Diversity-Informed Reflective Consultation and Radical Healing

A New Paradigm for Infant and Early Childhood Mental Health Providers Serving Immigrant Families

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Abstract

This article offers an introduction to the creation and implementation of a workforce development project for frontline providers serving mixed-status immigrant families in infant and early childhood programs. The project comprised specialized training and an innovative approach to reflective consultation to provide an in-depth exploration grounded on diversity-informed practice and radical healing principles. This reflective consultation approach was conceptualized as a key tool to facilitate providers' competencies development, support their critical thinking and reflective capacity, buffer them from the secondary effects of the work, and ultimately serve as a catalyst for practice transformation and their own liberation.

Immigrant families who are undocumented or have mixed status[1] face unique barriers to accessing care and meeting basic needs. Hostile immigration policy, structural oppression, marginalization, and different forms of exploitation have a profound impact on the overall health and well-being, especially on those families with very young children (Cholera, Falusi, & Linton, 2020; Cholera, Ranapurwala, et al., 2020; Edyburn & Meek, 2021; Noroña, et al., 2021; Zayas & Bradlee, 2014). These children present unique socioemotional, physical, and developmental needs (Brabeck, Lykes, & Hunter, 2014; Lieberman & Bucio, 2018; Marks et al., 2018; Menjívar & Cervantes, 2016; Noroña et al., 2018; Osofsky et al., 2018; Rubio-Hernández & Ayón, 2016; Yoshikawa & Kalil, 2011; Zayas & Cook, 2016), often linked to exposure to chronic toxic stress (e.g., financial hardship, violence exposure, substandard living conditions, threats of family separation and loss), immigration trauma, historical trauma, ethno-racial

trauma (Adames & Chavez-Dueñas, 2017; Chavez-Dueñas et al., 2019; Fortuna et al., 2019; Liu et al., 2019; Noroña & Raskin, 2021b; Salas et al., 2013) and to systems of care plagued with inequities including restrictive social and health policies (Cholera, Falusi, & Linton, 2020; Cholera & Ranapurwala, et al., 2020; Edyburn & Meek, 2021; Kemmick Pintor & Call 2019; Marks et al., 2018; Perreira et al., 2018; Shattell & Villalba, 2008). Hence, undocumented or mixed-status families may be hesitant or reluctant to engage in services because of their fear of deportation and family separation, the absence of accessible and affordable care and of socio-culturally and linguistically sensitive services, among other obstacles.

Despite all of these adversities, it is important to highlight that many minoritized immigrant families have multiple assets that serve as microprotections (Liu et al., 2019; Marks et al., 2014) for their children. These may involve fostering family connectedness and transnational relationships; maintaining cultural

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[1] Children in immigrant families are defined as "those who are either foreign born or have at least 1 parent who is foreign born" (Linton et al., 2019). Children in immigrant families may be US citizens themselves but have at least one parent who is foreign born (who may be documented or undocumented). Children in immigrant families may be documented or undocumented.

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Infant and early childhood mental health providers can derive inspiration, hope, and strength from the close connection with mixed-status families.

traditions and practices to cope with stress and transmit ethno-cultural wisdom; and cultivating interdependent social networks centered around reciprocity and mutual aid, all of which can act as a counterforce against the effects of ethno-racial trauma, immigration-related trauma, and the intergenerational transmission of historical trauma (Liu et al., 2019, Noroña & Raskin, 2021b).

These are among the reasons why working with children in undocumented and mixed-status families requires specialized knowledge and skills in providers and can be uniquely rewarding and challenging. The workforce must navigate exclusionary social and health systems which can tax their psychological and physical resources, especially in the absence of equitable organizational support.

Due to the relational nature of the work with young children and their families, infant and early childhood mental health (IECMH) providers can derive inspiration, hope, and strength from the close connection with mixed-status families. However, they are also unavoidably exposed to the distress, pain, inequities, and trauma experienced by them. Therefore, it is not whether a stress response will appear in the provider as a result of this exposure, but to what degree (Best Start Resource Center, 2012). Most importantly, there is consistent evidence (Choi, 2011; Lusk & Terrazas, 2015; Molnar et al., 2017) that providers serving vulnerable and traumatized children and families, like marginalized immigrant families, often experience the secondary effects of the work. Providers may present physical and emotional reactions to bearing witness to the harm and suffering in their clients. These reactions can manifest on a spectrum including burnout, vicarious traumatization, and secondary traumatic stress (STS) and are a professional risk linked to feelings of empathy and compassion in the provider. STS presents symptoms that mirror the symptoms of individuals directly exposed to traumatic events. Providers might experience feelings of guilt, fear, or recurrent thoughts about the events affecting a child, family, or community. They may

avoid thinking or speaking about the traumatic events, meeting with the child or family, or develop symptoms of hyperarousal, such as sleep difficulties and irritability. STS in particular is a debilitating condition and its symptoms often can be lived in silence and with a sense of fear and shame by the person who is experiencing it (Matlow et al., 2021).

There is also evidence (Comas-Diaz et al., 2019; Greponne, 2021; Lusk & Terrazas, 2015) that for providers who experience structural oppression and inequities in the workplace and other contexts, the risk of STS and primary trauma can be exacerbated. Many immigrant providers carry the burden of witnessing the impact of systems of oppression (e.g., racism, xenophobia, transphobia, classism, nativism, linguicism) in their clients while simultaneously experiencing similar impacts in their own lives. For instance, at their workplaces, they may carry large and complex caseloads, perform multiple informal functions (e.g., being translators, interpreters, cultural brokers), lack adequate supervision in the language in which they are practicing, or not receive supervision at all (Noroña et al., 2012). All of these stressors may increase their risk for burnout, vicarious trauma, or STS. Organizations can play a key role in elevating or minimizing the risk of STS and primary trauma among the workforce.

Safeguarding Provider Well-Being

A growing body of literature highlights the importance of organizational accountability in preventing and addressing risks for burnout, vicarious trauma, STS, and other work-related stressors through strategies that focus on safeguarding the well-being of the provider (Kerig, 2018; Miller et al., 2019, Molnar et al., 2017). These multilevel strategies range from individual interventions through systems-wide changes, including the following:

- providing education on the effects and early signs of STS and other forms of secondary effects of work-related stress;

- promoting provider access to dominant and nondominant healing practices (e.g., individual psychotherapy, mutual support groups, mindfulness, and yoga);

- creating training opportunities to build provider knowledge and skills;

- adopting trauma-informed, diversity-informed, and antiracist policies regarding operations, organizational functioning, and service delivery; and

- promoting reflective practice at all levels of the organization, to create and sustain spaces for workers to process trauma exposure and other aspects of the work, and to engage in ongoing analysis of organizational functioning.

These strategies are related to workforce development; unfortunately in the IECMH field there is a dearth of models that are tailored to the support and professional development of providers serving young children in minoritized communities.

The Supporting Immigrant Families Learning Collaborative Project

Because of the complex nature of working with children from birth to 5 years old in undocumented and mixed-status families, there is an urgency to offer IECMH frontline providers with tools and resources to not only implement best practices with these families, but to ensure the workers' own sustainability and well-being. There are no existing workforce development models that address this charge, so the authors developed, piloted, and evaluated a training and consultation project called the Supporting Immigrant Families Learning Collaborative (SIF-LC). It was designed to enhance the capacity of the IECMH workforce, serving immigrant children in community and home-based settings, by providing up-to-date knowledge and fostering the development of specialized skills using a learning collaborative (LC) training approach to promote adoption and implementation of new practices across organizations. This approach involved (a) relationally based, antiracist and trauma-focused, developmentally and diversity-informed didactic training and group reflective consultation; and (b) ongoing practitioner and agency consultation to translate knowledge into practice and to support staff well-being (e.g., via agency reflective supervision).

In consonance with diversity-informed practice, the reflective group consultation component proposed for the LC was grounded on principles of social and racial justice, a commitment to radical healing (French et al., 2020) and consequently to the creation of a trusted and supportive community of learners. It was conceptualized as a key tool to facilitate participants' learning and skill development, support their critical thinking and reflective capacity, promote their protection from the effects of the work, and ultimately serve as a catalyst for practice transformation (Noroña & Acker, 2016). This reflective consultation modality became particularly meaningful for the emotional sustainability of the individuals and teams participating in the LC, given the historical-socio-political moment when the project started. The SIF-LC was launched at the beginning of the COVID-19 syndemic. A *syndemic* refers to the aggregation of multiple epidemics, which in this case included the coronavirus, systemic racism, and police brutality (Howard, 2022; Roberts, 2021). As it is well known, the COVID-19 syndemic magnified and intensified existing social and racial inequities around the globe. In the US, the burden of the crisis fell disproportionately on Black, Indigenous, and Other People of Color (BIPOC), elders, immigrants, refugees, and other marginalized groups (Cholera, Falusi, & Linton, 2020; Galvan et al., 2021; Valdez et al., 2022). For undocumented immigrant families and their children, the syndemic exacerbated extant restrictive policies, discrimination, and inequities and introduced new ones such as loss of income, increased risk of exposure to COVID-19 (by living in multigenerational or crowded housing, or working as essential workers in unsafe working conditions), lack of access to health insurance and paid leave, increased fear of accessing public benefits, exposure to intrafamily violence, among others (Cholera, Falusi, & Linton, 2020; Page et al., 2020).

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Secondary traumatic stress presents symptoms that mirror the symptoms of individuals directly exposed to traumatic events.

Frontline providers from participating agencies in the SIF-LC were required to develop creative ways to meet the basic and emotional needs of these families who were facing extreme levels of social and economic instability. They worked tirelessly from home via telehealth, or at times in-person, in a highly unpredictable, frightening, and stressful period all while caring for their own children and families. The reflective consultation sessions became a consistent and reliable space where they could share experiences, feelings, and resources as they navigated an ever changing and distressing world. Moreover, in the sessions they could process the traumatic impact of the syndemic on themselves and on their communities, agencies, and client families; share stories of survival, solidarity, bravery, and hope; and reflect on self-preservation in the midst of loss, fear, and pain. As will be discussed later in the article, some of these themes are related to the anchors of radical healing (French et al., 2020).

This article will (1) explore the SIF-LC Project methodology and framework, (2) justify the need for new paradigms of reflective supervision and consultation (RS/C) to support a diverse workforce serving diverse children, (3) describe the components of an RS/C approach proposed for the SIF-LC based on radical healing and diversity-informed practice principles, (4) illustrate the application of central aspects of this approach via a case vignette, and (5) discuss implications for the workforce.

SIF-LC Methodology and the Role of Diversity-Informed RS/C

The SIF-LC Project offered a workforce development model for serving young children in immigrant families that was

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For undocumented immigrant families and their children, the syndemic exacerbated extant restrictive policies, discrimination, and inequities...

not previously available in the field of IECMH. It involved four objectives:

- enhance the knowledge, competencies, skills, and well-being of the workforce serving this population;

- promote sustainable practice change in these individuals, their organizations and systems;

- advocate for racial equity and social justice on behalf of immigrant families by increasing access to high-quality, specialized services; and

- ultimately improve the overall outcomes for young children in immigrant families.

The following sections provide a brief description of the SIF-LC methodology, a rationale for the need of new approaches to RS/C in the field of IECMH, the core principles conforming the project's framework, and an in-depth explanation of the diversity-informed RS/C approach proposed for the LC.

The SIF-LC Methodology

Didactic training alone has limitations in terms of catalyzing and sustaining practice change (Fritz et al., 2013; Noroña & Acker, 2016). As mentioned previously, the SIF Project used a LC methodology which takes place over a span of an extended period of time (e.g., 9, 12, 18 months) and includes a combination of intensive didactic trainings interspersed with consultation sessions facilitated to a group of teams representing different organizations (Beidas et al., 2012; Nadeem, Gleacher & Beidas, 2013; Nadeem, Gleacher, et al., 2013; Noroña & Acker, 2016). In this way, providers and their organizations have access not only to interactive in-person/remote training, but also to ongoing support from the consultants and from their consultation members as they learn and apply what they are exploring and learning in their particular work environment. This methodology is an effective strategy to promote practice change and support the implementation of evidence-based models on a large scale

(Fritz et al., 2013; Markiewicz et al., 2006; Nadeem, Gleacher, & Beidas, 2013; Nadeem, Gleacher, et al., 2013). There is evidence that ongoing expert consultation may increase the adoption, learning, and sustainability of evidence-based models by an already practicing workforce and, consequently, help trainers, practitioners, and organizations address implementation barriers (Beidas et al., 2012; Fritz et al., 2013; Nadeem, Gleacher, & Beidas, 2013; Nadeem, Gleacher, et al., 2013;)

The SIF-LC Project was developed, implemented, and evaluated by an ethnically, racially, and socio-culturally diverse IECMH interdisciplinary team. It was composed by a principal investigator specialized in the implementation and outcome of IECMH interventions, a project evaluator and coordinator with postgradute training in pediatric occupational therapy and experience in coordinating LCs (e.g., child–parent psychotherapy); a training content developer and coordinator with a background in public health and social work and experience coordinating multisite projects; a Latin American bilingual attorney with experience in program management, immigration policy, and serving immigrant families; and three social workers with training and experience serving young children in immigrant families, reflective supervision, and consultation. Two of these members are bilingual and from Latin America and two are trained to conduct LCs in evidence-based models. All team members participated in the virtual didactic trainings where they had different roles (e.g., training logistics, training technology, facilitating the training). The members with training in social work and RS/C facilitated the virtual group reflective consultation.

The SIF Project adopted and adapted the LC methodology on the basis of evidence regarding its effectiveness in supporting practice change in providers and on the role of specialized consultation in facilitating this change. As mentioned previously, the approach to consultation in the SIF-LC was grounded on the RS/C relationship-based framework and on principles of racial and social justice and radical healing, among others. The group reflective consultation was considered an essential component to creating a holding environment for sharing, healing, and learning. The next section will discuss the importance of the RS/C framework for the IECMH workforce as well as its limitations in terms of antiracist and equitable practices.

Why RS/C

The terms *reflective supervision* and *reflective consultation* are often used interchangeably but they refer to different processes. The primary distinction between reflective supervision and reflective consultation relates to the relationship between the individual providing reflective practice and the organization. Reflective supervision occurs within an agency or a program while reflective consultation is contracted by an agency or program. Reflective supervisors engage in reflective practice, clinical/case, and administrative tasks, often concurrently. Reflective consultants facilitate reflective practice to an individual or group to promote IECMH (Alliance for the Advancement of Infant Mental Health, 2018; Shivers, 2022).

In the field of IECMH, reflective supervision and reflective consultation both refer to "a collaborative relationship for professional growth that improves program quality and practice, ...by cherishing strengths and partnering around vulnerabilities to generate growth" (Shahmoon-Shanok, 2009, p.7). Each of these processes has been recognized as a promising practice in preventing and combating the secondary effects of the work (Miller et al., 2019; Van Berckelaer, n.d.) and in promoting best practices to service young children. Reflective supervision and consultation are each a relational-based approach defined as "the regular collaborative reflection between a service provider (clinical or other) and supervisor [consultant] that builds on the supervisee's [consultee] use of her thoughts, feelings, and values within a service encounter" (Van Berckelaer, n.d., p. 1). Each is proposed as a benevolent space to step out of the business and intensity of the work and notice aspects of it where the provider may feel emotionally activated. Insights gained from self-reflection and reflecting with the supervisor/consultant or a group can be used to make meaning of the provider's experience as well as that of the child and family. These reflective modalities encourage practitioners to attend to the parallel process; or, the importance of all relationships and how they affect each other (e.g., the consultant supervisor–provider relationship, the provider–child/family relationship, and the caregiver/s–child relationship; Noroña & Acker, 2016). RS/C can be provided individually or as a group. The group RS/C model offers in addition a space for mutual learning, support, and exchange of resources, and it operates on the fundamental belief that the parallel process can be a powerful agent of change in the work with very young children and their caregivers (Noroña & Acker, 2016). In this article, reflective supervision indicates the supervision within-agency and reflective consultation refers to the support provided by the SIF Project's consultants. The abbreviation RS/C that will be used hereafter, refers to reflective supervision and consultation not as interchangeable terms but as terms that denote different but related processes.

Despite the evidence and benefits described in the previous paragraph, the prevalent RS/C research, theory, training, and practice approaches in the field of IECMH have had limitations from a social and racial justice perspective and have often reproduced inequities (Noroña, 2020; Shivers et al., 2022; St. John et al., 2018). These inequities include:

- Access to positions of leadership and supervisory roles have historically been granted to White individuals who are highly educated and already hold positions of power.

- Until very recently there have not been equitable and transparent pathways in endorsement bodies, RS/C training and mentorship programs, and in organizations for the promotion of leadership and professional development (Thomas et al., 2019) of BIPOC and of individuals representing other minoritized identities, such as linguistic, gender identity, socioeconomic status, education, ability, and nationality (Noroña, 2020; St. John et al., 2018; Teran et al., 2017; Thomas et al., 2019).

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The reflective consultation sessions became a consistent and reliable space where they could share experiences, feelings, and resources as they navigated an ever changing and frightening world.

- Therefore, nationwide there has been a lack of representation in these positions of BIPOC and of individuals embodying those aforementioned aspects of diversity (Noroña, 2020; St. John et al., 2018; Teran et al., 2017; Thomas et al., 2019).

- The conceptual models supporting the teaching, mentoring, learning, and practice of RS/C in the field of IECMH have been based on Eurocentric perspectives and values which consequently have not responded to or reflected the sociocultural, historical, political, linguistic, ethnic, racial, and other diversity aspects of the young children served by IECMH programs and of the providers working with them (St. John et al., 2018; Thomas et al., 2019).

- Moreover, the dynamics of power and privilege in the consultant–consultee/supervisor–supervisee/practitioner–family relationships, historically have not been intentionally and consistently addressed by these models (Noroña, 2020; St. John et al., 2018; Thomas et al., 2019).

- In addition, the literature and published workforce resources on RS/C in IECMH with a focus on racial equity, social justice, diversity, and culture is scarce (Hardy & Bobes, 2017; Hause & LeMoine, 2022; Heffron et al., 2007; Noroña et al., 2012; Noroña et al. 2021; Shivers et al., 2022; Stroud, 2010; Van Horn, 2019; Wilson et al., 2018).

Nevertheless, there is also an increasing sense of urgency to acknowledge race, power, and equity in reflective practice and to increase the capacity of those who provide reflective supervision (and reflective supervision/consultation) to integrate more of a racial equity lens into their day-to-day work. (Shivers et al., 2022, p. 8)

Therefore, the SIF-LC team aimed to engage in a new form of RS/C grounded on diversity, antiracist and trauma-informed practices, and on developmental and relational approaches.

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A developmental and relational approach highlights the salience and powerful influence of the quality of attachment relationships on young children's overall growth and development.

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Stance, Core Principles, and Framework

The following core practices, principles, and approaches constituted the framework for every aspect and component of the SIF-LC project informing the curriculum development, training, and consultation logistics and process; the stance cultivated by the SIF-LC team; and the relationships among its members.

Diversity-Informed Practice

The Diversity-Informed Tenets for Work with Infants, Children and Families Initiative (Thomas et al., 2019) defined diversity-informed practice as a

> dynamic system of beliefs and values that shapes interactions between individuals, organizations and systems of care. Diversity-informed practice recognizes the historic and contemporary salience of racism, classism, sexism, able-ism, homophobia, xenophobia, [transphobia] and other systems of oppression and strives for the highest possible standard of inclusivity in all spheres of practice: teaching and training, research and writing, policy and advocacy, as well as direct service. (p. 49)

The Tenets are a set of 10 guiding principles of diversity, equity, inclusion, and belonging that raise awareness about the inequities entrenched in society, institutions, and systems of care, urging and empowering practitioners, organizations, and systems serving young children and their families to identify and dismantle these systems of oppression (Thomas et al., 2019). The Tenets are grounded in the conviction that the work of diversity, equity, and inclusion is not about the other, but about the self. Tenet #1 Self-awareness Leads to Better Services for Families reminds practitioners and systems about this responsibility and encourages them to engage in a process of critical self-reflection.

Critical self-reflection refers to the process in which the provider identifies the assumptions influencing their thoughts,

use of words or other forms of communication, and actions (awareness); locates the historical and cultural roots of these assumptions; questions their meaning (Stein, 2000) and purpose (analysis); takes responsibility for their impact on others (accountability); and develops alternative ways of being and acting (taking action; Leadership for Educational Equity, n.d.; Noroña, 2020; Noroña & Raskin, 2021b). This process behooves individuals to challenge themselves as well as the established dominant social, political, cultural, and professional constructions in their contexts (Cheng et al., 2015; Garcia et al., 2009; Mezirow, 2006; Reyes Cruz & Sonn, 2011; Stein, 2000; Thomas et al., 2019). This requires time, intentionality, and effort and is why providers should not be expected to engage in critical self-reflection in isolation. It explains too why RS/C rooted on racial and social justice is so important in the sustainability of the providers and in the promotion of liberation work in connection and collaboration with others. Liberation refers to

> the creation of relationships, societies, communities, organizations, and collective spaces characterized by equity, fairness, and the implementation of systems for the allocation of goods, services, benefits, and rewards that support the full participation of each human and the promotion of their full humanness. (Love et al., 2007, p. 2)

Trauma-Informed Approach

A trauma-informed approach consists of becoming and remaining aware of the possible effects that trauma exposure can have on the functioning of individuals, communities, organizations, and systems. It also involves tailoring services to provide spaces where individuals can feel empowered and emotionally and physically safe. The nature, extent, and compounding effects of the events faced by mixed-status immigrant families can place not only the children's but all family members' psychological, relational, and developmental functioning at risk. A trauma-informed approach to serve this population must encompass:

- a careful assessment of the children's and family's strengths and needs including an exploration, appreciation, and understanding of their sociocultural, linguistic, historical, political, and family contexts prior to and post-migration

- a commitment to preventing retraumatization and restoring or promoting a sense of safety, empowerment, and dignity for all (Barlett et al., 2016; Trauma Informed Oregon, 2020). Trauma-informed approaches require intentional effort at the systemic, organizational, and provider levels to avoid repeating current and historical patterns of injustice or oppression on these children, their families, and the providers representing groups who have been marginalized. Transparency, collaboration, choice, and the inclusion of nondominant ways of knowing like ancestral and cultural traditions that can be restorative are strategies that can support individuals in feeling seen, feeling heard, and having agency and a sense of control and belonging.

Antiracism as Central to Trauma-Informed Care Approach

The harmful impact of systemic racism on BIPOC children and their families, including mixed-status families, has been well documented (National Child Trauma Stress Network, 2002; Powell et al., 2022). Therefore, to be truly trauma-informed practitioners, agencies and systems must be antiracist.

Being antiracist results from a conscious decision to make frequent, consistent, equitable choices daily. These choices require ongoing self-awareness and self-reflection as we move through life. In the absence of making antiracist choices, we (un)consciously uphold aspects of white supremacy, white-dominant culture, and unequal institutions and society. Being racist or antiracist is not about who you are; it is about what you do. (National Museum of African American History and Culture, 2020, p. 6)

This means that systems, programs, and practitioners must unveil, recognize, and address the current and historical traumas suffered by children and families by committing to principles and implementing strategies to advance racial equity. Racial equity is a part of racial justice and it involves "work to address root causes of inequities, not just their manifestation. This includes elimination of policies, practices, attitudes, and cultural messages that reinforce differential outcomes by race or that fail to eliminate them" (Racial Equity Tools, 2020). The adoption of shared principles and strategies for antiracism and racial equity is crucial in systems of care in order to "help mitigate cognitive biases and dismantle white supremacy culture that inevitably prevails even when the best laid intentions are to advance healing and justice" (Powell et al., 2022, p. 6). (For more on principles and strategies for antiracist and trauma-informed systems and organizations, see the Learn More box.)

Relational and Developmental Approaches

These approaches are based on the premise that young children's development and the establishment of early attachments are the result of a transactional process between the child, the caregiving context, and the environment surrounding the young child and their primary caregivers or family. The environment includes relationships with other people, sociocultural influences, historical and current sociopolitical elements, and the impact of inequities and systems of oppression. A developmental approach emphasizes that every child, parent, family, community, provider, organization, and system is in the process of constant development (Reflective Supervision Collaborative, 2021). A relational approach highlights the salience and powerful influence of the quality of attachment relationships on young children's overall growth and development. From this perspective, and under the belief that "relationship affects relationship" (Lieberman & Van Horn, 2008), the quality of the relationship that providers can establish with mixed-status families can become a changing factor in enhancing and repairing child–parent relationships and the caregivers'/parents' own healing, sense of agency, and hope. Relational and developmental approaches can consequently improve overall outcomes for

Within the context of group reflective consultation, some of the key considerations for promoting relational safety involve setting the holding space for the group.

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young immigrant children (Lieberman et al., 2015; Lieberman & Van Horn, 2008).

Related to the supervisory/consultant relationship, these perspectives underscore the importance for both the supervisor/consultant and the supervisee/consultee to keep in mind what each brings to and expects of the relationship so strategies tailored to the strengths and needs of the supervisee/consultee and the families they serve can be identified, developed, and implemented. These perspectives "also allow for the reality that it takes time for new concepts to be integrated, for the safety and trust needed for learning to occur, and new processes/practices to take root" (Reflective Supervision Collaborative, 2021, p. 4).

A Collaborative, Multipronged, and Multilayered Approach

The complexity of the experience of young children in mixed-status families underscores the importance of developing interdisciplinary approaches, interagency collaborations, and provider networks to address the needs of this population, share resources, and find support for providers. This work cannot be done in isolation (Noroña et al., 2018; Osofsky et al., 2018).

Organizational Accountability Related to the Professional Development and Care of the Provider

For providers serving young children there is often a relationship between intersectionality, social location, power, privilege, and the likelihood of having access to resources to perform the job successfully, to maintain a work-life balance and upward mobility, and to benefit from buffers from stress (Cuellar et al., 2019; Lusk & Terrazas, 2015; Teran et al., 2017). This relationship underscores the centrality of organizational equity and accountability in the well-being of workers. A workplace climate where dignity and accountability are preserved opens the possibility of psychological safety in relationships and the workplace and has a parallel effect in the work with families

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Frontline providers were able to reflect on some of the challenges and inequities in their organizations or how their work impacted their personal lives, without concerns of compromising their job.

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(Davis, 2021). The SIF-LC model encouraged organizational accountability and equity by:

- Requiring the participation of the agencies' leadership in the didactic sessions, reflective activities, and affinity group reflective consultation calls. This requirement is essential in ensuring that the organization will make accommodations (e.g., time release, coverage) and allocate resources (e.g., ensure access to laptops, Wi-Fi, and a private space) so frontline providers can fully engage in the didactic sessions and RS/C sessions.

- Engaging in a collaborative organizational assessment prior to the LC and reassessment in the course of the LC. Here there is a possibility to identify the agency's strengths and needs related to equitable and inclusive practices with the families and the workforce, and to engage in a plan to address areas of need.

- Encouraging agencies to critically examine their work climate; conduct diversity, equity, inclusion, and antiracism assessments; and, in accordance with the results of these assessments, engage in action plans to implement strategies toward organizational change and transformation.

- Increasing awareness in organizations and leadership about the prevalence of direct and secondary effects of the work in providers serving marginalized and traumatized children and their families and the connection of White supremacy, culture, ethnoracial trauma, and STS in BIPOC providers (Powell et al., 2022).

- Consistently work toward and model a dignity-centered approach (Davis, 2021) with the aspiration that doing so promotes the preconditions for repair, connection, and community after conflict. This approach requires addressing the everyday verbal and nonverbal dignity violations

that maintain the dominant culture and minimize, dismiss, and erase the experiences and contributions of BIPOC individuals (Davis 2021; Powell et al., 2022).

- Uplifting, centering, amplifying, and learning from the voices of providers representing communities impacted by racism, opening spaces to their active participation in decision-making processes and in the implementation of changes to dismantle racism and other forms of oppression in service delivery and human resources policies and practices (Powell et al. 2022; Thomas et al., 2019).

- Supporting agencies and practitioners to implement and sustain "socio-structural reforms and promote practices to foster truth, atonement and collective repair and to enhance radical healing" (Powell et al., 2022, p. 1) for BIPOC families, communities, and providers.

- Supporting agencies to implement and sustain practices that can serve as a resource for workforce preservation and growth (e.g., diversity-informed RS/C, radical healing).

The Need for Diversity-Informed RS/C

As mentioned previously, the SIF-LC provided reflective consultation to the participating agencies. As a reminder, in this article, reflective consultation is used to refer to the ongoing external support provided by the SIF-LC consultants and reflective supervision refers to the within-agency supervision. The approach developed by the SIF-LC team was a group reflective consultation modality that was hoped would enhance the within-agency reflective supervision. Therefore, in the next section and the remainder of the article the authors will refer to this modality as Diversity-Informed RS/C.

Given the limitations described previously about prevalent RS/C paradigms in IECMH, the SIF-LC proposes a modality of RS/C that offers the space and resources to promote an analytical approach in the supervisor/consultant and the supervisee/consultee "to deconstruct their values, attitudes, political, professional and theoretical influences in order to reconstruct meaning with changes in awareness and action" (Rankine, 2018, p. 34). The diversity-informed-RS/C model

- cultivates critical self-reflection to increase self-awareness;

- explores accountability, privilege, and power in supervisory/consultation relationships;

- supports the stratesies and goals of antiracist trauma-informed practice;

- engages in decolonizing knowledge and practice in IECMH;

- promotes relational safety;

- mirrors and is sustained by radical healing principles; and

- fosters compassion satisfaction and vicarious resilience in the provider.

The following sections will examine each of these elements.

Cultivating Critical Self-Reflection to Increase Self-Awareness

For providers working with minoritized children, families, and communities, increasing self-awareness on their identities, sociocultural context, and social location, and how these impact their perceptions and interactions of the families they serve, is key to increasing the insight and skills needed to implement antioppressive interventions that are developmentally, relationally, and culturally responsive (Noroña et al., 2021a). Self-awareness is enhanced and deepened by cultivating critical self-reflection and the related capacities of awareness, analysis, accountability, solidarity, and taking action toward change.

As an example, Table 1 lists a variety of reflective prompts that can be used in RS/C relationships and individually by practitioners for promoting critical self-reflection.

Table 1. Questions That Promote Critical Self-Reflection

Areas of exploration for consultant/supervisor, consultee/supervisee, practitioner for personal development	Prompts for reflection
1. Explore the provider's identities and positionality	• How do my identities impact how I perceive myself, perceive my client families, my supervisees/consultees, and how they might perceive me? • How have my identity markers (e.g., race, education, socioeconomic status) and positionality informed my values, beliefs, preconceptions, and the expectations I have for my clients, supervisees/consultees, and myself? • How do similarities or differences in my identities and social location to those of client families or of supervisees/consultees I work with make me feel?
2. Explore the sociohistorical, political, professional, and theoretical contexts and influences	• How do these values, beliefs, and assumptions reflect dominant paradigms about health, attachment, parenting, raising children, and addressing and recovering from grief, pain, distress? • What are the messages I received about these issues growing up? • What are the messages I received from my professional training? • What do I know about the history of my ethnic, racial, and cultural group? • How has having or not having access to that knowledge impacted my assumptions, perceptions, and biases about other communities?
3. Explore the provider's increased awareness and commitment to change	• In what ways have my ancestor's successes benefited others or been at another's expense? • In what ways have my ancestors used race, economics, gender, and politics to continue past and current inequities? (Garcia et al., 2009) • In what ways were my ancestors targeted by oppression because of their race, ethnicity, immigration status, or any other aspect of their identities? • In what ways have I reproduced, maintained, or supported systems of oppression in my work? • In what ways do I carry out my moral obligation to correct current social inequities? (Garcia et al., 2009) • Are these actions meaningful to those who have been injured/targeted or just meaningful to me? (Garcia et al., 2009) • In what ways do my supervisors, colleagues, and organization challenge me to increase my critical reflection and take actions toward change? (Garcia et al., 2009)

4. Explore willingness and commitment to take action toward change	• Am I ready to move toward relational action (Hernandez-Wolfe & McDowell, 2012) by:
	  • repairing relationships where I was oblivious to the impact of my privilege, power, and/or my actions/words?
	  • accepting feedback about this impact
	  • seeking mentorship/reflective supervision to support me in this process
	  • dealing with the fear of potential losses (e.g., relationships, mentors, a job, privilege positionality in a group) as I engage in this process of questioning structural racism, White supremacy culture, and taking action
	• Am I going to start taking action steps toward being accountable for social and racial justice/equity by (Hernandez-Wolfe & McDowell, 2012)
	  • staying at my growing edge and understanding that to stay "awake" I need to look for opportunities for growth and for staying accountable
	  • using my positionality, privilege, or power from wherever I am to create awareness about systems of oppression
	  • speaking out/taking risks
	  • becoming a co-conspirator by forming alliances, organizing working in solidarity others to unveil, address, dismantle inequities affecting the families I serve, my colleagues, and my community
	  • teaching, mentoring, presenting at speaking engagements, writing, and publishing articles

Source: Adapted from "Raising Critical Consciousness in Family Therapy" by M. Garcia, I. Kosutic, T. McDowell, & S. A. Anderson, 2009, *Journal of Feminist Family Therapy, 21*(1), 18–38; Table 1 Reflections Toward Cultural Formulation in Noroña et al., 2021) and "From the Margins to the Center: Moving Towards a Resilience-Based Model of Supervision for Queer People of Color Supervisors" by A. Singh and K. Y. S. Chun, 2020, *Training and Education in Professional Psychology, 4*(1), 36–46.

Photo: New Africa/shutterstock

To establish trust and safety, participants should first have a clear sense of who is in the consultation group, the schedule for group sessions, and the expectations for attendance and participation.

The SIF-LC curriculum offered carefully designed experiential activities and opportunities for individual and group reflection during the didactic sessions to support individuals and teams in the development of self-awareness, their capacity for critical analysis, accountability, and for taking action (Sealy, 2021) in response to systems of oppression. The topics that emerged during these reflections continued to be discussed in the reflective consultation sessions where practitioners had the support of the consultants and the group. The goal was that this process of critical reflection cultivated in the training sessions and emphasized by the affinity group reflective consultations with leaders, supervisors, and frontline workers, would inform and transform the agency supervision via a parallel process. In this way participants could continue working on developing this central skill of critical self-reflection for the work with young children in all families, but especially with minoritized families. And it was hoped that this work would be in connection and collaboration with others in their teams and agencies. Some of the areas that were intentionally examined during the didactic and reflective consultation sessions included:

- exploration of each participant's own history, experiences, identities, and social locations;

- reflection and analysis of the historical, sociocultural, familial, political, and professional roots of their beliefs, values, and expectations (e.g., about child development, parenting, family structure, ethnic, cultural and linguistic differences, immigration policy);

- reflection and analysis of how all of these factors were impacting their perceptions and relationships with others as well as how others perceive and relate to them (e.g., including clients and colleagues);

- their contributions to perpetuating systems of oppression or to transformative change in their work and lives; and

- what actions they might want to take to mitigate and/ or dismantle oppression (e.g., taking small steps toward change as an individual, organizing and supporting others toward change, looking for resources to encourage others to act).

Exploring Accountability, Privilege, and Power in Supervisory/Consultation Relationships

It is important to explore issues of accountability, privilege, and power in the supervisory/consultation relationship (and parallel issues in the direct service relationship), such as the following: How has the supervisee/supervisor or consultant/consultee used their privilege in the RS/C relationship? What dimensions of privilege have been silent in the RS/C process? Has there been any misuse of privilege? If so, what needs to be discussed, and how would parties be accountable to each other? (Hernández & McDowell, 2010; Hernández & Rankin, 2008).

The SIF-LC implementation model used a team approach in which consultants worked collaboratively in dyads or triads (Noroña & Acker, 2016; Thomas et al., 2019), which promoted the exploration of accountability, privilege, and power in the consultant–consultee relationship and among the SIF-LC team. The didactic trainings were cofacilitated by two or three SIF-LC team members and the reflective consultations were cofacilitated by two SIF-LC members. As noted previously, reflective consultation was provided by team members trained in reflective consultation and practice, IECMH, and diversity-informed practice as well as with experience working with immigrant families and other minoritized groups.

Cofacilitating the didactic training and reflective consultation groups with a trusted colleague can increase the quality of the consultants' work as it reflects a relational approach. Working collaboratively allows the consultants to share knowledge and skills, keep one another accountable, support each other, and avoid feelings of isolation (Noroña & Acker, 2016). In addition, each consultant is positioned differently in regard to social location, which can broaden the group's reflection and understanding about the implications of intersectionality, power, and privilege in relationships and in the work with families (Thomas et al., 2019). To promote equity, the consultants viewed and framed their role in the reflective consultation sessions as facilitative, and not as experts.

Facilitators strive to create the conditions wherein individual participants register their own feelings and generate their own insight and ideas. Facilitators work to make links among participants so that everyone learns from one another, and thus pave the way for personal and group discoveries. (Thomas et al., 2019, p. 45)

The SIF-LC facilitators worked intentionally to avoid positioning themselves as the holders of knowledge, power, expertise, or the deliverers of content (Thomas et al., 2019). And to build a collaborative, relational, and reflective process with one another and the group. The SIF-LC team met weekly and the SIF-LC group facilitators biweekly to reflect on their work in the project, which was essential in their aspiration to hold a

stance of critical self-reflection, of humility, and of openness to learning with and from each other and the group.

Supporting the Strategies and Goals of Antiracist Trauma-Informed Practice

Key activities in providing antiracist trauma-informed practice include recognizing the impact of historical trauma and racism on individuals, families, communities, and the workforce; supporting leaders and supervisors to continually analyze, recognize, and address the ways in which they and their organizations contribute to oppression; promoting the creation and sustainability of formal and informal spaces in the workplace to identify and address stress related to trauma and racism and other systems of oppression; providing well-being strategies for BIPOC workers to manage primary and secondary trauma related to racism and other systems of oppression (Powell et al., 2022); open equitable access to professional advancement and influence to providers from marginalized communities; honoring nondominant bodies of knowledge and ancestral and sociocultural traditions as sources of recovery and healing in the workforce and families served; promoting transparency; collaboration in the supervisory/consulting relationship; and encouraging a sense of agency and empowerment in the provider to take actions toward change.

Engaging in Decolonizing Knowledge and Practice in IECMH

Participants can foster decolonization of knowledge and practice in IECMH by questioning theories and practices that reproduce inequities generated and maintained by dominant groups (e.g., the implications of using Eurocentric-based assessments and interventions with immigrant families).

Promoting Relational Safety

One of the central elements of diversity-informed RS/C is the co-construction of a supportive yet critical space for mutual challenge and collaboration where supervisors/consultants and supervisee/consultees can openly raise questions; challenge perspectives and opinions; and express fears, ideas, and feelings, as well as concerns related to racism, power, privilege, systems of oppression, and location of self and other (Hernández & McDowell, 2010; Hernández & Rankin, 2008; Noroña, 2020). Relational safety is not about unwavering validation of the supervisee/consultee but about the development of critical thinking in a caring and transparent relational process (Hernández & Raskin, 2008). Here providers can explore the impact of their own values, beliefs, and biases on their work; examine the role of systems of oppression in their their lives and in relationships with families, colleagues, and in their practice; and intentionally engage in actions that address the inequities affecting their clients. This process holds supervisor/consultant and supervisee/consultee accountable and is in itself transformational (Hernández & McDowell, 2010; Noroña et al., 2021).

Therefore, one of the key considerations for promoting relational safety in group reflective consultation involves setting the holding space for the group. This will be described in detail in a later section of the this article. It broadly involves ensuring

Fostering a provider's sense of compassion satisfaction and vicarious resilience may be an essential component to providing quality infant and early childhood mental health care to immigrant families with young children and retaining the workforce.

that: the participants have access to confidential space (virtual or in person) and compliant with HIPPA regulations; there is protected time and support for them to engage in the group sessions regularly; there is clear communication with the participants and their senior leaders about the group schedule and expectations for attendance; there are group agreements about confidentiality and other aspects of the group; the group composition (e.g., affinity groups by role, identities like self-identified racial groups) and the rationale for the group composition is discussed and agreed with the participants and their agency leadership (McCormick et al., 2020; Noroña & Acker, 2016).

Regarding group composition, it is important to note that creating affinity groups can be helpful for the reflective consultation process. Affinity groups are designed to promote a trustworthy space where everyone in that group shares a particular identity, purpose, or goal. These shared identifiers or interests can contribute to the development, over time, of a caring but brave space for discussing experiences, for critical analysis, and for inspiration to take action to promote racial and social justice in the work with immigrant families and in the relationship among providers (Shivers et al., 2022). Some reflections about group composition based on the SIF-LC experiences are shared in the next paragraph because of their impact on the group process. The SIF-LC consultation groups were organized by role (administrators or senior leaders, supervisors and frontline staff) not only to foster relational safety but to work together with individuals representing all levels of the organization, toward practice change as providers, supervisors, leaders, teams, and agencies.

The SIF-LC team had intended to facilitate three simultaneous consultation groups of 6−8 participants assigned by role: administrators/senior leaders, supervisors, and frontline staff. Eventually the senior leaders and supervisors merged into one consultation group as some of the supervisors were also the

senior leaders at their organizations. This consolidation left two consultation groups: a senior leadership/supervisor group and a frontline provider group.

Consultants found that this group composition enabled participants to discuss work and personal related concerns, dilemmas, and stressors as well as successes openly with one another. It also allowed them to share tailored resources and strategies for working with immigrant families which were directly applicable for their role. All of this sharing ultimately increased their sense of trust in the group and in the consultants. For example, frontline providers were able to reflect on some of the challenges and inequities in their organizations, or how their work impacted their personal lives, without concerns of compromising their job. Some of them talked about feeling "stretched thin" or "pulled in many different directions." Others shared that they didn't feel supported and that their supervision session would be frequently skipped or canceled. They also spoke about supervision being focused on administrative work and not on processing, check in, or reflecting. They regularly discussed how they felt that bilingual providers were assigned additional labor and more complex cases and how some of them felt targeted at work.

Mirroring and Being Sustained by Radical Healing Principles

The psychology of radical healing and framework was created to confront, metabolize, and mitigate the impact of identity-based wounds created by racism in BIPOC people (Powell et al., 2022). Radical healing refers to a set of principles and strategies that promote individual and collective healing from ethno-racial violence and other forms of historical and ongoing systemic oppression (French et al. 2020) which result in ethno-racial trauma (Comas-Diaz et al., 2019) among minoritized, racialized, and marginalized people. Table 2 further outlines these principles. Radical healing centers strengths, cultural traditions, and testimony as forms of resistance and strategies for both individual and collective liberation. For White people, and other people with privileged identities, or in positions of power (including BIPOC individuals), radical healing principles can be used to guide (a) critical self-reflection in when and how one's actions have contributed to liberation or perpetuated oppression and (b) actions of co-conspiratorship and solidarity toward transformative change (Noroña & Raskin, 2020). Combined, these principles connect with each other to offer a vision for antiracist, trauma-informed care that challenges mainstream interventions designed to help individuals cope with racism and racial trauma and promotes practices and policies that support them toward liberation and thriving (Powell et al., 2022). Most important, because radical healing is also a framework for collective well-being, it urges systems and organizations to engage in an ongoing commitment to carry out a vision for antiracist and trauma-informed care. This effort requires leaders and their organizations and systems to establish organizational cultures based the interconnected anchors.

Given the goals of the SIF-LC and as the project was launched in the midst of the COVID-19 syndemic, the radical healing

Table 2. Radical Healing Principles

Collectivism	Connection of personal liberation with that of broader BIPOC communities—locally, nationally, or internationally
Increasing self-awareness and critical consciousness	BIPOC communities' capacity to critically reflect and act upon their sociopolitical environment
Strength and resistance	Calling on the radical tradition of BIPOC ancestors who have survived centuries of atrocities through acts of everyday resistance, defiance, rebellion, and the production of art and preservation of cultural expressions (e.g., language, rituals, healing practices). BIPOC individuals and communities are not defined by the oppression and identity wounds they have experienced, they also carry a rich legacy of cultural traditions and thriving that can represent a source of well-being and strength.
Cultural authenticity and self-knowledge	Resisting colonized knowledge and practices as the only way of knowing and being and instead honoring ancestral wisdom and promoting racial-cultural and ethnic pride
Maintaining radical hope	A sense of agency to change things for the greater good, the belief that fighting for justice is possible and that it will not be in vain. Practicing radical hope involves reflecting on the radical traditions of BIPOC ancestors who transformed their circumstances and moved toward liberation as sources of inspiration and agency.
Practice restorative self-care practices	Audre Lorde stated, "Caring for myself is not an act of indulgence. It is self-preservation, and that is an act of political warfare." Engaging in restorative wellness practices that can benefit the individual and the community, including resting, taking a break from the work, sleeping, dancing, singing, or incorporating ancestral or Indigenous healing practices to process experiences of dehumanization and oppression and to find strength.

Note: BIPOC = Black, Indigenous, and other People of Color. Source: Adapted from *Being Anti-Racist Is Central to Trauma-Informed Care: Principles of an Anti-Racist, Trauma-Informed Organization*, by W. Powell, J. Agosti, T. H. Bethel, S. Chase, M. Clarke, L. F. Jones, W. F. Lau Johnson, C. R. Noroña, B. C. Stolbach, & E. Thompson, 2022, National Center for Child Traumatic Stress.

framework became increasingly relevant for supporting the participants and for the SIF-LC team's own sustainability. Here are some examples of how the radical healing framework was infused and also emerged in the work with the participant teams.

1. It soon became evident that the agencies and the individuals participating in the LC were experiencing ongoing stress, unpredictability, and fear while navigating new and increasing demands to serve client families and to attend to their own families, in the context of the syndemic. It was also evident that some of the providers who shared similar identities

with the mixed-status families reported additional stressors related to the systemic inequities discussed before. The radical healing principles provided an opportunity to explore with the participants the roots and effects of the syndemic in their lives and the lives of their client families. This prevented the internalization of negative perceptions about themselves (e.g., I am having difficulties with time management) or their clients (e.g., They are careless about health safety protocols) and helped to identify strategies for resistance, thriving, critical reflection, and restoration of hope. They also allowed for reflections on what self-preservation and well-being mean from an intersectionality and antiracist perspective, involving explorations of what it meant to each provider, based on their own histories and identities, and on how they wanted to honor the right for restorative self-care. One of the central activities in one of the first didactic sessions was the introduction to the radical healing framework and the creation of a personal map for the implementation of the principles by each provider as they continued their participation in the LC. This map with steps for reflection, accountability, and action was reviewed and discussed in more depth during the consultation sessions.

The group reflective consultation was considered an essential component to creating a holding environment for sharing, healing, and learning.

2. The radical healing framework supported the SIF-LC team to maintain a critical lens about how the project was responding to the needs of the participants and the families they served, and to tailor all aspects of the project to intentionally:

   a. Promote awareness about the impact of racism and other systems of oppression on the young children in immigrant families served, and the providers supporting them.

   b. Identify strategies for increasing safety, healing, and empowerment in the mixed-status families and among the minoritized workforce (e.g., immigrant providers of color).

   c. Highlight the responsibility and role of organizations and systems of care in promoting racial equity and social justice as core aspects of IECMH services.

   d. Offer information, tools, and strategies to promote practice and systems change.

3. In a parallel process, the principles helped in orienting some of the reflections with program directors and supervisors during reflective consultation with these leaders regarding how to actualize a vision for antiracist, trauma-, and diversity-informed IECMH organizations and systems.

4. As trust developed within group reflective consultation, themes related to radical healing emerged in the participants' narratives about their client families, their work contexts, and their own lives. This included themes such as reconnecting with ancestral and cultural traditions as a source of healing and thriving; cultivating ethnic, racial, and cultural pride; increasing awareness in clients and the self about the impact

of racism; and focusing on self-preservation as a radical act. This was particularly palpable as moments of instability, uncertainty, and fear heightened at several points during the peaks of the syndemic.

Fostering Compassion Satisfaction and Vicarious Resilience in the Provider

Compassion satisfaction is defined as the intrinsic sense of fulfillment derived from providers' work in caring for other people (Sacco & Copel, 2018). Vicarious resilience refers to the inspiration and personal growth of the provider resulting from exposure to their clients' capacity to recover, increase self-awareness, and thrive in the face of extreme adversity, loss, grief, and trauma (Hernandez-Wolfe, 2018). A central aspect of vicarious resilience involves the understanding and acknowledgment of how dynamics of power and privilege, marginalization, and powerlessness impact the supervisor/consultant-provider-family relationship (Brown & Ryan, 2003). Vicarious resilience requires that the provider is willing to be "voluntarily influenced by their clients. A conscious decision to do so means that therapists acknowledge how their experiences with privilege or marginalization shape their ability to listen, empathize and voluntarily learn from their clients' ability to cope with adversity" (Hernandez-Wolfe, 2018, p. 12).

Within the reflective consultation space, some of the participants were able to make connections between their experiences with privilege and marginalization and their motivation and capacity to work and learn with the immigrant families in their caseload. Most of the first- and second-generation immigrant providers were motivated to work with immigrant families as a way to give back to their communities and to use their skills (e.g., as a bilingual provider) to improve services and systems. Most of them identified their client's stories of bravery, thriving, resourcefulness, and resistance to oppression as sources of inspiration, hope, and incentive to continue the work.

The Importance of Setting the Stage for Diversity-Informed RS/C

When starting a new consultation group, a facilitator's first task is to establish trust and safety. This will allow participants to better use the consultation space, bring their authentic selves, and feel comfortable making mistakes. Therefore, the consultant should partner with organizational leadership to assess organizational readiness for participation in the reflective consultation. This process should include a contract (an agreement, commitment, or memorandum of understanding) with participating organizations. Organizations should be prepared to provide the resources required for participation (e.g., Wi-Fi, technology, time, space, and allocation of resources).

As mentioned previously, to establish trust and safety, participants should first have a clear sense of who is in the consultation group, the schedule for group sessions, and the expectations for attendance and participation. Expectations for engagement in the consultation calls should be considered and adjusted according to participating staff's access to reliable Wi-Fi, devices with video functions, technology literacy, and access to a private quiet space. Particularly if staff are working from home, access to a private and quiet space may be challenging. They may need to attend to other duties, such as caring for children or other family members. It is important that agencies provide their staff with the necessary support and tools for virtual engagement. Flexibility is key in order for consultants to respond equitably to the evolving needs of group members. Consultants should familiarize themselves with the platform functions (e.g., mute/unmute, chat functions, polls, breakout rooms, and waiting rooms) so they can provide support to participants and take advantage of the different engagement modalities of the virtual platform.

Centering Critical Self-Reflection and Relational Safety in Group Content and Process

It is the responsibility of the consultants to create a holding environment that is protected and trustworthy where participants can raise questions and share their insights and self-explorations as well as their concerns and accomplishments related to their learning, relationship with colleagues and supervisees/supervisors, and their work with families (Noroña & Acker, 2016). In this holding space, participants are also supported and encouraged to engage with the consultants in a process of mutual challenge and collaboration to "dispute theories and practices that reproduce the status quo of inequities generated and maintained by the cultural and social capital of dominant groups (Almeida, Dolan Del Vecchio, & Parker 2007; Hernandez, 2004)" (Hernández & McDowell, 2010, p. 29). To cultivate this space, the consultants pay close attention to the quality of the consultants–consultees relationship and parallel process in the senior leader–supervisor, supervisor–frontline worker, frontline worker–family; caregivers–child relationships and the relationships among group participants. They remain available, dependable, present, and accountable. Although the group might not always feel emotionally comfortable (Hernández & McDowell, 2010), they work consistently to maintain an open and mindful stance, try to listen carefully, provide empathy, and pay close attention to content (what happened) and process (the emotional experience) in the group.

Developing Relational Safety in Context and Fostering "Brave Spaces"

In diversity-informed group reflective consultation work, critical thinking and critical consciousness are cultivated through critical reflection and dialogue (Freire, 1970) and require time, practice, intentionality, openness, and vulnerability on the part of the consultant and consultees. Diversity-informed group

consultation work therefore allows the consultant and consultees to locate themselves and the families they serve within systems of power and privilege, and to better understand, navigate, and combat personal implicit and explicit biases, structural inequities, and work toward liberation-based practices in IECMH (Berger et al., 2018; Hernández & McDowell, 2010; Hernández & Rankin, 2008). This paradigm for group reflective consultation intentionally seeks to:

- push the boundaries of what we have learned, known, believed in, and perceived;

- invite us to unlearn, question, and take risks;

- "speak the unspeakable" about racism, homophobia, xenophobia, sexism, classism, colonialism, and other isms; and

- unveil the current and historical impact of these interlocking oppressive forces in ourselves, our relationships, our client families, our practices, and on the systems that serve them.

Therefore, the idea of promoting "safe spaces" for group work in this model represents an illusion and an expression of privilege (Arao & Clemens, 2013).

Reflective supervision occurs within an agency or a program while reflective consultation is contracted by an agency or program

A safe space is intended to be free of criticism, conflict, bias, or radical actions, ideas, or conversations. "While learning may occur in these spaces, the ultimate goal is to provide support" (Break Away, 2017, p. 1). An alternative framework is based on the premise that group dialogues on social and racial justice and diversity require bravery. Learning in this context involves risk, the pain of unlearning and giving up prior ways of knowing and being, and being able to make space for new ways of seeing and understanding experience. This approach for group work and learning seeks to cultivate brave spaces rather than safe spaces and the need for courage rather than the illusion of safety (Arao & Clemens, 2013; Break Away, 2017).

A brave space promotes dialogue, recognizes differences, and holds each person accountable to do the work and reach a new understanding about themselves, others, and social and political structures. Hence, it involves taking risks, being vulnerable, and experiencing discomfort (Break Away, 2017). Beginning to address issues related to racism, privilege, and oppression in diverse groups inevitably can bring up complex emotions including anger, anxiety, ambivalence, and apathy, as well as defense mechanisms like avoidance, resistance, and enactments (Tummala-Narra, 2009). A central aspect of formulating a brave space is that complex dynamics, controversy, conflict, and nonclosure are welcomed, deconstructed, and considered part of the learning and transformative process (Arao & Clemens, 2013).

Formulating a brave space also requires the collaborative establishment of ground rules with the group as part of the process of learning and reflecting about social justice. Arao and

Clemens (2013) highlighted how challenging familiar ground rules in group work and facilitation can move a safe space to a brave space. Some examples include:

- Don't Take Things Personally reformulated to Own Your Intentions and Your Impact

- Agree to Disagree reformulated as Controversy With Civility

- Challenge by Choice reformulated as Consider the Impact of Your Participation

- Analyze what Respect means in regard to bravery and the sociocultural context

- Analyze what No Attacks means in relation to bravery and the sociocultural context

These or similar agreements can be used to support diversity-informed group RS/C work. Currently many antiracist workshops and process groups begin with an agreement signaling bravery as well as the importance of benevolence to ourselves and to others as part of the growth process. These foundational agreements might become just as ubiquitous as confidentiality for clinical material. The SIF-LC facilitators proposed the following agreements for the group consultation: reflective and respectful listening, open mind, willingness to take risks, openness to nonclosure, willingness for introspection and intentional critical self-reflection, protection of confidentiality, and take space and make space.

In diversity-informed group reflective consultation, developing relational safety and fostering brave spaces can be offered concurrently or on a continuum to validate and challenge consultees as they face the trials and self-discoveries inherent to diversity, equity, inclusion, belonging, and antiracist work. As has been highlighted previously, a level of vulnerability and discomfort is necessary for authentic and impactful work to happen; however, the reflective consultant plays an important role in considering

- the experience for all members of the group, including potential triggers and trauma reminders that might affect the psychological safety of some participants; and

- how to create both supportive and brave spaces to validate group members and hold each other accountable (Break Away, 2017). For example, what plans are in place to help participants re-establish psychological safety after having been triggered or experiencing traumatic stress reactions?

Diversity-Informed RS/C in Action

To aid the reader in visualizing diversity-informed-RS/C in action, the SIF-LC team has designed a brief vignette, exploring common themes that emerged throughout the implementation of the didactic sessions and facilitation of the group reflective consultation.

General Background

Four early childhood centers are participating in a learning collaborative focusing on increasing the capacity of the organizations and staff to serve BIPOC and immigrant families. The following vignette illustrates the use of reflective consultation grounded on principles of diversity-informed, antiracist and trauma-informed, and radical healing practices. This new framework of reflective consultation in the field of IECMH can promote the well-being of the staff, increase their critical reflection and self-awareness about systems of oppression, and mobilize systems and practice transformation to serve minoritized families.

The Provider

Amelia Castro is a cisgender, White, second-generation Cuban-American woman who recently obtained her master's degree in social work. She reported that, although she learned Spanish as a child, English is her primary language and she does not feel confident using Spanish with clients and therefore had hoped to work with English-speaking families. She was hired 2 months ago as a family social worker at an early childhood center until she completes her licensure requirements.

The Family

Carlos Fuerte is a 9-month-old adjusted age infant who lives with his mother Claudia Fuerte. Claudia immigrated 12 months ago from Nicaragua. Carlos was born prematurely and is presenting some fine and gross motor delays. The family is new to the early childhood center.

Description of the Encounter

Amelia and one of the mental health clinicians conduct a home visit with Carlos and Claudia. The mental health clinician is a cisgender, White, woman who is monolingual in English. After completing an assessment process, the mental health clinician asks Amelia to translate her feedback to Claudia about Carlos' functioning. She recommends a referral to early intervention, and Amelia is charged with helping the family identify a program close to their home.

After this home visit, Claudia has stopped bringing Carlos to the center and neither Amelia nor the mental health clinician have heard anything from the family in 2 weeks, despite Amelia's attempts to reach them. The early childhood center's protocol when a child does not come in is to first call the family, then send a letter indicating that the program is trying to contact the family. After this, if the family does not respond and the child does not show up for 2 consecutive weeks, they are dropped out of the program.

Group Reflective Consultation Session

The virtual reflective consultation session begins with the facilitators greeting participants and reminding them of the

purpose of the consultation group space: to share their experiences, questions, or concerns related to the families served, or to themselves as they are performing their work. Then the group reviews the group agreements for a brave space that they have cocreated previously. Different members read these agreements aloud and then the facilitators ask if there are any agreements that are missing or the group would like to add to the list. To promote critical reflection, the group uses a semistructured reflective strategy for group discussion in which group members take turns speaking and listening (Fishbowl, 2014; Hester & Walker-Jones, 2009; Noroña & Acker, 2016). To start, one participant discusses their work with a family or a work-related issue and poses questions to the group. During the first part of the discussion, group members listen attentively and do not interrupt the presenter to ask questions or offer suggestions. After the presentation, the facilitators and group members ask questions for clarification. Then, group members engage in a reflection on what the presenter shared, while trying to hold multiple perspectives within a framework that is relational as well as developmentally, antiracist, and trauma-, and diversity-informed. During this initial reflection period, group members refrain from giving solutions, advice, or asking more questions to the presenter. After the group finishes their reflective discussion, the presenter reflects on what they heard and discusses any new insights as a result of listening to the group, and whether the discussion helped answering any of the presenter's questions. Then, facilitators wrap up the discussion by summarizing what was shared between the group and the presenter and wondering if there are further reflections from the group. The process concludes with facilitators or a group member sharing a word or reflection about the experience.

Amelia's Consultation Questions

Amelia discusses the background information of the family, what happened during the encounter with the family, and the following wonderings to the reflective consultation group:

- What did I do wrong?

- I don't feel confident speaking in Spanish with the family but I had to serve as a translator during this encounter and I am wondering if I said something confusing and pushed them away?

- I am feeling very conflicted about the situation, and I am not sure how to manage what I am feeling.

- I am not sure it is fair to close the case?

- What should I do to re-engage with the family? Shall I insist and try to visit them, unannounced, before I have to close the case?

- What if I am in a similar situation again and I miscommunicate with a family?

After listening attentively and creating space to hold the words and affect expressed by Amelia, the group validates her conflicted feelings, her concerns, and sense of unfairness. The group reflects on:

- the family and Amelia's experience: the group wonders how it must have felt, in the moment, for the family and Amelia, to place Amelia unexpectedly in the role of a Spanish translator. This after Amelia had expressed concerns regarding her fluency in Spanish. They reflect on the assumptions made by the colleague and the program about Amelia and how her hesitancy was ignored.

- how Amelia is being asked to perform a role (translator for a colleague) outside of her job description and training and the equity implications for Amelia and the family

- the past and current sociocultural and political context of the family, and whether the family has experienced immigration trauma, vulnerability to detention, deportation, and the fear of being exposed. The group wonders whether any of these concerns have implications in terms of their participation in the center.

- The group also wondered if Amelia could approach her supervisor to clarify the expectations for her role particularly as they relate to providing interpretation/translation services and serving monolingual families. She was transparent during her hiring process regarding her skills to provide bilingual services.

- The group reflects on the mechanisms of acculturation and assimilation as mechanism of White supremacy culture forcing immigrants to repress, deny their whole selves, to fit in the dominant culture and language.

- They invite Amelia to reflect if increasing her bilingual skills to provide direct services to monolingual Spanish-speaking is something she would like to explore in the future, how she might feel about this, and what kinds of supports she would need in this journey.

After listening to the group's reflections, Amelia reflects on:

- her identities, her social location, her family's immigration history, their efforts to acculturate and assimilate to the United States, and her ambivalence related to aspects of her sociocultural background and her identities (e.g., speaking Spanish or being seen as an immigrant)

- the implications of this ambivalence on how she and the mental health clinician presented to the mother (e.g., authority figures)

- how the encounter was conducted and how she and her colleague's identities (e.g., ethno-racial identity, nationality, language) may have impacted the family's sense of safety and consequently their engagement with the center. Specifically, Amelia reflects on the place of privilege and power from which she and her colleague reported the assessment results to the mother and made recommendations for early intervention services. This was done without considering how the results were perceived by Claudia and what a home visit from unfamiliar providers might mean for a mixed-status family.

Then, the group and Amelia:

- Discuss how to approach engagement with the family differently so it prioritizes their sense of safety and empowerment.

- Reflect on how the agency termination protocols may feel punitive and insensitive to the structural barriers faced by immigrant and other minoritized families and are producing moral distress in Amelia.

- Highlight Amelia's new insights about her ambivalent feelings related to her heritage.

Amelia shares that she has been reflecting on the impact of racism and internalized oppression in her and her family and that she is interested in exploring and having greater understanding on her racial, linguistic, and cultural background; her family's history of assimilation; and developing a sense of pride and ownership of these aspects of her identity.

- Wonder together what Amelia hopes and needs from the agency in order to feel seen, heard, and supported in her professional development and in her identity as a second-generation immigrant provider.

- Empower Amelia to bring up the experience in supervision and explore the expectations for her role.

- Discuss resources and information agencies that Amelia could use with the family.

Impact

There were multiple impacts of this group consultation on Amelia and her approach to engagement with the family.

- This group consultation expanded Amelia's critical self-reflection about her identities, family history, and the implications of her family's immigration history on her self-perception, values, beliefs, and experiences.

- It also increased her awareness of how systems of oppression are reproduced. This awareness deepened her understanding of the family's experience and fostered an interest of what a more compassionate, antiracist, trauma- and diversity-informed approach with families in similar circumstances might entail.

- It empowered her to advocate for the family and herself in her agency.

- It also clarified, for Amelia, her own areas of growth and supports needed for this growth (e.g., reflective supervision). It left her with:
    - increased awareness about her social location and identities and their effects on her work,
    - an enhanced sense of competencies while supporting immigrant families,
    - a sense of validation about the stress of the work, and

- recognition of the limitations of providers

- Most important, it offered her a brave and safe space created by a collective where she could be challenged, be vulnerable, learn, and be part of a community who understood the work. All of which is in consonance of radical healing and social and racial justice principles.

Implications for Policy and Practice

There are many implications of diversity-informed RS/C for the workforce and to the quality of IECMH care provided to immigrant families with very young children. By preventing and addressing the effects of primary trauma and STS in providers at the organizational level, diversity-informed RS/C can help retain the existing (and emerging) workforce that embodies the diversity of the families served by IECMH programs. The IEMCH workforce has high burnout and turnover rates, partially due to systemic challenges such as low compensation, large caseloads, and perceived low value of the services, which can all compound to increase the risk for STS (Frosch et al., 2018; Morelen et al., 2022). Such an investment in the workforce is also essential for promoting professional growth and expanding access to positions of leadership to a diverse workforce.

> *The environment includes relationships with other people, sociocultural influences, historical and current sociopolitical elements, and the impact of inequities and systems of oppression.*

Diversity-informed RS/C can have a powerful effect on the provider's sense of compassion satisfaction and vicarious resiliency, which are considered to be protective factors for STS at the individual level. Fostering a provider's sense of compassion satisfaction and vicarious resilience may be an essential component to providing quality IECMH care to immigrant families with young children and retaining the workforce. Research methodologies that include the participation of immigrant families and the providers serving them are needed to gain understanding regarding the possible ripple effects of diversity-informed RS/C in effectively promoting the workforce well-being and fostering equitable and just environments and practices for immigrant families and their providers.

Learn More

National Child Traumatic Stress Network
Being Anti-Racist Is Central to Trauma-Informed Care: Principles of an Anti-Racist, Trauma-Informed Organization
www.nctsn.org/resources/being-anti-racist-is-central-to-trauma-informed-care-principles-of-an-anti-racist-trauma-informed-organization

In summary, from a trauma-informed, racial equity, and social justice perspective, there is a pressing need to promote organizational and systemic changes that allow the creation of trusted spaces. Those spaces must allow for critical and ongoing self-reflection; learning from the top down and the bottom up about the impact of oppression, exclusion, and inequities in service delivery and on the workforce; and enhancing radical healing of BIPOC families and providers. RS/C can each be effective vehicles for these processes when rooted on racial equity and social justice principles. They have the potential to becoming paradigms to guide the field of IECMH into a call to action and a movement to decolonize knowledge and practice, de-center White supremacy culture, dismantle racism and other systems of oppression, and promote socio-structural and practice changes on behalf of minoritized families and providers (Noroña et al., 2021 Powell et al., 2022; Shivers et al., 2022).

Acknowledgment

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