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Creating a Workforce in Early Childhood Mental Health: Defining the Competent Specialist

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Summary

What are early childhood mental health services? Who should provide them, and who has the right to say who can provide these services? In the past decade different workgroups and organizations have attempted to define the characteristics of competent early childhood mental health (ECMH) providers in order to guide the field and establish common benchmarks for quality. These sets of competencies define topics of knowledge that ECMH providers should have, establish areas of service and treatment, and outline requisite skills and abilities.

At the Herr Research Center for Children and Social Policy at Erikson Institute, we have compared six sets of competencies, each developed by a group of professionals attempting to establish standards and training guidelines for providers within their particular states: Michigan, California, Vermont, Florida, Indiana, and Connecticut. Our comparison across these six state systems focused on their purpose, structure, content, and implementation. Because no national standard for what an ECMH professional should know or do has been established, the extent to which these state systems

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overlap in content and approach suggests a convergence of beliefs and ideas about competency standards.

Overall, there is a fair amount of similarity across the six systems—in purpose, content, and even language used to describe competencies. The systems converge on a global definition of who can consider themselves an ECMH specialist, encompassing different levels of expertise and multiple disciplines. All rely heavily on an infant mental health orientation to treatment and care (e.g., acknowledging the importance of relationships, the importance of other family members in the life of the child, the need to pay attention to the family's life context, and the value in self reflection), sometimes at the expense of excluding important features of other service delivery models. Although all six systems can be applied across the entire birth-to-5 age range, they focus more heavily on social-emotional issues in the birth-to-3 period than on these same issues in preschool (3 to 5 years).

So far, these competencies are not "high stakes" standards; for the most part, they are not connected to any form of licensure, state oversight, or financial reimbursement. Although one system (Michigan) is embedded in an established endorsement program that has been licensed for use by infant mental health associations in other states, the other systems are being used mainly to guide training and professional development activities. It is an open question regarding who should provide oversight of the ECMH workforce—whether this should be a state function, a role for local professional associations within a state or community, or a task for a national group or organization. In addition, there is a continuing need for evaluation of these competency systems, to figure out how to accurately they capture the knowledge and abilities of those seeking to address the mental health needs of young children.

Note

This research report was revised on June 19, 2008. Changes were made to the table in Appendix A on pages 31 and 32 and two lines of text in the body of the report were altered to reflect those changes.

A Note About Nomenclature

One of the challenges in analyzing early childhood mental health competencies is deciding upon a common set of terms to use to describe them. For the sake of comparison, below we describe the terms used in this document.

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. There are many different ways to define what is meant by social and emotional well-being in this age range (as well as emotional and behavioral challenges). 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 (Zero To Three, 2002). In other words, the central tasks of this age are to learn how to be with others, control oneself, and master the world.

For the purposes of this document, we align social-emotional well-being with mental health. There are political and professional undertones for using "mental health" versus "social-emotional health" at this age range. For example, it might seem more palatable to some stakeholders not to refer to mental health when talking about young children. Using the term social-emotional may also serve to include a broader set of professionals who might not otherwise see themselves as working in the field of mental health. On the other hand, there is the tendency when *not* using the term mental health to overlook the very real possibilities of young children suffering from emotional pain and behavioral challenges, where they and their families feel "stuck" and unable to move (Emde, 2001). It depends, in other words, on which end of the continuum one wants to focus (see also Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2007). We use ECMH in this document even when the competency system refers to itself as focused on social-emotional health.

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 professionals who work with families in this capacity, so this is a very broad term and open to some debate. Vermont reserves the term "specialist" only for its highest level of competency, while Michigan distinguishes between an "infant family specialist" (Level 2) and an "infant mental health specialist" (Level 3). Three systems even include parents or other family members as possible targets for their systems, which strains the definition as set here. We use the term ECMH specialist, however, for the sake of simplicity. It is also a reasonable assumption that a person who can demonstrate their alignment with all of the areas of specialized knowledge and practice defined by these competency systems can consider themselves a specialist, at least at their specified level.

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 giving public approval to candidates who have demonstrated their abilities and knowledge as detailed by a particular competency system (such as through testing or portfolio review). There is considerable uncertainty regarding the use of the term "endorsement" or related terms such as "certification", "credential", or "license." *Endorsement* implies that a professional association has given their approval or assurance that a candidate meets its definition of a competent professional, although this assurance does not have legal standing. *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 typically applied narrowly to a designated profession, such as psychology, social work, or medicine, and are governed at the state level. Since the ECMH systems detailed here are purposefully multidisciplinary, an ECMH license is an unlikely outcome of these competency systems.

Endorsement is very similar to *certification*, a term also used to describe the process of demonstrating professional competence. An outcome of a certification process is a *credential*, a demonstration of a person's skills. In short, there is little practical difference between the terms endorsement, certification, and credential, all of which can occur at the local, state, or national level. Endorsement, however, is often viewed as an add-on to a professional's existing license or certification (so, for example, a state may allow a specialized endorsement to be added to a candidate's already existing teacher certification or license). The Michigan Association for Infant Mental Health (MI-AIMH) uses the term endorsement for their process, in part, to suggest that this designation does not replace the requirements of a candidate's profession (see Weatherston, Moss, and Harris, 2006).

This past decade has witnessed increasing attention among researchers and practitioners regarding the social-emotional and mental health needs of children ages 5 years and younger. For example, recent reports describe 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, & Van Ginkel, 2002; Gomby, 2007), and reported concerns of child care and early intervention providers (Cutler & Gilkerson, 2002). Early childhood mental health (ECMH) services address these and other problems, but states lack efficient systems for delivering these services. ECMH services are characterized by some unique features that have contributed in some way to this hindrance. Moreover, there does not appear to be a viable workforce of specialized providers who can meet the expressed mental health needs (Meyers, 2007) of young children. As a consequence, there is an inadequate supply of ECMH services, and most of those that do exist are underfunded.

Several unique features distinguish ECMH services from mental health services for older children and adults (Knitzer, 2000). First, ECMH services often are viewed in the context of prevention, and thus may not be specifically dealing with serious emotional disturbance. Second, ECMH services often are delivered in natural settings for young children, such as home or child care, and often include indirect services to the parent or caregiver. This presents an added complexity in that it requires alternate models of treatment and funding. Third, assessment and diagnosis can be challenging at this age period. The most widely accepted diagnostic systems for mental disorder (e.g., DSM-IV) have few categories that are applicable to younger children; and the most widely used system for young children (DC: 0-3) has not yet been accepted by the health care industry. Finally, children's mental health providers often lack knowledge regarding specific issues of early childhood and family development.

Although the clinical specialty of early childhood mental health has been in existence for at least 30 years (for review, see Fitzgerald & Barton, 2000), few clinical training programs offer this specialization. Moreover, as we will discuss, the ambiguous nature of the field makes it difficult to define exactly who should be providing these services. In the past decade, there have been attempts to define and categorize specific competencies for ECMH providers in order to guide the field and establish a common nomenclature and benchmarks for quality (see "A Note About Nomenclature"). These sets of competencies, in general, define areas of knowledge that ECMH providers should have, establish areas of service and treatment, and outline skills and abilities that practitioners at different levels should possess.

We have identified six sets of competencies, each developed by ad hoc groups of professionals with expert knowledge in children's mental health working to establish standards for providers within their particular state (see Table 1).[1] The competency systems are at different levels of development. The Michigan system, for example, is actively disseminated to other states as part of an endorsement program, 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*	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.
**This system is currently under revision, with changes expected in summer 2008.*

To what extent do these systems differ from each other? In this research report, we will first describe the above competency systems, and then compare them with regard to purpose, structure, content, and implementation. Although no national standard has been established for what an ECMH professional should know or do, the extent to which these competency systems cover the same territory suggests a convergence of beliefs and ideas. Unique qualities in only one or a few competency systems might reflect local issues or provide information to guide revision of the other systems to correct an oversight. We will conclude by discussing the use and administration of these competency systems, and by raising questions for future investigation.

Current Systems and Their Uses

As noted earlier, at least six different ECMH competency systems have been developed.[2] We discuss them chronologically, in order in which they were developed.

Michigan

The Michigan competencies are part of the Michigan Association for Infant Mental Health's (MI-AIMH) endorsement program. The competencies focus on issues pertaining to children birth to 3 years of age and are embedded within four levels of endorsement, based on the education and related experience of the participants

[2] We became aware of two other competency systems too late to include them in the current analyses: one developed by the Infant Mental Health Promotion Project of the Sick Kids Hospital in Toronto, Canada, and another by the Wisconsin Association for Infant Mental Health. There may, of course, be other systems of which we are not aware.

Table 2. 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 (CDA) or associate's degree	Bachelor's degree	Master's degree or Ph.D.	Master's degree, Ph.D., or M.D.
Reflective Supervision and/or Consultation	N/A	Minimum of 24 clock hours within 2 years	Minimum of 50 clock hours within 2 years	Minimum of 50 clock hours within 2 years
References	Three (one must meet requirements for Level 3 or 4 endorsement)	Three (one must meet requirements for Level 3 or 4 endorsement)	Three (one must be from a reflective supervisor/ consultant)	Three (one must be from a reflective supervisor/ consultant)
Written Examination Required	No	No	Yes	Yes
Service Examples	Childcare worker, doula	Part C service coordinator, NICU nurse, parent educator, CPS worker	Mental health clinician, clinical nurse practitioner, early intervention specialist	Researcher, faculty member, policy specialist, early intervention administrator

From Weatherston et al., (2006).

(MI-AIMH, 2002). The association specifically uses the term *endorsement*, as opposed to *certification* or *licensing*, to emphasize that the process is an overlay to whatever professional qualifications the 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 birth to age 3.

There are four levels of endorsement, and the application is evaluated based on the requirements for the candidate's designated level: infant/family associate, infant/family specialist, infant mental health (IMH) specialist, and IMH mentor (see Table 2). The infant/family associate (Level 1) has either an associate's degree or child development associate (CDA) degree, and typically holds such positions as childcare worker or paraprofessional home visitor. Level 1 candidates are required to show documentation of 30 hours in-service training, sign a code of ethics document, and receive reference ratings from three supervisors, one of whom meets the requirements for a Level 3 or 4 endorsement.

The infant/family specialist (Level 2) has a bachelor's degree and 2 years of early childhood work experience as a minimum requirement. Individuals at this designation typically hold positions such as NICU nurse or child welfare worker. All other Level 1 requirements apply, in addition to a minimum of 24 hours of reflective supervision within the past 2 years.

IMH specialists (Level 3) have a master's degree or Ph.D. and 2 years of early childhood experience. Examples of the IMH specialists include licensed clinical social workers, psychologists, clinical nurse practitioners, and highly trained early intervention workers. As with earlier levels, Level 3 candidates must show documentation of 30 hours of in-service training and sign a code of ethics document. They must have a minimum of 50 hours of reflective supervision and/or consultation within the past 2 years, and at least one of their three reference ratings must be from their reflective supervisor or consultant.

Finally, the IMH mentor (Level 4) is an individual with a master's degree, Ph.D., or M.D. degree and has 3 years of postgraduate experience as a policy and/or practice leader in IMH. Examples include researchers, physicians, policy specialists, and administrators for infant-toddler programs. Level 3 and Level 4 candidates have similar requirements, differing primarily

in employment focus, with Level 3 directed towards clinical practice and Level 4 directed towards policy, research, and training.

After the review of the portfolio requirements, MI-AIMH notifies candidates in Level 1 and 2 about whether they have received endorsement. Level 3 and 4 candidates must also complete and pass a 3-hour, two-part exam that includes both multiple-choice questions (covering both early development and clinical issues) and a qualitative assessment of the candidate's reflective capacities (with candidates responding in writing to case vignettes). This exam was developed by MI-AIMH with assistance from Melissa Kaplan-Estrin of Wayne State University (see Kaplan-Estrin, 2003). It uses a test bank from which questions are circulated, and qualitative responses are reviewed by an expert panel using a 5-point rating scale. In order to maintain endorsement status, participants must submit annual documentation of completing 15 hours of training that promotes infant mental health and must renew their membership with the MI-AIMH.

Table 3. Michigan Competency Domains by Level

Level	Competency Domains
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	*All domains of Level 1, plus the following additional knowledge and skill areas:* Therapeutic practice Mentoring
3: Infant Mental Health Specialist	*All domains of Levels 1 and 2, plus the following additional knowledge and skill areas:* Psychotherapeutic and behavioral theories of change Disorders in infancy/early childhood Mental and behavioral disorders in adults Treatment planning Developmental guidance Supportive counseling Parent-infant/toddler psychotherapy
4: Infant Mental Health Mentor	*All domains of Levels 1–3, plus the following additional knowledge and skill areas:* Adult learning theory and practice Research and evaluation[3] Reflective clinical supervision Crisis management Consulting Group process Program management and development

The content of the competencies differ across levels, although requirements in one level build upon the next as candidates seek higher levels of endorsement (see Table 3).

Currently, the Michigan system has been licensed to Arizona, Kansas, Minnesota, New Mexico, Oklahoma, and Texas, although most of these states have just begun to establish a local endorsement process. Overall, this system acknowledges professionals already in the field and is not considered a training program, although the competencies that are embedded in this system could be used as the basis of a training program (and were originally developed in earlier form to guide training programs in Michigan).

California

Training standards[4] from California were developed as part of the pilot program "California's Infant, Preschool, and Family Mental Health Initiative" (CA-IPFMHI), which was funded by the First 5 California Children and Families Commission operated through California's Department of Mental Health from 2001 to 2003

[3] Michigan guidelines note that a Level 4 endorsee should be an active researcher in the study of infant relationships, attachment, infant development and behavior, and/or families.

[4] *Training standards* is the term used most regularly by CA-IPFMHI to describe the outline of knowledge and practice areas. These areas are also, however, referred to as competencies within their documentation (e.g., CA-IPFMHI, 2003a), the term we are using here to describe them.

Table 4. California Participant Requirements by Training Track

Category	Core Providers	Mental Health Professionals
Professional Background	Varied, including child care, early intervention, nursing, occupational therapy, special education	Eligible for mental health licensure—e.g., psychologists, marriage and family therapists, licensed clinical social workers, psychiatrists
Course work Requirement	90 hours	180 hours
Supervised Clinical Experience	60 hours	500 hours

(CA-IPFMHI, 2003a, 2003b; Knapp, Ammen, Arstein-Kerslake, Poulsen, & Mastergeorge, 2007). The project was a collaborative effort by WestEd Center for Prevention and Early Intervention and eight counties throughout the state—Alameda, Fresno, Humboldt, Los Angeles, Riverside, Sacramento, San Francisco, and Stanislaus. 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 on birth to age 5.

Unlike Michigan, the standards that emerged from CA-IPFMHI were developed to guide a training protocol. This training protocol included a combination of academic course work at the undergraduate and graduate level; workshops and continuing education courses; supervised clinical practicums, internships, and postdoctoral training; and clinical experience with supervision.

Two sets of standards were identified based on the participants' professional background (which, in turn, determined their level of training): mental health professionals and core providers. Those in the mental health professional training track are required to document twice as much course work and more than eight times the required amount of supervised clinical experience as those in the core provider track (see Table 4).

The California model divides training into two broad areas, birth to 3 and 3 to 5, but also allows for their integration again into a more comprehensive birth to 5 sequence. The competencies divide into eight categories, regardless of the developmental period covered (see Table 5).

Table 5. California Competency Domains: Birth–5 Years

Parenting, family functioning, and child-parent relationships
Infant/Toddler/Preschool Development
Biological and psychosocial factors impacting outcomes
Understanding high-risk influences upon early relationships
Risk and resiliency
Observation, screening, assessment, diagnosis and intervention
Interdisciplinary collaboration
Ethics

In general, the domains of knowledge expected of core providers and mental health professionals are similar, although the training of the mental health providers is more intensive and practice-based, to allow "the mental health professional to be able to move from an understanding of core concepts to more in-depth clinical applications and interventions appropriate for young children and their families within the context of their agency and practice area" (CA-IPFMHI, 2003a, p. 13). The training for core providers is focused on increasing understanding of early mental health concepts and principles of practice to assist in their ability to provide preventive or health promotion services, and to guide their referrals to mental health professionals.

It was assumed that participants could demonstrate competency in the knowledge and service domains through their participation in the training and supervised clinical experience. This system, however, did not reach the level of 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). Participants were still

encouraged to develop a personal profile to document training and clinical work, and a portfolio template was developed to assist in this documentation. Although "the longer-term goal of establishing a statewide entity responsible for personnel standards and a state endorsement, certification and specialization in this area" (CA-IPFMHI, 2003a, p. 45) was stated, this did not occur. County-based training remained available after the initial pilot, and the state department of mental health continued funding a modified form of the program. In the post-pilot phase, efforts were focused on integrating mental health services into state-funded Special Needs Programs, with the competencies as "a reference in determining education, training and experience needed for qualified core and mental health service providers" (Arstein-Kerslake, Knapp, & Merchant, 2005, p. 37). More recently, workgroups have been meeting to create a new set of competencies. These competencies are based on the original set, but expanded to three levels. They are expected to be completed in the summer of 2008 (C. Lilas, personal communication, February 21, 2008).

Vermont

Over a 4-year period in Vermont, representatives from special education, mental health, and early intervention and higher education collaborated to develop an early childhood mental health competency protocol that could be used to guide development of a system of service delivery around social-emotional well-being in young children and their families.[5] These competencies, finalized in 2007, are aligned with other competency protocols such as Vermont's Early Childhood Professionals (developed by the Northern Lights Career Development Center) and the Higher Education Collaborative on Early Childhood Education and Early Childhood Special Educator endorsements, as well as related college course work (Vermont Early Childhood and Family Mental Health Competencies Practice Group, 2007). Unlike the other five states, Vermont's program focuses on children from birth to 8 years and their families.

Four levels of professionals who might engage in ECMH training have been identified. They are similar to the levels developed in the Michigan system, although educational credentials and degrees are implied, rather than stated explicitly as with Michigan:

- *Foundation professionals*: childcare 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*: childcare 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.

Although Michigan emphasizes more leadership and administration at its highest level, Vermont maintains somewhat greater clinical emphasis at Level 4.

The Vermont competency categories are broken down further into subsections (Table 6) that vary in specificity and depth depending on the level of the candidate. Although the work group notes 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 categories and subcategories of competencies.

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[5] Work to support the social-emotional needs of young children in the state had already been in process, however, including an earlier outline of mental health competencies and the development of a resource guide to help early childhood professionals to deal with challenges in working with young children and their families.

Table 6. 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

Currently certification or endorsement is not available in the state. The competencies are considered to have multiple purposes, but are primarily intended to guide training, education, and professional development.

Florida

A work group from Florida State University (FSU) drafted a three-level framework of ECMH service provision (FSU Center for Prevention and Early Intervention Policy, 2001).[6] It is based on the anticipated level of training and service delivery of the ECMH workforce, as shown in Table 7. The first level, *front-line providers,* which includes childcare providers, home visitors, and caseworkers, is seen as having a service responsibility for strengthening the caregiver/child relationship, supporting responsive caregiving in their work with clients, and making referrals for further screening and/or assessment if needed. The second level, *developmental professional*, refers to social workers, psychologists, child development specialist, and nurses. Level 2 service responsibilities are directed at development and relationship-focused early intervention with children and their families. Candidates for this competency level require skills in identifying social-emotional concerns that require attention. They must be able to integrate relationship-based practices with the child's existing services, provide direct service focused on the family's and/or child's needs, and provide consultation that would support the parent-child relationship. Finally, *IMH specialists* refer to master's-level professionals or above who have additional training in infant mental health therapy and psychopathology, including knowledge in infant/toddler development and adolescent and adult psychopathology, as well as understanding of the importance of quality parent-infant interactions. The Level 3 candidates 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 family.

Specific competencies have been articulated for Level

[6] Although the FSU document title is "Florida's Strategic Plan for Infant Mental Health," the target population is children birth to 5 years of age.

Table 7. Participants and Service Responsibilities for Early Childhood Mental Health Providers in Florida by Level

Category	Level 1: Front-line Providers	Level 2: Developmental Professionals	Level 3: Infant Mental Health Specialists
Service Providers	Parents, childcare providers, health care providers, home visitors, parent educators, social workers, child protection caseworkers, police officers, judges, lawyers	Social workers (MSW), psychologists, mental health therapists, child development specialists, early interventionists, therapists (OT/PT/speech), public health nurses, developmental pediatricians	Master's level professionals or above who have additional training in IMH therapy/ psychopathology
Priority Population	Expectant families and families of all children birth to age 5	Families of children with delays, disabilities, health problems, or multiple risk factors	Families with children diagnosed with emotional disorders, severe mental health problems, or experience of abuse, neglect or violence.
Service Responsibilities	Strengthening the caregiver/ child relationship; providing responsive caregiving training	Promoting developmental, relationship-focused early intervention	Provides infant mental health treatment

Note: Portions of this chart include information taken from the Florida Strategic Plan for Infant Mental Health *(FSU Center for Prevention and Early Intervention Policy, 2001).*

3 only. A national panel of 23 experts rated and rank-ordered 143 competencies in seven domains (see Table 8) believed to be required of early childhood mental health professionals (Quay, Hogan, & Donohue, 2007).

Table 8. Florida Competency Domains: Level 3

Normal development
Abnormal (atypical) development
Emotional/Behavioral disorders
Assessment
Intervention
Community resources and referral services
Organizational skills and communication skills

Currently, the competencies are being used both as a guide for the FSU training program in infant mental health and as a self-assessment for current participants in the program (A. Hogan, personal communication, December 19, 2007). To date, Florida has no plans to develop an endorsement process or establish a state credential.

Indiana

The Indiana State Department of Health proposed the development of the Early Childhood Comprehensive Strategic Plan in June 2005 to address concerns regarding the lack of coordination in early childhood initiatives. An additional concern was that inadequate staff training (especially in rural areas) was leading to the dissemination of inaccurate and confusing information for families, and missed opportunities for services (Indiana State Department of Health, 2007). Sunny Start, an initiative that came from the Early Childhood Comprehensive Strategic Plan, formed the Social and Emotional Training and Technical Assistance Committee. This committee was developed to create a plan for promoting social and emotional health and development through screening, dissemination of information, and training of personnel.

Members of the Social and Emotional Training and Technical Assistance Committee reviewed existing competency sets (including those that had been drafted by the Indiana Association of Infant and Toddler Mental Health), selected the format, and determined

the competencies that would be required for Indiana's workforce and service delivery systems. The committee then approved the competencies, followed by approval from the core partners of Sunny Start. These competencies have been disseminated in a document to be used to guide training and service delivery in Indiana.

The Indiana ECMH competency system focuses on children birth to 5 years of age and consists of three levels of competencies, categorized by the type of services that will be provided:

- *Promotion professionals* (Level 1) are responsible for working with all children and families as front-line providers. Examples of Level 1 professionals include the following: early child care/education professionals; primary health care providers; paraprofessionals; and religious institution nursery/education providers. As with other competency systems (such as Florida and Vermont), Indiana also includes parents and family members under Level 1.
- *Prevention professionals* (Level 2) are responsible for working with children who are at risk for social-emotional developmental problems and their families. Level 2 candidates include developmental professionals such as Healthy Families home visitors/parent educators, foster parents, early interventionists, Head Start/Early Head Start workers, public health nurses, licensed social workers (LSW, early childhood special education personnel, legal system personnel, public safety personnel, as well as pediatricians and developmental-behavioral pediatricians.
- *Intervention professionals* (Level 3) are responsible for working with children who have persistent mental health challenges and their families. Level 3 candidates include licensed mental health professionals, such as psychologists, licensed clinical social workers (LCSW), psychiatrists, marriage and family therapists; licensed mental health counselors; psychiatric nurse practitioners; and developmental-behavioral pediatricians.[7]

Each candidate level requires competencies in six different domains (Table 9). The content within each category varies in terms of specific details and service requirements depending on the level of the candidate.

Table 9. Indiana Competency Domains

Parenting, family functioning, and child/parent relationships
Child development
Biological and psychosocial influences
Observation, screening, assessment, diagnosis, and intervention
Interdisciplinary collaboration
Ethics and supervision

Indiana's competency levels build on one another. For instance, Level 2 candidates are required to have mastered all competencies in Level 1. Level 3 candidates are expected to have mastered all competencies in Level 1 and 2. Currently, the training protocol is under development and there are no current plans to seek the implementation of an endorsement process.

Connecticut

In Connecticut, the development of competencies has occurred in the context of the Building Blocks initiative, a systems of care program funded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) beginning in 2005 for the southeast region of the state. Workforce development is a major goal of Building Blocks, and to this end a work group has developed a training sequence to be rolled out regionally at first, then statewide. The training covers three domains: (a) promotion and strengthening; (b) prevention and intervention; and (c) screening assessment and diagnosis (M. Holmberg, CT Association for Infant Mental Health, personal communication, February 27, 2007).[8] The domains include an overview of information related to systems of care, infant mental health, and positive behavior support, as well as topics specific to each domain. Although levels have not been articulated as part of the trainings, the training domains correspond to three levels: promotion and strengthening for frontline providers; prevention and intervention for mental health specialists; and screening, assessment and diagnosis for professionals who focus on children

[7] Developmental-behavioral pediatricians are listed at both Level 2 and Level 3.

[8] Draft documents from November 16, 2006, were presented that outline the training sequences and competencies.

with diagnosable mental health problems. In addition, the grant application for Building Blocks proposed a three-level training program modeled on the Florida competency system (Building Blocks, *n.d.*).

Given the early stage of development, the Connecticut system cannot yet be considered an established competencies system. Nevertheless, with workforce development a major goal and focus of the evaluation of the Building Blocks initiative, their progress is worth noting. Ultimately, there is the hope that a formal endorsement process will come out of the initiative activities in collaboration with state groups such as the Connecticut Association for Infant Mental Health (Building Blocks, *n.d.*).

Comparing Competency Systems

In this section of the research report, we explore similarities and differences among the six systems we have reviewed, dividing our comparison into two broad areas: (1) a structural comparison involving professional levels, age range, and purpose; and (2) a content comparison involving knowledge and practice. First, however, we discuss a philosophical underpinning—namely, the shared focus on infant mental health—of the ECMH competency systems.

Focus on Infant Mental Health

One important commonality among the six systems is the focus on infant mental health. This term refers generally to the social emotional well-being of children from birth to age 3. More specifically, however, infant mental health has developed as a philosophy of care for young children, often including children 3 to 5 years. This infant mental health approach originated in the works of Selma Fraiberg and others, and has been extended and promoted by organizations such as Zero To Three.[9] As Fitzgerald and Barton (2000) note in their historical overview, although there is no set definition for infant mental health, it is "rooted in the understanding that developmental outcomes emerge from infant characteristics, caregiver-infant relationships, and the environmental contexts within which infant-parent relationships take place" (p. 3).

Zero To Three's Infant Mental Health Task Force defines infant mental health as "the healthy social and emotional development of a child from birth to 3 years, and a growing field of research and practice devoted to the promotion of healthy social and emotional development; prevention of mental health problems; and treatment of the mental health problems of very young children in the context of their families." Furthermore, "Responsive relationships with consistent primary caregivers help build positive attachments that support healthy social-emotional development. These relationships form the foundation of mental health for infants, toddlers and preschoolers" (Zero To Three, *n.d.*).

Lieberman (1998) extends these points by outlining five principles that guide infant mental health:

1. Infants exist in relationships, mostly dyad-specific.
2. Individual differences are an integral component of an infant's functioning.
3. Infants exist in particular environmental contexts that influence functioning.
4. IMH practitioners make an effort to understand how behaviors feel from the inside, not just how they look from the outside.
5. The intervener's own feelings and behaviors will impact the intervention.

These and other definitions, although somewhat different in emphasis, acknowledge 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 also Kaplan-Estrin & Weatherston, 2005).

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. The most immediate consequence of a holistic approach is that infant mental health is multidisciplinary. Different professionals work in different contexts in treating or providing services to children, and the provision of infant mental

[9] An organization founded by colleagues and students of Selma Fraiberg and originally called the National Center for Clinical Infant Studies.

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 providers of these services.

Structural Comparison of Competency Systems

Looking across the competency systems established and evolving in six states, we see that three elements are addressed in each: professional levels for ECMH providers, the age range of children to be served, and the purposes of each system. In this section, we will explore how these elements are incorporated into each state's system.

Professional level. Who can be an early childhood mental health specialist? Each system embraces a broad definition of the early childhood mental health provider. Although the labels may differ, the providers within each system range from child care workers with associate's degrees to licensed therapists with a doctorate or medical degree. Three of the systems (Florida, Indiana, and Connecticut) also note that parents or family members should be included, although few details are provided about how they would be integrated into workforce development activities.

At the same time, there are attempts to make distinctions between what is expected of the different professions, and what training should be provided. Most of the models distinguish at least between the entry-level worker and the specialist.[10] For Michigan and Vermont, this is roughly the distinction between the first two and latter two levels. For Florida and Indiana, Level 3 appears to stand out from the other levels (this is emphasized by the Florida work group having so far only created competencies for this third level). California is something of an exception in that the system makes the distinction between licensed/certified mental health professionals and everyone else (core providers) who provide ancillary services (health specialists as well as child care providers). The California system specifically avoided the term *levels* in order to guard against a hierarchical training system (see Finello & Poulson, 2005); however, when placed in the context of the other systems, it does appear to have a bilevel structure (and current work suggests that levels will be explicitly incorporated into the competencies revision).

Age range. The definition of early childhood varies among the systems. The Michigan system focuses solely on families with children birth to 3 years of age, while the Vermont system covers the age range of birth to 8 years. The other four programs encompass development from birth to 5 years. Overall, then, the six programs are similar in covering issues relevant to the first 3 years of life, with all but one (Michigan) extending coverage into the preschool years. A related question, however, is the extent to which the content of the competency systems reflect the issues relevant to these age ranges. This topic will be taken up in the next section.

Purpose. Among the six systems, three programs have specific, operationalized purposes. California's and Connecticut's systems are linked to a specific training program, while the Michigan system is part of an endorsement process. The other three competency systems were developed to guide training and professional development more generally.

Although the Michigan competencies are not officially aligned with any state certification or licensing system, there is evidence that they are being used to guide employment and hiring of early childhood mental health providers in that state. In a number of state-funded programs, service providers are required to submit portfolios in order to reach endorsement at a certain level. For example, ECMH consultants in the Child Care Expulsion Project need to be endorsed at Level 2 or Level 3, depending on their educational background. Rather than placing the burden specifically on the individual employees, however, the endorsement process is built into the grant-making process. The state department of community health, in making grants to agencies, requires applicants to detail a plan by which they will provide the necessary reflective supervision and support to allow current and prospective employees to develop their portfolios and successfully seek endorsement. In this way, the system attempts to "put standards in place

[10] As noted earlier, Connecticut has not developed levels specifically, but noted an intention to follow Florida's three-level structure in their grant proposal.

where there are none and build capacity through training and reflective consultation" (D. Weatherston, personal communication, August 20, 2007).

Competencies Analysis

In reviewing the content of the individual state systems, we used content analysis (e.g., Patton, 1987), a 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 inductively grouped under nine more inclusive categories of content, as described in Table 10. The full listing of content areas, broken down by competency system, is included in Appendix A.

The level of detail provided in describing the content areas varies considerably across the systems. California's written materials provide much more skeletal information on the topics. For example, a content area may simply be listed as "attachment issues." On the other hand, Michigan and Vermont provide explicit examples of areas of competency, as seen in this description in the Vermont system, designated as a Level 2 competency: "Demonstrates knowledge of the role relationships play in social/emotional development and specific positive and negative factors that influence attachment and bonding, and their effects." This variation in detail limits somewhat the direct comparisons that can be made. Thirty-nine content areas are covered in five or six of the competency systems (see Appendix A), while 28 areas are unique to either one or two of the systems. The rest are covered in three or four of the systems. This suggests a plurality, but not necessarily a consensus, regarding necessary areas of knowledge and ability.

Basic principles. Certain principles of practice emerge repeatedly in the different competency systems. These include the importance of attachment; paying attention to cultural, ethnic, and language diversity in families; maintaining a strength-based orientation to practice; engaging in family-centered practice; and ethics.[11] All systems reference the concept of "ghosts in the nursery" (Fraiberg, 1980), or the need to pay attention to the influence of the caregiver's relationship history on their relationship with their child.

To varying degrees, all six competency systems address the importance of relationships. Relationship-based practice is a central tenet of early childhood services (Weston, Ivins, Heffron, & Sweet, 1997; Emde, Korfmacher, & Kubicek, 2000), although the meaning of this term is somewhat broad and open to interpretation. It can refer generally to the interdependent web of relationships in which the child develops, or more specifically to the importance of the parent-child relationship. The ability to *form* relationships with families, another aspect of relationship-based practice (see Emde et al., 2000), is mentioned by all but one of the systems.

Other principles of early childhood services are less frequently mentioned. Outcomes-based or evidence-based practice, a major movement in mental health care systems and policy (e.g., American Psychological Association Presidential Task Force, 2006) is noted by only three systems, as is providing services in natural settings. Being able to take multiple perspectives (i.e., understanding both the needs of the child and the parent) is noted specifically only by the Michigan system.

Developmental knowledge. All systems list as a competency the understanding of child development, although the specific content varies by system. Only three systems specifically mention preschool development while five of the six note infant/toddler development (and only Vermont makes note of development past preschool). Although the systems sometimes break developmental knowledge down to specific categories (cognitive development, language and literacy development, pregnancy), they typically discuss development in more general terms. For example, in the California system,

[11] The Florida competencies were designed to be used with experienced mental health practitioners. For this reason, some areas of competencies that were assumed to be part of a general mental health training program were deliberately excluded (Quay et al., 2007). This is a likely reason why, for example, ethical issues are not part of the Florida competencies.

Table 10. Knowledge and Practice Content Across Competency Systems

Content	Examples
Basic Principles	Importance of attachment, cultural/contextual influences, ethical practice, 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 (pregnancy, infant-toddler development, preschool-aged development, school-aged), specific areas of development (cognitive, biological/physical, affect/emotions, language/literacy), and specific topics of development (brain development, nutrition, sensory regulation, temperament)
Understanding of Mental Health Challenges	Depression or anxiety in young children, behaviorally challenging children, autism, communication/interaction problems, parent mental illness, trauma, and family violence
Risk Factors	General issues of risk and resilience, along with specific risk factors such as family disruption, environmental risk, poverty, substance abuse, and prematurity
Direct Service	Mention of intervention in general, but also specific topics, such as provision of emotional support, psychotherapeutic services, interactive guidance, referrals, promotion of problem-solving techniques, and working specifically with children
Assessment	Screening, interviewing, observation, diagnosis, use of specific assessment instruments
Other skills	Administration, advocacy, communication/listening, consultation, leadership abilities, supervision-mentoring (including reflective supervision), research and interdisciplinary collaboration
Systems Issues	Knowledge of and work with community programs (including child care) and reporting obligations, as well as other rules and regulations
Provider Development	Issues of personal and professional development, reflective capacity

one specific competency is listed as "How development may affect behavior and the care-giving environment." All systems emphasize the importance of understanding atypical development or special needs populations (although for Florida, this is limited to children with developmental disabilities). The systems also cover special topics of development, such as brain development (all systems), sensory regulation and processing (all but Michigan), and temperament (all but Michigan). Some topics that would seem to be important to early childhood mental health are not specifically noted across the systems, such as gender development (no systems), breast feeding (only Florida), physical development (brief mentions in Connecticut and Florida), or play (three systems). It is possible that these topics are covered as part of the general overview of development, but the absence of specific mention is noteworthy.

Topics that might be considered more central to preschool-aged children are mentioned infrequently. For example, relationships with peers (or social skills more generally) are only noted in three systems, with Vermont providing the most detail. In the Vermont system, developmental knowledge specific to children older than 5—such as early academic achievement, the development of close friendships, and the internalization of social rules and obligation—are not mentioned, although it is the only system that incorporates classroom learning environments.

Mental health challenges. Because these systems, for the most part, deal with providers across the realms of prevention and intervention, finding the correct terms to use to describe mental health issues is not simple. Specialists at lower levels, for example, may not be expected to work with parents or children with mental health disorders or active diagnoses. To distinguish ECMH work from early childhood work in general, however, it is reasonable to expect that ECMH specialists will have knowledge and skill to work with families who face at least some mental health challenges or difficult life circumstances.

Given this, it is noteworthy that mental health challenges are rarely noted in the competencies. Although mental health "disorders" are mentioned generally in all but one system, specific disorders that occur in the population of children from birth to age 5, such as depression, anxiety, or autism, are rarely mentioned. Behavior challenges, considered the most frequently noted reason for referral of young children into mental health settings (e.g., Gadow, Sprafkin, and Nolan, 2001) are present in only three systems, and distractibility or inattention is noted in only one (Florida). Issues around children and families who experience trauma are only mentioned in three systems. On the other hand, family violence or maltreatment is noted by four of the systems, and parent mental illness (often maternal depression) is noted by all six.

Risk factors. The category of risk factors includes competencies related to factors that increase the chances for mental health challenges (as well as protective factors that support development). Global concepts of risk are mentioned across all six systems, but there is little agreement on specific topics. Family disruption (through divorce or death or child welfare actions) is noted in five of the systems, as is the more general concept of "environmental risk." Other risk categories, such as poverty, teen parenthood, prematurity or low birth weight, and physical illness in the parent or child are noted in three or fewer systems. Substance abuse, considered one of the strongest challenges for family support providers (e.g., Margie & Phillips, 1999), is also specifically noted in only three systems. Factors that *support* development are also noted in these systems, but again only in very general terms without mention of specific protective features (e.g., Florida: "Is knowledgeable about the potential role of protective factors in ameliorating the potential effect of risk factors"). This is somewhat surprising given that all systems specifically note a strength-based orientation to service provision.

It is possible that the global categories of risk and resilience cover the specific topics. But the fact remains that specific risk or protective factors have little mention in the written documentation of the competencies, many of which are being disseminated to guide training and professional development. This is particularly noteworthy because many candidates for training or endorsement at earlier levels (such as at Level 1 or Level 2) likely work in programs that serve higher-risk families (such as Early Head Start, Head Start, or Early Intervention). For this reason, having current knowledge about the impact of specific risk factors on a child or family's well-being should be an important element of best practices in these settings.

Direct services. As with the previous categories, there are both global competencies that are apparent across most of the systems (such as intervention generally) and specific forms of treatment or service provision that are mentioned less frequently and less consistently. All of the systems list therapy or psychotherapy as a competency, typically at the higher levels,[12] and all systems note the ability to provide referrals as a competency. At earlier levels, competency systems are more likely to use terms such as *support* to refer to service provision (e.g., Indiana Level 2: "Knows how to support infant/young child and parent relationships as described in the early childhood mental health literature").

The Michigan system is the most comprehensive in terms of direct service. It notes many different types of intervention, such as interaction guidance (McDonough, 1999), developmental guidance, or leading parent groups. A notable exception is the provision of behavioral support (such as positive reinforcement or use of time-outs), which is not part of the Michigan competencies.[13] Direct work with children, although noted in five systems, is less often mentioned than direct work with parents or families. For example, the Florida competencies simply state: "Can relate to and interact comfortably with young children." This is likely due both to the infant mental health orientation of these systems, which promotes dyadic and family work, and to an increased emphasis on the period from birth to age 3.

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[12] Both Vermont and Michigan do make brief mention of therapy skills at Level 2. For example, Michigan notes: "Effectively implements relationship-based, therapeutic parent-infant/young child interventions that enhance the capacities of parents and infant/young children."

[13] Although behavioral theories of change are mentioned as a developmental principle, there is no specific mention of behavioral interventions in the MI-AIMH competency guidelines.

The Vermont system provides relatively more detailed competencies about work with children (for example, at Level 3: "Uses play therapy and other expressive therapies"), likely because of its extended age range.

Assessment. There is a high level of congruence across the systems regarding the importance of specialists being able to assess children and families. All six systems emphasize assessment, observation, and diagnosis (with four of the systems referring to the DC: 0-3 diagnostic system and/or DSM-IV). Most also include screening (Michigan does not specifically note screening as a competency different from assessment). Although gathering information and beliefs from parents about their child is a central skill of assessment with preverbal and minimally verbal children, only three programs specifically include interviewing as a competency.

Other skills. All of the competency systems that we reviewed have a multidisciplinary orientation in which ECMH specialists are expected to go beyond the provision of direct services. Working and communicating with other providers across disciplines are universally recognized as competencies, as is the development of service plans (although only Florida includes documentation as a specific skill). Listening skills is noted as a competency in five of the systems. Beyond these competencies, however, there is little agreement regarding what other skills an ECMH specialist should have.

Leadership skills in general are noted by four of the systems, although administrative skills are included in only two (Michigan and Vermont, both with four levels of competency). The ability to supervise or mentor others is seen in only three systems, all at higher levels of endorsement. Providing *reflective* supervision, an essential component of staff reflective practice (see below) is noted in only two of the systems. Consultation, which is increasingly a way that ECMH specialists are brought into services (Cohen & Kaufmann, 2000; Green, Everhart, Gordon, & Gettman, 2006) is mentioned in only three of the systems.

Systems issues. We use the term *systems issues* to describe the ability of the ECMH specialist to work within systems of care, to understand regulatory and policy issues that govern their service provision, to help families navigate these systems, 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 but, again, the specifics differ. Four of the programs note knowledge of reporting issues for child welfare as a competency, although foster care and institutional care are very briefly mentioned in only three. Also of interest for a mental health competency system is how few of the systems (only two) include understanding of medication issues. Although few ECMH specialists would have prescriptive privileges, the use of medication to treat mental health conditions in young children is rapidly growing (Gleason et al., 2007), which would make it a likely topic for training and knowledge.

Provider development. Finally, provider development refers to the ability of the provider to seek out additional training and professional development, either through formal training, additional reading and research, or through supervision. Such activities are noted by all but one of the systems. Provider development also refers to the providers' abilities at reflective practice and their use of self in their work with families and young children. Reflective capacity is considered another central quality of the early childhood mental health specialist (Gilkerson & Shahmoon-Shanok, 2000; Heffron, Ivens, & Weston, 2005), and is mentioned by five of the six systems.

Summary Analysis

Overall, there is a fair amount of similarity across the six systems in purpose and content and in the language used to describe competencies. One obvious reason for this is that the people or work groups who created each system often used other systems as background information or guides. This was explicitly noted in Indiana (Indiana State Department of Health, 2007) and in Connecticut, and is likely true for the others as well. It is also likely that each system was created by teams who shared values or philosophies of service. As noted earlier, an infant mental health orientation is pervasive across the systems. Michigan's competency system was created in part by people trained by Selma Fraiberg and her colleagues, and the principles of practice that she outlined in her work and training model has had considerable influence in Michigan (see Weatherston et al., 2006) and in the field both nationally and internationally.[14] It is no surprise that family-centered practice, for example, is mentioned with frequency across all the systems, or that attachment theory and relationship-based care are emphasized.

We focus our discussion on three key topics that have emerged from our analyses. One concerns how the competency systems define early childhood mental health specialists. The second centers on the ultimate purpose of the competency systems. The final topic concerns who provides the oversight for the competencies.

What Do These Competency Systems Tell Us About the ECMH Specialist?

All of these systems stipulate that the ECMH specialist should be trained as a generalist; that is, they take a holistic view of the child and encompass many topics beyond a narrow definition of mental health. Most systems, in fact, do not cover specific disorders or conditions (such as autism or disruptive behavior, or child maltreatment), even at the higher levels (typically Level 3), where intervention or treatment for these conditions would be expected. All systems do, however, cover topics that are *related* to healthy social and emotional functioning, such as sensory processing and regulatory issues or nutrition.

This underscores the fact that the competency systems, in general, and especially at the lower levels, have a greater focus on the philosophy or approach to care (that is, an infant mental health approach) than on specific skills and abilities. There is, in particular, less specific practice "content" at the lower levels of endorsement. This indicates that the systems see the importance of specialists at Level 1 or Level 2 understanding the *approach* to care (e.g., respecting culture, recognizing the importance of relationships, valuing self-reflection) as opposed to specific actions (e.g., what strategies work to help parents with a disruptive toddler). The California system explicitly notes this as a distinction between the Core Providers and the Mental Health Professionals (CA-PMFHI, 2003a).

All systems also emphasize the importance of working with other professionals across disciplines. Clearly, the systems are attempting to strike a balance between establishing a minimum level of knowledge for the specialist while also emphasizing the need to rely on the skills and abilities of other professionals. In other words, is the purpose of these systems to ensure that the ECMH specialist knows enough to communicate with these other professionals? Or should the ECMH specialist provide guidance and service around these areas themselves?

Another important point is that although five of these systems cover the preschool period, at their core, they remain a set of infant mental health competencies.[15] Overall, the intention is for these competencies to address the needs not just of infants and toddlers and their families, but also of 3-, 4-, and 5-year-olds (along with 6- to 8-year-olds, in the case of Vermont's). There is less indication, however, that issues unique to particular time periods beyond the infant and toddler period are covered in the competencies.

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[14] The MI-AIMH, founded by students of Selma Fraiberg in 1977, is the first professional association focused specifically on infant mental health and was a precursor to the World Association for Infant Mental Health, of which it is now an affiliate (see Fitzgerald & Barton, 2000).

[15] Although Michigan is aligned with the birth-to-3 age range, groups that have licensed the system in other states have begun to use them (with the approval of the MI-AIMH) with practitioners who work with children through age 5.

For example, California's system divides training specifically into a birth-to-3 period and an age-3-to-5 period. Yet documentation of the specific knowledge areas suggests only a few differences between the age periods. The content areas (see Table 5) are virtually identical between the age periods, with only a few exceptions. The bulk of the difference rests with the clinical component, where participants engage in supervised experience specifically with infants and toddlers or preschool-aged children (or both, for the combined birth to five curriculum). California is not unique in this regard. Issues relevant mostly to preschool and later years (such as use of peers, classroom learning environments, use of behavioral methods) are treated less frequently than issues relevant to infants and toddlers.[16] As a simple example, although attachment and the centrality of the parent-child relationship are noted in all systems, relationships with peers is only included in three.

What does this suggest? 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 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. For example, behaviorist, cognitive-behavioral, or parent-training approaches to working with a young child's conduct (see Fox & Dunlap, 2007) are largely left out of the competencies. Psychiatric intervention, although controversial with young children, is increasing among the preschool population (Rappley, 2006), but there is little indication from the written materials that the current systems require ECMH specialists to be knowledgeable about this area. Response To Intervention (RTI), a variation on the recurrent movement to incorporate empirically validated treatments into mental and behavioral health services, is another rapidly growing approach in children's mental health services, including services for young children (e.g., Barnett et al., 2006) that is not covered by these competencies.

Our goal is not to argue one way or the other on the appropriateness of an infant mental health orientation to ECMH services. However, it is important to recognize the bias in the competency systems. An infant mental health approach likely "works" with older children because the principals of infant mental health do not just apply to the first 3 years of life. The attachment relationship does have influence across the lifespan (Ainsworth, 1989). Paying attention to relationships, to the context of people's lives, and to their cultural and family background, and focusing on what clients need and want seem important no matter the age of the client. Asking providers to think about their role in the provision of services seems like good practice in general. So adopting a philosophy of care that puts emphasis on these matters is a very reasonable strategy, even when working with children beyond the age range on which it was first developed. On the other hand, as discussed earlier, there are important areas of knowledge and practice in early childhood mental health that are largely under-addressed by the current systems.

How Should These Systems Be Used?

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 ECMH specialists provides important guidelines for higher education institutions or other organizations in establishing 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. Opportunities for ongoing professional development, with endorsement as an end result, provide incentives for professionals to be up-to-date on best practice research and treatment or service provision. A competency system could guide portfolio development and help to identify gaps in practitioner and administrator or supervisor knowledge. Using levels within a competency system could also ensure that trainings are targeted most effectively to frontline

[16] In the Vermont system, areas of developmental knowledge specific to children older than 5—such as early academic achievement, the development of close friendships, and the internalization of social rules and obligation—are also infrequently mentioned, as are services for older children, such as implementation of social skills curricula.

providers, to mental health professionals, to leadership, and to allied disciplines. For California, for example, there are some clear differences in the training provided to core providers and mental health professionals.

A competency system should provide a strong foundation for training programs. This is suggested both by the Vermont system (which worked with higher education stakeholders) and the California system as it moved into the Special Needs Programs. However, at this point, the stakes are not that high if a training program chooses not to follow any of the existing competencies. Some national organizations for mental health professionals (such as the American Psychological Association) provide guidance through their accreditation of educational and training programs, and there are strong professional incentives to graduate from an approved program. There is currently no national association overseeing ECMH or giving approval to ECMH training programs (see below), so there is no approval to lose if the competencies are not followed. In other words, without a larger organization or system setting up "carrots and sticks" to push these training programs forward, using competency systems to focus training has its limitations.

The second reason for the importance of ECMH competency systems is the enhancement of professional credibility. As it now stands, the title "Early Childhood Mental Health Specialist" is not well known and has unclear meaning. Most consumers (i.e., parents of young children) are unaware of what early childhood mental health entails and who should provide these services. They rely on family members or their pediatrician for advice, even if not satisfied by the information they receive (Melmed, 1998). The competency systems described here provide a benchmark for what knowledge and skills are needed in order to provide mental health services to very young children and their families. These systems provide a visible standard not previously available. This visibility, in turn, enhances accountability and lends validity to professionals who say they are endorsed to provide mental health services and social-emotional expertise for the youngest members of the population.

Using the competencies as an aspect of endorsement or certification raises additional questions, however, especially given the structure of most of the existing systems. How will the service providers present themselves? Does it diminish the value of endorsement to a psychologist to know that a child care provider can also be endorsed, albeit at a different level? How will the public understand the distinction between a paraprofessional home visitor with Level 1 endorsement and a licensed clinical social worker with Level 3 endorsement when presented with an early childhood mental health worker?

Michigan, the only system that provides endorsement along with its competency system, has not yet examined these issues, but the MI-AIMH has kept track of the number of individuals seeking different levels of its endorsement, with the largest number of applicants endorsed at Levels 2 and 4.[17] If, however, agencies or programs begin to use endorsement at certain minimum levels as a hiring preference or qualification (as has begun in Michigan), this will give the endorsement system real-world impact and may further establish its credibility, as well as enhance the professional credibility of the endorsed provider.

The third reason to use the competencies is as a gatekeeper for practitioners. If we assume that people who are endorsed as ECMH specialists through one of the different competency systems are (on average) more skilled and competent than those who have not demonstrated these competencies, then these systems could be used as a way to establish quality control and to ensure that people hired by certain agencies or for certain roles have the qualifications to work with young children and their families. In reality, although most states have licensing requirements for particular mental health professionals (e.g., psychologists, clinical social workers, marriage and family therapists), that does not preclude someone from providing unorthodox or non-sanctioned mental health treatment under a different professional label. For example, one needs a license to legally provide

[17] Of the approximately 140 participants who have received endorsement as of December 2007, 36 percent were at Level 2, 35 percent at Level 4, 24 percent at Level 3 and only 5 percent at Level 1 (D. Weatherston, personal communication, December 12, 2007).

psychological services in most states, but anyone can provide "therapy" without regulation.

In fact, anyone can likely call himself or herself an early childhood mental health specialist without a special certification or license. No state currently recognizes this specialized knowledge or skill set as a job function that needs oversight or regulation. A competency system embedded within an endorsement program that is tied to state certification or credentialing could provide more oversight to the field and guard against unqualified practitioners. Even if not connected to a state oversight system, a competency-based endorsement can at least provide "a level of assurance to families, agencies, and the public at large that the person who is providing services to infants, very young children, and their families meets standards of knowledge and skill that have been approved by a professional organization devoted to promoting infant mental health" (Weatherston et al., 2006; p. 5).

The fourth reason concerns financial reimbursement. So far, it has been difficult for certain aspects of ECMH services to qualify for reimbursement through private insurance or public health monies (see Stebbins & Knitzer, 2007; Kenny, Oliver, & Poppe, 2002). There are some emerging signs that, although state governments may not show interest in using competencies for credentialing, they could have a role in Medicaid reimbursement rates. Both Michigan and New Mexico state governments are establishing new rules that tie Medicaid reimbursement for certain ECMH activities to provider endorsement, using the MI-AIMH endorsement program (D. Weatherston, personal communication, December 10, 2007). As was noted previously, there are efforts in Michigan to tie grant funding to a program's ability to hire staff endorsed at certain levels (or to encourage current staff to seek endorsement). Both of these activities suggest the possibility of using competencies for decisions in hiring, salary, and program budgeting. On an individual level, too, it may be possible some day to see providers in private practice charging more for their services based on their endorsement level (another example of how endorsement may enhance professional credibility).

Who Should Oversee the Process?

There are different entities—both private and public—that could oversee an ECMH competency system. Most of the existing competency systems came into being because of some motivation from the state government—a strategic plan that was developed for a state agency (e.g., Florida) or because of state funding (e.g., California). No state government entity, however, has taken on the obligation of overseeing the competency system or the process of endorsement. Although there was the hope that this might occur in California, changes in funding and the direction of service provision did not allow this. The Michigan system typically works through local affiliates of the World Association for Infant Mental Health (WAIMH). Although some of the affiliates have sought state funding to purchase the license (such as New Mexico and Kansas), it remains essentially a private endorsement program—professionals overseeing other professionals.

Affiliates are typically volunteer-led organizations that have limited budgets. They also have their own workforce problems, in that volunteers are usually very busy and are attempting to fit in the responsibilities of the affiliate work with their existing work schedules. For this reason, taking on the oversight of an endorsement or competency system is not an easy process, and affiliates interested in this role need to proceed very carefully before taking on this responsibility. Most likely, the local infant mental health association would need to add permanent positions in order to oversee the endorsement or competency system, which requires further financial resources.

Is there a way for the current ECMH competency systems to fit with state oversight systems? There has been some movement to integrate concepts of ECMH competencies into state infant-toddler or early childhood education credentialing systems. New Jersey, for example, put infant mental health competencies at the beginning of the latest draft of its infant-toddler credential (Coalition of Infant-Toddler Educators, 2007). Although much shorter than the competency systems reviewed here, the 21 items do cover some of the same topics, such as relationship formation with families, brain development, and supporting the parent-child

relationship. Typically, however, infant-toddler or early childhood credentials are geared towards frontline providers in child care and early childhood services (for example, the New Jersey competencies are much more focused on direct work with children).

It is unclear to what extent an infant-toddler credential or ECE certificate would appeal to practitioners with graduate or postgraduate training who do not intend to work in child care, preschool teaching, or the early intervention system. On the other hand, infant-toddler credentials have been incorporated into state professional development career lattices, as is done in New Jersey, Illinois (see Illinois Network of Child Care Resource and Referral Agencies, 2007) and other states. It is possible for competencies that are part of an ECMH endorsement process to be incorporated into a career lattice as well. The Vermont competencies, for example, are part of that state's Unified Professional Development System and are aligned at the first two levels with core competencies for early childhood professionals (Vermont Early Childhood and Family Mental Health Competencies Practice Group, 2007)

Conclusions

Competency systems provide a benchmark of relevant competencies needed to provide early childhood mental health services and set a standard for what professionals must know in order to be considered legitimate providers. Especially as the mental health needs of young children gain traction as a public policy issue, there is no question that competency systems are a valuable addition to the field.

One of the challenges in discussing these competency systems is that most are still works in progress. All were developed by a committed group of professionals working together over a long period of time to reach a consensus that would appeal to the needs of various stakeholders. So far, however, most of them exist only on paper or on Internet web sites, waiting to be used as a guide for training or professional development, with their ultimate utility uncertain. Even California, attached to a specific training program, found the purpose and structure of the program changing as funding priorities shifted.

This demonstrates the difficulty of establishing a competency system that meets the needs and priorities of the emerging network of early childhood mental health providers. One reason for the popularity of the Michigan system (embedded in the MI-AIMH endorsement program) is that it comes complete and ready to use, with the laborious and challenging task of establishing common outcomes and language already behind it. Still, however, the process of purchasing the license and implementing the program within a state takes several years (D. Weatherston, personal communication, December 10, 2007; see also Weatherston et al., 2006).

In other words, developing early childhood mental health competencies seems both very necessary and very difficult. We conclude our discussion with four issues paramount to the further development of these competencies: real-world application, evaluation, preschool relevance, and the quest for national competencies.

Real-World Application

The competencies need to move from stand-alone documents to plans that have clear applications in practice. So far, the efforts made have been tentative, with pilot programs for training (as seen in California), provision of state funds to purchase an endorsement system (New Mexico and Kansas), contingencies for grant funding of programs (Michigan), and Medicaid reimbursement (New Mexico and Michigan). To make this transition from document to plan, there needs to be greater involvement of policy players, particularly at the level of state government. State officials have both the experience and the standing to guide the development of the competencies (whether developed specifically for a state or borrowed or licensed from another organization) in a way that will facilitate their integration into current early childhood and mental health practice, funding, and credentialing systems.

For example, it should be possible to align or incorporate a levels-based ECMH competency system into a state's early childhood professional career lattice. Doing so would both provide a useful frame for ECMH competencies and would send a clear message about the value of embedding mental health into early childhood

education and care. But there are other systems beyond early childhood care and education in which the mental health needs of young children should be addressed, such as child welfare, early intervention, and health care, as well as mental health systems themselves. Working with stakeholders to make ECMH competencies relevant to these systems requires careful planning and political insight.

Evaluation

Using the competencies for real-world applications requires that these competencies have demonstrable validity, and this further suggests that a critical eye must be turned towards their research and evaluation. There is currently little empirical evidence that these systems are effective in developing competent ECMH specialists.

As (mostly) works in progress, the lack of empirical research on these systems is understandable. Many of these competencies were developed by workgroups who used existing research and clinical literature as one starting point in their development; as a consequence, they could be considered as best practice documents, even if the systems themselves have not been tested. The Florida system is unique in that its creators vetted their system with an empirical process, asking nationally recognized (albeit confidential) experts in the field to comment on, rate, and rank-order their initial list of competencies (Quay et al., 2007). No items were removed from the initial list, and only a few new items were added based on feedback from the expert panel. Over two-thirds of the items had a mean rating of 4 (*highly desirable*) or greater on a 5-point scale,[18] and all had a rating suggesting that they were seen at least as *very desirable*.

Despite this initial work, the Florida system has not been validated on providers in the field or students in training programs.[19] Only the California system has been part of an outcome evaluation (CA-IPFMHI, 2003b), but it focused mostly on self-reported gains in awareness, knowledge, and expertise of practitioners as a result of participating in the training activities. Even the Michigan system, which has a well-established endorsement program surrounding it and has been licensed to other states, is only in the process of developing an evaluation plan. Given the expanding popularity of this program, it does seem like a crucial step to show that the system is accurately ascertaining the knowledge and abilities of those who seek its endorsement.[20]

We recommend that serious effort be applied to evaluating the existing competency systems, and that any future competency systems include a plan for evaluation (as well as *funding* for evaluation) as part of its development. There are challenges in conducting field-based research on these systems: they cover multiple domains of knowledge that will be put to multiple uses across providers at different levels of experience, background, and training. It is often quite unclear what the comparison should be. In addition, assessing *practice* is a much more challenging endeavor than assessing content knowledge. No one evaluation activity, then, can answer the questions about the utility and effectiveness of these systems in developing a competent workforce in early childhood mental health. Multiple methods will be necessary, such as combining initial face validity work (as was done with the Florida system) with self-evaluation measures (as was done in California), and with more objective measures of skill and practice, such as the use of case vignettes (e.g., Heverly, Fitt, & Newman, 1984). Finally, the impact of establishing these competencies on early childhood systems of care is also a worthy focus of evaluation (see Perry, Woodbridge, & Rosman, 2007).

Preschool Relevance

This is, of course, ultimately a topic for research and evaluation, but it is reasonable to conclude that current and future competency systems need to take a

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[18] This was seen even with scale descriptors designed to attenuate restricted range: 1=Probably not necessary; 2=Desirable but not a "must"; 3=Very desirable; 4=Highly desirable; and 5=Essential competency.

[19] As noted earlier, this process has started with the FSU training program.

[20] As noted earlier, Michigan does have an exam for candidates at Levels 3 and 4, which combines both multiple choice questions to assess knowledge and written essay responses to measure clinical thinking. This testing process, however, is itself still in need of evaluation.

critical look at the appropriateness of their content for the preschool-aged population. 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. The Florida system acknowledges this. Many of the experts used to rank its competency items came from the board of Zero To Three or the editorial board of the *Infant Mental Health Journal* and are associated with psychodynamic approaches to work with families. Some have also suggested that the item ratings might have been different if the panel had more experts associated with behavioral or cognitive-behavioral approaches (Quay et al., 2007), which are more often seen with preschool-aged children than with infants and toddlers.

As noted earlier, many of the principles associated with an infant mental health approach are relevant for work with the age-3-to-5 population (as well as older children). The lack of preschool-relevant content is due more to omissions than inclusion of items that are age-inappropriate. For this reason, we recommend that efforts be made to ensure adequate representation of mental health issues and interventions that cross theoretical perspectives. When competency systems are developed or adopted, professionals with expertise with the mental health needs of preschoolers need to be involved in the process. As states and public school districts become more involved in preschool programming, the involvement of school personnel who are responsible for mental health and behavioral issues (such as school psychologists and early childhood special educators) also is critical.

The Quest for National Competencies

One major question that has not been addressed here so far is whether or not a national set of early childhood mental health competencies should be developed to guide the field. As early childhood mental health gains (some) political prominence or traction, work groups and stakeholders in different states have been faced with this issue of developing their own standards, or borrowing (or licensing) standards from other sources. There has been the call for some national agency to provide oversight to endorsement or competency development (Myers, 2007). Such an agency would also be charged with the responsibility of advocacy so that agencies and funding agencies recognize the value of having endorsed individuals providing services, thereby encouraging incentives for growth and professional development in the field.

Zero To Three has facilitated meetings around ECMH workforce development and has been a source of information about the competency systems through its annual National Training Institute and its professional journal. So far, however, it has shown little interest in taking on national oversight. There is a current movement, led in part by members of the MI-AIMH, to develop a United States national affiliate to WAIMH.[21] This national affiliate would act as an umbrella organization to the state infant mental health associations, and it is conceivable that a national group such as this could provide a more unified voice about early childhood mental health competencies as well.

The closest approximation to a national system is the ongoing development of the MI-AIMH endorsement systems. At this point, there is an affiliate group of seven states. Although each association that has purchased the system is free to rename it for their own state, they are not free to make modifications to the system on their own. Instead, any potential changes must be approved by the MI-AIMH and changed in every other state. The rationale is to maintain consistency across states, so that there is a common understanding regarding the competencies. This allows for the possibility of the transfer of an endorsement across states, so that someone endorsed in Texas, for example, would also be able to maintain and renew their endorsement if they were to move to New Mexico.

We are *not* making a recommendation for a national set of early childhood mental health standards, at least not yet. Although there are many common features across the six systems we reviewed, there are enough differences in content, structure, and purpose to suggest that local concerns and issues are still very relevant for training, professional development, and endorsement. The experience of the states using the MI-AIMH

[21] Most affiliate organizations of WAIMH represent an entire country, but in the United States there are many different state chapters that are local affiliates, such as the MI-AIMH.

competencies and endorsement program will, over time, 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.

Final Thought

The noted developmental psychologist Arnold Sameroff has told of testifying in front of a congressional committee and being threatened with having his arms tied behind his back because of his (and other academics') predisposition to say "On the one hand…" and "On the other hand…" During the development of this document, the authors have been asked by many different parties what competency system they think is best. Although we risk the same fate as the noted Dr. Sameroff, there is no better answer than "It depends."[22]

It depends on the purpose of the competency system. It depends on the local context and needs that require such a system. It also depends on the existing competency systems being further developed, refined, and evaluated. To put these systems in competition with each other defeats the purpose of this comparative analysis, which is to gain insight regarding the efforts of professional development of early childhood mental health providers (and those interested in the mental health in the early years) and make recommendations to help move the field forward.

[22] When we give this answer, the follow-up question inevitably comes: "Yes, but what do you really think?"

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Appendix A: Competency Content by System

Category	Sources	References	CA	CT	FL	IN	MI	VT
Basic Principles								
Attachment	6	26	x	x	x	x	x	x
Context	4	10	x	x	x			x
Culture	6	55	x	x	x	x	x	x
Ethics	5	24	x	x		x	x	x
Family (importance of)	6	44	x	x	x	x	x	x
Family-centered practice	6	46	x	x	x	x	x	x
"Ghosts"/historical precedents	6	14	x	x	x	x	x	x
Maintaining multiple perspectives	1	2					x	
Outcomes-based	3	19			x		x	x
Parenting processes	6	31	x	x	x	x	x	x
Relationship/alliance formation	5	50		x	x	x	x	x
Relationship-based care	5	34	x	x	x		x	x
Relationships (importance of)	5	13	x	x		x	x	x
Strength-based	4	31			x	x	x	x
Work in natural settings	3	22				x	x	x
Development Knowledge								
Affect emotions	4	18		x	x		x	x
Atypical-special needs	6	25	x	x	x	x	x	x
Brain development	6	15	x	x	x	x	x	x
Breast feeding	1	1			x			
Cognitive development	3	6		x	x		x	
Development (general)	5	24	x		x	x	x	x
Infant development	5	9	x	x	x		x	x
Language/literacy development	3	10		x			x	x
Nutrition	5	9	x	x	x	x		x
Parent-child relationships	5	52		x	x	x	x	x
Peer relationships (child)	3	11	x	x				x
Physical development	2	2		x	x			
Play	3	12		x	x			x
Pregnancy	4	11	x	x	x		x	
Preschool development	3	8	x	x				x
School-age development	1	10						x
Sense of self	1	2						x
Sensory & regulation	5	16	x	x	x	x		x
Sleep	3	3		x	x	x		
Social-emotional development	4			x	x	x	x	
Temperament	5	21	x	x	x	x		x
Transitions	2	5		x				x

(continued)

Category	Sources	References	CA	CT	FL	IN	MI	VT
Mental Health Challenges								
Anxiety	1	3			x			
Autism	1	1			x			
Behavior challenges	3	5		x	x	x		
Communication or interaction problems	3	11	x		x			x
Depression	2	3			x		x	
Disorders (unspecified)	5	15		x	x	x	x	x
Distraction/inattentiveness	1	1			x			
Maltreatment & family violence	4	7	x	x	x		x	
Parent mental illness	6	11	x	x	x	x	x	x
Trauma	3	8		x	x	x		
Risk Factors								
Environmental risk	5	18		x	x	x	x	x
Family disruption	5	10		x	x	x	x	x
Maternal obesity	1	1			x			
Physical illness in child	3	5	x		x			x
Physical illness in parent	3	5	x	x	x			
Poverty	2	5		x				x
Prematurity/low birth weight	2	3	x		x			
Risk and resiliency	6	27	x	x	x	x	x	x
Safety issues (family)	1	5					x	
Stress	3	6		x		x		x
Substance abuse	3	4	x		x			x
Teen parent	2	3	x	x				
Direct Service								
Behavioral support	4	10		x	x	x		x
Concrete assistance	3	8			x		x	x
Crisis help	3	7			x	x	x	
Developmental guidance	3	17			x		x	x
Emotional support	3	5			x	x	x	
Group work	2	5					x	x
Interaction guidance	1	1					x	
Intervention (general)	6	86	x	x	x	x	x	x
Life skills development	1	5					x	
Problem solving	3	11				x	x	x
Referrals	6	26	x	x	x	x	x	x
Social support	3	9			x		x	x
Specific curriculum	2	4		x				x
Therapy (non-specified)	6	20	x	x	x	x	x	x
Direct work with children	5	22		x	x	x	x	x

(continued)

Category	Sources	References	CA	CT	FL	IN	MI	VT
Assessment								
Assessment (general)	6	44	x	x	x	x	x	x
Diagnosis	6	12	x	x	x	x	x	x
Interviewing	3	4			x	x		x
Observation	6	34	x	x	x	x	x	x
Screening	5	9	x	x	x	x		x
Specific assessment instruments	4	14		x	x	x		x
Other Skills								
Administration	2	28					x	x
adult learning	2	4		x				x
Advocacy	4	14			x	x	x	x
Communication	6	53	x	x	x	x	x	x
Conflict resolution	3	15		x			x	x
Consultation	3	19				x	x	x
Documentation	3	3	x		x		x	
Leadership	4	16		x	x		x	x
Listening	4	8			x	x	x	x
Modeling behavior to others	1	5					x	
Research and evaluation	4	17		x	x		x	x
Service plan development	5	23	x		x	x	x	x
Supervision-mentoring	3	45			x		x	x
Reflective supervision	2	4					x	x
Teaching	2	28					x	x
Thinking skills	2	8					x	x
Working with difficult families	2	2	x		x			
Working with other disciplines	6	59	x	x	x	x	x	x
Writing	4	12	x	x			x	x
Systems								
Child care	5	16	x	x		x	x	x
Community resources	6	27	x	x	x	x	x	x
Foster/institutional care	3	5	x	x			x	
Medication issues	2	4			x	x		
Reporting obligations	4	18		x		x	x	x
Rules & regulations	4	14		x		x	x	x
School/classroom learning environment	1	9						x
Systems issues (general)	6	52	x	x	x	x	x	x
Provider Development								
Personal or professional development	5	16	x		x	x	x	x
Reflection	5	29	x	x		x	x	x

TOTAL: 109 Categories

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 birth to age eight 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.

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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 birth to age eight. Now in its 40th year, Erikson Institute advances the ability of educators, practitioners, researchers and decision-makers to improve the lives of children and their families.