Understanding IECMHC

Nydia Ntouda: On today's webinar, we have Kadija Johnson and Amittia Parker. First up to introduce themselves will be Amittia. Take it away.

Amittia Parker: Greetings, everyone. It's very great to be with you all today. I am Amittia Parker. I am a trainer and provide training and technical assistance through the National Center on Health, Behavioral Health, and Safety. I also want to introduce myself as an individual who was a mental health consultant in programs in Kansas City, where I reside. I'm really excited about being here with you and wish I would have had a training like this when I started my role in a program. I'm going to pass it to my colleague Kadija, who is amazing and who will introduce herself.

Kadija Johnson: Thank you, Amittia. It's a pleasure to be with everyone and especially to be with you, Amittia. I, too, am part time faculty at Georgetown Center for Child and Human Development in relation to this National Center for Health, Behavioral Health, and Safety. For the prior three decades before joining Georgetown, my career has really been devoted to developing, implementing, disseminating, writing, and doing infant and early childhood mental health consultation, which I hope positions Amittia and I both well to talk with you about today's topic.

We're going to launch right in. As a reminder, please put your questions in the Q&A, and we'll make an attempt to have time at the end to respond to them as we go through our presentation of foundations. Our goal today is to really give you some foundation principles and practices for implementing infant and early childhood mental health in a robust, comprehensive way that enhances and ensures the highest quality services are received by Head Start programs, staff, and families. We're going to start, though, by examining some of the challenges that Head Start programs and the families that you all serve in Head Start are facing.

To talk about how infant and early childhood mental health consultation can be implemented effectively to address these obstacles or challenges which have exponentially increased in the last several years. Toward the end of our time together, Amittia is going to share information about a new course, which will expand upon, amplify some of what we talk about today, a new course on infant and early childhood mental health consultation that offers a learning experience for mental health consultants and really for anyone who wants to know more about this practice.

I'm going to start, as I said, by describing the challenges that you or all Head Start programs and most early childhood education programs all over the country typically are plagued by and have been exacerbated over the last several years are exponentially greater today. I'm going to offer a little bit of empirical evidence about the challenges. Not because you need confirmation of your own experience, but because I hope this is a way of reminding you that you're not alone in

Head Start or in your position as administrators, directors, mental health consultants, in trying to address these struggles.

I'm going to highlight just a few of the findings that you see on this page. The first one, according to attendees polled at a national Head Start Association Conference in 2022 — we're not that far away. An estimated 30% of staff positions in Head Start programs were currently unfilled. 90% of the respondents said that they had to close — maybe temporarily but had to close classrooms in their programs due to the lack of staff. Another one of the big obstacles is that in studies conducted actually pre-pandemic, between 25% to 40% of Head Start early care educators reported symptoms of depression.

High levels of clinical depression and extremely high stress, and this was pre-pandemic. And then last to highlight — a report on the impacts of the pandemic on young children and their parents. That was done actually close to the beginning of the pandemic in 2020. Shows that, and I quote, "Even then," quote, "the percentage of young children with significant difficulties is much higher than," quote, "normal." I'm not sure what normal refers to. But this was based on data from the Strengths and Difficulties questionnaire that was filled out, completed by parents.

Given the struggles not only of children and families, but of our Head Start teachers, home visitors, and staff, how can mental health consultation help? First of all, I want to say that early childhood mental health consultation is not a panacea for all of the ills facing Head Start or all early childhood education programs. But early childhood mental health consultation can, when really thoughtfully designed and comprehensively implemented, address some of the challenges we're facing and that I just described.

Before we look, though, at particular practices — and that's what we're going to do today, is to look at, what are some of the best practices in mental health consultation that can increase the likelihood that we have the most efficacy in reducing these challenges? But before we get into the practices themselves, I want to begin, as I always begin, by defining infant and early childhood mental health consultation. And providing just some examples of its effectiveness in addressing the current struggles.

What is it? And want to tell you that this definition, this definition for me is evolving, it's dynamic, it changes. And that I could spend the entire hour if not the entire day taking out each part and going more deeply into this definition to talk about what it is. Early childhood mental health consultation is an evidence-based multi-level mental health strategy. I want to stop right there. What do we mean by multi-level?

By multi-level, what I mean is that we don't intervene. Mental health consultants don't intervene. Exclusively at the level of the individual child or family. But always are traversing on that vertical trajectory. We're traversing between thinking about yes, children whose challenges, whose behavior might be puzzling or concerning to staff and child-focused consultation. But were also available to think about and best, made best use of, when we also

are able to work at a programmatic level. Meaning at the classroom level or the level of working with home visitors.

At that programmatic or systemic level, to really think about policies and procedures that will support or conversely are harming young children and their families. And that this strategy, this multi-leveled mental health strategy, spans the care continuum. This for me, if the multi—level is the vertical axis, this is the horizontal axis that we can move fluidly as mental health consultants from promotion, meaning preserving and promoting the emotional and social well-being of all of the children and families, and I would add staff in a site, to prevention to intervention.

The intervention is not a direct intervention. It's an indirect practice mental health consultation. What does that mean? It means intervention through the primary adults in a child's life. That means that as mental health professionals, we partner, we collaborate with other providers and parents who care for or offer services to infants, young children, and their families. It's indirect, and that always the aim is toward benefiting individual children and families and all of the families in the program. But that happens through the partnership with the provider. So that the services of mental health consultation are really aimed at capacity building of the adults.

If we think this as a capacity-building endeavor, we have to ask ourselves, what capacities do we think it's important to support or where need be enhanced in those directly working with young children and families? Home visitors and teachers. I would suggest that capacities related to supporting or where need be increasing the social and emotional awareness, competency, and knowledge of teachers and family home visitors also enhancing reflective confidence.

What's reflective confidence? The idea of being self-aware. Self-aware of our own beliefs and biases and how they impact for good or for ill all of the children and families we serve. Reflective confidence and competence in the adults who support young children. With that definition, let's look at how this practice of mental health consultation, this mental health subspecialty, can begin to address some of the challenges that we are all across the country struggling with in Head Start.

Recognizing that really it is the adults in children's life, the adults' well-being that is central to children's development. If we think about this, we know that that's true of parents. That if parents are stressed, struggling, don't have resources, are experiencing racism or other forms of systemic oppression, no matter how much they want to be present to their children, it's compromised.

I'm asking that we extend that same understanding to the other important adults in children's lives, meaning their teachers. When we spend five days a week, eight hours a day, sometimes with children as young as six to eight months, those relationships matter. The adults' well-being, as it allows or inhibits from being present to accurate really reading the cues, attuning to children's needs, will matter mightily to that child's development. Because what we know and we may have benefited from a science, meaning neuroimaging that showed us pictures of the brain, but I think our grandparents and their grandparents before them knew that it's the

moment-to-moment experiences, the moment to moment interactions between young children and their caregivers that contributes to all domains of development.

We may be talking primarily about social and emotional development. But how a child is understood, is treated, will influence their cognitive capacities, their language ability. Even their fine and gross motor skills are determined by relationships. So that what we want to do, I would suggest in mental health consultation, is primarily focused on the well-being of the adults who are in direct relationship with the children. Attending to the impacts of trauma, racism, marginalized status of providers, is integral to their ability to optimally care for children.

I think also that early childhood mental health consultation derives its power by being what I call a broad-based service. Most mental health services are seen solely as an intervention strategy around a specific child who might already have a diagnosable difficulty or whose score on an ASQ or behavior in the classroom is of concern and therefore being challenging. And while yes, mental health consultation is and should tend to the difficulties of individual children, it I think is important part that we think of early childhood mental health consultation as a more upstream approach, as able to benefit all children in a classroom. Not just the child who is struggling.

Early childhood mental health consultation can promote the mental health, the social and emotional well-being, of all children in a site. We want to attend, therefore, to not only all children, but all levels of the system, as they are interconnected and either work well or unfortunately bode poorly for all children in a Head Start site. How? How does mental health consultation promote particularly provider well-being? And why does it matter to strengthen staff's capacity and their well-being?

As we acknowledged earlier, stress is at an all-time high for many of us. But for many Head Start providers in particular. What we know is that teachers who report greater job stress, depression, and anxiety tend also to be the teachers who report greater levels of problem behaviors in their children. This isn't surprising when any of our resources are taxed. If we think about ourselves, when we're feeling overstressed, overwhelmed, depressed, we are more irritable. We have less resources to bring to those around us. It's not a surprise that when teachers are stressed, they report more problem behaviors.

Conversely though, studies show us that teachers who participate in early childhood mental health consultation, when that consultation is aimed at supporting teachers, those teachers describe decreased stress and are less likely to rely on suspension, expulsion, or harsh disciplinary practices as ways of remedying their tension. When you're stressed or depressed, it's hard also to feel like anything you do matters. We're talking now about this idea of self-efficacy. Many teachers describe feeling ineffective, especially in addressing challenging behaviors.

I can tell you from a process evaluation and a program and mental health consultation program that I directed for three decades; we asked providers prior to consultation using a teacher self-efficacy measure whether much of what they did during the day mattered. Questions were

questions like, do you think that anything you do with the children in your care contributes to their development?

Regrettably, unfortunately, the majority of teachers, almost 60% of teachers prior to mental health consultation, said no. If we think about it, if you don't think that what you do matters, why would you be interested in expanding on it, changing it? Influencing your practice. So that what feels important here is that what mental health consultation has been shown to do is to boost the sense of efficacy for teachers and home visitors.

As I said, I would really posit that feeling like your actions have an impact on children and families is a necessary precursor to changing our perspectives and our behavior. Also, mental health professionals are people who should, I think, appreciate, and address the impacts of stress and trauma. As mental health professionals, we are trained to do so.

By inviting, listening deeply, and leaning into staff and families' distress. Being able to engage in sometimes uncomfortable, disheartening, difficult conversations, mental health consultants can help providers and parents to first recognize, regulate, and channel troubling experiences that otherwise would likely be passed along to or obstruct their ability to respond well to children in their care.

Research is confirming that these characteristics, these characteristics of what I’m really talking about, is the relationship. The relationship between us as a mental health consultant and our consultees — teachers, home visitors, in the case of child-focused consultation, parents. That research is confirming what I have hypothesized for a long time, and that is that our way of being with our consultees, the way a mental health consultant comports herself, her demeanor.

What do we mean by that? I mean the way that we are curious about the provider’s experience. The way that we respect the provider’s experience and expertise. The way that we do not judge how people are currently providing care. That through parallel process, through, as my mentor [Inaudible] Paul called, the platinum rule. The even higher order rule than the golden rule. We all learned the golden rule or many of us when we were little that said, do unto others — treat other people the way you want to be treated.

And what my mentor [Inaudible] Paul said is, there's an even higher order rule. And that is, do unto others as you would have them do unto others and apply to mental health consultation. What this means is when we are curious about the subjective experience of our consultees, of providers and parents, when we think that their experience matters, when we respect the work they're doing, they are more likely in turn to be curious about the experience of children. To respect, be attuned to children's cues and have better relationships with the children in their care.

What some of my colleagues — actually colleagues in Arizona. Eva Shivers at Indigo Cultural Center and Annie Davis, previously of Georgetown, have found by analyzing the statewide data of Arizona's infant and early childhood mental health consultation initiative is that consultative relationships, the quality of those relationships, matters more. When the focus of mental

health consultation is a boy of color, what does that look like? I want to tell you here that the references for any of the studies that I mentioned during this presentation you have as a handout. So that what Indigo Cultural Center – what Annie Davis and Eva Marie Shrivers found was that at the beginning of consultation, of all the children who teachers said they were concerned about, whose behavior they wanted to focus on with and through mental health consultation, when you disaggregated that data, when you looked at African American and Latinx boys, teachers initially — pre-mental health consultation, teachers initially rated those children, even among all children they were concerned about, as more concerning.

They said that often those children from their perception were more impulsive, more aggressive, had less self-control. Yet, at just a six-month interval, at a six-month interval, what teachers said was that they rated those children, those African American Latinx children as similar to and actually exceeded in terms of their gains. The other children about whom they were concerned. What does this tell us? It may tell us something about a change in children's behavior.

But what it absolutely tells us about is a change in teachers' perceptions of those children, and therefore a way of understanding and treating them. Which matters mightily to children. When the teacher said, I previously didn't feel very attached to this child. But now, I feel more attached. I feel more able to persevere in supporting this child. What we know now is that that child will feel that attachment, will feel that teachers attempt to understand and respond contingently to his behavior. This happened, though, and this is an important qualifier. These positive outcomes and changes of perception and therefore for children happened only with two circumstances for boys of color.

One when the consultant – and I recognize this as a funny term to use – expertise, when we're talking about ourselves, experience of how we think about cultural sensitivity or our experience or journey, I would say, in terms of critical self-awareness around equity, diversity, and culture. But when mental health consultants said, I am on my own journey, I am studying our history, I am thinking about and aware of the ways in which systemic racism is imbued in all of our institutions and knowing that early childhood education is not immune to those. Those, those consultants, as well as consultants who matched, racially matched, the teachers that they were consulting to, those were the instances when we saw positive outcomes.

Let's turn to, what are some of the fundamental practices that can help us ensure these positive outcomes that we've been talking about? And I'm going to begin with, if you remember when I started, and I talked about this being a multi-level service. I'm going to start with the levels.

Typically in consultation to Head Start classrooms, there are three types of consultation offered. And they're usually referred to as programmatic, classroom, or in home visiting, home visiting groups, or child and family focused. These first two types – programmatic, classroom, and home visiting — these are aimed at supporting, or where need be, enhancing the program and the staff's ability, the capacity of staff are aimed at the ability to engage, to engage more fully in relationships with children.

But also, in relationships with one another. Mental health consultation focuses on not only the teacher/child or the family/home visitor relationship but focuses on the concentric ring of adult relationships in a system. Interstaff, relationships, director/staff, manager/staff relationships. Why? Because adult relationships matter to how children can be understood, held, and treated. In child focus consultation is, as it describes, a child-focused consultation is when there is a concern about a child's development, their social and emotional development, or their behavior.

The idea is that the focus would always include the parents of that child, the mental health consultant meeting with, and all of the important adults in a child's life – teachers, parents, and integrating the knowledge gained from conversations with these adults and through observation so that the mental health consultant can add her expertise about development, both typical and pathological. And her knowledge of mental health and relational responses to help make meaning of the child's behavior and then translate that meaning with teachers into a plan for responsive action.

Although I've described these types of consultation discretely in their little boxes, they are typically, and we find most effective when provided simultaneously and by one mental health consultant. Regardless of type though, I want to focus on the central. I'll look at all activities, but I want to focus on the central activity that is the crux of consultation.

The crux of change. The crux of positive outcomes. At is this first one. That is reflective consultation meetings with staff, with teachers, with home visitors, with family advocates, with managers and administrators. In the case of child-focused consultation, meetings with parents. What I'm stressing here is that we can't create a collaborative relationship.

We can't, as mental health consultants, contribute our knowledge or expertise or hear about the knowledge and expertise of others, address adult well-being, if we're not meeting with the staff and the families. Predictable, even if their periodic consultation meetings are essential to our – I know, not easy. Especially now with the staff shortage that we talked about in the beginning of our presentation. And I hope you can still hear me. I'm getting a message that my internet's unstable.

Amittia: Just for a second there, but it was just as you were transitioning. It's fine.

Kadija: Thank you so much, Amittia, for verifying that. Just to say once again, in case you didn't hear, is the primary activity of mental health consultation is meetings between teachers, staff, administrators, and the mental health consultant. While carving out time might be difficult and therefore be a goal, not a given, it is part of what we want to develop and have as part of a partnership agreement when we enter and ongoingly. Because that's the only place that consultation can happen.

Consultation groups are configured based on teams that work together, such as visitors or classroom staff. And group meetings are at times supplemented with individual meetings.

Individual meetings with staff who might have a specific need or staff member who is particularly stressed. Therefore, these are time limited.

We also know that it's important to supplement these meetings with observations. Observations may be of a classroom or of a child. But I want to say that observations for children are – or should be, from my perspective, only undertaken with specific parental permission. I know that we get permission for mental health consultation from all parents at the beginning of the year.

But why does permission at the moment when we're initiating a child focus consultation matter? I think if any of us are parents, we know that if somebody's going to be directly thinking about or involved with our child, it is only respectful that we have a chance to know that person, understand who they are. And most important perhaps, is that we can't as mental health consultants or teachers, we can't really understand a child or what's contributing to their difficulties or delays without talking to parents and getting parents' invaluable perspectives and long-term knowledge of the child.

We always want to have parental I want to say that a child observation are of most benefit or are only of benefit when the purpose is clearly articulated and agreed upon in advance by the important people in that child's life. Often, we think that observation is mental health consultation. What I'm suggesting is observation in and of itself is not an intervention. Observations are one but only one avenue of gaining information.

And that developing a complete picture of a program, a classroom, or a child, relies on the consultant's ability to elicit and integrate through meetings, more in-depth and long-term perspectives of the people who know a child or a classroom best. Meaning the staff and the parents. And then together, the consultant's observations in tandem with that information and along with the staff, we co-create strategies to support children and families.

And I want to just take a minute to talk about the final activities. And that is that when, in the case of a child-focused consultation, when what we find together with parents and staff is that there is a need for additional support outside the Head Start program in addition to all of the supports that Head Start can offer. In instances where a child's or family's needs exceed the interventions that are developed for and implemented in the classroom or home visiting environment, then a mental health consultant can assist in securing appropriate resources.

Along with managers and family advocates can look for and secure resources. And with parental family permission, we can act as a liaison between those outside services. And the school, the classroom, to ensure continuity among all of the services being provided to a child and family. Lastly but definitely not least, just want to stress that mental health consultation can, and I think should, also be directed at school administrators.

Because meeting with the people at all levels of the system is necessary to promote practices that support systemic health as well as individual well-being. And how we do that, some of the ways, and I'm going to just highlight a few ways that these activities are enacted. And starting

with the ways in which mental health consultants can be involved, engaged with families. Engagement of and collaboration with families of course, is, as I said, essential when the child is the focus. When the family's child is the focus of consultation.

When a particular child is the focus, I talked very briefly about how a mental health consultation might occur. But I also want to say that introducing ourselves to all families in a program – in the beginning of the year, through open houses, through newsletters, through being involved in any kind of correspondence. Pictures on the wall that says to families, a mental health consultant is available to you and to the teachers at this site to be able to think about families' concerns that may exceed or be different from those of the parents – sorry, of the providers.

As an adjunct, this is not inherent in mental health consultation. But often if a mental health consultant has become a part of the team, integrally involved with the program, we have found that co-facilitating support groups, socialization groups, parent education groups offered by Head Start staff, that the co-facilitation with a mental health professional, can not only enhance those meetings, but serves again as a capacity building endeavor for staff.

That often-supporting staff in being able to think about a mental health perspective. Not making staff into mental health practitioners but supporting staff to be able to function in a way that highlights, highlights parental experience, highlights social and emotional needs through the co-facilitation is another capacity-building endeavor. And enhances family engagement in programs.

Of course, this is central that the services provided, whether those are directly to families or also to staff, is that those be culturally congruent and have an equity focus. What do we mean by that? Is that what we mean is that as cited, like in Arizona's outcomes as an example in the Arizona early childhood mental health consultation program, is that what we saw was the best outcomes for children and families happened when there was an ethnic and cultural match.

A racial match between staff, families, and the mental health consultant, recognizing that there may be many cultures represented in a Head Start site. And so that's not always going to be possible. Also recognizing that the current mental health composition of mental health consultants around the country is primarily almost 95% white women.

While we need to do better in increasing pathways for more diverse mental health consultants, we also have to ensure that as mental health consultants or programs that employ mental health consultants, that there is an emphasis on not just training, but on really having ongoing dialogue around the needs, the cultural needs, the needs toward acknowledgment of systemic oppression, and the ways in which implicit, often unconscious bias influences all of us in this country steeped in the inequities, that we have to make a conscious practice. For ourselves as mental health consultants, and then in turn, with those that we work with.

Lastly, I want to talk just a tiny bit lastly in terms of elements of effective practice. I want to talk a bit about the frequency and duration of services. I want to start with saying there's not

mutually agreed upon best practices in terms of duration or frequency. But research offers some valuable information in terms of duration – and recognizes that mental health consultation is ongoing in Head Start programs.

But what I want to say is that the good news is that research is showing effectiveness in models that have different durations. But what we've learned is more frequent ongoing relationships is showing and correlated with most effectiveness. And this all leads to evidence which I don't have to show you – evidence of changes at both the family level. Positive changes when we implement these practices that I've just referred to with fidelity, with consistency. Leads to best practices in children and also the kind of changes in capacity that we talked about in the beginning in terms of staff's reflective capacity. Their sensitivity and attunement toward children and families.

My last comment before turning it over to Amittia to tell us more about how you might be able to think about, to get more information about mental health consultation, is that I just want to acknowledge that all of this is predicated on the idea that you can find staff. And if we can't find staff, here are some ideas about the ways in which you might locate a mental health consultant by connecting with your state's infant and early childhood mental health association by partnering with graduate programs at universities and colleges.

And beginning to consider what we have found during the pandemic is that some of the activities of mental health consultation can be extended through telehealth options. Thank you very much. I realize that was a very fast overview of mental health consultation and the foundations. Now Amittia will help us to think about a new opportunity that won't have to be as rushed as mine was in thinking about how we can learn more about the foundations of infant and early childhood mental health.

Amittia: Yes. You've given us so much to think about, right, in a short period of time. Really highlighting the role of early childhood mental health consultation and programs and what that looks like. There's a lot that's there. And some who are watching may be wondering, how can I learn more? Where can I find more about infant early childhood mental health consultation?

We have a course that is on the ELCKC website that we want to walk you to in case it might be helpful for you or those whom you work with. The Foundations for Infant Early Childhood Mental Health Consultation course was recently revised. And it really is a course that was designed to share more information about consultation.

And that's not the only course that the National Center on Health Behavior Health and Safety has there in the IPD portfolio. We have some other courses that you might find helpful as well. One on preventing infectious diseases, one on movement in the brain. I Look Out strategies is focused on preventing child incidents. We're really trying to build this portfolio with resources and opportunities – options. Options, not opportunities. Options for you all to engage with additional learning around some of these really important pieces and practices in the work. You can go to the next slide.

I just wanted to take a moment to show you how to get to the IPD portfolio suite, if you will. You start with the ELCKC's website. And you go there. And then when you get there – you can go to the next slide. You hit IPD – was not the next slide, it was the next.

Kadija: Sorry, Amittia.

Amittia: Apologies. As you see, if you scroll down, you'll click IPD at the bottom. Now if you have not done any courses before – you can go to the next slide – you'll need to register. By doing that, you click Join. There's also a step by step in how to get set up with the IPD Individualized Professional Development portfolio site. You'll want to do that or walk through that the first time.

But from there, once you're set up, all you have to do is log in and then search for the course that you desire to pursue. Next slide. The Foundations for Infant Early Childhood Mental Health Consultation is listed there. You'll be able to access the course there if you choose to. If you have any questions though, you can contact the IPD help desk. The website is listed there at the bottom of that slide. That's that, y'all.

Kadija: Thank you. Thank you, Amittia.

Amittia: Give you an opportunity to see what it looks and feels like to get to that place in case you find it helpful. In the remaining minutes, this is just showing what it looks and feels. My apologies. Once you get into the course. You'll be able to see the different courses you have completed. It's really cool in that it can calculate the continuing professional development hours, and you have a little transcript that shows all the things you've done. It's a really amazing resource for continuing to grow and learn about Head Start and programs and serving young children [Inaudible]. I recommend you check that out if you haven't so far.

With the remaining time we have, we would love to invite any questions. I can start with one that came in while you were sharing about not just the importance of infant early childhood consultation. But you were getting in a place where you're starting to talk about the impact of infant early childhood mental health consultation. I believe you answered this question live when you came back around to it. But one of the questions is asking for you to repeat the piece related to what happens after six months of consultation. I believe you were just highlighting that the value that can be added or impact or changed findings.

Kadija: Thank you, Amittia. And thanks for the question. yes, this particular outcome that we were talking about was in relation to the particular power of mental health consultation in what we might think about is addressing issues of racism or other kinds of bias. this was from data from Arizona's statewide infant and early childhood mental health consultation program, which is called Smart Support.

You may remember that I said that all of the references were given to you in a handout. the references to look at more in depth around the outcomes of this particular work is – you have. They are from Dr. Eva Marie Shiver and her colleagues at Indigo Cultural Center. Specifically

what we were talking about was this idea that what we're finding generally, meaning that many studies, studies done by Beth Green at the University of Oregon and others, have found that the most – the best predictor, the most salient factor in positive outcomes for children as a result of mental health consultation has to do with the ways teachers report their relationship with the consultant. The idea, that parallel process idea that I was mentioning, that idea of the platinum rule, what studies are showing and some of us hypothesize is that the ways in which the teacher perceives the mental health consultant to be interested in her subjective experience.

Tending to her or his well-being. Being a team player. Not coming in as the sole expert, but rather collaborating with. Those factors lead to the best outcomes for all children. But what the particular emphasis that I was citing was related to that quality of the relationship mattering even more when the child who was the focus of mental health consultation is a child, a boy, of color. What that means is that when those consultees, those teachers said, my consultant really understands me.

Part of why they felt like their consultant understood them was because either there was an ethnic and racial match between consultant and consultee, or because when looking at which consultants the teacher said they had a best relationship with, those were consultants who said, I, I have, either in my program or as a sole practitioner, I have engaged intentionally in thinking about, in researching and studying, in the internal journey of self-awareness around social justice, equity, diversity.

I've been doing my work. Therefore, I am able to explicitly engage in conversations about inequities, whether that's racism, whether that's about gender identity, whether that's about ableism. Those consultants who felt maybe not comfortable, but willing to lean into difficult topics. Those were the consultants who teachers said they had the best relationship with. I'm getting to your question, and then what they found when they looked at the data on those children who teachers who had the best relationships were working with, those teachers said, I had initially felt like I couldn't understand this child. Or I saw him as more threatening or more aggressive.

Common misperceptions of boys of color. After the work, together, after six months of mental health consultation, those teachers said, I understand this child differently. I see them differently. I feel more able to engage with them. Maybe these are children whose traumas or difficulties have led to them having behaviors that are challenging, delays that are difficult concerns. The teacher felt more able to address those after six months of consultation with someone she felt was a partner with him.

Amittia: Yes. Thank you so much for sharing that additional context. Kadija is so helpful. I want to elevate one piece that you didn't get to mention as you walked that walk on the parallel process. It is the importance of high-quality training and reflective supervision for consultants. Training and reflective supervision in which there is equity embedded within it to equip the consultants to go there, right, or to be willing or be more open.

The fact that they would have a safe landing space to process their own pieces and to continue to learn and grow is another key element in this process. I see we have got some questions. Ain't that just like how — ain't that how it is? How the questions are coming in at the end. I think we'll have time to answer one more, Nydia. Is that OK?

Nydia: We can squeeze in one more.

Amittia: OK, one more.

Kadija: OK.

Amittia: There's a —

Kadija: Amittia, why don't you pick and respond to one.

Amittia: Yeah, there's a question about working with children with special needs and how much more likely they are to come into Head Start programs. Head Start is willing to invite them and be inclusive. Yet, there are struggles with receiving services and supports in the classroom. The question is, what would you recommend on how to better help meet the needs of some of those kiddos with special needs?

I love this question. I think it's really important. It really reflects some of the systemic issues across our nation right now in terms of part C and part B being able to meet some of those needs. Because there are staffing issues and also delays in services noted within those spaces as well. It's definitely impacting Head Start programs and being able to get the coaching or the support around how to best support the young child and the family.

I would say that there are a lot of things that one might explore. But the situations are so nuanced. What are the needs of the child? I do think I notice people more intentionally and simultaneously not waiting, but engaging with other community partners while they await for support or they are in the process of being supported by part B and part C. I think that's just one of the things that come to mind for me, is to explore additional community partnerships within the public and private sector depending on what those specific needs are. Do you have any thoughts of also, Kadija?

Kadija: Oh, I do. But I also want to be respectful of our time. I think we're at the end of it. Thank you very much for coming in and giving your voice, albeit at the very end. Amittia, I really appreciate doing this with you. Maybe, I'm sure we would like to move along.

Nydia: Thank you both. You guys, we managed to squeeze in a couple questions there. Thank you so much again to our presenters, Kadija Johnston, Amittia Parker, for this very important information today. If you have more questions, you can go to MyPeers or write to help@ecetta.info. The evaluation URL will be placed in the chat, and it will appear when you leave the Zoom platform.

Remember that after submitting the evaluation, you will see a new URL. And this link is the one that will allow you to access, download, and save, and print your certificates. You can subscribe to our monthly list of resources using this URL. You can find our resources in the Help section of the ECLKC or write us. Again, it's help@ecetta.info. Thank you all for your participation today, and I think you can close the Zoom platform. Thank you, everyone.