"Infant, Toddler and Early Childhood Mental Health Competencies: A Comparison of Systems" Webinar—Questions From Participants

Note Abbreviations: Jon Korfmacher (JK), Deborah Weatherston (DW), Marie Kanne Poulsen (MP), and Kathy Mulrooney (KM)

Is there an emphasis on prevention?

JK: Most (but not all) of the competency systems are tiered or multilevel, which includes service providers such as home visitors who work primarily in prevention-oriented approaches. The competencies also have a strong focus on risk and resilience, even more so than the focus on mental health challenges, which suggests a strong prevention orientation.

What was the website you mentioned for home visiting programs?

KM: Maternal Infant and Early Childhood Home Visiting (MIECHV) website through U.S. Department of Health and Human Services (HRSA): http://mchb.hrsa.gov/programs/homevisiting/index.html

I hope we can discuss including evidence-based intervention practices such as child–parent psychotherapy into the competencies.

JK: MI-AIMH Competencies and Endorsement as well as California include theoretical foundations, knowledge of treatment strategies, and evidence-based approaches. For the most part, the different competency systems make general reference to evidence-based approaches without actually mentioning the specific forms or models of evidenced-based treatment.

I am interested in learning what trauma screens are used in Michigan and California as we are trying to work on this in New Hampshire.

DW: Because infant mental health services have at the center of their work, the MI-AIMH Competencies and Endorsement are inclusive of trauma. Trauma is identified specifically under the first core knowledge domain: attachment, separation, trauma, and loss. We have not specified the use of particular trauma screens; rather, we encourage the development of understanding through observation, listening, screening, and assessment of both parent and infant or young child together, attending and responding to parental histories of loss as they affect the care of the infant/very young child, the parent's development, the emotional health of the infant/young child and the parent(s), and the developing relationship. We do not specify specific approaches, but of course

expect the strategies and services to effectively reduce risks when trauma has occurred for either the infant or parent(s) and encourage healing for both.

MP: In California, the following trauma screens are being used: UCLA PTSD Reaction Index, Traumatic Events Screening Inventory, and Trauma Symptom Checklist for Young Children.

Deborah Weatherston just mentioned reciprocity between the League States, using the MI-AIMH system. I am interested in reciprocity between systems as we know how mobile the workforce is.

DW: MI-AIMH is creating an Alliance for the Promotion of Infant Mental Health that has at the core the Competencies and Endorsement, the *Infant Mental Health Journal*, and Early Attachments: IMH Home Visiting. These are three important efforts that go beyond the borders of Michigan and now call for a larger organization that is national/international. League partners are essential leaders in each component and in this effort. Once the Alliance is formed, with a board and by-laws, we anticipate partnering with others who share the commitment (e.g. California, university research collaboratives, to name just two). This will not provide a mechanism for reciprocity, but may enable us to work together on behalf of babies, very young children, and families. I very much hope so as there is much that we can do together by joining hands collaboratively, for example focusing on reflective practice, infant and family assessments, advocacy for *DC:0–3R*, etc.

Also referring to what Deborah Weatherston mentioned in terms of the "League of States"—can I please get clarifications about what the other states are involved?

DW: The following states are involved: Alaska Infant and Toddler Mental Health Association; Arizona Infant Toddler Children's Mental Health Association; Colorado Association for Infant Mental Health; Connecticut Association for Infant Mental Health; Idaho Association for Infant Mental Health; Indiana Infant and Toddler Mental Health Association; Kansas Association for Infant Mental Health; Michigan Association for Infant Mental Health; Minnesota Infant and Early Childhood Mental Health Association; New Jersey Association for Infant Mental Health; New Mexico Association for Infant Mental Health; Oklahoma Association for Infant Mental Health; Rhode Island Association for Infant Mental Health; Texas Association for Infant Mental Health; Virginia Association for Infant Mental Health; West Virginia (TEAM for WV Children); Wisconsin Alliance for Infant Mental Health; Washington Association for Infant Mental Health (July 2014).

I hope there will be an opportunity to deepen our knowledge about specific strategies for working in group care settings. What ratios work best in group care to facilitate that bonding and continuity of care between center and home-based? What are good exemplars of this best practice to follow up on?

An important effort within the league of states is for the leadership from each IMH association to participate in sub-committees. One sub-committee addresses training; another addresses policy. Both support exchange of ideas that others across states might use. Because the MI-AIMH Competencies include infant family associates who are primarily early care and education staff, the issues of group care, continuity of care, and best practice are something that league leaders address in trainings provided for early care staff.

Question for Marie Kanne Poulsen (CA)—What birth care providers were included (obstetricians /midwives)? And/or was any of the work and research from March of Dimes Prematurity Prevention Campaign included?

MP: A faculty member from a Prenatal & Perinatal Psychology training program was an active member of the Infant-Family Mental Health Work Group. Members of the workgroup were active in neonatal follow-up programs and involved with prematurity prevention. March of Dimes research has contributed to the field of infant-family mental health in California.

I am an early interventionist with an MA in psychology, very knowledgeable about IMH, doing work for over 10 years, but was told that I am not qualified to be an IMH Specialist because I don't have a degree in mental health or social work.

DW: The Michigan Endorsement is interdisciplinary. We intentionally do not exclude people because of discipline. Rather, we encourage a balance of intensive training that is competency-based and reflective supervision while providing infant mental health services to infants, toddlers, and their families, with the relationship as the focus and the instrument for change. I refer you to the MI-AIMH website www.mi-aimh.org and invite you to contact Nichole Paradis (Michigan) at nparadis@mi-aimh.org for additional conversation.

Does meeting the competency guidelines for MI-AIMH or California tie practitioners to specific evidence-based interventions?

DW: The MI-AIMH Competencies are intentionally broad in their focus, specifying approaches that are relationship-based and, as appropriate, explore issues including attachment, separation, trauma, and loss that affect development and the care of infants and very young children within a relational framework for intervention. I refer you to the Competency Guidelines® at www.mi-aimh.org.

MP: A diverse group of evidence-based mental health interventions has been sanctioned through many local Departments of Mental Health in order to access funds through the Mental Health Services Act. The competency guidelines expose providers to foundational knowledge in the infant-family mental health field and to a variety of

evidence-based practices (EBPs), and emphasize the importance of implementation within the context of clinical experience and family belief systems, values, and preferences. The choice of specific evidence-based interventions is up to the individual candidates and/or their agencies.

How is a master's in psychology not a degree in "mental health?"

DW: A master's in psychology would be seen as a degree in mental health. However, there are other criteria that an applicant must meet to qualify for Endorsement through the MI-AIMH system that 17 state affiliates are now using.

I am interested in states, models, people who have tooled up people with early childhood credentials and experience in child care to do Early Childhood Mental Health (ECMH) consultation in child care/early education programs.

DW: Please see the listing of states (above) as the MI-AIMH Competencies and Endorsement is inclusive of early childhood and early care professionals and also early childhood mental health consultants. I welcome contact: dweatherston@mi-aimh.org.

Will we hear what the "competencies" are?

More information can be found in Jon's report available at: www.zerotothree.org/iecmhcompetencies. The table at the end lists all of the categories of the competencies content. To see the specific competencies, the reader is referred to the original sources.

How are we convincing states to reinvest money into mental health programs, when many states have seriously cut that funding?

KM: It is helpful to align with current state initiatives such as Race to the Top, Project LAUNCH, ECCS, Build, etc. Build strong policy around infant-early childhood mental health; consider how Medicaid and other funding can cover infant mental health support and intervention. Make a case with papers such as Jon Korfmacher's to raise awareness of the need and of existing examples in other states.

How is the para-educator working with infants and toddlers supported through the competencies?

KM: The Michigan Endorsement begins with Level I— Infant/Family Associate which requires CDA, or associate's degree in a related area or 2 years of infant/childhood paid work experience (including college, AA, and CDA work) plus 30+ hours of defined training/portfolio. This level would be applicable for para-professionals in such categories as child care and home visiting.

What is the state of New York doing in terms of early childhood mental health?

KM: NYS has the Infant Mental Health Association of the Greater Capital Area, the statewide Early Care and Learning Council (ECLC), and the Early Childhood Advisory Council (ECAC). Currently NYS does not have a system of competencies or endorsement.

Regarding NY—We don't have an IMH Association. Currently exploring Michigan system and what might work in NY?

Contact Nichole Paradis at nparadis@mi-aimh.org or Deborah Weathersoton at dweatherston@mi-aimh.org. They would be happy to talk to you!

Do you know of any higher education early childhood programs that are incorporating the competencies into the curriculum?

DW: Yes, there are many in the league states: Arizona State University, University of Minnesota through CEED, Dual Degree program in IMH and Nursing, Education, and Social Work at Wayne State University in Michigan, Infant Studies graduate program at Michigan State University, University of Wisconsin's Certificate Program. Please see the full PowerPoint in which I gave examples of these higher education programs that are incorporating the competencies into the curriculum. Since they are interdisciplinary, they include early childhood. Montclair State University in NJ offers a graduate certificate in Infant Mental Health through its Center for Autism and Early Childhood Mental Health aligning course material with Michigan Competencies.

MP: California State University Northridge offers an Infant-Toddler-Family Mental Health Certificate. The courses can be used as electives for a Master of Arts in Early Childhood Education. Mills College has a Master of Arts in Infant Mental Health as one of the offerings in the Early Childhood Education Program. San Diego State University is offering courses in Early Childhood Socio-Emotional & Behavior Regulation Intervention Specialization as a Graduate Certificate Program. These courses can be used toward a Master of Arts in Social Work. The Early Childhood Special Education Credential Program at California State University Sacramento has aligned many of the Infant-Family and Early Childhood Mental Health competencies with their curriculum. Alliant International University Clinical Psychology Programs in Fresno, Sacramento, and San Diego have built graduate courses based on the competencies. The Los Angeles Campus offers Continuing Education classes drawing from the competencies.

Florida has a license to use Michigan's Competency Guidelines only—they do not endorse with Michigan's System?

DW: No. A large human service agency in Florida has licensed the use of the competencies only. The competencies provide standards for training of staff who work throughout their agency. It is not linked to Endorsement.

How are these systems interfacing with Part C programs?

The Infant Family Services Specialist (Level II) would be the type of person doing Part C work within the Michigan systems.

JK: I think this is handled differently with each state, and it probably depends upon how mental health is handled within each state's Part C early intervention system.

North Carolina has only had a formal Infant Mental Health Association for a couple of years and they have yet to address this issue. They have focused on just getting state systems to recognize how deficient the system is for providing mental health supports for children under 3 in North Carolina. Can any of the presenters provide some insight?

DW: The MI-AIMH Competencies have provided standards that help in advocating for services for children 0-3. The league leaders have formed a subcommittee on advocacy to share ideas and strategies for getting state systems to provide such services. An excellent league example is in New Mexico where once the competencies were licensed, spokespersons successfully advocated for services for 0-3 and families and now, after some years, have influenced state systems in behavioral health and home visiting.

Will there eventually be reciprocity between all states that have an endorsement process?

There is already reciprocity within all of the League States.

But, for those of us in California, if we venture into any of these states, will there be reciprocity in the endorsement process?

DW: At this point in time, there is not an agreement regarding reciprocity. A main point of difference is that the MI-AIMH system requires successful completion of an exam for infant mental health specialists and mentors. Until we can resolve this between CA and league leaders, we can't agree to reciprocity. However, we might begin with working collaboratively as partners around the promotion of infant mental health through the Alliance for the Promotion of Infant Mental Health (just being formed—see above).

MP: Endorsed providers have reported that once the California Endorsement Process was understood, their infant-family and early childhood mental health expertise was honored. Providers can refer program directors in other states to the California Center website, www.cacenter-ecmh.org, for detailed descriptions of competencies. There has been discussion, initiated by Deborah Weatherston, about trying to figure out some kind of reciprocity.

Are child welfare workers trained as well?

DW: This is a group that the league leaders continuously reach out to through training efforts that are linked to the core competencies.

For those of you who don't have an IMH organization in your state yet (like NY), you may need to establish one yourselves. Here in Utah, our IMH organization was founded in 2003, basically after one person (working for the state department of health) had brought together a lot of people from all kinds of areas who were working with infants or young children in some way. After several of these meetings, UAIMH was founded. We are still small, but it starts with a few people. After seeing this seminar, I would love to connect with other states and see who we, here in Utah, can help develop further.

You might also look at the World Association for Infant Mental Health website for specific guidance about forming an IMH association: www.waimh.org.

Why is California not part of the league? In spite of the knowledge of IMH at the systems level, as a foundation executive, I find little knowledge of it at the local level.

The League includes those states who have adopted the Michigan Competency system. California has its own system. However, representatives from California have been invited to attend an annual League activity, and there have been many exchanges about the need to jointly support the importance of competencies in general, rather than highlight individual differences that to an extent reflect different regional needs. For example, a representative from the League and from California jointly presented at a ZERO TO THREE National Training Institute, emphasizing the value of a competency system. Leaders from both groups are interested in continuing to work together to strengthen the field through the use of meaningful standards. The webinar offered the opportunity for communication and the sharing of ideas.

Do you know of any colleges or universities in South Carolina that offer training in Infant and Mental Health?

JK: I am not aware of any programs in SC. I would possibly consult with the Children's Trust, specifically the home visiting coalition in SC, to see if members have information on education or training opportunities: http://www.scchildren.org/about_us/programs/home_visiting/home_visiting_coalition/

If a state chooses to join the League of States, purchasing both the competencies and endorsement system, can you provide an estimate of what would it cost (both in terms of funding and staff time) to implement?

Contact Deborah Weatherston at dweatherston@mi-aimh.org for more complete information. If a state chooses to license the use of the competencies and endorsement under their own name (e.g. Connecticut Competency Guidelines®), there is a cost: $20,000 for licensing the use of the Competencies only or $40,000 for licensing the use of the Competencies and Endorsement process and including data entry system. The license is for 3 years, renewable at $1,250 annually after that. Training and technical assistance is figured separately. Costs in terms of staff time are: 1/2 time paid coordinator initially and an IMH association structure, usually volunteer, but may have some paid time for administrative tasks.

It looks like the training, clinical, and reflective hours required for a California endorsement are much greater than the Michigan system. What was the thinking in CA that led to these higher standards? Have they found these requirements limit the number of endorsement candidates?

MP: California's infant-family and early childhood mental health specialists are licensed mental health providers with the responsibility of assessment, diagnosis, and treatment planning for mental health disorders with medical necessity. County funds supporting infant-family and early childhood mental health training have added value to the endorsement process and have increased the number of candidates. It was the belief in California that work with infants and toddlers requires greater depth and training than is typically provided in course work available through most programs. Those individuals who take undergraduate or graduate courses that include key elements within the knowledge domains may submit those courses as evidence of their training in those areas. We also wanted to ensure that the full range of issues was included regardless of whether the individual would be providing intensive therapeutic services and diagnostic (mental health) assessments or would be screening and determining need for referral to more intensive and specialized services. The requirements for the transdisciplinary providers and the mental health specialists include the same topical areas with different intensity of hours or content depending on the work they would be doing.

Have the competencies and trainings decreased repeat child maltreatment? Or reduced time in foster care?

DW: This would require funding for research/evaluation that goes beyond what a "grassroots" effort has been able to identify. One would hope that having trainings that are linked to core competencies and having a workforce development plan that is specific to competencies and well-defined criteria would strengthen and build capacity among those working with infants, toddlers, and families as prevention services or those involved in the child protection system.

Most (certification) programs are very expensive. How are you recompensed and at what level?

DW: There are examples of state systems that now require endorsement for certain jobs and also some who give raises based on earning endorsement (Michigan Competency/Endorsement system).

I am an early childhood educator with an ECE Child Development Permit in California, but notice the Commission on Teacher Credentialing has no information on their website about additional authorizations on this. This is the first time I have heard about competencies and certification on the topic in my state. I also run a statewide foster care advocacy organization and this topic has never come up with local or state level partners...this is something to look further into, I believe.

Currently, the Guidelines address transdisciplinary providers with a bachelor's level degree. Expanding the Guidelines to include individuals holding Associate degrees has been under discussion.

(In reference to a national set of competencies) But there isn't really one for adult mental health now, is there?

JK: I agree and make that point in the paper. As far as I know, there are not mental health practice competencies specific for other age periods.

How can we develop a national framework for infant and toddler mental health competencies? Should a national framework even be developed?

The national competencies proposed sounds a lot like the Common Core teaching standards process. Analyzing and learning from that process and implementation would be important. (Miranda Pond)

For states that don't have competencies a national framework is imperative in establishing professionalism in the field. (Lisa Negrini)

A national set of competencies could be an advantage. (Deb Thompson)

Thinking about universal competencies is important to provide common ground for all of us as a field of IMH. However, I would caution regarding specific needs/strengths of diverse families we work with in regard to culture and language.

Other disciplines have national competencies for "certification" and continuing education requirements to maintain licensing (i.e., ASHA). Why could this not be possible?

There are those for psychologists, social workers, and counselors. (Frances Davis)

KM: Because Infant Mental Health is specialty area in different disciplines, general licensing and credentialing boards are less inclined to issue guidelines on credentialing specialties.

More research on evidence-based interventions and practices working with infants and parents in home settings versus clinical settings needs to occur.

JK: The issue of the difference between home-based and clinic-based IMH services is an interesting question, but I am not aware of research that systematically examines these differences.

How is infant mental health being considered in the child welfare and court systems?

In my county, we have a Children's System of Care—please look into this model in Placer County, CA. (Miranda Pond)

Is there a formal listing of the various Infant Mental Health training programs/certifications available at this time? Does ZTT maintain one?

JK: I am not aware of a national list and think it would be a great idea. WAIMH has a short list in the links and resource section of their website, but it is not comprehensive: http://www.waimh.org/i4a/pages/index.cfm?pageid=3284