Herr Research Center for Children and Social Policy
at Erikson Institute

Research Brief • 2008, No. 1

The Competent Early Childhood Mental Health Specialist

Jon Korfmacher and Aimee Hilado

Summary

Over the last decade mental health and early childhood professionals in several states have begun to develop competency systems to guide the field in determining what constitutes a knowledgeable and skilled early childhood mental health (ECMH) provider. Competency systems generally define domains of knowledge, skills, and abilities that ECMH providers should have, and establish areas of service and treatment. Although there is no national standard for what an ECMH provider should know or do, the extent to which established state competency systems overlap suggests some convergence of professionals' beliefs and ideas. In this research brief we summarize findings from our comparison of ECMH competency systems across six states, highlighting convergences in the systems' structure, content, and use. Based on our findings, we provide recommendations for policy and practice, discuss how competency systems could be used, and address a key policy question in the field: *Should a national set of early childhood mental health competencies be developed?*

This research brief summarizes findings from the research report *Creating a workforce in early childhood mental health: Defining the competent specialist* (available for download on our website). Published periodically, Herr Research Center briefs offer concise, policy-oriented summaries of our studies or syntheses of knowledge around a specific research question. To download research reports and other Herr Research Center products, please visit *www.erikson.edu/hrc.*

This work was funded in part by the Department of Justice as part of a larger study examining children's mental health consultation, assessment, and workforce policies in the Midwest region.

Herr Research Center
for Children and Social Policy
at Erikson Institute
420 North Wabash
Chicago, Illinois 60611
www.erikson.edu/hrc

ECMH services assist families and practitioners in assuring optimal social-emotional health of young children from the prenatal period through preschool. The need for these specialized services is evident from findings of several recent research studies documenting an increasing incidence of social-emotional and mental health challenges among young children. Specifically, these studies indicate higher than expected rates of

- preschool expulsion for behavioral problems (Gilliam, 2005),
- perinatal depression and anxiety in mothers of young infants (Coates, Schaefer, & Alexander, 2004; Lusskin, Pundiak, & Habib, 2007),
- depression and trauma in families participating in voluntary family support programs (Stevens, Ammerman, Putnam, and Van Ginkel, 2002; Gomby 2007), and
- reported concerns of child care and early intervention providers (Cutler & Gilkerson, 2002).

Despite wide recognition of the importance of providing specialized mental health services for young children, these services remain sporadic and underfunded. One likely contributor to this limitation is that there does not appear to be a viable workforce of providers who can meet the specific needs of this population (Meyers, 2007). Clinical training programs that offer ECMH specialization are relatively rare, and the ambiguous nature of the field makes it difficult to define exactly who should be considered an ECMH specialist. We have identified ongoing initiatives in six states—Michigan, California, Vermont, Florida, Indiana, and Connecticut—that strive to promote ECMH workforce development by creating a framework for training and practice. Within each of these six states, work groups consisting of a variety of stakeholders and professionals—in the areas of mental health, policy, and education, among others—have begun to outline ECMH competencies in an effort to better serve the social-emotional and mental health needs of children ages five and younger. These six sets of competencies establish the specialized knowledge and skills of providers wishing to specialize in ECMH services, and may provide a foundation for developing standards and criteria for training and certification.

Comparison of six ECMH competency systems

Overview of methodology

In reviewing the individual state systems, we used content analysis (e.g., Patton, 1987), a common qualitative method of analysis where documents and other texts are examined for the presence (as well as absence) of certain words, phrases, concepts, or ideas. This method allowed us to organize and compare the listing of knowledge, skill, and training areas across the supporting documents that we could find for each system. We did not have a pre-ordained classification system, but developed categories as the systems were reviewed and re-reviewed, modifying them and rearranging them as appropriate. Ultimately, 109 content areas emerged and were then grouped inductively under nine inclusive categories of content as described in Table 2.

Each of the six sets of competencies included in our analysis was developed as a way to establish standards for providers within the respective workgroups' particular states (see Table 1 for a summary).[1] The competency systems were developed for different uses and some are more complete than others. The Michigan system, for example, is actively disseminated to other states as part of an endorsement system, while other systems were developed only to guide training and professional development within their state. Some are in draft status, with their ultimate purpose yet to be determined.

[1] For shorthand, we will refer to each system by the name of the state in which it was developed. These systems, however, are not governed by the state or (as of yet) part of the state's credentialing or licensing system.

Table 1. Overview of the ECMH Competency Systems

State	Age focus	Competency levels	Purpose
Michigan	Birth to 3 years	1. Infant/Family associate 2. Infant/Family specialist 3. Infant mental health specialist 4. Infant mental health mentor	Framework for endorsement process available through Michigan Association for Infant Mental Health. Currently licensed to groups in AZ, KS, MN, NM, OK, and TX.
California[1]	Birth to 5 years	1. Core providers 2. Mental health professionals	Framework for county-based training programs. No endorsement available, but trainees encouraged to develop portfolios documenting training and background.
Vermont	Birth to 8 years	1. Foundation 2. Intermediate 3. Advanced 4. Experienced	Guide for training and professional development.
Florida	Birth to 5 years	1. Front-line providers 2. Developmental professionals 3. Infant mental health specialists	Guide for training and professional development.
Indiana	Birth to 5 years	1. Promotion 2. Prevention 3. Intervention	Guide for training, supervision, mentoring.
Connecticut	Birth to 5 years	Under development	Framework for draft training sequence developed, with goal of statewide endorsement.

Note: Table organized chronologically, from oldest to most recently developed system.

[1] This system is currently under revision, with changes expected in summer 2008.

Structural comparison

Table 1 summarizes the characteristics of these six competency systems, identifying them by state and comparing them across three key program features: age range of children targeted for specialized services, levels of differentiation among ECMH providers (e.g., competency levels), and purpose. Most of these six systems were developed for the 0-to-5 age range. Vermont also includes children up to age 8 and their families. Michigan is focused on 0 to 3, although associated organizations in other states that have purchased a license for the Michigan system use it for the 3-to-5-year range as well. The six systems also operate with a broad definition of who should be considered an early childhood mental health specialist, from frontline providers who may have only an associate's degree to licensed mental health providers such as psychologists. They all are structured to make distinctions among differently credentialed providers, identifying two, three, or four levels of competency standards.

Among the six systems, three were developed for a specific end-use related to training or professional endorsement. The Michigan system is part of an endorsement process for individual practitioners: practitioners may develop a portfolio and (at the final two levels) take a written examination to receive endorsement from the Michigan Association for Infant Mental Health (MI-AIMH). California's and Connecticut's systems are linked to training programs developed to cover the specific competencies content. The other three competency systems were developed to guide training and professional development more generally (e.g., providing a guide to higher education institutions that may be considering ECMH coursework).

In summary, the convergence across these six systems suggests a common agreement that ECMH

Table 2. Early Childhood Mental Health Knowledge and Skill Content Areas

Content Areas	Examples
Basic principles	• Importance of attachment • Cultural/contextual influences • Ethical practice • Family-centered practice • Relationship-based practice
Developmental knowledge	• General developmental milestones/ issues • Specific periods, areas and topics of development
Understanding of mental health challenges	• Depression or anxiety in young children • Behaviorally challenging children • Autism • Communication/interaction problems • Parent mental illness • Family violence
Risk factors	• General issues of risk and resilience • Specific risk factors such as family disruption, environmental risk, poverty, substance abuse, and prematurity
Direct service	• Provision of emotional support • Psychotherapeutic services • Referrals • Working specifically with children
Assessment	• Screening • Interviewing • Observation • Diagnosis • Use of specific assessment instruments
Other skills	• Administration • Advocacy • Consultation • Supervision-mentoring • Research • Interdisciplinary collaboration
Systems issues	• Work with community programs (including child care) • Reporting obligations • Rules and regulations
Provider development	• Personal and professional development • Reflective capacity

systems should cover the entire age range of at least 0 to 5. All systems also establish hierarchical levels of competency standards, encompassing providers at different levels of specialization and/or type of service delivered. There is less consensus in how competency systems should be used—whether to guide an active endorsement process, build a framework for specific training programs, or provide a basic roadmap for professional development.

Content Comparison

We conducted a content analysis of the different knowledge, skill, and training areas described in the documentation for the six competency systems. One hundred and nine content areas emerged in this analysis; we have collapsed these into nine categories (summarized in Table 2). Documentation from all six competency systems addressed, to some extent, content across each of these nine categories. Of the 109 individual content areas, 39 are addressed in the documentation for at least five of the six competency systems; 29 of the content areas are unique to only one or two of the systems. The remaining 39 content areas are covered in the documentation for three or four of the systems. Taken together, these patterns suggest a plurality, but not necessarily a consensus, among the states' systems regarding areas of knowledge and ability required for a competent ECMH specialist.

Importantly, the six systems converge in their general approach to ECMH issues. First, the systems share an *infant mental health orientation*. Although infant mental health refers generally to the social emotional well-being of children from birth to age 3, it has come to represent a philosophy of care for young children. The philosophy also extends to children through 5 years of age. It emphasizes the importance of relationships and 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. The philosophy of infant mental health 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 to approaching a child's social-emotional well-being.

Second, the six systems share the position that the ECMH specialist should be *trained as a generalist*. That is to say, these competency systems take a holistic view of the child and cover many topics beyond a narrow definition of mental health, such as sensory processing and regulatory issues or nutrition. At the same time, however, many specific mental health challenges at this young age are infrequently noted, such as depression, anxiety, autism, behavior challenges, distractibility and inattention, or trauma.

Third, all of the systems specify that providers should *understand child development* in the early years. There is less emphasis, however, on specific topics of development in the preschool period. Examples of the latter include relationships with peers, the importance of play, and interactions in group/classroom settings.

Finally, although most of the 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 specialists who work in early childhood*. This is a subtle but important distinction. By adopting an infant mental health approach, the systems are choosing not to emphasize other philosophies of care that can be associated with this age range, such as more behavioral approaches to working with children.

Recommendations for policy and practice

The findings from our analysis of the six ECMH competency systems suggest a number of key issues to consider in building a viable ECMH workforce, including the governance and oversight of these systems as they are used for training and professional development, their continued program improvement, and the incorporation of age-specific developmental and mental health concerns.

The competency systems need to move from standalone documents to plans that have clear applications in practice, such as is seen with the Michigan system. To do this, there needs to be greater involvement of policy players, particularly at the level of state government. State officials have both the experience and the insight to guide the development of the competencies in a way that will facilitate their integration into current early childhood and mental health practice, funding, and credentialing systems. Working with stakeholders to make ECMH competencies relevant to these systems requires careful planning and political insight.

Serious effort should be made to evaluate the existing competency systems. Any future competency systems should include a plan for evaluation (and the funds required) as part of its development. Although all the systems were carefully developed by dedicated workgroups focused on best practices, there has been little actual systematic study of their validity and success in improving social-emotional and mental health services

How should ECMH competency systems be used?

Training and professional development. Having an established set of competencies for ECMH specialists provides important guidelines for higher education institutions or other organizations in creating training programs. ECMH specialist candidates will have a better understanding of what is expected of them and what they are expected to know in their role.

Enhancement of professional credibility. Most consumers are unaware of what early childhood mental health entails and who should provide these services. These systems provide a visible standard not previously available, which can be used by professionals to signify their specialized skills and knowledge.

Gatekeeper for practitioners. ECMH competency systems could be used to ensure that people hired as ECMH specialists or for ECMH purposes have the qualifications to work with young children and their families. At this point, however, in none of the cases reviewed in this study has any state government entity taken on the obligation of overseeing the competency system or the process of endorsement.

Financial reimbursement. There are some emerging signs that use of competencies can have implications for reimbursement or remuneration. A few state governments are establishing new rules that tie Medicaid reimbursement for certain ECMH activities to provider endorsement, using the MI-AIMH endorsement program. Such activities suggest the possibility of using competencies for decisions in hiring, salary, and program budgeting.

needed for young children. Similarly, there is little empirical evidence that these systems are effective in developing competent ECMH specialists.

We also recommend that current and future competency systems take a critical look at the appropriateness of their content for the preschool-aged population. When competency systems are developed or adopted, professionals with expertise in the mental health needs of preschoolers should be involved in the process. This includes professionals working with preschool children in larger school systems, such as school psychologists and early childhood special education teachers. There are both developmental and clinical topics relevant to mental health issues for 3- to 5-year-olds that receive little attention in the current competency systems.

Conclusion

Should a national set of early childhood mental health competencies be developed to guide the field, as has been suggested (e.g., Meyers, 2007)? Our analyses suggest the need for caution in moving toward national competencies. Although there are many common features across the six systems we reviewed, there are enough differences in content, structure, and purpose to suggest local concerns and issues are still very relevant for training, professional development, and endorsement. The experience of the seven states using the Michigan competencies and MI-AIMH endorsement program will provide valuable insights regarding how these local concerns and issues are addressed for groups trying to develop a common process and language. In the meantime, more evaluation needs to occur with the existing systems, and more dialogue is necessary to ensure that the mental health concerns of older children within this age range are appropriately addressed.

Glossary of terms

Early Childhood Mental Health (ECMH): Connoting social and emotional health or well-being for children and their families up to 5 years of age, with an absence of emotional and behavioral challenges. For the purposes of the research described in this brief, we borrow from the ZERO TO THREE Infant Mental Health Task Force in describing this realm as the developing capacity of the young child to (a) form close and secure relationships; (b) experience, regulate, and express emotions; and (c) explore the environment and learn.

ECMH Specialist: A professional who works with young children and their families who are experiencing or are at risk for emotional and behavioral challenges. All of the competency systems discussed here define different levels of such professionals and do not consider them all to qualify as "specialist." We use ECMH specialist more generically and without regard to these levels, for the sake of simplicity.

Competency System: A detailing of areas of knowledge and practice required of a specialist. Although some documents have used "training standards" or "training content" (depending on the purpose of their system), we have assumed these to be equivalent.

Endorsement: The process of a professional organization's provision of public approval to a candidate who has demonstrated their abilities and knowledge as detailed by an established competency system. Endorsement differs from licensing in that the latter refers to the granting of permission or authorization to practice in a way that would otherwise be unlawful. Endorsement is similar to certification and credentialing, but implies a less formal process.

References

Coates, A. O., Schaefer, C. A., & Alexander, J. L. (2004). Detection of postpartum depression and anxiety in a large health plan. *Journal of Behavioral Health Services & Research, 31*(2), 117–133.

Cutler, A., & Gilkerson, L. (2002). *Unmet Needs Project: A Research, Coalition-building, and Policy Initiative on the Unmet Needs of Infants, Toddlers, and Families (Final report).* Chicago: University of Illinois–Chicago and Erikson Institute.

Gilliam, W. S. (2005). *Prekindergarteners left behind: Expulsion rates in state prekindergarten systems.* New Haven, CT: Yale University Child Study Center.

Gomby, D. S. (2007). The promise and limitations of home visiting: Implementing effective programs. *Child Abuse and Neglect, 31*, 793–799.

Lusskin, S. I., Pundiak, T. M., & Habib, S. M. (2007). Perinatal depression: Hiding in plain sight. *Canadian Journal of Psychiatry, 52*, 479–488.

Meyers, J. C. (2007). Developing the work force for an infant and early childhood mental health system of care. In D. F. Perry, R. K. Kaufmann, & J. Knitzer (Eds.), *Social and Emotional Health in Early Childhood: Building Bridges between Services and Systems* (pp. 97–120). Baltimore, MD: Paul H. Brookes Co., Inc.

Patton, M.Q. (1987). *How to Use Qualitative Methods in Evaluation.* Newbury Park: Sage Publications.

Stevens, J., Ammerman, R. T., Putnam, F. G., & Van Ginkel, J. B. (2002). Depression and trauma history in first-time mothers receiving home visitation. *Journal of Community Psychology, 30*, 551–564.

Herr Research Center for Children and Social Policy

The Herr Research Center for Children and Social Policy informs, guides, and supports effective early childhood policy in the Great Lakes region. Unique in its regional approach, the center brings together perspectives from policy and research to promote the well-being of young children from 0 to 8 and their families. Our researchers design and conduct original research, evaluations, and analysis on the optimal organizational design, funding mechanisms, monitoring practices, and implementation strategies of early childhood programs and services. We then channel this knowledge to state and local legislators, program administrators, advocates, foundation officials, and other participants in the policy process to improve the overall effectiveness of programs and policies for young children and their families.

Currently, major work produced by the Herr Research Center for Children and Social Policy is concentrated primarily in the areas of early childhood education, mental health and social-emotional well-being, and understanding the needs of immigrant children and their families.

The center is endowed with a generous gift from the Jeffrey Herr Family, with additional support from the McCormick, Joyce, and Spencer Foundations and the Children's Initiative, a project of the Pritzker Family Foundation.

Administration

Eboni C. Howard, Ph.D.
Director, Frances Stott Chair in Early Childhood Policy Research

Celina Chatman-Nelson, Ph.D.
Associate Director

Authors

Jon Korfmacher, Ph.D., is a faculty associate of the Herr Research Center, an associate professor at Erikson, and a graduate fellow of ZERO TO THREE. Aimee Hilado, M.S., M.S.W., is a research assistant with the Center and a doctoral student in social work. The two are currently completing a study of early childhood mental health workforce development and training.

Erikson Institute

Erikson Institute is an independent institution of higher education that prepares child development professionals for leadership through its academic programs, applied research and community involvement. It is the nation's only graduate school to focus exclusively on child development from 0 to age 8. Erikson advances the ability of educators, practitioners, researchers and decision-makers to improve the lives of children and families.