Essential Elements of Infant and Early Childhood Mental Health Consultation: Inside the Black Box of Preschool Expulsion Prevention

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Abstract: Exclusionary discipline practices differentially harm young children of color. As early childhood education systems seek to close these gaps to ensure all young children have access to high quality early learning experiences, the field requires more evidence-based approaches that can be scaled and replicated. Infant and early childhood mental health consultation (IECMHC) has been associated with lower rates of preschool expulsion; but the field lacks clear guidance on the essential elements of high quality IECMHC. Without such guidance, researchers cannot build a credible evidence base for the causal link between IECMHC and exclusionary discipline. An interdisciplinary research team, with support from the national Center for Excellence in IECMHC, led a consensus-building process to identify the essential activities of IECMHC as implemented across settings. The three-stage Delphi Process resulted in a list of five essential elements and 26 activities that define IECMHC and make concrete its emphasis on relationships and equity. This greater clarity around the activities of IECMHC can help inform future research and evaluation, as well as workforce and professional development.

Keywords: exclusionary discipline, fidelity, early childhood education, infant and early childhood mental health consultation, Delphi Process

Introduction

Early childhood education (ECE) settings – including childcare and preschool – are intended to be supportive environments for young children to develop pre-academic, social, and self-regulatory skills during the most rapid and impactful stage of development across the lifespan (Bartlett & Smith, 2019; Phillips et al., 2022). Furthermore, ECE can be a potent force for increasing equity by providing enriching experiences for young children impacted by systemic patterns of oppression including racism and/or socioeconomic disadvantage (Melhuish, 2011; Yoshikawa et al., 2013). The lofty potential of ECE is undermined by exclusionary discipline (ExD), which removes a student from the school setting via expulsion or suspension. A seminal study revealed that rates of expulsion for three- and four-year-olds from state-funded pre-kindergarten were approximately three times higher than the rates for school-aged children (Gilliam, 2005). The risk of expulsion among young children is not distributed equally. In public pre-K, the rates of ExD for Black and Indigenous children were about 2.7 and 1.6 times higher than those for White children, respectively. Additionally, the rate of use of ExD for boys was about 4 times higher than the rate for girls (Fabes et al., 2021). In addition to racial and gender disparities, children who have experienced early adversity and children with attentional deficits are at increased risk of ExD, despite being a group of children who may benefit most from stable and positive relationships with ECE staff (Zeng et al., 2019, 2020). Although ExD is typically described as a consequence of children's challenging behaviors, it is better understood as a decision made by ECE staff, often when they feel overwhelmed and under-supported (An & Horn, 2022; Martin et al., 2018; Mondi et al., 2022) and when they hold negative perceptions of the child's parents (Zulauf & Zinsser, 2019). Teacher interpretations of child behavior may reflect the influence of implicit bias, as well as misunderstandings of behavior that can be both

challenging but developmentally typical (Davis et al., 2020; Meek & Gilliam, 2016). Despite being a response to behavior, ExD is not an effective behavior management technique; in fact, it removes very young children from the settings where they may be able to access needed early intervention supports, including developmental assessments and referrals for external services (Meek & Gilliam, 2016)

For these reasons, a range of policy efforts have been implemented recently to curtail the use of ExD in ECE (Loomis et al., 2022). While policy change has been promising, ECE staff must have access to alternatives; otherwise, there may be unintended negative consequences such as "soft expulsion" or changes to enrollment criteria (Meek at al., 2020). In reflecting upon their workforce preparation, ECE staff cite behavior management as a leading unmet need (Hemmeter et al., 2022; Snell et al., 2012). They also experience a myriad of additional stressors including low pay and stressful work environments (Cumming, 2017; Hall-Kenyon et al., 2014; Hubel et al., 2020) – and many of those stressors were exacerbated by the COVID-19 pandemic (Crawford et al., 2021). Staff who more frequently use social-emotional learning supports (e.g., books and charts teaching about emotions, meetings with supervisor) have been shown to request fewer expulsions – a link that was mediated by reduced teacher stress (Zinsser et al., 2019). A more supported ECE workforce is an essential component of lasting reductions in ExD.

One of the few supports for the ECE workforce that has been linked with reduced expulsion rates is Infant and Early Childhood Mental Health Consultation (IECMHC). IECMHC has been implemented in a range of settings that serve young children, and the past ten years have seen a vast increase in federal and local funding for this service across the nation. IECMHC indirectly benefits children by bolstering the skills and reflective capacity of the adults who care for them, and by improving the policies and practices of child-serving programs (Brennan et al.,

2008; Center of Excellence for IECMHC, 2021; Silver et al., 2022). Several studies have documented an association between IECMHC implemented in early childhood education (ECE) settings and reduced programmatic rates of expulsion as well as reduced expulsion risk for individual children (as measured by the Preschool Expulsion Risk Measure; Albritton et al., 2019; Conners Edge et al., 2020; Perry et al., 2008; Upshur et al., 2009). Based on the mounting evidence linking IECMHC with reductions in exclusionary discipline, policymakers cite it as one of just several services promoted as a potential antidote to preschool suspension and expulsion (Loomis et al., 2022; U.S. Department of Health and Human Services and U.S. Department of Education, 2014). However, research has not yet determined whether IECMHC may close disparities in ExD based on race and gender (Albritton et al., 2019).

While there are relatively few studies that have investigated the direct link between IECMHC and ExD, many studies have demonstrated the link between IECMHC and correlates of ExD. For instance, many studies using different designs and measures have found that IECMHC is associated with improved teacher self-efficacy, reduced child externalizing behaviors, improved social emotional competencies, and more positive teacher-child relationships (Meek & Gilliam, 2016; Silver et al., 2022). These studies have been conducted over the course of several decades, reflecting different populations of children and adults, various geographic locations, a range of amounts or intensities of IECMHC, and multiple ECE setting types (Silver et al., 2022). One study demonstrated that, after IECMHC, racial disparities in teacher-rated conflict with children were eliminated. Specifically, teachers rated their relationships with Black children as higher in conflict at baseline compared to their relationships with White children, and after six months of consultation there was no difference in teacher-rated conflict between Black and White children (Shivers et al., 2021). These findings, along with

practice-based perspectives from the field, suggest that IECMHC may be an effective tool for addressing racial disparities (Shivers et al., 2021; Silverman & Hutchison, 2019). This evidence is critically important in light of the disproportionate use of exclusionary discipline with children of color – particularly Black children – in the absence of objective differences in challenging behaviors based on race (Sabol et al., 2021; Zinsser et al., 2022).

IECMHC is unique in that the particular activities the consultant employs are adjusted to meet the specific needs of the consultee and setting. The theory of change for IECMHC highlights that it is a combination of 1) the particular activities of consultation and 2) the strength of the relationship formed between consultant and consultee that directly affects providers' capacity to enhance infant and early childhood mental health. The direct effects on providers include improved self-efficacy, behavior management strategies, and relationships with children; expanded provider abilities indirectly lead to child outcomes, such as reduced challenging behavior and improved pro-social skills (Tidus et al., 2022). It is also theorized that not only are child outcomes improved, but racial disparities in those outcomes are attenuated through the trusting alliance formed between the consultant and consultee, and the ensuing open dialogue around race and bias, including biased attributions of child behavior (Davis et al., 2021; Davis, Perry, et al., 2020).

While all IECMHC studies cited here are based upon the above foundational understanding of the work, it is a limitation of the evidence base to date that there is wide variability in IECMHC implementation. Despite its promising evidence, the field lacks definitive guidance on the essential activities of IECMHC – as distinct from related services such as coaching. The lack of clear parameters stymies efforts to train and supervise consultants in a uniform manner; advocate with policymakers for expanded funding streams; and conduct cross-

site research studies. Best practices in implementation science dictate that implementation of an intervention should be monitored with a fidelity measure, which is a tool to assess the extent to which essential model components are delivered as intended (Fixsen et al., 2005). The fidelity of implementation has implications for understanding the effectiveness of an intervention, scaling the intervention, and ensuring the validity of research on the intervention. High fidelity implementation is associated with greater likelihood of positive outcomes, while neglecting fidelity can hinder scaling efforts (Carroll et al., 2007; Fixsen et al., 2005). Addressing fidelity helps identify implementation challenges and improves the validity and reliability of research findings (Durlak & DuPre, 2008). Without knowing if an intervention is consistently delivered as intended, any null findings could either reflect a lack of intervention effectiveness or a lack of adherence to the intervention (Carroll et al., 2007).

The purpose of this study was to clearly articulate the essential elements and activities of IECMHC across settings, and – consistent with the theory of change – to explicitly center the importance of the relationships formed and the promotion of racial equity in those activities. By seeking to understand the "black box" of consultation, the processes by which IECMHC directly affects the adults who work with young children could become clearer. These adults make the decision about whether to expel a child, and their wellbeing, implicit biases, and overall skillfulness in fostering social-emotional health in the classroom have significant impacts on young children. Improved understanding of the activities of IECMHC would help illuminate the pathway(s) through which IECMHC may enhance ECE experiences and outcomes for young children and in particular for children from racially minoritized groups who are at increased risk for ExD.

Methods

The Delphi Method

To accomplish the task of articulating the essential activities of IECMHC, a scholarly process called a Delphi method was selected. First described by the RAND Corporation in 1969 (Dalkey, 1969), this method was designed to build consensus among expert stakeholders. It is well-suited to providing insights into complex and/or controversial topics about which there is little extant empirical knowledge (Iqbal & Pipon-Young, 2009). It was selected because it allowed the researchers to center consultant expertise and experience in a manner that aligns with, but goes beyond, member checking, consistent with a value for participatory action research (Motulsky, 2021).

In a Delphi process, researchers identify a panel of subject-matter experts and lead them through an iterative process of data collection, analysis, and refinement until consensus is reached on the topic of interest (Linstone et al., 1975). While data collection can integrate multiple approaches – including surveys, in-person and virtual interviews, and focus groups – the current objectives were met using three rounds of online survey data that included qualitative and quantitative items. The survey format provides anonymity for panelists, alleviating the issue of peer pressure to conform to majority opinion – particularly for the first round of data collection. This format also allows for equal voice for all participants, not just a few dominant individuals (O'Neill et al., 2019) and enables researchers to recruit from a geographically diverse applicant pool. Further, the survey format gives panelists time to fully develop their thoughts and contributions without interruption or externally imposed time limitations, which can be an issue with in-person methods.

The Delphi method employs multiple rounds of researcher-created surveys, beginning with an "idea generation" survey leading to one or more "evaluation" surveys in which panelists

react to the idea synthesis that occurred after the first survey (Iqbal & Pipon-Young, 2009). This method has been used successfully to identify core components of related fields such as evidence-based home visiting (Haroz et al., 2022) and reflective supervision in the infant mental health field (Tomlin et al., 2014). Using the Delphi method also allows for a balance of inductive and deductive reasoning, thus lends itself as an appropriate method to define the essential elements and activities of IECMHC.

Participants

The selection of panelists is one of the most important parts of a Delphi process (Vernon, 2009). To achieve a strong and diverse panel whose expertise aligned with study objectives, the research team sought experienced consultants who presented a range of geography, personal demographics, and IECMHC program characteristics (including settings served). In addition, the team looked for consultants with demonstrated knowledge of the consultative stance (Johnston & Brinamen, 2006) and racial equity-advancing consultation practice since these topics would be asked about in detail in this study.

The team developed a web-based online application using Qualtrics software and disseminated it widely via a 14,000+ member national IECMHC-focused listserv maintained by the Center of Excellence for Infant and Early Childhood Mental Health Consultation[1] and direct email outreach to known contacts in the field. In addition to closed-end questions, the application survey included two open-ended questions: “Please describe how you apply the consultative

[1] The Center of Excellence for Infant & Early Childhood Mental Consultation (CoE for IECMHC) funded by the Substance Abuse and Mental Health Services Administration, is a national center providing technical assistance to programs, communities, states, territories, and tribal communities, and electronic professional development to individual mental health consultants to increase access to high quality mental health consultation throughout the country. The Center aims to impact the field of IECMHC by supporting the growth and advancement of the profession. The CoE is housed at the Georgetown University Center for Child and Human Development with partners at the Children's Equity Project (housed at Arizona State University), Tulane University and others.

stance in your work" and "What specific actions and activities do you implement to advance equity and cultural sensitivity within the programs/settings that you serve?"

Full-time consultants and supervisors formerly serving as consultants, preferably with at least 5 years of IECMHC experience, were invited to apply. Individuals with experience providing consultation in "non-traditional" (i.e., non-ECE settings) were particularly encouraged to submit applications to support generalization of findings to all consultation settings.

The recruitment phase spanned from early September to mid-October 2021 (see Figure 1 for full timeline). Out of 154 applicants, 30 panelists were selected based on an extensive review process. This sample size is consistent with accepted Delphi methodology, which generally includes less than 50 participants (Witikin & Altschuld, 1995) and most commonly between 15 and 20 (Ludwig, 1997). Panelist selections balanced the priorities of 1) geographic and racial/ethnic diversity, 2) extensive IECMHC professional experience, 3) implementation setting variability, and 4) high-quality responses to open-ended prompts about the consultative stance and equity. The research team oversampled applicants who provided thoughtful open-ended responses *and* served non-traditional settings given the importance of these perspectives in discerning truly essential IECMHC activities. Among this pool, the team selected as diverse a panel as possible across race, ethnicity, and geography. The selected panel incorporated representation from consultants who served one or more non-traditional settings, including home visiting (15%), early intervention (13%), elementary schools (8%), child welfare (5%), and primary care (4%). Of the 26 respondents who completed the first survey, 54% indicated they have experience in more than one setting. Most were Master's-prepared professionals (90%) with, on average, 9 years of consultant experience. As reflects the current IECMHC workforce,

the majority identified as female (93%) and White (70%; see Table 1) which aligns with the applicant pool, where 60% identified as White and 94% identified as female.

As part of their acceptance to participate in the study, panelists who indicated on their application that they served non-traditional setting(s) were asked to confirm which implementation setting they felt most comfortable representing in the study. Given that several applicants served multiple non-traditional settings, low response to representation of "primary care" warranted omission of this perspective from the study. With each survey that was administered, panelists were again prompted to confirm that the consultation setting they indicated at acceptance would be used as their primary frame of reference when responding to survey questions.

Procedures

This study employed three iterative rounds of data collection, which is a common practice and thought to be sufficient for reaching consensus (Hsu & Sandford, 2007). Data collection took place over eight months, from Fall 2021 to Summer 2022, with each survey spaced approximately 2 months apart (see Figure 1). All surveys were administered using a web-based survey platform, Qualtrics. Of the 30 who were invited to participate, 29 participated in at least one of the three surveys and the majority (26) completed all three surveys.

Given the nature of the study, the Georgetown University Institutional Review Board deemed it exempt from full review. Panelists provided informed consent prior to completing the first survey. As incentive, a $30 Amazon gift card was provided for each survey submitted.

The initial, open-ended survey generated responses that were synthesized by the research team and shared back with panelists in two subsequent rounds to reach group consensus. This

study intentionally refrained from beginning with a predefined list of activities to prove or disprove, to maximize the benefit of applying the Delphi method and to avoid leading the panel.

Survey 1.

The first survey asked a series of open-ended questions that prompted panelists to provide detailed information about the activities they perform as a mental health consultant. The primary objective of the first survey was to learn ***what*** the consultants do and, just as importantly, ***how*** they do it (incorporating considerations related to equity and relationships). Panelists wrote in activities one-at-a-time with separate sections to enter in activities grouped by consultation "levels" that are well-established in the field: child/family/individual, classroom/home/group, programmatic, and other. See Table 2 for an example of a panelist's responses to the prompts, describing a child/family/individual level activity.

Qualitative analysis was used to integrate the responses into an initial list of essential activities that would be shared with panelists in Survey 2 to gauge their agreement or lack thereof with the synthesis of information provided in Survey 1. Qualitative analysis unfolded in multiple steps: 1) exploratory content analysis of activities across implementation setting types and 2) hybrid thematic coding (Braun & Clarke, 2006; Fereday et al., 2006). These steps were designed to pursue the dual objectives of: 1) isolating the activities of IECMHC that are universal across settings, and 2) elevating the equity-enhancing and relationship-based aspects of IECMHC that are consistent with its theory of change (Center of Excellence for IECMHC, 2021), but poorly defined in prior attempts to articulate the activities of IECMHC. The process of qualitative analysis of Survey 1 unfolded in three concurrent stages.

One stage prioritized identifying the concrete activities core to IECMHC across settings. Primary documents were divided up by implementation setting type: 1) ECE, 2) elementary

schools, 3) home visiting, 4) early intervention, and 5) child welfare. As previously mentioned, primary care was omitted due to insufficient numbers of experts working in this setting. For each implementation setting, a team of two reviewed all responses submitted by the panelists representing that setting and created a setting-specific list of activities. The five resulting activity lists were then compiled and integrated into one list that represented all settings. Because the purpose of this Delphi was to generate a list of activities that were universal across implementation setting types, not exclusive to ECE, this step served as important "check and balance." Also, this step helped to eliminate the impact of differential response rates per setting because each setting had one list of activities regardless of the number of respondents.

In order to incorporate the nuanced insights shared by panelists on fostering robust relationships and promoting equity for children, two parallel coding endeavors were undertaken as a means of addressing this gap. One research team member with expertise in equity and antiracist practices reviewed all primary documents, pulling out activities and/or responses to the equity follow-up questions that described action items for enhancing equity. Similarly, a research team member with expertise in therapeutic and consultative relationships reviewed all primary documents and pulled out activities and/or responses to the relationship-building follow-up questions that panelists mentioned pertaining to relationship-building.

Ultimately, the research team had created 1) an integrated activity list that was agnostic to setting; 2) a list of approaches related to how consultants build trusting, nonhierarchical relationships with consultees; and 3) a list of approaches consultants take specific actions to enhancing the cultural responsivity of their consultation. The full research team reviewed the lists and proposed ways to integrate them. Through an iterative process, they were synthesized into an initial list with 27 activities and 5 elements. One element was specific to relationship-

building and one was specific to equity, and those constructs were also infused into the other elements.

Survey 2.

The initial list of essential elements and activities generated by the qualitative analysis of Survey 1 responses formed the foundation of Survey 2. In Survey 2, the participants viewed each individual element and activity and were asked to rate how essential they thought each element and activity is to IECMHC. The participants used a sliding Likert scale from 0-100 with 5 labels ranging from "Strongly Disagree" to "Strongly Agree." Panelists were invited to share open-ended feedback after they rated each essential element ("Please explain your response") and at the end of the survey ("Please share any additional feedback on the Elements and Activities of IECMHC. In particular, please indicate if you think anything is missing, should be reworded, or should be omitted"). Additionally, the participants who had indicated they provided IECMHC in multiple settings were asked whether the five overarching elements were essential across settings ("Do you believe that this element could be essential across settings? Please respond on behalf of the settings you indicated above where you have provided IECMHC. For example, if you have worked in ECE and Home Visiting, please share your thoughts on whether it could be considered essential in both of those settings").

Survey 2 data analysis was primarily quantitative. At this stage of the Delphi process, a standard for consensus is set, and researchers assess which items have reached consensus and which have not. Items that have reached consensus are considered final, whereas those that do not reach consensus are edited to attempt to reach consensus in the next round (Brady, 2015; Linstone et al., 1975).

There is no universal standard for consensus, in part given the variability in response types possible, and there have been over 15 types of consensus measurement used in previous Delphi studies (von der Gracht, 2012). Two accepted methods are: 1) to set a standard a priori based on a prior study or existing metric in the field, or 2) to set a standard based on the dispersion of the data obtained in the first round of data collection (Vernon, 2009; von der Gracht, 2012). Given the lack of prior studies to indicate a meaningful cut-point for these data, the team opted for the latter approach. For each item, the research team used the following threshold for consensus: at least 80% of participants rated the item 80 or higher on the aforementioned agreement/disagreement scale of 0-100. For the items that did not reach consensus based on Survey 2, qualitative responses from all participants were reviewed. After examining the qualitative responses for the "non-consensus" items and reaching internal agreement across the research team, those items were edited and prepared for re-review by the panelists in Survey 3.

Survey 3.

The final survey presented revised versions of the items that did not achieve consensus. For each of those items, participants were asked whether they thought that the revised item was essential to IECMHC and therefore should be retained, or whether it should be dropped because it was still not essential. Respondents were shown the original items, consensus levels, alternative wording, and then asked whether the new item was essential to IECMHC. Alternatively, for one item, the researchers did not suggest alternative wording but instead asked whether panelists agreed that it should be dropped. An example of this question type from Survey 3 is provided below:

Original wording of activity that did not reach group consensus: "Transition to service conclusion with supports in place to maintain progress."

Results: 69.2% of you scored this one above 80 on a scale from 0-100. The average score was 79.62. This was below the threshold for group consensus.

We created alternative wording based on your feedback: "Support and empower consultees through staff transitions, shifts in the focus of consultation, or case closures (in time-limited consultation)."

- *Yes, it is an essential activity of IECMHC*
- *No, drop this item"*

Because this was the last survey, no additional rounds of edits could be accommodated. Revised items that reached consensus were retained for the final activity list, and those that failed to reach that standard were dropped.

Results

Survey 1

Of the 30 panelists, 28 participated in Survey 1. As described above, Survey 1 yielded substantial qualitative data that were coded in a multi-stage process using content analysis and then hybrid thematic analysis (Braun & Clarke, 2006; Fereday et al., 2006). An example of a completed activity response matrix response can be found in Table 2. Through the qualitative analyses conducted using the data from Survey 1, the researchers identified five fundamental elements and a total of 27 specific activities associated with IECMHC. The five essential elements are: 1) Structure the process for consultation, 2) Build and nurture strong, equitable consultative relationships that foster readiness for and commitment to consultation, 3) Optimize consultee capacity to support IECMH through new ways of thinking and acting, 4) Empower consultees to enhance equity in their roles, and 5) Attend to consultant skills, self-care, and self-awareness.

Survey 2

This round, as described previously, utilized a rating scale to attain agreement on items generated from Survey 1 with an open-ended option following. Twenty-six panelists completed Survey 2. This largely quantitative survey analysis aimed to establish standards for consensus and edit items not reaching that consensus. For most of the activities as well as all five of the essential elements, at least 80% of panelists rate it 80 or above on a scale from 0-100, with higher numbers reflective of stronger agreement that the item was essential (see Table 3). Four activities did not reach consensus at this stage. For those that did not reach consensus, qualitative responses were used to edit the items (qualitative information not included in Table 3).

Survey 3

In Survey 3, participants were asked to react to the proposed changes (revision or removal) to the four items that did not reach consensus from Survey 2. For each item, they were given a dichotomous choice to keep the item or drop it from the list altogether. A similar consensus metric was used; consensus was defined as at least 80% of participants agreeing on an action for the item (either editing it as suggested or removing it). Panelists reached consensus that the three revised items should be kept for the final list and the non-revised item should be dropped (see Table 4 for the results of Survey 3). For instance, the activity "Define the intended outcome of consultation (who will benefit and in what ways?) and the consultees with whom you should work across multiple spheres of influence" did not reach consensus in Survey 2 with only 61.54% of respondents indicating it was essential to IECMHC. The revised version reached 92.86% agreement on keeping the activity when worded as follows: "Identify the central issue(s) or challenge(s) to be addressed in consultation and decide which individuals to engage in

consultation based on their spheres of influence." Based on these results, the activity list was finalized. At the conclusion of the study, the Delphi process yielded five essential elements and 26 activities.

Discussion

Teachers and directors make the decision to suspend or expel children from early childhood education (ECE) settings when they feel stressed, unable to help the child, and out of alternatives (Martin et al., 2018; Mondi et al., 2022). ExD is used more often with children of color, especially Black boys (Office of Civil Rights, 2016), and studies have illuminated the role of implicit biases in teachers' understanding of child behavior (Gilliam et al., 2016). To eliminate the practice of ExD in early childhood settings, ECE staff need additional supports that help them to retain, educate, and form positive relationships with children whom they perceive to be challenging. IECMHC is one of several interventions demonstrated to address ExD in ECE. It has been linked to reduced rates of ExD, as well as changes that may affect the likelihood of ExD, such as teacher-reported externalizing behaviors, teacher self-efficacy and knowledge about child development (Tidus et al., 2022). While IECMHC has yet to be shown to have disproportionate impact on reducing ExD for children of color (Albritton et al., 2019), evidence shows that it has a disproportionately positive impact on teachers' relationships with children of color (Shivers et al., 2022). This likely reflects the impact of the consultative relationship on teachers' ability and inclination to self-reflect, to see each child as an individual, and to understand the larger context of child behaviors (Davis et al., 2020). This is made possible by the fact the IECMHC is implemented with flexibility; consultants form responsive relationships with the consultee and adapt their services to the needs of the setting.

This flexibility, however, presents a challenge for the field in concretely defining IECMHC such that consultants and interested parties understand the parameters of the service and how to gauge high quality service delivery. As IECMHC is scaled up, efforts to assess implementation quality and fidelity have lagged for myriad reasons including a dearth of appropriate measures. This study represents the most thorough and participatory approach to articulating the essential activities of IECMHC to date. Prior efforts to define the activities of consultation (e.g., Duran et al., 2009) have been successful in their scope, yet the current study goes beyond articulating *what* consultants do to also include *how* they do it. In particular, this study directly sought to document how consultants form strong consultative alliances with consultees and how they enhance equity in their roles, constructs that are often highlighted as essential to IECMHC yet have not previously been operationalized (Center of Excellence for IECMHC, 2021; Davis et al., 2021; Johnston & Brinamen, 2012).

By leveraging a consensus-building research method, the researchers engaged with IECMH consultants and supervisors in three iterative rounds of data collection resulting in a list of five essential elements and 26 activities that all panelists agreed upon. This agreement occurred despite the fact that panelists represented five distinct settings in which consultation is provided; were geographically diverse; and represented racial/ethnic diversity among themselves and the populations they served. The importance of forming relationships and enhancing equity were both evident in the final list, in which those constructs are presented as standalone essential elements, as well as infused into the activities described in the other essential elements. The essential elements and activities derived from this Delphi study help to refine the IECMHC Theory of Change by making concrete a previously-undefined component, "engaging in IECMHC" (Center of Excellence, 2021).

The current study has potent implications for the field. Overall, more clearly defining an intervention increases its credibility and perceived legitimacy to the larger field. As with any intervention, certain definitional elements are needed to train the workforce, communicate with interested parties, obtain funding, and evaluate outcomes. Yet a central principle of IECMHC is that services are tailored to the individuals and context such that it is maximally responsive to the needs and cultural milieu of the program. This tension between clarity and flexibility has been mitigated by the development of this list of the essential elements and activities of IEMCHC that is specific enough to provide guidance while also generic enough to be endorsed by consultants across diverse sites and settings. The essential activities list is a tool that may create new opportunities for training, advocacy including engaging champions, securing funding, and embedding policies that support advancement of the field.

As the field of IECMHC continues to grow, concerted effort is needed to ensure a robust pipeline of qualified consultants. To this end, the essential activities list can be used to create or refine IECMH consultant training curricula, and/or to serve as an outline for a future universal training for all IECMH consultants. Further, it can be used as a tool for articulating expectations and prompting consultant self-reflection in ongoing administrative and reflective supervision. By providing increased clarity about what IECMHC is and how it is distinguished from related services and supports, these results can be used to educate policymakers about IECMHC and how it makes a unique contribution to the early childhood system, thereby justifying funding allocations. Furthermore, a clearer understanding of the complexity of IECMHC could support policy efforts to create pay structures that are commensurate with consultants' unique skillset and to create partnerships with universities to build a pipeline of future IECMH consultants.

Finally, there are robust implications for future IECMHC research and evaluation. A universal list of IECMHC activities opens new opportunities for researchers and evaluators to align IECMHC with best practices in program evaluation and dissemination and implementation science. Most immediately, these results can be used by existing programs to create fidelity measures for IECMHC that can be used across contexts. Consultants can then be trained to use a fidelity tool to guide their work, and future research could then evaluate the impact on their behavior and adherence to these essential elements and activities. It can also be used in future studies that seek to explore the link between specific IECMHC activities and outcomes (e.g., fostering consultee self-reflection and better handling of ExD requests).

Limitations

As with all research, the current study has limitations. By nature, Delphi studies employ relatively small samples, and smaller sample sizes are generally assumed to reflect more limited generalizability of findings. In this case, the researchers took considerable efforts to improve generalizability, recruiting from a sampling frame that reflects the field and purposively oversampling where needed. The quality of findings from a Delphi study depends on the composition of the panel of participants. A major research activity was the selection of an experienced and diverse panel; decisions were made based on a range of criteria including location, race/ethnicity, experience, and settings served. Nevertheless, no panel could perfectly represent the diversity of IECMHC implementation nationally, and results must be interpreted with that in mind. For instance, this study was not able to include perspectives from consultants to primary care settings, so the applicability of these findings to primary care is unknown. In addition, while participants were told to hold a particular setting in mind while answering the questions, the researchers cannot be sure the extent to which they did so. Because many panelists

had experience in multiple settings - including ECE, the most common setting for IECMHC - the results may be skewed towards the activities most characteristic of IECMHC in ECE settings.

These results should be viewed as a significant step forward in articulating the activities that define IECMHC, yet the resulting list cannot be viewed as an official measure of fidelity for IECMHC. The creation of a fidelity measure is an important next step that would build upon these findings. They are also not tailored to support implementation in any particular setting. For example, while the elements and activities all apply to ECE, the language intentionally does not pertain solely to ECE. Hence, to directly apply these results to ECE, users could adapt the terms used to fit the ECE setting (e.g., use "ECE staff" rather than "consultee") and the existing content could be supplemented with ECE-specific examples. Finally, it is not yet clear which of these activities lead to which outcomes; in a context where greater clarity about how to eliminate exclusionary discipline is urgently needed, more research is warranted among racially diverse communities to determine the mechanisms of change for that particular outcome.

Conclusion

By centering this analysis on the voices of expert consultants and supervisors working in diverse settings and with diverse populations, these results have implications for IEMCHC programs across the country. The panelists consistently elevated the centrality of establishing shared understanding, respect and rapport among consultants and consultees. In addition, they shared their practices for using their role to advance equity and antiracism. Overall, mental health consultants work alongside the early childhood workforce to shape new, inclusive ways of thinking and acting. New perspectives on children's behavior can diffuse situations that might otherwise lead to exclusionary discipline and can - by contrast - lead to support for positive social and emotional development. Future IECMHC analyses should continue to investigate

pathways through which these activities can be harnessed to address the social justice imperative of reducing ECE exclusionary discipline.

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Table 1. Characteristics of Panelists (n=29)

	n	%	*Mean*	*SD*
Gender				

Female	27	93.10%
Male	1	3.45%
Prefer to self-describe	1	3.45%
Race(s)*		
Asian	2	6.06%
Black/African or Caribbean Descent	5	15.15%
Middle Eastern/North African	0	0%
Native Hawaiian/Pacific Islander	1	3.03%
Native, Indigenous, or Aboriginal (e.g., Native American, Alaskan Native, Aboriginal Australian)	0	0%
White/European Descent	23	69.70%
Other	2	6.06%
Ethnicity**		
Hispanic or Latinx	1	3.45%
Not Hispanic or Latinx	28	96.55%
Highest educational level		
Bachelor's Degree (B.A., B.S.)	1	3.45%
Master's degree (MSW, M.A.)	26	89.66%
Doctorate (PsyD, PhD, EdD, MD)	2	6.90%
Settings in which they provide(d) IECMHC*		
Head Start	17	16.19%
Home visiting	16	15.24%
Early Intervention	14	13.33%
Elementary Schools	8	7.62%
Center-based child care	17	16.19%

Home-based child care	11	10.48%
Child Welfare	5	4.76%
Primary Care	4	3.81%
Other	13	12.38%

Years of experience

Total length of time working in IECMHC field	11.66	6.83
Years as IECMH consultant	8.81	5.39
Years as IECMHC supervisor	2.09	3.62
Years as program director/manager	2.3	4.28

*Response to a multi-select multiple choice question
** Race /ethnicity were also collected as an open-ended question

Table 2. Survey 1 Activity Inventory – Child/Family/Individual Consultation Example

IECMHC Activity: <u>WHAT</u> You Do	"Develop goal(s) to support social-emotional well-being."
Activity Implementation: <u>HOW</u> You Do It	"Review the observations, discuss staff/teacher concerns not addressed through observations or assessments. With the staff/teacher determine one to three goals that promote growth of social-emotional skills and well-being. Based on the teacher/staff current capacity, determine areas for child's growth and issues of greatest concern such as safety, need for diagnostic assessment, etc. The consultant and staff/teacher determine one to three achievable goals for the teacher, group and/or child. The consultant and teacher/staff determine what strategies/ideas will be implemented to achieve the goal(s), who will be responsible for any aspects of implementation, a timeline for when the goals should be reviewed, what level of communication/support the staff/teacher will want from the consultant to employ strategies, ideas and information."
Activity Objective(s): <u>WHY</u> You Do It	"Determining specific goals helps staff/teachers and consultants to truly promote the social-emotional well-being of young children. This process empowers and equips the adults in seeing progress, building their capacity to create environments for all children to realize social-emotional well-being in their settings."

Equity and Cultural Sensitivity: How Your Activity(s) <u>SUPPORT(S)</u> It	"As teachers learn and successfully use the process of goal setting, planning for goal achievement and reaching goals, they begin to recognize that this process is effective, fair and useful for all children. When guided, they begin to see the importance of considering accommodation as part of creating an equitable environment. Successful teachers are more likely to be open to new ideas, learning about different cultures and self-reflection about their own biases."

Table 3. Survey 2 Results

Essential Elements and Activities	*(n=26)*				
	Mean	*SD*	*Range*	*% above 80*	*IQR Score*
***Element 1*: Structure the process for consultation**	91.31	12.30	50	84.62%	15
Activities: Begin consultation: Clarify role and orient to consultation	92.81	13.51	50	88.46%	9.75
Define the intended outcome of consultation (who will benefit and in what ways?) and the consultees with whom you should work across multiple spheres of influence.	78.77	23.12	75	**61.54%***	**36.25****
Initially, and repeatedly, gather information and explore context to develop shared understanding	92.5	14.30	46	88.46%	6.75
Collaboratively develop a shared vision and plan for consultation	92.58	9.17	38	92.31%	10.75
Support consultees as they implement the vision/plan	94.54	7.80	25	96.15%	10.75
Refer consultees to supplemental services as needed and/or beneficial	87.73	16.02	45	**76.92%***	**20****

Monitor progress, make adjustments, and address new issues as needed	93	11.17	40	88.46%	10
Transition to service conclusion with supports in place to maintain progress	79.62	28.03	10	**69.23%**	**29.5****
***Element 2*: Build and nurture strong, equitable consultative relationships that foster readiness for and commitment to consultation**	97.46	5.83	21	96.15%	0
Activities: Establish and maintain rapport, trust, and respect	99.42	1.98	9	100%	0
Communicate using best practice interpersonal skills, both verbal and nonverbal	98.58	4.63	18	100%	0
Create a sense and an expectation of belonging and inclusion	99.08	3.81	19	100%	0
Share power, value mutual expertise, and allow consultees to lead in goal-setting and decision-making	97.5	6.91	32	96.15%	0
Attend to consultees' personal wellbeing while maintaining boundaries of consultant role	96.88	6.23	25	96.15%	3.75
***Element 3*: Optimize consultee capacity to support IECMH through new ways of thinking and acting**	94.84	8.12	30	96.15%	9.75
Activities: Share knowledge to enhance consultees' understanding of IECMH and how to support it	92.31	10.27	30	88.46%	18.25
Promote strategies that will strengthen consultee capacity to	97.19	5.40	19	100%	2.25

foster healthy, equitable, responsive relationships and environments					
Pursue multilevel, comprehensive change	83.88	16.17	50	**65.38%***	**23.25***
Strengthen interpersonal relationships and communication between and among consultees, families, and others who directly or indirectly care for children	96.23	11.13	49	92.31%	0
Foster consultees' ability and inclination to reflect	98.54	3.87	15	100%	0
Explore the contextual, cultural, developmental, and environmental influences on the situation being discussed in consultation	99.42	2.08	10	100%	0
***Element 4*: Empower consultees to enhance equity in their roles**	93.31	11.92	50	92.31%	9.75
Activities Discuss interpersonal dynamics related to culture, bias, and discrimination within the consultative relationship	97.38	6.55	25	96.15%	0
Provide information and perspectives on critical equity topics	92.12	12.47	52	84.62%	9.75
Facilitate consultee reflection on systemic equity issues and how they affect the consultee and children/families	97.69	6.60	30	96.15%	0
Collaboratively develop strategies to address identified concerns and areas for improvement around equity	96.54	6.01	20	100%	5

***Element 5*: Attend to consultant skills, self-care, and self-awareness**	98.15	5.64	25	96.15%	0
Activities Actively engage in consultant self-care	96.15	8.77	40	96.15%	3.75
Actively engage in consultant capacity-building	97.23	5.34	17	100%	1.5
Continuously build consultant cultural humility, awareness of their own cultural identity and how it may affect consultation, and ability to engage in potentially challenging conversations	99.27	2.59	10	100%	0
Exemplify desirable skills and behaviors for consultees to adopt	98.19	4.53	20	100%	0

*indicates consensus level below threshold of 80%

**indicates Interquartile Range above threshold of 20. The interquartile range (IQR) is a statistical measure used to describe the variability or spread of a dataset. It is calculated as the difference between the upper quartile (Q3) and the lower quartile (Q1) of a distribution. The IQR represents the range of the middle 50% of the data and is less affected by extreme values or outliers compared to the range.

Table 4. Survey 3 Results

Activity in Survey 2	*Round 2 % Above 80(IQR)*	*Revised Activity in Survey 3*	*Round 3 Dichotomous Consensus*
Define the intended outcome of consultation (who will benefit and in what ways?) and the consultees with whom you should work	61.54 % (36.25)	Identify the central issue(s) or challenge(s) to be addressed in consultation and decide which individuals to engage in consultation based on their spheres of influence	**Keep** revised version (92.86% agreed)

across multiple spheres of influence.			
Refer consultees to supplemental services as needed and/or beneficial	76.92 % (20)	Recommend and/or facilitate linkages for children, families, and/or consultees to supplemental services or supports that are contextually, culturally, and linguistically appropriate whenever possible	**Keep** revised version (100% agreed)
Transition to service conclusion with supports in place to maintain progress	69.23 % (29.5)	Support and empower consultees through staff transitions, shifts in the focus of consultation, or case closures (in time-limited consultation).	**Keep** revised version (85.19% agreed)
Pursue multilevel, comprehensive change	65.38 % (23.25)	Drop item	**Drop** item (71.42% agreed it can be dropped)

Figure 1. Study Timeline