

Infant, Toddler, and Early Childhood Mental Health Competencies:

A Comparison of Systems

Introduction

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In the United States, the past few years have seen heightened interest in and recognition of the mental health needs of infants, toddlers, and young children. Although those who have been working with young children and their families have known it to be true for decades, the general public is slowly coming around to the understanding that our youngest children can suffer from serious mental health disorders, that exposure to physical and emotional trauma during this period can have lasting consequences, and that many children have unmet social and emotional needs—with strong implications for development and learning.¹ Recent publications and initiatives have highlighted this increased focus on infant, toddler, and early childhood mental health (ITECMH), such as the special section of an issue of *American Psychologist* (“Infant Mental Health,” 2011), and an updated paper by the National Scientific Council on the Developing Child (NSCDC, 2008/2012). In addition, heightened interest in the findings from the Adverse Childhood Experiences Study in scientific (Anda, Butchart, Felitti, & Brown, 2010) and popular literature (Tough, 2012) have fueled the drive to understand these needs and offer services to promote child well-being, prevent early mental health challenges from occurring, and if necessary, provide treatment as early as possible.



As interest increases in addressing the mental health needs of young children, so too has concomitant interest in supporting the training and practice of service providers who work with these young children and their families. Workforce development has become a central policy issue in ITECMH (Nelson & Mann, 2011), but providers generally receive very little training on the unique needs of young children (Meyers, 2007). Finding mental health professionals who understand early childhood development, conduct appropriate screening and assessment strategies, and provide evidence-based treatment strategies for this age period that incorporate dyadic or family-centered approaches is challenging. Mental health training programs (including those for social work, psychology, psychiatry, and counseling) rarely offer specialized coursework in or practicum experience with the infant, toddler, or preschool age range.

Jane Knitzer pointed out more than a decade ago that unique features distinguish ITECMH services from mental health services for older children and adults (U.S. Public Health Service, 2000). First, ITECMH services often are viewed in the context of prevention and thus may not be seen as specifically dealing with serious emotional disturbance. This conception has been altered to some extent by recognition of the impact of trauma in early childhood (see NSCDC, 2008/2012) and the need for tertiary mental health services. Second, ITECMH services often are delivered

¹ Admittedly, the general public is always coming around to this point, and we consistently remain optimistic about signs of “recent interest” in the field that will dramatically increase services and supports to our youngest and most vulnerable. This increase does not always happen, but this optimism has fueled the slow but steady progress our field has seen in the past 30 years.

in natural settings for young children, such as home or child care, and often include indirect services to the parent or caregiver. Both of these features create additional complexity, as they require alternate models of treatment and funding. Third, assessment and diagnosis is challenging during this age period, because many measures and diagnostic criteria do not fit young children. Struggles over the transition between the fourth and fifth editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; American Psychological Association, 2000, 2013) have highlighted this issue (Thomas, *n.d.*), and the most widely used system for young children, the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition*, (DC: 0–3R; ZERO TO THREE, 2005) typically needs a crosswalk to the DSM to allow acceptable diagnosis for the health care and insurance industry. Finally, children’s mental health providers often lack knowledge of specific issues in early childhood and family development, such as the normative severity of disruptive behavior, individual variation in language development, and developmental progression of the parent–child relationship.

As an additional aspect of complexity, the early childhood field is transdisciplinary with regard to social and emotional development. Multiple professions lay claim to the development and social-emotional well-being of young children, including psychology, social work, psychiatry, counseling, pediatrics, nursing, physical therapy, speech and language therapy, occupational therapy, early care and education, and family support. Although true for any age period, the extent of transdisciplinary work in early childhood services is notable, as can be seen by even a cursory review of the organizing documents of most state infant mental health associations. For this reason, no one professional guild has taken the lead in establishing standards or requirements for providers who work with young children around social-emotional well-being.

Filling this leadership void, however, are local efforts to identify competencies that ITECMH specialists should have in order to engage in effective prevention, promotion, and treatment strategies with families with young children. Most of these competency systems have emerged from state-level associations or task forces, with interdisciplinary groups of professionals coming together to summarize and describe the content knowledge and skills of practitioners who work with the birth-to-5 years age period. These competency systems are the focus of the current review.

There are four main reasons why competency systems are needed for early childhood mental health. The first concerns training and professional development. An established set of competencies for ITECMH specialists provides important guidelines for higher education institutions or other organizations in establishing training programs and provides guidance for individuals to choose specific training. The second reason for the existence of ITECMH competency systems is the enhancement of professional credibility. Competency systems provide a benchmark for what knowledge and skills are needed in order to provide relationship based services promoting social and emotional well-being. These systems provide a visible standard not previously available. The third reason to use competency systems is to ensure practitioners are qualified to work with infants, young children and their families. These systems could ideally be used to ensure that people hired in certain roles have the knowledge, skills and experiences to effectively work with young children and their families. Such requirements could serve to inform or even protect the public or potential employers through clear specification of training needed and achieved. The fourth reason concerns financial reimbursement. It is possible that competencies could be used to assist in decisions about hiring, salary, and program budgeting. Financial reimbursement also concerns third party payers. For example, state Medicaid policies could require endorsement at a certain level for reimbursement.

In 2008, the Herr Research Center for Children and Social Policy at Erikson Institute published a review of early childhood mental health competency systems (Korfmacher & Hilado, 2008; hereafter referred to as “the 2008 review”). The review compared and contrasted the content and structure of six sets of competencies, those developed by groups in California, Connecticut, Florida, Indiana, Michigan, and Vermont. The findings suggested a considerable amount of content overlap among the six competency systems. Although some competency systems were more comprehensive than others, for the most part, each system covered topics within nine broad areas that were established by the 2008 review. The review also highlighted many unanswered questions about the use of these competency systems, including how they could be seen to enhance practice, which types of providers are the most appropriate to target, and who is best qualified to oversee an endorsement process.

REASONS WHY COMPETENCY SYSTEMS ARE NEEDED FOR EARLY CHILDHOOD MENTAL HEALTH

1. Training and professional development
2. Enhancement of professional credibility
3. Ensure practitioners are qualified
4. Financial reimbursement

In the 6 years since the original review was published (Korfmacher & Hilado, 2008), there have been a number of changes to the ITECMH competency system landscape. Some of the existing competency systems have extended their applied reach (in particular, the Michigan and Vermont systems), while other written competency drafts have essentially become dormant (the Connecticut and Indiana systems).² Revisions and updates have been made to other competency systems. The California system, for example, was expanded to include considerably more detail than was in its earlier draft. Credentialing or endorsement processes have been further developed in most of the systems, and online tools have been refined to allow reviewers to view and comment on applications and to communicate with applicants. Finally, new competency systems have come into play in some states (such as Colorado and Ohio) that were not included in the initial review.

Around the time that the 2008 review was published, ZERO TO THREE sponsored a national meeting to discuss the nascent movement of competency system development, and a call was made (at this point, still unanswered) to develop a set of national competencies (Nelson & Mann, 2011). ZERO TO THREE, as a leader in promoting the social, emotional, and developmental needs of our nation’s youngest children, has initiated a conversation on this issue of national competencies. An updated review of the ITECMH competency landscape is an important source of information for this task.

The current report, then, is an update of the 2008 review (Korfmacher & Hilado, 2008). It is divided into four sections. The first section reviews what is meant by ITECMH competencies and deals with some issues of nomenclature. The second section provides a brief overview of the six competency systems that are the focus of this review (California, Colorado, Florida, Michigan, Ohio, and Vermont). In the third section, results of the comparative analysis are presented, summarizing areas of agreement and disagreement. The final section of the report goes once more into the policy breach and discusses the relevance of these competency systems to the current early childhood mental health movement.

² Indiana and Connecticut, however, have adopted and now use the Michigan competency system, as described later.

What Are Infant, Toddler, and Early Childhood Mental Health Competencies?

As noted in the 2008 review (Korfmacher & Hilado, 2008), one challenge in analyzing ITECMH competency systems is deciding on a definition for the different terms the concept encompasses. One important term is *infant mental health*. ZERO TO THREE's Infant Mental Health Task Force (2002) defines infant and early childhood mental health as "the developing capacity of the child from birth to three to experience, regulate, and express emotions; form close and secure interpersonal relationships; and explore the environment and learn, all in the context of family, community and cultural expectations for young children."³

It is important to note that this is a broad definition of mental health, and it is aligned with the similar concept of *social-emotional well-being*. There are political and professional undertones in using *mental health* rather than *social-emotional health* for this age range. Some stakeholders and professionals may not feel comfortable referring to mental health problems in very young children, especially those who view their work as promotion of good mental health rather than as therapeutic treatment (see also Emde, 2001; Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2007; Korfmacher, 2012). However, because all but one of the competency systems use "mental health" in their titles, this report will follow their lead.

The second term to understand is *early childhood*, which can variously refer to birth to 3 years old, birth to 5 years, or birth to 8 years and may include the prenatal period as well. The competency systems discussed here are being applied to the period birth (or prenatal) to at least 5 years of age, with the Vermont system going up to age 8 years. However, it is important to recognize that there are unique aspects of development in the infant and toddler period. Current service sectors often distinguish the birth-to-3 period from the later early childhood period, such as the early intervention and special education sector, preschool programming sector, and child care regulations. Even though *infant mental health* is much more succinct than *infant, toddler, and early childhood mental health* (abbreviated here as ITECMH), accuracy dictates use of the more ungainly term.

Another term to define is *competency*. Competencies describe content knowledge (e.g., about child development or risk factors), as well as practical skills and abilities (such as treatment approaches, assessment skills, or reflective capacities) that specialists must have in order to successfully perform their duties. *ITECMH competencies*, then, are specific and detailed areas of knowledge and practice required of someone who works with young children and their families.⁴ In the initial review (Korfmacher & Hilado, 2008), categories of competencies were developed inductively as the different systems were reviewed and re-reviewed; the competencies ultimately fell into nine primary categories. For the current analyses, these content categories were reviewed again, and some modifications and additions were made based on the addition of the more recently developed systems (see Appendix).

ITECMH COMPETENCIES

ITECMH competencies are specific and detailed areas of knowledge and practice required of someone who works with young children and their families.⁴

³ ZERO TO THREE has actually used two different definitions for infant mental health. See Korfmacher (2012) for details.

⁴ Although some documents have used the terms *training standards* or *training content* (depending on the purpose of their systems), we have assumed these to be equivalent to competencies.

Specialist is another term needing brief clarification. Most of the competency systems define different levels of professionals who work with families in a mental health capacity. California reserves the term specialist for only those who can obtain state mental health licensure. The Vermont system also reserves the term specialist for only its highest level of competency, while Michigan distinguishes between an “Infant Family Specialist” (Level 2) and an “Infant Mental Health Specialist” (Level 3). In this report, the term *ITECMH specialist* is used more generally for the sake of simplicity.

Finally, these competency systems are often, but not always, put into the service of some process of giving public approval to a candidate who has demonstrated these abilities and knowledge, such as through testing or portfolio review. Different terms are used to describe this process, such as *license*, *endorsement*, *certification*, or *credential*. *Licensing* refers to the granting of permission or authorization to practice in a way that would otherwise be unlawful, implying a formal oversight process. Licenses are applied narrowly to a designated profession, such as psychology, social work, or medicine, and are usually governed at the state level. Because the ITECMH competency systems detailed here are purposefully multidisciplinary, an ITECMH license is an unlikely outcome of these competency systems.

There is little practical difference between the terms endorsement, certification, and credential. All can occur at the local, state, or national level and all imply the approval or assurance that a candidate meets their definition of a competent professional, even if this assurance does not have legal standing (see Korfmacher & Hilado, 2008, for review). The Michigan Association for Infant Mental Health (MI-AIMH) (as well as the California Center for Infant-Family and Early Childhood Mental Health) uses the term endorsement for its process, in part to suggest that this designation does not replace the requirements of a candidate’s profession (see Weatherston, Moss, & Harris, 2006). Other competency systems (Ohio, Colorado, Vermont) have used the term credential in their documentation.

What Are the Currently Operating Competency Systems?

Information is publically available about at least six ITECMH competency systems operating in the United States (see Table 1).⁵ For ease of description, the name of the state in which the competency system was originally developed is used. That nomenclature is not meant to imply that the competency system is used universally within the state or endorsed by the state government or, in the case of Michigan, is only used within that one state.

Three states divide their competency systems into multiple levels.⁶ The different competency systems encompass a range of ages, from prenatal up to age 8 years. How the competencies are used varies considerably as well, although all are used at least as a guide for training and professional development. In a change from the 2008 review, five of the six competency systems are connected to a credential or endorsement program currently in use or in the process of piloting.

⁵ It is possible that there are other competency systems that were not uncovered at the time of this review, so this list should not be considered exhaustive.

⁶ In addition, one system (Florida) proposed multiple levels but only developed competencies for its top level.

Table 1. ITECMH Competency Systems Overview

STATE	AGE FOCUS	COMPETENCY LEVELS	PURPOSE
CALIFORNIA	Prenatal to 5 years	1. Trans-disciplinary mental health practitioner 2. Advanced trans-disciplinary mental health practitioner 3. Mental health specialist 4. Reflective practice facilitators (I & II) 5. Reflective practice mentor	Framework for training and endorsement process through CA Center for Infant-Family and Early Childhood Mental Health at WestEd.
COLORADO	Birth to 8 years	Single multidisciplinary level	Guide for professional development, and serves as a quality assurance system. Basis for a credential program.
FLORIDA	Birth to 5 years	Infant mental health specialists	Guide for training and professional development.
MICHIGAN	Prenatal to 3 years (Prenatal to 5 years also allowed)	1. Infant/Family associate 2. Infant/Family specialist 3. Infant mental health specialist 4. Infant mental health mentor	Framework for endorsement process available through MI Association for Infant Mental Health. Currently licensed to 16 other state associations, including AL, AZ, CT, CO, ID, IN, KS, MN, NJ, NM, OK, RI, TX, VA, WV, & WI. In addition, one program in Florida has purchased the competencies but not the endorsement system.
OHIO	Birth to 5 years (implied)	Single level, for ITECMH professionals who provide consultation or treatment	Guide for advocacy, training, and professional development. Credential program currently being piloted.
VERMONT	Birth to 8 years (NH: birth to 6 years)	1. Foundation 2. Intermediate 3. Advanced 4. Experienced	Guide for training and professional development. Credential program piloted in Vermont at intermediate level and currently being piloted in New Hampshire at intermediate and advanced levels.

CALIFORNIA

Training standards from California were originally developed as part of the pilot program, “California Infant, Preschool, and Family Mental Health Initiative” (CA-IPFMHI), which was funded by the First 5 California Children and Families Commission and operated through California’s Department of Mental Health from 2001 to 2003 (CA-IPFMHI, 2003a, 2003b; Knapp, Ammen, Arstein-Kerslake, Poulsen, & Mastergeorge, 2007). The project was a collaborative effort by the WestEd Center for Prevention and Early Intervention (CPEI) and eight counties throughout the state. Departments of mental health and community partners within these counties jointly implemented a model for integrated infant-family and early mental health service delivery, focused up to age 5 years. The standards that emerged from CA-IPFMHI were developed to guide a training protocol composed of academic coursework, workshops and continuing education, supervised clinical experiences, and postdoctoral training, as applicable.

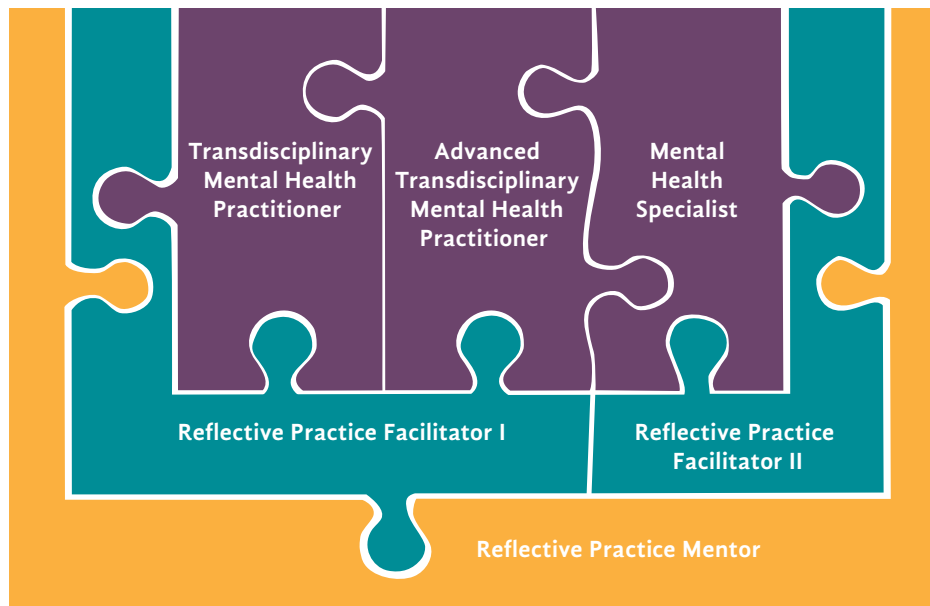
Two sets of standards were identified based on the participants’ professional backgrounds: mental health professionals (providers eligible for licensure) and core providers (providers working in such related fields as child care, early intervention, nursing, occupational therapy, or special education). Mental health providers had more rigorous and intensive standards than did the core providers. The original competency system was never used for certification or endorsement, as no state agency or professional association was willing to take on this task during the initial pilot period (see Finello & Poulson, 2005).

In 2009, however, revised competency standards were published. These standards, titled *California Training Guidelines and Personnel Competencies for Infant-Family and Early Childhood Mental Health* (California Infant-Family & Early Childhood Mental Health Training Guidelines Workgroup, 2012), were developed during a 2-year process by a work group consisting of infant-family and early childhood specialists involved in training programs throughout the State of California, as well as representatives from the California Department of Mental Health, WestEd, ZERO TO THREE, and the Infant Development Association of California. The work group also developed an endorsement system that has been piloted and refined. This system is operated out of the California Center for Infant-Family and Early Childhood Mental Health,⁷ a component of WestEd’s CPEI. The system includes a website (cacenter-ecmh.org) that hosts the training guidelines and competencies, the competency application process, and general information and resources devoted to infant and early childhood mental health. One of the strengths of the California system is that it has developed a set of electronic tools for application, review of materials, and storage.

The current California competency system has three broad categories, two of which are analogous to the previous levels: mental health specialist (professionals licensed or license eligible), transdisciplinary mental health practitioner (allied professionals, similar to the core providers in the previous California system), and reflective practice facilitator. The transdisciplinary category has an additional “advanced” subcategory. Facilitation, in this model, is similar in broad form to supervision, although facilitators may not necessarily provide direct clinical or administrative supervision to the providers. The reflective practice facilitator category itself is divided into three subcategories: Level 1, Level 2, and Mentor. Rather than viewing these categories strictly as levels (assuming a hierarchy), the work group used a jigsaw representation to show how the professions relate to each other (see Figure 1).

⁷ The author is a member of the advisory committee for the Center, although he has not been an active member.

Figure 1. California infant-family and early childhood mental health endorsement categories



Retrieved March 23, 2013, from the California Center for Infant-Family and Early Childhood Mental Health at WestEd Center for Prevention and Early Intervention, <http://cacenter-ecmh.org/wp/wp-content/uploads/2012/09/NestingGraphicWeb.gif>.

The endorsement categories are summarized in Table 2. In general, the requirements for endorsement in terms of education, required supervision, and clinical hours become more stringent as one moves from transdisciplinary practitioner, to advanced transdisciplinary practitioner, to specialist. The two categories of reflective practice facilitator have identical endorsement requirements, except that Level 2 facilitators have to be endorsed mental health specialists, while Level 1 facilitators may be endorsed transdisciplinary practitioners. Finally, reflective practice mentors, who provide support to facilitators, must be previously endorsed reflective practice facilitators (Level 1 or 2) and meet additional training and mentoring experience.

The competencies for transdisciplinary practitioners and specialists are divided into eight categories, as shown in Table 3. Adherence to competencies is measured by number of hours of training or coursework done across the eight broad categories, which is proven by a transcript or portfolio review, rather than a checklist of specific indicators. Candidates can choose to specialize prenatal to 3 years, 3 to 5 years, or the entire prenatal-to-5-year spectrum.

Table 2. California Endorsement Requirements by Level

CATEGORY	TRANS. MH PRACTITIONER	ADVANCED TRANS. MH PRACTITIONER	MH SPECIALIST	RPF (I, II) ^a
EDUCATION	B.A./B.S. in related field ^b	Masters degree and/or 8–10 years of experience	Master's degree or higher in related field	Unspecified degree; 1 year FT work equivalence
TRAINING	120 hours across competency categories	120 hours across competency categories	260 hours across competency categories	29 hours, specified
PROFESSIONAL LICENSE OR CREDENTIAL	None required	None required	Required in related field	Trans. MH practitioner or MH specialist endorsement
CLINICAL HOURS	60/120 ^c	60/120 ^c	500/1000 ^c	N/A
REFLECTIVE FACILITATION HOURS	12/24 ^c	12/24 ^c	60/120 ^c	48, plus at least 1 practice observation
SERVICE EXAMPLES	early intervention, special education, nursing, occupational therapy, speech and language pathology	early intervention, special education, nursing, pediatrics, occupational therapy, speech and language pathology, social work	Professionals in MH field	Akin to clinical supervisor

Note. FT = full time; MH = mental health; RPF = reflective practice facilitator.

^a Reflective practice mentors have specific requirements different from facilitators. See <http://cacenter-ecmh.org/professional-development/categories/effective-practice-facilitator-mentor-rpfm/>.

^b A current “grandparenting” window allows experienced providers without formal college degrees to apply for transdisciplinary mental health practitioner status. This was done, in part, to acknowledge the considerable number of bilingual and bicultural providers and community educators who have not had access to formal education opportunities (M. Heffron, personal communication, September 23, 2013).

^c Hours differ depending on whether the practitioner or specialist focuses on one age period or the entire age range.

Table 3. California Competency Domains: Prenatal–5 years

Parenting, Caregiving, Family Functioning, & Child-Parent Relationships
 Infant, Toddler, and Preschool Development
 Biological and Psychosocial Factors Impacting Outcomes
 Risk and Resiliency
 Observation, Screening, and Assessment
 Diagnosis and Intervention
 Interdisciplinary/Multidisciplinary Collaboration
 Ethics

Source: California Infant-Family & Early Childhood Mental Health Training Guidelines Workgroup (2012).

The reflective practice facilitator competencies were adapted from a journal article that outlined reflective supervision skills (Heffron, Ivins, & Weston, 2005) and are divided into three major areas:

- 1. Clarity Regarding Roles and Ethics**—understanding of the parameters of early childhood mental health practice, including legal issues, ethics, and professional boundaries
- 2. Understanding of Interpersonal Influence Issues**—helping the practitioner to understand relationship-based practice, such as use of the helping relationship, understanding of family relationships, and ability to reflect on interpersonal dynamics in help-giving
- 3. Facilitation Skills**—the facilitator’s own ability to support the professional growth and identity of the practitioner

Various infant mental health training programs in the state have aligned their curricula with the California competencies, including the University of California, San Francisco Infant-Parent Program, Alliant University, and trainings provided through the Infant Development Association of California. As of September 2013, 27 transdisciplinary practitioners had been endorsed, 15 advanced transdisciplinary practitioners, and 113 mental health specialists. Within this group, 87 had been endorsed additionally as reflective practice facilitators or mentors (M. Heffron, personal communication, September 23, 2013).

COLORADO

There are two sets of early childhood mental health competencies in the state of Colorado. In 2010, the Colorado Office of Professional Development released the *Early Childhood Social & Emotional Interdisciplinary Core Knowledge & Credential* (Colorado Office of Professional Development, 2010). This office, which now exists in a modified form as part of the Office of Early Learning and School Readiness in the state Department of Education, developed the

credential over a 3-year process to meet one of its seven goals to promote optimal social and emotional development in young children through professional development. The competencies are extensive, listing 34 categories and 408 specific indicators across seven broad domains of competency:

1. Child Development
2. Family Dynamics
3. Responsive Child-Focused Supports & Practices
4. Risk & Resilience
5. Cultural Competence
6. Professionalism
7. Interdisciplinary Collaboration

The state Department of Education has offered a credential connected to these competencies that requires at least a bachelor's-degree level of education in a field related to early childhood. As this requirement suggests, the competencies were designed not necessarily for a clinical profession, although it was noted that the credential would be applicable to a range of professionals, including "early childhood teachers, child welfare consultants, nurses, home health care providers, social workers, mental health consultants, coaches and mentors, therapists, home visitors, and parent educators" (ZERO TO THREE, 2010, para. 6). As of March 2013, eight people had been awarded the credential (S. Opsahl, personal communication, March 26, 2013), and there were plans to further promote the credential as part of Colorado's Early Learning Challenge Fund activities.

In 2010, however, the Colorado Association for Infant Mental Health (CoAIMH) also adopted the Michigan competency and endorsement system, and it has been unclear how or to what extent these two sets of competencies would work together. As of October 2013, the CoAIMH had endorsed 20 professionals using the four-level Michigan system (J. Ash, personal communication, October 29, 2013).

FLORIDA

A work group from Florida State University (FSU) drafted a three-level framework for early childhood mental health service provision (FSU Center for Prevention and Early Intervention Policy, 2001). Although the first two levels (front-line providers and developmental professionals) were never fully operationalized, specific competencies were articulated for Level 3. This third level, infant mental health specialist, refers to master's-level (or higher) professionals who have specific training in infant mental health therapy and psychopathology, including knowledge of infant-toddler development and adolescent and adult psychopathology, as well as understanding of the importance of quality parent–infant interactions. Infant mental health specialists must be able to provide therapeutic interventions for young children with mental health needs and their families. They require skills necessary to establish a relationship with the family based on the family's strengths, to provide intensive treatment with the parent–child dyad, and to provide consultation to all service providers working with the child and the family.

To develop the final set of competencies applicable to Level 3 specialists, a national panel of 23 experts rated and rank-ordered 143 competencies in seven domains (Quay, Hogan, & Donohue, 2009):

1. Normal Development
2. Abnormal (Atypical) Development
3. Emotional/Behavioral Disorders
4. Assessment
5. Intervention
6. Community Resources and Referral Services
7. Organizational Skills and Communication Skills

Currently, the competencies are being used both as a guide for FSU training programs in infant mental health and as a self-assessment for current participants in the training programs (Hogan & Stone, 2012). Participants rate themselves in each item across the seven domains using a five-point scale. Analyses have demonstrated that participants report improvements in their skills, knowledge, and abilities over their time in training in most areas. Florida has no current plans to develop an endorsement process or establish a state credential.

MICHIGAN

The Michigan competencies, *Competency Guidelines for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health*, are the oldest and the most widely-recognized of the ITECMH mental health competency systems. They are part of the MI-AIMH's endorsement program (MI-AIMH, 2002/2011a, 2002/2011b). The competencies are embedded within four levels of endorsement, based on the education and related experience of the participants (see Table 4). The MI-AIMH specifically uses the term endorsement, as opposed to certification or licensing, to emphasize that the process is an overlay to whatever professional qualifications practitioners bring to their work (Weatherston et al., 2006). Candidates seeking endorsement create and submit a portfolio that documents their work and experiences with children from birth to age 3 years, with endorsement at Level 3 and Level 4 also requiring successfully passing a written exam with both multiple-choice and narrative-case-vignette responses. Level 3 and Level 4 candidates differ primarily in professional focus, with Level 3 directed toward clinical practice and Level 4 directed toward clinical leadership, policy, and research and academic positions (Level 4 candidates select which track is most applicable).

Table 4. Michigan Endorsement Requirements by Level

CATEGORY	LEVEL 1: INFANT FAMILY ASSOCIATE	LEVEL 2: INFANT FAMILY SPECIALIST	LEVEL 3: INFANT MENTAL HEALTH SPECIALIST	LEVEL 4: INFANT MENTAL HEALTH MENTOR
EDUCATION	Child development associate or associate's degree ^a	Bachelor's or master's degree	Master's degree or Ph.D.	Master's degree, Ph.D., or M.D.
TRAINING	30 clock hours of relationship-based education & training ^b	30 clock hours of relationship-based education & training ^b	30 clock hours of relationship-based education & training ^b	30 clock hours of relationship-based education & training ^b
WORK EXPERIENCE	2 years paid; early-childhood-related ^a	2 years paid, post-bachelor's; services promote infant mental health	2 years, supervised, postgraduate (or 1 year internship); culturally sensitive, relationship-focused, infant mental health service	3 years, postgraduate experience in clinical, policy, or research/ faculty leadership position (clinical must also meet Level 3 work experience)
REFLECTIVE SUPERVISION AND/OR CONSULTATION	N/A	Minimum of 24 clock hours within 2 years, from Level 2–4 provider	Minimum of 50 clock hours within 1–2 years	Minimum of 50 clock hours within 2 years
REFERENCES	3 ^c	3 ^c	3 ^{c,d}	3 ^{c,d}
WRITTEN EXAMINATION	No	No	Yes	Yes
SERVICE EXAMPLES	Child care worker, doula	Part C service coordinator, NICU nurse, parent educator, home visitor	Mental health clinician, clinical nurse practitioner, early intervention specialist	Researcher, faculty member, policy specialist, early intervention administrator

Note: NICU = neonatal intensive care unit. Adapted from “MI-AIMH Endorsement (IMH-E®) Overview” [Web page], retrieved March 24, 2013, from www.mi-aimh.org/endorsement.

^a Education and work experience can substitute for each other at Level 1.

^b As specified in the competency guidelines.

^c One referent must meet requirements for Levels 2–4 endorsement.

^d One must be from a reflective supervisor/consultant.

The contents of the competencies differ across levels, although requirements in one level build upon the next as candidates seek higher levels of endorsement (see Table 5).

Table 5. Michigan Competency Domains, by Level

LEVEL	COMPETENCY DOMAINS ^a
1: INFANT FAMILY ASSOCIATE	Theoretical foundations Law, regulation, and agency policy Systems expertise Direct service skills Working with others Communicating skills Thinking skills Reflection
2: INFANT FAMILY SPECIALIST	<i>All domains of Level 1; subdomains expanded to include:</i> Therapeutic practice Disorders of infancy/early childhood Mentoring
3: INFANT MENTAL HEALTH SPECIALIST	<i>All domains of Levels 1 & 2; subdomains expanded to include:</i> Psychotherapeutic & behavioral theories of change Mental and behavioral disorders in adults Treatment planning Developmental guidance Supportive counseling Parent–infant/very young child therapies & practices Life skills Consulting Parallel process
4: INFANT MENTAL HEALTH MENTOR	<i>All domains of Levels 1–3; subdomains expanded to include:</i> Adult learning theory and practice Research and evaluation Reflective supervision Coaching Crisis management Group process Leading people Program administration Research & administration

^a Competency domains have subdomains; those subdomains common across all levels are not included here for the sake of brevity.

Source: Michigan Association for Infant Mental Health. (2002/2011b).

Currently, the Michigan model has been licensed to 16 other state infant mental health associations (see Table 1), which are in various stages of the endorsement process. The MI-AIMH competency guidelines and the endorsement are renamed by the entity purchasing the license (e.g., the Indiana Association for Infant and Toddler Mental Health Endorsement for Culturally Sensitive, Relationship-Based Practice Promoting Infant Mental Health). The process of licensing and using the system is a serious commitment. As of July 2013, the cost of a 3-year license for the Michigan endorsement system was \$35,000 (\$20,000 for the competencies alone), with \$1,000 annual renewal fees thereafter (with additional fees for continued use of the exam and the electronic database system). Endorsement systems must be set up through a state infant mental health association, preferably one that is an affiliate of the World Association for Infant Mental Health.⁸ In 2007, all then-participating state affiliates met to discuss the integration of the MI-AIMH endorsement into state systems. A result of that meeting was the creation of the Endorsement League of States, formalizing working relationships to build capacity around the use of the MI-AIMH competencies and endorsement in each state (see Weatherston, Kaplan-Estrin, & Goldberg, 2009). League leaders plan annual retreats to promote infant mental health across disciplines and service systems, using the competencies and endorsement process as the framework. Monthly conference calls support the Leaders, and there are sub-committees for social policy, training, and research related to reflective supervision.

More than 900 individuals have earned endorsement through the participating state associations using this system, approximately half through the MI-AIMH. The largest number of endorsed professionals are at Level 2 (infant family specialists), followed by Level 4 (infant family mentors), with fewer numbers endorsed at Levels 1 and 3, although these numbers are sure to change as states encourage competency-based workforce development. Overall, this system acknowledges professionals already in the field and is not considered to be a training program, although its use within a state likely promotes the acquisition of skills and knowledge through various training and professional development outlets. Efforts are under way to develop an online training program in collaboration with Tulane University using the Level 2 and Level 3 competencies as a curriculum guide (D. Weatherston, personal communication, March 19, 2013).

OHIO

Ohio's Core Competencies for Early Childhood Mental Health Professionals were developed by a 12-person work group from around the state, covering a broad range of experience and expertise (Ohio Department of Mental Health [ODMH], 2009). The group continued work that was initially begun with the social-emotional work group of BUILD Ohio (Himmegar, 2008). The document was "written to promote professional development, skills, and attitudes necessary for working with diverse populations" (ODMH, 2009, p. 5) and served as a first step in articulating multidisciplinary competencies in ITECMH practitioners. The competencies are one component of Ohio's ITECMH program, conceived as a continuum of services and supports, although the primary focus is consultation (Himmegar, 2010). Ohio's early childhood mental health plan recommended that ITECMH specialists (viewed as consultants or therapists) be licensed mental health professionals. The recently developed

⁸ Although a separate entity, the World Association for Infant Mental Health actually grew out of the Michigan Association for Infant Mental Health.

Ohio Early Childhood Mental Health Professional Credential, primarily aimed at consultants, requires mental health licensing for applicants, although a “grandfather” period in 2012 allowed existing consultants and therapists to be credentialed without a license.⁹ Those seeking the credential must demonstrate coursework or professional development that aligns with the competencies.

The Ohio competencies are divided into domain areas, which are seen to build sequentially on one other (see Table 6). In other words, knowledge of a young child’s social-emotional development is the primary foundation of the competencies but must be viewed in the context of relationships. From this basic knowledge, the specialist can add assessment and intervention skills and knowledge, with professional practices (including ethics) as the final step. As shown in Table 6, only the latter three domains are further broken down into subdomains.

Table 6. Ohio ITECMH Competency Domains

1. Social-Emotional Growth & Development
2. Family & Community Relations
3. Assessment
• Foundations & Principles • Gathering & Documenting • Summarizing & Reporting
4. Interventions
• Child • Family • Early Care & Education Caregivers
5. Professional Development
• Foundations & Principles • Continuous & Reflective Professionalism • Leadership & Advocacy

Source: ODMH (2009)

The domain of health, nutrition, and safety was consciously excluded from listed competencies, as this area were seen as being addressed in only limited ways by ITECMH professionals (ODMH, 2009). This is noteworthy because it is one of the few times that an ITECMH competencies document specifically limits the field of its practice. In most cases, as will be shown in the comparative analysis, competencies attempt to be as expansive as possible. Another noteworthy element is that the Ohio competencies do not specify an age group, although the OH ITECMH program is generally focused on ages birth to 5 years.

⁹ See: www.opdn.org/documents/ECMH%20Credential%20Guidance%20January%202013.pdf and www.opdn.org/documents/ecmh_grandfather_howto.pdf

VERMONT

A work group in Vermont developed ITECMH competencies, *Vermont's Early Childhood and Family Mental Health Competencies*, over a 4-year period, presenting a final version in 2007 (Vermont Early Childhood and Family Mental Health Competencies Practice Group, 2007). Representatives from special education, mental health, early intervention, and higher education collaborated to develop a protocol to guide development of a service delivery system around social-emotional well-being in young children and their families. The competencies, focused on children ages birth to 8 years, were aligned with other state early childhood care and education protocols.

The Vermont system identifies four levels of professionals who might engage in ITECMH training. They are similar to the levels developed in the Michigan system, although educational credentials and degrees are implied rather than stated explicitly as in Michigan:

- **Foundation professionals:** child care providers, those who work in Head Start or home health. The competencies required for Level 1 are considered the foundation for working with young children and their families.
- **Intermediate professionals:** child care directors, kindergarten teachers, and registered nurses. Level 2 candidates must be knowledgeable about competencies that bear on skills needed in working with children and families who exhibit challenges.
- **Advanced professionals:** special education teachers and mental health consultants. Level 3 professionals must show skills in planning or providing direct services or consultation around early childhood mental health challenges.
- **Specialist professionals:** licensed therapists, professors, agency directors, or those holding medical degrees. Competencies required at Level 4 reflect the expert skills that are needed in working with the most challenging situations as well as the ability to provide leadership in the field.

Compared to the Michigan system, which split the highest level into clinical, research, and policy emphases, the Vermont system maintains a greater clinical emphasis at Level 4, although there are competencies focused on leadership.

The Vermont competency domains are broken down further into subsections (Table 7) that vary in specificity and depth depending on the level of the candidate. Although the work group noted that the levels are hierarchical, with later levels building on previous ones, the Vermont system is arguably the most elaborate in terms of designating particular content for each level for all domains and subdomains of competencies.

Table 7. Vermont Competency Domains

COMPETENCY CATEGORY	SUBSECTIONS
PHILOSOPHY AND PROFESSIONAL ORIENTATION	Family-centered, strengths- and outcomes-based philosophy Self-knowledge, self-assessment, and professional development Ethics and confidentiality Effective communication skills Teamwork and collaboration
CHILD DEVELOPMENT	Knowledge of child development Impact of relationships Social and emotional development Impact of environmental factors
FAMILY SYSTEMS	Family characteristics Factors impacting family functioning Supporting families
ASSESSMENT	General knowledge of assessment Implementation of assessment
ADDRESSING CHALLENGES	Risk and resilience factors in children and families Specialized knowledge of working with vulnerable and identified populations Effective transition
SYSTEMS RESOURCES	Resources and systems Laws, policies, and procedures Program planning and evaluation

Source: Vermont Early Childhood and Family Mental Health Competencies Practice Group (2007)

At the time of the original report (Korfmacher & Hilado, 2008), the Vermont competencies were not connected to any specific professional development program. In the past 2 years, however, a credential using the second level (intermediate) of the competencies as a foundation was piloted by Vermont Northern Lights Career Development Center and is currently being offered through “regional cohorts,” in which groups of professionals work together over a 12-to-20-month period to meet credentialing requirements.¹⁰ The credential is designed for experienced professionals working with children, families, or staff (such as a consultant), whether through home visiting or as part of a center-based environment (such as a classroom, group setting, or clinic). As of July

¹⁰ See the Vermont Northern Lights Career Development Center website at <http://northernlightscdc.org/career-pathways/credentials-and-certificates/early-childhood-and-family-mental-health-credential/> for detailed information on the credential and application forms.

2013, five individuals participating in the initial pilot had received the credential after a period of approximately 15–20 months, with at least three more credential applications in process (Vermont Northern Lights Career Development Center, 2013a, 2013b). A recent newsletter noted that developing the portfolio was the most challenging part of earning the credential for the pilot group (Vermont Northern Lights Career Development Center, 2013a). In addition, the applicants who worked as part of a cohort had greater success than those who applied as individuals, which supports the current structure of embedding the credentialing process in regional cohort groups.

In 2011, the New Hampshire Association for Infant Mental Health (NHAIMH) borrowed and slightly adapted the Vermont competency system for use in its own state. *New Hampshire's Early Childhood and Family Mental Health Competencies* (NHAIMH, 2011) are designed for children under 6 years old and their families (compared to the upper limit of 8 years old for the Vermont competencies). Aside from the change in age and small changes in wording, the competency systems of the two states are essentially identical, the result of NHAIMH's collaboration with the Vermont Early Childhood Mental Health Practice Group, which developed the Vermont competency system. The most recent activity of the New Hampshire competency system was a statewide self-assessment of approximately 180 early childhood service providers, who participated in trainings around the core competencies (Antal & Schreiber, 2013). Plans are underway to develop a voluntary credential for intermediate- and advanced-level practitioners (Levels 2 and 3) and for reflective practice consultants. Piloting began in the fall of 2013 and will continue through September 2014.¹¹

Other ITECMH Competency Systems

The six competency systems described in the preceding sections are the focus of the comparative analysis in this paper. However, other competency systems exist that are available in different forms and levels of completeness. They are briefly reviewed here:

ILLINOIS

The *Infant and Early Childhood Mental Health Foundational and Functional Competencies*, by the Illinois Association for Infant Mental Health, represents more than 4 years of work.¹² The competencies are in draft form and are the basis of a pilot credential system. The competencies, focused on ages birth to 5 years, are divided into seven categories. What is noteworthy about this set of competencies is that the seven categories were designed to intersect, with the competencies presented in a grid or set of matrices to show their interrelationships.

The competencies were reviewed by a group of 10 ITECMH professionals who agreed to be a pilot cohort for the endorsement system. In a somewhat similar manner to the Vermont competency system, the Illinois system's application for endorsement requires applicants to participate in a year-long series of small (three to five members) reflective learning groups, in which the competencies are reviewed and participants work through and reflect on their

¹¹ See the NHAIMH website for more details: <http://www.nhaimh.org/ecfmhc>

¹² The author is a member of the board of Illinois Association for Infant Mental Health and served on the steering committee that oversaw the project.

areas of strength and areas of challenge. The groups are led by a facilitator who serves as a member of a three-person panel that reviews each applicant's materials, along with a case study that is brought to the panel as a kind of "oral defense." As of October 2013, a second pilot group of 14 individuals is working with a revised draft of the competencies, and the ILAIMH expects the competencies and the endorsement system to be finalized by 2014.

PENNSYLVANIA

Recommendations from an early childhood mental health advisory committee to the Pennsylvania Department of Public Welfare (DPW) included a set of mental health competencies from conception to age 5 years as part of its professional workforce development strategies (Pennsylvania Early Childhood Mental Health Advisory Committee, 2009). These strategies, developed as a four-tier system, were heavily borrowed from the California system. Tiers 1 and 2 focus on "core providers" who work in promotion and prevention capacities, analogous to transdisciplinary and advanced transdisciplinary providers in the California system. Tier 3 focuses on specialists who provide mental health intervention services to young children and their families, and Tier 4 contains many of the same competencies focused on reflective facilitation and supervision as in the California system.

Although these competencies exist as part of the advisory committee's recommendations, it is unclear to what extent they are being implemented within Pennsylvania. The advisory committee met between 2008 and 2012. A large portion of its efforts was devoted to the ITECMH consultation, conducted as part of the DPW Office of Child Development and Early Learning's ECE quality rating and improvement program, the Keystone STARS program. There is a plan to embed some of the language of the competencies into a revision of the core body of knowledge expected of early childhood practitioners in the state, but this revision is not yet final or public (M. Walsh, personal communication, April 2, 2013).

CANADA

The *Competencies for Practice in the Field of Infant Mental Health* are a succinct (2 pages) list of knowledge and practice competencies developed in 2002 for the Infant Mental Health Promotion Project (IMHPP) when it was overseen by the Hospital for Sick Children in Toronto. The IMHPP has since become an independent, membership-based coalition of infant mental health professionals across Canada (see <http://www.imhpromotion.ca>). The IMHPP competencies, updated slightly in 2011, are part of a package of best-practice and policy guidelines, including guidelines for organizational quality in agencies providing infant mental health services (IMHPP, 2011). Although the IMHPP does not offer a credential or endorsement system, its website has a short, interactive learning module on use of the competencies in practice.

Summary

Overall, ITECMH competencies exist within systems that share many common elements. Most of the competency systems embrace a broad definition of the early childhood mental health provider (Florida and Ohio have a more limited scope). The providers cover multiple disciplines and range from child care workers with associate's degrees to licensed therapists with graduate degrees. Some of the systems attempt to make distinctions between different levels of practice or expertise. Both the Michigan and the Vermont systems divide levels of practice into four levels, with the first two levels in each corresponding to front-line providers without mental health licenses, and the latter two levels reserved for those who directly work in a mental health capacity or are engaged in leadership or the broader policy system. The California system makes a distinction between licensed/certified mental health professionals and others (e.g., transdisciplinary providers) who provide ancillary services, such as health specialists or child care providers.

The definition of early childhood varies among the systems. Both the Colorado and Vermont systems cover the age range of birth to 8 years. New Hampshire uses the same competencies as Vermont, but only up to 6 years. Three other systems (California, Florida, and Ohio) encompass development up to 5 years, with California beginning prenatally. The Michigan system as originally developed focused on families with children ages birth to 3 years (as well as pregnant women), although its use has been promoted with families of children up to 5 years old (Weatherston et al., 2009). Overall, the six systems are similar in covering issues relevant to the first 3 years of life, with all extending coverage into the preschool years. A related question, however, is the extent to which the contents of the competency systems reflect the issues relevant to these age ranges. The next section of this report takes up this topic.

Although each competency system was designed to guide training and professional development in general, most systems also have specific, operationalized purposes as part of an endorsement process. This is a change since the previous review (when only Michigan had an endorsement procedure in place) and reflects the increased interest in providing legitimacy or at least recognition for specialization in this age period. The endorsement processes differ across the systems, although each involves some kind of portfolio or transcript review. Michigan is the only system to require (at its highest levels) passing an exam in addition to a portfolio review.

COMPARING THE CONTENTS OF THE COMPETENCY SYSTEMS

One aspect shared by all of the reviewed competency systems is a philosophical framework for infant mental health. That is, the competencies do not merely reflect specific content about mental health issues and concerns in this age period; they also emphasize common core themes of an infant mental health approach. These themes include acknowledging the importance of relationships and of other family members (especially parents) in the life of the child, the need to pay attention to the family's life context, and the value of self-reflection (see Lieberman, 1998, for a concise overview of these themes).

The infant mental health field also emphasizes a holistic approach to working with children, recognizing the interconnected aspects of development. Because a child’s development is considered integrated, there are multiple avenues for approaching a child’s social-emotional well-being. The most immediate consequence of a holistic approach is that the infant mental health field is multidisciplinary. Different professionals work in different contexts to provide services or treat children, and the provision of infant mental health services does not rest under the strict purview of licensed clinical mental health professionals (see Fitzgerald & Barton, 2000, for a more detailed discussion). This has implications for the competency systems, in that they all take a “big tent” approach to defining both providers of these services and competency domains. It is obvious from even a cursory review that the competencies are focused beyond the narrow parameters of mental health. Early childhood mental health competencies ensure practitioners have the knowledge, skills and experiences to support healthy development with an emphasis on young children’s social and emotional well-being since social and emotional competence in children is the foundation of all later development.

Content analysis was used to review the content of the individual state systems. Content analysis is a qualitative method in which documents and other texts are examined for the presence (and absence) of certain words, phrases, concepts, or ideas (e.g., Patton, 1987). This method allowed us to organize, categorize, and compare knowledge, skill, and training areas listed in the supporting documents for each system. The categories used to organize the competencies were not preordained. Rather, they were developed and modified as the systems were reviewed and re-reviewed.¹³ For example, the text units listed in Table 8 all received a code indicating the importance of the helping relationship or therapeutic alliance:

Table 8. Helping Relationship Examples

CALIFORNIA	Successfully initiates and sustains an effective working relationship with parents that nurtures their strengths and emerging capacities.
COLORADO	Recognizes ways to provide professional, emotional, and physical availability to families.
FLORIDA	Establishes and maintains a therapeutic alliance with parents and caregivers.
MICHIGAN	Establishes trusting relationship that supports the parent(s) and infant/very young child in their relationship with each other and that facilitates needed change.
OHIO	Respects families by valuing their opinions, nurturing their involvement, and maintaining a relationship even when family opinion contradicts best practice or realistic possibilities.
VERMONT	Establishes the climate for family–professional collaboration.

¹³ The author and Jessica Fulford, a research assistant on the project, coded all competencies and met regularly to review and resolve disagreements. Fulford entered all codes into NVIVO, a qualitative data analysis software, to aid in data management and analysis.

For the current review, the categories from the original report were maintained, with categories added as needed to deal with newly emerging content or to subdivide a category into smaller components (e.g., carving out a specific category of toddler development from the original category of infant development). Category codes that appeared within only one system were removed for separate discussion (see Table 11). Text representing a specific competency could receive multiple codes; for example, Table 9 presents a somewhat extreme example from California, with one text unit receiving 13 codes.

Table 9. Multiple Code Example

TEXT	CODES
<i>Demonstrates knowledge of the effects of risk factors such as genetics, medical complications, prematurity/low birth weight, substance exposure and teratogens, and the impact of familial, cultural, social, physical and/or economic factors including poverty, abuse, and neglect on development and relationships.</i>	Understanding context Understanding culture Importance of relationships General knowledge of development Impact of maltreatment/family violence Biologic/genetic risk Environmental risk Physical illness in child Physical illness in parent Impact of poverty Prematurity/low birth weight General knowledge of risk/resilience Substance abuse

The 2008 review (Korfmacher & Hilado, 2008) concluded that competency systems varied considerably in the level of detail they provided to describe the content areas, with some systems relatively sparse in their description and others providing more extensive text. The current analyses, however, suggest that this lack of detail does not still hold true. Many of the shorter competency systems analyzed in 2008 were either revised or were not included in this update because they are not actively used, and the systems reviewed here all provide fairly detailed descriptions of the competencies. It is possible that the competency systems run the risk of moving toward the other extreme: providing too much detail. The example in Table 9 raises the question of the extent to which an early childhood mental health specialist must demonstrate specific knowledge across the 13 different topics embedded within a single competency item.

Ultimately, 116 content areas emerged that appeared in at least two competency systems. These were inductively grouped under 10 inclusive categories of content, as described in Table 10. The full list of content areas, subdivided by competency system, is included in the Appendix.

Table 10. Knowledge and Practice Content Across Competency Systems

CONTENT AREA	EXAMPLES
BASIC PRINCIPLES	Importance of attachment, cultural/contextual influences, family and family-centered practice, strength-based practice, and relationship-based practice
DEVELOPMENTAL KNOWLEDGE	General developmental milestones/issues as well as specific periods of development (e.g., infancy), specific areas of development (e.g., social-emotional), and specific topics of development (e.g., temperament)
HEALTH	Prenatal and child health concerns, including nutrition, labor, and delivery; also parent health concerns
UNDERSTANDING OF MENTAL HEALTH CHALLENGES	Mental health disorders in children, behaviorally challenging children, parent mental illness, trauma, and family violence
RISK AND PROTECTIVE FACTORS	General issues of risk (and resilience), along with specific risk factors such as family disruption, environmental risk, poverty, stress
DIRECT SERVICE	General mention of intervention, therapy, or services, but also specific topics, such as provision of emotional support, interactive guidance, referrals, and working specifically with children
ASSESSMENT	Screening, interviewing, observation, diagnosis (including specific mention of <i>DC:0-3R</i>), use of specific assessment instruments
OTHER SKILLS	Ancillary skills to direct service delivery, such as administration, consultation, supervision, mentoring, research, and interdisciplinary collaboration
SYSTEMS ISSUES	Knowledge of and work with community programs (including child care), reporting obligations, and other rules and regulations
PROVIDER DEVELOPMENT	Issues of personal and professional development, reflective capacity, help seeking

Sixty-one content areas are covered in five or six of the competency systems (see Appendix), and 16 content areas are unique to only two of the systems. The rest (39) are covered in three or four of the systems. The overlap in systems is higher than in the 2008 review, suggesting that there are emerging areas of consensus in ITECMH competency conceptualizations.

Some content areas were only referred to in one competency system each (see Table 11). This is not surprising. Each competency system has idiosyncratic text or content that, for whatever reason, was important to the working group that developed that competency document.

For example, all systems have content pertaining to the importance of interdisciplinary collaboration; however, the Vermont system is unique in noting the importance of teamwork (which is not necessarily interdisciplinary), mentioned in 12 separate competency statements across the four levels.

What is surprising, however, is that a number of the specific competencies central to the purpose of supporting mental health in the early years appear in only one system. For example, although four systems mention using diagnostic systems (most notably *DC: 0–3R*; ZERO TO THREE, 2005), only Florida’s competency system includes specific mental health disorders, such as depression or anxiety. Florida’s is also the only system to mention psychotropic medications, a controversial but still important topic in early childhood (Drury & Gleason, 2012). In another example, Colorado’s is the only competency system to mention specific intervention curricula by name, a topic discussed in further detail later in this paper.

Table 11. Selected Codes Applied to Only One Competency System

CONTENT CODE	COMPETENCY
Empathy/moral development	Colorado (4 mentions)
Specific childhood disorders: Anxiety Depression Autism Distraction/Inattentiveness Attachment disorder	Florida (1 mention each; 2 for anxiety)
Teen parent	Ohio (1 mention)
Specific intervention curriculum	Colorado (1 mention each of 10 different models)
Foster care/out-of-home placement	Michigan (5 mentions)
Medication issues	Florida (1 mention)
Breastfeeding	Florida (1 mention)
Teamwork	Vermont (12 mentions)

The following sections consider each of the major content areas in turn.

BASIC PRINCIPLES

As in the 2008 review (Korfmacher & Hilado, 2008), certain topics were grouped together under the category of basic principles because they cut across the other categories and represent essential approaches to helping families with young children. All of the topics coded as basic principles were noted in a majority of the systems, with all but two in at least five of the six systems. Referencing culture and diversity was the most frequently coded topic, followed by a focus on the helping relationship that develops between service provider and family, and maintaining a strength-based approach. As would be expected in an infant mental health approach, an emphasis on family issues and having a family-centered practice occurs in all the systems, as does attachment and a focus on relationship-based care. Ethical practice is appropriately emphasized across all systems. A recognition of the impact of the parent's own past on his or her current relationship with the child, captured in the phrase "ghosts in the nursery" (Fraiberg, 1980) and a signifier of a classic psychodynamically based approach to infant mental health work, is noted across almost all the systems, but much less frequently than the other basic principles codes.

One of the topics in the basic principles category, "outcomes-based approaches" (used in four systems, with 30 mentions total) is noteworthy for what it does not emphasize. For example, the Vermont system lists the following competency: "Employs an outcomes-based approach to planning and applying interventions" (Vermont Northern Lights Career Development Center, 2013a, p. 9, 34). This phrase uses "outcomes" in a broadly applied and generally undefined manner. Systems rarely note the importance of services being "evidence-based" or for specialists to have knowledge of or employ empirically-validated interventions. An evidence-based approach was noted in three systems (California, Florida, and Vermont) with only four mentions total, a low number given its current emphasis in both early childhood practice (Khetani & Kasiraj, 2009) and mental health care systems and policy (Substance Abuse and Mental Health Services Administration, *n.d.*).¹⁴

DEVELOPMENTAL KNOWLEDGE

Understanding child development, both typical and atypical, is highly valued in these competency systems, and this content area has the most topic codes. In many cases, the competencies simply reference the importance of understanding children's development in general. Although all systems mention knowledge of prenatal development, other periods of development are inconsistently noted, including neonatal (two systems), infancy (four systems), toddlerhood (three systems), preschool (two systems), and the school-age period (three systems). In terms of specific topics, it is not surprising that the most frequently coded categories are social-emotional development (96 mentions across all six systems) and the parent-child relationship or interactions (59 mentions across all six systems). In contrast, only two systems mention sleep in their competencies, although this is a common challenge for families in this period. Understanding children's response to transitions is noted in only half of the systems. Although language development is noted in all systems, two systems (Florida and Vermont) explicitly mention how infant behavior serves as a form of communication.

¹⁴ Some systems have additional competencies focused on using research and evaluation for program improvement. These were coded separately under research and evaluation (see the Other Skills section below) but were too general to be considered to show an evidence-based emphasis.

HEALTH

In contrast to developmental knowledge, an understanding of child and family health issues is much less frequently noted, and almost half of the references are related to pregnancy, labor, or delivery. There is no health-related competency noted by a majority of systems. Because these systems are multidisciplinary, it is perhaps not surprising that there is a reduced emphasis on health, as this may be seen as an area of expertise best left to the health care field, such as nursing, pediatrics, obstetrics, or family medicine. As noted previously, the authors of the Ohio system systematically excluded health-related competencies for this reason. On the other hand, child health and development are inexorably intertwined. Child nutrition, for example, is crucial to growth and development, yet few systems expect any knowledge of nutrition, even on a cursory level. As shown in Table 11, breastfeeding—a central public health concern in the early years and focus of many early childhood home visiting program models—is noted only by one system, and even then only in relation to parent substance abuse.

UNDERSTANDING OF MENTAL HEALTH CHALLENGES

One of the major conclusions of the 2008 review (Korfmacher & Hilado, 2008) was how lightly competencies specifically geared to infant, toddler, and early childhood mental health touched upon specific mental health challenges in the early years. Based on review of this category's application across the different competency systems (as shown in the Appendix), this conclusion still stands. Relatively few categories emerged from coding that fit within this dimension, and they cover a relatively small proportion of text across the competency system documents. For example, even though behavioral challenges are mentioned in four of the six systems, most of these systems refer to these challenges only once (Florida does so twice). This infrequent mention is despite the fact that behavioral challenges in the preschool period is a significant policy issue that has received considerable attention in recent analyses and publications (e.g., Gilliam, 2008) and is arguably one of the issues driving the current focus on early childhood mental health.¹⁵

Although most programs note the importance of attending to a young child's mental health needs, they do so only in general terms. For example, the Michigan system notes at Level 3 that the infant mental health specialist "[r]ecognizes risks and disorders of infancy/early childhood conditions that require treatment, intervention, and/or the assistance of other professionals from health, mental health, education, and child welfare systems" (Michigan Association for Infant Mental Health, 2002/2011a, p. 20). Only the Florida system mentions specific mental health disorders, such as depression, anxiety, autism, and reactive attachment disorder. All competency systems note the importance of attending to child maltreatment and family violence, with three systems using language in their competencies focused on trauma more generally. All systems also mention understanding parent mental health challenges as a competency. Of interest is that many of these competencies note specific mental health challenges in parents (such as depression, anxiety, posttraumatic stress disorder, psychosis, and dissociation), even while the child disorders go unmentioned.

¹⁵ As another example, see the Center on the Social and Emotional Foundations for Early Learning (CSEFEL; www.csefel.vanderbilt.edu/index.html), a federally-funded, multistate effort to disseminate practices for promoting social-emotional development and for addressing challenging behaviors in early childhood.

The reason for this reticence to focus on specific disorders or challenges in children is unclear. It is possible that the systems do not want to limit themselves to particular disorders or conditions and attempt to cover as much terrain as possible with these generally worded competencies. Another explanation may be that the strength-based underpinnings of the competency systems influence a relative paucity of text on mental health problems. For example, although behavioral challenges are infrequently noted, there is a greater emphasis on the need to practice behavioral support to promote positive behaviors in children. It is also possible, given the multidisciplinary focus of these systems, that detailing specific mental health disorders would not be as applicable to professions that do not focus on the diagnosis of these disorders. In general, any competency standards for the ITECMH field needs to be broad enough to have meaning across multiple service settings, disciplines, and communities of service yet rigorous enough to promote and uphold quality in a field that is rapidly changing.¹⁶

In general, any competency standards for the ITECMH field needs to be broad enough to have meaning across multiple service settings, disciplines, and communities of service yet rigorous enough to promote and uphold quality in a field that is rapidly changing.¹⁶

Regardless of the reason, the relatively small number of mentions of mental health issues in competency systems with “mental health” in their titles is noteworthy, particularly compared to the amount of text devoted to normative developmental issues. When rating themselves at the beginning of an infant mental health training program using the Florida competencies, participants rated themselves lowest on the domain of emotional and behavioral disorders (Hogan and Stone, 2012). This suggests the need to focus on this domain in ITECMH workforce development initiatives.

RISK AND PROTECTIVE FACTORS

Most competency systems emphasize the need to understand the impact of different risk factors on child development and well-being. Resilience or protective factors are also frequently mentioned, fitting with the strength-based orientation of all of these systems. Many of the references are unspecified or make note only of general risk and resilience, without specific types (e.g., neighborhood violence). However, there is a particular focus on environmental risk factors, either proximal factors such as cigarette smoke or lead exposure, or more distal factors such as poverty or racism. Biologic or genetic risk factors are less frequently mentioned. Two systems (California and Michigan) specifically mention the needs of immigrant families, mostly in the context of understanding their rights and the regulations that apply to them.

DIRECT SERVICE

In the coding system developed for this review, the practice of the ITECMH specialist is divided into three broad categories: direct service, assessment, and other skills. Direct service refers to activities that provide direct help and support to families, including mental health treatment, preventative forms of support and guidance, and referrals and service coordination. One of the surprises of this analysis is that there is no specific mention of infant–parent

¹⁶ Thanks to D. Weatherston for this last comment.

or child–parent psychotherapy (e.g., Fraiberg, 1980; Lieberman & Van Horn, 2008), once the leading treatment approaches in early childhood mental health. Two systems obliquely referenced this treatment approach but in language that was too general to code. The Michigan systems notes as a competency for infant mental health specialists (Level 3), “parent-infant/very young child relationship-based therapies and practices” (Michigan Association for Infant Mental Health, 2002/2011a, pg. 14). The Florida system mentions “dyadic therapeutic techniques as described in the Infant Mental Health Literature” (Quay et al., 2008; pg. 188).

With one exception, there are no mentions of any specific form of treatment. This may be because the system authors did not want to be seen as endorsing any one particular model of treatment.¹⁷ On the other hand, given the current policy focus on evidence-based treatment, it is noteworthy that no specific models are presented as important for ITECMH specialists to know about (e.g., Powell & Dunlap, 2009). The only exception is that the Colorado system, within one competency, lists 10 different intervention curricula spanning prevention, intervention, and treatment:

Describe several evidence-based and social and emotional promising practice approaches to use with young children, (e.g., Incredible Years, Nurse Family Partnership, ECE Cares, Devereux Early Childhood Initiative, Touch-points, Circle of Security, Hi-Scope, Pyramid Model, Relationship Roots, etc.).
(Colorado Office of Professional Development, 2010, p. 10)

Other activities with families are frequently mentioned in the competencies (suggesting the diversity of work experiences for ITECMH specialists expected by the competency systems) across the spectrum of prevention to intervention to treatment, including providing referrals, life-skills development, problem-solving, and adapting or changing environments for families and children. Since the 2008 review (Korfmacher & Hilado, 2008), the number of references to direct work with children has increased, although these references are also typically left unspecified. For example, one indicator in the Vermont system simply states: “employs processes that build children’s resiliency” (Vermont Early Childhood and Family Mental Health Competencies Practice Group, 2007, pp. 20, 28).

ASSESSMENT

There is a high level of consensus across the systems regarding the importance of specialists being able to assess children and families. Assessment skills in general are frequently noted, and all six systems emphasize skills in observation and (to a lesser extent) interviewing. Four systems have competencies related to diagnosis of mental health conditions, including use of the *DC:0–3R* system (ZERO TO THREE, 2005). Most also include screening as a competency separate from assessment. In addition, all but the Michigan system mention specific assessment instruments, although the only instrument noted by more than one system is the Parent-Infant Relationship Global Assessment Scale (three systems), a component of the *DC:0–3R* diagnostic system.

¹⁷ The Michigan system did modify its text to be more inclusive (D. Weatherston, personal communication, August 28, 2013). Although not part of the competency text, the Michigan guidelines note that “these therapies and practices may include, but are not limited to, parent-infant psychotherapy, interaction guidance, and child-parent psychotherapy” (MI-AIMH, 2002/2011a, p. 24).

OTHER SKILLS

Aside from direct intervention with families or assessment, there are many other skills noted across the six competency systems. This also demonstrates the diversity of roles that ITECMH specialists take on in their work. Given this diversity, it is perhaps not surprising that the most frequently endorsed skill is working across disciplines with other professionals. Other competencies reflect professional and interpersonal skills that would be expected of mental health specialists, such as listening, communication, the ability to model behavior to others, and conflict resolution. Documentation and service plan development are also mentioned across the competency systems. Confidentiality, an important ethical principle in mental health work, is noted in five of the six systems.

This area also includes leadership skills, including administration, teaching, and supervision or mentoring. Administration is only noted in the Michigan and Vermont systems, the two systems that have a level specifically designed for administration and leadership. Given the importance of reflection and personal development in these systems, it is interesting that only four systems specifically note supervision (including reflective supervision); neither the Colorado nor Florida systems include this competency.

Mental health consultation is mentioned in only three systems. This is surprising, given that mental health consultation to preschool, early child care settings, and home visiting programs is increasingly a way that ITECMH specialists are brought into services (Nelson & Mann, 2011; Smith, Stagman, Blank, Ong, & McDow, 2011). Finally, competencies related to research and evaluation are mentioned in four systems. Both the Colorado and Ohio systems, however, mention competencies in terms of consuming research information rather than conducting research or evaluation activities.

SYSTEMS ISSUES

The systems issues category covers the ability of the ITECMH specialist to work within systems of care, to understand the regulatory and policy issues that govern service provision, and to reach out to other relevant community services (such as child care, child welfare, or health care). In general, all the competency systems cover these issues, although the specifics differ. All systems include competencies focused on knowledge of other community services for families. Only three of the systems consider knowledge of reporting issues for child welfare to be a competency. Five systems note the need to work with or have knowledge of child care programs, a common setting for young children. Of these five systems, four also specifically mention understanding of classroom or preschool settings.

PROVIDER DEVELOPMENT

Provider development refers to the ability of the ITECMH specialist to seek out additional training and professional development, through either formal training, additional reading and research, or supervision. Such activities are noted by all of the competency systems and may be worded to focus on either the professional or the personal development of the provider. The current analysis developed a new topic area of help-seeking (recorded in five systems) to distinguish seeking assistance from others from a more formal process of receiving supervision. Provider development also refers to the provider's abilities in reflective practice and his or her use of self in working with families and young children. Despite some uncertainty in the field regarding the exact definition of reflective capacity, it is considered to be another central quality of the early childhood mental health specialist (Heffron et al., 2005; Weatherston et al., 2010) and is mentioned by five of the six systems.

Summary

Although there are some differences among the competency systems, results of the current analyses demonstrate considerable similarity in purpose and content. There is a common philosophy of service or shared values across these systems very much grounded in infant mental health. These systems all emphasize a relationship-based, strength-based, family-centered approach to helping families, with an emphasis on understanding cultural and contextual factors affecting families and service provision. The systems are mostly multidisciplinary. All place strong focus on understanding development during the early years as well as risk and protective factors that may impede or promote development. There is little emphasis on child health or specific early childhood mental health challenges, concerns, or disorders. The competency systems emphasize the variety of roles in which ITECMH specialists often find themselves. They are comprehensive in listing services and supports provided to families but largely ignore particular curricula or intervention models. Although most of the systems note the importance of program outcomes, there is less concern with evidence-based practice or the research supporting best practices, a blind spot not uncommon in the infant mental health field (Korfmacher, 2012).

What Is Still Needed?

The 2008 review (Korfmacher & Hilado, 2008) made four broad recommendations for future development of the competencies: (a) applicability to early childhood service systems, (b) ensuring relevancy to the preschool years, (c) research and evaluation, and (d) development of national competencies. To a large extent, these are still the issues that the field is grappling with as these competency systems develop further.

APPLICABILITY

Competency systems serve many functions, including training guidelines, self-assessment tools, and quality indicators. The most noteworthy development since the 2008 review (Korfmacher & Hilado, 2008) is the number of competency systems that are linked to endorsement or certification programs. Most of the systems have established or are piloting a process so that candidates can enter a review process and receive some designation of their competency as ITECMH specialists. The Michigan system continues to be the best developed and most widely used system, now licensed to 16 other infant mental health associations for use in their states. As in the California system, the Michigan system has also introduced an online endorsement process and electronic data management system that streamlines applications and review. Based on the changes in the past five years, one can expect in the near future a dramatic increase in the number of people across the United States who have some kind of endorsement, whether through an association using the Michigan system, or through one of the other endorsement systems in California, Ohio, Colorado, or Vermont (as well as the system currently being piloted in Illinois).

But what is the value of endorsement? That is still a question that cannot be fully answered until the endorsement systems are better integrated into existing early child service systems and until there is a critical mass of endorsed professionals. It is possible that endorsement systems could provide oversight to professional work, such as in the context of a state licensing system. Two of the systems described here, from Ohio and Colorado, have their competencies and credentials embedded within a state government agency. In both cases, the credentials are not a prerequisite for professionals to operate as ITECMH specialists. There are, however, examples within the League of States of using the Michigan system of endorsement requirements for certain funded positions. For example, since 2009, Michigan Medicaid has required home-based service providers or infant mental health providers for the Department of Community Health to be endorsed at least at Level 2 in order to receive reimbursement (see Weatherston, Goldberg, & Paradis, 2011).

An endorsement system may also be incorporated into best-practice requirements for early childhood program models. For example, Healthy Families America, a widely used home visiting program model, has recently updated its program standards to recommend that home visitors receive MI-AIMH Level 1 or Level 2 endorsement, and that its supervisors and reflective practice consultants have Level 3 or Level 4 endorsement or its equivalent in other systems in states where the Michigan system is not used (Healthy Families America, 2013).

Should endorsement systems be prescriptive? There is not much precedent for multidisciplinary mental health credentials that are age specific. For example, there are no mental health credentials to work specifically with school-aged children, teens, adults, or the elderly. What makes the early childhood period so unique? As the examples in the previous paragraph suggest, some states are taking steps to make a credential or endorsement a requirement for hiring or funding, but, more often, states seem to be simply recommending or encouraging credentials or endorsements as best practice within the state. Programs using the Michigan system have had the most experience with these “carrots and sticks,” as has been detailed elsewhere (Smith et al., 2011; Weatherston et al., 2011).

There is also the question of how the ITECMH competencies fit in with other competency or professional development systems developed in other sectors of the early childhood service system. There are many examples of these offerings within states, either through teaching credentials or licenses, or through career lattices (see National Center on Child Care Professional Development Systems and Workforce Initiatives, 2013, for examples). Most have at least some focus on aspects of social-emotional development. In some cases, such as in Vermont, the ITECMH credential exists alongside other state credential or competency offerings.¹⁸ Beyond state systems, other groups or agencies have established competencies that are similar to the ITECMH competencies described here, such as the recently-developed Head Start and Early Head Start Relationship-Based Competencies (National Center on Parent, Family, and Community Engagement, 2012). Overall, however, we are only at the beginning stages of integrating ITECMH principles and competencies into state and federal early childhood workforce development initiatives across education, early intervention, and special education disciplines, or in mental health practice in general (Cohen, Oser, & Quigley, 2012).

¹⁸ See <http://northernlightscdc.org/career-pathways/credentials-and-certificates/>.

SPANNING EARLY CHILDHOOD (AND BEYOND)

The ITECMH competency systems somewhat disagree about what period of early childhood to cover. All systems cover the first 3 years (with some attention to the prenatal period), but most go beyond that or are being used for the age period beyond 3 years. The 2008 review (Korfmacher & Hilado, 2008) noted that most of these systems more strongly emphasized infant mental health than preschool mental health. That is, there was little emphasis on topics of particular relevance to the preschool period, such as peer relationships, dealing with challenging behavioral or attentional problems, school readiness areas such as early literacy and math, or understanding of the preschool or classroom context. This has changed to some extent. The revision of the California competencies, along with the addition of the Ohio and Colorado competencies, has increased the number of indicators focused on this later early childhood period. Still, issues directly related to mental health and social-emotional well-being in the preschool and later period are underrepresented. For example, none of the competency systems cover Response To Intervention, an approach to incorporate empirically validated treatments into mental and behavioral health services and a requirement for many special education services (Buysse & Peisner-Feinberg, 2010; DEC, NAEYC, & NHSA, 2013).

Overall, a point made in the 2008 review is worth repeating: Although the competency systems are designed to guide the development of early childhood mental health specialists, it is more accurate to consider them as systems for developing infant mental health expertise for those working in early childhood systems. (Korfmacher & Hilado, 2008). Adopting an infant mental health approach means that these systems are putting less emphasis on other philosophies of care, such as behavioral, cognitive-behavioral, or parent-training approaches to working with a young child's conduct (see Fox & Dunlap, 2007).

Many infant mental health principles are extremely relevant to the later years, including to children in the primary grades, youth, and their families. For example, recently-developed core competencies for children's behavioral health in New Hampshire borrowed strongly from the Early Childhood and Family Mental Health Competencies (New Hampshire Children's Behavioral Health Core Competencies Leadership Team, 2012). As a recent evocative case study points out, however, there are dangers in maintaining too strong a focus on the intense attachment-based principles of infant mental health as a child grows up, when the focus should shift to other developmental issues (Berg, 2011).

RESEARCH AND EVALUATION

There continues to be very little research on the reliability or validity of these ITECMH competency systems. When the competencies are connected to an endorsement system, it is unclear whether independent reviewers would agree in their assessment of a candidate's qualifications or competency attainment. It appears that this reliability work has simply not been done. It is also unclear to what extent the attainment of these competencies actually relates to improved practice in ITECMH services. In other words, the validity of these systems have yet to be empirically demonstrated. The only disseminated empirical research is on the Florida competency system. Developers of this system have published two reports showing its content validation through expert opinion (Quay et al., 2009) and its use as pre- and post-self-report assessment of skill development in infant mental health training cohorts (Hogan & Stone, 2012). These are initial steps, but there is still considerable evaluation work needed.

As recommended in the 2008 review (Korfmacher & Hilado, 2008), serious effort should be applied to evaluating the existing competency systems, and any new competency system should include a plan for evaluation (as well as funding for evaluation) as part of its development. This is, of course, easier said than done, and conducting field-based research on these systems is challenging: They cover multiple domains of knowledge and address different types of providers at different levels of experience and professional background. How to develop some kind of comparison group or condition is not immediately obvious. In addition, assessing practice is always a more difficult proposition than assessing content knowledge, especially when dealing with relatively abstract topics such as reflective capacities. The professional groups and organizations that oversee these competency systems are typically undertaking these endeavors with limited resources, so it is easy for research and evaluation to be relegated further down the priority list.¹⁹

Such challenges call for multiple evaluation methods and the development of objective measures of skill and practice that can “bootstrap” conclusions about the validity of these systems through ongoing evaluation efforts. There has been an increased interest in conducting research on the Michigan competency system, and the League of States currently has a subcommittee that is developing a research agenda. The use of electronic data management systems, such as in California and Michigan, may assist in this process.

Finally, establishing the validity of these competency systems is really only a first step, as the overall impact of these competencies on early childhood systems of care and the children and families served is also an important focus of evaluation (see Perry, Woodbridge, & Rosman, 2007). The MI-AIMH has been collecting examples of changes in training programs, policies, and funding within states that adopt its system (Weatherston et al., 2011), but more systematic evaluation is also necessary. In short, does the use of competency systems actually lead to improved ITECMH services to families, and does this lead to improvements in child and family functioning? This question further suggests the need to be cautious when encouraging or mandating the use of a particular set of competencies.

NATIONAL COMPETENCIES

Should there be a national set of competencies? Some advantages seem clear. A uniform set of competencies would provide coherence to an emerging field that has developed in fits and starts, with various local communities establishing their own definitions, endorsement rules, and areas of focus. This would also address the challenge of reciprocity among states that have different competency systems. There is already considerable overlap between the systems, suggesting a convergence of thought. One system, the MI-AIMH system, has an established history of branching out across its borders and developing a League of States that have licensed its system, thereby steadily working through many of these issues.

On the other hand, there are disadvantages to a national set of competencies. First, there are already existing systems that have set up their own infrastructure in a way that fits their own purposes and needs. How would a national system accommodate these local contexts?

¹⁹ The author brings his personal experience to this point, as this has been an ongoing challenge in the development of the Illinois competency and credential system.

Two competency systems examined in the 2008 review (Korfmacher & Hilado, 2008), from Indiana and Connecticut, are no longer being used because the local associations have adopted the Michigan system. Because these previous competency systems were never used in the states as part of any endorsement process, this was likely not a difficult transition. But for other states that have developed an endorsement or credentialing system, adopting a new uniform system would likely create more challenges. There may, for example, be issues of importance locally that are not addressed in the national competencies. To what extent would groups be allowed to adapt competencies to better fit their own local contexts? Because the Michigan system is licensed to associations in other states, these associations do not have the ability to make local adaptations. Instead, any changes to the competencies are made across the entire League of States.

Second, what would be the purpose of the national system? If there is already a lack of clarity regarding the purpose and use of the developed competency systems, it seems that this issue should be resolved at the beginning, rather than after a national system has been developed. Would national competencies be used as part of uniform standards or testing? This has been done for licensing exams given for psychologists, social workers, and other mental health professionals. For these professions, states are responsible for regulation and licensure, using the national exam as one part of locally developed processes (for example, states can establish their own cut-off for passing scores). It is also possible that a national set of competencies could be used to establish standards for higher education training or professional development programs, akin to the “common core” that most states have recently adopted to guide primary and high school learning standards. Professional organizations have established accreditation systems for graduate programs to create consistency in coursework and streamline the process for licensure of graduates.

Finally, there is the tricky issue of who would actually oversee this national system. Given the transdisciplinary nature of the field, no one profession would be able to claim ownership in a competency set. There is currently no national, membership-based association for infant or early childhood mental health that could assume this responsibility. This lack suggests that this responsibility would need to be taken on by a different type of organization. There are a number of research, educational, and advocacy organizations focused on child development and social policy (e.g., Child Trends, Center for Law and Social Policy, National Center for Children and Poverty, and, of course, ZERO TO THREE) that could potentially be involved in this process.

At this point, it seems more productive to focus on communication and collaboration between the systems rather than the emergence of a single national system. Is it possible to create a network of multiple systems that will provide opportunities for sharing and learning from others, while still allowing for retention of the unique features of the individual competency systems? Many (if not all) of the competency systems described here are works in various stages of progress. Each system will need to be reviewed, updated, and modified as new trends emerge in the field, new needs arise, or new problems present themselves under a changing policy landscape.²⁰ There seems to be great value in the development of a shared space or a “big tent” (to borrow a political euphemism) under which to assemble to explore common challenges, such as adaptation and sustainability.

²⁰ Thanks to M. Heffron for this point.

Conclusion

In the past 5 years, the interest in and use of ITECMH competencies has increased dramatically. The Michigan competency and endorsement system continues to expand to new states. California revamped its competency and endorsement process. Vermont's system was put in service of another certification process and adapted for a neighboring state (New Hampshire). Two new systems (in Colorado and Ohio) were developed and disseminated, and a third (from Illinois) is on its way. There is still a need to study and evaluate these systems, but practitioners and other stakeholders are seeing the value in the process of outlining and ascertaining skills and competencies in this field. We should expect increasing number of clinicians, consultants, supervisors, and other service providers to seek out and receive some kind of endorsement or certification.

Many practical issues must still be worked out, including how the existing systems relate to, communicate with, and learn from each other. The current review suggests increasing convergence in both the content of the competencies and in the practice of providing endorsement. To invoke a parallel process (as is the prerogative of any self-respecting ITECMH specialist), just as infants cannot exist outside the context of a relationship, neither should any of us who seek to help this infant be expected to do the same. Given the value placed on a relationship-based approach to work, there is every reason to expect that collaboration is possible as the ITECHM field moves forward to promote the well-being of our youngest children and their families.

Acknowledgments

Jessica Fulford was my research assistant and partner in coding all of the competencies in this version of the report. I am extremely thankful for her hard work on the project.

Thank you also to Mary Claire Heffron and Deborah Weatherston for their review of an earlier draft and for their valuable and insightful feedback. Grateful acknowledgement is also made to those who provided additional information crucial to the creation of this report, including Jordana Ash, Marla Himmegar, Anne Hogan, Sudy Opsahl, Herbert Quay, and Michele Walsh.

Special thanks to Cindy Oser and to Julie Cohen at ZERO TO THREE for information, feedback, and patience during the creation of this report.

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Appendix. Competency Categories for Infant, Toddler, and Early Childhood Mental Health (noted in 2 or more competency systems)

CATEGORY	SOURCES	REFERENCES	CA	CO	FL	MI	OH	VT
BASIC PRINCIPLES								
attachment	6	42	•	•	•	•	•	•
context	5	43	•	•	•		•	•
culture	6	141	•	•	•	•	•	•
ethics	6	44	•	•	•	•	•	•
family (importance of)	5	29	•	•		•	•	•
family-centered practice	6	53	•	•	•	•	•	•
“ghosts”/historical precedents	5	10		•	•	•	•	•
maintaining multiple perspectives	5	11	•	•		•	•	•
outcomes-based	4	30	•		•	•		•
parenting processes	5	15	•	•	•	•		•
relationship/alliance formation	6	87	•	•	•	•	•	•
relationship-based care	6	56	•	•	•	•	•	•
relationships (importance of)	6	31	•	•	•	•	•	•
strength-based	6	74	•	•	•	•	•	•
work in natural settings	4	13	•		•	•		•
*impact of physical environment	6	36	•	•	•	•	•	•
*individualized approach	5	31	•	•		•	•	•
DEVELOPMENTAL KNOWLEDGE								
affect emotions	3	12		•	•			•
atypical-special needs	6	35	•	•	•	•	•	•
brain development	6	15	•	•	•	•	•	•
cognitive development	6	36	•	•	•	•	•	•
prenatal development	6	17	•	•	•	•	•	•
infant development	4	17	•	•	•	•		
language/literacy development	6	36	•	•	•	•	•	•
parent–child relationships	6	59	•	•	•	•	•	•
peer relationships (child)	4	23	•	•			•	•
physical development	5	28	•	•	•	•	•	
play	5	18	•	•	•		•	•
*toddler development	3	30	•	•		•		

CATEGORY	SOURCES	REFERENCES	CA	CO	FL	MI	OH	VT
preschool development	2	25	•	•				
school-age development	3	18	•	•				•
sense of self	2	2	•	•				
sensory & regulation	5	26	•	•	•		•	•
sleep	2	3	•		•			
social-emotional development	6	96	•	•	•	•	•	•
temperament	4	18		•	•		•	•
transitions	3	18		•			•	•
*neonatal development	2	9	•	•				
*gender/sexual orientation	2	4		•				•
behavior as communication	2	2			•			•
development (general)	6	53	•	•	•	•	•	•
MENTAL HEALTH CHALLENGES								
behavior challenges	4	5	•		•		•	•
*communication / interaction problems	3	8			•	•		•
disorders (child, unspecified)	6	21	•	•	•	•	•	•
maltreatment & family violence	6	15	•	•	•	•	•	•
trauma	3	5	•		•		•	
parent mental illness	6	13	•	•	•	•	•	•
RISK FACTORS								
environmental risk	6	19	•	•	•	•	•	•
biologic-genetic risk	3	10	•	•	•			
family disruption	4	14	•		•	•		•
poverty	4	8	•	•	•			•
risk and resiliency (general)	6	79	•	•	•	•	•	•
stress	5	11	•	•	•		•	•
parent substance abuse	5	11	•	•	•		•	•
*immigrant families	2	4	•			•		
HEALTH								
nutrition	3	8	•		•			•
pregnancy	3	10	•		•	•		
*labor and delivery	2	5	•	•				

CATEGORY	SOURCES	REFERENCES	CA	CO	FL	MI	OH	VT
prematurity/low birth weight	3	5	•	•	•			
physical illness in child	2	6	•		•			
physical illness in parent	2	4		•	•			
*child health (general)	2	3		•				•
DIRECT SERVICE								
behavioral support	5	24		•	•	•	•	•
concrete assistance	3	7	•		•	•		
crisis help	3	7	•		•	•		
developmental guidance	6	27	•	•	•	•	•	•
emotional support	3	4		•	•	•		
group work	3	5	•			•	•	
interaction guidance	6	23	•	•	•	•	•	•
intervention (general)	5	92	•	•		•	•	•
life skills development	3	5		•	•	•		
problem solving	4	16		•		•	•	•
referrals	6	47	•	•	•	•	•	•
social support	4	9		•	•	•		•
therapy (non-specified)	4	12	•			•	•	•
direct work with children	5	45		•	•	•	•	•
*parent training	5	15		•	•	•	•	•
*creating/adapting environments	3	20		•			•	•
ASSESSMENT								
assessment (general)	6	119	•	•	•	•	•	•
diagnosis	4	14	•		•	•		•
*DC:0-3R diagnostic system	4	11	•		•	•		•
interviewing	6	15	•	•	•	•	•	•
observation	6	65	•	•	•	•	•	•
screening	4	10	•	•	•			•
specific assessment instruments	5	9	•	•	•		•	•
OTHER SKILLS								
administration	2	35				•		•
adult learning	4	8	•		•		•	•
advocacy	6	31	•	•	•	•	•	•
communication	6	116	•	•	•	•	•	•
*confidentiality	5	11	•	•		•	•	•

CATEGORY	SOURCES	REFERENCES	CA	CO	FL	MI	OH	VT
conflict resolution	5	16		•	•	•	•	•
consultation	3	31				•	•	•
documentation	5	11	•		•	•	•	•
leadership	5	28	•		•	•	•	•
listening	6	17	•	•	•	•	•	•
modeling behavior to others	6	25	•	•	•	•	•	•
research and evaluation	4	46		•		•	•	•
service plan development	6	35	•	•	•	•	•	•
supervision-mentoring	4	40	•			•	•	•
reflective supervision	4	18	•			•	•	•
teaching	4	50			•	•	•	•
thinking skills	4	31	•	•		•	•	
working with difficult families	2	2			•			•
working with other disciplines	6	142	•	•	•	•	•	•
writing	2	11				•		•
SYSTEMS								
child care	5	22	•	•		•	•	•
community resources	6	54	•	•	•	•	•	•
*public policy	2	5				•		•
reporting obligations	3	15		•		•	•	
rules & regulations	5	55	•	•		•	•	•
school/classroom environment	4	16	•	•		•		•
systems issues (general)	5	39	•		•	•	•	•
media	2	3		•				•
PROVIDER DEVELOPMENT								
personal or professional development	6	57	•	•	•	•	•	•
reflection	5	64	•	•		•	•	•
*seeking help	5	26	•		•	•	•	•
TOTAL: 116 CATEGORIES								

NOTE: DC:0-3R = Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition.

*Indicates a new category added since the 2008 review (Korfmacher & Hidalgo, 2008).