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Development, Implementation, and Sustainment of Multicultural Peer-Consultation Teams in Distinct Mental Health Settings: An Implementation-Focused Comparative Case Study

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Multicultural peer-consultation teams represent one promising approach to supporting mental health providers by providing consultation that is multiculturally conscious and integrates front-and-center concepts related to diversity in identities and lived experiences (i.e., multiculturalism), intersectionality, inclusivity, health equity, antiracism, and anti-oppression. Herein, we take an implementation science-informed approach to describing the development, implementation, and sustainment of multicultural peer-consultation teams in two professional settings—a Veterans Affairs hospital and a psychology department training clinic. We operationalize the core and adaptable components of this model. Last, we reflect on our collective lessons learned and offer recommendations based on our efforts to create teams across mental health care settings. Thus, the present article may function as an implementation blueprint of sorts that others can follow as they consider ways that they can create similar teams at their institutions.

Public Significance Statement

With increased recognition of widening health inequities disproportionately impacting communities that have been systematically excluded and/or harmed by the mental health field, there is a crucial need for educational approaches that empower and equip clinicians with the knowledge and skills to provide care that is multiculturally conscious, inclusive, equitable, antiracist, and anti-oppressive. Multicultural peer-consultation teams represent one approach aligned with these goals. This article describes the multicultural peer-consultation model and reports on its implementation across distinct mental health care settings, with the aim of continued wide-scale dissemination to ultimately make a sustained public health impact.

Keywords: multicultural, peer-consultation, implementation, sustainment, core versus adaptable components

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Zoe Smith, PhD, LCP (*she*, *her*, *hers*), is an assistant professor of psychology at Loyola University Chicago. She earned her doctorate in clinical psychology, with a concentration in child and adolescent psychology, from Virginia Commonwealth University and completed a clinical internship at University of Chicago Medicine. Her current work focuses on creating culturally responsive assessments and interventions for Black and/or Latina/e/o adolescents with attention-deficit/hyperactivity disorder (ADHD) using community based participatory research methods. Advocacy is an incredibly important part of her work, and she is currently partnering with the Collaboration for Community Wellness to increase access to free, public mental health centers on the West and South sides of Chicago in addition to her research, teaching, and academic service. Smith is also working on a Robert Wood Johnson Foundation Health Equity Scholar for Action grant that focuses on creating trauma-informed assessments for Black and Latina/e/o adolescents with suspected ADHD.

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In the past several years, the COVID-19 pandemic gave way to greater national awareness of health inequities, a mounting mental health crisis where the need for services far outweighs the workforce capacity, and racial reckoning spurred by a light being shown on instances of police brutality and social conditions differentially impacting Asian, Black, Indigenous, and/or Latina/o/é/x individuals (Neville et al., 2021). Arguably, there has never been a more urgent time for mental health fields to create the infrastructure that supports the mental health workforce in growing and supporting one another as we collectively work toward cultivating an anti-oppressive approach and move toward eliminating mental health inequities (Neville et al., 2021) that have been perpetuated by our own fields (American Psychological Association, 2021). With the increased focus on multiculturalism shown through the publication of the

group at the Medical College of Wisconsin. Her primary research interests include attention and executive function development in children with neurogenetic conditions and developmental disabilities, as well as the effects of medical care on adaptive living skills. Her work is currently supported by a Young Investigator Award from the Children's Tumor Foundation to better understand the neural underpinnings of attention functioning in school age children with neurofibromatosis Type 1.

Rachel Zelkowitz, PhD (*she*, *her*, *hers*), is a clinical research psychologist in the Women's Health Sciences Division of the National Center for Posttraumatic Stress Disorder at VA Boston Healthcare System and an assistant professor in the Department of Psychiatry at Boston University Chobanian & Avedisian School of Medicine. Her research focuses on identifying modifiable factors that maintain comorbidity of posttraumatic stress disorder (PTSD) and related traumatic stress symptoms with self-destructive behaviors. She is interested in how these vary by gender identity. Her work is supported by a career development award from the Department of Veterans Affairs (IK2 CX002439). She is an active member of the VA Boston Psychology Diversity & Inclusion Committee, where she helped found the Multicultural Consultation Team.

Benjamin W. Katz, MS (*they*, *them*, *theirs*), is a doctoral candidate in the clinical psychology program at the University of Wisconsin–Milwaukee. Ben works with Shawn Cahill in the Fear, Exposure and Anxiety Research Lab and is a practicum trainee at the Center for Behavioral Medicine, a comprehensive dialectical behavior therapy clinic. Their research interests center around treatment outcomes for exposure-based interventions for posttraumatic stress disorder (PTSD) and mechanisms underlying engagement in reckless, self-destructive, and health compromising behaviors in PTSD resulting from chronic interpersonal trauma.

Brianna Young, MS (*she*, *her*, *hers*), is a doctoral student in the clinical psychology program at the University of Wisconsin–Milwaukee. Brianna's current research interests include early detection and intervention strategies for children with neurodevelopmental disorders including Williams syndrome, autism spectrum disorders, and ADHD, as well as co-occurring anxiety disorders. She is currently working on a treatment development study related to the use of play and humor infused exposure therapy with young children with Williams syndrome and specific phobias. Brianna is also spearheading a pilot study based on the Black Participatory Research framework to identify gaps in the mental health care system for Black families of children with Williams syndrome.

Colleen Sloan, PhD (*she*, *her*, *hers*), is the training director for VA Boston's Clinical Psychology Internship Program and clinical associate professor of psychiatry at Boston University Chobanian & Avedisian School of Medicine. She also serves as a staff psychologist within the Women's Trauma Recovery Team at VA Boston. She is involved both locally and nationally in education, training, and consultation in sexual and gender minoritized (SGM) health. She has expertise in treatment for trauma-related problems and emotion dysregulation including prolonged exposure and dialectical behavior therapy. Her research interests involve SGM health disparities and the utilization and modification of evidence-based psychotherapies, particularly dialectical behavior therapy and trauma-focused treatments, when working with SGM people. Sloan oversees and collaborates on multiple projects and initiatives related to recruitment and retention of diverse staff and trainees and education/training on cultural humility and responsiveness.

Joseph Carpenter, PhD (*he*, *him*, *his*), is an assistant professor in the Department of Psychiatry at Boston University Chobanian & Avedisian School of Medicine, and a clinical research psychologist in the Women's Health Sciences Division of the National Center for Posttraumatic Stress Disorder at VA Boston. His research focuses on mechanisms of change underlying the treatment of clinical fear and anxiety, in particular the application of research on basic memory and learning processes to improve treatment of posttraumatic stress disorder. He is currently supported by an National Institutes of Mental Health-funded career development award examining the integration of memory support strategies into cognitive processing therapy to improve memory and learning of therapy content. He is an active member of the VA Boston Psychology Diversity and Inclusion Committee, serving as a co-chair on several projects related to the cultural responsiveness of mental health services and workplace climate within psychology.

Aliya Saulson, MSW, LCSW (*she*, *her*, *hers*), is a psychotherapist working in a group private practice, ChangeWell Psych, in Charlotte, NC. She obtained her master of social work from Smith College in 2019 with a concentration in psychodynamic therapy. Aliya has experience working with adults of all ages and genders and particularly enjoys working with young women in emerging adulthood and those who are part of the LGBTQIA+ community. Aliya enjoys working with clients on a variety of issues including: anxiety, depression, life transitions, grief, self-image/self-love, identity, heartbreak, and trauma. Aliya deeply respects the vulnerability and courage it takes to engage in therapy and takes great intentionality in creating a space where clients can bring their whole selves. Aliya makes it a priority to fiercely advocate for her clients in all spaces, and values being an interdisciplinary member of Charlotte Trans Health, a multidisciplinary group dedicated to increasing affirming trans health care in the Charlotte area. Aliya views multicultural consultation teams as a rich ingredient to increasing inclusive, antiracist, multiculturally aware clinical care on the microlevel.

Christine Larson, PhD (*she*, *her*, *hers*), is professor of psychology and director of clinical training in the Clinical Psychology Program and Department of Psychology at the University of Wisconsin–Milwaukee. Chris's research interests are in the area of affective translational neuroscience. She and her lab investigate the neural underpinnings of emotion regulation and emotion dysregulation in the context of trauma and internalizing symptoms. These processes are studied in the context of socioenvironmental factors fostering risk and resilience for mental health outcomes. The laboratory's work has been funded by a number of sources including the National Institutes of Health. Chris is committed to optimizing training and student experience in clinical psychology. She has served on the executive board of the Academy of Psychological Clinical Science and chaired a working group on Reducing Barriers to Graduate Education. As part of the council of directors of clinical psychology, she has served on the Burnout Task Force.

Our positionality statements follow: We, the authors of this article, are mental health care providers trained in different academic disciplines including clinical psychology, counseling psychology, and clinical social work. Our authorship team is composed of three graduate students, three academic faculty, three staff psychologists at a Veterans Affairs hospital (who also hold affiliation within an academic medical school), and one provider working in private practice. Given the nature of this article, we firmly recognize that our own identities, backgrounds, and experiences shape how we carry out our professional roles. We represent a range of racial,

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"Multicultural Guidelines" from the American Psychological Association (e.g., American Psychological Association, 2017), there was a corresponding increase in descriptions and evaluations of multicultural training efforts. Despite an increase in training mandates and efforts in this area, there continue to be repeated calls for increased training in this area (Bell et al., 2019).

Multicultural peer-consultation (Nagy et al., 2019, 2022) represents one route toward this goal. Within multicultural peer-consultation, team members convene regularly to provide support to one another to ensure that the clinical care they deliver upholds the principles of multiculturalism, and by extension liberation psychology, diversity, inclusion, health equity, antiracism, and anti-oppression, among others. The promise of multicultural peer-consultation teams (referred to henceforth as "MCTs") is that they represent an ongoing forum, whereby a range of professionals in clinical and educational settings can continually learn from one another and grow in their knowledge, awareness, and skills as it pertains to their roles as mental health care providers, supervisors, researchers, and consultants. Importantly, the MCT model is versatile and can be helpful for trainees as well as staff and providers alike. Indeed, the principle of peer consultation, in which all members are valued and expected to contribute to the team regardless of the number of formal training years, is paramount.

There are several features of the MCT model that are innovative, create benefits, and address some of the limitations of traditional methods for multicultural instruction such as courses, workshops, and immersion activities. First, one essential aspect of the MCT model lies in its longitudinal nature, which supports continued learning and growth. Compared to one-time or time-limited approaches (e.g., courses, workshops, immersion activities), the MCT model allows members to receive ongoing support with their therapy clients and for themselves across time and professional development stages.

Second, the MCT model lends itself to wide-scale dissemination and thereby increases the sustainable workforce capacity of clinicians who can provide multiculturally conscious mental health care. Baked into the peer-consultation model is a focus on scaffolding whereby current members orient newer members to the model and therefore equip all team members with knowledge and skills to co-develop the team space, facilitate team meetings, and seek and provide consultation. By participating on the team, over time, team members gain the abilities that allow them to develop new teams or ensure the sustainability of an existing team. Anecdotally, we have found a common phenomenon whereby a team member transitions to an external role and creates an MCT in their new workplace, which has led to the MCT model being increasingly disseminated nationally and across settings (such as academic medical centers, psychology training clinics, Veterans Affairs [VA] hospitals, and private practice). The growing interest in this model has also highlighted the need for implementation strategies to assist the replication of the model in new settings, such as offering consultative support from the model's developers to local champions. Recognition of this need has led to the creation of the Multicultural Peer-Consultation Consortium (members of which includes authors of this article). This support empowers these champions to establish new teams in locations where the model has not been previously utilized and to request and seek consultation from other individuals who have developed MCTs in other national locations and distinct professional settings.

Third, the multidisciplinary team approach encouraged by the MCT model promotes humility and cross-pollination of ideas (team members "see things from different perspectives"). MCTs may be composed of individuals at different professional levels (e.g., students, interns, externs, postdocs, fellows, staff, faculty), distinct training disciplines (e.g., psychology, social work, psychiatry), and inherently comprise individuals with a range of identities and lived experiences. This creates a space wherein members learn from one another (what we refer to as a "horizontal structure") rather than traditional methods for instruction wherein there is one "expert" offering the content ("vertical structure"). In this way, this model

ethnic, and cultural backgrounds and self-identify as Latina/e/o (Latinx), Black, multicultural, White, and Native American. We also have members of our team who self-identify as cisgender women, cisgender men, and transnonbinary. Moreover, members of our team self-identify as queer, bisexual, pansexual, and straight. Members of this writing team reside in Wisconsin, North Carolina, Massachusetts, and Illinois.

The authors would like to extend a heartfelt note of gratitude to all of the members of their respective multicultural peer-consultation teams through the years. The desire to create such a team at one's institution is merely an idea until there is a critical mass of individuals who buy into the mission and tirelessly contribute to seeing it through. Thus, implementing this model across such distinct geographic locations and professional settings would truly not have been possible without the passion and drive of many of our colleagues who have supported our respective visions for transforming multicultural education in mental health fields. In addition, the authors thank those individuals who have spent considerable time championing the initial development and implementation of this model at their institutions, and who have been devoted to participating in the network of facilitators of multicultural peer-consultation teams that we have come to know as the Multicultural Peer-Consultation Team Consortium. Your passion for and commitment to this work is what has allowed us to build a close network and community through which we have been able to support one another as we carry out this initiative on a national scale. Last, the authors thank their colleagues who provided input early on in the conceptualization of this piece and who encouraged us to develop this article with the hopes of supporting others who also are motivated to develop a similar consultation service at their institutions. In this article, the authors use the term "we" to acknowledge all the individuals who have participated in multicultural peer-consultation teams and to represent the voices of all those who have supported the multicultural peer-consultation teams movement.

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challenges systems of power that can be deeply rooted in mental health fields and academia.

Aims

The scientific base pertaining to peer-consultation teams is nascent. Although the last few years have seen the proliferation of such teams occurring in a range of professional settings and geographic locations, there is a need for implementation-focused toolkits for others interested in developing their own such teams. The present article is one step toward this overarching goal. The aims of this article are threefold. First, we operationalize the core and adaptable components of the MCT model. Second, we present a comparative case study by describing the development, implementation, and sustainment of this model across two distinct settings—a psychology department training clinic and a VA hospital. Third, we reflect on lessons learned through our collective endeavors to establish such teams and provide consultation to other professionals seeking to create similar peer-consultation services at their institutions.

Theoretical Underpinnings

Merely describing the MCT model may not be sufficient to lead to successful implementation of the model in new settings. We therefore intentionally focus this article on processes and contextual factors that we navigated in our efforts to develop, implement, and sustain this model in our respective settings to allow future developers of such teams to learn from our collective experience. The Exploration, Preparation, Implementation, Sustainment (EPIS) Framework (Aarons et al., 2011) provides guidance on the phases of implementation of a particular intervention—in this case, the MCT model. Though the phases of the EPIS Framework are presented in a linear fashion, as the name seemingly indicates, the framework can be bidirectional depending on dynamic and changing contextual factors. Thus, developers of local MCTs may need to reconceptualize how to develop, implement, and sustain the MCT model given the local and external environments (e.g., institutional constraints) at their particular site over time. There should be careful consideration of the implementation strategies that may be necessary to ensure that the model can be sustained across time and endure changes that are likely to occur, for example, developing a standard operating procedures document that can be passed down to facilitators of the team, a document that outlines team norms and agreements that are consistent with the internal culture of the team, and training and consultative support to new team facilitators and members. Refer to Supplemental Materials 1 for a description of aspects of the EPIS model that can be useful in implementing an MCT.

Operationalization of the Multicultural Peer-Consultation Model

Adaptations to innovations, programs, interventions, and initiatives (in our case, the MCT model) are inherent in the pursuit of wide-scale dissemination and implementation. While there is no reigning gold standard approach to adaptation, many have called for rigorous and systematic approaches to maintain the integrity of the innovation that is being implemented (Shelton et al., 2020). This requires an understanding of the key ingredients (henceforth, "core components") to not invertedly alter the purported mechanisms of change (Shelton et al., 2020). Similarly, it is important to know which aspects could be modified (henceforth, "adaptable components") to maximize the fit, appropriateness, and relevance of the innovation in a new setting. See Supplemental Materials 2 for a graphic depiction of our (the authors of this article) consensus of these components. It is important to note while this is our theoretical operationalization of the model, these assertions have yet to be empirically tested.

We posit that core components of MCTs entail (a) *peer-consultation* (i.e., team members address clinical consultation needs of team members through requesting and providing input on clinical care and clinical research; see Supplemental Materials 3, e.g., consultation questions and Supplemental Materials 4, for a hypothetical case) and (b) *team agreements* (i.e., an understanding of how team members will interact with one another; how they will represent the clients/patients for whom they seek consultation; and the expectations/roles/responsibilities of team members; see Supplemental Materials 5).

Adaptable components comprise (c) *didactic presentations* (i.e., education and training provided by either/both team members and outside presenters), (d) *action committees* (i.e., team members organize efforts to ensure their settings can be optimally inclusive and respectful of the clients/patients served as well as employees), and (e) *social gatherings* (i.e., team members convene outside of formal team meetings to form companionship/community with one another for the goal of promoting safety and trust within the group).

While exploring the distinction between core and adaptable components of a model, it is crucial to acknowledge that all components hold intrinsic value and contribute to the model's overall efficacy. The term "adaptable" is not employed to inadvertently diminish the significance of these elements relative to "core components." Instead, it emphasizes their potential for tailoring to specific contexts, enabling optimal fit across diverse settings. Consider, for instance, a site where an established didactic series exists through coursework or hospital Grand Rounds. In such a scenario, a MCT may decide they do not need to develop their own didactics or choose to implement a reduced didactic component due to already established multicultural didactics and continuing education at their site or through allied or other local groups. Importantly, an overarching goal of MCT is fostering team awareness, cultural humility, and the development of knowledge and skills for therapeutic engagement with patients/clients from systemically oppressed backgrounds. Lifelong learning, including participation in formal didactics and continuing education, is considered a critical shared value among MCT members and encompasses the spirit of MCT. To this end, the MCT team facilitators, acknowledging the existing didactic opportunities at the site, would then encourage participation in such didactics to complement its own MCT components.

In addition to the components that comprise the MCT model, one important aspect of this model has to do with the style the model embodies. The spirit of the MCT model is that it engenders a collective orientation and therefore is co-created by all members, upholds collaboration through shared decision making, urges shared responsibility among members whereby team members rotate roles (e.g., facilitator, note-taker, observer, logistics planner, etc.), and encourages the free exchange of ideas and knowledge where all team members contribute equally rather than solely those who are deemed to be "experts." We posit that these features of the model are the pillars that allow teams to build sufficient psychological safety

and trust to optimally engage in this work, which at times can pull for vulnerability and willingness to engage in difficult dialogue.

Considering the different settings in which MCTs have been implemented, their features (e.g., the composition of the team, the structure of meetings, the frequency and length of meetings) can greatly vary. Each group of professional colleagues forming their own team will have to wrestle with different considerations along the continuum of implementation (i.e., exploration, preparation, implementation, sustainment) to determine the needs, constraints, and resources available in their setting to develop an optimal consultation service. Information about these considerations will inform the extent to which the adaptable components will be modified to fit each site. Refer to Supplemental Materials 1 for an outline of different questions to consider that can guide this process.

Implementation of the Model Across Settings

The present article builds upon two prior reports of the initial development of a multicultural peer-consultation team situated within the psychiatry department of a large academic medical center in the Southern United States (Nagy et al., 2019) and an evaluation of its implementation and early sustainment (Nagy et al., 2022). Herein, we expand on this work by describing the process for developing this model within distinct professional settings and geographic locations. Namely, we describe two exemplary teams situated within a VA hospital in the Northeastern United States (VA Boston Health Care) and a clinical psychology doctoral program in the Midwestern United States (University of Wisconsin–Milwaukee). Both exemplar teams involved a mix of trainees and staff/licensed providers; however, there is no reason that the MCT structure could not be adapted to teams exclusively comprised of staff. Indeed, some of the members of our Multicultural Peer-Consultation Consortium have such a structure. The sections below include a narrative describing reflections from early champions of these teams with a focus on process so that other groups endeavoring to create similar teams can glean lessons from their efforts and therefore facilitate implementation. We selected the following two teams as they are comparatively more established within our Multicultural Peer-Consultation Consortium, and therefore, we can more fully describe their efforts through the phases demarcated by the EPIS model (Aarons et al., 2011). Supplemental Materials 6 contains descriptions of the logistics of these exemplar MCTs and Supplemental Materials 7 contains information about development and sustainment of exemplar MCTs.

MCT Embedded Within a Veterans Affairs Hospital

From Fall 2019 to Summer 2020, exploration and preparation began when two postdoctoral fellows and a staff psychologist pursued bringing an MCT to the VA medical center. Our original vision was to incorporate both didactics and peer-led case consultation. Thus, our first meeting in August 2020 took the form of a seminar on responding to microaggressions perpetrated by veterans in clinical settings.

In response to other ongoing efforts to develop a didactic series on multiculturalism at VA Boston and results from our needs assessment (see Supplemental Materials 8) indicating greater interest in case consultation than didactics, the team organizers decided to focus exclusively on peer-led consultation. We pursued a pilot series of monthly peer-consultation meetings within the psychology service over the 2020–2021 training year. At the initial meeting, team organizers introduced team agreements modeled after those used by the MCT at Duke University (Nagy et al., 2019, 2022) and solicited feedback on these agreements from attendees. Potential types of consultation questions were discussed, and team organizers modeled a consultation request to promote initial team discussion. Beginning in Year 2, meeting(s) at the start of the training year have also included team member "introductions," in which each member shares an aspect or two of their identity that they consider most salient using the ADDRESSING framework (Hays, 2022). Staff members modeled these introductions to demonstrate vulnerability. The nonevaluative nature and value of peer consultation for the team are continuously reiterated; staff members in supervisory positions were instructed not to include MCT participation in their evaluations of trainees. Team leaders and staff members have attempted to model vulnerability, humility, and fallibility, as well as to reinforce trainees for sharing their struggles with challenging situations. However, we acknowledge that the power differential between staff and trainees, many of whom are evaluated by the staff in other contexts, cannot be fully erased.

Meetings in Years 1 and 2 took place after the standard VA "tour of duty" (i.e., work hours). This setting decision was in response to a needs assessment indicating one of the biggest barriers to participation was a conflict with existing obligations. Attendance during the first year ranged from 9 to 22 people and averaged 15 participants, and this slightly increased in Year 2 ($M = 17$, range = 12–25). Trainees and staff were approximately equally represented. We initially asked participants to indicate whether they would attend via email to receive the meeting link, so that we could monitor attendance; however, our current practice is to send out the meeting link to the psychology service more broadly. Interested staff or trainees can then request to be added to our group on Microsoft Teams to receive automatic calendar invites and access relevant materials (e.g., team agreements and clinical resources). We invite consultation questions ahead of time and post these on the Teams wiki page. For therapy client-specific questions, we ask that submitters send a secure email and not include any patient health information. We also solicit *ad hoc* consultation items at each meeting. Approximately half of the consultation questions are submitted ahead of time.

We invite consultees to complete a brief feedback form on the perceived usefulness of the team's consultation. We also informally invite those who have solicited consultation to provide updates on their specific therapy clients, programs, and so forth at future team meetings. Finally, we survey team members after each training year to assess reactions to the team and suggestions for improvement. One example of a decision implemented in response to such feedback was moving the team meeting to be held during the standard tour of duty during Year 3, a change that coincided with a notable increase in attendance ($M = 22$, range 12–32).

MCT Embedded Within a Psychology PhD Department Training Clinic

The multicultural peer-consultation team at the University of Wisconsin–Milwaukee was established in Fall 2021 by three graduate students and one faculty member (who was also the director of clinical training) following the receipt of a university-

sponsored antiracism grant. The grant's funds were partially used to support its initial development via a day-long workshop and consultation with a champion who helped establish an MCT in the Southern United States (Duke University; Nagy et al., 2019, 2022). MCT meetings occurred on a biweekly schedule for approximately 1 hour in duration via Zoom. During Year 1, approximately 10–15 members attended per group. We developed the MCT at the University of Wisconsin–Milwaukee in three phases spanning one academic year. In the first phase, we discussed the need for an MCT, how it would complement and extend existing program training elements, whether to include faculty, and whether the MCT should be required or optional. We also assessed member preferences for group parameters and logistics (e.g., frequency, duration, meeting location), developed documents to facilitate consultations, discussed and evaluated group agreements, and developed a shared vision of the MCT among group members.

In the second phase, we focused on the implementation of process-oriented discussions of group dynamics, building and maintaining trust to promote vulnerability and cultural humility, as well as group cohesion and belongingness. Considering that the standard in graduate-level clinical psychology programs generally is based in a vertical and evaluative context, we sought to ground the group values and principles in a collectivistic and horizontal structure. During each meeting we continually surveyed comfort with group parameters to clarify and establish processes for new and continued membership, for addressing ruptures, delegating division of labor, and evaluating student comfort with faculty presence and participation, all to uphold the horizontal nature of the team. Power dynamics, positionality, intersectionality, privilege, and disadvantage were common themes that grounded consultation discussions. We also use verbal affirmations (e.g., "I can see how that would have been challenging for you," "It sounds like you did the best you could at that moment") and behavioral support (e.g., sharing resources, manuals, offering language to use with a client) among members, as these were identified as an important backdrop for members to engage in vulnerability and openly seek guidance or varied perspectives. In line with the horizontal nature of the team, facilitators rotate on a volunteer basis at each meeting to ensure an even distribution of responsibilities among group members.

The third and current phase of the MCT at the University of Wisconsin–Milwaukee involves the sustainment of the team—members convening on a biweekly basis. The structure is effectively the same as it was the first academic year, in terms of meeting frequency and duration. The primary differences in the current iteration during the second academic year include (a) increased frequency of social get-togethers outside of the MCT (e.g., coffee and pastries at a nearby park); (b) no formal consultation request submission via Qualtrics; (c) inviting staff to join the MCT; and (d) a hybrid meeting format to facilitate attendance.

Reflections, Lessons Learned, and Recommendations

As MCTs continue to spread, we hope to provide the information we have learned throughout this process. Below, we highlight areas of growth we have discovered and ways to facilitate future endeavors for replication and sustainment of the model in new professional settings and geographic regions. Importantly, although we draw from the two exemplar sites in this article, the following section includes reflections, lessons learned, and recommendations from additional MCTs who are members of the Multicultural Peer-Consultation Consortium with teams falling along different EPIS phases.

Exploration

In exploring the extent to which developing an MCT at a specified site could be warranted, it might be useful to compile input from a wide range of individuals who may come into contact with the team, including trainees (e.g., graduate students, practicum students, interns, postdocs), providers and staff, individuals in supervisory roles (e.g., faculty, clinical supervisors), and administrative decision makers (e.g., directors of clinical training, internship directors, administrative personnel in charge of determining clinical caseloads and budgets, department chairs, school deans). It could be useful to inquire about existing infrastructure devoted to multicultural training, remaining training multicultural gaps that need to be filled, and how building an MCT does (or does not) align with institutional or programmatic training and clinical priorities (i.e., the extent to which having an MCT would reasonably be incorporated into training and clinical support efforts), and any potential obstacles to participation on the team (e.g., institutional constraints, logistics, bandwidth of facilitators and potential participants, motivation, willingness and capability to effectively participate on an MCT). We have found it helpful to compile and present data regarding the perceived need of and the level of interest and buy-in for developing an MCT. This helps decision makers at a site so that they may use data-informed decision making when considering the extent to which they may offer institutional support toward the development of the team and which resources to allocate to such an initiative. This has been done through both informal methods (e.g., conversations with colleagues), as well as formal ones (e.g., distributing a brief survey to individuals who might come into contact with the team).

Preparation

The initial development of an MCT is typically done by local champions, who are often team facilitators. For some teams, facilitation may be conducted solely by trainees (e.g., advanced graduate students, interns, postdocs), for other teams this may be done by professional colleagues without supervisory roles (e.g., licensed providers, staff) or supervisors (e.g., faculty, clinical staff), and for others it may be co-facilitated by trainees and professionals. At this stage, local champions are faced with a range of constraints and decision points to ensure that the format of the local MCT balances the perspectives and input of the individuals who are interested in participating and/or supporting the team (e.g., trainees, supervisors, and administrative decision makers).

Importantly, it has been documented in the literature that culturally conscious treatments and supervision are highly valued by trainees but often lack structural institutional support (Pugh et al., 2022). The lack of structural support may also impact supervisors, faculty, and staff who value culturally conscious treatments, supervision, and service activities that promote inclusion, as well as those who hold minoritized identities themselves (Campbell, 2021). Thus, it is imperative to consider how participation on an MCT would be supported considering that it is not uncommon for MCT members to hold identities that are systematically oppressed and/or are often the people called on to provide "Diversity, Equity, and

Inclusion" service for free without commensurate recognition, credit, or compensation for their time and labor (Joseph & Hirshfield, 2011). Navigating "credit" is generally difficult, as institutions often are interested in multicultural work, but frequently do not prioritize the acquisition of adequate infrastructure in place to provide resources such as course buyouts, compensation, or protected time/tour of duty outside of more typical credits (Clark et al., 2023).

In addition, it is difficult to navigate how to include credit into an already developed program (e.g., Are other courses cut? Do interns, externs, postdocs, and fellows take away another clinical hour for didactics?). Examples of credit that can be granted to faculty and staff can include compensation; formal recognition as a part of tenure and promotion; or reduction in teaching, service, and clinical duties. For faculty and staff, as well as trainees, it is important to consider how to protect time from busy schedules to participate in the MCT (e.g., including during standard work hours, removing other required meetings so MCT can be prioritized). For trainees, it is possible to receive course credit, compensation, and/or clinical hour(s) of group supervision. If granting course credit, consideration would need to be given to how to uphold the spirit of the MCT model that encourages a nonevaluative structure and mitigates power differentials as much as possible. Thus, if course credit is offered, a pass/fail system may help in providing less direct oversight and evaluation. Any grade for course credit must be discussed collaboratively between grantors and grantees of this credit to allow for the openness of these teams. In some settings, it may not be appropriate or possible to create courses for credit that trainees (e.g., interns, externs, postdocs, fellows) complete; however, training programs could mandate participation in an MCT to fulfill programmatic requirements. During those cases, attention is warranted to determine ways in which the nonevaluative spirit of MCTs can still be upheld.

As outlined in this article, MCTs hold core and adaptable components, thus, it is helpful to survey potential participants as well as key decision makers in each setting about their perceptions of training gaps and/or additional consultation supports that may be needed. Local champions of teams are encouraged to collaborate with potential team members to ascertain which aspects of the MCT model may make sense to include at their site. For example, some teams include both didactics and consultation, though these teams meet more regularly (biweekly), while other programs focus on consultation (and meet less frequently, e.g., monthly). Typically, MCTs without didactics include continuing education through alternative methods, thus MCT facilitators and participants do not create their own separate didactics. It will also be helpful to compile input about availability and preferences for frequency and focus of meetings to determine specific implementation plans.

Implementation

When implementing an MCT, careful consideration of various factors is essential to ensure the effectiveness and success of the team. These considerations center on several critical aspects including scheduling logistics, determining who will participate on the team, the power dynamics among members of the team, how team meetings will be structured—that is, which components of the model will be incorporated, and how the impact of the team could be evaluated. These considerations can contribute to the success of the team, enhance team member engagement, and promote a supportive and collaborative atmosphere in line with the model, ultimately supporting the training and professional development of all members. It is, therefore, imperative to approach these considerations with a strategic and holistic perspective to maximize the value and impact of the MCT.

A general first step in setting up an MCT entails scheduling the team, which can include some deliberation about frequency of meetings, length of meetings, location of meetings, and time of meeting during the week. Moreover, it may be helpful for teams to reflect on how members of the team can dedicate time and energy to participating on the MCT as well as explore if there are any ways that the MCT could be embedded into the existing infrastructure and workflows (e.g., whether classes, meetings, or duties could be removed to allow for time for participating on an MCT). MCTs differ in meeting modality (e.g., virtual, in-person, hybrid), all of which come with benefits and drawbacks. Given that trainees, faculty, and staff have many competing demands, many MCTs have found video conferencing convenient, as it does not preclude individuals who are off-site from participating (e.g., working across a large system with multiple sites, at an off-site clinical rotation, working from home). That said, we have also found that it can be challenging to host hybrid meetings, where some members attend in-person and others virtually, as conversations could more organically occur with in-person attendees and there is a risk those can feel left out who are attending virtually. Alternatively, it may also happen that if most members are attending virtually, while only a few are in-person, conversation might more naturally occur among those attending virtually. In addition, making the MCT open to flexible attendance has shown promise: VA Boston experienced an increase in attendance when an RSVP system was eliminated as well as when the time of the meeting was shifted to "within tour of duty."

Teams are also encouraged to consider who they would like to invite to participate on the team, and this will depend on the context of their site. For example, there may be some training settings within a particular discipline where the potential participants could be students as well as faculty and staff. In other settings, the team members might solely comprise individuals at the same stage of training or career. The decision about who to invite might require reflection on power dynamics at play especially if there would be members of the team who have an evaluative or supervisory role over other members of the team; existing level of comfort, safety, and compatibility among colleagues; ability to attend team meetings and level of commitment to the team; the desired size of the team (balancing inclusivity with having a manageable team); and diverse representation in identities, experiences, and disciplines of team members.

Developing community agreements at the beginning of MCT conception (and each cycle—semester, academic year, or calendar year—thereafter) is imperative, and this can lay the foundation for creating a horizontal team structure. Thus, during the first few meetings of an MCT, it is helpful to be self-reflective and discuss the inherent power structures within the setting the MCT takes place. Indeed, power dynamics among trainees, staff, and faculty have been a focus of this discussion, but it is important to consider other dynamics that exist (e.g., dual relationships wherein students act as clinical/academic teaching assistants for one another, students competing for funding, identities/privileges held, interns supervising practicum students) that could impact group cohesion. Although during the MCT meeting, power is aimed to be distributed as evenly

as possible, it is likely that other evaluative aspects (e.g., grades in other classes, clinical supervision, thesis/dissertation committees, need for letters of recommendation) contribute to how comfortable trainees or individuals being supervised feel in joining, participating, and engaging in the team. Faculty and staff have also reported being hesitant to join in some instances, as they want trainees to feel empowered and worry that by attending, they will inevitably introduce problematic power dynamics. On the other hand, it is possible that those with more relative power *not* showing up could send an unintended message to trainees that the faculty and staff do not prioritize this type of work. Thus, finding a balance through creating team norms and referring to them if someone in the team notices a power shift (and thus a deviation from a horizontal structure) has been helpful. This should include open and transparent conversations within the horizontal structure.

An important consideration of fostering developmentally appropriate scaffolding and support includes providing orientation to the MCT model when new members rotate through the team and/or at the beginning of a new semester, academic year, or calendar year which can take the form of sharing existing materials (e.g., team agreements, mission and vision statements, websites), co-developing a schedule of didactic presentations that can optimally meet the training and educational needs and goals of members (if didactics will be included), and supporting team members in learning *how* to ask for and provide consultation—for example, existing members of the team can model request formulation and providing consultation. It is also important to identify additional barriers to seeking consultation that may occur (e.g., perceived self-efficacy for requesting and providing consultation requests). In our experience, we have found it particularly valuable to praise the efforts of newer and more junior members (e.g., graduate students, interns, externs) of the team as they execute and rehearse the skills of seeking consultation, which holds the potential of motivating them to continue seeking and providing consultation, enhancing their perceived self-efficacy in being able to ask for and incorporate feedback to enhance the care they provide to their clients, and in shaping their consultation-specific clinical skills.

As previously mentioned, some teams solely include peer-consultation in their teams, whereas others might also include didactics, action committees, and/or social gatherings. Therefore, the model is flexible so that individuals developing a team could tailor their team to their specific context. Still, when customizing specific team components, reflection on the overarching goals of the MCT—awareness, cultural humility, and skills in working with a diverse clientele—is paramount to facilitate the process of guiding teams to creatively meet this goal through the integration of both internal (i.e., MCT) and external (e.g., the department, clinic, hospital) programming. Regarding consultation, MCTs have found that soliciting both prepared consultation questions and *ad hoc* consultation items has been a helpful balance in filling the case consultation portion of the meeting. This allows team members to see some of the topics beforehand, which may help them prepare a resource or recommendation but also allows for spur-of-the-moment or more immediate case concerns that have come up that week. This approach allows for efficiency *and* flexibility in responding to current events and how they are affecting not only clients but also MCT members.

Finally, we believe applying a program evaluation framework during implementation will help those wishing to establish an MCT conceptualize how to best fit the needs of their teams. Multiple teams include brief surveys to learn what is continuing to work and what may need to change. Anonymous feedback could help all members feel open to sharing and receiving accurate feedback. This would also help in implementing and developing the content of the MCT, since group needs or availability may change after the preparation phase, leading to changes in programming (e.g., removing didactics and prioritizing consultation).

Sustainment

Although most MCTs are in the previous three EPIS stages, teams are encouraged to reflect on how the team they develop could be maintained in the long term. First, it might be helpful to advocate for pathways for structuring the environment (e.g., incentive structures) to allow for participation on the team and the creation of "credit" for attendance on the team. Second, as new team members might join at different points, to maintain the internal culture of the team, it would be helpful to provide support to newer team members regarding how they can request and provide consultation in a culturally conscious way and orient new team members to the standing team agreements. Similarly, there could be personnel changes that may occur across time (e.g., trainees graduate, interns and externs complete a rotation at the location of the MCT, new demands create time conflicts for member precluding them from participating, etc.), therefore, it is all the more important to have shared ownership and collective decision making over the MCT so that the team can withstand such changes and the integrity of the team is maintained.

Constraints on Generality and Reflexivity

A primary benefit of establishing an MCT to fit a particular setting is that many of the components of an MCT are adaptable and thus are modifiable to the idiosyncratic constraints of a particular team and its setting of practice. A key constraint to consider involves the workplace climate of the setting in which one wishes to establish an MCT. For example, environments that are critical of inclusivity and antiracism initiatives may be relatively less likely to provide resources or support for a consultation team focused on increasing multiculturally conscious clinical care and clinicians compared to workplace climates in which multiculturally conscious care and training are prioritized. Importantly, even a full team of committed members can be limited by an institution's inability (e.g., under-resourced) or lack of motivation to instill incentive structures (e.g., credit) to support these initiatives. Another constraint to consider includes the clinical growth from actively participating in an MCT. Engaging in self-reflection regarding clinical work and one's positionality can be uncomfortable and challenging and may not be a priority for some with either limited willingness or capacity for perspective-taking. Should consultation remain on a surface level (i.e., nonreflective) by avoiding discussion of provider's identities and biases, this may impede clinicians from being able to use consultation effectively to enhance their client care and own clinical growth.

Conclusions

This article offers a guide for multidisciplinary mental health providers to create, establish, and flourish in the inclusion of multicultural peer-consultation into training and health care environments through establishment of an MCT. This article includes a call to action for *all* levels of power and privilege to prioritize, value, and

appropriately credit multiculturalism work. We encourage all who provide mental health care to work toward the creation of an MCT and use this guide to incorporate the values of cultural responsibility, liberation, and equity into practice and training. In addition, even if establishing an MCT is not feasible at an institution as it currently stands, we hope these examples, reflections, and problem solving will help people increase multiculturalism training at their sites. This has been called for routinely, for example, by the Training and Education in Professional Psychology journal (Bell et al., 2019).

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