. Within programs, it was recommended that IECMHCs connect with other TA providers and coaches working within a given program at least quarterly, and ideally more frequently.
 - **Plan and implement an ongoing system for program evaluation and data collection** from the beginning. Statewide evaluation systems should be linked to an overarching program logic model, and measures should reflect service implementation as well as a holistic set of intended short and longer-term outcomes. The evaluation should use equity-oriented evaluation approaches that are based on partnerships with the BIPOC community members and organizations that this model is focused on supporting.
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9

Build support for ongoing, stable funding from as few sources as possible;

Oregon's state investments in the system bode well for consistency in funding.

What is IECMHC?

IECMHC⁴ is a prevention-based approach to working with ECE providers to support young children’s social and emotional development that has also been shown to reduce rates of preschool suspension and expulsion. In this model, mental health professionals with expertise in early childhood development work with ECE providers to improve their skills for promoting positive social-emotional development and responding effectively to children with existing mental and behavioral health challenges and/or children who are perceived by the ECE provider as challenging (Center for Excellence for Infant and Early Childhood Mental Health Consultation, 2021). IECMHCs often do observations of children and classroom practices, conduct social-emotional assessments, and provide training and reflective support for teaching staff about children’s social and emotional behavior. Mental health consultation is not considered “therapy,” and according to the model developers, is not about “fixing kids.”

Newly revised IECMHC competencies elevate equity by addressing explicit and implicit biases that influence ECE providers’ perceptions of, and behaviors towards, BIPOC children. In so doing, equity-focused IECMHC seeks to shift ECE providers’ internal representations of young children and increase positive relationships between ECE providers and children with different levels of ability and from different racial, ethnic, and linguistic backgrounds. Research shows that IECMHC can reduce racial and gender disparities in children’s preschool experiences by supporting the adults and systems that make decisions about children (Shivers, Farago, & Gal-Szabo 2021).

That the time is right to make these investments is clear. Respondents in this study were unequivocal in voicing the need for increased support related to understanding and working with children whose behaviors they described as “challenging.” Further, recent survey results (Pears et al., 2021) found that Oregon’s ECE providers have extremely limited access to IECMHC, with fewer than 10% of ECE providers who work outside state-funded preschool programs reporting access to a consultant. At the same time, over half of these ECE providers reported feeling that they struggle to manage children’s behavior at least some of the time. Early childcare and education providers are overwhelmed with the challenges of their jobs, and their need for support was a key theme throughout the data collection process.

Moreover, research demonstrates that suspension and expulsion in early childhood is a significant event during a critical, foundational period for learning, development, and growth (Gilliam & Shahar, 2006; Stegeline, 2018). In addition to short-term hardships, these early experiences with suspension and expulsions have long-term consequences and cascading effects including lower overall school engagement, likelihood of repeated suspension and expulsions, school dropouts, and increasing the likelihood of contact with the juvenile justice system and subsequent arrest (American Psychological Association Zero Tolerance Task Force, 2008; Fabelo et al., 2011; Harowitz, 2015; Mittleman, 2018; Nicholson-Crotty et al., 2009; Skiba et al., 2014; Yang et al., 2018). Interventions focused on targeting the reduction of early childhood suspension and expulsion are critical to interrupting the “preschool to prison pipeline” which disproportionately affects BIPOC children (Meek & Gilliam, 2016).

Methodology

Study Sample

Seventy-six individuals participated in 47 one-on-one interviews and 5 focus groups. Participants included Oregon professionals representing mental health and ECE program leadership (n=16); IECMHC consultants (n=9); Early Intervention/Early Childhood Special Education (EI/ECSE) representatives (n=5); ECE providers (n=32); and national IECMHC experts (n=14). Oregon respondents worked across 19 counties, representing 40.3% rural, 46.8% urban, and 12.9% suburban/mixed rural populations.

Because Oregon’s IECMHC model is intentionally centering racial equity, interviews and focus group data collection prioritized hearing from BIPOC-identified respondents. Approximately 65% of participants identified as BIPOC. Of those that identified as BIPOC, 42% identified as Native American/American Indian, 28% as Black, 28% Latino/a/x, and 8% as Asian or Pacific Islander. Ninety-six percent identified as being female.

Data collection for interviews and focus groups occurred through web conferencing (e.g., Zoom). Participants completed an anonymous survey providing background information using a web-based survey platform. Interviews and focus groups were digitally recorded and transcribed for analysis. All participants were offered \$50.00 gift cards as an acknowledgement of their time and expertise. Interviews lasted approximately 60 minutes and focus groups ranged from 60-120 minutes. Transcripts were coded to identify key themes and analyzed by the PSU research team.

4 For more information about IECMHC programs, see <https://www.iecmhc.org/>.

Results & Key Design Considerations

Below we summarize recommendations and considerations for designing the statewide system. Considerations for core IECMHC program components are presented first (**Consultation Approach and Model Assumptions**). Next, recommendations foundational to building a culturally responsive, anti-racist model are presented (**Implementing a Culturally Responsive and Anti-Racist Model**). These recommendations are pulled out in a separate section in order to highlight their importance and **not** to suggest that racial equity should be viewed as an “add-on” or optional component—quite the contrary. Respondents and the Georgetown Center of Excellence for IECMHC agree that equity is, and should be, central to every aspect of IECMHC, from service delivery, to staffing and supervision, to program policies and administration.

Finally, we summarize recommendations related to establishing the state infrastructure (**Infrastructure & Model Administration**), e.g., funding, coordination across systems, and program evaluation, again noting potential equity implications as applicable.

A. Consultation Approach and Model Assumptions

Scope of IECMHC: Promotion, Prevention, or Intervention?

- Respondents emphasized that IECMHC is primarily a prevention-focused model to support the capacity of ECE providers and programs to meet the social/emotional needs of young children.
- IECMHC was described as a holistic approach that can transform the ways that ECE providers, families, and children work with each other.
- Some state models of IECMHC center around the needs of specific children; however, national experts cautioned about over-emphasis of this aspect of consultation to the detriment of prevention, promotion, and ECE provider capacity development.
- However, current understanding of IECMHC varies widely, with some still viewing it as a “last resort” service for providing intensive, child-focused intervention.
- Many acknowledged that there is a need for supports at both “ends” of the prevention-intervention continuum.

Model Flexibility versus Standardization

- Respondents strongly recommended a flexible model that can individualize consultation activities based on need.
- Likewise, consultants need to be able to flex their role to meet the differing community and program needs across the state.

Consultation Strategies and Role

- Respondents agreed that consultants should be trained and supported to provide support at multiple levels (program, classroom, child, family), and that consultation is highly skilled, complex work.
- Respondents repeatedly emphasized the importance of having consultants consistently present in a program or classroom, building the trusting relationships with staff, families and children that are critical to effective consultation.
- Consultants likewise described doing classroom observations and being able to provide classroom-level advice, strategies, and support for staff within the

classroom context as a foundational aspect of their role.

- One of the most important things that consultants do is to help ECE providers to understand the broader context for children’s behavior, taking into account an understanding of child-development; community, family, and historical trauma; systemic racism; and other factors that can contribute to children’s struggles to manage their emotions and behaviors.
- Part of this work is to help normalize developmentally-appropriate behaviors that can often be mis-labeled as “problems.”
- ECE leaders from Oregon noted that IECMHCs can also provide much needed staff training on mental health, a gap they perceived in currently available training.
- Consultants should also be familiar with the research on disproportionate suspension/expulsion, implicit bias, and the role of their own cultural identifications and positionalities on the consultation process.

Consultant Caseload, Frequency, and Duration of Consultation

- Respondents acknowledged that caseload and service frequency and duration is often driven by the reality of limited resources, rather than best practice.
- In designing a new system, it was strongly recommended that caseloads be limited and duration extended to allow sufficient time to develop strong relationships, ECE provider understanding and insight, and program capacity.
- A typical caseload appears to be anywhere from 9-18 sites, with virtually everyone agreeing that lower caseloads would be more effective. Some of the most well-established and highly-regarded programs have caseloads closer to 4 sites.
- Many cautioned against a short-sighted impulse to spread resources “too thin” in an effort to be “fair” and serve greater numbers; current Oregon IECMHCs noted that the growing need for their services can lead to pressure to increase caseloads beyond what is likely needed for effective consultation.
- Respondents likewise urged flexibility rather than standardized timelines, in responding to program needs.

- When asked to specify an adequate duration of services, national experts generally agreed that 6-months would be the minimum time period required for working intensively to address some limited kinds of child-specific issues, but continued to emphasize the importance of consultants building long-term relationships with ECE providers to prevent future crises.
- For longer-term capacity building and maintenance—the crucial “prevention” aspect of IECMHC—at least one year of involvement was recommended.
- Longer-term involvement is likewise viewed as necessary to support authentic equity and anti-racist work with ECE providers and ECE programs.
- Several suggested using a template to clearly lay out goals of the consultation, roles and responsibilities of consultants and ECE providers, types of activities the consultant and ECE provider will engage in, and the timeline and process for both beginning and ending the consultation.
- Many respondents noted that it was important to specifically include in the agreement elements of the work related to implicit bias and racial equity; the Center of Excellence likewise now recommends setting those expectations upfront.
- Negotiating these agreements is another area in which consultants will require training and support.

Access and Referral Pathways

- Respondents shared that many ECE programs and providers in Oregon are either unaware of IECMHC or fundamentally misunderstand the nature of consultation.
- Large, established ECE programs are more likely to be aware of and already have access to IECMHC—and may be the most likely to seek out these new, additional services.
- Given these realities, the ELD should develop mechanisms for ensuring equitable access by smaller programs, e.g., consider moving away from a simple, “first come, first served” model of accepting referrals that is likely to be skewed toward those with the most resources and power.
- Likewise, to support interest in and access to the new services by smaller programs, the ELD should develop a thoughtful, culturally responsive communication plan.
- Feedback indicates that the term, “Early Childhood Mental Health Consultation” is a particular barrier for many ECE providers and families, especially BIPOC families, that activates stigma, historical trauma, and mistrust of the system—and does a poor job of communicating the true nature of IECMHC. Oregon should consider using more welcoming language to brand and communicate about its program.

Supporting Early Learning Program Readiness for Consultation

- Respondents agreed that formal agreements between programs and consultants were essential to supporting realistic expectations and effective relationships.

Consultant Qualifications, Competencies, and Professional Development Supports

- Respondents were unanimous in stating that IECMHC requires specialized knowledge across multiple disciplines and bodies of knowledge, including the research regarding disproportionate suspension/expulsion and implicit bias in ECE settings.
- Likewise, the role is considered highly skilled, with consultants working at multiple levels within a given organization, and using varied strategies to support administrators, ECE providers, children, and families.
- Typically, IECMHCs enter the role with a Masters degree.
- Respondents were also clear that comprehensive onboarding, regular reflective supervision, and ongoing training are critical to consultation success and should be explicitly included and budgeted for in Oregon’s model.
- As discussed in greater detail below, respondents agreed that effective consultation is supported by having consultants who reflect the communities served.
- An understanding of local community histories, cultures, and current contexts is likewise seen as foundational to the work—as is an understanding of one’s own culture identification and social position.
- Many recommended that Oregon anchor its IECMHC model in The Center of Excellence’s IECMHC consultation competencies.⁵

5 <http://www.iecmhc.org/documents/IECMHC-competencies.pdf>

B. Implementing a Culturally Responsive and Anti-Racist Model

The Crucial Importance of BIPOC Consultants

The need to expand the consultant workforce generally, and to increase the number of BIPOC consultants in particular, was a key theme across many respondents. The reasons for focusing specifically on developing, hiring, and retaining BIPOC consultants were clearly articulated, and are summarized below.

- There was widespread agreement that a consultation workforce that reflects the communities served is much more likely to be effective. Specific reasons for this related to the ways in which BIPOC consultants: (1) are grounded in a shared history, culture, and language; (2) are better positioned to overcome mistrust; (3) have a deeper understanding and skills for navigating issues related to mental health within BIPOC communities.
- Currently, the vast majority of IECMHCs are White-identified women.

Strategies for Increasing the Number of BIPOC Consultants

- Identifying and addressing existing barriers to joining the IECMHC workforce experienced by minoritized groups was identified as critical.
- To address the severe shortage of BIPOC consultants, respondents recommended creative problem-solving at multiple levels, ranging from short-term to long-term, and from individual workarounds to coordinated systems-level change.
- Note that there was little interest in “lowering” standards; everyone agreed that mental health consultation requires extensive background knowledge and a high skill level.
- BIPOC respondents in particular talked about the desire for high-quality services in their communities and referenced past experiences with being served by less skilled or experienced professionals.
- Respondents would like to see the state IECMHC program build formal partnerships with colleges and universities, cultivate strong relationships with relevant graduate internship programs, and clearly communicate program and community needs for BIPOC IECMHC interns.
- Others noted that Master’s level social workers may be particularly good IECMHC candidates given their social justice orientation and higher BIPOC representation.
- Generally, respondents talked about the importance of not serving as “gatekeepers” to the role, but rather of finding ways to advertise and recruit for positions that would be perceived as welcoming and accessible.
- Some respondents made the case for recruiting BIPOC candidates with less formal education, while providing supplemental, on-the-job professional development support and pathways—including financial support—to advanced degrees.
- At the same time, caution was urged around the risks of deprofessionalizing the BIPOC IECMHC workforce and permanently creating a second tier of consultants, in the name of increasing diversity. It was recommended that lowering the degree requirement should only be used as a temporary, transitional strategy—and only if coupled with the above supports.
- Other recruitment strategies mentioned included recruiting directly from the ECE workforce, which is more likely to reflect the communities served.

Supporting and Retaining BIPOC Consultants

- Respondents highlighted support and retention of BIPOC consultants as equally important design considerations.
- Intentionally and explicitly centering and promoting equity within the state program, from the individual to the system level, was seen as foundational to supporting BIPOC consultants.
- Likewise, increasing BIPOC representation at the supervisory, leadership, and administrative levels was identified as central to creating a welcoming and inclusive workplace and supports an intentional strategy for the recruitment and retention of BIPOC IECMHCs.
- Respondents said that salaries and benefits should be competitive and care should be taken not to ask BIPOC staff to take on unpaid equity work, nor to educate White colleagues.

- It was also recommended that the state program implement safe spaces and culturally responsive supervision for BIPOC consultants, supervisors, and administrators, e.g., affinity groups.

Addressing Implicit Bias and Racism

- The vast majority of experts interviewed agreed that a key role for consultants is to actively and intentionally address implicit and explicit bias as a root cause of disproportionality in suspension and expulsion rates.
- This includes work to address racial bias as well as the intersection with gender and disability bias that all contribute to disproportionality in rates of early childhood suspension and expulsion
- Experts cautioned against avoiding these sometimes challenging conversations; to do so was described as being complicit in perpetuating bias.
- Indeed, it was recommended that formal IECMHC agreements with ECE providers include clear expectations around addressing bias in the context of consultation.
- In Oregon, BIPOC consultants expressed more comfort and preparedness to take on this role than did White consultants (or EI/ECSE specialists); additional training and support in this area is likely to be important.
- In order to do effective anti-bias, anti-racist work, respondents noted that sufficient consultation time must be available to develop ongoing relationships and trust between consultants and ECE providers.
- In addition, the system needs to develop required racial equity training for ECE providers—generally, and in particular for those working with IECMHCs. The system should provide education about disproportionate suspension and expulsion and the ways that implicit bias emerges within ECE settings.

Training for Current and Future Consultants to Support Anti-Bias, Anti-Racist Work

- As noted above, the model will need to provide training, ongoing professional development, and reflective supervision to support consultants to engage in effective anti-racist and anti-bias work with ECE providers.
- Budget and adequate time for professional development and reflective supervision for consultants and their supervisors should be built into the model, so that they take place on paid work time, and are not treated as an optional, unpaid “extra.”
- White-identified consultants would likely also benefit from the opportunity to do equity-related self-reflection and learning in the context of White affinity spaces.
- Additionally, given the current reality that White women are significantly overrepresented among IECMHCs, White consultants should be expected to spend time in the communities they are serving, learning the histories and current contexts, and building the authentic relationships that support effective consultation.

C. Infrastructure and Model Administration

Putting in place the necessary infrastructure for the new IECMHC system is critical to ensuring success. This includes providing sufficient funding; ensuring strategic and intentional alignment and coordination of IECMHC services with other ongoing professional development, technical assistance, training, and coaching supports (e.g., EI/ECSE specialists, quality improvement specialists, etc.); developing training and other professional development resources for the IECMHC workforce; and engaging in ongoing program evaluation for quality and systems improvement. Key infrastructure recommendations are summarized below.

Centralization versus Decentralization

To best structure the system to support equity, Oregon's system should combine elements of both centralized and decentralized systems. For example, elements that would benefit from centralization might include standards of practice, training, support and supervision, and evaluation. Centralization of such elements would likely increase efficiency and support high-quality service delivery. On the other hand, consultation service delivery itself might be highly decentralized and customized to local, community needs and preferences.

Alignment & Coordination with Existing Technical Assistance & Professional Development Systems

A wide variety of TA providers work across Oregon in different capacities serving ECE classrooms. Classrooms have different access to TA providers based on available resources. Building relationships and communities of practice with shared language, frameworks, and theories of change across these various TA providers will support better communication and coordination and is foundational to success for the IECMHC system. This issue was a key theme across interviews, noting the fragmentation of current early childhood systems and supports and the potential for additional confusion in developing this new system. Specific recommendations included:

- The system should establish some formal structures for cross-system coordination, such as regular meetings with supervisors from all the TA programs that may be represented in ECE classrooms.
 - IECMHCs should connect with other TA providers and coaches working within a given program at least quarterly. Ideally, more frequent case staffings or team meetings should be held when multiple TA providers are supporting a specific child, ECE provider, or ECE classroom
- to align approaches and avoid duplication of effort.
- The system should consider providing a series of trainings using Zoom, accessible to professionals from the range of different ECE TA positions. These trainings should be responsive to the program's commitment to centering equity and offer an opportunity to build shared frameworks.

Funding Recommendations

- Build support for ongoing, stable funding from as few sources as possible; Oregon's state investments in the system bode well for consistency in funding.
- Consider other funding sources, especially those that are more durable and ongoing, and those that allow flexibility (e.g., philanthropy).
- Time-limited federal grants can be useful for testing or implementing specific model pieces as long as concurrent sustainability planning is ensured.
- Allocate sufficient funds from the outset in building the needed state infrastructure for program administration and contracting, technical support and workforce development, systems alignment and coordination, and data systems and evaluation.

Evaluation

- In order to support accountability and continuous quality improvement, mechanisms for data collection and program evaluation should be developed, budgeted for, and built into the system from the very beginning.
- Consistent with the equity focus of the Oregon model, Oregon's evaluation should likewise utilize equity-oriented approaches to evaluation, in authentic partnership with BIPOC communities and organizations.
- Developing a logic model for Oregon's planned system will be an important foundational step for evaluation planning.
- Evaluations should include both implementation measures and key short and longer term outcomes that reflect the breadth and depth of intended outcomes for IECMHC.
- As relevant and appropriate, evaluation planning should take into account lessons learned from past and ongoing evaluations of IECMHC, and draw from existing resources, e.g., successful strategies and tools.

Community Input Sessions

In order to garner further input on the design considerations, the PSU team contracted with a facilitator to solicit feedback from 4-6 groups of diverse stakeholders and community partners. In total, 48 individuals participated across 5 engagement sessions and 5 individual interviews. Participants in these input sessions included representatives from Health Share Oregon, AFSCME, Relief Nurseries, IECMHCs, Oregon Alliance, and statewide ECE providers. See Appendix E for complete input session report.

Key findings from these feedback sessions suggested that:

- 1. Participants were excited about the opportunity.** A majority of participants were excited about the proposed recommendations. Participants particularly underscored the need for IECMHC in their communities, the emphasis on BIPOC communities, and saw significant value in its emphasis on supporting ECE providers.
- 2. Participants voiced concerns reflecting historical distrust and past negative experiences with White-dominant systems.** These included:
 - a.** Fears that IECMHC would be duplicative of existing programs, including supports already being provided by BIPOC-led organizations.
 - b.** Concerns that the title “IECMHC” would be a barrier for BIPOC ECE providers and family members (overly long, complex, and potentially triggering stigma related to “mental health”).
 - c.** That a significant amount of responsibility for program success would be placed directly on ECE providers or on the consultants.
 - d.** Skepticism that the program would be able to achieve the equity goals.

Throughout the feedback sessions, and in line with what respondents shared throughout the project, the theme of trust and mistrust emerged—especially from BIPOC ECE providers. Participants emphasized the importance of building trust in consultant-consultee relationships, consultant-community relationships, and community-state relationships. To do this, participants described the need for slowly building authentic relationships across these sets of partners, and in particular with consultants. Oregon has an opportunity to build trust by continuing to meaningfully engage BIPOC ECE providers and families as the model is developed and implemented, and by taking observable steps to center equity in IECMHC model planning and implementation.

Conclusions & Next Steps

Oregon is in a unique position to be the first state to design and implement a statewide IECMHC program that explicitly uses an anti-racist lens. The time is now to invest in and build a transformative IECMHC system in Oregon that authentically listens to, learns from, and partners with minoritized communities to keep children in safe and stable early care and education learning environments. One clear message from this project is that there is no single “right” way to implement effective IECMHC. At its core, IECMHC seems to be as much a philosophy—a way of being in the world—as a specific technique. Accordingly, it is important to establish a shared set of values, guidelines and expectations upon which to build an equity-centered system, combined with sufficient flexibility to be responsive to local contexts, histories, and needs. This report serves as a decision-making framework to support the vision for a system that centers the needs of BIPOC children and families and infuses anti-bias and anti-racist commitments at every level. National attention is focused on Oregon’s innovative approach: the state and its early childhood partners are urged to embrace this challenge and commit to transformative change on behalf of all our children and families.

Introduction & Project Overview

Purpose and Goals of Current Project

In Fall 2020, as a step in laying the foundation to create Oregon’s system of supports for preventing PreK suspension and expulsion, the Oregon Early Learning Division (ELD) and the Build Initiative reached out to Portland State University’s Center for Improvement of Child and Family Services (CCF) to lead a process of community engagement and a review of national early childhood mental health consultation models that could be used to guide plans for implementing an Infant and Early Childhood Mental Health Consultation (IECMHC) system. ELD recognized the team at PSU’s previous experience in this area and significant expertise in developing recommended strategies to strengthen early childhood mental health practices in rural and statewide systems. It was also important that PSU was leading efforts in research studies that gathered complementary data on the experiences of parents and early care and education (ECE) providers as it relates to children being asked to leave care. The depth of knowledge of the PSU team in early childhood mental health and related work that lead ELD to develop a contract with PSU. In particular, the ELD and the IECMHC Steering Committee (see Appendix B for Steering committee membership) requested that PSU gather information about how to design an IECMHC system that prioritized and centered the needs, experiences, and strengths of BIPOC children, families, and ECE providers. In so doing, the state felt that not only could an effective system be developed to support children who are disproportionately represented among those asked to leave early learning settings, but that a better system for all children could be designed. Rather than replicating an existing model that may not have been developed for, by, or with BIPOC communities, the ELD saw this as an opportunity to create a system with the needs of BIPOC children and families at the center.

This document reflects the year-long information gathering process developed by the PSU team, with input from the IECMHC Steering Committee and consultation with Indigo Cultural Center.⁶ In designing the methods and prioritizing which voices to bring into the research, the team worked to go beyond “the usual” systems representatives, doing intensive outreach and recruitment to hear from IECMHCs and supervisors, ECE program directors and staff, early intervention/early childhood special education (EI/ECSE) staff, and other key stakeholders from African American/Black, Latino/a/x, Native American/American Indian, Immigrant/Refugee, and other BIPOC communities. Interviews with national experts in IECMHC focused on understanding the role of consultation in addressing issues of implicit bias, institutionalized racism, and disproportionality in suspension and expulsion rates. In all, we spoke with 76 key stakeholders across 47 interviews and 5 focus groups.

The purpose of this report is to act as foundational guidance for the many decisions that the ELD will need to make about how to implement the first phase of a critically import-

⁶ <http://indigoculturalcenter.org/>

ant statewide system of supports for children, families, and ECE providers. One clear lesson from the data-gathering process was that there is no one “right” way to implement effective IECMHC; instead, what is important is to build a system based on a shared set of clear guidelines and definitions for what quality, culturally responsive services must include, with sufficient flexibility for local communities to individualize services and strategies based on local contexts, histories, and needs. Thus, rather than providing a “how to” manual for developing this system, the recommendations in this report (“Key Design Considerations”) are meant to act as a framework for decision-making that supports a vision for how such a system could look if race equity is put at the center of the model. The goal is to offer a framework that defines a vision for a high-quality approach that takes seriously the importance of addressing the root causes of preschool suspension and expulsion and lays out parameters for the role of IECMHC in addressing these causes. As Oregon’s system is developed and implemented, it will be critical to continue to gather information about the effectiveness of the systems and services, and to use that information to continue to adapt and improve the model. Oregon has a unique opportunity to implement an innovative approach to IECMHC, and to learn along the way about what it takes to provide high-quality, culturally specific and responsive supports that allow children to remain in safe, stable, early learning environments.

Project Background & Policy Context

Statement of the Problem

Across the United States, rates of expulsion and suspension in early childhood are a growing concern. While it is challenging to get an accurate count of total expulsions and suspensions in early childhood, it has been estimated that approximately 50,000 preschoolers are suspended each year (Malik, 2017) and almost 9,000 are permanently expelled (Gilliam, 2005). Nationally, the rate of expulsion from state-funded preschool programs is three times higher than that for K-12 schools (Gilliam, 2005). Children of color make up the largest group of expelled and suspended children, with Black children being suspended at the highest rates. ECE settings disproportionately suspend and expel young children based on race, gender, disability, or participation in special education (Meek & Gilliam, 2016; U.S. Department of Education, 2016). In Oregon, Latino/a/x children (6.1%) are expelled 1.5 times more than White children (4.2%) and multiracial children (14.3%) are expelled almost 3.5 times more than White children (Burton et al., 2020). Primarily Spanish speaking children (9%) or other non-English language (9.3%) are expelled approximately 2 times

as often as children who primarily speak English (4%).

Suspension and expulsion in early childhood is a significant event during a critical, foundational period for learning, development, and growth (Gilliam & Shahar, 2006; Stegelin, 2018). In addition to short-term hardships experienced by children and parents, these early experiences with suspension and expulsions have long-term consequences and cascading effects including lower overall school engagement, likelihood of repeated suspension and expulsions, school dropouts, increasing the likelihood of contact with the juvenile justice system and subsequent arrest (American Psychological Association Zero Tolerance Task Force, 2008; Fabelo et al., 2011; Harowitz, 2015; Mittleman, 2018; Nicholson-Crotty et al., 2009; Skiba et al., 2014; Yang et al., 2018). Interventions focused on decreasing early childhood suspension and expulsion are critical to interrupting the “preschool to prison pipeline” which disproportionately affects BIPOC children (Meek & Gilliam, 2016).

Role of IECMHC

IECMHC is one approach that has begun to show evidence of effectiveness for reducing the rates of suspension and expulsion (Davis & Perry, 2014; Gilliam, 2005; Hepburn, et al., 2013; Perry et al., 2008). IECMHC⁷ is a prevention-based approach which is rooted in supporting the social, emotional, and behavioral health and development of young children. The goal of the IECMHC model is to promote positive mental health in early childhood to equip ECE providers with the skills to respond effectively to children with existing mental and behavioral health challenges (Center for Excellence for Infant and Early Childhood Mental Health Consultation, 2021). Consultants with a background in children’s emotional development and behavior provide a variety of supports for ECE providers to help ensure that all children can be included and supported in early childhood programs. Consultants often do observations of children, social-emotional assessments, and might provide coaching or advice for teaching staff about children’s social and emotional behavior. Consultants also sometimes provide individualized child and family-focused services when needed. Mental health consultation is not considered “therapy,” and according to model developers, is not about “fixing children.” The hope is that providing IECMHC will help reduce the disproportionate rate of young children, especially children of color, being asked to leave their child care settings, either temporarily (suspension) or permanently (expulsion), because of emotional and/or behavioral concerns.

Newly revised IECMHC competencies elevate equity by addressing explicit and implicit biases that influence ECE provider per-

7 For more information about IECMHC programs, see <https://www.iecmhc.org/>.

ceptions of, and behaviors towards, BIPOC children. In so doing, equity-focused IECMHC seeks to shift ECE providers' internal representations of young children and increase positive relationships between ECE providers and children with different levels of ability and from different racial, ethnic, and linguistic backgrounds. The model is well-positioned to disrupt racism, bias, and other forms of marginalization within the context of consultation and the consultative alliance. Research shows that IECMHC can reduce racial and gender disparities in children's preschool experiences by supporting the adults and systems that make decisions about children (Shivers et al., 2021). Factors attributing to these reductions include strong consultant-ECE provider/staff relationships, high capacity to engage in culturally specific practices, addressing issues of equity, and having ethnic matches between consultants and consultees (Davis et al., 2018; Howes & Shivers, 2006; Shivers et al., 2021).

opment, anti-bias practice, inclusive practice in ECE programs, and to provide technical assistance to support the stability of children's placements in ECE programs. Concurrently, Senate Bill 236¹⁰ (see Appendix A) initiated a ban of suspension and expulsion in early care and education programs, to be implemented beginning in 2026. The impetus for the ban is to address the disproportionate expulsion and suspension of young children of color once mental health consultation resources are in place to support ECE programs.

Implementing IECMHC in Oregon— Current Legislative Context

In 2020, Governor Kate Brown convened the Racial Justice Council (RJC) to center minoritized communities' perspectives, backgrounds, and experiences to advance transformational change.

Together, the RJC developed a Racial Justice Action Plan⁸, which influenced the state's short-, medium-, and long-term goals to address structural racism—putting Oregon on a track to build a stronger, fairer, and more equitable Oregon where everyone can thrive. The RJC has centered, for the first time, the dismantling of systemic racism from our civic institutions at a statewide level, starting with advancing the RJC's budget and policy recommendations. During the 2021 Legislative Session, Governor Kate Brown and the RJC have secured over \$3.2 billion in decisive investments to begin the process of recognizing—and undoing—systemic racism in Oregon. Within the plan was a \$5.8 million investment through House Bill 2166⁹ (see Appendix A) to establish the Early Childhood Suspension and Expulsion Prevention Program, building a cadre of IECMHCs and a centralized process for early childhood programs to request technical assistance to support stable and inclusive placements for children and to prevent expulsion or suspension, disproportionately impacting BIPOC children.

Within this bill, IECMHC is considered a primary resource for ECE providers to request technical assistance to support children's social emotional development, positive racial identity devel-

8 https://www.oregon.gov/lcd/Commission/Documents/2021-09_Item-2_Directors-Report_Attachment-A_DEI-Action-Plan.pdf

9 <https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB2166>

10 <https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/SB236>

Methodology

Project Oversight

The work on this project was completed in partnership with the Oregon Department of Education Early Learning Division who was partnered with the Build Initiative. The ELD, in partnership with BUILD, developed The Oregon IECMHC Steering Committee which guided the process to engage stakeholders to develop recommendations for the IECMHC model from September 2020–November 2021. PSU is the ELD’s contracted partner to interview stakeholders and assess findings to create the recommended components that will inform the IECMHC model.

Study Sample

The participants in this project included Oregon ECE and mental health stakeholders, as well as representatives from other states who are implementing and supporting IECMHC at a state or local level. Data were collected through key stakeholder interviews and focus groups with the goal of centering the voices and experiences of BIPOC stakeholders and representing urban and rural areas, tribal settings, and those serving a variety of cultural and linguistic populations. In total, 76 respondents participated in 47 one-on-one interviews and 5 focus groups. Eligibility was restricted to 5 categories:

1. Oregon mental health and ECE leadership (n=16)
2. Oregon IECMH consultants (n=9)
3. Oregon EI-ECSE representatives (n=5)
4. Oregon ECE providers (n=32)
5. National IECMHC experts (n=14)

Oregon respondents worked across 19 counties, representing 40.3% rural, 46.8% urban, and 12.9% suburban/mixed rural populations. Because Oregon’s IECMHC model is intentionally centering racial equity, the decision was made to prioritize interviews and focus groups with BIPOC-identified respondents. Approximately 65% of our respondents identified as BIPOC. Of those that identified as BIPOC, 42% identified as Native American/American Indian, 28% as Black, 28% Latino/a/x, and 8% as Asian or Pacific Islander. Ninety-six percent identified as being female.

National experts represented 8 states and held positions and expertise as consultants, policy advisors, state administrators, ECE program directors, reflective supervisors, and experts with specific cultural communities. Approximately 36% of the national experts identified as BIPOC, of those 80% were Black/African American and 20% were Native American. All national experts identified as being female.

A detailed summary of the background characteristics and geographic areas represented is included in Appendix D.

Data Collection

Participant Recruitment, Outreach and Engagement

The research team collaborated with the IECMHC Steering Committee to identify possible respondents. In order to understand the experiences and needs for IECMHC, we prioritized respondents who had direct experience as, or with, IECMHCs.

Collaborating with the ELD and the IECMHC steering committee, the research team compiled an original list of possible stakeholders. The research team contacted possible respondents by email, with follow-up emails sent approximately 2 weeks later. Snowball and convenience sampling were used to solicit study participation. A combination of individual in-depth interviews and focus groups using semi-structured interview guides were used to talk with BIPOC individuals in these roles and/or with persons who work specifically with programs and families from nondominant racial/ethnic and linguistic backgrounds to learn about their experiences with and perspectives on IECMHC services.

Data Collection Methods

Interview and focus group protocols were tailored to each participant category based on their role in IECMHC and the ECE system (see Appendix C for interview protocols). The research team solicited feedback for these protocols from the ELD, Build Initiative, and the state IECMHC steering committee. Interview questions were prespecified and included probes. Follow up questions and exploration of emerging topics during the interview was also encouraged. Data collection for interviews and focus groups occurred through the web conferencing program most convenient to the participants. Participants were asked to fill out an anonymous demographic information survey using Qualtrics. Interviews and focus groups were digitally recorded and professionally transcribed for analysis. All participants were offered Amazon gift cards worth 50 USD as an incentive to participate and to compensate them for their time and expertise. Interviews lasted approximately 60 minutes and focus groups ranged from 60-120 minutes.

Analysis Approach

To analyze these data, a constant comparative analytic method was used, where analysis began during data collection and a 6-member team moved between analysis and collection (Creswell & Poth, 2018). To manage inter-coder reliability, each member reviewed all data independently and then met as a team to discuss, compare, and come to a consensus on emerging themes (Tracy, 2019). Interviews were analyzed within each respondent category (Oregon mental health and ECE leadership, Oregon IECMH consultants, Oregon EI-ECSE representatives, Oregon ECE providers, and National IECMHC experts). That is, interviews from each respondent category were coded, generally by question. Coding pairs were assigned to analyze each category of interviews. Analysis occurred in a multi-stage process, in a series of cumulative coding cycles to conduct a thematic analysis process (Creswell & Poth, 2018; Hsieh & Shannon, 2005).

Stage 1 was initial, or open, coding, which involved examining the transcripts and assigning codes to individual words, phrases, or sections using descriptive coding to summarize concepts (Saldaña, 2016) and in-vivo coding using participants' own words describing their experiences (Charmaz, 2006). In Stage 2, data were themed, which involved immersion in the data and organizing codes into categories of similar constructs (Saldaña, 2016). Discrepancies in coding and theming were discussed and resolved, although it should be noted that there were only minor incidents of coding divergence.

Primary themes were summarized and a thematic content analysis was created in Stage 3 (Ayres et al., 2003). Themes were compared within and across interviews and within and across participant groups in order to surface prominent and divergent themes. Thematic content analysis allows for researchers to look for collective meaning across data, and make sense of those commonalities. Overall, this approach seeks to elevate and understand lived experiences (Charmaz, 2006; Vaismoradi et al., 2013).

Throughout each stage the team met weekly to compare observations and personal reflections for the purpose of further analysis and self-reflection (Creswell & Poth, 2018). The research team presented preliminary findings during monthly meetings with the statewide IECMHC steering committee, eliciting reflections and program design input (Tracy, 2019).

Lastly, as an additional engagement process, input sessions were offered to Oregon stakeholders on final, equity-focused, key design considerations.

“

We [mental health consultants] want to support [ECE] providers, we want to make sure that they don't burn out because those behaviors can be challenging for them. We want to make sure that we recognize how difficult it is and that we try to find the best support for children, for [ECE] providers, and for families.

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Results

The goal for this study was to provide information that could support the ELD to make key decisions about how to design an IECMHC system that is centered on providing culturally responsive and anti-racist supports. In alignment with approaches such as Targeted Universalism (Powell et al., 2019; Powell et al., 2009; Powell & Roediger, 2012) Oregon is creating a system that is intentionally built on the perspectives and needs of BIPOC children, families, and ECE providers in order to better meet the needs of all. This goal is reflected in the current research effort's methods, analysis, and presentation of findings.

Organization of Results

In making final program design decisions, it is important to consider the perspectives of BIPOC stakeholders at every stage of the program design. In presenting results, we first provide information related to IECMHC program design components that comprise a statewide system. Within each design component section, we discuss the key design considerations and issues raised by the stakeholders who participated in our interviews and focus groups. Following this, we purposefully separate the findings that were seen as foundational to building a truly culturally responsive, anti-racist model. We do this in order to **highlight their importance**, rather than to compartmentalize this work. The ELD should make these considerations central to all decisions made about the design of Oregon's IECMHC system. Finally, we summarize results and recommendations related to establishing critically important state infrastructure (e.g., funding, coordination across systems, and program evaluation). These three sections are organized as follows:

- A. Consultation Approach and Model Assumptions** which addresses overall program design issues such as consultant scope and level of intervention, consultation strategies, model flexibility versus standardization, frequency and duration of services, consultant caseload and capacity, access and referral pathways, consultant qualification, creating program readiness, and professional development and reflective supervision;
- B. Implementing a Culturally Responsive and Anti-Racist Model** which highlights key elements and issues for creating a system that is intentionally focused on the needs and perspectives of BIPOC and other minoritized communities; and
- C. Infrastructure and Model Administration** which addresses options and important decisions needed about statewide contracting, oversight, funding, technical assistance, and evaluation and considers alignment and coordination with other technical assistance programs and ECE providers.

Oregon's ECE Community Voiced a Need for IECMHC

The Oregon ECE stakeholders that we spoke with, who were majority BIPOC, were clear that they see a need for increased support related to understanding and working with children whose behaviors they described as “challenging.” BIPOC ECE providers, and national experts shared their observations that there were often disparate experiences of suspension and expulsion based on race, gender, poverty, and disability. An equity focused, anti-racist IECMHC approach was seen as necessary to address this problem and to examine the ways that ECE providers’ internal beliefs and assumptions impact their relationships with the children.

In addition, there was a clear concern with what was described as a growing number of children with “big behaviors,” a term which was used frequently by early childhood leaders to refer to externalizing behaviors that were perceived to be dangerous to the child, other children, or the ECE providers, and/or were experienced as extremely disruptive to classroom functioning. Many of the people we interviewed described the extent of children’s challenging behavior, the difficulty staff have in managing challenging behaviors, and the ongoing perceived need to remove children from the classrooms. Leaders, consultants, and ECE providers described a number of different ways that these behaviors, as well as the practices used to mitigate them, are impacting children, families and staff, as parents grow frustrated with repeated calls about their child’s behavior, staff are increasingly stressed and burnt out, and children are moved from ECE provider to ECE provider.

“ I think the challenge we have is more in having children in the classroom who might really need to be in early intervention or who might be appropriate for a different program; struggling to balance just how to manage and keep children safe and to meet all of their social emotional needs.”

Many respondents shared that removing children from the classroom was a last resort and caused them to feel uncomfortable or uneasy. At the same time, many reported that they have needed to remove children from the classroom, or adjust schedules, to manage incidents of these “big behaviors.” One participant shared that children were being removed from the classroom on a daily basis:

“ It ended up being in many cases we would remove the rest of the [students] from the classroom and go outside or take a walk. Sometimes it would be the child coming out of the classroom with a teacher for some quiet one-on-one interaction. In some years, it could have been daily between the different classrooms and the child.”

At least one early childhood leader noted that these types of behaviors and mitigation efforts can lead parents to need to withdraw their children from the program and can in turn cause a pattern of unstable care arrangements and a lack of continuity in care for children.

“ Being removed from the classroom and asking them to leave, it goes hand in hand. When a parent gets frustrated to the point of, “OK, they’re calling me every day because the child’s not listening. I’d rather take them somewhere else.” It is like they’re not technically asking them to leave, but they’re getting them to the point where the parents are not able to do anything, because they’re asking them to be removed from a classroom just for the parents to pull them and go somewhere else. It’s an ongoing cycle.”

ECE leadership highlighted the direct link between the challenge of managing children’s behaviors, the lack of support for ECE providers, and the subsequent negative impact on staff well-being and retention. National experts also highlighted the notoriously high rate of turnover in ECE settings, and emphasized the key role that mental health consultation can play by creating another source of support for staff, helping staff feel more competent in the work, and helping reduce the frequency and intensity of challenging behaviors.

“ Because if you have a child that is running out of the classroom, the teacher is going to want to run out of the classroom and not come back. We don’t want to do that. We want to support teachers, we want to support [ECE] providers, we want to make sure that they don’t burn out because those behaviors can be challenging for them. We want to make sure that we recognize how difficult it is and that we try to find the best support for children, for [ECE] providers, and for families.”

It was clear from those we spoke with, as well as both national and statewide data, that ECE providers need an increased level of professional development and support in working with children to promote positive emotional and social development, prevent behavior problems from escalating, and managing “big behaviors” when they do emerge. IECMHC is one key component for providing this support.

A

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Policy makers don't like gray. We live in the gray. We do, and once you understand that, you can get a better handle on it, consultation begins to make sense to you because you live in the gray. It is what it is. If you're trying to make all these concrete gestures and processes so that we can quickly see it, count it... it doesn't work. It falls apart.

”

RESULTS

Consultation Approach and Model Assumptions

As described previously, there is growing evidence that IECMHC can be an effective model for supporting children, families, and ECE providers. At the same time, the way that IECMHC model has been implemented varies widely from state to state and across different communities. Below we summarize what we learned from national experts and Oregon stakeholders about what they felt would be most important to consider in designing an IECMHC approach that centers the needs, strengths, and experiences of BIPOC children and ECE providers. By intentionally developing a system that focuses on better supporting those children who are disproportionately impacted by suspension and expulsion, the state expects to be able to better serve all ECE providers and children in Oregon. Below we summarize the key findings from the interviews and focus groups related to designing the IECMHC approach and model. Results are organized into the following sections:

- 1. Scope of IECMHC** considers where the IECMHC approach fits within a prevention, health promotion, and direct intervention continuum;
- 2. Model Flexibility versus Standardization** highlights the importance of considering ways to build flexibility into IECMHC's work while also meeting the need for consistent standards of practice and clear role expectations;
- 3. Consultation Strategies and Role** reviews different levels of support in which Oregon IECMHCs are currently engaged: program, classroom, and child/family. This section also reviews the specific work consultants do to build program staff skills and knowledge;
- 4. Consultant Caseload and Capacity** summarizes variations in caseload across sites and discusses the corresponding service implications;
- 5. Frequency and Duration of Consultation** examines how often and for how long consultants should work with ECE sites;
- 6. Access and Referral Pathways** discusses the ways that ECE providers learn about consultation services and barriers to accessing them;
- 7. Supporting Early Learning Program Readiness and Setting Expectations for Consultation** explores ways consultants can lay the foundation for a successful consultation relationship and gauge receptivity to the model. Further, this section emphasizes the importance of clearly articulating expectations, creating formal agreements, and laying out an expected timeline;
- 8. Consultant qualifications and competencies** highlights the breadth and depth of knowledge required on the part of consultants; and

9. Professional development support for consultants

reviews the importance of onboarding, ongoing training, and reflective supervision in the successful implementation of IECMHC.

Within each section, important factors that should be considered in developing Oregon’s IECMHC system are highlighted as “**Key Design Considerations**,” followed by more detailed synthesis of perspectives and issues raised by study participants.

1. Scope of IECMHC: Promotion, Prevention, or Intervention?

KEY DESIGN CONSIDERATIONS

- Respondents emphasized that IECMHC is primarily a prevention-focused model to support the capacity of ECE providers and ECE programs to meet the social/emotional needs of young children.
- IECMHC was described as a holistic approach that can transform the ways that ECE providers, families, and children work with each other.
- Some state models of IECMHC center around the needs of specific children; national experts cautioned about over-emphasis of this aspect of consultation to the detriment of prevention, promotion, and ECE provider capacity development.
- However, current understanding of IECMHC varies widely, with some still viewing it as a “last resort” service for providing intensive, child-focused intervention.
- Many acknowledged that there is a need for supports at both “ends” of the prevention-intervention continuum.

One of the central themes to emerge from the interviews with national experts, Oregon leadership, and Oregon consultants was the holistic nature and transformational potential of mental health consultation. Almost everyone we spoke with was adamant that IECMHC is not intended to simply be a child-level or even ECE provider-level approach, but to “*consider all levels of influence*” in a child’s life. Similarly, the focus is not on remediating specific situations or children, although consultants are often called in for that very purpose.

“ We [IECMHCs] do a lot of triaging, with the understanding with the [ECE] providers that for now, let’s talk about [getting] the situation stabilized. Then let’s begin to look at some root issues here. More often than not, what we find is that the challenging child isn’t so much challenging, as the adult is challenging.

That’s not to say that we have not had children that yes, do require further services along with the family. We’ve done referrals to those agencies that could better work with that child and family. However, about 80% of the time we find that teachers’ environments can use more help around understanding what a social-emotional learning environment is and the power of the relationship, and what does that mean for cognition and learning?”

Instead, according to the experts we spoke with, the intention is to facilitate, model, and build relationships that transform the entire ECE environment in support of shared well-being for everyone involved. Ultimately, the model is intended to be preventive in nature, so that we would expect to see more children thriving and fewer “problem” behaviors over time.

Detailing the many different things they did within their role as an IECMHC, this leader serving rural Oregon shared:

“ We provide whole classroom observation and whole classroom coaching plans. We do teacher burnout surveys to just address self care or try to see where staff are at. We offer reflective supervision support, both individual and whole team. We offer professional development on any topic that the site needs. We offer, of course, the individual consultation for a specific child that’s been referred. That includes observation. We use different rating scales to assess where they’re at developmentally. Referrals to more intensive, community based mental health providing for the family. Referrals to housing or any other community service that they would need that would stabilize their mental health and behavior. We do FBAs [functional behavioral assessments] and individual behavior support plans for the kids.”

Oregon mental health and ECE leadership shared the understanding that IECMHC should primarily be a prevention program focused on making sure that ECE providers have the training and support they need up front in order to be prepared to confidently engage with challenges as they arise. They discussed the distinct difference between prevention services and treatment services and the tension that often exists between the urgent needs and lack of resources experienced by communities, families, and ECE providers and the challenge to invest the time and resources in long term prevention efforts. A national expert shared:

“ [Focusing on one child]...is not the only nor necessarily the most efficient and effective way to think about this intervention... If we’re talking about it being a capacity-building endeavor, all of us know that internal long-term change takes time... Aiming the effort at the adults and on behalf of all children in the setting, not just those

who are identified as having difficulty, is important.”

This sentiment was echoed by an Oregon mental health leader:

“If we do prevention wise on their part and our part, we’re not running around putting out fires. People are prepared. They have the training they need. They have the support they need. They can stay calm when things start to get a little like, “I’m getting nervous.” OK. It’s OK to get nervous, but you got to have classroom management.” There are things that you can put in place so that you don’t have all those behaviors happening. Doing a lot of that up front so that we don’t get called because we’re not going to be able to do that. We don’t want to. That’s not really our role, to be running around.”

At the same time, some Oregon leaders and consultants talked about and understood mental health consultation as a “last resort” resource, focused primarily on “high need” children and families. They discussed the dual role of building ECE provider capacity and supporting staff to manage challenging behaviors in the classroom. Prevention resources, in their mind, are essential, just not what they understand mental health consultation to be. This was often related to the reality that across the state there are wide disparities in access to social/emotional and special education resources and personnel, accessible community mental health services, and adequate classroom support and coverage.

“There’s a huge difference between prevention services and treatment services. That’s the constant tension that I experience, whether that be community meetings with other agencies and [ECE] providers, or just in the mental health circle, the difference between prevention services, what that means, and what we do, versus treatment. It is very different.”

2. Model Flexibility versus Standardization

KEY DESIGN CONSIDERATIONS

- Respondents strongly recommended a flexible model that can individualize consultation activities based on need.
- Likewise, consultants need to be able to flex their role to meet the differing community and program needs across the state.

One overarching theme reflected across all interviews was the need for a flexible approach that allowed consultants to individualize consultation activities to the needs of the classroom, programs, and individuals involved. Many leaders and consultants shared their need for consultants to respond to concerns as they arise and be responsive to changing priorities. Region, level of

resources, type of program, and availability of additional social/emotional or special education staff often drove the consultative relationship, level of support, and focus of intervention. There was strong advocacy for an Oregon-specific model to have built-in flexibility to meet the many differing needs in ECE classrooms across the state while also maintaining the balance of having a structured model with clear role expectations and consistent standards of practice structures in place (further discussed in the section: Supporting Early Learning Program Readiness & Setting Expectations for Consultation).

“There needs to be flexibility around making changes and changing course in the [consultation] approach. It can’t be that prescriptive. You can’t send assessments and say, “Fill them in and send them to me and I’ll evaluate them.” No, because some of the language and some of the questions you ask do not figure the way in their culture. You have to be more accommodating.”

National experts and Oregon stakeholders agreed that a fully standardized approach to the focus of the intervention was counter to the varying needs often identified by ECE classrooms and ECE providers. Oregon ECE leadership and ECE providers we spoke with described that they would want their consultants to meet a constellation of needs, which included building staff skills, the ability to understand and support children effectively, providing additional perspective and insight about specific situations or children, increasing access to mental health support, and adding capacity for staff training. Having standards of practice that allow for consultants to fill needs as they arise was emphasized. In kind, consultants also saw this need as critical, especially given how different classrooms, centers, communities, and regions have access to varying amounts of classroom and community resources and services. Flexibility built into the system allows consultants to adapt as classroom needs shift.

3. Consultation Strategies and Role

KEY DESIGN CONSIDERATIONS

- Respondents agreed that consultants should be trained and supported to provide support at multiple levels (program, classroom, child/family), and that consultation is highly skilled, complex work.
- Respondents repeatedly emphasized the importance of having consultants consistently present in a program or classroom, building the trusting relationships with staff, families, and children that are critical to effective consultation.

- Consultants likewise described doing classroom observations and being able to provide classroom-level advice, strategies, and support for staff within the classroom context as a foundational aspect of their role.
- One of the most important things that consultants do is to help ECE providers to understand the broader context for children’s behavior, taking into account an understanding of child-development; community, family, and historical trauma; systemic racism; and other factors that can contribute to children’s struggles to manage their emotions and behaviors.
- Part of this work is to help normalize developmentally-appropriate behaviors that can often be mislabeled as “problems.”
- ECE leaders from Oregon noted that IECMHCs can also provide much needed staff training on mental health, a gap they perceived in currently available training.
- Consultants should also be familiar with the research on disproportionate suspension/expulsion, implicit bias, and the role of their own cultural identifications and positionalities on the consultation process.

Part of offering a flexible model of IECMHC relates to the focus of the IECMHC intervention work. Consultants can, and often do, provide supports at multiple levels: program level (e.g., providing group training and/or supervision, supporting staff wellness activities); classroom level/supporting ECE providers (e.g., helping ECE providers work on skills that support the classroom broadly, such as changes to environments, classroom/group activities and skills); and child and family level (e.g., supporting needs and behaviors of individual children, trainings or other parent education work). Stakeholders we spoke with talked about the importance of having consultants who can move across these levels and tailor supports based on what is needed for a particular program, classroom, ECE provider, or child.

Program Level Supports

A primary goal for consultation described by many Oregon leaders and consultants was to provide workforce wellness for ECE providers and staff, and more specifically supporting ECE provider wellbeing in the context of their work. When IECMHCs were embedded within programs, it reduced barriers to staff receiving needed support. Regardless of the level or focus of intervention, the regular, physical presence of consultants was emphasized as being critical. The ability of consultants to spend time at each site helped to support relationship building, trust, and contextu-

al understanding of what was occurring in the classrooms.

In addition to providing emotional support, consultants worked to support staff capacity and were viewed as a much-needed resource for additional training support. Access to mental-health related training was described as a challenge by several ECE leaders and consultants were able to bridge this gap.

“*Train staff members. By that, I mean training on mental health issues, adverse childhood experiences and trauma, and its effect on the body of those children and in their behavior. Train on positive guidance and train on different tools that can be used to support those children during those episodes. Having it available on our hands right away... Because if you have a child that is running out of the classroom, the teacher is going to want to run out of the classroom and not come back.*”

Several leaders described the connection they observed that when they could ensure staff were being supported, the staff were then able to work more effectively with children and families. Consultation was viewed as an important way to provide this support to staff.

“*... if the staff are being supported, then I’m sure that then the family is going to be supported... It’s like a parallel process, and then they can do the same with those families.*”

Classroom Level Supports/ Supporting ECE Providers

A key role for consultants that was identified by many stakeholders was having highly skilled consultants in the classroom actively engaging with children, families, and ECE providers. By having a regular physical presence in classrooms, consultants can develop the trusting relationships with staff and families that is critical to effective consultation. One ECE leader shared:

“*There’s a lot of value in having people in the classroom. Not just observing flies on the wall, but also actively engaging with kids and with families who are in the room to develop a sense of trust with parents and with kids.*”

Consultants also talked at length about how important it was to spend time in classrooms to support relationship building and getting a first hand understanding of classroom dynamics. One consultant shared:

“*The most important thing is that we actually are coming into classrooms. Not just someone telling us what’s happening, but us being able to go into the classroom and be able to observe and see what’s happening. That’s really important. Sometimes, there might be an idea of what’s happening.*”

When we actually get a chance to really sit down, take a step back, and just observe everything, then we can make a more informed recommendation. Sometimes, people think this is why it's happening, but we might see... what's happened before the behavior. That's really important. Just having that flexibility and that time to be able to sit and observe."

While everyone agreed that a critical component of IECMHC was for consultants to have consistent time set aside to be in the classroom, some also warned about the trap of falling into the role of operating as a classroom assistant rather than an IECMHC. National experts particularly shared that it can be challenging to resist this, but that setting up early expectations about contracted time can help.

Most often consultants identified supporting ECE providers and the larger learning environment as their role, followed by supporting families and children. The focus of intervention was regularly negotiated with the specific ECE settings, and consultants often flexed their role to meet the specific needs of the centers they served. Resources accessible to a given classroom or community influence individual classroom needs and contracted time.

"In working with staff, it [IECMHC] builds capacity within staff and just general capacity. If there's somebody in the room who can offer that extra support when there are bigger behaviors or when mental health consultants can identify what happened in that moment... I don't think a lot of classrooms or groups have that kind of reflection and that intentional reflection, or necessarily have the know-how to reflect on things that happened in that moment, why those moments are important, what were the missed opportunities, [and] what were the opportunities that staff took advantage of and used as a teaching moment or as a way for them to practice."

Consultants working in the classroom offered another level of support for ECE providers by conducting classroom observations with the goal of developing specific recommendations to support classroom dynamics, and to directly help ECE providers with skills or interventions for managing challenging behaviors. This included in-person classroom support.

"Consultants are real clear that we come alongside. We provide, guide, and support; technical assistance. We're your greatest cheerleaders, and we're expecting you to do the work."

Child and Family Level Supports

While IECMHC is often framed as a service to provide supports related to the specific needs of a particular child, this role was de-emphasized by national experts. Consultants we spoke with

described child and family focused activities comprising less of their work than other activities. Some consultants focused their time doing parent coaching or problem solving with families on concerns either they, or the ECE providers, identified. Parallel to supporting ECE providers, consultants described providing support to families by leading parenting classes or parent training on a variety of topics for parents whose children attended the given center. Consultants also shared resources and referrals for a variety of social support and family needs when asked.

That said, consultants described the need for child-focused interventions such as conducting targeted observations of child behavior and providing direct interventions with specific children while they were in the classroom. This approach was described most often in cases when specific child behavior was more extreme and/or the program was not receiving additional support of behavior specialists such as EI/ECSE staff. When talking about these distinctions one IECMHC shared:

"I might do a session or two with a specific family or child. Mostly, it's working with the teachers about their own experiences. I think I'm really lucky because the programs that I work with have robust supports. They have coaches and behavior specialists that work with individual child cases. That to me has been a gift."

Understanding Children's Behavior in Context

IECMHCs and leaders emphasized the importance of helping staff to see and understand children's behavior in context, both in terms of developmental trajectories and in terms of the broader community context. It was stressed that this understanding be multilayered to include specific classroom related dynamics, and community supports and resources. It was emphasized across those we interviewed that the ways that racism and community trauma has impacted children, families, and communities could not be separated from child behavior and classroom dynamics. ECE Providers were also not immune to these impacts. This points to the importance of IECMHCs working with ECE providers to help them understand root causes for behavior. The ability to bring comprehensive knowledge of child development to their work is fundamental. In order to be most effective, particularly when working with minoritized communities, consultants must have a deep understanding of how traumatic events—present day and historical—impact children on the individual-, family-, and community-level. Many of the people we spoke with recalled the challenging ways trauma is expressed and communicated by young children. One ECE leader shared:

"We had some children with significant trauma in their life, significant adverse childhood experiences in their younger

ages that were expressing their feelings with throwing away materials and throwing chairs and whatever was in front of them to other children and adults, which is very unsafe. Again, that's a way of them communicating something. It could be the pain that they're having because of those experiences. It could be frustration because they're not getting their way. It could be many, many different things."

When ECE providers lack the knowledge about these connections, it may be harder to understand and intervene with children when they lash out. Another ECE leader described:

“ I feel that the biggest challenge is that the teachers are too quick to judge and label that child as being a problem child. As a supervisor over the last years and years, I've had to talk to teachers about assuming that a child has a behavior, because you don't know what is going on in that child's home.”

To address these challenges, many of the ECE leadership we spoke with recommended that consultants who have a deep understanding of families' community and cultural contexts would be best positioned to work most effectively with families and staff.

“ The biggest or the hardest thing for [ECE providers] to deal with is when our families, our parents, and/or sometimes the children, are exhibiting PTSD behaviors, depression, suicidal thoughts, coming back to the US, and then reliving trauma, especially as it's happening today. There's a lot of retaliation and discrimination against the BIPOC communities, which also includes the refugee and immigrant families, and it's very difficult as home visitors to support families when they're going through that.”

In addition to understanding the developmental impact of racism and community trauma on young children and families, it is just as important to understand the ways that age appropriate behaviors may be misinterpreted as violent, threatening, or aggressive due to implicit bias. Balancing the intricacies of the two are critical in the way ECE providers understand, and respond, to BIPOC children in their communities and classrooms.

4. Consultant Caseload and Capacity

KEY DESIGN CONSIDERATIONS

- Respondents acknowledged that caseload and service frequency and duration is often driven by the reality of limited resources, rather than best practice.
- In designing a new system, it was strongly recommended that caseloads be limited and duration extended to

allow sufficient time to develop strong relationships, ECE provider understanding and insight, and program capacity.

- A typical caseload appears to be anywhere from 9–18 sites, with virtually everyone agreeing that lower caseloads would be more effective. Some of the most well-established and highly-regarded programs have caseloads closer to 4 sites.
- Many cautioned against a short-sighted impulse to spread resources “too thin” in an effort to be “fair” and serve greater numbers; current Oregon consultants noted that the growing need for their services can lead to pressure to increase caseloads beyond what is likely needed for effective consultation.
- Respondents likewise urged flexibility rather than standardized timelines, in responding to program needs.

In practice, caseloads varied significantly by state and program. Two of the longest-running and/or best funded programs shared that consultants are expected to carry four sites (sometimes with multiple classrooms at each site). Consultants were typically spending one day per week at each site, or sometimes 2 days per week for larger centers. This structure reportedly also allows for sufficient time to be built into consultants' schedules for the reflective supervision and professional development central to successful implementation of IECMHC.

On the other hand, most of the other programs reported much higher caseloads, for example, 9-18 sites per consultant, with correspondingly lower expectations for frequency and duration of visits. Sites may house single or multiple classrooms. A number of programs mentioned consultants spending 2-3 hours per week, per site. In all cases, it was clear that programs were functioning within their budget constraints, rather than representing a consensus around the “right” or most effective approach. As one expert commented:

“ Caseloads are always running high or overflowing a bit. That's an implementation challenge.”

Consultant caseload and capacity is directly dependent on the frequency and duration of contact with consultees. Not surprisingly, we heard similar tensions around balancing budget constraints with what is considered best practice. National experts repeatedly expressed concerns about consultants being spread “too thin”:

“ Partly, there's also a balance, because consultation is probably one of the harder jobs that you could do, if you're doing it really well. You know what the approach is like, holding multiple perspectives, working at all levels, all the way up to the system.”

To do that, I feel like I have to make sure consultants also aren't running all over the place just constantly. You're not going to be grounded. How are you going to go in, hold space, be more reflective, and really be present for folks if you're overextended and having to go from one site to another all day long?"

This perspective was echoed by local ECE providers:

"I feel it's most helpful and most effective... the more time they spend in [the classroom]. We've had consultants that would come in for an hour or half an hour, and then we would only see them once a month, maybe. I didn't feel they truly understood what our classroom was like because it always seems that the one day someone comes in, the class is fine...then the next day is a terrible day. Everything goes crazy. [I recommend that IECMHCs] consistently come in and come in more often."

Caseload also depended on whether the consultant is full- or part-time. In a number of states/programs, consultants are part-time, often splitting their time with clinical work, whether in private practice or at a community-based mental health agency. In some cases, the decision was made to staff consultants part-time in an effort to increase overall coverage, (i.e., in some regions the need might not be high enough to justify a full-time consultant). Long travel times were repeatedly mentioned, locally and nationally, as a huge barrier to serving more sites, and as a drain on consultant energy. One national expert described once having a round-trip "commute" of seven hours, each day.

In considering the "ideal" caseload, some national experts also observed that it depends in part on achieving the right balance of sites in terms of the required level of involvement. Newer sites, for example, might need more consultative time, while sites in a "winding down" phase might need less. This would seem an important consideration in strategically balancing sites across consultants.

One national expert, speaking from a state that utilizes a high proportion of independent consultants, spoke of the built-in incentive to perhaps take on more sites than they can effectively serve, in an effort to generate more income.

Oregon respondents overall agree that there are presently not enough consultants in Oregon to meet the current need. Further, given that each classroom has distinctly different needs with different community profiles, many in leadership described how having a "one size fits all" model in regards to caseload size is challenging and inequitable. This is a particular challenge described by consultants serving rural sites because they are often driving many hours to reach sites. Consultant caseload needs to incorporate classroom need, availability of other classroom sup-

ports, and travel times. Additionally, consultant case load and capacity should consider how to reflect meeting the inevitable increasing needs as programs expand over time. One mental health leader shared:

"... what happens when [ECE] programs have expanded over the years and they haven't added any more consultation? Our team felt like they had to stretch themselves more, and more, and more. They just can't keep up with the demand. The funding hasn't gone up. The number of consultants hasn't gone up. We're starting to have those conversations about, "Let's look into the future. These programs have expanded. We have been adding. How can we start figuring out some funding to make that happen?" We can't keep doing it at that level because then, you got to start, "We can't do this anymore. We can't do that anymore. We don't have the capacity."

5. Frequency and Duration of Consultation

KEY DESIGN CONSIDERATIONS

- When asked to specify an adequate duration of services, national experts generally agreed that 6-months would be the minimum time period required for working intensively to address some limited kinds of child-specific issues, but continued to emphasize the importance of consultants building long-term relationships with ECE providers to prevent future crises.
- For longer-term capacity building and maintenance—the crucial "prevention" aspect of IECMHC—at least one year of involvement was recommended.
- Longer-term involvement is likewise viewed as necessary to support authentic equity and anti-racist work with ECE providers and ECE programs.
- More ongoing, regular consultation (as opposed to "one-off" or short-term consultation) is particularly important for supporting ongoing staff wellness and building relationships with staff and families.

Consistent with the recommendation that the Oregon model be flexible, national experts similarly advised against rigidly standardizing aspects of the model such as dosage or duration while also recognizing the pragmatic aspects of public policy-making. In general, the experts we spoke with seemed to agree that shorter-term consultation, e.g., two to three months (Conners Edge et al., 2021; Perry et al., 2008) is often sufficient to "stabilize the situation and start to shift perceptions, at least of a focus child."

Lasting transformation of the environment, however, is expected to take considerably longer—and to be well worth the investment, especially using a prevention lens. For example, one national expert observed a high rate of repeat child-level IECMHC referrals from the same programs, suggesting that shorter periods of child-focused intervention may not be as effective at building that longer-term capacity and truly shifting classroom climate. Likewise, others pointed to research suggesting that it is the quality of the consultant-consultee relationship that drives positive outcomes (Davis et al., 2018; Duran et al., 2010; Green et al., 2012; Hepburn et al., 2007; Johnston & Brinamen, 2006). In that case, a longer-term investment in relationships is more likely to support broader and more durable change in the environment. The high rate of turnover in many child care settings was also noted as a rationale for longer-term involvement with programs; in effect, those consultant-consultee relationships need to be reforged on a regular basis. One national expert likewise talked about doing “maintenance” check-ins, even after a site is formally closed out.

“Sometimes, they’re just doing so well, but they say, ‘But we miss you!’ They miss the consultants. I’ve had times I’ve had to switch sites and they’re, ‘We want you back!’ You know...attachment just sticks, the relationship sticks.”

Several national experts also reflected specifically on the time required to support authentic conversations, insight and growth vis-a-vis racial and other biases that ECE providers and program administrators may be bringing to interactions with and perceptions of children in the classroom. As already noted, suspension and expulsion represents the most visible “extreme” end of what is often a spectrum of unsupportive and/or harmful perceptions of BIPOC children. The goal of IECMHC is not simply to prevent suspension and expulsion, but to help facilitate an environment where every child (and ECE provider) feels whole and supported. This is less likely to be accomplished in a short-term, child-focused period of intervention.

When considering frequency and duration, a suggestion was made to clarify the intended level of intervention (i.e., child-level vs. classroom-level). The recommendation frequency and duration of consultation would then vary accordingly. For some programs, frequency and duration are negotiated at the beginning of the consultation relationship, according to program interest and need, and are renegotiated periodically over time, with no prescribed end date. Other programs have more established timelines for specific phases of engagement, based on their own conceptual models. Most seem to offer the option to “renew,” once the initial service period has concluded. Most of the experts we talked with agreed that it was helpful to have at least some

parameters around the model and that although IECMHC was designed to be flexible, it was not intended “to be everything.”

It was noted that the research in support of a 6-month intervention was not intended to suggest that 6-months was the ideal service duration, but instead chosen to facilitate an effective and feasible research study, given limited resources (as is often the case). More study is required to better understand the additional benefits that are expected to accrue as a result of longer-term consultation. A mental health leader in Oregon shared:

“The engagement takes time... The research shows and our experience has taught us, it takes a good year to lay the groundwork and the foundation and the relationship with the program. Then things shift. Movement’s different after that initial year.”

Oregon leaders and consultants generally mirrored experiences described by national experts. In regards to current IECMHC, there was considerable variability in frequency by program need, consultant capacity, and financial resources.

“We were trying to go weekly, if possible, or at least, every other week.... We’d like to go every week. Sometimes, it’s just not manageable to be able to do that every week. Also, depending on the classroom and what the needs are, there might be some classrooms that need a lot more support. You might need to go on there a lot more often. Some are like, ‘Oh. We’re fine. We love to see you, but it’s not an emergency for you to come and see us regularly. We got things.’”

“[Dosage] varies dramatically, really depending on engagement, on need... On average, we came to maybe three hours a week that a site would receive in terms of on site consultation services, but again, that varies so dramatically based on the types of services that they are asking for.”

Some experts argued in favor of concentrating resources where most needed, i.e., according to the greatest experience of disproportionality, rather than spreading resources thinly, across a large number of recipients, in a (potentially misguided) effort to be “fair.”

“I know the rationale, which I get, is like, ‘Oh, we’ll never have enough mental health consultants,’ especially given the pipeline and the money needed for that. ‘We’ll never have enough to serve all the needs. Isn’t it better to have short duration and more breadth?’ One of the ways to address that is more about giving priority to certain kinds of settings or certain populations. My way is rather than giving everybody a little bit, I think about, ‘How do we define those programs that are most in need?’”

At the same time, it was noted that “targeting” resources in this way also runs the risk of identifying the individual child and/or community as the problem, rather than surfacing and addressing root causes, i.e., racism and systemic inequities. Likewise, there has reportedly been backlash from mainstream dominant systems in some locations where attempts have been made to prioritize minoritized populations for mental health consultation.

Another national expert observed that paradoxically, the programs that are least in need of IECMHC are often those most likely to request it. Funneling disproportionate resources to already strong programs may simply reinforce inequities; funds might be better invested in concerted outreach and relationship-building with programs that seem more reluctant to engage.

6. Access and Referral Pathways

KEY DESIGN CONSIDERATIONS

- Respondents shared that many ECE programs and ECE providers in Oregon are either unaware of IECMHC or fundamentally misunderstand the nature of consultation.
- Large, established ECE programs are more likely to be aware of and already have access to IECMHC—and may be the most likely to seek out these new, additional services.
- Given these realities, the ELD should develop mechanisms for ensuring equitable access by smaller programs, e.g., consider moving away from a simple, “first come, first served” model of accepting referrals that is likely to be skewed toward those with the most resources and power.
- Likewise, to support interest in and access to the new services by smaller programs, the ELD should develop a thoughtful, culturally responsive communication plan.
- Feedback indicates that the term, “Early Childhood Mental Health Consultation” is a particular barrier for many ECE providers and families, especially BIPOC, that activates stigma, historical trauma and mistrust of the system—and does a poor job of communicating the true nature of IECMHC. Oregon should consider using more welcoming language to brand and communicate about its program.

Regular access to consultants varied considerably from program to program across the Oregon stakeholders with whom we spoke. Some ECE programs had long-standing relationships with IECMHCs through contracts or other sources. Head Start programs have federal standards requiring IECMHC, although the guidelines provide little detail about how IECMHC is defined or should

be operationalized.

In Oregon, stakeholders talked about the under-utilization of consultation services in some communities, and the need for more work to help ECE programs and ECE providers to understand what IECMHC is and why it could be helpful. Oregon leadership, consultants, and EI/ECSE representatives shared an overall frustration with what they described as a general lack of awareness among the ECE provider community about what services were available and how IECMHC can help. Mental health leaders and independent IECMHCs described spending considerable time and effort to advertise and promote their services. Referrals to consultants were generally described as “word of mouth” rather than through established pathways or proactive models of ongoing, regular consultation.

“We have flyers. We have emails. We make phone calls. We do pop in meet and greets and leave our cards and our fliers. We present at conferences, the professional development conferences. We will offer to do a presentation around something like trauma informed care or something related to early childhood behaviors. At the end of that, we ask for five minutes to just explain what we offer and what we do.”

“We do have an ongoing model of consultation, and so we have long term partners. It does turn over occasionally, especially with the pandemic. Unfortunately, we had a child care center that closed so we might do a little bit of recruitment. It isn't a frequent piece, unless it's a new grant or project. Five years ago, we started a project with home visiting and community based programs. We did have to do outreach in terms of engagement there.”

The ECE providers that we spoke with had differential experiences with access to IECMHC depending on three configurations of ECE setting: centers with embedded consultants, centers who contracted out to an agency or independent consultant, and home-based ECE providers. Centers who had embedded consultation, (e.g., Head Start centers, who specifically require IECMHC), talked about how having the regular embedded social/emotional support provided by consultants was particularly helpful. They talked about how this consistent presence allowed ECE providers to build trusting relationships with their consultants and consultants to feel like a part of the team. ECE providers working for centers without embedded consultants described considerably less access to consultants. Some described meeting every two weeks, or monthly, and the level of the consultation tended to focus on specific child cases and more emergent classroom situations as they came up. Home-based ECE providers were more likely to describe not having access to IECMHC or not knowing

where to access them, some even saying they were not aware of the IECMHC model or where to access them. ECE providers suggested that consultants would better support them and their classroom if the IECMHC model specifically included regularly scheduled visits, not just “as needed,” and an intentional focus on building relationships with children and staff.

As part of the introductory period for the consultative relationship, consultants and national experts recommended that expectations for consultation are clearly identified up front. Within these formalized conversations, consultants should concretely review what services and supports they provide and revisit these expectations on a regular basis.

One of the perceived barriers to ECE providers using IECMHC services is ongoing confusion and stigma (among ECE providers and families) about mental health services, and some questioned the use of the term “Infant and Early Childhood Mental Health Consultation.” Many of the other people that we spoke with in Oregon agreed. Even amongst national experts this had been something that they had been arguing “for years” against using, but felt like there had been little headway made in changing.

BIPOC ECE providers and consultants discussed the reality that mental health was stigmatized in many communities. They often shared the need to spend a lot of time trying to explain what a consultant was and what support they offered because the title was an immediate barrier for families.

One rural ECE provider shared:

“That is something that I have had to explain in so many different ways, that it is not directly what it sounds like. When I even say that, I just automatically now explain the role that that person plays and the ways that they help. Often, I’ll direct it more that they can offer ways for us to do things differently in the classroom, to meet the children’s needs. I have to change it so much that it’s not that we think that your child has a mental health issue or that your family is dealing with that... That is a big problem with the name.”

When asked about possible names, the suggestions that ECE providers shared were more specific to the consultants position. This particular ECE provider shared these suggestions:

“Well, something along the lines of an Individual and Family Support specialist, maybe. Maybe making it more about everyone. Using the word mental, I don’t know if it’s the buzzword is the term, but instantly everyone flares up. Just checking out, I would say an Individual and Family Support Services specialist... Classroom and Family Social and Emotional Support Specialist

or Classroom Social and Emotional Support specialist.”

7. Supporting Early Learning Program Readiness and Setting Expectations for Consultation

KEY DESIGN CONSIDERATIONS

- Respondents agreed that formal agreements between programs and consultants were essential to supporting realistic expectations and effective relationships.
- Several suggested using a template to clearly lay out goals of the consultation, roles and responsibilities of consultants and ECE providers, types of activities the consultant and ECE provider will engage in, and the timeline and process for both beginning and ending the consultation.
- Many respondents noted that it was important to specifically include in the agreement elements of the work related to implicit bias and racial equity; the Center of Excellence likewise now recommends setting those expectations upfront.
- Negotiating these agreements is another area in which consultants will require training and support.
- Consider using a questionnaire or other survey designed to assess ECE provider readiness assessment¹¹.

One issue that repeatedly emerged in conversations with both Oregon consultants and with national experts was the importance of ensuring that early childhood programs are “ready” to engage with consultation services. While all the national experts spoke of the need for flexibility and responsiveness in the consultation relationship, many experts emphasized the importance of bringing structure and intentionality to the process as well. Several important structural elements for creating a strong foundation for programs to enter into agreements and relationships with consultants were identified: gauging readiness/receptivity to the model, clearly articulating expectations, creating formal agreements with programs, and laying out an expected timeline. It was acknowledged that this work of laying a foundation for consultation represents yet another complex layer of the work that is very different from providing support in the classroom around specific child behaviors and requires both systems support for providing education and information about the nature of consultation, as well as additional consultant skills and comfort in discussing and working through these agreements.

11 <https://gucchd.georgetown.edu/products/Readiness%20Assessment.pdf>

Gauging readiness/receptivity to the model

A number of national experts talked about the tendency for some ECE providers to expect consultants to come in and “fix” a child in question, and a relative rigidity or unwillingness to engage around the role their own behavior or the environment might be playing.

“We found that yeah, it depends upon the mindset of the [ECE] provider. Some [ECE] providers, no matter how great you do the front-loading and talk about the experience and this is what you can expect, they just want you to come in and do something with him or her. Do something with them, there’s nothing wrong with us, we just want to get back to teaching. Do they stay or do they go? Do we suspend them and do we get your blessing? Tell us something so we can get back to being who we were. Sometimes who we were is a hot mess, but that’s OK.

It does require the [ECE] provider to have a level of consciousness where they are willing to be open and receptive to make the change that they feel they need to make... because we’re not going to do that. We don’t come in to do that. I tease my consultants all the time. We don’t have tutus. We don’t have fairy dust or wands. We’re not the nice, lovely ladies with the party bag, so we can pull out tricks.

It depends upon the receptivity of the [ECE] provider... more times than not, our port of entry is the perceived challenging child.”

One expert talked about developing a simple set of readiness indicators that they use, but also acknowledged that it’s a snapshot of a single moment in time and does not necessarily reliably predict who will or will not successfully engage. One example for a site readiness assessment is one developed by Kids Connect (Kids Connect: Integrated Health and Mental Health Consultation, n.d.)¹². This readiness tool is designed to be implemented on-site in child care centers and family child care homes and seeks to identify ECE sites that are ready for the implementation of an IECMHC program.

Lay a foundation for consultation with formal agreements that clearly articulates goals, services, and expectations

In part due to the tendency of ECE providers to initially view consultation as a child-level “fix,” national experts emphasized the importance of clearly describing the consultation approach and articulating clear expectations for what the work will look like, and how both ECE providers and program administrators will be

expected to participate.

“One of the things that we pride ourselves on is that we’re real clear about the type of consultation that we provide. We don’t do crisis consultation. We don’t do a formal case management. We do more of the... I will say traditional sorts of consultation. Consultation that encompasses this whole notion of being proactive, as well as interventionary.”

Another expert shared experiences of witnessing consultants drift into the role of classroom assistant:

“If you’re green and you’re newer, you don’t realize what your role is. That rubbing backs, sweeping the floor, and helping with tooth brushing, that that’s probably not your role and your best use of your time. Things happen, and OK, on occasion, but when you become part of the ratio [that’s a problem].”

On the other hand, in some areas, e.g., under-resourced rural areas, IECMHCs may be called upon to step outside the more conventional consultant role:

“We take a real comprehensive approach... we did the referral, we checked the boxes, we have the meetings, we sent them out somewhere. Because 9 times out of 10, we got no place to send them to. There’s no place to go. They don’t serve them anyway. We could make the referral to feel good and check our box, but we’re still going to be the ones left doing the big haul on it.”

To avoid such pitfalls, several national experts, and Oregon IECMHCs advised the use of concrete, formal agreements to support the consultation relationship and process.

“In terms of how long to work with the site, I think there always needs to be either a service agreement or MOU [memorandum of understanding]. That needs to be in place. I think every program should have that. The service agreement or MOU needs to spell out what the service delivery is going to entail. What the consultant will be doing and the frequency of it, in terms of classroom, in terms of meetings with the teachers, with the center directors. Number of hours. Number of hours they might be able to provide groups. Additional support. Number of hours of observation. That there’s some reassessment to happen if there’s a change in leadership. That services can be terminated if expectations aren’t met.”

This sentiment was echoed by an Oregon consultant:

“That piece of the model needs to shift in terms of [specifically describing] the referral process and agreement. I will need to create a contractual MOU or some interagency agreement

¹² <https://gucchd.georgetown.edu/products/Readiness%20Assessment.pdf>

that says, “By doing this, this is what you’re agreeing to,”... In some cases, it would feel good to [ECE providers/programs], because sometimes mental health or behavioral health is so stigmatized. It feels bigger and scarier to them that the ambiguousness of what we do versus what they do, that lack of clarity of roles, even when you explain it verbally.”

Several experts likewise noted that it should be made explicit in such agreements that bringing an equity lens and addressing implicit bias is an important part of the consultant’s role, and that both ECE providers and administrators should be prepared to engage in such conversations. (This recommendation is described more fully below, in the section on “Implementing a Culturally Responsive and Anti-Racist Model: Consultants Should Explicitly Address Implicit Bias and Racism”).

At a more individual level, other experts talked about co-creating action plans with each ECE provider, as well as with the center director:

“ You co-create goals with the teachers where you have the teachers invested along with you in terms of what we should focus on. What do you want to prioritize? What’s important to you in terms of how I’m here to support you?

The same for the Center Director. The consultant has an action plan with the Center Director. The consultant is always grounded in terms of what they’re there to do. Based on what the teachers have said they want to focus on, what they need support with, you’re always feeding that back to them [the Center Director].”

According to some of the national experts, part of clearly articulating expectations and putting guardrails on the process is laying out an expected timeline for the consultation work (again, with the caveat that flexibility always needs to be built into this approach).

“ You want a process that also helps you to be able to move consultation along in a very meaningful kind of way so folks don’t get lost. [Without a plan and timeline], the consultants can get lost, and the ECE providers will get lost inside of it, or the consultant gets sucked down the proverbial rabbit hole and find themselves not even beginning to address why they’re there in the first place.”

One national expert shared a model that involves 4 phases: orientation, transitional, monitoring and maintenance. This example is described in some detail below:

“ In the **orientation phase**, we go in. We can only be in that phase no more about 30 or 45 days. It’s the initial phase. We do what’s called front loading. We come in with all of the

materials, all of what it is that you’re going to experience inside of consultation, and then we want to hear what your expectations are. We give you a sense of what this experience is going to be like for you. We come in with a consultative agreement, we have a consultative plan.

We encourage consultants to do a tour. We do encourage consultants to meet with everybody in the place, including the janitor because everybody plays a role. This is no more than about 45 days. That consultant can meet with them to get a sense of what it is that they need based on the tour that the consultant does and the informal observations that the consultant is doing because consultants are always in observational mode.

Whatever data they are collecting, they’re able then to sit with the director or whoever the designee is, to talk about what the process is going forward. Even if we get called in for the child who they perceive is challenging, we still want to see what the place looks like in addition to the child that you’re talking about.

*A consultative plan is then developed in collaboration with the director and whoever else are the stakeholders. Then, from there, once the consultative plan is completed and signed off on, it then moves into the **transitional phase**. This is where much of the work gets done through the [ECE] provider, with the consultant.*

From there, we decide, “OK, it would make sense to see this [ECE] provider maybe twice a month. We can be inside of their site anywhere from two to three hours.” Why? Because you give yourself enough time for consultations, giving yourself time for PD, professional development, giving yourself time for any other activities that may be related to your consultation.

We come back again within the month and depending upon what that means in terms of what other additional consultations or activities are required in relationship to the consultation. Some will say their site is doing quite well. They’re really receptive to consultation, the PDs are making sense.

They’re coming back looking for techniques and strategies that they may have talked about, whether it be a PD or maybe a particular teacher, and they say that the teacher’s doing great. They’ve worked their consultative plan. They’re working well with the consultant, and we’re coming up on about the third month.

Their consultative plan is reviewed every 90 days, and it’s reviewed with all the stakeholders. This is how it’s going. How are you feeling about it? Any changes or adjustments that needs to be made. If not, they keep moving on. Let’s say six months down the road....We’re beginning to see that they’re doing great, and the need for consultation is not

as great as when that consultant first came to the door.

They have what's a discussion with that [ECE] provider, and then, from there the consultant tells the [ECE] provider, "I think you're doing quite well. I think it's time that you move into the **monitoring phase**," and that's really what the consultant is doing. Now you begin to see a decrease in hours.

Maybe that consultant was in it for three hours, now may only be there for one or two hours. Maybe that consultant was there twice in a month, maybe they're only there once a month. It depends on what's the level of progress that's being made. The [ECE] provider's doing well. They're working their plan, you're seeing some shifts, some changes in perspectives, some changes in practices.

The director is reporting that things are going well, and consultation is working for them. From there, depending upon how well they're doing, consultation can end in the monitoring phase because we did six months, and we're good, and we can end here.

Or, depending upon maybe there's still just a little bit more of a need for consultation, and it doesn't mean they can't move into the next phase because they can, which is a **maintenance phase**, which is even less time and less visitation. Then, in the maintenance phase, at some point, the [ECE] provider is closed.

They complete a course of consultation. Of course, a consultation for one [ECE] provider may be 6 months, or another may be 3 months, or another may be the whole 15 months."

At the same time, this same expert continued to come back around to the need for nuance and flexibility in adopting this general timeline and the danger of falling back on oversimplified or rigid approaches:

“Policy makers don't like gray. We live in the gray. We do, and once you understand that, you can get a better handle on it, consultation begins to make sense to you because you live in the gray. It is what it is. If you're trying to make all these concrete gestures and processes so that we can quickly see it, count it... it doesn't work. It falls apart.”

8. Consultant Qualifications and Competencies

KEY DESIGN CONSIDERATIONS

- Respondents were unanimous in stating that IECMHC requires specialized knowledge across multiple disciplines and bodies of knowledge, including the research regarding disproportionate suspension/expulsion and implicit bias in ECE settings.
- Typically, IECMHCs enter the role with a Masters degree.
- Likewise, the role is considered highly skilled, with consultants working at multiple levels within a given organization, and using varied strategies to support administrators, ECE providers, children, and families.
- Many recommended that Oregon anchor its IECMHC model in The Center of Excellence's IECMHC consultation competencies¹³.

IECMHC requires significant breadth and depth of knowledge and skills. The national experts and consultants interviewed agreed that in addition to specialized knowledge of early childhood development, culturally responsive, and anti-bias approaches to early care and education, and foundational mental health knowledge, consultants need to have strong interpersonal skills, reflective capacity, be skilled at working with groups, and have an understanding of working within and across systems. Overall, national experts, Oregon ECE leadership, and Oregon consultants agreed that Georgetown's Center of Excellence (CoE) for IECMHC was the most well-regarded resource for information and training for IECMHC. The CoE provides a range of equity-informed IECMHC resources including a comprehensive guide to core consultant qualifications and competencies required for effective multi-level IECMHC (child, family, home, classroom, programmatic, and system-wide) (Center for excellence for infant and early childhood mental health consultation, 2021).

13 <http://www.iecmhc.org/documents/IECMHC-competencies.pdf>

9. Professional Development Supports for Consultants

KEY DESIGN CONSIDERATIONS

- Respondents were clear that comprehensive onboarding, regular reflective supervision, and ongoing training are critical to consultation success and should be explicitly included and budgeted for in Oregon’s model.
- As discussed in greater detail below, respondents agreed that effective consultation is supported by having consultants who reflect the communities served.
- An understanding of local community histories, cultures and current contexts is likewise seen as foundational to the work—as is an understanding of one’s own culture identification and social position.
- Oregon’s model should likewise consider how to support professional development and reflective supervision for agency-based or independent IECMHCs already practicing in the state.

Onboarding and Ongoing Training

The theme of providing comprehensive onboarding support and ongoing professional development came up repeatedly across national experts and the Oregon-specific interviews with consultants and mental health leadership. A number of national experts emphasized that when hiring consultants, they looked more for certain mindsets or capacities that could be developed than strictly degrees:

“You have to have the degree, according to city requirements, but more important to me is to screen for reflective capacity, relational quality, humility. I’m happy to spend a year providing other pieces of training/onboarding if those core pieces are there. I don’t want somebody who wants to be a therapist or is behavioral.”

On the other hand, another expert noted the irony that in every other field, one usually becomes a “consultant” toward the middle or end of their careers, after many years of experience—but IECMHCs are typically “exactly the opposite.”

“The combination of not having a pipeline, even in graduate schools, related to mental health consultation in early childhood means that it’s incumbent on any program who’s hiring to be able to provide the post-graduate training and support. In my experience... people are hiring mental health people to do the work of infant and early childhood mental health consultation,

who’ve had no training in either. It’s variable and random and from my perspective, most of the time, inadequate, the training and support that people get on the job. That’s where I feel one of the things I can always contribute or I want to contribute to people who are starting up new systems. Let’s put as much emphasis into the idea of developing a workforce as developing services. My worry is that we will not replicate the findings that have put mental health consultation in this valued and valuable position if it’s done by people who’ve had no support, training, education or experience in all of what goes into it.”

National experts shared success with providing opportunities and training for consultants to engage in-depth in learning about the community they were serving as part of their onboarding process, including reading about community history, participating in neighborhood walks, and getting to know key people in the community.

Reflective Supervision

Reflective supervision by someone knowledgeable about, and skilled in, IECMHC was identified by national experts and Oregon consultants as an essential component of the model, critical for supporting effective mental health consultation. Supervision should be equity focused and support consultants to engage in culturally responsive anti-racist practice, with particular attention to supporting BIPOC consultants (further discussed in the section: Supporting and retaining BIPOC consultants). Regular reflective supervision should occur individually and/or in a peer group context, and included in consultants’ paid FTE.

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If we don't dissect it [implicit bias and racism], we oppress, and we live it out on people. The dissection is about becoming clearer about yourself... We locate ourselves. I have to locate where I sit. My staff has to locate. When we do case presentations, you have to locate where the family exists. You have to think about how your age, race, class, gender, religion may oppress or hurt the other.

”

RESULTS

Implementing a Culturally Responsive and Anti-Racist Model

Oregon's stated goal is to create an IECMHC system that is intentionally built on the perspectives and needs of BIPOC children, families, and ECE providers in order to better meet the needs of all. Below we highlight what we heard from respondents regarding the system components likely required to support this goal, with the acknowledgement that many with whom we spoke also observed that no one has yet to “figure this out.” There is a need for ongoing learning at all levels, as work is done to transform existing IECMHC work and systems. The key issues highlighted by participants are organized in the following sections:

- 1. The Crucial Importance of BIPOC Consultants** which highlights the importance of having a workforce that matches the communities served, the current shortage of BIPOC consultants present in the current workforce, and strategies to increase the number of BIPOC consultants. This section further identifies the need for consultants to be grounded in shared community history and able to address historical and present day issues of mistrust between minoritized communities and publicly available services.
- 2. Consultants Need to Explicitly Address Implicit Bias and Racism**, which identifies the central importance of consultants explicitly addressing implicit bias and racism in the context of their role.
- 3. Establish Clear Expectations with ECE Providers about Anti-Racist Consultation** examines the need for specific training and professional development to support consultants to engage in anti-bias/anti-racist work.
- 4. Provide Training to Current and Future Consultants for Doing Anti-Bias, Anti-Racist Work** shares the present need for more BIPOC consultants and strategies for building and supporting this pipeline.
- 5. Consultation Systems Should Support BIPOC Early Learning Staff and Consultants to Recognize the Impacts of Internalized Racism and Racial Trauma** highlights the need for explicit expectations between consultants and ECE providers around addressing racism and implicit bias in the consultation work.
- 6. Consultation Systems Need to Support BIPOC Early Learning Staff and Consultants to Recognize the Impacts of Internalized Racism and Racial Trauma** discusses the need for adequate training and reflective supervision centering the experiences and impact of internalized oppression and racial trauma within the context of this work. This further examines ways to support and retain BIPOC consultants.

1. The Crucial Importance of BIPOC Consultants

KEY DESIGN CONSIDERATIONS

- There was widespread agreement that a consultation workforce that reflects the communities served is much more likely to be effective. Specific reasons for this related to the ways in which BIPOC consultants: (1) are grounded in a shared history, culture, and language; (2) are better positioned to overcome mistrust; (3) have a deeper understanding and skills for navigating issues related to mental health within BIPOC communities.
- Currently, the vast majority of IECMHCs are White-identified women.
- When not possible in the short-term, there need to be clear expectations that mainstream dominant staff will spend time in communities, learning the histories, and building authentic relationships.

While there are widespread general concerns with the lack of qualified workforce for IECMHC, both in Oregon and nationally, this challenge is particularly acute in terms of BIPOC consultants. That said, there was widespread agreement that a consultation workforce that reflects the communities served is much more likely to be effective. Specific reasons for this related to the ways in which BIPOC consultants: (1) are grounded in a shared history, culture, and language; (2) are better positioned to overcome mistrust; and (3) have a deeper understanding and skills for navigating stigma related to issues of mental health within BIPOC communities.

Grounding in Shared History, Cultural and Language

First, nationally and in Oregon, BIPOC respondents in particular talked about the importance of being grounded in a community's shared history, culture, and language—both past and contemporary. White consultants are unlikely to pick up on or even know to look for nuances in communication and are likely to be removed from the community itself, with relatively few points of reference.

“People come in and they make a statement. That statement means a lot if you said it to another Black folk person. Saying it to a White person, they don't even understand what you say. They keep going. You automatically feel like...You feel a little deflated each time because they're missing something super important you're saying.”

Likewise, many BIPOC ECE providers and families will be bringing lifelong experiences of racial harm to the interactions with con-

sultants, maybe even at the hands of other White “helpers” in their lives (e.g., former ECE providers, caseworkers, supervisors, etc.). This sentiment of mistrust was shared by many of the BIPOC leaders, consultants, and ECE providers we spoke with and can be a significant barrier to the consultative alliance. Realistically, White IECMHCs carry their own implicit and explicit racial biases that could also result in additional harm in the context of consultation.

Many ECE leaders and ECE providers stressed the challenge of working with consultants who struggled to understand their cultural and community contexts. They often expressed hesitancy when working with consultants whose understandings of community and cultural context were not based on their own lived experiences.

When consultants are not BIPOC, or from the communities that programs are serving, this can not only be a barrier to effective practice, but can lead to additional harm. Misunderstandings of child behaviors, parenting practices, and ECE provider or classroom level decision-making may occur. At a minimum, White consultants need to have done work to understand and address their own implicit biases and how these show up in their work with staff and children.

“They [consultants] don't have the same lived experience as our children and our families. Many times, we have to make them aware, remind them of that. Some of them are very open about it and they will accept it in a good way, but some of them we have seen that they feel offended... It can be challenging, and it is stressful on [ECE] providers of color. Again, because you're putting the blame on the victim. Having to explain to this specialist or this consultant about what implicit bias is and what racism is, and what some of those inappropriate ways of approaching the services with those children and families are... Because instead of feeling that they are being supported, they feel that they are being judged again by a White person. That they didn't get what our families, our children, and our [ECE] providers are coming from.”

According to the national experts, this question speaks to a central dilemma in IECMHC. Everyone agrees that a consultation workforce that reflects the communities served is much more likely to be effective. While the sentiment across interviews nationally and in Oregon centered on a need for cultural and community matching, none believed that simply “matching” by race was a remedy for mistrust and legacies of harm, but having a consultant that reflects one's own culture is likely to create an important baseline level of comfort and accelerate the relationship-building process. Consultants that reflect the community

are also better positioned to make adaptations or interpret the consultation approach in a way that resonates with cultural values and understandings.

“Reality is the reason I think sometimes having someone who is similar to you is helpful. I think about it from my own therapy. I don't go to therapists who are White... If I need to walk into therapy and also educate, I'm not getting therapy. I'm doing my job again... That's the challenge that White folks sometimes miss. They haven't worked to understand what communities of color and people go through. They got this generic nonsense in books but understanding what people exist in.”

Other BIPOC ECE providers shared the importance of being able to see their culture and communities reflected back to them in the work, curriculum, material, and trainings provided to them by consultants. Two national experts with whom we spoke talked about the opportunity to, and importance of, incorporating traditional healing practices into the menu of options offered by mental health consultation. BIPOC ECE providers shared that they viewed the IECMHC model as being “Eurocentric” and more difficult to relate to. One African American ECE provider shared:

“... we've also lost the arts. I remember music, the African music or the dancing or the artwork, that kind of stuff will also be another avenue for the youth, for young kids. They just don't get that anymore. That connection back to those cultural roots that I think us who are older African Americans that has touched our hearts, but it has been those kinds of things that they don't have that anymore.”

While having bilingual consultants was seen as critical, many respondents emphasized the importance of having bilingual consultants who are also bicultural. Across many of the focus groups, BIPOC ECE providers shared their concerns that their interactions with children, and the interactions between the parents and their children, could be misinterpreted by bilingual consultants who did not understand the cultural and historical contexts and nuances of caregiving and parenting.

Ability to Overcome Mistrust through Understanding Culturally Specific Trauma History

Another theme that emerged in many of our interviews nationally and in Oregon was the critical importance of IECMHCs understanding of the impact of historical and present-day racism experienced by many minoritized communities, families, ECE providers, and children. For example, Native ECE providers talked about the ways that they are dealing with a multitude of complex trauma, including historical and generational trauma, the ongoing problem of murdered and missing indigenous women,

and the impact of the recent discoveries in the United States and Canada of child burial sites at state-sponsored boarding schools. African American ECE providers talked about the effects of historical and everyday racism on themselves and their communities, including state-sponsored police violence.

BIPOC ECE providers shared how these larger contextual issues affected caregiving and community and family well-being, and often led to conversations about mistrust in the system. ECE providers shared concerns about trusting a new, state-run IECMHC program to meet their needs and to be a good fit with their communities and cultural orientations. Native ECE providers in particular emphasized the need for long-term relationships with consultants—someone who would come and commit to working with them for an extended period of time. They talked about the high turn-over rates of outside professionals serving their programs, which many ECE providers across groups, particularly in rural communities, also identified as a challenge. An ECE provider in one of the Native focus groups shared:

“... Our people have trust issues. You got to earn that trust with us. The way [our Pastor] did that was he stayed here 50-some years. He went out and about to be with the families. He was mistreated because they weren't sure to trust him or not because he was White. He built that trust. He was right out there powwowing. He was right out there when we were burying our loved ones. He was doing ceremonies. He was saying words. It was not 8:00-5:00 job for him. He was on the clock, around the clock. The importance of whoever decides to come join us is hang tough. Don't leave us. Stay with us. Get to know us. Don't be here just one year and then head out. That's where we have trust issues.”

BIPOC ECE providers also shared challenges trusting state workers, or someone who they thought was connected to the state, and concerns that Child Protective Services (CPS) might become involved. As one ECE provider from the African American focus group described:

“Once families are asked to meet with others to have that discussion about their child and mental health, it then feels like they're being judged. It feels like Social Services may get involved. Then you've turned something into what supposedly is to help them, and then they're in fear of having their children taken from them because of the way they parent. It's hard to trust. That's one reason that it's hard for someone that hasn't walked in their shoes to be able to connect with them.”

Another expressed:

“We get a lot of White folks who just come in who don’t understand the African American community and so they start putting their stuff onto a lot of families. I think [for] families [who] have had any involvement with DHS, they don’t want any involvement with mental health folks, because they know that’s a direct link of not getting their kids back. There’s a lot of mistrust.”

Ability to Address Deeply-Rooted Stigma Related to Mental Health

Addressing stigma and misperceptions about mental health when working with many BIPOC communities was also highlighted as an important aspect of consultation, and another area in which BIPOC consultants are likely to be more effective. Across the interviews, regardless of roles, participants discussed the ways that the term “Infant and Early Childhood Mental Health Consultation” may be a barrier for service use because of general social stigma associated with “mental health problems” and specific stigma tied to historical systems of state oppression for communities of color. Due to the term alone, respondents suggested, families may not be willing to engage with consultants or other mental health providers. Effective consultants need to be aware of existing stigma and to be able to engage in conversations in ways that avoid further shame or harm to families.

BIPOC respondents suggested that if families were provided with support from someone who understands/is from their community, it would make it easier to mitigate these barriers related to mental health stigma. Consultants could be important facilitators of conversations with families and staff about mental health and well-being, and could potentially be central to breaking down existing stigma.

“Another consideration, as well, when you’re working with a community is how are you going to bring this up, this conversation, without making them feel like they’re being judged or stigmatized.”

“If we can provide them [the families] with enough support, then we can mitigate some of the development and mental health challenges. Very often in these communities, these are not addressed. It’s a social stigma. It’s critical to have program staff or those who are delivering the services from within the community...”

“There’s still a stigma within our community in our Latino families believing that mental health is only for people that are crazy or that are going nuts. There has to be a lot of education about the importance of mental health. We have

gotten better, especially in early childhood education, letting parents and families know what mental health is and that that’s part of everyone, and that that is as important or more than your physical health, as well as providing different tools and resources on how to take care of your mental health.”

BIPOC Consultants Can Be Empowering “Role Models”

One expert also spoke about the role played by BIPOC consultants as modeling and reflecting pride in and hope for families and communities, as opposed to an outside, White professional holding all the expertise.

“We believe, our values and our mission...are ‘La cultura cura’ (culture heals); ‘Tú eres mi otro yo’ (I am reflected in you); ‘Sí se puede’ (we can be empowered together). Those values, when you have staff who embody them....I feel like there’s a way that, if you think about consultation, about instilling hope, the importance of instilling hope and being empowered to own your destiny.”

“At the end of the training, this woman, I want to say she was Ethiopian, she came up to me and she said, ‘I was so shocked when I walked into this room and I saw it was a black woman who was doing this training.’ She said, ‘Thank you.’ She said, ‘I go through a lot at my job.’ She was telling me some of the things that she’s been going through at her job. She said it was so inspiring to see someone that looks like me to host this knowledge, so those of us who are out here really starving.”

2. Strategies for Increasing the Number of BIPOC Consultants

KEY DESIGN CONSIDERATIONS

- The need to more closely interrogate existing barriers to joining the IECMHC workforce experienced by minoritized groups and do creative problem-solving at multiple levels of potential intervention, from individual workarounds to coordinated systems-level change.
- The model must consider short- and long-term recruitment strategies for consultants, supervisors, and administrators.
- The model should build in employment and financial supports for BIPOC individuals to meet degree requirements.
- Paraprofessionals may be used cautiously, and as a transitional strategy, as long as attention is paid to supporting paraprofessionals to grow into permanent (credentialed) consultant positions. Permanently relying on

a paraprofessional workforce to increase diversity, center lived experience, and meet equity needs may unintentionally reinforce systems of inequality in the workforce.

- Strategies to increase recruitment of candidates who are more likely to reflect the communities served, could include recruiting directly from the ECE workforce.
- The state IECMHC program should build formal partnerships with colleges and universities, cultivate strong relationships with relevant graduate internship programs, and clearly communicate program and community needs for IECMHC interns.
- Respondents also recommended building parallel relationships with Oregon primary and secondary schools in order to build interest in middle and high school students regarding career opportunities in IECMHC.
- Master’s level social workers may be particularly good IECMHC candidates given their social justice orientation and higher BIPOC representation.

In order to implement a state IECMHC system in Oregon, key issues related to the current IECMHC workforce must be addressed. The shortage of BIPOC consultants and consultants who are bilingual and bicultural in these roles is a current challenge nationally as well as in Oregon. Issues emerge at multiple points of the workforce development system, from how to create career ladders and “pipelines” for training IECMHCs, to how to support and retain these staff in their roles.

Ensuring that the IECMHC workforce reflects the communities served is a complex and nuanced undertaking that requires a multi-pronged approach, with no “silver bullet” solutions. National experts that we spoke with, including BIPOC-identified experts, maintained throughout that the role requires a high level of knowledge and skill. As one expert shared:

“They [the tribes] say, ‘Yeah, it is important that we have a consultant who looks and talks like us, but we also still want them to be qualified. Don’t just send us whoever’”

As the state moves forward to create and support this critical workforce, several issues need to be considered. The current reality is that the vast majority of the workforce, both consultants and supervisors, is made up of White women.

“I’m sure you know that about 95 percent of the [ECE] providers of mental health consultation are White women in this country. If we have any sense of diversifying that pipeline, we’re going to need to be able to provide monetarily what it takes for people to stay in this work, and the

training and support to even get into the work itself.

How do you hire, employ and sustain a multi-racial, multi-ethnic group of mental health consultants? What’s needed to do that? Also recognizing you have 95 percent of the consultants now are White and female. We aren’t going to discard that group of people, so what do we need to do? What do they need?”

The experts we spoke with proposed a multi-pronged approach to simultaneously working with and working to address this fundamental disconnect.

Make Systems Changes Now to Meet Short Term Needs

In the near term, national experts shared some recommendations for increasing the diversity of the IECMHC workforce. For example, a number of national experts talked about the importance of not serving as “gatekeepers” to the role, but rather of finding ways to advertise and recruit for positions that would be perceived as welcoming and accessible.

“I don’t want someone to stumble across that [minimum qualifications] with an interest in becoming a consultant, see that and say, ‘Oh, well, I don’t meet that, so I’m just not going to do it.’ We’re trying to be intentional about what sort of language we’re using. I don’t want to be a gatekeeper. We can say like, ‘If you feel like you don’t meet this yet, please reach out to us,’ and then we build opportunities to get people there.”

Others similarly shared efforts to build flexibility into the requirements—coupled with additional supports for candidates that might not meet all of the initial requirements:

“We do have staff exemptions for people who are close to meeting the requirements, but not quite there. We can make a request to the funder, ask if we can hire this person, and give justification for how we plan to provide extra supervision [and training] and are going to send them through an infant mental health certification program.”

“What if someone says, ‘OK, I’ve got a bachelor’s in early childhood? Can they start doing the work if they are also interning or being mentored or supervised by someone? We’re just starting to have these conversations. We’re not there yet, but this is where we’re looking to go.’”

Note that there is no interest in “lowering” standards; everyone agreed that mental health consultation requires extensive background knowledge and a high skill level. Nonetheless, the typical White IECMHCs begins as a young, often inexperienced graduate with little to no experience in early childhood. Every expert talk-

ed at length about the extensive onboarding and ongoing professional development that is needed to effectively “grow” consultants. In light of this, the case could be made for recruiting BIPOC candidates with less formal education, but experiences and understandings that are very difficult to “train” or cultivate in White candidates, while providing supplemental, on-the-job professional development support and even pathways to advanced degrees. One Oregon mental health leader shared:

“I have worked with [ECE] providers who maybe just finished some community college, but they were incredibly gifted and knowledgeable when it comes to providing care to children. They could not get hired for some of the jobs that she would have been great for because of that lack of education, which also I feel like not everybody has that money to attend university or community college for that matter... We are missing some excellent candidates that could do excellent work at a high level because of that requirement with that education piece.”

Consider Supports for BIPOC Consultants Related to Degree Requirements

Only two national experts that we spoke with suggested that it might be possible, with robust support and extensive professional development (and budget for the same), to grow someone with a BA—or maybe an AA—into the role. At the same time, both expressed some caution around this idea and emphasized that it would be entirely dependent on actually providing the kind of comprehensive support required.

“If you’re thinking about not using Master’s level folk then your PD [professional development], really has to be tight because it does take a level of training at a Master’s level that can be created and can be used for those who may be at a bachelor’s level or even at a AA level. That’s where a lot of life experience could come into play. But definitely, there has to be a strong PD piece there to help folk to build their capacity, as well as practice. Yeah. I think it’s possible, but, definitely, that element must be in place for it to work in a way that can help you create what we call our thinking consultation, which is not case management, which is not crisis intervention. It’s not coaching. It really is living in that grey and being able to provide supports in a way that helps you to come alongside someone and be a resource, an ultimate resource for that individual.”

Most experts (including multiple BIPOC-identified experts) were in agreement that even with a Masters degree, new consultants would likely need considerable onboarding and ongoing professional development.

“Consultation is even harder than clinical work because you’re holding multiple perspectives and multiple bodies of knowledge.”

“It really [does require] a lot of reflective support, a lot of ongoing professional development, because you’re dealing with humans, and you’re dealing with emotions. We’re dealing with this whole notion of relationships. It really takes a lot of ongoing training and support just to wrap your head around what that means as a consultant and particularly when you’re dealing with children of color and addressing our own biases, addressing what racism has done in this country, and how does it even impact this field—because it does.”

Likewise, several BIPOC-identified national experts cautioned against abandoning (or minimizing) efforts to support aspiring BIPOC individuals to access masters level education in a well-intentioned but potentially misguided attempt to make the system more accessible. Without simultaneously working toward system change in higher education, such an approach could simply reinforce perceptions that BIPOC individuals are inherently better suited to paraprofessional roles.

The use of paraprofessionals to increase diversity by centering lived experience rather than professional degrees may temporarily lead to a sense of increased equity. However, without explicit supportive pathways built into the model for degree attainment, this could ultimately reinforce current inequities where professional consultants are White and paraprofessionals are primarily BIPOC.

Several national experts shared that, while they believe that individuals without a master’s degree can do the work of consultation, they also believe that supports, particularly financial supports, should be in place to help them attain a master’s degree in the course of their career:

“I could see folks who have had great training, support, and supervision, and 10 to 15 years of experience of doing that kind of work... I could see them being consultants, but having a system and support to move them towards getting that clinical master’s is ideal, even if it means paying for their schooling. If they have to move, helping with housing. Doing something to really support and invest in a person because of what can come back and come out of and pay back to the community, especially if they’re of the community.”

National experts and BIPOC consultants in Oregon emphasized that building an educational pipeline likewise requires financial support for aspiring BIPOC consultants:

“It would be great if there could be some monies to support people of color going into the field of mental health. Men going into the field of mental health, men of color. Maybe we might see more of us in the field. That would be great.”

One expert also noted that social workers are more likely to be BIPOC-identified than other mental health professionals (Salsberg et al., 2017), so recruiting social workers may be another effective way to increase representation. Another pointed out that Masters level social workers may be particularly good candidates for the IECMHCs role, as a social justice orientation is built into their education and training:

“The majority of our staff are social workers, who for the most part have a social justice mindset. That was part of what they were hoping would be included within the work that they—promoting social justice equity. That’s helpful.”

“I think it really has to be extremely intentional, going to those places and spaces. Universities, looking at other fields, maybe folk want to cross fields, looking in child welfare, looking very intentionally in those places and spaces where you do have people of color who may be interested in crossing over and doing this work.”

Lastly, one national expert highlighted the importance of doing more work to understand both the barriers and the necessary remedies, before rushing to implement a system that can’t live up to its promise:

“There’s a real danger if we move ahead with creating programs to provide the service, and we haven’t done a corollary effort at making sure there are people to provide them. If we decided that it was a really good idea to start to have heart transplants... so, OK, let’s do the service and not think about making sure that we had enough people to train to do the service. I feel like this is equally complex if not more so than heart surgery.

Let’s put as much emphasis into the idea of developing a workforce as developing services. My worry is that we will not replicate the findings that have put mental health consultation in this valued and valuable position if it’s done by people who’ve had no support, training, education or experience in all of what goes into it.”

In particular, it was noted that asking BIPOC individuals directly about barriers to becoming an IECMHCs and possible strategies for increasing interest in and access to the role would be instrumental to supporting an equity-focused IECMHC system.

Recruiting Directly from the Community

BIPOC respondents clearly expressed a need for consultants with an understanding of community and cultural contexts based on their own lived experiences, and emphasized that an equity-centered consultation model must include pathways for BIPOC individuals to become IECMHCs.

“We need to create pathways for more people of color to get to this field of mental health consultation. That’s the only way that we are going to increase culturally specific or culturally responsive services for the children, the families, and the [ECE] providers that are serving those children and families... I think the state has the responsibility to create those pathways to increase the number of consultants that are consultants of color that are coming from those same backgrounds of the families and the children that we are serving, and the [ECE] providers that are serving those families on a daily basis.”

The BIPOC ECE providers and consultants identified high turnover of White consultants, geographically coming from outside BIPOC communities, as a major barrier to effective IECMHC. This was especially true for rural and Tribal ECE providers, who described significant challenges building positive consultative alliances with White consultants. To address turnover specifically, Oregon consultants, leadership, and ECE providers recommended recruiting directly from the ECE community in order to find potential consultants with classroom and ECE experience who were more likely to be invested in a long-term career in IECMHC. Because of an agreed upon lack of knowledge about IECMHC as a career in the community, many also talked about the important role of promoting the career and its pathway in high school or earlier.

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Create Intentional Partnerships with Colleges and Universities

Another strategy described by national experts, Oregon consultants, and Oregon mental health leadership for building workforce capacity is collaboration with local colleges and universities to create IECMHC internship programs. Several respondents reported already experiencing success working with graduate level interns.

3. Explicitly Address Implicit Bias and Racism

KEY DESIGN CONSIDERATIONS

- The vast majority of experts interviewed agreed that a key role for consultants is to actively and intentionally address implicit and explicit bias as a root cause of disproportionality in suspension and expulsion rates.
- This includes work to address racial bias as well as gender and disability bias that contribute to disproportionality in rates of early childhood suspension and expulsion
- Experts cautioned against avoidance of these sometimes challenging conversations; to do so was described as being complicit in perpetuating bias.
- Indeed, it was recommended that formal IECMHC agreements with ECE providers include clear expectations around addressing bias in the context of consultation.
- In Oregon, BIPOC consultants expressed more comfort and preparedness to take on this role than did White consultants (as well as EI/ECSE specialists); additional training and support in this area is likely to be important.
- In order to do effective anti-bias, anti-racist work, respondents noted that sufficient consultation time must be available to develop ongoing relationships and trust between IECMHCs and ECE providers.
- In addition, the system needs to develop required racial equity training for ECE providers—generally and in particular for those working with IECMHCs. The system should provide education about disproportionate suspension and expulsion and the ways that implicit bias emerges within ECE settings.

The national experts we interviewed shared the view that early childhood mental health consultation has a potential for working intentionally to surface, grapple with, and heal the “isms” that plague American society and show up in child care settings as well (racism, classism, sexism, etc.). The most frequently-referenced example of how racism and sexism show up within early care and education is the disproportionate suspension and expulsion of Black and Brown boys from early childhood care. Research has demonstrated that this disproportionality stems from bias, either implicit and/or explicit, rather than any actual difference in the rate of problematic behaviors (Gilliam et al., 2016). At the same time, the experts we spoke with were quick to point out that suspension and expulsion is only the tip of the iceberg in thinking more broadly about the wellbeing of BIPOC children in child care:

“For every child who’s expelled, we know that there are 10, 20, 30 behind them, children of color, who’ve experienced maybe less intense, but no less harmful, microaggressions, perceptions and about who they are, messages about their inadequacies or them being threatening.”

Preliminary evidence for the success of IECMHC in reducing the rate of suspension and expulsion of Black and Brown boys has generated considerable interest in the model. The mechanism by which IECMHC seems to mitigate bias, however, is not well-understood. For example, research suggests that IECMHC provided without explicit discussion related to reducing racial bias still seems to help reduce rates of suspension and expulsion, particularly for Black boys (Davis, Shivers & Perry, 2018; Shivers, Farago & Gal-Szabo, 2021). Some policy makers have questioned whether it is necessary or advisable for IECMHC programs to directly address potential bias in the context of the consultation relationship. We put this question to the national experts interviewed and got a resounding, “YES.” The vast majority of our experts agreed that IECMHC programs should be prepared to directly address implicit and explicit bias in order to facilitate authentic transformation of relationships and systems.

As one BIPOC expert eloquently explained:

“If we don’t dissect it [implicit bias and racism], we oppress, and we live it out on people. The dissection is about becoming clearer about yourself... We locate ourselves. I have to locate where I sit. My staff has to locate. When we do case presentations, you have to locate where the family exists. You have to think about how your age, race, class, gender, religion may oppress or hurt the other.”

When speaking with Oregon consultants, many also shared that discussing and addressing implicit bias was a key element in the work that they do, but there was a trend of BIPOC consultants feeling more comfortable and prepared to address these complicated issues than their White counterparts. In conversations with EI/ECSE representatives, they also tended to feel more unprepared to discuss this or felt this was not their role. EI/ECSE representatives and consultants both talked about the challenge of working with ECE providers who brought strong expectations and assumptions that certain groups of children (primarily Black, Brown, and Native boys, as well as boys who are physically large for their age) are more likely to exhibit behavior “problems.”

An Oregon BIPOC IECMHC shared:

“At one point, people [consultants] didn’t even talk about this. I know on our team, some people did it more. I’m just going to say, the people of color, the black folks. That was just part of their work. For other folks, it was like an add-on, [they were] not comfortable talking about it. In the past couple years, we said, ‘That is our role... what we do in trying to help other consultants be more brave, more comfortable bringing it up.’ Even as we meet with our partners... I meet with all the directors, do a meet-and-greet. I said, ‘This is what we’re going to be talking about. This is part of our role.’ That helped. Even though some folks said, ‘We’re still struggling incorporating that’... We’re going to bring it up. Even if it’s uncomfortable, we’re going to talk about it, ‘How can we avoid this?’ It’s still a pretty new conversation for a lot of the consultants on our team.”

In order to do effective anti-racist, anti-bias work, respondents talked about the importance of ensuring that consultants could build the “deep trust,” relationship-building and skill that is necessary to effectively broach such topics over time:

“When you can hold people’s experiences and you have enough trust, you can unpack a little bit where somebody’s biases might come from, and then be able to connect it to how they might potentially be seeing a child. That takes skill and we do need to address that.”

This expert also cautioned that the needs of children and families always come first, with the implication that less skilled intervention could backfire:

“If it’s not going to benefit the child in the family, we need to be careful, think, and be cautious. We got to center the needs of children and family first. Some teachers, we’ve got to figure out how to get them there.”

At the same time, the national experts that we spoke with agreed that explicit conversations about and professional development around racial equity have not (in most places) been central to the model, but should be important elements of mental health consultation moving forward. Perhaps not surprisingly, the current state of policy and practice in this regard reflects this, with some experts describing this aspect of mental health consultation as being in “its infancy.” Interviews with the experts related to this area made it clear that no one has yet to identify the “magic formula” for opening up and effectively facilitating such conversations; and in truth that such a thing likely will never exist. At the same time, there was general agreement that to simply avoid naming and interrupting bias is to be complicit in perpetuating the same. The field is currently feeling and learning its way to-

ward developing this core aspect of IECMHC practice. Some key ways to create a model that centers anti-bias, anti-racist consultation that were described included: (1) creating contractual or other clear expectations that this is a part of the IECMHC’s role; (2) ensuring that consultation models allow time for consultants to develop trust and strong relationships with ECE providers; and (3) strengthening professional development supports for consultants specific to anti-bias, anti-racist knowledge and skillsets.

National experts and Oregon consultants discussed how the result of this disproportionate focus on children with perceived externalizing behaviors, less consultant time was used to address children with internalizing behavior (anxiety, social isolation, depression), and children with these characteristics were overlooked. They noted this behavioral pattern is more common for girls, and worried that girls were being left out of the work.

4. Establish Clear Expectations with ECE Providers about Anti-Racist Consultation

KEY DESIGN CONSIDERATIONS

- Communicate a clear expectation that IECMHC may involve explicit conversations around racial bias within the context of consultation.
- Create formal contracts or agreements between consultants and ECE providers that specify the nature of anti-racist/anti-bias supports which include activities to address equity that will be explicitly provided as part of the consultant’s role and goals for this work.

We heard from respondents that it is important to establish from the very beginning explicit expectations that consultation will include anti-bias and anti-racist conversations, and to include such expectations in written agreements with ECE providers and ECE programs. One national expert shared an example of an unsuccessful early attempt to explore the possibility of implicit bias with an ECE provider without introducing the expectation earlier in the process, and how consultants might start to build strategies for addressing bias into more “touchpoints” with ECE providers. They said:

“For example, I can tell you about a group supervision we were having where somebody said, ‘I’m pretty sure that race is an issue in this referral.’ [The group] gave lots of strategies for how to bring that up, and the [consultant] still waited until the third visit to bring it up. It turns out that her instinct was right. She was not invited back to the center. That had been the thought, if I can build a relationship then

I can bring up race, and they'll still let me come back. As soon as she brought up, "Hey, I think there might be some implicit bias," she was not invited back to the center."

“That’s an example of why we felt this need to shift our thinking into, ‘how do we systemically talk about this more’, so that when we come in and say this as a consultant, it doesn’t catch them off guard. Then we started to try and bring in that cultural and historical trauma as a bigger presence in all of our trauma training, [and] other venues where we were training. How do we sprinkle this into the other opportunities that we have to interact with people instead of making it a standalone training?”

National experts and Oregon consultants shared how writing equity work into their contracts up front with ECE programs has helped serve as a primer for these conversations and the more challenging work later on in the consultative relationship. As one expert explained:

“We are thinking with people about what helps and what harms children, and being more explicit about that including racism, so that from the very beginning, we are poised and upfront about that being a part of what we’re going to address together.”

Another shared incorporating anti-bias and equity conversations with their consultees (at all staff levels) “in the same way that we would about anything that impacts for good or for ill children and families at this site.”

5. Provide Training to Current and Future Consultants to Support Anti-Bias, Anti-Racist Work

KEY DESIGN CONSIDERATIONS

- The model will need to provide training, ongoing professional development, and reflective supervision to support consultants to engage in effective anti-racist and anti-bias work with ECE providers.
- Budget to support adequate time for professional development and reflective supervision for consultants and their supervisors should be built into the model, so that they take place on paid work time, and are not treated as an optional, unpaid “extra.”
- White-identified consultants would likely also benefit from the opportunity to do equity-related self-reflection and learning in the context of White affinity spaces.
- Additionally, given the current reality that White women are significantly overrepresented among IECMHCs, White

consultants should be expected to spend time in the communities they’re serving, learning the histories and current contexts, and building the authentic relationships that support effective consultation.

Experts noted the nuanced and challenging nature of conversations about implicit bias, equity, and racism, and the need for considerable professional development and deep self-reflection in order to be effective:

“We always tied the work to the Walter Gilliam study to understand preschool expulsion, and then specifically the implicit bias that’s associated with it, so that in theory your consultants are going to be addressing that when they’re out with teachers. It’s not that simple. There is a lot of cultural norms that you have to violate to bring something like that up right away. We see that reflective supervision is a component that we need to beef up so that could happen better, which is what led me to the community of practice where I’m at. We needed to beef up on our understanding of our own implicit bias. Talk about that in reflective supervision and figure out how that’s impacting our work.”

Consultants (particularly consultants of color) also shared that when approaching ECE providers with concerns related to implicit bias, they were most successful when reframing the concern around the broader social context related to racism, rather than around an individual child. Having positive relationships with ECE providers and ECE programs, and deep understandings of the region, communities, and histories of the families and ECE providers who serve them is likewise critical to this important work. A national expert shared:

“They’ve [consultants] got to talk about the adult’s behavior without pathologizing or condemning the adults but the idea that we all live and breathe in a racially toxic pool. There’s no way not to have all of our systems represent those policies. We got to stay firmly focused on the systems and the structures, not the individuals.”

Further, experts highlighted the need for educating consultants and ECE providers around other, inter-related systemic forms of oppression:

“What we weave throughout is the importance of recognizing a larger socio-political context and power dynamics that are in play, and how White supremacy impacts systems and systems can be oppressive. We call it out, acknowledge it and talk about it. Help them think about it. Think about their own intersectionality within these systems, what comes up for them and then with those they’re consulting too.”

6. Support BIPOC Staff and Consultants to Recognize the Impacts of Internalized Racism and Racial Trauma

KEY DESIGN CONSIDERATIONS

- The model should provide adequate training and reflective supervision focused on the experiences and impact of internalized racism and racial trauma on BIPOC ECE providers and BIPOC IECMHCs.

National experts also talked about the need for BIPOC consultants to be able to talk about the impacts of internalized racism with BIPOC ECE providers, and for BIPOC IECMHCs to receive support around this from their supervisors. These conversations were seen as critical to understanding how internalized racism may show up as implicit bias toward Black and Brown children as well. Research around implicit bias has confirmed the same (Bates & Glick, 2013; Gilliam et al., 2016; Murray et al., 2008).

“The themes have been around like, ‘Hey, we do have to understand that consultants of color have bias too and that those statistics say that we’re going to disproportionately recognize children of color as well.’ Though the conversation might look different, the need for the education was highly supported across professionals of color and White professionals. Also, when I was doing that trauma-informed family engagement training, I just asked, I said, ‘You know, we have a lot of participants of color in here. Do you feel like you need this training?’ and I wish I would have kept that chat box because it was overwhelmingly yes. [The comments were], ‘We are so hard on our own community and our people, and our bias is so strong, and we’ve been taught to tear each other down, and we need to be called on that and be challenged to build each other up.’”

The implicit bias stemming from internalized racism was clearly distinguished from intentional discipline strategies implemented within a pragmatic protective framework designed to prevent disproportionately harsh, and potentially deadly treatment experienced by Black and Brown boys in White dominant spaces. While closely related to internalized racism, the national experts specifically discussed that these strategies are designed to prepare Black and Brown children for living in a racist society:

“The traumatic impact is real, and the way the black community has been building up and training children up to respond is real, and they talk about that in the training and why they’re harder on the black children in their space because they know that society will be. They’re not going to put up with it later, so we can’t put up with it now, kind of concept.

Moving into a space of let’s talk about it as trauma and what other factors might be present here, and how has that changed this child’s development and looking beyond race and that there’s a universal impact of trauma regardless of your color.

It led to this: what can you do and what do you do, and if you’re noticing the praise isn’t present across your program, is that something you want to keep? I get it. You probably haven’t gotten a lot of praise over the years in a White society, but is that what you want to perpetuate with the kids that you’re serving? It led to some honest conversations about their experience and if they wanted to recreate that same experience or if they wanted it to be different.

We do trainings on implicit bias, and talk about the research, and talk about Dr. Gilliam’s work and others. That’s an awareness thing. Obviously, there are a lot of people that don’t even know that this is a thing, that there’s disproportionality within suspensions and expulsions, particularly with young children and boys of color. We also have the backing of others with this too. Many of our technical assistance programs are talking more and building awareness around the disproportionality and what implicit bias can look like and striving to interrupt it. Again, it is still, at this point, striving, and aspirational, and we don’t have a great way to measure it either. I’d be really interested in that part about how to measure your effectiveness with interrupting expulsions based on [bias].”

Supporting and Retaining BIPOC Consultants

KEY DESIGN CONSIDERATIONS

- Respondents highlighted support and retention of BIPOC consultants as equally important design considerations.
- Intentionally and explicitly centering and promoting equity within the state program, from the individual to the system level, was seen as foundational to supporting BIPOC consultants.
- Likewise, increasing BIPOC representation at the supervisory, leadership, and administrative levels was identified as central to creating a welcoming and inclusive workplace and supports an intentional strategy for the recruitment and retention of BIPOC IECMHCs.
- Respondents said that salaries and benefits should be competitive and care should be taken not to ask BIPOC staff to take on unpaid equity work, nor to educate White colleagues.

- It was also recommended that the state program implement safe spaces and culturally responsive supervision for BIPOC consultants, supervisors, and administrators, e.g, affinity groups.

Numerous national experts talked about the challenges retaining BIPOC consultants, especially after investing considerable resources in their professional development. In many places, IECMHC is still a relatively low-paid role relative to other positions that require comparable levels of education and experience, e.g., as a therapist or hospital social worker.

“It’s hard. Even then when you get them, they might stay a year or two, and then they’ve been trained up really, really well. They look super, super successful. Go off somewhere else because they’re a diamond in this field.”

An important aspect of retention is providing quality, equity-focused ongoing supervision and support for BIPOC consultants. This supervision should include support related to their own experiences of racism and discrimination:

“How can you, as a black consultant who is experienced in particular harms and injustices in your own home environment, your own home agency, consult in such a way where you’re mindful of how to have that dialogue with your consultees when you’re not getting fueled, fed, and supported in the way that you need to in order to have those in your home agency? You got all of that going on. Sure, there’s a parallel process. You’ll be able to relate. How will you be able to guide and support your consultee when you yourself are like, ‘I don’t know the other side of this; I don’t know. I don’t know what that looks like.’”

Creating a system that situates consultants within organizations that have BIPOC supervisors and program leaders (and, simultaneously continuing to build the workforce of skilled BIPOC consultants who can serve in these roles) is another area for Oregon to prioritize.

The consultants and the experts we spoke with highlighted the importance of having BIPOC supervisors to provide reflective supervision for BIPOC consultants. For many of the same reasons that it is important for a consultant to reflect the community, it is important that mental health consultation supervisors reflect their supervisee and IECMHC program leadership reflect the communities and consultants served by a statewide Oregon program.

Finally, it was noted that it is critical that BIPOC consultants should not be asked, either explicitly or implicitly, to fill the role of educating White people about racism, nor asked to take on extra, unpaid equity work. This was identified by BIPOC consultants as a significant stressor in their positions, many of whom shared

that they were the only BIPOC consultant on staff.

“I would imagine you will get a number of women who are people of color, as you begin to build this. I would ask that they not be the leaders in this. It’s not their place to have to explain this or to find ways to work with other people of color. It isn’t.”

Centering Equity at All Levels of IECMHC Programming

Centering and promoting equity across each level of the program helps to systemically support BIPOC consultants and promote anti-racist consultation. Informed by an intersectional lens, centering racial equity at every level encompasses policy, administration (including contracting relationships), leadership, supervision, and direct practice (at the organizational-, classroom-, and family/child-levels). This means explicit conversations, expectations, and accountability measures should be put into place, with a budget to support personal, reflective work, at every level. Putting these measures in place at an institutional and systemic level moves away from the common expectation that individuals within a given agency carry the heavy burden of anti-racist and equity focused work, day-to-day, on their own (Shivers et al., 2021).

Examples of where anti-racist and anti-bias standards of practice could be developed, integrated, and monitored for accountability across a statewide IECMHC program and the local structures, organizations, and/or agencies that guide its local implementation include:

A. Foundational Documents

1. Theory of Change (should include anti-racism language)
2. Mission/Vision (should include anti-racism language)
3. Logic Model (should include anti-racism language)
4. Oregon's History: Advocating for anti-racism efforts in early childhood initiatives

B. Hiring and Recruitment

1. Building and feeding a pipeline for a diverse pool of applicants
2. Approach to interviewing
3. Interview questions to assess level of knowledge/awareness of racial equity issues
4. Interview stance and strategies

C. Retention and Promotion

1. Compensation
2. Organizational Climate (commitment to transformation)
3. Leadership Development
4. Continued growth of existing senior leadership
5. Promotion of BIPOC consultants into supervisor and other leadership positions

D. Short-Term Orientation and Long-Term Orientation

1. Foundational documents during new employee orientation (e.g., Diversity-Informed IECMHC Tenets)
2. Activities
3. Reading List
4. Training Videos

E. Reflective Supervision

1. Supporting Consultants
2. Supporting Supervisors
3. Group Supervision – agenda setting – warming up the space
4. Learning and Healing Activities / Experiences

F. Partnering with Programs and Consultees

1. Program and Classroom Readiness
2. Letter of Commitment
3. Center of Excellence (CoE) Competencies
4. New Competency: Authentic knowledge of community – falling in love
5. Development and implementation of classroom-level and child-level (as appropriate) Action Plan with ECE providers through an equity lens. (Also see CoE Competencies for more examples)
6. Development and implementation of classroom- and program-level Action Plan with ECE Program Director using an equity lens. (Also see CoE Competencies for more examples)

G. Ongoing Professional Development

1. All-Staff Trainings
2. Equity workgroups
3. Affinity groups

C

“

It takes trusting deep relationships where people are willing to hold people’s experience, understand where people have come from, and create opportunities or reflective spaces where people can explore some of those complex intersectional pieces and how it impacts them, their actual response to families.

”

RESULTS

Infrastructure and Model Administration

1. Centralization versus Decentralization

KEY DESIGN CONSIDERATIONS

- To structure the system to best support equity, Oregon’s system should centralize some functions, such as developing standards of practice, training, support and supervision, and evaluation, and decentralize other functions better suited to local customization, e.g., service delivery itself.
- Oregon’s model should likewise consider how to support professional development and reflective supervision for agency-based or independent IECMHCs already practicing in the state.

In designing a statewide public program, a key question is the optimal level of centralization of decision-making and administration. Decentralized systems are commonly understood to allow for more responsiveness to local conditions and to be more nimble, while centralized systems may support greater consistency, fairness, and efficiency. National experts were asked about their experiences with and the equity implications for how IECMHC programs were administered in their areas; programs themselves ranged from highly centralized to highly decentralized.

Based on their experiences, national experts observed that states with decentralized IECMHC systems may face a double-bind when working to build an IECMHC workforce that reflects the communities served. On one hand, consultants based in local communities may be more likely to reflect those communities. There may be great value in having consultants drawn from the community itself; it is reasonable to assume that such consultants already understand the community and are more likely to be viewed with trust. They likewise observed that decentralization may offer a greater degree of flexibility and customization to local conditions in implementation.

At the same time, they said, this perspective also runs the risk of inadvertently prioritizing the experiences and needs of the dominant group in any given area. For example, the reality is that all communities, including rural or frontier communities, are increasingly diverse—yet leadership tends to reflect the dominant group. In that case, local control may also perpetuate implicit biases and patterns in structures that include hiring, training, and supervising that maintain existing underrepresentation of BIPOC consultants, and influence implementation of the model itself. Likewise, consultants drawn from the dominant group may bring their own biases into their consultation work, potentially resulting in patterns of unequal treatment.

Some national experts working within decentralized IECMHC systems indeed reported feeling somewhat powerless, for example, to steer hiring processes in a more equitable direction:

“That was something we talked about very openly and honestly and something that I couldn’t quite get to because of how our structure was. How we got around that was having these conversations with supervisors. The supervisors and the local agencies were the ones making the decisions and filling these positions. We had lots of conversations about what that is, and what that looks like, and why it is, but there wasn’t a lot of movement when I was there.”

“This is an exaggeration, but sometimes I think of our hiring as more like veto power than hiring. If someone is not a fit, we say, ‘This is not a fit. Let’s keep looking.’ It’s not like we’re [using our own proactive criteria for] hiring.”

Furthermore, it is important to point out that without a mandate to provide IECMHC, under a decentralized statewide system, some regions could potentially choose to allocate state funding elsewhere. As one national expert explained:

“One big challenge is how we are funded. It’s a challenge, and it’s a good thing too... Our primary funding is from a state agency. That funding relies on regional councils to make funding decisions on how they are going to distribute funding within each community. Not all communities have access to Mental Health Consultation because it depends on whether or not that region chooses to fund it. Some regions, the funding formula is based on the percentage of children under five that reside in the region, so smaller regions that are less highly populated have less funds, and therefore less or no access to Mental Health Consultation.

We describe ourselves...I’m guilty of saying that we’re statewide because, in a way, we are statewide, but really we’re state available [to] regions [that] opt-in. Now, most of the highly populated regions do opt-in. Some of the lower populated areas, they would love to opt-in, but if they paid for Mental Health Consultation they would have... They are also funding home visiting services, quality improvement systems, oral health, a whole array of strategies to work in the region, and Mental Health Consultation is just one of them. They have to make those tough decisions. When your pot is only so big, it can only go so far, so that’s a real challenge.”

Given these risks, a number of national experts advocated for a thoughtful combination of centralization and decentralization (and standardization vs. customization), in structuring a system to best support racial equity in IECMHC. For example, some pro-

grams have centralized the hiring and reflective supervision pieces, while still drawing consultants from local communities. The success of this approach appears to be partially dependent on the commitment of the centralizing body to ensure BIPOC representation in leadership and supervision. Another approach utilized in one location, is to intentionally contract with culturally specific, community-based organizations to provide IECMHC. The primary drawbacks to using this approach are the unavailability of such programs in some areas, as well as potentially limited organizational capacity to support implementation.

In terms of the contracting relationship between the state and local entities, those we interviewed recommended having straightforward conversations from the start, and working to set expectations around important aspects such as hiring:

“I think having explicit conversations with the leadership at the very beginning about hiring practices and looking at data in terms of what their catchment areas look like, and encouraging that to influence who they hired for this position. Now again, we’re talking often about the relationship between the state and the county, and there can be tricky relationships around how I can’t tell you to do this, and I can’t tell you to do that.”

There is some agreement among experts on common barriers to consistent, high quality IECMHC services when service delivery is decentralized. These barriers include:

- Lack of consistent coordination among local agencies in the provision of IECMHC services.
- Lack of identifiable, consistent IECMHC Standards of Practice that provide structure and accountability in IECMHC service delivery.
- Lack of consistent training on IECMHC services to support IECMHC workforce development.
- Lack of consistent expectations, strategies, and support in anti-racist, anti-bias, and culturally responsive approaches.
- Lack of consistent funding sources to support the use of IECMHC Standards of Practice.

Addressing these barriers will ensure that regional structures, organizations, and/or agencies that house and deliver IECMHC programming are prepared and supported to deliver high quality, consistent, equity-centered services. IECMHC Standards of Practice for regional service delivery can include elements related to service agreements, plan development, organizational structure to support reflective supervision, training, staffing, and evaluation support.

Coordinating with Consultants in the Community

National experts spoke of the potential pitfalls when allowing individuals to operate as independent IECMHCs. Some states encourage such consultants to get ongoing reflective supervision, but neither require nor reimburse for it. This could be particularly problematic when it comes to recognizing and addressing bias in the classroom—and in one’s self. Likewise, it is difficult to gauge whether such consultants might have access to the kinds of ongoing professional development opportunities widely understood as essential to the practice. Experts also expressed concerns regarding the longevity of independent consultants, in the face of deeply challenging work and limited supports.

Developing a way to coordinate between statewide systems and independent consultants working outside an existing state system was shared as both a necessity and a challenge by national experts. Often, independent consultants were exempt from the requirements and expectations that the state-funded consultants were subject to. Considering how the state model will interact with independent consultants will be important as professional development, onboarding, and training requirements and opportunities are developed.

2. Alignment and Coordination with Existing Technical Assistance and Professional Development Systems

KEY DESIGN CONSIDERATIONS

- A wide variety of TA providers work across Oregon in different capacities serving ECE classrooms. Classrooms have different access to TA providers based on available resources. Building relationships and communities of practice with shared language, framework, and theories of change across these various TA providers will support better communication and coordination and is foundational to success for the IECMHC system.
- The system should establish some formal structures for cross-system coordination, such as regular meetings with supervisors from all the TA programs that may be represented in ECE classrooms.
- IECMHCs should connect with other TA providers and coaches working within a given program at least quarterly. Ideally, more frequent case staffings or team meetings should be held when multiple TA providers are supporting a specific child, ECE provider or classroom to align approaches and avoid duplication of effort.

- The system should consider providing a series of trainings using Zoom, accessible to professionals from the range of different ECE TA positions. These trainings should be responsive to the program’s commitment to centering equity and offer an opportunity to build shared frameworks.

National experts as well as Oregon stakeholders noted that ECE providers may have multiple technical assistance (TA) providers, including IECMHCs, working with programs and present in the classroom at the same time. In Oregon, this might include Quality Improvement Specialists who provide training and coaching to ECE providers related to overall instructional quality, instructional coaches, EI/ECSE specialists providing support for specific children, ECE providers’ supervisors, program directors, or school principals, and other coaches or specialists working with ECE providers, ECE programs, and children. Communication and coordination between and among multiple TA providers can be challenging at times, for a variety of reasons, including perceived differences in status and power, different tools used and information provided, and different lenses brought to the work. There may also be concerns about redundancies and inefficiencies, as well as communicating mixed messages to staff and administration.

One expert shared that she tried to develop a document that outlined all the different TA providers and their respective roles in the classroom, but eventually abandoned the effort after consulting with colleagues in other states:

“I talked to ----, and ---- was like, ‘Yeah, we tried. We just decided, let’s not even go there because it was too hard.’”

On the other hand, we learned that some states have been able to establish structures focused on coordination, for example, a monthly meeting with the supervisors of all the TA programs represented in the classroom; a required quarterly meeting for all TA providers serving a program. While reportedly effective, these mechanisms also required a long-term investment of time and energy:

“In the beginning, there were some turf issues of, ‘Wait a minute. This is what I do.’ 10 years later, there’s much more collaboration, and talking things through, and less defensiveness along those lines, which is really important too. As it turns out, there is enough work for everybody. It is time consuming (the collaboration).”

Another national expert talked about developing a shared theory of change across TA providers, to ensure consistency and maximize effectiveness:

“What’s our theory of change around how we help adults respond to the needs of children and families in a culturally sensitive, trauma-informed, strength-based relational way? Are we all on the same page about how we see adults learning?”

Regarding the racial equity work in particular, this expert argued that shared learning and relationship-building across TA providers was important to pushing back on mainstream dominant “mental health” perspectives and interrupting bias:

“We have a lot of coaching models, we have a lot of trainings, but the folks on the ground, they’re often...I’m going to say, ‘Mental health perspective. It’s coming in!’ [bringing a pathology perspective]. It’s a process, and it takes deep relationships and trust to get to a place where you can address things like implicit bias, which is a big topic right now. Even addressing dismantling racism, like anti-racist education practices, to get to those places to affect that kind of change, it’s not a training, from my perspective. It takes trusting deep relationships where people are willing to hold people’s experience, understand where people have come from, and create opportunities or reflective spaces where people can explore some of those complex intersectional pieces and how it impacts them, their actual response to families.”

One state shared an unexpected opportunity presented by COVID-19, which was to provide consistent, comprehensive training to a wide cross-section of child- and family-serving professionals, simply by virtue of the stay-at-home order. The original training was designed with ECE providers and IECMHCs in mind, and intended for an audience of 50 participants per training. With the transition to Zoom, however, hundreds of participants eventually registered for each training, including professionals from public health, mental health, education, early intervention, home visiting, and others.

“Then you had everybody participate because at the beginning they were paying people. They said, ‘We’ll find some professional development because we don’t know what else to have you do.’ [We] got a really mixed audience then... and we had actually a lot of state level people because the state is not going to lay anybody off... Early intervention, I’m telling you we had to have trained at least half of their staff in the state. They had a huge turnout for it.”

ECE providers were actually under-represented in these trainings, due to ongoing responsibilities and limited time for professional development. Over the course of 10 training sessions, this state trained about 1500 professionals, far exceeding the original target.

The content of the training also evolved over the course of the 10

trainings, in response to the increasingly diverse audiences and specific feedback around audience needs and interests. Originally, the training was conceptualized as being specific to trauma-informed family engagement. The trainers realized that they really needed to provide some baseline information around trauma and the impacts on development; next they incorporated content relevant to cultural and historic trauma experienced by local communities. Additional content was likewise added around reflective supervision.

Early feedback from Black participants alerted trainers to some unrecognized aspects of the training that centered mainstream dominant assumptions and perspectives. Consultation was sought from BIPOC colleagues and the training retooled to include considerable content and experiential activities relevant to understanding structural inequities and implicit bias:

“We were three White trainers training this training. Now we had a very diverse audience. I learned through lots of mistakes through this work about how to create a safe space for professionals of color and White professionals to share and learn and be held in very different ways with the same content.”

This state also shared the content of this training with the evaluators and invited Oregon to adapt any aspects of the training that seem useful to the Oregon context. The state shares some similarities with Oregon in being largely rural (predominantly White) with a relatively small number of more racially and ethnically diverse urban centers.

3. Funding Recommendations

KEY DESIGN CONSIDERATIONS

- Build support for ongoing, stable funding from as few sources as possible; Oregon’s state investments in the system bode well for consistency in funding.
- Consider other funding sources, especially those that are more durable and ongoing, and those that allow flexibility (e.g., philanthropy).
- Time-limited federal grants can be useful for testing or implementing specific model pieces as long as concurrent sustainability planning is ensured.
- Allocate sufficient funds from the outset in building the needed state infrastructure for program administration and contracting, technical support and workforce development, systems alignment and coordination, and data systems and evaluation.

A key question for Oregon in building the infrastructure for a statewide IECMHC system is identifying sufficient and sustainable funding. The funding for the model design process and initial planning was provided by the federal Preschool Development Grant (PDG). In the 2021 Legislative session, state legislators invested \$5.8 million in state revenue funds through House Bill 2166 for initial implementation of the statewide IECMHC system. These funds were earmarked for use primarily in the second year of the biennium. In future legislative sessions funds will be requested for operation of the program for the full biennium. Additional conversations amongst state agency leadership will contribute to identifying sources of funding that may be leveraged to support the ongoing operations of a statewide IECMHC system.

Having consistent, stable funding from the state provides a good starting point for Oregon's system. Coordinating multiple funding streams is an ongoing challenge mentioned by stakeholders we spoke with in other states. They shared that IECMHC is often funded by multiple, sometimes short-term, federal funding streams to support IECMHC, with federal Child Care and Development Fund (CCDF) funds being used most often, usually in combination with a variety of other federal funding streams, including:

- Race to the Top
- Project LAUNCH (Linking Actions for Unmet Needs in Children's Health)
- MIECHV (Maternal, Infant and Early Childhood Home Visiting)
- SAMHSA Substance Abuse Prevention (Opioid Response Grant)
- SAMHSA Mental Health Block Grant

More recently, states have also used federal COVID-relief funds (e.g., GEER—Governors Emergency Education Relief; ARPA – American Rescue Plan Act) to supplement IECMHC funding. One state similarly mentioned using disaster relief dollars that were available to CCDF agencies following a flood. Some states also draw on and combine a variety of city, county, and state-level funds, as well as private philanthropic dollars. Multiple national experts talked about the challenges of managing the requirements and expectations of multiple funding streams across sectors and levels of government:

“We have worked to have more of a braided and blended system. With that comes a lot of extra work.”

“Cross-funder consistency [is a challenge]. We developed this... model, but now it's a question of getting everybody to officially buy into it. A lot of our state agency partners contributed to the development of the model on a surface level. They're like, 'Yeah,

this is great.' Now, are they really funding it to the extent that they say they're going to? We might make recommendations on, 'OK, it would be X amount of hours is the dosage,' but maybe they're only funding a quarter of that or something.”

Likewise, many spoke of ways in which available funding—rather than greatest need or best practice—might drive program characteristics, e.g., by determining where the IECMHC is housed/administered; by determining the settings and eligibility for IECMHC services; by determining dosage and duration of services, etc.

National experts also highlighted the “constant” need to advocate for new and additional funding, especially as shorter-term funding streams wind down, with many reporting at least transitory gaps in funding, or funds that seemingly stabilize and stagnate at a lower level than that of the initial start-up phase. Often, the remedy appears to be another, temporary stop-gap measure, rather than identification of a sustainable funding source:

“The last thing we wanted was to tap into another short-term funding source, and that's what happened.”

Several national experts mentioned the important role that philanthropy has played (or sometimes continued to play) in the initial rollout of IECMHC in their states, often funding professional development and program evaluation in particular. Philanthropic funding is especially appreciated for the greater flexibility it typically offers and was highlighted as an important complement to public funding:

“I would say the benefit of grant funding is that you have much more flexibility on things. We give and take. We didn't have a prescribed frequency or dosage other than broad guidelines of 'here's what generally a full caseload looks like.' It's based on need.”

Overall, the national picture was of a complex, patchwork system of typically shorter-term and sub-optimal funding for IECMHC, with correspondingly high administrative and transaction costs. Very few programs reported enjoying relatively stable, dedicated funding streams, such as a state tax (e.g., on tobacco) or a specific city, county, or state-level IECMHC initiative. Not surprisingly, perhaps, the programs with the most stable funding also appear to be some of those with the smallest caseloads, longest service periods, and well-developed approaches to supporting a racially and linguistically diverse IECMHC workforce, as well as equity-focused IECMHC services. By passing its own dedicated IECMHC funding stream to support development of a statewide IECMHC system, Oregon would seem to be on the right track. At the same time, it is important that initial funding streams be used to support the needed statewide infrastructure, workforce

development, and evaluation systems that create the backbone of effective IECMHC systems.

4. Evaluation

KEY DESIGN CONSIDERATIONS

- In order to support accountability and continuous quality improvement, mechanisms for data collection and program evaluation should be developed, budgeted for, and built into the system from the very beginning.
- Consistent with the equity focus of the Oregon model, Oregon’s evaluation should likewise utilize equity-oriented approaches to evaluation, in authentic partnership with BIPOC communities and organizations.
- Developing a logic model for Oregon’s planned system will be an important foundational step for evaluation planning.
- Evaluations should include both implementation measures and key short and longer term outcomes that reflect the breadth and depth of intended outcomes for IECMHC.
- As relevant and appropriate, evaluation planning should take into account lessons learned from past and ongoing evaluations of IECMHC, and draw from existing resources, e.g., successful strategies and tools.

The national experts interviewed were adamant that evaluation should be a core element of any statewide IECMHC model. Further, the National Center for Excellence in IECMHC at Georgetown University includes evaluation as one of the five required components of the IECMHC approach.¹⁴ This idea was reinforced in our interviews with national experts, who noted that evaluation is often treated as an “extra,” but should no more be seen as an optional add-on to the model than reflective supervision or ongoing professional development.

Key functions identified for program monitoring, feedback, evaluation, and research included:

- Understanding who is (and is not) being served, especially in terms of race/ethnicity
- Gauging program satisfaction (on the part of administrators, staff, and families)
- Supporting continuous learning and quality improvement

- Specifying and tracking outcomes
- Understanding the elements of and mechanisms that support effective IECMHC (and for whom)
- Demonstrating effectiveness
- Ensuring accountability to funders

National experts strongly recommended planning for and implementing evaluation right from the start, especially in terms of informing implementation and refinement in the early stages.

“We learned from the evaluation process of how to improve our system and what’s working, and areas to be tweaked.”

Similarly, respondents recommended developing program logic models, identifying expected outcomes and supporting basic consistency in approach/service delivery across sites and consultants. Alongside widespread agreement that IECMHC requires flexibility and customization, there seems to be consensus that some guardrails around the model are also necessary and useful.

“I’ve heard Neil Horen at Georgetown say, ‘Mental health consultation isn’t everything, but it’s also not anything.’”

The National Center for Excellence in IECMHC includes a number of resources¹⁵ for planning and developing quality program monitoring and evaluation systems; in alignment with what we heard from the national experts, developing a logic model that maps out activities and how these are expected to lead to short and long term outcomes are foundational in their evaluation model. Their recommended steps for evaluation are:

Step 1. Develop a Theory of Change and Logic Model

Step 2. Explore Existing Evidence Base

Step 3. Develop Research Questions

Step 4. Select Measurement Tools

Step 5. Analyse and Communicate Results

Additionally, given Oregon’s emphasis on developing an anti-racist, equity-centered IECMHC model, models of equity-focused evaluation should be prioritized (e.g., Ishimaru, 2020). These models are built through collaborative processes and can help ensure that the research questions, measures, and data collection methods are culturally responsive. Further, these methods are community and program-driven, promoting grassroots ownership of data, rather than positioning data as an “add on” re-

¹⁴ <https://www.iecmhc.org/>

¹⁵ <https://www.iecmhc.org/resources/research-and-evaluation/>

quired by the funder (and, which may be seen as having limited value to implementers working “on the ground”).

This approach to evaluation would also help to address concerns raised by national experts, who noted that traditionally-defined rigorous research regarding IECMHC is often not focused on the most important questions for understanding quality and effectiveness. The shortcomings of existing IECMHC research were highlighted, in particular, the focus on relatively brief intervention time periods and shorter-term expected outcomes. This research, it was argued, tells us that IECMHC has positive impacts on the most proximal outcomes, such as ECE provider perceptions, but does not provide a lot of insight into why or how those outcomes result from IECMHC, how enduring they might be, and to what extent classroom environment and practices are transformed. Likewise, there has been little research to date regarding the impact on implicit bias.

In terms of measurement, national experts talked about the inadequacy of focusing exclusively on rates of suspension and expulsion as the primary outcomes of interest. Suspension and expulsion of individual children, they explained, should be viewed as “the tip of iceberg”:

“... It needed to be something that drastic for people to bring their attention to very young children, and to very young children of color, and how they were being treated, but to use suspension and expulsion as the bellwether, feels problematic to me. For every child who’s expelled, we know that there are 10, 20, 30 behind them, children of color, who’ve experienced maybe less intense, but no less harmful, microaggressions, perceptions and about who they are, messages about their inadequacies or their being threatening.”

Although preventing disproportionate suspension and expulsion is important, program capacity building and transformation of classroom climate is seen as having broader and potentially more enduring impacts on quality of care. Likewise, some experts pointed out that child-level outcomes may not be immediately evident, due to various factors, including ongoing stressors outside of the child care setting.

“Sometimes the [child] outcomes are down the road, but we’re very immediate in terms of wanting to see change. I look at things more like...these teachers’ values, how they’re viewing families. The capacity to have empathy, to feel more capable to implement what we call our trauma-informed practices. How they learn to partner with families in a way

where they value families and see them as a partner, a true partner in improving the lives of the children. If I can see this partnership happen, to me, that’s an incredible outcome. I don’t know. We don’t measure those types of pieces, though.”

Overall, a number of relevant outcome variables were identified by the national experts, and should be considered when developing data systems and evaluation for Oregon’s system:

- ECE provider perceptions of children and families
- ECE provider-child interactions
- ECE provider satisfaction with consultation
- Child strengths and challenges
- Classroom quality observation measures, especially focused on social-emotional quality of environments
- Suspension and expulsion rates
- ECE provider stress, support, and well-being
- Measures of implicit racial bias

Other potential mediating variables were also mentioned, such as the quality of the relationship between the consultant and an ECE provider, as well as other important outcomes such as ECE provider turnover rate. Some states have incorporated many of the tools recommended by the CoE, e.g., the Teaching Pyramid Observation Tool for Preschool (TPOT¹⁶), and associated infant-toddler version (TPITOS¹⁷), and end-of-the-year surveys for ECE provider and program administrators:

“What we used to do was only one survey at the end of the year. It was much longer. It asked about satisfaction. It was developed also from the Georgetown toolkit. What did you learn? What skills did you gain? What are you actually implementing? What is the feedback that you want to give us? How was your relationship with the consultant?”

Almost every national expert that we spoke with highlighted the importance of ongoing program evaluation and research to support accountability and continued learning, particularly around the apparent role of IECMHC in addressing racial (and other) biases in the classroom.

Some respondents likewise noted the importance of getting feedback from BIPOC ECE providers and families, as part of that accountability mechanism:

16 <https://products.brookespublishing.com/Teaching-Pyramid-Observation-Tool-TPOT-for-Preschool-Classrooms-Manual-Research-Edition-P759.aspx>

17 <https://brookespublishing.com/product/tpitos/>

“A big piece that we didn’t get to, but I’m fairly certain is happening now, or they will, is finding a mechanism for feedback loops. In our evaluation piece, we had satisfaction surveys and things like that. I would have loved to see a more intentional feedback loop specifically around families and childcare [ECE] providers, bringing them to the table as part of the system to help inform and make decisions going forward.”

Several states shared that data collection was sometimes experienced as burdensome by both programs and consultants, and compliance could be an issue. Whenever possible, they recommend using tools that are useful to ECE providers and consultants and “help inform practice in a real way.”

“Again, we’re not asking you to collect anything that doesn’t have multiple purposes. We want to help you think about how to use this in your consultation. This should be useful information to you. Sometimes you can lose sight of that and just be checking boxes, or like I’m trying to drag this ages-and-stages questionnaire out of somebody, but I’ve lost sight of the fact that this tells me that the child has a developmental delay. That’s important to know. Constantly bringing it back to the purpose of most of it, because it’s a pain. Nobody likes paperwork.”

Likewise, it was noted that supporting data collection required a considerable amount of technical assistance:

“They need a lot of TA to do it well...it requires a lot of technical support and a lot of working into supervision sessions, making meaning of the data.”

Finally, one national expert recommended using a flexible approach to building a robust data system, noting that information needs may change as the programs mature and investing in complex electronic systems too early can be problematic:

“The lesson would be to get your act together before you try to build a data system. We built it too early. There are still some things we’re living with like, I don’t even know why that’s on the interview form at this point except that it’s too hard to change the data system.”

Another similarly cautioned against requiring data collection without also putting in place and supporting an infrastructure for housing and using that data:

“Data collection by consultants takes time so make sure to carve out their time for that, but having a system that collects it and then obviously a team of evaluators is super important, otherwise you’ll be sitting on data that no one looks at.”

In terms of funding for IECMHC, a number of states described initially contracting with an outside evaluator, often funded by philanthropy, to “test” the effectiveness of pilot IECMHC programs. Such evaluations were reportedly helpful in building support for the model, and in some cases, resulted in increased funding and program expansion. In many cases, however, securing funding for ongoing evaluation beyond a basic level of program monitoring has been more challenging. State systems should include ongoing data collection and evaluation in budgeting for needed IECMHC infrastructure from the outset, in order to continually inform and improve model implementation, quality, and effectiveness.

Finally, it is worth noting that there is much to be learned from other state and regional evaluation efforts beyond what could be captured in these stakeholder interviews. Oregon would be well-served to avoid “re-creating the wheel” in terms of evaluation approaches and tools, although at the same time given the unique equity-focused plan for Oregon’s IECMHC model, there are opportunities for evaluation innovation as well. Some existing evaluation resources are compiled by the National CoE, including the evaluation and research methods being used in locations such as Arizona, Arkansas, Colorado, Connecticut, District of Columbia, Illinois, Maryland, Michigan, and Pennsylvania.

Recommendations and Model Considerations Moving Forward

In moving forward, we offer the following summary of design considerations. As stated previously, these are not meant to provide a detailed implementation plan, but instead to serve as foundational guiding principles for building an anti-racist, equity-focused IECMHC system. In finalizing these we sought input on study findings from the IECMHC Steering Committee and from national experts. Additionally, we engaged a facilitator to obtain input from Oregon community representatives. A summary of key themes from these community input sessions is included below. As implementation decisions are made, Oregon would do well to continue to gather input on successes, challenges, and lessons learned, and to continue to hear from BIPOC and other stakeholders about how to best achieve the long-term goal of addressing root causes of disparities in rates of early learning suspension and expulsion in young children.

Summary of Key Design Considerations

- 1. Ensure that the model uses an equity-based, holistic approach** rooted in principles of racial equity and prevention to support the capacity of ECE providers and ECE programs to meet the social/emotional needs of young children. Consultants need to be trained and able to address racism and implicit bias in addition to providing support for social-emotional well-being at the individual child, family, classroom, and program level.
- 2. Ensure a flexible model** that can individualize consultation activities based on needs, strengths, and community context, but which is guided by foundational principles for ensuring a high-quality, equity based approach.
- 3. Provide sufficient on-site/classroom time and limit caseloads** so that consultants and ECE providers can build the authentic, trusting relationships that are needed for their work together. Respondents repeatedly emphasized the importance of having consultants consistently present in a program or classroom, and of being able to spend time “on site” to build the trusting relationships with staff, families, and children that are critical to effective consultation. Providing IECMHC in this way has the added benefit of being seen as normative rather than as “fixing” children or ECE providers. To support these foundational relationships, it was strongly recommended that **caseloads be limited** and **duration of services** be prioritized. National experts generally agreed that 6-months would be the *minimum* time period required for working intensively to address some limited kinds of child-specific issues, but continued to emphasize the importance of consultants building long-term relationships with ECE providers to prevent future crises. For longer-term capacity building, as well as the critical equity and anti-racist work with ECE providers, at least one year of involvement was recommended.

“

What’s our theory of change around how we help adults respond to the needs of children and families in a culturally sensitive, trauma-informed, strength-based relational way? Are we all on the same page about how we see adults learning?”

”

- 4. Ensure equitable access** to consultants based on ECE provider needs and supported by a culturally responsive communication plan and systems that prioritize consultation for smaller programs that do not have access to IECMHC services. This might include moving away from a simple, “first come, first served” model of accepting referrals that is likely to be skewed toward those with the most resources and power. Moreover, avoid stigma and unintended barriers to accessing the services by renaming “Early Childhood Mental Health Consultation” and creating more welcoming language to brand and communicate about its program.
- 5. Create formal templates for outlining services, roles, and expectations for consultants and ECE providers, and include equity work as an expected component.** Respondents agreed that formal agreements between programs and consultants were essential to supporting realistic expectations and effective relationships. Several suggested using a template to clearly lay out goals of the consultation, roles and responsibilities of consultants and ECE providers, types of activities the consultant and ECE provider will engage in, and the timeline and process for both beginning and ending the consultation. Many respondents noted that it was important to specifically include in the agreement elements of the work related to implicit bias and racial equity; the Center of Excellence likewise now recommends setting those expectations up front.
- 6. Develop, hire, and retain qualified BIPOC consultants** who are (1) grounded in a shared history, culture, and language; (2) better positioned to overcome mistrust; and (3) have a deeper understanding and skills for navigating issues related to mental health within BIPOC communities. Ensure consultants have specialized knowledge across multiple disciplines and bodies of knowledge, including the research regarding disproportionate suspension/expulsion and implicit bias in ECE settings, and consider using the Center of Excellence’s IECMHC consultation competencies¹⁸ as a basis for education, training, and hiring. To address the severe shortage of BIPOC consultants, respondents recommended creative problem-solving at multiple levels, ranging from short-term to long-term, and from individual workarounds to coordinated systems-level change. Intentionally and explicitly centering and promoting equity within the state program, from the individual to the system level, was seen as foundational to supporting BIPOC consultants, as was increasing BIPOC representation at the supervisory and administrative levels. White consultants currently in the field should be provided with required training related to equity and interrupting oppression, and supported to do their own work to understand community and historical contexts, White privilege, power, and their own identities and potential biases.
- 7. Ensure that addressing implicit bias and racism is a core part of IECMHC services.** The vast majority of experts interviewed agreed that a key role for consultants is to actively and intentionally address implicit and explicit bias as a root cause of disproportionality in suspension and expulsion rates. The state should develop and implement accountability strategies for ensuring that all IECMHCs and supervisors are housed in regional organizations that demonstrate robust support and commitment to ongoing equity transformation at the organizational and programmatic level.
- 8. Allocate sufficient funds from the outset in building state infrastructure** for program administration and contracting, technical support and workforce development, systems alignment and coordination, and data systems and evaluation. Specifically:
- **Create statewide systems to support implementation** that can reduce workload and improve service quality, while allowing sufficient local flexibility to meet community-driven needs.
 - **Establish state and local level structures for cross-system coordination**, such as regular meetings between cross-agency TA and quality improvement providers at the state, regional, and program level. Within programs, it was recommended that IECMHCs connect with other TA providers and coaches working within a given program at least quarterly, and ideally more frequently.
 - **Plan and implement an ongoing system for program evaluation and data collection** from the beginning. Statewide evaluation systems should be linked to an overarching program logic model, and measures should reflect service implementation as well as a holistic set of intended short and longer-term outcomes. The evaluation should use equity-oriented evaluation approaches that are based on partnerships with the BIPOC community members and organizations that this model is focused on supporting.
- 9. Build support for ongoing, stable funding from as few sources as possible;** Oregon’s state investments in the system bode well for consistency in funding.

¹⁸ <http://www.iecmhc.org/documents/IECMHC-competencies.pdf>

Summary of Community Input Sessions

In order to gain further input on recommendations developed in this report, our team contracted with a facilitator to hold discussions with diverse stakeholders and community partners. In total 48 individuals were interviewed across 5 engagement sessions and 5 individual interviews. Participants in these input sessions included representatives from Health Share Oregon, AFSCME, Relief Nurseries, IECMHCs, Oregon Alliance, and statewide ECE providers. See Appendix E for complete community input session report).

Key findings from these feedback sessions suggested that:

1. Participants were excited about the opportunity.

A majority of participants were excited about the proposed recommendations. Participants particularly highlighted the need for IECMHC in their communities, the focus on BIPOC communities, and saw significant value in its emphasis on supporting ECE providers.

2. Participants voiced concerns reflecting historical distrust and past negative experiences with White-dominant systems. These included:

- a. Fears that IECMHC would be duplicative of existing programs, including supports already being provided by BIPOC-led organizations.
- b. Concerns that the title “IECMHC” would be a barrier for BIPOC ECE providers and family members (overly long, complex, and potentially triggering stigma related to “mental health”).
- c. That a significant amount of responsibility for program success would be placed directly on ECE providers or on the IECMHCs.
- d. Skepticism that the program would be able to achieve the equity goals.

Throughout the feedback sessions, the theme of trust and mistrust emerged—especially from BIPOC ECE providers. Participants emphasized the importance of building trust in consultant-consultee relationships, consultant-community relationships, and community-state relationships. To do this, participants described the need for slowly building authentic relationships across these sets of partners, and in particular with consultants.

In terms of model implementation, ECE providers shared:

1. That they would like to be able to access consultants through multiple channels, including in person, through Zoom/online, and phone.
2. Support for having a centralized hotline, noting

the importance of having a dedicated number to speak to someone in your language,—and especially for Spanish-speaking ECE providers.

3. Finally, reflecting the overarching theme related to the importance of establishing trusting relationships, participants emphasized the importance of being able to work with a specific, identified consultant.

While participants were excited about the proposed program and resonated with the anti-racist focus, there was also considerable wariness about whether a truly anti-racist, anti-bias program could be executed. Creating an innovative system that disrupts assumptions about and patterns of interacting with BIPOC and other minoritized communities will require deeply reflective and creative work, as well as a strong plan for holding all partners accountable for equity-focused consultation.

Study Limitations

As with any study, it is important to note limitations to the methods and findings presented. First, this study focused specifically on engaging community partners to provide input about how an IECMHC model could look in Oregon—results are not meant to generalize more broadly. That said, in interviews with national experts it seems clear that Oregon’s approach is unique nationally, and that there are key lessons from what was learned that can meaningfully inform other IECMHC work that is happening across the country.

Second, participants were recruited using snowball and convenience sampling, and thus those we spoke with may have been those with better understanding of IECMHC, and more vested interest in the model implementation. The sample was constrained by the study timeline and our use of professional connections largely driven by members of the Steering Committee. Further, although we attempted to prioritize culturally and linguistically diverse stakeholders, we do not claim to have a truly “representative” sample and likely missed other important issues in our data collection and interpretation. During the upcoming implementation planning phase of this project, the implementation team should seek out voices that have not yet been heard and take care to implement feedback sessions with those communities, as well as continue to invite additional feedback from all communities.

Finally, and perhaps most importantly, given our time and resources, it was beyond the scope of this project to include parents and families in the data gathering. Learning directly from families with children who have been suspended or expelled from early care and/or who are at risk of being asked to leave services, will be important for future research related to Oregon’s model.

Conclusion and Next Steps

Oregon is in a unique position as the first state to design and implement a statewide IECMHC program that explicitly centers an anti-racist lens. The time is now to invest in and build a transformative IECMHC in Oregon that authentically listens to, learns from, and partners with minoritized communities to keep children in safe and stable early care and education learning environments. One clear message from this project is that there is no single “right” way to implement effective mental health consultation. Instead it is important to build a system based on a shared set of clear values and structures to support an equity-centered IECMHC system, with sufficient flexibility to respond to local contexts, histories, and needs. This report serves as a framework for decision-making to support the vision of an IECMHC system that centers the needs of BIPOC children and families. As we seek to make this a new reality, Oregon must be intentional, self-reflective, and diligent in maintaining the commitment to racial equity in early childhood education.



References

1. Ake, W., & Menendian, S. (2019). Targeted Universalism: Policy & Practice.
2. American Psychological Association Zero Tolerance Task Force. (2008). Are zero tolerance policies effective in the schools?: An evidentiary review and recommendations. *The American Psychologist*, 63(9), 852-862.
3. Ayres, L., Kavanaugh, K., & Knafl, K. A. (2003). Within-case and across-case approaches to qualitative data analysis. *Qualitative Health Research*, 13(6), 871-883. <https://doi.org/10.1177/1049732303013006008>
4. Bates, L. A., & Glick, J. E. (2013). Does it matter if teachers and schools match the student? Racial and ethnic disparities in problem behaviors. *Social Science Research*, 42(5), 1180-1190. <https://doi.org/10.1016/j.ssresearch.2013.04.005>
5. Murray, C., Murray, K. M., & Waas, G. A. (2008). Child and teacher reports of teacher-student relationships: Concordance of perspectives and associations with school adjustment in urban kindergarten classrooms. *Journal of Applied Developmental Psychology*, 29(1), 49-61, 49-61. <https://doi.org/10.1016/j.appdev.2007.10.006>
6. Burton, M., Green, B. L., Miao, A. J., Pears, K. C., Scheidt, D., & Tremaine, E. (2020). Oregon preschool development grant birth to age 5 strengths and needs assessment: Statewide household survey results. https://oregonearlylearning.com/wp-content/uploads/2021/04/FINAL_psu-pdg-ph3-household-survey.pdf
7. Center for excellence for infant and early childhood mental health consultation. (2021). Consultant Competencies. <http://www.iecmhc.org/documents/IECMHC-competencies.pdf>
8. Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London; Thousand Oaks, Calif.: Sage Publications.
9. Conners Edge, N. A., Kyzer, A., Davis, A. E., & Whitman, K. (2021). Infant and early childhood mental health consultation in the context of a statewide expulsion prevention initiative. *Journal of Educational and Psychological Consultation*, 1-22. <https://doi.org/10.1080/10474412.2021.1983440>
10. Creswell, J. W., & Plano Clark, V. L. (2007). *Designing and conducting mixed methods research*. Thousand Oaks, CA: Sage Publications.
11. Davis, A., & Perry, D. (2014). *Healthy futures: Year four evaluation of early childhood mental health consultation by the District of Columbia Department of Behavioral Health*. Washington, DC: Georgetown University Center for Child and Human Development. <https://www.iecmhc.org/wp-content/uploads/2020/12/DC-Healthy-Futures-Year-4.pdf>
12. Davis, A. E., Shivers, E. M., & Perry, D. F. (2018). Exploring culture, race, and ethnicity in early childhood mental health consultation: The role of the consultative alliance. *Perspectives*, 3(2), 149-171. https://www.researchgate.net/publication/329947818_Exploring_Culture_Race_and_Ethnicity_in_Early_Childhood_Mental_Health_Consultation_The_Role_of_the_Consultative_Alliance
13. Dowd, A. C., & Bensimon, E. M. (2015). *Engaging the "race question": Accountability and equity in higher education*. New York: Teachers College Press.
14. Duran, F. B., Hepburn, K. S., Kaufmann, R. K., Le, L. T., Allen, M. D., Brennan, E. M., & Green, B. L. (2010). *Research synthesis: Early childhood mental health consultation*. Nashville, TN: The Center on the Social and Emotional Foundations for Early Learning. http://csefel.vanderbilt.edu/documents/rs_ecmhc.pdf

15. Fabelo, T., Thompson, M. D., Plotkin, M., Carmichael, D., Marchbanks, M. P., & Booth, E. A. (2011). *Breaking schools' rules: A statewide study of how school discipline relates to students' success and juvenile justice involvement*. New York: Council of State Governments Justice Center. <https://csgjusticecenter.org/publications/breaking-schools-rules/>
16. Gillborn, D. (2005). Education policy as an act of white supremacy: Whiteness, critical race theory and education reform. *Journal of Education Policy*, 20(4), 485–505
17. Gilliam, W. S. (2005). *Prekindergarteners left behind: Expulsion rates in state prekindergarten systems*. Foundation for Child Development New York, NY. https://medicine.yale.edu/childstudy/zigler/publications/National%20Prek%20Study_expulsion%20brief_34775_5379_v1.pdf
18. Gilliam, W. S., Maupin, A. N., Reyes, C. R., Accavitti, M., & Shic, F. (2016). Do early educators' implicit biases regarding sex and race relate to behavior expectations and recommendations of preschool expulsions and suspensions? Yale University Child Study Center. https://medicine.yale.edu/childstudy/zigler/publications/Preschool%20Implicit%20Bias%20Policy%20Brief_final_9_26_276766_5379_v1.pdf
19. Gilliam, W. S., & Shahar, G. (2006). Preschool and child care expulsion and suspension: Rates and predictors in one state. *Infants & Young Children*, 19(3), 228–245. <https://doi.org/10.1097/00001163-200607000-00007>
20. Green, B. L., Everhart, M., Gordon, L., & Gettman, M. G. (2006). Characteristics of effective mental health consultation in early childhood settings: Multilevel analysis of a national survey. *Topics in Early Childhood Special Education*, 26, 142–152. <https://doi.org/10.1177/02711214060260030201>
21. Harper, S. R. (2012). Race without racism: How higher education researchers minimize racist institutional norms. *The Review of Higher Education*, 36(1), 9–29.
22. Horowitz, M. (2015). *Early Childhood Suspension and Expulsion*. Center on Enhancing Learning Outcomes (CEELO). 1-6. http://ceelo.org/wp-content/uploads/2015/08/ceelo_annotated_bib_expulsion_2015_08_final_web.pdf
23. Hepburn, K. S., Kaufmann, R. K., Perry, D. F., Allen, M. D., Brennan, E. M., & Green, B. L. (2007). *Early childhood mental health consultation: An evaluation tool kit*. Washington, DC: Georgetown University, Technical Assistance Center for Children's Mental Health; Johns Hopkins University, Women's and Children's Health Policy Center; and Portland State University, Research and Training Center on Family Support and Children's Mental Health. <https://gucchd.georgetown.edu/products/ECMHCToolkit.pdf>
24. Hepburn, K. S., Perry, D. F., Shivers, E. M., & Gilliam, W. S. (2013). Early childhood mental health consultation as an evidence-based practice: Where does it stand. *Zero to Three*, 33(5), 10–19.
25. Howes, C., & Shivers, E. M. (2006). New child-caregiver attachment relationships: Entering childcare when the caregiver is and is not an ethnic match. *Social development*, 15(4), 574–590. <https://doi.org/10.1111/j.1467-9507.2006.00358.x>
26. Hsieh, H.-F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, 15, 1277–1288. <https://doi.org/10.1177/1049732305276687>
27. Ishimaru, A.M. (2020). *Just schools: Building equitable collaborations with families and communities*. New York, NY: Teachers College, Columbia University.
28. Johnston, K., & Brinamen, C. (2006). *Mental health consultation in child care: Transforming relationships among directors, staff, and families*. Zero to Three Press.
29. Kids Connect: Integrated Health and Mental Health Consultation. (n.d.) Early care site readiness assessment. <https://gucchd.georgetown.edu/products/Readiness%20Assessment.pdf>
30. Malik, R. (2017). New data reveal 250 preschoolers are suspended or expelled every day: The new national survey of children's health sheds some light on a troubling epidemic. Center for American Progress. <https://www.americanprogress.org/article/new-data-reveal-250-preschoolers-suspended-expelled-every-day/>
31. Mittleman, J. (2018). A downward spiral? Childhood suspension and the path to juvenile arrest. *Sociology of Education*, 91(3), 183–204. <https://doi.org/10.1177/0038040718784603>
32. Meek, S. E., & Gilliam, W. S. (2016). Expulsion and suspension in early education as matters of social justice and health equity. *NAM Perspectives*.
33. Nicholson-Crotty, S., Birchmeier, Z., & Valentine, D. (2009). Exploring the impact of school discipline on racial disproportion in the juvenile justice system. *Social Science Quarterly*, 90(4), 1003–1018. <https://doi.org/10.1111/j.1540-6237.2009.00674.x>
34. Okonofua, J. A., & Eberhardt, J. L. (2015). Two strikes: Race and the disciplining of young students. *Psychological Science*, 26(5), 617–624. <https://doi.org/10.1177/0956797615570365>
35. Pears, K.C., Miao, A.J., Burton, M., Green, B.L., Hatfield, B. & Scheidt, D. (2021). Survey on the effects of COVID-19 on Oregon's early care & education workforce and programs. Report submitted to the Oregon Early Learning Division and Early Learning Council, June 2021. https://oregonearlylearning.com/wp-content/uploads/2021/07/ppi-provider-survey-FINAL-accessible_7.20.21.pdf
36. Perry, D. F., Dunne, M. C., McFadden, L., & Campbell, D. (2008). Reducing the risk for preschool expulsion: Mental health consultation for young children with challenging behaviors. *Journal of Child and Family Studies*, 17(1), 44–54. <https://doi.org/10.1007/s10826-007-9140-7>
37. Powell, J. A., Ake, W., & Menendian, S. (2019). Targeted Universalism: Policy & Practice. <https://escholarship.org/content/qt9sm8b0q8/qt9sm8b0q8.pdf>
38. Powell, J. A., & Roediger, D. R. (2012). *Racing to justice: Transforming our conceptions of self and other to build an inclusive society*. Indiana University Press.

39. Powell, J., Menendian, S., & Reece, J. (2009). The importance of targeted universalism. Washington: Poverty & Race Research Action Council. <http://www.prrac.org/pdf/MarApr2009PRRACstim.pdf>
40. Saldaña, J. (2016). The coding manual for qualitative researchers (3rd ed.). Thousand Oaks, CA: Sage Publications.
41. Salsberg, E., Quigley, L., Mehfoed, N., Acquaviva, K., Wyche, K., & Sliwa, S. (2017). Profile of the social work workforce. The George Washington University Health Workforce Institute. <https://www.cswe.org/Centers-Initiatives/Initiatives/National-Workforce-Initiative/SW-Workforce-Book-FINAL-11-08-2017.aspx>
42. Shivers, E. M., Farago, F. & Gal-Szabo, D. E. (2021). The role of infant an early childhood mental health consultation in reducing racial and gender relational and discipline disparities between Black and White preschoolers. *Psychology in the Schools*, 2021, 1-19. <https://doi.org/10.1002/pits.22573>
43. Shivers, E. M., Gal, D. & Meaney, C. (2019). Evaluation of Alameda County Behavioral Health Early Childhood Mental Health Consultation Standards of Practice Training and Technical Assistance Pilot. Report prepared by the Indigo Cultural Center. Report prepared for and funded by Alameda County Behavioral Health (ACBH), Child & Young Adult System of Care, Birth – 8 Division. <https://www.iecmhc.org/wp-content/uploads/2020/12/ACBH-ECMHC-SOP-Evaluation-Report-pdf>
44. Skiba, R. J., Arredondo, M. I., & Williams, N. T. (2014). More than a metaphor: The contribution of exclusionary discipline to a school-to-prison pipeline. *Equity & Excellence in Education*, 47(4), 546-564. <https://doi.org/10.1080/10665684.2014.958965>
45. Stegelin, D. A. (2018). Preschool suspension and expulsion: Defining the issues. Institute for Child Success, Greenville, SC. <https://www.instituteforchildsuccess.org/themencode-pdf-viewer/?file=https://www.instituteforchildsuccess.org/wp-content/uploads/2018/12/ICS-2018-PreschoolSuspensionBrief-WEB.pdf>
46. Tracy, S. J. (2019). *Qualitative research methods: Collecting evidence, crafting analysis, communicating impact* (Vol. 2). Chichester, West Sussex, UK: John Wiley & Sons.
47. U.S. Department of Education, O. o. C. R. (2016). 2013-2014 Civil rights data collection a first look: Key data highlights on equity and opportunity gaps in our nation's public schools. Retrieved from <https://www2.ed.gov/about/offices/list/ocr/docs/2013-14-first-look.pdf>
48. Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & Health Sciences*, 15(3), 398-405. <https://doi.org/10.1111/nhs.12048>
49. Yang, M. Y., Harmeyer, E., Chen, Z., & Lofaso, B. M. (2018). Predictors of early elementary school suspension by gender: A longitudinal multilevel analysis. *Children and Youth Services Review*, 93, 331-338. <https://doi.org/10.1016/j.childyouth.2018.08.008>

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Appendix A. Senate and House Bills

House Bill 2166

81st OREGON LEGISLATIVE ASSEMBLY--2021 Regular Session

Enrolled House Bill 2166

Introduced and printed pursuant to House Rule 12.00. Pre-session filed (at the request of Governor Kate Brown for Office of the Governor)

CHAPTER

AN ACT

Relating to education equity; creating new provisions; amending ORS 326.051, 327.254, 329A.280, 329A.330, 342.120, 342.147, 342.437, 342.940 and 348.295 and sections 4 and 5, chapter 756, Oregon Laws 2015; and declaring an emergency.

Whereas an equitable system of education means a system that enables every child to have an equal chance for success in education; and

Whereas an equitable system of education must take into consideration the whole child, including the child's background, personal characteristics, family situation, mental health and social emotional development; and

Whereas all children deserve to receive high quality, culturally responsive, developmentally appropriate and inclusive early childhood care and education regardless of race, ethnicity, language or disability; and

Whereas not all children are given the same opportunity to succeed in education, as children in early childhood care or education programs are disproportionately disciplined based on race, ethnicity, language or disability; and

Whereas there are limited opportunities for early childhood care and education professionals who serve some of this state's most vulnerable low income families to access professional development resources that are culturally specific or language diverse or that are related to behavioral health; and

Whereas providing resources and professional development to early childhood care professionals and educators could improve equity in education by reducing the disproportionate imposition of discipline, including suspension and expulsion; and

Whereas social emotional learning is a central component of an integrated model of mental and emotional health that also includes racial equity, trauma-informed principles and practices and strengths-based multitiered systems of support; and

Whereas social emotional learning skills, in conjunction with racial equity, trauma-informed principles and practices and strengths-based multitiered systems of support, can contribute significantly to mental and emotional health and overall health promotion and can be an integral part of school culture, climate, safety and mental and physical health promotion efforts; and

Whereas social emotional learning skills, in conjunction with racial equity, trauma-informed principles and practices and strengths-based multitiered systems of support, can enable school communities to create just, equitable and inclusive cultures in which all students, staff and leaders belong and feel respected, valued and affirmed in their individual and intersectional interests, talents, social identities, cultural values and backgrounds; and

Whereas social emotional learning skills, in conjunction with racial equity, trauma-informed principles and practices and strengths-based multitiered systems of support, can help schools culti-

Enrolled House Bill 2166 (HB 2166-B)

Page 1

View the full text of House Bill 2166 at <https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB2166>.

vate understanding, examine biases, reflect on and address the impact of racism, build cross-cultural relationships and foster adult and student practices that close opportunity gaps and create more inclusive school communities that deliver high quality educational opportunities and outcomes for all students; and

Whereas social emotional learning should be incorporated into all academic content standards as part of an integrated model of mental and emotional health, with the explicit goal being to promote antiracism and educational equity and to create conditions for all students to thrive; and

Whereas this state's commitment to equity includes a culturally responsive educator workforce, which requires a vigorous and comprehensive commitment to relevant professional development and supports for educators who are serving this state's diverse learners; and

Whereas high quality educator preparation and ongoing, effective professional development and supports for educators are critical variables to an equitable education system, excellent teaching, educator retention and improved learning and development; and

Whereas recent actions taken by the Legislative Assembly have emphasized the need to address professional development for educators who serve children and students in early childhood and in kindergarten through grade 12; and

Whereas this state seeks to recruit and retain more diverse educators for the purposes of enhancing the capacity of all educators to create safe, equitable and inclusive learning environments and addressing institutional racism that limits opportunities for many children and students; now, therefore,

Be It Enacted by the People of the State of Oregon:

EARLY CHILDHOOD SUSPENSION AND EXPULSION PREVENTION

SECTION 1. (1) The Early Childhood Suspension and Expulsion Prevention Program is established. The Early Learning Division shall administer the program as provided by this section.

(2) The purposes of the Early Childhood Suspension and Expulsion Prevention Program are to:

(a) Reduce the use of suspension and expulsion in early childhood care and education programs; and

(b) Reduce disparities in the use of suspension and expulsion in early childhood care and education programs based on race, ethnicity, language, ability or any other protected class identified by the Early Learning Council by rule.

(3) The Early Childhood Suspension and Expulsion Prevention Program shall achieve the purposes described in subsection (2) of this section by:

(a) Incorporating into early childhood care and education programs racial equity, trauma-informed principles and practices and strengths-based multitiered systems of support;

(b) Supporting the capacity of families, educators and early childhood care and education professionals to promote children's social emotional well-being and growth;

(c) Creating a source for early childhood care and education professionals to request technical assistance related to children's social emotional well-being and growth;

(d) Building capacity in communities to deliver technical assistance that supports:

(A) Children's social emotional development;

(B) Children's positive racial identity development;

(C) Antibias practices in early childhood care and education programs; and

(D) Inclusive practices in early childhood care and education programs;

(e) Enhancing community-based supports for families that have a history of trauma, are involved in multiple systems of support or need connection to intervention services;

(f) Providing early childhood care and education professionals with access to technical assistance to support the stability of placements in early childhood care and education programs; and

(g) Developing and supporting practices that reduce the use of suspension or expulsion.

(4) Under the Early Childhood Suspension and Expulsion Prevention Program, the Early Learning Division shall establish:

(a) Common definitions related to antibias practices in early childhood care and education;

(b) Common definitions related to inclusive practices in early childhood care and education;

(c) Common definitions and guidelines for early childhood care and education suspension and expulsion;

(d) Standards and guidelines for program administration and for the delivery of technical assistance services that are culturally responsive and that ensure technical assistance is implemented with a focus on antibias and inclusive practices;

(e) Requirements for knowledge, skills and competencies for technical assistance specialists and mental health consultants participating in the program, with a focus on racial equity, the science of child development, trauma-informed principles and practices, social emotional learning principles, antibias practices and inclusive practices;

(f) Standards for data collection and evaluation to assess the impacts of the program, including eliminating disparities in exclusionary practices based on race, ethnicity, language, ability or other protected classes; and

(g) Requirements that early childhood care and education programs certified or registered under ORS 329A.280 or 329A.330, or receiving public funding for early childhood care and education services, must request services from the Early Childhood Suspension and Expulsion Prevention Program when a young child in an early childhood care or education program is facing potential expulsion.

(5) In support of the Early Childhood Suspension and Expulsion Prevention Program, the Early Learning Division shall coordinate with the Oregon Health Authority to develop a plan for integrated mental and behavioral health and social and emotional supports for children and families, including establishing a resource list of diverse, community-based mental health consultants to support the goals of the suspension and expulsion program.

(6) The Early Learning Council may adopt any rules necessary for the administration of this section.

SECTION 2. ORS 329A.280 is amended to read:

329A.280. (1) A person may not operate a child care facility, except a facility subject to the registration requirements of ORS 329A.330, without a certification for the facility from the Office of Child Care.

(2) The Early Learning Council shall adopt rules for the certification of a family child care home caring for not more than 16 children. The rules shall be specifically adopted for the regulation of certified child care facilities operated in a facility constructed as a single-family dwelling. Notwithstanding fire and other safety regulations, the rules that the council adopts for certified child care facilities shall set standards that can be met without significant architectural modification of a typical home. In adopting the rules, the council may consider and set limits according to factors including the age of children in care, the ambulatory ability of children in care, the number of the provider's children present, the length of time a particular child is continuously cared for and the total amount of time a particular child is cared for within a given unit of time. **The rules must require compliance with the provisions of section 1 of this 2021 Act.**

(3) In addition to rules adopted for and applied to a certified family child care home providing child care for not more than 16 children, the council shall adopt and apply separate rules appropriate for any child care facility that is a child care center.

(4) Any person seeking to operate a child care facility may apply for a certification for the facility from the Office of Child Care and receive a certification upon meeting certification requirements.

(5) A facility described in ORS 329A.250 (5)(d) may, but is not required to, apply for a certification under this section and receive a certification upon meeting certification requirements.

SECTION 3. ORS 329A.330 is amended to read:

329A.330. (1) A provider operating a family child care home where care is provided in the family living quarters of the provider's home that is not subject to the certification requirements of ORS 329A.280 may not operate a child care facility without registering with the Office of Child Care.

(2) A child care facility holding a registration may care for a maximum of 10 children, including the provider's own children. Of the 10 children:

- (a) No more than six may be younger than school age; and
- (b) No more than two may be 24 months of age or younger.

(3)(a) To obtain a registration, a provider must apply to the Office of Child Care by submitting a completed application work sheet and a nonrefundable fee. The fee shall vary according to the number of children for which the facility is requesting to be registered, and shall be determined and applied through rules adopted by the Early Learning Council under ORS 329A.275. The fee shall be deposited as provided in ORS 329A.310 (2). The office may waive any or all of the fee if the office determines that imposition of the fee would impose a hardship on the provider.

(b) Upon receipt of an initial or renewal application satisfactory to the office, the office shall conduct an on-site review of the child care facility under this section. The on-site review shall be conducted within 30 days of the receipt of a satisfactory application.

(4) The office shall issue a registration to a provider operating a family child care home if:

- (a) The provider has completed a child care overview class administered by the office;
- (b) The provider has completed two hours of training on child abuse and neglect issues;
- (c) The provider is currently certified in infant and child first aid and cardiopulmonary resuscitation;

(d) The provider is certified as a food handler under ORS 624.570; and

(e) The office determines that the application meets the requirements of ORS 181A.200, 329A.030 and 329A.250 to 329A.450 and the rules promulgated pursuant to ORS 181A.195, 181A.200, 181A.215, 329A.030 and 329A.250 to 329A.450, and receives a satisfactory records check, including criminal records and protective services records.

(5) Unless the registration is revoked as provided in ORS 329A.350, the registration is valid for a period of two years from the date of issuance. The office may not renew a registration of a provider operating a family child care home unless the provider:

- (a) Is currently certified in infant and child first aid and cardiopulmonary resuscitation;
- (b) Has completed a minimum of eight hours of training related to child care during the most recent registration period; *and*
- (c) Is certified as a food handler under ORS 624.570[.]; **and**

(d) When applicable, has complied with the requirements of section 1 of this 2021 Act prior to imposing an expulsion.

(6) A registration authorizes operation of the facility only on the premises described in the registration and only by the person named in the registration.

(7) The Early Learning Council shall adopt rules:

- (a) Creating the application work sheet required under subsection (3) of this section;
- (b) Defining full-time and part-time care;
- (c) Establishing under what circumstances the adult to child ratio requirements may be temporarily waived; and
- (d) Establishing health and safety procedures and standards on:
 - (A) The number and type of toilets and sinks available to children;
 - (B) Availability of steps or blocks for use by children;
 - (C) Room temperature;

- (D) Lighting of rooms occupied by children;
 - (E) Glass panels on doors;
 - (F) Condition of floors;
 - (G) Availability of emergency telephone numbers; and
 - (H) Smoking.
- (8) The office shall adopt the application work sheet required by subsection (3) of this section. The work sheet must include, but need not be limited to, the following:
- (a) The number and ages of the children to be cared for at the facility; and
 - (b) The health and safety procedures in place and followed at the facility.
- (9)(a) If the Office of Child Care determines that it is necessary to protect the health and safety of the children for whom a child care facility is to provide care, the office may impose a condition on the facility's registration that is reasonably designed to protect the health and safety of children. The office may impose a condition during the application process for an initial registration, during the application process for a renewal of a registration or at any time after the issuance of a registration.
- (b) Except as provided in paragraph (c) of this subsection, when the office imposes a condition on a child care facility's registration, the facility shall be afforded an opportunity for a hearing consistent with the provisions of ORS chapter 183.
 - (c)(A) If the office finds a serious danger to the health and safety of the children receiving care at a child care facility, the office shall notify the facility of the specific reasons for the finding and may impose an emergency condition on the facility's registration without a hearing.
 - (B) If the facility demands a hearing within 90 days after the office notifies the facility of the emergency condition, a hearing consistent with the provisions of ORS chapter 183 must be granted to the facility as soon as practicable after the demand and the agency shall issue an order consistent with the provisions of ORS chapter 183 confirming, altering or revoking the order imposing the emergency condition.
- (10) The office, upon good cause shown, may waive one or more of the registration requirements. The office may waive a requirement only if appropriate conditions or safeguards are imposed to protect the welfare of the children and the consumer interests of the parents of the children. The office may not waive the on-site review requirement for applicants applying for an initial registration or renewal of a registration.
- (11) The Early Learning Council, by rule, shall develop a list of recommended standards consistent with standards established by professional organizations regarding child care programs for child care facilities. Compliance with the standards is not required for a registration, but the office shall encourage voluntary compliance and shall provide technical assistance to a child care facility attempting to comply with the standards. The child care facility shall distribute the list of recommended minimum standards to the parents of all children cared for at the facility.
- (12) In adopting rules relating to registration, the Early Learning Council shall consult with the appropriate legislative committee in developing the rules to be adopted. If the rules are being adopted during a period when the Legislative Assembly is not in session, the Early Learning Council shall consult with the appropriate interim legislative committee.
- SECTION 3a. (1) Section 1 of this 2021 Act and the amendments to ORS 329A.280 and 329A.330 by sections 2 and 3 of this 2021 Act become operative on July 1, 2022.**
- (2) Notwithstanding the operative date set forth in subsection (1) of this section, the Early Learning Division may take any action before the operative date set forth in subsection (1) of this section that is necessary for the division to exercise, on and after the operative date set forth in subsection (1) of this section, all of the duties, functions and powers conferred on the division by section 1 of this 2021 Act and the amendments to ORS 329A.280 and 329A.330 by sections 2 and 3 of this 2021 Act.**
- (3) For the purpose of ensuring that the Early Learning Division may exercise, on and after the operative date set forth in subsection (1) of this section, all of the duties, functions and powers conferred on the division by section 1 of this 2021 Act and the amendments to**

ORS 329A.280 and 329A.330 by sections 2 and 3 of this 2021 Act, the division shall develop and implement a plan for the implementation of section 1 of this 2021 Act and the amendments to ORS 329A.280 and 329A.330 by sections 2 and 3 of this 2021 Act.

(4) No later than February 1, 2022, the Early Learning Division shall report to the appropriate interim committees of the Legislative Assembly. The report shall address the progress on the plan required to be developed and implemented as provided by subsection (3) of this section.

SECTION 3b. (1) The Early Learning Division shall conduct a study on:

(a) The use of suspension and expulsion in early childhood care and education programs; and

(b) Efforts to reduce and prevent the use of suspension and expulsion in early childhood care and education programs.

(2) The division shall report the results of the study required under this section to the appropriate interim committees of the Legislative Assembly no later than September 15, 2024.

SECTION 3c. Section 3b of this 2021 Act is repealed on December 31, 2024.

SOCIAL EMOTIONAL LEARNING STANDARDS

SECTION 4. (1) The Department of Education, in consultation with the Early Learning Division and the Teacher Standards and Practices Commission, shall convene an advisory group to propose for adoption by the State Board of Education:

(a) Social emotional learning standards for public school students in kindergarten through grade 12; and

(b) A statewide social emotional framework for public school students in kindergarten through grade 12.

(2) The standards and framework proposed by the advisory group must:

(a) Be developmentally appropriate;

(b) Align with other models and practices of the department related to mental health;

(c) Include racial equity and trauma-informed principles and practices within strengths-based multitiered systems of support;

(d) Increase public school students' social emotional development;

(e) Promote self-awareness, awareness of others, critical thinking and understanding regarding the interaction between systemic social structures and histories, contributions and perspectives of individuals who:

(A) Are Alaska Native, Native American, Black, African American, Asian, Native Hawaiian, Pacific Islander, Latinx or Middle Eastern;

(B) Are women;

(C) Have disabilities;

(D) Are immigrants or refugees;

(E) Are lesbian, gay, bisexual, transgender, queer, two-spirit, intersex, asexual, nonbinary or another minority gender identity or sexual orientation; or

(F) Have experienced disproportionate results in education due to historical practices; and

(f) Promote the creation of school cultures that support kindness, care, connection, equity, diversity and inclusion.

(3) The advisory group shall submit a report to the board that describes the proposed standards and framework. The board shall consider the report when adopting the standards and framework.

(4) Subject to the direction from the board, the department shall determine the number and frequency of meetings to be held by the advisory group prior to the submission of the report required under subsection (3) of this section.

SECTION 5. (1) The Department of Education shall convene the advisory group required by section 4 of this 2021 Act no later than September 1, 2021.

(2) The report required under section 4 of this 2021 Act must be submitted to the State Board of Education no later than September 15, 2022.

(3) The board shall adopt social emotional learning standards and the social emotional framework described in section 4 of this 2021 Act no later than September 15, 2023.

(4) The board shall require school districts to implement the standards and framework no later than July 1, 2024.

SECTION 6. Sections 4 and 5 of this 2021 Act are repealed on January 2, 2025.

EDUCATOR EQUITY

SECTION 7. ORS 342.437 is amended to read:

342.437. (1) As a result of this state's commitment to equality for the diverse peoples of this state, the goal of the state is that the percentage of diverse educators employed by a school district or an education service district reflects the percentage of diverse students in the public schools of this state or the percentage of diverse students in the district.

(2) [The Department of Education] **The State Board of Education, in consultation with the Educator Advancement Council,** shall use federal reports on educator equity to monitor school district and education service district progress on meeting the goal described in subsection (1) of this section, in relation to the recruitment, hiring and retention of diverse educators.

SECTION 8. ORS 326.051 is amended to read:

326.051. Subject to ORS 417.300 and 417.305:

(1) In addition to such other duties as are prescribed by law and pursuant to the requirement of ORS chapter 183, the State Board of Education shall:

(a) Establish state standards for public kindergartens and public elementary and secondary schools consistent with the policies stated in ORS 326.011.

(b) Adopt rules for the general governance of public kindergartens and public elementary and secondary schools.

(c) Prescribe required or minimum courses of study.

(d) Adopt rules for public kindergartens and public elementary and secondary schools consistent with the policy stated in ORS 342.437.

[(d)] (e) Adopt rules regarding school and interscholastic activities.

[(e)] (f) Adopt rules that provide that no public elementary or secondary school shall discriminate in determining participation in interscholastic activities. As used in this paragraph, "discrimination" has the meaning given that term in ORS 659.850.

[(f)] (g) Adopt rules that will eliminate the use and purchase of elemental mercury, mercury compounds and mercury-added instructional materials by public elementary and secondary schools.

(2) The State Board of Education may:

(a) Consistent with the laws of this state, accept money or property not otherwise provided for under paragraph (b) of this subsection, which is donated for the use or benefit of the public kindergartens and public elementary and secondary schools and use such money or property for the purpose for which it was donated. Until it is used, the board shall deposit any money received under this paragraph in a special fund with the State Treasurer as provided in ORS 293.265 to 293.275.

(b) Apply for federal funds and accept and enter into any contracts or agreements on behalf of the state for the receipt of such funds from the federal government or its agencies for:

(A) Educational purposes, including but not limited to any funds available for the school lunch program;

(B) Career and technical education programs in public elementary and secondary schools; and

(C) Any grants available to the state or its political subdivisions for general federal aid for public kindergartens, public elementary schools and public secondary schools and their auxiliary services, improvement of teacher preparation, teacher salaries, construction of school buildings, ad-

ministration of the Department of Education and any other educational activities under the jurisdiction of the State Board of Education.

(c) Adopt rules to administer the United States Department of Agriculture's National School Lunch Program and School Breakfast Program for public and private prekindergarten through grade 12 schools and residential child care facilities.

SECTION 9. ORS 342.147, as amended by section 8, chapter 756, Oregon Laws 2015, and section 2, chapter 317, Oregon Laws 2017, is amended to read:

342.147. [(1)(a)] (1) The Teacher Standards and Practices Commission shall establish by rule standards for approval of educator preparation providers and educator preparation programs.

(2) Standards for approval of an educator preparation provider may allow approval of an institution of higher education, a school district in this state, an education service district in this state or any other entity in this state that sponsors or provides an educator preparation program.

[(b)] (3)(a) Standards for approval of an educator preparation program must include:

(A) Requiring an educator preparation program to be accredited by a national organization that represents teachers, policymakers and teacher educators and that provides accreditation based on nationally recognized standards and on evidence-based measures; and

(B) Approving a public educator preparation program of more than four years' duration only if educator preparation programs that are reasonably attainable in a four-year period, **or the equivalent**, are also available in the system of higher education and are designed to culminate in a baccalaureate degree that qualifies their graduates for entry-level teaching licenses.

[(c)] (b) Standards for approval of an educator preparation program for early childhood education, elementary education, special education or reading must require that:

(A) The program provide instruction on dyslexia and other reading difficulties; and

(B) The instruction on dyslexia be consistent with the knowledge and practice standards of an international organization on dyslexia.

(4)(a) Notwithstanding subsection (3)(a)(A) of this section, standards for approval of an educator preparation program may allow an educator preparation program to operate provisionally without accreditation by a national organization if the educator preparation program is:

(A) Offered by an accredited educator preparation provider; or

(B) A nontraditional pathway to licensure program offered by an educator preparation provider, regardless of whether the educator preparation provider is accredited.

(b) A nontraditional pathway to licensure program shall be considered an approved educator preparation program if the nontraditional pathway to licensure program complies with standards established by the commission. The commission shall establish standards for nontraditional pathway to licensure programs that:

(A) Are substantially similar to the standards under subsection (3)(a) of this section;

(B) Require the commission to consider the current efforts of educator preparation programs to serve the same educator workforce as the proposed nontraditional pathway to licensure program; and

(C) Require the proposed nontraditional pathway to licensure program to submit to the commission a preoperational capacity review from a national accrediting organization that is approved by the commission.

(c)(A) Nothing in this subsection requires a nontraditional pathway to licensure program to:

(i) Culminate in the granting of a degree; or

(ii) Prohibit a candidate from being employed as an educator while participating in the program.

(B) Nothing in this subsection prevents an accredited educator preparation provider from offering a nontraditional pathway to licensure.

(d) An approved educator preparation program that operates provisionally as provided by this subsection may not operate provisionally for more than four years from the date that the educator preparation program first received approval to operate provisionally.

[2] (5) The commission shall adopt rules that:

(a) Require approved educator preparation programs for early childhood education, elementary education, special education or reading to demonstrate that candidates enrolled in the programs receive training to provide instruction that enables students to meet or exceed third-grade reading standards and become proficient readers by the end of the third grade, as designated by the State Board of Education. For the purposes of this paragraph, an approved educator preparation program may make the demonstration through course curriculum, approved textbooks or other program requirements.

(b) Allow approved educator preparation programs leading to graduate degrees to commence prior to the candidate's completion of baccalaureate degree requirements and to combine undergraduate and graduate level course work in achieving program completion.

[3] (6) Whenever any educator preparation provider or educator preparation program is denied approved status or has such status withdrawn, the denial or withdrawal must be treated as a contested case under ORS chapter 183.

[4] (7) Nothing in this section is intended to grant to the Teacher Standards and Practices Commission any authority relating to granting degrees or establishing degree requirements that are within the authority of the Higher Education Coordinating Commission or any of the public universities listed in ORS 352.002, or that are within the authority of the governing board of any private institution of higher education.

SECTION 9a. (1) Notwithstanding the operative date set forth in section 2, chapter 756, Oregon Laws 2015, as amended by section 9, chapter 756, Oregon Laws 2015, and section 25, chapter 72, Oregon Laws 2018, the Teacher Standards and Practices Commission may take any action before the operative date identified by this subsection that is necessary for the commission to exercise, on and after the operative date identified by this subsection, all of the duties, functions and powers conferred on the commission by the amendments to ORS 342.147 by section 9 of this 2021 Act.

(2) For the purpose of ensuring that the Teacher Standards and Practices Commission may exercise, on and after the operative date identified by subsection (1) of this section, all of the duties, functions and powers conferred on the commission by the amendments to ORS 342.147 by section 9 of this 2021 Act, the commission shall develop and implement a plan for the implementation of the amendments to ORS 342.147 by section 9 of this 2021 Act. The plan must:

(a) Be developed in collaboration with the Educator Advancement Council and the Department of Education; and

(b) Prioritize increasing:

(A) Participation by teacher candidates in nontraditional pathway to licensure programs;

(B) Educator diversity; and

(C) Educator retention.

(3) No later than January 1, 2023, the Teacher Standards and Practices Commission, in collaboration with the Educator Advancement Council and the Department of Education, shall report to the appropriate interim committees of the Legislative Assembly. The report shall address the progress on the plan required to be developed and implemented as provided by subsection (2) of this section.

SECTION 10. Section 4, chapter 756, Oregon Laws 2015, as amended by section 10, chapter 756, Oregon Laws 2015, is amended to read:

Sec. 4. (1) The Teacher Education Program Accreditation Account is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Teacher Education Program Accreditation Account shall be accredited to the account.

(2) Moneys in the Teacher Education Program Accreditation Account are continuously appropriated to the Teacher Standards and Practices Commission to award grants to educator preparation programs for the purpose of having the programs accredited by the organization described in ORS 342.147 [(1)(b)(A)] (3)(a)(A), as amended by section 8 [of this 2015 Act], **chapter 756, Oregon Laws 2015, section 2, chapter 317, Oregon Laws 2017, and section 9 of this 2021 Act.**

SECTION 11. Section 5, chapter 756, Oregon Laws 2015, is amended to read:

Sec. 5. (1) The Teacher Education Program Accreditation Account established by section 4 [of this 2015 Act], **chapter 756, Oregon Laws 2015**, is abolished on July 1, [2022] **2025**.

(2) Any moneys remaining in the account on July 1, [2022] **2025**, that are unexpended, unobligated and not subject to any conditions shall be transferred to the General Fund on July 1, [2022] **2025**.

SECTION 12. ORS 342.120 is amended to read:

342.120. As used in this chapter, unless the context requires otherwise:

(1) "Administrator" includes but is not limited to all superintendents, assistant superintendents, principals and academic program directors in public schools or education service districts who have direct responsibility for supervision or evaluation of licensed teachers and who are compensated for their services from public funds.

(2) "Administrative license" means a license issued under ORS 342.125 (3)(f) or (g).

(3) "Approved educator preparation program" means a licensure program that:

(a) **Prepares persons to become educators in any grade from preprimary through grade 12;**

(b) Is offered by an approved educator preparation provider [and]; and

(c) Meets the standards of the Teacher Standards and Practices Commission, **as provided by ORS 342.147.**

(4) "Approved educator preparation provider" means [an entity] **a sponsor or provider of an educator preparation program** that meets the standards of the Teacher Standards and Practices Commission [for preparation of licensed educators for preprimary programs through grade 12], **as provided by ORS 342.147.**

(5) "Instruction" includes preparation of curriculum, assessment and direction of learning in class, in small groups, in individual situations, online, in the library and in guidance and counseling, but does not include the provision of related services, as defined in ORS 343.035, to a child identified as a child with a disability pursuant to ORS 343.146 to 343.183 when provided in accordance with ORS 343.221.

(6) "Instructional assistant" means a classified school employee who does not require a license to teach, who is employed by a school district or education service district and whose assignment consists of and is limited to assisting a licensed teacher in accordance with rules established by the Teacher Standards and Practices Commission.

(7) "Teacher" includes all licensed employees in the public schools or employed by an education service district who have direct responsibility for instruction or coordination of educational programs and who are compensated for their services from public funds. "Teacher" does not include a school nurse as defined in ORS 342.455 or an instructional assistant.

(8) "Teaching license" means a license issued under ORS 342.125 or 342.144.

(9) "Underrepresented person" means:

(a) A person having origins in any of the black racial groups of Africa, but who is not Hispanic;

(b) A person of Hispanic culture or origin;

(c) A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent or the Pacific Islands; or

(d) An American Indian or [Alaskan] **Alaska** Native having origins in any of the original peoples of North America.

SECTION 13. ORS 348.295 is amended to read:

348.295. (1) In addition to any other form of student financial aid authorized by law, the Higher Education Coordinating Commission may award scholarships to culturally and linguistically diverse

teacher candidates to use at approved educator preparation providers, as defined in ORS 342.120, for the purpose of advancing the goal described in ORS 342.437.

(2) Scholarships awarded under this section shall be in amounts of [\$5,000] **\$10,000** each academic year, for a maximum of two academic years.

(3) The commission shall adopt rules necessary for the implementation and administration of this section in consultation with the Educator Advancement Council and the Department of Education.

SECTION 14. ORS 342.940 is amended to read:

342.940. (1) As used in this section and ORS 342.943, “educator” means a teacher, administrator or other school professional who is licensed, registered or certified by the Teacher Standards and Practices Commission.

[(2)(a) The Educator Advancement Council is created, as provided by ORS 190.010 (5) and with the authority described in ORS 190.110, for the purposes of providing resources related to educator professional learning and other educator supports.]

[(b) The council shall function through an intergovernmental agreement, as provided by ORS 190.003 to 190.130. The intergovernmental agreement shall outline the governance framework and the administrative details necessary for the efficient and effective implementation of the duties of the council.]

[(3)(a) The council shall consist of members who are representatives of the members of the intergovernmental agreement creating the council, including representatives of state agencies, school districts and education service districts].

[(b) In addition to the members of the council specified in paragraph (a) of this subsection, the council shall consist of members who are:]

[(A) Practicing educators, early learning providers and professionals and school district board members; and]

[(B) Representatives of educator preparation providers, education-focused nonprofit organizations, education-focused philanthropic organizations, professional education associations, community-based education organizations that represent families and students, post-secondary institutions of education and federally recognized tribes of this state.]

[(c) The majority of the members of the council identified under paragraphs (a) and (b) of this subsection may identify additional members of the council.]

(2) The Educator Advancement Council shall be established and function under an intergovernmental agreement, pursuant to ORS 190.003 to 190.130. The purposes of the council are to provide resources related to educator professional learning and to provide other educator supports.

(3) Parties to the intergovernmental agreement establishing the council must include:

- (a) The Department of Education;**
- (b) The Early Learning Division;**
- (c) The Teacher Standards and Practices Commission;**
- (d) The Higher Education Coordinating Commission;**
- (e) A school district; and**
- (f) An education service district.**

(4) The intergovernmental agreement establishing the council shall outline the governance framework and the administrative details necessary for the efficient and effective implementation of the duties of the council, including:

(a) Designating the maximum number of members of the council.

(b) Identifying the process for the council to select the chairperson of the council. The chairperson must be one of the members of the council and shall be responsible for overseeing official council business.

(c) Identifying the process for the council to appoint the executive director of the council. Appointment of the executive director must be by written order, filed with the Secretary of State, and the executive director shall serve at the pleasure of the council. The executive director shall be responsible for the daily operations of the council, including the appoint-

ment of all subordinate officers and employees of the council. Officers and employees of the council shall be considered persons in state service for purposes of ORS chapter 240, and, subject to ORS chapter 240, the executive director shall prescribe their duties and fix their compensation.

(5)(a) The council shall consist of:

(A) Members who are representatives of the parties to the intergovernmental agreement establishing the council, as identified in subsection (3) of this section.

(B) No more than 10 members who are practicing educators, early learning providers and professionals and school district board members.

(C) No more than 10 members who are representatives of educator preparation providers, education-focused nonprofit organizations, education-focused philanthropic organizations, professional education associations, community-based education organizations that represent families and students, post-secondary institutions of education and federally recognized Indian tribes of this state.

(b) Subject to any limits designated as provided by the intergovernmental agreement establishing the council, the majority of the members of the council identified under paragraph (a) of this subsection may propose additional members of the council. The inclusion of additional members on the council shall be subject to the procedures established by the council under the intergovernmental agreement.

[(4)] (6) The council shall:

(a) Establish a system of educator networks, as described in ORS 342.943, by which every educator in this state has access to professional learning opportunities;

(b) Coordinate the distribution of moneys to educator networks from the Educator Advancement Fund based on the needs of the educators identified by the networks;

(c) Connect educator networks and facilitate communications within and among the networks to improve teaching and learning; and

(d) Continuously assess the needs of educators in this state and coordinate priorities based on the moneys available for distribution from the Educator Advancement Fund.

[(5)] (7) The Department of Education shall provide support to the strategic direction of the council by:

(a) Conducting and coordinating research to monitor:

(A) Teaching and learning conditions;

(B) Educator workforce supply and demand; and

(C) Common outcomes and measures anticipated to promote improvement in teaching and learning.

(b) Assisting the council in coordinating and connecting educator networks, supporting professional learning priorities, enabling access to professional learning and supports, leveraging funding sources and managing innovation funds.

(c) Recommending statutory and agency rule changes needed to support the purposes of the council.

(d) Supporting programs that help to achieve the purposes of the Educators Equity Act.

(e) Supporting a statewide plan for increasing:

(A) The supply of culturally diverse teacher candidates; and

(B) The successful recruitment of effective educators to work in high-need schools and in practice areas with a shortage of educators.

(f) Identifying high-leverage educator practices to be developed by educators throughout their careers.

(g) Providing accountability of the council by ensuring that the council:

(A) Gives preference, when making recommendations about funding distributions, to entities that have demonstrated success in improving student indicators.

(B) Considers the delivery of services for the benefit of all regions of this state when establishing the system of educator networks.

(C) Works toward improving student progress indicators identified by the Department of Education or set forth in ORS 350.014.

(D) Includes and connects education providers and leaders from prekindergarten through post-secondary education.

(h) Providing staff support for the administrative functions of the council.

(i) Developing a system that allows for the statewide dissemination of emerging practices and evidence-based models.

(j) Providing technical assistance to the council, including online systems for sharing professional learning resources and supporting educator networks.

(k) Administering the distribution of grant and contract funds for programs described in this section.

(L) Providing administrative support to the educator networks, including:

(A) Making recommendations to the council about the selection of the sponsors of educator networks;

(B) Providing technical assistance to educator networks; and

(C) Entering into grant agreements or contracts for the distribution of funds to educator networks.

[(6)(a)] **(8)(a)** The State Board of Education and the Teacher Standards and Practices Commission may adopt any rules necessary at the request of the council to support the council or to perform any duties assigned to the board or commission under this section.

(b) The council may adopt rules pursuant to ORS chapter 183 for the purpose of ORS 342.943.

(9) The council shall be considered a board for purposes of ORS chapter 180.

PUBLIC CHARTER SCHOOL EQUITY

SECTION 15. Section 16 of this 2021 Act is added to and made a part of ORS chapter 327.

SECTION 16. (1) As used in this section:

(a) “ADMw” means weighted average daily membership, as calculated under ORS 327.013.

(b) “Eligible public charter school” means a public charter school that is not a virtual public charter school, as defined in ORS 338.005, and that has a student population of which at least 65 percent of the total student population is composed of students from the following combined student groups:

(A) Racial or ethnic groups that have historically experienced academic disparities, as described in ORS 327.180 (2)(b)(B); and

(B) Students with disabilities, as described in ORS 327.180 (2)(b)(C).

(2) In addition to those moneys distributed through the State School Fund, the Department of Education shall award grants under this section to eligible public charter schools from the Statewide Education Initiatives Account.

(3) The amount of a grant awarded to an eligible public charter school under this section = the public charter school’s ADMw × the difference between:

(a) The amount of the General Purpose Grant per ADMw for the school district that has contractually established payment for the provision of educational services to the public charter school’s students under ORS 338.155 (2) or (3); and

(b) The amount of the General Purpose Grant per ADMw that the public charter school receives under a contract for the provision of educational services to the public charter school’s students under ORS 338.155 (2) or (3).

(4) The purpose of grants distributed under this section shall be to increase academic achievement, including reducing academic disparities, for:

(a) Students from racial or ethnic groups that have historically experienced academic disparities, as determined under rules adopted by the State Board of Education; and

(b) Students with disabilities.

(5) Any eligible public charter school may apply for and receive a grant as provided by this section. A grant application must:

(a) Describe how grant moneys will be used to advance the purpose described in subsection (4) of this section.

(b) Specify the supports that will be:

(A) Provided to students with a disability; or

(B) Used to enhance special education and related services that are provided by a school district under ORS 338.165 to the students of the public charter school.

(c) Identify any applicable longitudinal performance growth targets for the public charter school that have been established:

(A) Under contract between the public charter school and the sponsor of the public charter school; or

(B) By the public charter school or the school district in which the public charter school is located for purposes of grants from the Student Investment Account, as provided by ORS 327.190.

(d) Be submitted based on the timelines and forms prescribed by the department.

(6)(a) If the department determines that a grant application complies with the requirements prescribed under this section, the department shall enter into a grant agreement with the eligible public charter school.

(b) A grant agreement must include longitudinal performance growth targets for the public charter school. If the grant application identified longitudinal performance growth targets, those targets shall be included in the grant agreement. If the grant application did not identify longitudinal performance growth targets, the public charter school shall collaborate with the department to develop longitudinal performance growth targets. Longitudinal performance growth targets must:

(A) Be based on data available for longitudinal analysis; and

(B) Use the following applicable metrics:

(i) Third-grade reading proficiency rates, as defined in ORS 327.190;

(ii) Regular attendance rates, as defined in ORS 327.190; and

(iii) Any other metrics identified by the department in collaboration with the public charter school.

(7) After the department and the public charter school have entered into a grant agreement, the department shall award a grant to the public charter school in the amount calculated under subsection (3) of this section. A grant recipient shall deposit grant moneys received under this section into a separate account and shall apply the amounts in that account as provided by the grant agreement.

(8)(a) Each year, each grant recipient must submit to the department a description of:

(A) How grant moneys received under this section were used to advance the purpose described in subsection (4) of this section and to meet performance growth targets in the grant agreement; and

(B) Progress made by the grant recipient toward meeting the performance growth targets in the grant agreement.

(b) A grant recipient shall provide the information required under this subsection based on the timelines and forms prescribed by the department. To the greatest extent practicable, the department shall accept the information described in this subsection in the manner that it is made available by a public charter school to the sponsor of the public charter school.

(9) To the greatest extent practicable, any requirements prescribed by the department or the board under this section in relation to an application, a grant agreement or the submission of information under subsection (8) of this section shall reduce any redundancies between a grant awarded under this section and a grant awarded from the Student Investment Account. Reduction in redundancies includes accepting for the purposes of grants awarded under this section any applicable forms or information submitted by the public

charter school to the department or a school district for the purposes of a grant awarded from the Student Investment Account.

(10) A public charter school and a school district may not consider moneys received by the public charter school under this section when establishing payment for the provision of educational services to the public charter school's students under ORS 338.155 (2) or (3).

(11) Prior to November 1 of each odd-numbered year, the department shall submit to the appropriate interim legislative committees a report related to the grants awarded under this section. The report must describe:

(a) The public charter schools that applied for the grants and the public charter schools that received the grants;

(b) The longitudinal performance growth targets included in grant agreements, as provided by subsection (6)(b) of this section; and

(c) Progress made toward meeting longitudinal performance growth targets, as reported under subsection (8)(a) of this section.

(12) The State Board of Education shall adopt any rules necessary for the distribution of grants under this section.

SECTION 17. ORS 327.254 is amended to read:

327.254. (1) The Department of Education shall use moneys in the Statewide Education Initiatives Account to provide funding for statewide education initiatives, including:

(a) Funding the High School Graduation and College and Career Readiness Act at the levels prescribed by ORS 327.856;

(b) Expanding school breakfast and lunch programs;

(c) Operating youth reengagement programs or providing youth reengagement services;

(d) Establishing and maintaining the Statewide School Safety and Prevention System under ORS 339.341;

(e) Developing and providing statewide equity initiatives, including the black or African-American education plan developed under ORS 329.841, the American Indian or Alaskan Native education plan developed under ORS 329.843, the Latino or Hispanic education plan developed under ORS 329.845 or any similar education plan identified by the department;

(f) Providing summer learning programs at schools that are considered high poverty under Title I of the federal Elementary and Secondary Education Act of 1965;

(g) Funding early warning systems to assist students in graduating from high school, as described in ORS 327.367;

(h) Developing and implementing professional development programs and training programs, including programs that increase educator diversity and retain diverse educators;

(i) Planning for increased transparency and accountability in the public education system of this state;

(j) Providing additional funding to school districts participating in the intensive program under ORS 327.222;

(k) Providing technical assistance, including costs incurred for:

(A) The coaching program described in ORS 327.214; and

(B) The intensive program described in ORS 327.222, including costs for student success teams;

(L) Funding public charter schools, as described in section 16 of this 2021 Act;

[(L)] **(m)** Funding education service districts, as described in subsection (2) of this section; and

[(m)] **(n)** Funding costs incurred by the department in implementing this section and ORS 327.175 to 327.235 and 327.274.

(2)(a) The amount of a distribution to an education service district under this section = the education service district's ADMw × (the total amount available for distribution to education service districts in each biennium ÷ the total ADMw of all education service districts that receive a distribution).

(b) For purposes of this subsection, ADMw equals the ADMw as calculated under ORS 327.013, except that the additional amount allowed for students who are in poverty families, as determined under ORS 327.013 (1)(c)(A)(v)(I), shall be 0.5.

(c) An education service district shall use moneys received under this section as provided by a plan developed by the school districts located within the education service district. A school district that declines to participate in the development of the plan or that has withdrawn from an education service district as provided by ORS 334.015 is not entitled to any moneys distributed to the education service district under this subsection.

(d) A plan developed under this subsection must:

(A) Align with and support school districts in meeting the performance growth targets of the school districts developing the plan;

(B) Include the provision of technical assistance to school districts in developing, implementing and reviewing a plan for receiving a grant from the Student Investment Account;

(C) Provide for coordination with the department in administering and providing technical assistance to school districts, including coordinating any coaching programs established under ORS 327.214; and

(D) Be adopted and amended as provided for local service plans under ORS 334.175 and approved by the department.

(e) Each education service district must submit an annual report to the department that:

(A) Describes how the education service district spent moneys received under this subsection; and

(B) Includes an evaluation of the education service district's compliance with the plan from the superintendent of each school district that participated in the development of the plan.

(3) The State Board of Education shall adopt rules necessary for the distribution of moneys under this section.

SECTION 18. Section 16 of this 2021 Act and the amendments to ORS 327.254 by section 17 of this 2021 Act become operative on July 1, 2022.

APPROPRIATIONS

SECTION 19. In addition to and not in lieu of any other appropriation, there is appropriated to the Department of Education, for the biennium beginning July 1, 2021, out of the General Fund, the amount of \$5,800,000 for the Early Childhood Suspension and Expulsion Prevention Program established under section 1 of this 2021 Act.

SECTION 20. In addition to and not in lieu of any other appropriation, there is appropriated to the Teacher Standards and Practices Commission, for the biennium beginning July 1, 2021, out of the General Fund, the amount of \$527,792 for the development of standards for nontraditional pathway to licensure programs under ORS 342.147.

SECTION 21. Notwithstanding any other law limiting expenditures, the amount of \$2,000,000 is established for the biennium beginning July 1, 2021, as the maximum limit for payments of grants-in-aid, program costs and purchased services by the Department of Education from the Statewide Education Initiatives Account established under ORS 327.250, for grants awarded to public charter schools under section 16 of this 2021 Act.

CAPTIONS

SECTION 22. The unit captions used in this 2021 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2021 Act.

EFFECTIVE DATE

SECTION 23. This 2021 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2021 Act takes effect July 1, 2021.

Passed by House June 25, 2021

.....
Timothy G. Sekerak, Chief Clerk of House

.....
Tina Kotek, Speaker of House

Passed by Senate June 26, 2021

.....
Peter Courtney, President of Senate

Received by Governor:

.....M,....., 2021

Approved:

.....M,....., 2021

.....
Kate Brown, Governor

Filed in Office of Secretary of State:

.....M,....., 2021

.....
Shemia Fagan, Secretary of State

81st OREGON LEGISLATIVE ASSEMBLY--2021 Regular Session

**Enrolled
Senate Bill 236**

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with pre-session filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of Senate Interim Committee on Education for Children's Institute)

CHAPTER

AN ACT

Relating to discipline used in early learning; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. (1) The Early Learning Division shall conduct a study on:

- (a) The use of suspension and expulsion in early childhood care and education programs; and
- (b) Efforts to reduce and prevent the use of suspension and expulsion in early childhood care and education programs.

(2) The division shall report the results of the study required under this section to the appropriate interim committees of the Legislative Assembly no later than September 15, 2024.

SECTION 2. Section 1 of this 2021 Act is repealed on December 31, 2024.

SECTION 3. An early childhood care or education program may not suspend or expel any child if the program receives state public funds from the Early Learning Division or the program is certified under ORS 329A.280 or registered under ORS 329A.330.

SECTION 4. (1) Section 3 of this 2021 Act becomes operative on July 1, 2026.

(2) Notwithstanding the operative date set forth in subsection (1) of this section, the Early Learning Council and the Early Learning Division may take any action before the operative date set forth in subsection (1) of this section that is necessary to enable the council and division to exercise, on and after the operative date set forth in subsection (1) of this section, all of the duties, functions and powers conferred on the council and division by section 3 of this 2021 Act.

SECTION 5. No later than July 1, 2022, the Early Learning Division must submit to the appropriate interim committees of the Legislative Assembly a report on the proposed implementation of section 3 of this 2021 Act. The report must include a description of the processes for conducting investigations and contested case hearings under ORS chapter 188 for any violations of section 3 of this 2021 Act and must make any related recommendations for legislation.

SECTION 6. This 2021 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2021 Act takes effect July 1, 2021.

View the full text of Senate Bill 236 at <https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/SB236>.

Passed by Senate May 4, 2021

Repassed by Senate June 24, 2021

.....
Lori L. Brocker, Secretary of Senate

.....
Peter Courtney, President of Senate

Passed by House June 22, 2021

.....
Tina Kotek, Speaker of House

Received by Governor:

.....M....., 2021

Approved:

.....M....., 2021

.....
Kate Brown, Governor

Filed in Office of Secretary of State:

.....M....., 2021

.....
Shemia Fagan, Secretary of State

Appendix B. Steering Team Membership

Steering Team Membership

Purpose: The Oregon Infant and Early Childhood Mental Health Consultation (IECMHC) Steering Committee guided the process to engage stakeholders to develop recommendations for the IECMH Consultation model from September 2020-November 2021. PSU is the Early Learning Division's contracted partner to interview stakeholders and assess findings to create the recommended components that will inform the IECMH model.

Name	Organization	Expertise or Representation
Jon Reeves	Early Learning Division	Community systems and professional learning
Andi Bales Molnar	Early Learning Division	Early Learning Professional Learning System
Kimberly Moua	Early Learning Division	Early Childhood Equity Fund
Valeria Atanacio	Early Learning Division	Tribal Affairs in Early Care and Education
Miriam Cecilia	Early Learning Division	Child Care Licensing
Meredith Villines	DOE EI/ECSE	Oregon EI/ECSE, Inclusion, Pyramid Model
Laurie Theodorou	OHA Child and Family Behavioral Health	Infant & Early Childhood Mental Health
Fran Pearson	OHA Behavioral Health	School-based mental health and IECMH
Karissa Palmer	Multnomah Preschool for All	Early care and education program implementation
Hadiyah Miller	CCR&R Multnomah County	Coaching Manager at CCR&R, Co-founder and leadership for Black Child Development PDX
Marina Merrill	Children's Institute	Early childhood systems, quality improvement, intersectionality of research, program, and policy
Soobin Oh	Children's Institute	Early care and education implementation, anti-bias/anti-racist early education practices
Elena Rivera	Children's Institute	Early childhood health, Medicaid policy, CCO delivery system
Claudia Vargas	Ford Family Foundation	Rural Oregon and community implementation of IECMH
Robin Hill-Dunbar	Ford Family Foundation	Rural Oregon and community implementation of IECMH
Beth Green	PSU	Early Childhood & Family Support Research
Jessica Rodriguez-JenKins	PSU	Early Childhood & Family Support Research
Lorelei Mitchell	PSU	Early Childhood & Family Support Research
Elizabeth Tremaine	PSU	Early Childhood & Family Support Research
Carey McCann	BUILD Initiative	Early childhood systems, expulsion and suspension policy and systems development in states
Sheila Smith	National Center for Children in Poverty	Early childhood and social-emotional health research and policy, national trends and state examples

Appendix C. Interview Protocols

National Experts

Developing a Statewide System for Infant/Early Childhood Mental Health Consultation

Interview protocol for national expert stakeholders

Interviewer name: _____

Date of Interview: _____

Respondent ID#: _____

Thank you for agreeing to talk with me today. As you may know, the state of Oregon is prioritizing work to address the known disparities in the rates of preschool suspension and expulsion for children of color. As part of this effort, the Oregon Early Learning Division is working on a statewide model for Early Childhood Mental Health Consultation that promotes the strengths and assets of children, families, and providers of color, and which creates a system that prioritizes their preferences and experiences. We are reaching out to you today because of your involvement in early childhood mental health consultation, and hope to learn more about the approaches and models that you are familiar with so we can bring that information into Oregon's planning process.

Before we start, I'd like to review the consent form with you. Did you receive the consent form we emailed you?

IF YES – Great, please follow along while I review the form with you.

IF NO – Ok, I will resend you a copy when we're finished. Can I send this to your email address?

[REVIEW CONSENT FORM – Voluntary nature of the interview, confidentiality, risks/benefits]

YOUR PARTICIPATION IS VOLUNTARY. You may stop participating at any time and you may choose not to answer questions.

CONFIDENTIALITY. Your responses will be kept confidential. We will ask permission to share any specifics in the final report and with the ELD and if you would like anything removed from our notes or transcripts. The information collected will only be used only for this project.

RISKS. There are no major risks associated with participating, however you may feel uncomfortable with some of the topics. It is possible some of this information may be seen by people outside the project, so we will not put your name on any of the materials including the transcript of this interview.

BENEFITS. You will help leaders at the Early Learning Division understand how Infant and Early Childhood and Mental Health Consultation services can be designed in ways that best support Oregon's care providers, children, and families. As a thank you for your time you will receive a \$50 amazon gift card.

1

Developing a Statewide System for Infant/Early Childhood Mental Health Consultation

[Ask for permission to record and certify consent has been provided on the consent form; record the participants verbal consent].

I'd like to ask your permission to record our conversation today. We will use our notes and the recording to make a transcript of the interview. After we have the transcript, we will delete the notes and recording. The transcript will not include your name or other ways to identify you.

Is it okay with you if I start the recording now? Yes:___ No: ___

[Start recording]

Do you have any questions before I begin?

[Get consent]

Great - do you agree to participate in the interview? Yes:___ No: ___

In preparation for this interview, I've done some background research on your program...I understand [short summary blurb about program approach]...is that about right? Any clarifications you'd like to add?

Great, so let me start out by asking...

1. What would you say have been the biggest implementation successes in your state / with this program?

2. What have been the biggest implementation challenges?
 - a. How did the program address or work through these challenges?
 - b. What were the biggest "lessons learned" in implementing the program?
 - i. Are there things you would do differently, and if so, what are they?

3. Please tell me about the funding and administration of the ECMHC system.
 - a. How is the program funded?
 - b. Where does the program "live" in terms of agency auspices/oversight?
 - i. Is it state-administered or contracted out?
 1. If state-administered, what state agency(ies)/entity(ies) houses the program?
 - a. What's worked well? What are the challenges?
 2. If contracted out, what does that look like?
 - a. What's worked well? What are the challenges?
 - ii. Is the program centralized or decentralized?

Developing a Statewide System for Infant/Early Childhood Mental Health Consultation

- c. How, if at all, have the funding mechanism(s) driven program structure?
 - d. Overall, what are the advantages of your current administration and financing structures?
 - i. What are the challenges?
 - e. What are the equity implications for how the program is funded/administered?
 - i. Are there any ways that the funding or administrative structure acts as a barrier for BIPOC organizations, staff or families?
 - f. What is the long-term plan for ongoing funding (if applicable)?
4. Please tell me about providers and families involved in early childhood mental health consulting in your state....
- a. *[Skip if addressed in program materials or description provided]* What are the typical settings/types of providers involved?
 - b. *[Skip if addressed in program materials or description provided]* About how many programs/providers does a consultant support at a given time - and does this seem 'about right' in terms of caseload?
 - c. Approximately what proportion of providers are Black, Indigenous, or Persons of Color and/or speak languages other than English?
 - d. Approximately what proportion of families are Black, Indigenous, or Persons of Color and/or speak languages other than English?
 - e. To what extent do consultants reflect the cultural, racial, and linguistic backgrounds of providers served? Of families served?
5. To what extent have consultants been able to engage providers and families of color?
- i. What has supported effective engagement of BIPOC providers and families?
 - ii. Where have challenges been encountered?
6. How, if at all, do early childhood mental health consultants play a role in addressing the disproportionate suspension/expulsion of children of color?
- a. What does that look like in practice?
 - b. What kinds of training or other supports are provided to consultants around racial equity and culturally-responsive practice?
 - c. What role does supervision play (either consultants supervising/working with staff or supervision provided to consultants themselves)?

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- d. **[If not addressed above]** To what extent do you think implicit or explicit racial bias plays a role in the disproportionate suspension/expulsion of children of color?
- i. Why or why not?
7. What would you say have been the major “lessons learned” in your state’s implementation of early childhood mental health consultation, specifically around serving providers and families of color?
- a. What might you do differently next time?
 - b. What advice would you have for other states, such as Oregon, working to develop a model that explicitly centers providers and families of color?
8. My next questions have to do with the early childhood mental health consultant workforce. What are the strengths of your state’s current system for recruiting, training and supporting Early Childhood Mental Health Consultants?
- a. Are there any strategic efforts in place to recruit and retain more BIPOC consultants, and if so, what does that look like?
 - b. What are the qualifications for Early Childhood Mental Health Consultants in your state?
 - i. Is this different that your consultation workforce for rural and BIPOC communities?
 - c. What efforts has your state taken to ensure a strong infrastructure with reflective supervision for consultants?
 - i. Are there other ways that you support your consultants?
 - d. Do you have any training curricula you use that you would be willing to share?
9. How, if at all does the state coordinate the role of the early childhood mental health consultants with the other early childhood technical assistance resources that are going into programs [e.g., CLASS or other observations and coaching, TQRIS, licensing specialists, etc.]?
- a. Are there things you would suggest to better coordinate these two systems, and if so, what?
10. Tell me about how program evaluation was approached for your state's early childhood mental health consultation work?
- a. What is the primary goal of the program evaluation?

Developing a Statewide System for Infant/Early Childhood Mental Health Consultation

- b. Do you collect ongoing data for quality improvement?
[examples: data on how consultants spend their time, who is served, outcome data]
 - i. **If yes:** What data do you collect, and how is it used to support quality?
- c. What might you do differently next time?
- d. What are the most important early indicators of progress toward an effective consultation system/model, and how are these measured *[If not covered previously]*?

Interviewer Note: If time is short, ask if it is possible to send remaining questions via email or a brief survey. THEN SKIP TO Q13.

- 11. To what extent are the mental health and other needs of child care providers currently being addressed?
[examples: quality improvement, addressing exclusionary practices, families that need economic and housing supports]
 - a. What strategies seem to have the most impact?
 - b. To what extent are mental health consultants playing a role?
 - c. To what extent are early childhood network providers playing a role?
- 12. What do you think are the top 3-4 issues that lead children to be asked to leave care in your state? Why do you think these issues come up *{What are the root causes/contributors to these issues?}*
- 13. Is there anything else you think would be helpful for us to know about your experiences, or advice to Oregon as it moves forward to design ECMHC options?

For Participants Who Did Not Complete On-Line Survey:

Before we finish the interview, I wanted to check to see if you had a chance to fill out the survey we emailed you? These are just to get some basic demographic information about you. I can resend the link to the survey.

That's all the questions I have for you today. Thank you so much for taking the time to talk with me. We'll be working on putting all the information together and plan to have a final report to share at the end of the year. Please don't hesitate to contact me if you have any other questions or additional thoughts or suggestions.

Interviewer Reflection:

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[Please document any contextual information that might help you remember this conversation or that might help any coders in the analysis.]

Developing a Statewide System for Infant/Early Childhood Mental Health Consultation

Interview protocol for **Early Childhood Education Leadership**

Interviewer name: _____

Date of Interview: _____

Respondent ID#: _____

Thank you for agreeing to talk with me today. As you may know, the state of Oregon is prioritizing work to address the known disparities in the rates of preschool suspension and expulsion for children of color. As part of this effort, the Oregon Early Learning Division is working on a statewide model for Early Childhood Mental Health Consultation that promotes the strengths and assets of children, families, and providers of color, and which creates a system that prioritizes their preferences and experiences. We are reaching out to you today because of your involvement in early childhood mental health consultation, and hope to learn more about the approaches and models that you are familiar with so we can bring that information into Oregon's planning process.

Before we start, I'd like to review the consent form with you. Did you receive the consent form we emailed you?

IF YES – Great, please follow along while I review the form with you.

IF NO – Ok, I will resend you a copy when we're finished. Can I send this to your email address?

[REVIEW CONSENT FORM – Voluntary nature of the interview, confidentiality, risks/benefits]

YOUR PARTICIPATION IS VOLUNTARY. You may stop participating at any time and you may choose not to answer questions.

CONFIDENTIALITY. This interview is also confidential. The information you share will not be linked to you or any personal information about you. When we write up the findings from all the interviews, the report will include overall themes that we've heard.

That said, I can't keep anything related to you harming yourself or others confidential.

RISKS. There are no major risks associated with participating, however you may feel uncomfortable with some of the topics. It is possible some of this information may be seen by people outside the project, so we will not put your name on any of the materials including the transcript of this interview.

BENEFITS. You will help leaders at the Early Learning Division understand how Infant and Early Childhood and Mental Health Consultation services could be better for Oregon's care providers, children, and families. As a thank you for your time you will receive a \$50 amazon gift card.

Developing a Statewide System for Infant/Early Childhood Mental Health Consultation

[Ask for permission to record and certify consent has been provided on the consent form; record the participants verbal consent].

I'd like to ask your permission to record our conversation today. We will use our notes and the recording to make a transcript of the interview. After we have the transcript, we will delete the notes and recording. The transcript will not include your name or other ways to identify you.

Is it okay with you if I start the recording now? Yes: ___ No: ___

[Start recording]

Do you have any questions before I begin?

[Get consent]

Great - do you agree to participate in the interview? Yes: ___ No: ___

Great, to start, are you familiar with the Early Childhood Mental Health Consultation approach?

If NOT FAMILIAR with ECMHC: Let me tell you a little bit about the approach. Early Childhood Mental Health Consultation involves providing training and coaching to child care and early care and education providers that helps promote healthy social-emotional development, and which builds on child, family and provider strengths to ensure inclusive, supportive care for all children. The approach can include a variety of supports, such as training, observations of children and classrooms, coaching, mentoring, and one-on-one consultation. These consultation services are typically provided by someone with deep knowledge of social-emotional development and the ability to support providers, families, and children in ways that promote positive behavior and emotional well-being. The hope is that providing these supports will help reduce the number of children, and especially children of color, who are asked to leave preschool and early childhood settings because of their social, emotional, and behavioral needs. To provide information about how to best create effective consultation supports and systems, PSU is conducting interviews with current consultants, early care and education providers, and child care/early childhood program administrators. These questions are designed to help us understand what Consultation supports programs already have in place, what's working, and what's most needed. **[Proceed to Question 1]**

If FAMILIAR with ECMHC: The hope is that providing Early Childhood Mental Health Consultation will help reduce the disproportionate rate of preschool and early childhood suspension and expulsion. To help support this design work, PSU is conducting interviews with current consultants, early care and education providers, and child care/early childhood program administrators. **[Proceed to Question 1]**

Developing a Statewide System for Infant/Early Childhood Mental Health Consultation

1. Tell me a little about the kinds of coaching, training, and other supports that your program has in place right now to help staff promote positive behaviors and meet children’s social, emotional, and behavioral needs. [If you use Early Childhood Mental Health Consultation, we will ask specifics about that in a moment.]

[Prompts: Staff/teacher trainings (ask for description, examples)? Behavior Consultants? Observations? Informal vs. formal?]
2. What would help strengthen these supports to improve their effectiveness, and build on your staff’s strengths?
3. What are the biggest challenges your teachers/providers have in meeting the social-emotional needs of children in their care?
 - a. How often, if ever, do children need to be removed from the classroom?
 - b. How often, if ever, are children asked to leave the program, or “take a break” from care because of their social, emotional, or behavioral needs?
 - c. What kind of supports would help your staff be better able to meet these needs?
4. How would you describe the cultural and linguistic characteristics of the children and families your program works with?
5. Has your program worked with and/or is your program currently working with an Early Childhood Mental Health Consultant? **[If YES, proceed to 5a; If NO, skip to Question 15]**
 - a. Tell me a little about your current model and approach to working with these consultants? What kinds of supports do they provide?
 - b. *Follow up questions to ask if not mentioned:*
 - i. *[Access]:* When your program or staff needs to consult with a Mental Health Consultant, how do they get access to these supports?
 - ii. *[Frequency, Duration, Intensity]* How often does your program receive consultant services? How long does consultation typically last?
 - iii. *[Settings]* In what setting(s)? *[In classrooms, with families, supervision/staff groups, etc.]*

Developing a Statewide System for Infant/Early Childhood Mental Health Consultation

- iv. *[Challenges/Concerns]* What kinds of concerns do your staff typically bring to consultants?
 - v. *[Promotion]* To what extent, if at all, does your consultant provide support that promotes general social-emotional well being for children, families or your staff?
6. What has been most helpful to your staff about working with Consultants?
7. What has been most challenging?
8. What would help strengthen these supports to improve their effectiveness, and build on your staff's strengths?
9. To what extent would you say that the supports provided by Early Childhood Mental Health Consultation are culturally responsive to your staff and the children and families in the program?
- i. Why or why not?
 - ii. What would be needed to make this approach more culturally-responsive?

Organizational Readiness [For programs working with ECMHC]

10. When did you first start working with Mental Health Consultants?
11. How did staff respond to the approach at first? Over time?
12. What kinds of changes or structures, if any, did you need to put into place organizationally, to support Early Childhood Mental Health Consultation?
13. Given your experience, what suggestions do you have for supporting statewide implementation of this Consultation approach?

Developing a Statewide System for Infant/Early Childhood Mental Health Consultation

14. Is there anything else you think would be helpful for us to know about your work or experiences with children and families?

END HERE for programs working with ECMHC; Skip to Wrap Up.

Organizational readiness [For programs NOT working with ECMHC]

15. To what extent do you think this consultation approach sounds like it might be useful to your program, staff, and families?
- a. What aspects are most appealing? [*What do you think would be most helpful for your program?*]
 - b. What questions or concerns do you have about the consultation approach?
16. To what extent would you say Early Childhood Mental Health Consultation, as we've talked about it is a good fit for the children and families you work with?
- a. What would help make the model a good fit for your program?
 - b. What would be "red flags" that might get in the way of this approach being seen as helpful or successful?
17. What information, supports or training might your program need in order to be ready to participate in an Early Childhood Mental Health Consultation model?
18. What, if any, are the particular types of backgrounds, skills, or approaches that a Consultant should have to work effectively with your program staff, families, and children?
19. What suggestions do you have for the Early Learning Division and it's partners in developing statewide approaches to this type of Consultation Model?
20. Is there anything else you think would be helpful for us to know about your work or experiences with children and families?

END; Move to Wrap Up.

Developing a Statewide System for Infant/Early Childhood Mental Health Consultation

Wrap Up

For Participants Who Did Not Complete On-Line Survey:

Before we finish the interview, I wanted to check to see if you had a chance to fill out the survey we emailed you? These are just to get some basic demographic information about you and characteristics about your work with consultants. I can resend the link to the survey or if it's ok with you, we can just fill them out right now.

That's all the questions I have for you today. Thank you so much for taking the time to talk with me. We'll be working on putting all the information together and plan to have a final report to share at the end of the year. Please don't hesitate to contact me if you have any other questions or additional thoughts or suggestions.

Interviewer Reflection:

[Please document any contextual information that might help you remember this conversation or that might help any coders in the analysis.]

Developing a Statewide System for Infant/Early Childhood Mental Health Consultation

Interview protocol for **Mental Health Leadership**

Interviewer name: _____

Date of Interview: _____

Respondent ID#: _____

Thank you for agreeing to talk with me today. As you may know, the state of Oregon is prioritizing work to address the known disparities in the rates of preschool suspension and expulsion for children of color. As part of this effort, the Oregon Early Learning Division is working on a statewide model for Early Childhood Mental Health Consultation that promotes the strengths and assets of children, families, and providers of color, and which creates a system that prioritizes their preferences and experiences. We are reaching out to you today because of your involvement in Early Childhood Mental Health Consultation, and hope to learn more about the approaches and models that you are familiar with so we can bring that information into Oregon's planning process.

Before we start, I'd like to review the consent form with you. Did you receive the consent form we emailed you?

IF YES – Great, please follow along while I review the form with you.

IF NO – Ok, I will resend you a copy when we're finished. Can I send this to your email address?

[REVIEW CONSENT FORM – Voluntary nature of the interview, confidentiality, risks/benefits]

YOUR PARTICIPATION IS VOLUNTARY. You may stop participating at any time and you may choose not to answer questions.

CONFIDENTIALITY. This interview is also confidential. The information you share will not be linked to you or any personal information about you. When we write up the findings from all the interviews, the report will include overall themes that we've heard.

That said, I can't keep anything related to you harming yourself or others confidential.

RISKS. There are no major risks associated with participating, however you may feel uncomfortable with some of the topics. It is possible some of this information may be seen by people outside the project, so we will not put your name on any of the materials including the transcript of this interview.

BENEFITS. You will help leaders at the Early Learning Division understand how Infant and Early Childhood and Mental Health Consultation services could be better for Oregon's care providers, children, and families. As a thank you for your time you will receive a \$50 amazon gift card.

Developing a Statewide System for Infant/Early Childhood Mental Health Consultation

[Ask for permission to record and certify consent has been provided on the consent form; record the participants verbal consent].

I'd like to ask your permission to record our conversation today. We will use our notes and the recording to make a transcript of the interview. After we have the transcript, we will delete the notes and recording. The transcript will not include your name or other ways to identify you.

Is it okay with you if I start the recording now? Yes:___ No: ___

[Start recording]

Do you have any questions before I begin?

[Get consent]

Great - do you agree to participate in the interview? Yes:___ No: ___

Outreach/Contracting/Financing

1. Tell me about your organization's current role in providing Early Childhood Mental Health Consultation?

Probes below if not addressed.

- a. *[Contracting]* Do Early Care and Education programs contract with you directly for consultants?
 - i. **If YES:** what does that look like?
[Probes: Provider/Facility types they work with, family child care, Head Start, other? Who develops contracts and how?]
 - ii. **If NO:** who/what organization pays for or supports Early Childhood Mental Health Consultations that work in your program?
- b. *[Financing, if not addressed]* How are these services paid for?
- c. *[If applicable]* When contracting, how do you determine what kind of Early Childhood Mental Health Consultation supports a Early Care and Education program might need?
 1. Number of hours to contract?
 2. How many consultants?
- d. What are the pros and cons of the current funding stream(s) and process for Early Childhood Mental Health Consultation?
- e. What, if anything, would make the contracting and financing process easier or more streamlined?

Developing a Statewide System for Infant/Early Childhood Mental Health Consultation

2. To what extent does your program do outreach to Early Care and Education programs to “get the word out” about available Consultation services?
 - a. What has been most effective?

3. What kinds of supports do your Consultants provide?
[Prompts: Classroom/Teacher level? Organizational level? Child and family specific?]
 - i. How often do your Consultants provide services?
 - ii. In what setting(s)?
 - b. What has been going well for Consultants in their work?
 - c. What has been challenging?

4. How open do you find early childhood programs to Early Childhood Mental Health Consultation?

5. To what extent have your consultants been able to engage providers and families of color?
 - a. What has supported effective engagement of BIPOC providers and families?
 - b. What gets in the way?

Recruitment and Hiring

6. How do you find qualified Early Childhood Mental Health Consultants to work for your program?
 - a. What barriers do you experience in hiring Consultants?
 - b. Are there major gaps in training or experience that you have encountered?

7. What skills/qualifications do Consultants need to have to be effective?

8. How prepared do you feel Early Childhood Mental Health Consultants are to meet the needs of families and providers who are Black, Indigenous, and Persons of Color?
 - a. What would help improve this?

PD and Supervision

Developing a Statewide System for Infant/Early Childhood Mental Health Consultation

9. Tell me about how you provide training and professional development opportunities for your Early Childhood Mental Health Consultants?
 - a. What, if anything, would help to strengthen this process?

10. What kind of supervision do your Early Childhood Mental Health Consultants receive?
 - a. What, if anything, would help to improve this process?

11. What kinds of training or other supports are provided to Consultants specifically to support their capacity to provide culturally-responsive services, if any?
 - i. **[Probe if not addressed]** Do you provide any regular training or support related to unconscious or implicit bias?

 - b. What do you see as the role for Early Childhood Mental Health Consultants in addressing the disproportionate suspension/expulsion of children of color?
 - i. What role does supervision play (either Consultants supervising/working with staff or supervision provided to Consultants themselves)?

Organizational readiness

12. When did your organization start providing Early Childhood Mental Health Consultation?
 - d. *[If known]* What kinds of changes or structures, if any, did you need to put into place organizationally, to support Early Childhood Mental Health Consultants?

13. How easy or difficult do you think it is for traditional mental health service organizations to understand and support consultants and the Early Childhood Mental Health Consultation approach, and why?
 - i. What do organizations need to know before starting a Consultation program?

14. What suggestions do you have for designing and supporting statewide implementation of Early Childhood Mental Health Consultation?

15. Is there anything else you think would be helpful for us to know about your work or experiences with children and families?

Developing a Statewide System for Infant/Early Childhood Mental Health Consultation

For Participants Who Did Not Complete On-Line Survey:

Before we finish the interview, I wanted to check to see if you had a chance to fill out the survey we emailed you? These are just to get some basic demographic information about you and characteristics about your work with consultants. I can resend the link to the survey or if it's ok with you, we can just fill them out right now.

That's all the questions I have for you today. Thank you so much for taking the time to talk with me. We'll be working on putting all the information together and plan to have a final report to share later at the end of the year. Please don't hesitate to contact me if you have any other questions or additional thoughts or suggestions.

Interviewer Reflection:

[Please document any contextual information that might help you remember this conversation or that might help any coders in the analysis.]

IECMH Consultants and EI/ECSE Representatives

Developing a Statewide System for Infant/Early Childhood Mental Health Consultation

Interview Protocol for **Early Childhood Mental Health Consultants**

Interviewer name: _____

Date of Interview: _____

Respondent ID#: _____

Thank you for agreeing to talk with me today. As you may know, the state of Oregon is prioritizing work to address the known disparities in the rates of preschool suspension and expulsion for children of color. As part of this effort, the Oregon Early Learning Division is working on a statewide model for Early Childhood Mental Health Consultation that promotes the strengths and assets of children, families, and providers of color, and which creates a system that prioritizes their preferences and experiences. We are reaching out to you today because of your involvement in early childhood mental health consultation, and hope to learn more about the approaches and models that you are familiar with so we can bring that information into Oregon's planning process.

Before we start, I'd like to review the consent form with you. Did you receive the consent form we emailed you?

IF YES – Great, please follow along while I review the form with you.

IF NO – Ok, I will resend you a copy when we're finished. Can I send this to your email address?

[REVIEW CONSENT FORM – Voluntary nature of the interview, confidentiality, risks/benefits]

YOUR PARTICIPATION IS VOLUNTARY. You may stop participating at any time and you may choose not to answer questions.

CONFIDENTIALITY. This interview is also confidential. The information you share will not be linked to you or any personal information about you. When we write up the findings from all the interviews, the report will include overall themes that we've heard.

That said, I can't keep anything related to you harming yourself or others confidential.

RISKS. There are no major risks associated with participating, however you may feel uncomfortable with some of the topics. It is possible some of this information may be seen by people outside the project, so we will not put your name on any of the materials including the transcript of this interview.

BENEFITS. You will help leaders at the Early Learning Division understand how Infant and Early Childhood and Mental Health Consultation services could be better for Oregon's care providers, children, and families. As a thank you for your time you will receive a \$50 amazon gift card.

Developing a Statewide System for Infant/Early Childhood Mental Health Consultation

[Ask for permission to record and certify consent has been provided on the consent form; record the participants verbal consent].

I'd like to ask your permission to record our conversation today. We will use our notes and the recording to make a transcript of the interview. After we have the transcript, we will delete the notes and recording. The transcript will not include your name or other ways to identify you.

Is it okay with you if I start the recording now? Yes: ___ No: ___

[Start recording]

Do you have any questions before I begin?

[Get consent]

Great - do you agree to participate in the interview? Yes: ___ No: ___

Warm Up:

1. Tell me about your current position - What is your title/role?
 - a. What organization do you work for, and does this agency also provide early care and education programs?
[e.g. independent/contract by individual ECE programs, on staff of an ECE program/how many sites, part of an Early Childhood Mental Health Consultation team/org that offers consultation to ECE programs]
 - b. What kind of early childhood providers do you work with most often?
[e.g, Head Start, center-based, K12-based, family, etc.]
[Note, if they work across different provider types/setting, probe for differences depending on the setting throughout the interview]

Goals & Role

2. What do you see as your **primary goal** in providing consultation?
 - a. Can you tell me about the main things you do that are most important to achieving this goal?
3. Thinking about all the things you do in your role, what activities or supports do you think are **most important**?
***Probe:** [classroom/program practices? individual behavior/skills of a child? helping providers meet with parents? improving the practice of the ECE provider/program? Referral to other supports and services for the family?]*

Referral Process to Early Childhood Mental Health Consultants

Developing a Statewide System for Infant/Early Childhood Mental Health Consultation

4. How do you typically get connected to providers and/or families for consultation? [e.g. ECE program initiates, consultant reaches out to ECE programs, ECE submits/calls in a request]
 - a. What's working well with the referral process?
 - b. What could be improved?

5. What, if any, are the barriers to providers requesting consultation from you/your organization?
 - a. Do some programs/providers seem more receptive to consultation? Please tell me more about that.
Probe if not mentioned: [Do you feel that there are differences in how willing providers are to ask for your help depending on their cultural, racial, or linguistic background, and if so, tell me about that?]
 - b. Are there any financing barriers?
[e.g. what an ECE can afford to contract; or Consultation program can only serve a limited # of providers (by geography; type; first come first served, ect)]

6. Tell me about a time when you felt that you were successful in supporting a child who might have been at risk for being asked to leave a care setting or facility.
 - a. What was it about this situation that helped create a positive outcome?
Probes: [things about the family, the child, the child care provider, the classroom/setting environment, the availability of resources, other?]
Probes: [Do you coordinate your work with ECE quality improvement specialists or ECE TA (training and technical assistance) providers [e.g., when you find there is a need to improve basic developmentally appropriate practices in the setting]

7. Research suggests that teachers sometimes respond differently to children of color than they do to white children, or to boys vs. girls - even when displaying the same kinds of behaviors. **How often**, if at all, have you observed this happening in the context of providing consultation?
 - a. **IF YES:**
 - i. Please give me an example of when you've seen this happen.
 - ii. What do you do when you see this happening?
 - iii. What strategies have been most successful?
 - iv. What strategies have been less successful?

8. More generally, what would you say the ideal role of the consultant is in addressing potential conscious or unconscious racial bias in providers?
Probes: [involvement of trauma, child welfare/foster care, special needs/involvement of EI/ECSE systems?]

Developing a Statewide System for Infant/Early Childhood Mental Health Consultation

9. What recommendations would you make, if any, for supporting consultants to address these issues more effectively in their work?

10. Do you work directly with families and/or do home visits with families?

[If **NO**, skip to 11] **IF YES:**

- a. What kinds of services or work do you typically do with families?
- b. What are the benefits to working directly with families?
- c. What kinds of concerns, if any, do you hear from families about getting referred to you/working with you?

Probes if not mentioned: *[stigma, discrimination, labeling]*

- i. How do you address these concerns?
- ii. What approaches have been more/less successful?

Training & Early Childhood Mental Health Consultation Workforce

11. Can you tell me about your pathway to becoming a consultant?

- a. What interested you about the role?
- b. What barriers, if any, did you experience to becoming a consultant?

12. Tell me about the kinds of professional development and support that you receive?

Probes: *[supervision, peer or team learning/sharing, formal trainings or programs]*

- a. Which of these is most important to you?
- b. What supports would you like to have that you don't currently have?

13. How might the field recruit more people interested in becoming Early Childhood Mental Health Consultants?

- a. What kinds of information, supports and/or incentives might help?

14. *[FOR BIPOC/bilingual respondents]* What might help the field recruit and support more BIPOC and bilingual persons interested in becoming Early Childhood Mental Health Consultants?

- a. What kinds of information, supports and/or incentives might be important and/or helpful?

Input on Ideal/Improved Model

15. If you were able to create an "ideal" system of mental health consultation for early care and education providers, what would that look like?

Probes: *[frequency of visits to classroom, families; professional development supports; referral systems, billing systems]*

Developing a Statewide System for Infant/Early Childhood Mental Health Consultation

For Participants Who Did Not Complete On-Line Survey:

Before we finish the interview, I wanted to check to see if you had a chance to fill out the survey we emailed you? These are just to get some basic demographic information about you and characteristics about your work as a MHC. I can resend the link to the survey or if it's ok with you, we can just fill them out right now. {Interviewer complete Qualtric Parent Survey}.

That's all the questions I have for you today. Thank you so much for taking the time to talk with me. We'll be working on putting all the information together and plan to have a final report to share by the end of the year. Please don't hesitate to contact me if you have any other questions or additional thoughts or suggestions.

Interviewer Reflection:

[Please document any contextual information that might help you remember this conversation or that might help any coders in the analysis.]

Provider Focus Group: English

Early Childhood Mental Health Consultation Project

Child Care Provider Focus Group Protocol

DRAFT

Introduction (Facilitator) (5 minutes)

Thank you all for coming today to participate in this listening session. My name is _____ and I am from Portland State University. PSU is currently working with Oregon’s Early Learning Division to develop a statewide system for providing services known as “early childhood mental health consultation” that is specifically centered around the needs and preferences of families and providers of color. To help support this design work, PSU is conducting interviews and listening sessions with current consultants, early care and education providers, and child care/early childhood program administrators.

That’s why I am here today -- to talk with you about early childhood mental health consultation. We want to hear from you about what a system of early childhood mental health consultation should look like to best meet the needs and preferences of your communities. We are hoping you will be frank with your thoughts and feedback – the services will be more effective if the state really understands what providers and families need to be successful with all children.

Consent Form (Co-Facilitator) (5 minutes)

Before we start, I want to make sure that everyone received a copy of the Consent Form that we emailed. If anyone did not receive this consent form and needs a copy, please send me a message in the “chat” function of the Zoom meeting or just raise your hand now and we will send you a copy. If you need a hard copy mailed to you, please indicate that in the chat and we will follow up with you to make sure we have your current address. The information we are reviewing next is also described in the Consent Form.

[Go through the elements of informed consent together]. Are there any questions about the consent form before we get started?

Consent for Audio Recording (Co-Facilitator) (5 minutes)

I also want to check and make sure that everyone is ok with us recording the conversation today? The recording will start after everyone is introduced and will help us make sure we don’t miss any of your comments. We will only use the audio recording to make sure we have an accurate record of our conversation, and won’t include any names or other ways of identifying participants on the typed notes. Once we’ve typed up your comments, the recording will be deleted. However, if anyone is not comfortable with us recording the session, we will go ahead with written notes.

Is everyone comfortable with us recording today?

[Get verbal consent for taping].

Great, we will start the recording once we've done introductions.

Again, be assured that your names will not be used in any summaries, and to protect confidentiality, we will only use your first names here today. Your participation is voluntary, and all information that you share here today will be kept confidential to the extent possible. We ask that everyone agree to not share comments or information that is shared here today with anyone once the focus group is over. However, because we can't control what other participants might do, it's important to point out that what you discuss could be shared outside the group. You do not have to answer any question that you don't want to answer.

Ground Rules (Facilitator) (5 minutes)

To help our group run as smoothly as possible, and be a good experience for everybody, we'll use some guidelines for our time together:

Ground Rules

- No right or wrong answer
- Please listen respectfully to others
- We want to hear from everyone
- Please turn off cell phones
- Facilitator role is to guide the discussion
- What is said in this group, stays in this group (maintain confidentiality)

Gift Cards

The listening session will take a little more than an hour from here. When we're done, each of you will receive a \$50 Amazon gift card as a small way of saying thank you for sharing your experiences and wisdom.

Introductions (Facilitator) (5 minutes)

Great, so let's get started. Why don't we go around the room and please share your name and tell us briefly about your role, where you work, and maybe one thing you love about working with children.

[Go around room with introductions].

BEGIN DISCUSSION

Great, thank you! We'll go ahead and start the recorder at this time and start the conversation.

[START RECORDING]

First, I just want to see how many of you have worked with or had access to an early childhood mental health consultant? Just raise your hand if you have? Ok, great. Just so we're all on the same page, I do want to share with you all what I mean when I talk about mental health consultation. Early childhood

mental health consultation involves having someone with a background in children’s emotional development and behavior who provides a variety of supports for child care and early childhood education providers to help ensure that all children can be included and supported in early childhood programs. I am going to refer to this as “ECMHC” and the “consultant” for short.

ECMHC is focused on helping early childhood educators improve their knowledge and skills about how to support the social-emotional needs of young children. Consultants often do observations of children, social-emotional assessments, and might provide coaching or advice for teaching staff about children’s social/emotional behavior. Consultants also sometimes provide individualized child and family-focused services when needed. The hope is that providing ECMHC will help reduce the disproportionate rate of young children, especially children of color, being asked to leave (sometimes suspended or expelled) from their child care settings, either temporarily or permanently, because of emotional and/or behavioral concerns.

Let’s start out by talking a little bit about the children and families you work with.

1. How would you describe the communities you serve?
 - a. What strengths and gifts are children and families bringing into your classrooms?
 - b. What kinds of challenges do you sometimes see?
2. Thinking specifically about behaviors in the classroom, how often do you encounter those “big” or challenging behaviors in the classroom?
 - a. How often do you need to remove a child from the classroom?
 - b. How often do you ask a child to leave the program altogether?
3. Now I’m going to ask about your experiences working with Early Childhood Mental Health Consultants.
 - a. How often have you worked with an ECMHC?
 - b. What kinds of things does the consultant usually do for you and/or the children in your class?
4. Thinking about a time when you had a child with social or emotional behavioral challenges, how helpful was it for you to have someone to provide consultation support?
 - a. What did the consultant do that was helpful?

[for example: visit your classroom and observe classroom dynamics and provide you with coaching or strategies for working with them. Other ways they described their work with consultants]

- b. Are there ways for consultants to be more helpful in supporting you? [Reframe, if needed, “what would you change about the ECMHC services you have available to you?”]
5. To what extent have you felt your ECMHC reflected or understood your culture or community?
 - a. What about the culture or community of the children and families you work with?
 - b. Why do you think it is important (or not important) for someone like a mental health consultant to reflect or understand the cultural backgrounds of you and/or the families you work with?
6. What do you think is the most important thing for us to know about what makes early childhood mental health consultation most helpful or effective?
7. What concerns, if any, do you have about the approach, particularly for your communities?
 - a. What might help?
8. What suggestions do you have for how to make sure that Early Childhood Mental Health Consultation services reflect and respond to families’ cultural backgrounds?

[Probe: Who the consultants are, what experiences they have, what issues or challenges they need to be aware of, how often they need to be available to providers?]
9. What do consultants need to know about you as a provider and the community you serve in order to be as helpful as possible?
10. Is there anything else you think would be helpful for us to know about your work or experiences with children and families?

Proyecto de Consulta de la Salud Mental en la Temprana Edad
Protocolo de Grupo de Enfoque para Proveedores de Cuidado Infantil

Introducción (Facilitator) (5 minutes)

Gracias a todos por tomarse el tiempo de participar en este grupo de enfoque. Mi nombre es SANDRA LAU y soy de la Universidad Estatal de Portland. PSU está trabajando actualmente con la División de Aprendizaje Temprano de Oregón para desarrollar un sistema estatal para brindar servicios conocido como "**Consulta de Salud Mental en la Edad Temprana**" que se centra específicamente en las necesidades y preferencias de las familias y proveedores de cuidado infantil quienes son de color. Para ayudar a respaldar este trabajo de diseño, PSU está llevando a cabo entrevistas y grupo focales con consultores, proveedores de cuidado y educación temprana y administradores de programas de cuidado infantil o edad temprana.

Por eso estoy aquí hoy, para hablar con ustedes sobre **La Consulta de la Salud Mental en la Edad Temprana**. Queremos saber de usted, acerca de cómo debería ser un sistema de consulta de salud mental en la edad temprana para satisfacer mejor las necesidades y preferencias de sus comunidades. Esperamos que sea franco con sus opiniones y comentarios: los servicios serán más efectivos si el estado realmente comprende lo que los proveedores de cuidado infantil y las familias necesitan para tener éxito con todos los niños.

Consent Form (Co-Facilitator) (5 minutes)

Antes de comenzar, quiero asegurarme de que todos hayan recibido una copia del formulario de consentimiento que enviamos por correo electrónico anteriormente. Si alguien no recibió este formulario de consentimiento y necesita una copia, por favor envíeme un mensaje en el "chat" o simplemente levante la mano ahora y le enviaremos una copia. Si necesita que le enviemos una copia impresa, indíquelo en el chat y nos pondremos en contacto con usted para asegurarnos de que tengamos su dirección actual. La información que estamos revisando a continuación también se describe en el Formulario de Consentimiento.

[Go through the elements of informed consent together].

¿Hay alguna pregunta sobre el formulario de consentimiento antes de comenzar?

Consent for Audio Recording (Co-Facilitator) (5 minutes)

También quiero verificar y asegurarme de que todos estén de acuerdo con que grabemos la conversación de hoy. La grabación comenzará después de que nos presentemos todos y nos ayudará a asegurarnos de que no perdamos ninguno de sus comentarios. Solo usaremos la grabación de audio para asegurarnos de tener un registro preciso de nuestra conversación y no incluiremos ningún nombre u otra forma de identificar a los participantes en las notas escritas. Una vez que hayamos captado sus comentarios, se

eliminará la grabación. Sin embargo, si alguien no se siente cómodo con que grabemos la sesión, seguiremos adelante con notas escritas.

¿Todos se sienten cómodos con nosotros grabando el día de hoy?

[Get verbal consent for taping].

Una vez más, **tenga la seguridad de que sus nombres no se utilizarán en ningún resumen** y, para proteger la confidencialidad de todos Uds., solo usaremos sus nombres hoy. Su participación es **voluntaria** y toda la información que comparta aquí hoy se mantendrá **confidencial** en la medida de lo posible. Pedimos que todos estén de acuerdo en no compartir comentarios o información que se comparta aquí hoy con nadie una vez que finalice el grupo de enfoque. Sin embargo, debido a que no podemos controlar lo que podrían hacer otros participantes, es importante señalar que lo que discutan podría compartirse fuera del grupo. **Es importante recalcar que no tiene que responder ninguna pregunta que no quiera responder.**

Ground Rules (Facilitator)

(5 minutes)

Para ayudar a que nuestro grupo funcione de la mejor manera posible y sea una buena experiencia para todos, usaremos algunas pautas para nuestro tiempo juntos:

Reglas de juego

- No hay respuesta correcta o incorrecta
- Escuche con respeto a los demás.
- Queremos escuchar a todos.
- Apague los teléfonos móviles.
- La función del facilitador es guiar la discusión.
- Lo que se dice en este grupo, permanece en este grupo (mantener la confidencialidad)

Gift Cards

El grupo de enfoque tardará un poco más de una hora desde ahorita. Cuando hayamos terminado, cada uno de ustedes recibirá una tarjeta de regalo de \$ 50 como una pequeña forma de agradecerle por compartir sus experiencias y sabiduría.

Introductions (Facilitator)

(5 minutes)

Genial, comencemos. ¿Por qué no tomamos turno en presentarnos, por favor comparta su nombre y nos cuenta brevemente sobre su función/posición, dónde trabaja y quizás algo que le encanta de trabajar con niños?

[Go around room with introductions].

BEGIN DISCUSSION

¡Genial, gracias! Continuaremos y empezaremos a grabar en este momento y comenzaremos la conversación.

[START RECORDING]

Primero, solo quiero ver cuántos de ustedes han trabajado o han tenido acceso a un asesor/consultor de salud mental en la edad temprana. ¿Solo levante la mano si es así? Muy bien. Para que estemos todos en la misma página, quiero compartir con todos ustedes lo que quiero decir cuando hablo de la consulta de salud mental. **La consulta de salud mental en la edad temprana** implica tener a alguien con experiencia en el desarrollo emocional y el comportamiento de los niños que brinde una variedad de apoyos a los proveedores de cuidado y educación infantil para ayudar a garantizar que todos los niños puedan ser incluidos y apoyados en los programas de la Edad Temprana. Me voy a referir a esto como "ECMHC" y el "consultor/asesor" para abreviar.

ECMHC se centra en ayudar a los educadores de la edad temprana a mejorar sus conocimientos y habilidades sobre cómo apoyar las necesidades socioemocionales de los niños pequeños. Los consultores/asesores a menudo realizan **observaciones** de los niños, **evaluaciones** socioemocionales y pueden proporcionar orientación o **asesoramiento** al personal docente sobre el comportamiento socioemocional de los niños. Los consultores a veces también brindan servicios individualizados centrados en el niño y la familia cuando es necesario. **La esperanza es que ECMHC ayudará** a reducir la tasa desproporcionada de niños pequeños, especialmente niños de color, a los que se les pide que se vayan (a veces suspendidos o expulsados) de sus entornos de cuidado infantil, ya sea de manera temporal o permanente, debido a preocupaciones emocionales y / o conductuales.

Comencemos hablando un poco sobre los niños y las familias con las que trabajan todos Uds.

Warm up questions:

1. ¿Cómo describiría las comunidades a las que sirve?
 - a. ¿Qué fortalezas y dones están trayendo los niños y las familias a sus aulas?
 - b. ¿Qué tipo de desafíos ves a veces?
2. Pensando específicamente en los comportamientos en el aula, ¿con qué frecuencia encuentra esos comportamientos "grandes" o desafiantes en el aula?
 - a. ¿Con qué frecuencia necesita sacar a un niño del salón de clases?
 - b. ¿Con qué frecuencia le pide a un niño que deje el programa por completo?
3. Ahora voy a preguntarles sobre sus experiencias trabajando con consultores de salud mental de la edad temprana.

- a. ¿Con qué frecuencia han trabajado con un ECMHC?
- b. ¿Cómo le ayuda o que actividades suele hacer el consultor por usted y / o por los niños de su clase?

4. ¿Pensando en un momento en el que tuvo un niño/a con problemas sociales o emocionales de comportamiento, que tan útil fue para Ud. tener a alguien que le pueda proporcionar apoyo de consulta?

- a. ¿Que hizo el consejero que fue de ayuda?

[Por ejemplo: Visita su salón de clases y observa la dinámica del salón de clases y le proporciona alguna orientación o estrategias para trabajar con los niños. Alguna otra forma en que describa su trabajo con los consultores]

Follow up from question 4:

- b. ¿Cuáles son las formas en que los consejeros pueden ser más **útiles** para brindarle apoyo? [Reframe, si es necesario, “¿Qué cambiaría sobre los servicios ECMHC que tiene disponible para usted?

5. ¿En qué medida se ha sentido que su ECMHC reflejo o entendió su cultura o comunidad?

- a. ¿Y qué decir de la cultura o comunidad de los niños y las familias con las que trabaja?
- b. Por qué cree que es importante (o no importante) que alguien como un consultor de salud mental refleje o comprenda sus antecedentes culturales y / o las familias con las que trabaja?

6. ¿Qué cree que es lo más importante para nosotros saber sobre lo que hace la consulta de salud mental infantil más útil o eficaz? Ejemplo: ¿es su relación? ¿Entienden a la comunidad? ¿Hablan su idioma?

7. ¿Qué preocupaciones, si las hay alguna, tiene sobre el enfoque/método en particular para sus comunidades?

- a. ¿Qué es lo que podría ayudar?

Suggestions:

- 8. ¿Qué sugerencias tiene sobre cómo asegurarse de que los servicios de consulta de salud mental en la edad temprana reflejen y respondan a los antecedentes culturales de las familias?**

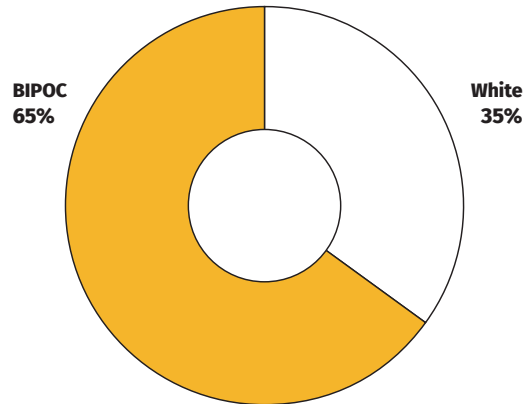
[Probe: Quiénes son los consultores, qué experiencias tienen, qué problemas o desafíos deben conocer, con qué frecuencia deben estar disponibles para los proveedores?]

- 9. ¿Qué necesitan saber los consultores sobre usted como proveedor y la comunidad a la que sirve para ser lo más útil posible?**

- 10. ¿Hay algo más que crea que sería útil/importante que sepamos sobre su trabajo o experiencias con los niños y las familias?**

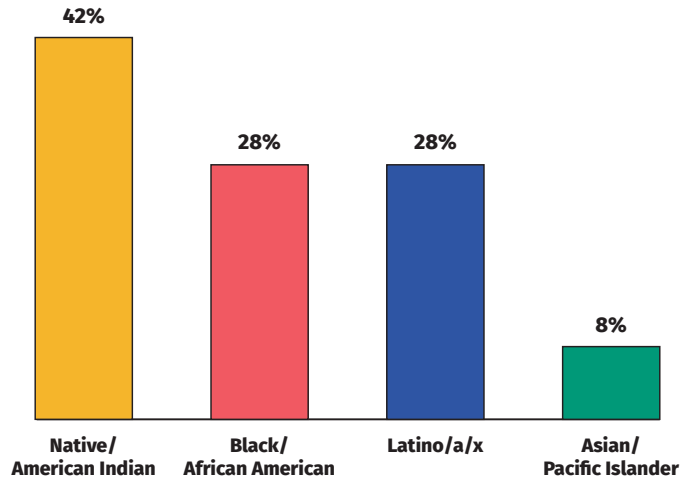
Appendix D. Demographic Information

Percent of Oregon Respondents who identified as BIPOC and White

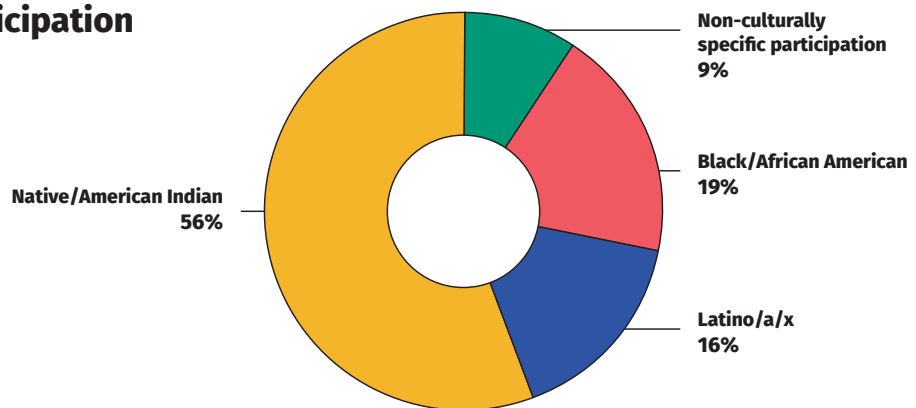


Percent Oregon BIPOC Respondents' Primary Race/Ethnicity

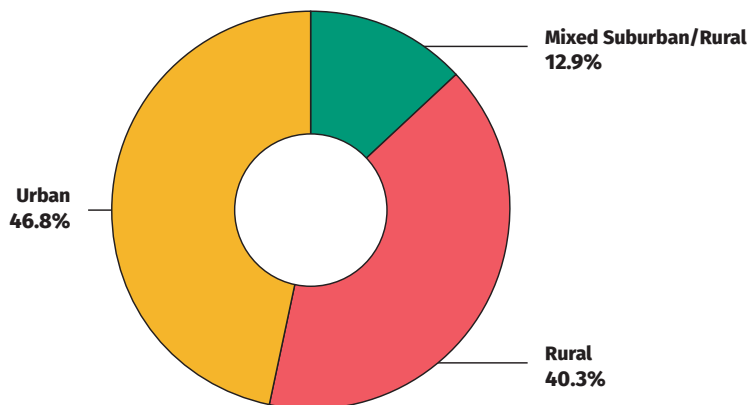
Note: Approximately 65% of our Oregon-based respondents identified as BIPOC.



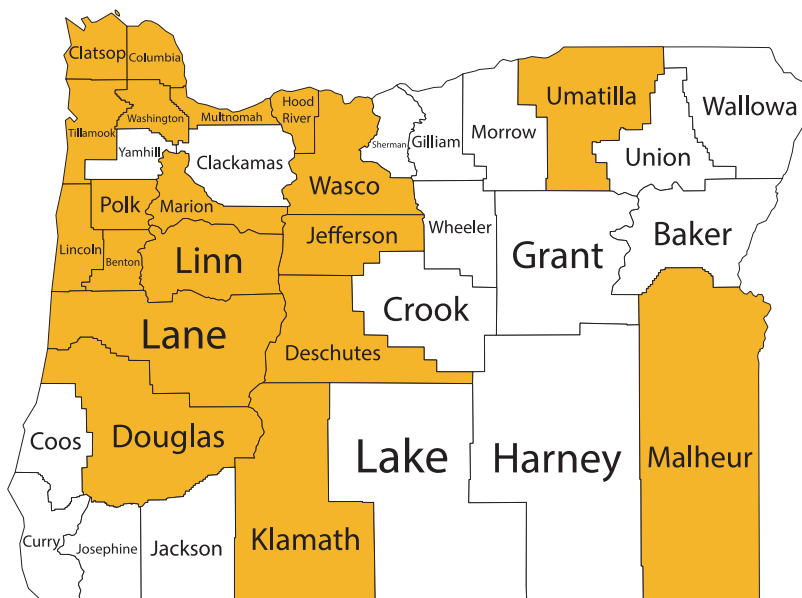
Percent ECE Provider Participation in Culturally-Specific Focus Groups or Interviews



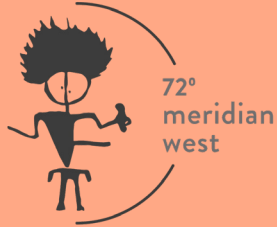
Percent Oregon Respondent Participation by Geography Type



Oregon Representation by County



Appendix E. Community Input Sessions Summary



Facilitation for Community Input Sessions - Summary

Center for the Improvement of Child and Family Services at PSU
Oregon Early Learning Division, Oregon Department of Education

December, 2021

Overall Impression

The vast majority of participants appeared excited about the proposed program. Some participants appreciated the proposed program's focus on collaboration, coordination, and having a holistic approach to early childcare. One participant stated, "I feel like if we know that these pieces are working together as separate entities ... would be very beneficial." Another participant appreciated its centralization of everyone's expectations. Participants cited multiple reasons for their excitement, including recognizing its need in their community, its emphasize on BIPOC communities, and its purpose being specifically for childcare providers.

General Need for the Program

Participants recognized the need for the program in their work and community, one stating, "We're seeing a lot of this social emotional and communication stuff come up" and another stating, "I need more support ... to get to the actual child." Some participants even cited privately funding their own infant mental health consultations when able, but there seems to be difficulty accessing that consultation everywhere else. They felt those who did receive infant mental health consultation saw positive outcomes in the children and families because of it.

BIPOC Emphasis

Many participants saw the proposed program's BIPOC prioritization essential and "hugely important." One participant stated, "I think really building in when we talk about anti-racism and these other components and implicit bias is important to have real strong reflective practice in the work." Some participants observed that the majority of the children they serve are people of color including Hispanic/Latinx, African American, and Indigenous communities. In addition, support on working with families from other backgrounds (socioeconomic or geographic differences for example) would be useful too. In addition, participants listed the following reasons they valued a BIPOC emphasis in the project:

- Need for consultation surrounding different cultures/backgrounds
- Current struggle to find BIPOC consultants/supervisors
- Cultural and language representation for families
- Increasing access at all levels

Acute stress among childcare workers

Many participants saw this program as a way to support childcare providers not only for the work that they do but for their self-care and mental health. Some observed that many in-home providers have little to no staff, low wages, and high expectations which perpetuate a highly stressful environment. In addition, some participants observed childcare providers tend to work in cultures that don't encourage mental wellness or asking for help. One participant stated, "I think this program would be phenomenal just for the support. And not, not only just helping their children and their families, but helping themselves because it's so hard, hard to do self-care when you're caring for so many others." Other reasons/experiences participants felt the program's opportunity to support the mental well-being of childcare providers are as follows:

- An opportunity to help providers open up and ask for help, especially in cultures where asking for help is seen as "bad"
- Better support for adult-isolated providers
- An opportunity for providers feeling "stuck" and "worn down" with certain children
- An opportunity to get the "big picture" of how classroom strategies may or may not be working

Tough Conversations

Participants also saw this project as an opportunity for support having "tough conversations" with parents if a child required services outside their scope of practice. Many participants expressed a hope for consultants to assist, train, or facilitate meetings with parents. Even starting inquires for children to be seen for behavioral issues were deemed "tough conversations." Many participants were also concerned about how parents would be involved in the proposed project out of fear they would not be able to get parental support for the program. One participant observed, "If we was trained how to do it correctly, to explain to the parents and do it differently, that they know their kids is still good in many other ways, I think parents will likely get on board faster."

- Both childcare providers and mental health consultants within the focus groups observed that these conversations with parents can be "really difficult."
- "That first conversation is one that childcare providers avoid with the parent."

-
- “Parents will be more apt to listen to somebody they’re not in contact with daily.”
 - “There’s always reasons behind [the behavior].”
 - Need to assist parents who were unable to obtain resources for their child previously
 - Need to motivate ambivalent or hesitant parents who don’t “see the value” in the intervention
 - Need to assist educating parents about the resource need
 - Solo tough conversations appearing “shaming” or “blaming” to the parent

Concerns or areas for improvement

While there were concerns about how the proposed program would be executed or fears that it would duplicate already existing resources, participants did not completely reject the proposed program. One rejection expressed that the proposed project’s acronym is “really long” and should be rewritten as something “friendlier” that could more easily be remembered. Some participants also cautioned about the potential for the program to put all the responsibility on just the childcare provider or just the consultant. One participant commented, “Our childcare providers tend to be the least paid and they have these enormous responsibilities.”

Among providers, there was disbelief regarding whether the program will actually exist, one provider mentioned: “I am not necessarily excited about the project, because I don’t see it happening. I don’t think there will be enough money invested in this to allow it to happen. I am doubtful the State will be able to pull this off, but if it happens that would be great” and “you say you are going to hire culturally diverse psychologists, but there is already a shortage, unless you are going to pay them a lot more money, and if so where is that money coming from?”

While participants were overall intrigued and excited about the potential of the proposed project, there were a number of concerns about its implementation and certain barriers to success. These concerns are as follows:

- While participants felt emphasis on BIPOC consultants was important, some expressed concerns that finding these consultants would be a challenge based on their own efforts to hire/connect with BIPOC consultants

- Participants expressed concern that the program will progressively place all responsibility on just the mental health consultants or childcare provider. One participant stated, “[F]iguring out how to build those relationships across, across the structures will be important.”
- While most childcare providers were eager for the opportunity to work with the program, some referred past experiences with similar consultants who were not helpful, felt like they were coming to “shut me down,” and challenges other providers may have about opening up to a consultant. One participant stated, “There’s a lot of mistrust right now.”

Past experiences

Participants cited past models or programs they felt were similar to the proposed project. These past experiences sparked excitement for the proposed program, concern of duplication of services, and concern of failure.

Some participants felt the proposed project was similar to past programs they had encountered that were not always successful. Hence, they expressed caution about expressing hope for the program. For example, and participant stated, “...we’ve implemented this in a variety of ways and had successes and failures because of that,” and “I’ve seen good consultation and not good consultation.” One participant commented that they had heard of a “very similar” project in the past that was not successful. This participant reflected, “They all seem like very good ideas, but they’re kind of pie[s] in the sky.” They expressed hope for this proposed program to be flexible in each region and county, for reflexive practice, have mutual targets, and relationship building.

One group of participants with experience with a system of supports through home visiting and early intervention expressed concern that the proposed program would mitigate or divert attention from existing resources that do similar work. One participant stated, “[T]here’s a lot of good things already happening that we need to lift up and support rather than do something completely, not that this is doing something completely new, but I think it’s important to uplift what is going well.” Some programs/resources participants referenced that conduct similar work were: Help Me Grow and MECP.

Participant Suggestions

a. Trainings

Participants urged for consultants to receive training prior to release for professional development and quality assurance, a “bar” demonstrating a standard needed for Endorsement®. Some participants felt trainings could be used to assure that consultants meet this bar. Some participants expressed the importance of this standard to assure that consultants would be “helpful” in comparison to past consulting experiences. The suggestions surrounding these trainings was complex. Participants recommended that trainings include:

- Buy-in (What is it that we are doing? Why are we doing this?)
- Ongoing, reflective practice sessions (checking-in, discussing concerns, successes, challenges)
- Anti-bias/anti-racist emphasis (“For that consultant to understand, and to integrate that work into what they’re doing.”)
- A certificate from PSU’s Infant Mental Health Certificate Program or its equivalent
- Ongoing professional development around core competencies that align professional development credits/CEUs to the consultant’s own licensure
- Emphasis on how the pieces (structure, program, environment, etc) connect with one another
- Training in practice
- Trainings be accessible in multiple languages
- Trainings be based on research models, assure competence through pre/post surveys

It should be noted that while some participants emphasized that consultants get trained or be required to get continuing education to be a consultant for licensure, some participants also expressed mistrust and poor experiences. Most of these participants were childcare providers. Nonetheless, childcare providers seemed interested in receiving trainings as well.

Participants also expressed hope that they would have access to culturally-sensitive consultants able to speak multiple languages, be anti-biased/anti-racists, be flexible to each provider, and be able to bridge the mistrust childcare providers may feel.

b. Communication and Coordination

Participants recommended a clear way for all involved in the proposed project to coordinate, such as a help line or referral process, as well as a clear communication campaign that is accessible to everyone. A mutually agreed upon line of communication or centralized location was emphasized for easy access. One participant observed, “There will need to be some way to coordinate how we understand the infant mental health lens in terms of child development.” Some suggestions are as follows:

- A centralized resource (one number, one name, one program)
- Resources tailored to different learning styles (such as flow charts for visual learners)
- Link on a website like the CCR or through Clackamas Early Childhood Intervention
- Accessibility in multiple languages without long phone paths to access desired language
- Hotline or helpline
- Flexible access methods to encourage connection and success

Childcare providers felt that Zoom or other forms of digital access to consultants would be helpful. Zoom meetings were envisioned as being able to see other people and to be able to interact with them as opposed to receiving consultation over the phone. Thus, it is likely that Zoom meetings where participants have their cameras off would not necessarily meet participant perceptions of Zoom meetings. One childcare provider observed that sharing physical spaces with others is also helpful and that they would be open to a hybrid model. They also felt it would be helpful to have different opportunities to share, grow, reflect, and come together. In short, having opportunities to build relationships with consultants and other providers would be useful.

Questions

The following are questions brought up in the focus groups. Core project planners are recommended to review these questions as representative of what the project’s communication campaign could emphasize or address.

- How will the proposed project align support with other existing programs?
- How is the program funded?
- How long will consultation last? How often will it occur? Will they be coming to our programs and giving support in the actual classroom?

-
- Will there be a manual or handbook?
 - Are there going to be parenting classes?
 - Are there going to be any parents?
 - For this program to exist, then what is going to happen with the parents?
What is the parental role in this proposed program?
 - Do childcare providers need to obtain parental consent to be able to access this program? If the parents don't agree that their child needs assistance?
 - Who is this program for? (I'm in daycare, would this program affect me also?)
 - Who gets to access this program?
 - How do these pieces work together?
 - Is this program going to be set up for providers to access their own support?

Offered resources to consider:

- A Long Talk, for "uncomfortable conversations."
- Center for Social Policy and Strengthening Families

Specific Questions

Consultants / Health

What made you excited about this project?

- The focus on BIPOC Communities and focus on Anti-Racist Practices
- Expanding funding and opportunities for IECMHC (long overdue). A statewide model is exciting!
- Not naming this project IECMHC due to stigma (although, that is something that needs to change)
- The preventative aspect of ECMHC, especially in preventing for higher levels of intervention
- The benefits it can provide to families that truly need it

Which aspects of the current recommendations could be improved? how?

- Coordination and consistency with Mental Health providers and identifying the roles of Childcare Providers and Consultants
- Terminology of IECMHC. The model varies greatly across agencies, and across the nation. A common (statewide) understanding of IECMHC is definitely needed, think this project provides the perfect opportunity for addressing it
- A well thought out messaging for the project, clearly explaining its different aspects and connecting it with what already exists
- Built in supports for providers in the difficult conversations with families
- Clarify when I-ECMH consultants should refer to Behavioral Health Services
- Building on all the existing strengths and partnerships that have been established across health, early learning and public health to create a seamless perinatal continuum of care, which would include IECMHC as part of that continuum.

What do you think is missing?

- How to recruit, hire and provide support to BIPOC providers, including consultants
- Clarity regarding the supervision of IECMH consultants. Regular reflective supervision, group supervision and/or collaboration are key.

-
- Establishing Community of Practice groups for consultants by region across the state as a way of offering support as well as sharing of resources/referral info.
 - Providing technical assistance services, by an experienced IECMHC or team of IECMHCs, could be very beneficial in supporting the onboarding/orientation of consultants across the state.
 - Details regarding how the workforce is going to be continually developed and supported. Clear guidelines regarding the training and qualifications needed to provide I-ECMHC.

Providers

What made you excited about this project?

- The idea of having access to Mental Health support for both providers and children. This would be even better if it had the family involved.
- Project brings hope for providers and early childhood educators

Which aspects of the current recommendations could be improved? how?

- Inclusion and support in the relationship with parents, as well as to parents directly (parenting classes for example). Important to clarify what the role of the parents is
- Making sure that this is not just a desk job or consisting of sporadic visits. this needs to have a “boots on the ground” approach

What do you think is missing?

- Support complete involvement with child, provider & families
- Making the resources known to all providers, using visuals about the resources being provided
- Program readily available for different languages and cultures from the get go

What supports or trainings would help you to feel more ready and successful working with IECMHC?

- Providing useful clarifying information for providers, what, who, when, where, how.
- How to have difficult conversations with the parents

Thematic Analysis - Summary

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How would you like to access IECMHC supports?

- Hybrid: visits in person and Zoom/online or phone. Not just email
- Hot line
- Having a person assigned directly to you, a name and a number
- (Spanish) An actual phone number to call, not to wait to press a button to speak with someone in your language