TRAINING PROFESSIONALS TO SUPPORT THE MENTAL HEALTH OF YOUNG CHILDREN AND THEIR FAMILIES: LESSONS FOR MASSACHUSETTS FROM THE NATIONAL LANDSCAPE

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

Connected Beginnings Training Institute was founded in July of 2006 by the United Way of Massachusetts Bay (UWMB) to expand research-based birth-to-five mental health training for professionals in Massachusetts who influence the emotional well being of very young children. Some sobering indicators of emotional troubles in the lives of very young children and their caregivers in Massachusetts are:

- Massachusetts ranked 9th highest in preschool expulsion rates among the 40 states with state-funded pre-kindergarten programs.
- A needs assessment conducted by Brandeis University showed that nearly 30% of young children enrolled in UWMB funded programs behaved in ways that were of concern to staff.
- In Worcester County, Together for Kids found that 34% of preschoolers in four preschool sites and one Head Start program were identified as "at risk" for emotional problems through a standardized screening process
- An evaluation of Healthy Families of Massachusetts, a universal home visiting program for first-time mothers under the age of 21, found that despite gains in many areas, 45% of the young mothers were clinically depressed at the end of the 18 month evaluation period.

  That a mother suffers from untreated clinical depression is a major concern because of its personal toll on the mother and potential to dampen a child's sense of well being and negatively influence cognitive and emotional outcomes as a child develops. When very young children hit, bite, defy or withdraw from adults and peers, and have difficulty focusing on play or tasks they are telling us how hard it is to manage emotions and be with others.

Inspired by their work with very young children, infant mental health researchers view such behavioral difficulties as solvable only by focusing on relationships. As the field has matured, the notion of infant mental health has expanded to include the prenatal period through at least age five. Therefore, in this report, the term Infant Mental Health (IMH) will refer to the developing capacity of children, ages birth to five to experience, regulate, and express emotions; to form close and secure relationships; and to explore the environment and learn within the context of family, community, and culture.

To respond to the rapidly expanding research base, training for professionals who work with babies, toddlers, and preschoolers must shift to a relational approach. The reality is that, many helping professionals in a key position to support the mental health of the 400,000 Massachusetts children aged birth to five, their parents, and other significant caregivers, were trained in frameworks that focused on either the child or the adult rather than their relationships. The responsibility for fostering nurturing relationships and repairing disruptions in them is not just the province of mental health professionals nor should it be. Each child will interact with many professionals who should be involved including pediatricians, infant-toddler and preschool teachers, social workers, and early intervention practitioners.

To get an idea of the variety of training practices employed for training this large potential audience we did a scan of the training environment in Massachusetts and found promising IMH programs and models that reach relatively small numbers of advanced mental

health clinicians and frontline practitioners in early care and education, early intervention, and social service. Scaling-up to reach a broader constituency will take investment in time, energy, and funds. We also looked at state-level investments in IMH training and found a few instances of investment and efforts at coordination.

Intuitively, it seemed Massachusetts was on the right track but we thought there were elements that were underdeveloped or missing. To get an idea of the variety of the practices employed to reach the broad practitioner group, we reviewed 24 individual training programs in 13 states and the District of Columbia. We found agreement across the country on philosophy, content, and skill set. All of the states have at least one post-graduate professional training program for already licensed mental health clinicians. Ten of these cover the birth-to-five age range. In Massachusetts the post graduate training program focuses on infants and toddlers. We identified some multidisciplinary training models offered at local or regional sites. We found 11 graduate programs that offer a specialization in IMH, a missing element in Massachusetts.

To explore coordination efforts we reviewed state-level initiatives. We found four states leading the way in developing coherent training systems for a broad group of practitioners. These states identified competencies needed for promotion, prevention, and intervention. One state developed a system for endorsement through a portfolio review process. None of the promising practices we found in other states can be adopted without adaptation to the unique opportunities and challenges in Massachusetts. However, we must move forward to build on the investments we are already making.

Recommendations for Massachusetts

- Promote a culturally competent IMH training model that supports and enhances the dynamics of relationships.
- Require foundation IMH training for all professionals interacting with babies, toddlers, preschoolers, their families, and other significant caregivers.
- Provide appropriate professional and/or academic recognition for IMH training.
- Deliver in-service training that brings together staff from every level of an agency or program e.g., director, supervisor, frontline.
- Encourage academic institutions to set up degree programs in broadly defined IMH.
- Include training in each state initiative focused on children ages birth to five.
- Integrate an evaluation component into all IMH training.

INTRODUCTION

The National Academy of Science's publication of *From Neurons to Neighborhoods*, which synthesized thirty-five years of basic science and evaluation research, affirmed biology is influential but emphasized the central role of relationships in guiding developmental outcomes (Shonkoff & Phillips, 2000). "Good enough" relationships enhance a child's self-confidence, promote comfort in the face of life's stressors, and support learning. When a parent or caregiver has difficulty responding in nurturing ways, the child suffers emotionally, physically, and intellectually and the caregiver experiences distress and discomfort.

When early mental health pioneers articulated the importance of early relationships, they focused their attentions on the period of infancy. As the field has matured, the notion of early childhood mental health has expanded to include the prenatal period through at least age five. In this report, the term Infant Mental Health (IMH), also known as early mental health or early social and emotional development, refers to the developing capacity of children ages birth to five to experience, regulate, and express emotions; to form close and secure relationships; and to explore the environment and learn within the context of family, community, and culture (Zero to Three, 2001).

Many professionals are in a key position to support the mental health of the 400,000 children aged birth to five, their parents, and other significant caregivers living in the Commonwealth of Massachusetts (U.S. Census Bureau, 2004).

- Over one quarter of them, 173,000, attend childcare and interact with early childhood educators (Massachusetts Early Education and Care, 2006).
- 29,000 babies and toddlers and their caregivers experiencing—or at risk for experiencing—developmental challenges will receive services from Early Intervention practitioners (R. Benham, personal communication, January 22, 2007).
- 12,000 children under the age of five who have experienced abuse and/or neglect will receive services from social workers in the Department of Social Services (Massachusetts Department of Social Services, 2004).
- Children usually see a pediatrician for 12 recommended well child visits from birth to five. Universal health care in Massachusetts makes this a more likely possibility for all 400,000 children.

The number of babies, toddlers, and preschoolers receiving mental health services in Massachusetts is not yet fully documented. However, a recent analysis of Early Intervention (EI) participants enrolled in EI programs from 1998 through 2000 shows that of the 7,337 infants between birth and twelve months enrolled with identified social/emotional delays, only 454 were referred to licensed mental health practitioners (Massachusetts Department of Public Health, 2006).

The responsibility for fostering nurturing relationships and repairing disruptions is not just the province of mental health professionals, nor should it be. A pediatrician who helps a mother notice her baby's engaging smile can mitigate that mother's anxiety and help her see her baby more clearly. A caring, consistent childcare teacher can ease the pain of a toddler and parent struggling to understand each other. A physical therapist trained to help a father accurately interpret his baby's looking away as a request for a break—not annoyance with the father—increases the father's pleasure and the baby's sense of competence.

Babies are born to communicate and parents are "wired" to respond but learning to become a good working team does not always come easily. Research using electronic imaging technology in the neurosciences and videotaping in the social sciences is rapidly expanding the knowledge base available to practitioners describing with increasing precision the unfolding process of relationship development and suggesting ever more effective ways to support interaction. Challenges to communication can arise from the young child's unique personality including temperament and biological strengths and challenges and from the caregiver's personality, experience in past relationships, knowledge of child development and psychological challenges. Fully nurturing babies and young children takes time and the support of others.

In a parallel process, professionals who work with young children and their parents rely on the nurturing connections that they develop with others to do their work well, expand their skills, and keep abreast of the rapidly developing knowledge base. Supervisory relationships within agencies and programs can help staff members to identify their knowledge, skills, and take next steps in acquiring and integrating training.

Responding to the rapidly expanding research base, training for professionals who work with babies, toddlers, and preschoolers must shift to a relational approach (Foley & Hochman, 2006; Norman-Murch, 2005). However, making that shift is a challenge. Most professionals currently working with very young children and their families were trained in paradigms that highlighted individual development. In addition, only a very few professional academic programs include in-depth coursework on infant, toddler, and preschool emotional well being that integrates a relational perspective. ***Infant Mental Health training must fill this gap.***

The need for substantial new investments in training has been recognized nationally.

> Substantial new investments should be made to address the nation's seriously inadequate capacity for addressing young children's mental health needs. Expanded opportunities for professional training, as recently called for by the Surgeon General…are essential first steps toward more effective screening, early detection, treatment, and ultimate prevention of serious childhood mental health problems. (Shonkoff & Phillips, p. 388)

Training in IMH principles and practices for multiple disciplines acknowledges that all early childhood practitioners are involved in the promotion of emotional well being and the amelioration of emotional concerns. However, this does not suggest that professionals from a wide range of disciplines will or should become psychotherapists (Foley & Hochman). Training that emphasizes the centrality of relationships advances a common perspective and a shared language for the professionals working with a family and encourages working partnerships among those professionals. For example, a childcare provider trained in a relational perspective will be more likely to seek help from a mental health consultant for insight how to work with a particular preschooler rather than asking the consultant to "fix" the child. Furthermore, a trained mental health consultant will be less likely to immediately take a preschooler out of a classroom rather than working with the classroom staff to provide individualized assistance.

Training can also influence policies and practices. In early care and education systems that fully integrate IMH principles, mental health consultations are regularly available and create collaborative relationships with staff to help promote a positive environment for staff, parents, and children in addition to being available to address the particular needs of individual children (Johnston & Brinamen, 2006).

Connected Beginnings Training Institute was founded in July of 2006 by the United Way of Massachusetts Bay (UWMB) to fill an identified need to expand research-based birth-to-five mental health training in Massachusetts for professionals who influence the mental health of children from birth to five. UWMB identified some alarming trends in Massachusetts, including the high incidence of pre-kindergarten expulsions (Gilliam, 2005), preschool children demonstrating emotional difficulties (Wenz-Gross & Upshur, 2006) and maternal depression (Jacobs, Easterbrooks, Brady, & Mistry, 2005). Concurrently, there is growing acknowledgment of the value of birth-to-five mental health training. With this intersection of need, opportunity, and momentum, the time is right for bringing together the disparate and innovative birth-to-five mental health efforts in the Commonwealth's public, private, and non-profit sectors into a coordinated, cohesive system.

This report reviews 24 individual training programs in 13 states. In addition it provides an overview of several state initiatives to coordinate training in several areas of the United States. To get an idea of the variety of training practices employed for training the large potential audience in Massachusetts we did a scan of the training environment and found promising IMH programs and models that reach a relatively small numbers of advanced frontline practitioners. The report is intended to be a catalyst for dialogue among trainers, policy makers, and professionals about how to scale-up to reach a broader constituency and to promote ongoing discussion with families and caregivers. The report does not claim to be fully comprehensive. There might be other programs in the U.S. with less visibility. The sample was compiled from the programs listed with Zero to Three and expanded to include additional programs and modified through additional research in the fall of 2006.

UNDERLYING PHILOSOPHY

A survey of 24 Infant Mental Health (IMH) training programs in 13 states and the District of Columbia reveals a common underlying theme: effective training requires a complex synthesis of philosophies concerning the social-emotional well being of the infant and family. Given the multidisciplinary history of the field of Infant Mental Health itself, the natural evolution has been for programs to consistently integrate relational, biological, developmental, cultural and contextual factors into the training process and into the content offered to training participants. Training programs place simultaneous emphasis on the inner world of young children and their caregivers and the dynamics of these central relationships. *While a training site may lean more heavily toward a particular discipline or philosophical model, at its core is a transactional, relationships-based approach to training and intervention.*

Infant Mental Health programs across the United States derive their specific "brand" of training from a number of existing training and intervention philosophies. A training model may be formulated based on the potential clientele (e.g., children ages birth to five whose parents are engaged in treatment for mental health issues), the trainees (e.g., early childhood educators, clinicians, medical staff), or particular assessment, intervention, or research tools. Programs may take a broad approach, offering an overview and introduction to the skills needed to work with young children and their families, or narrow in on a more specific set of skills (e.g., advanced clinical intervention training for post-graduates).

Training may accentuate a particular technique or skill, such as observation of the caregiver-child dyad, or a specific milieu (e.g., home visiting, childcare program). A large number of programs work within a particular discipline or domain. For instance, programs such as the School of Infant Mental Health (SIMH) in Denver, Colorado, and London, England, or the Observational Studies with Parents and Babies in Washington, D.C., emphasize clinical assessment and intervention within a psychodynamic framework using a Tavistock-based home visiting model. Alternatively, training may respond to the mental health needs of a specialized population, such as the Child Trauma Research Project in San Francisco, CA.

Selection of a training methodology or philosophical approach may also depend upon the nature of a training program's collaborative partnerships with other organizations. While stand-alone training programs may originate their own approach (e.g., Infant-Parent Institute in California and Champaign, IL), others have designed models based on the philosophical roots of the university, hospital, or agency with which they are affiliated (e.g., Irving Harris Program in Child Development and Infant Mental Health at the University of Colorado at Denver, Department of Psychiatry).

In sum, Infant Mental Health training practice across the country reflects central themes permeating the field of Infant Mental Health and specific methodologies designed by individual training sites. Universally inherent to training development has been the consideration of culture, collaboration, treatment, content, skill development, and philosophy, all of which are blended within each program in order to meet the needs of trainees and the families they serve. Yet each program has, in its own unique way, translated philosophy into practice. Thus, only an examination of the full landscape of infant mental training informs "best practice."

PARTICIPANTS

Infant Mental Health training participants come from a range of disciplines, including early childhood educators, physicians, nurses, doulas, occupational therapists, physical therapists, psychiatrists, psychologists, protective service workers, social workers, special education practitioners, juvenile and family court personnel, policy specialists, faculty members, and researchers. They work in hospitals and in community-based childcare, child welfare, academia, courts, primary health care clinics, Early Intervention, prevention, home visiting, and mental health settings. One way to group the target audience for IMH training is:

- *Professionals with graduate degrees including licensed mental health practitioners*
- *Students enrolled in masters or doctoral programs*
- *Professionals with high school, associates, bachelors and graduate degrees*

Programs differ significantly in their approach to participation in trainings; that is, configuration of the groups' participants in any given training varies. For instance, some programs target a single group (e.g., post-graduates in clinical psychology) while others intentionally combine groups varying skill levels and experience (e.g., experienced early childhood educators, mental health professionals, occupational, physical and speech therapists, and court personnel). The former model has the advantage of training a fairly professionally homogenous group, yet may not fully capitalize on fostering communication among the many professionals serving young children and their families. Conversely, the multidisciplinary model, while benefiting from information-sharing among professionals of different disciplines, faces the distinct challenge of training participants with different levels of knowledge and expertise.

Professionals with Graduate Degrees

Post graduate professionals pursuing additional Infant Mental Health training in include: licensed psychologists and social workers, physicians, nurses, occupational therapists, physical therapists, and speech therapists. The range of IMH training opportunities available to these participants includes: *clinical fellowships* (e.g., Columbia Center for Psychoanalytic Training and Research); c*ertificates/endorsement* (e.g., Alliant International University /California School of Professional Psychology, Erikson Institute or Irving B. Harris Training Center for Infant and Toddler Development/University of Minnesota); and *specialized trainings with no formal recognition* (e.g., Early Childhood Mental Health Training Program at Children's Hospital & Research Center in Alameda County, CA). Generally these programs are geared toward clinical intervention.

Students Enrolled in Masters or Doctoral Programs

Graduate students seeking training in Infant Mental Health are typically enrolled in masters and doctoral programs that work in collaboration with Infant Mental Health training programs or provide the coursework within their own departments (e.g., clinical social work, psychology, pediatrics, child development). These graduate programs may offer a single degree in an Infant Mental Health related field (e.g., Arizona State University Department of Family and Human Development or Napa Valley College) or a dual degree (e.g., combined child development/social work programs at Erikson Institute/Loyola or Bank Street College/Hunter School of Social Work).

Professionals with High School, Associate's, Bachelor's, or Graduate Degrees

Staff in agencies and programs who work directly with infants, toddlers, preschoolers and their families currently access Infant Mental Health training in all of the locations examined in this report: Arizona, California, Colorado, Connecticut, Florida, Illinois, Louisiana, Massachusetts, Michigan, Minnesota, New Jersey, New York, Oregon, Washington, and Washington, D.C. This group of participants includes early childhood educators, family childcare providers, early childhood directors and supervisors, early intervention workers, Head Start workers, protective service workers, court personnel, and home visitors. The typical model of training developed for what are often referred to as "frontline" workers combines several of these disciplines into a given training group rather than targeting a single area of professional practice. This group is generally involved in promotion of emotional well being and prevention.

A Note on Interdisciplinary Participation

Finally, several programs offer interdisciplinary training models that do not fit neatly into one of the three above categories. For example, the University of Washington has introduced an interdisciplinary pre-professional training combining graduate students in nursing, social work, psychology, public health, early childhood, special education, educational psychology, and other related disciplines at the Center on Infant Mental Health and Development. In Florida, the Harris Training Institute conducts a 10-month training series that combines non-clinical and clinical professionals in one training setting. All of the participants meet together on Fridays and clinicians return for specialized training on Saturday. The interdisciplinary model appears to mirror a philosophical approach that emphasizes professional collaboration and communication across disciplines.

Questions to guide discussion:

- *What are the benefits and challenges of heterogeneous training groups (e.g., mixed disciplines, varying levels of experience and training, differing professional roles in promotion, prevention, and intervention)?*
- *What are the benefits and challenges of more homogenous training groups?*
- *Who is the "target audience" of potential trainees in Massachusetts?*

CURRICULUM CONTENT

In developing curriculum content, IMH training programs make a series of decisions in order to balance breadth and depth. For instance, 11 of 24 programs define the age range of "Infant Mental Health" as birth-3 while 13 programs use the range of birth to five years old. Further, the programs may identify promotion, prevention, or intervention (or a combination) as a guiding aim of the curriculum. These decisions inform the content delivered within the programs' training sessions.

While programs may vary in their specific curriculum content, a survey of training programs in fourteen states identified several recurrent content areas that were explicitly mentioned in many programs' materials:

- *Emotional development of young children*

- *Emotional contribution of parents and other caregivers*
- *Dynamics of relationships*
- *Influence of culture on caretaking practices and expectations*
- *Contribution of trauma, substance abuse, and domestic violence to the infant-caregiver relationship*
- *Use of screening, assessment, intervention and research tools.*

For specific data on which programs or how many programs include any particular content area, consult Appendix A.

Emotional Development of Young Children

All of the programs addressed the emotional development of young children in their curricula. This developmental perspective takes into consideration the progression of the emotional experience of the young child, as well as the interaction of emotional states with other areas of development (e.g., cognitive, fine and gross motor, speech, and language). Social-emotional development is viewed as unfolding within and influenced by caretaking environments. This content covers the full range from normative development to early mental health disruptions and disorders.

Emotional Contribution of Parent and Other Caregivers

Because the child's development occurs within a context occupied by others, the emotional contribution of caregivers to the emotional and social experience of infants and young children is explicitly addressed in promotional materials for 23 of the 24 programs examined.

Dynamics of Relationships

Because relationships are transactional, 23 programs include an examination of the dynamics of relationships in their curricula. This element acknowledges that the relationship consists of not just the experience of the infant or young child and the experience of the caregiver as separate domains but also the interaction between and among them, which is continuously changing and developing as each responds to the other.

Influence of Culture on Caretaking Practices and Expectations

The influence of the culture or cultures surrounding the infant/child-caregiver relationship is another aspect many programs address. For example, some curricula identify specific ethnic communities practitioners may encounter, focusing on a cultural competence perspective. The list of competencies developed by the Florida State University Harris Institute includes the goal that a trained Infant Mental Health practitioner understands the impact of the cultural and community context in which the infant is being reared. Other programs take a microculture level approach. For instance, the Napa Infant-Parent Mental Health program encourages participants to consider the experience and expression of the unique individuals, as well as family and societal culture, and how this impacts parenting and the infant-parent relationship. Programs often did not include and explicit "cultural focus" in their literature yet may or may not have integrated culture throughout their curricula.

Contribution of Trauma, Substance Abuse, and Domestic Violence

Several programs address the impact of trauma, substance abuse, and domestic violence on the infant-parent relationship and the emotional experience of the young child. For instance,

the Child Trauma Research Project in San Francisco, CA, trains psychiatry and law professionals in early childhood mental health for treating children birth to six who are exposed to violence and experience traumatic loss. The project also trains staff at domestic violence shelters in recognizing and addressing the needs of infants, toddlers, and preschoolers in their shelters.

Screening and Assessment Tools

At least 10 programs explicitly mention in their materials that they train participants in the use of assessment and screening tools for social and emotional health and/or risk. These tools range from diagnostic measures (such as the DC:0-3) to developmental scales. The program recommendations for assessment tools may stem from the philosophical approach. For instance, psychodynamic programs seem to rely on observational assessment and "prefer to teach clinicians how to watch and how to be with infants and parents" (Trout, personal communication, October 23, 2006). Alternatively, ecosystemic oriented programs are more likely to integrate tools that have been standardized and normed (e.g., the Napa Infant-Parent program's use of the NCAST Feed & Teach).

Research and Outcome Measures

Research-oriented programs, often located in academic settings, employ a host of different measures selected according to the topics and hypotheses of the research. A full list of the specific tools, used for assessment, screening, or research and identified by the programs, is listed in Appendix B.

Questions to guide discussion:

- *To what degree should the complementary approaches of promotion, prevention, and intervention be included in IMH training and practice in Massachusetts?*
- *Which social and emotional early screening and assessment tools will best address the needs of practitioners and families?*
- *How can the IMH training curriculum best reflect and address the cultural diversity in Massachusetts?*

KEY SKILLS

Regardless of the level of training needed, four key skills emerge as essential to the training in—and, subsequently, the practice of—Infant Mental Health. They are: *observation, interpretation, self-reflection, and establishing and maintaining an empathic relationship*. While the wording may change from state to state and program to program, the concepts remain salient for all levels of practice. For example, Florida's Harris Institute articulates these concepts as a set of skills that then translates into practice in the form of a four-step model for practitioners: awareness *of development* (interpretation), *observation*, *identifying risk* (reflection), and *creating opportunities* (maintain relationship and build change).

COMPETENCIES

Beyond these four key skills, leaders in the IMH training field articulate more exhaustive and specific competencies that they envision as essential to the practice of Infant Mental Health. Florida State University's Harris Institute identified a list of 140 key competencies through an extensive process of searching the literature and interviewing experts. Michigan identified their key competencies through a rigorous 8-year process. Programs in several states have adopted or adapted these competencies for their use. Key competencies inform curriculum development, training offered, and the endorsement process.

Questions to guide discussion:

- *Which key skills and competencies are essential for best practice in IMH?*
- *Are there core competencies for working with ages birth-5 and discrete competencies for birth-3 and 3-5?*

DELIVERY METHODS

The specific method of delivery of Infant Mental Health training programs are determined by the needs of the participants and the resources of the environments where the training takes place. The interaction of needs and resources often trigger program decisions on delivery elements including the program's setting, teaching methods, practicum or field placement, and program length.

Structure and Setting

A program's setting may dictate many aspects of the training program, including the degree of tailoring to the target audience, the requirements for participation, and the potential participants. The following list details specific structures and settings typical within the field of Infant Mental Health training:

- Academic—In the academic setting, participants are seeking degrees or certification for professional practice. The university identifies a structure of coursework to be completed with somewhat limited adaptation to individual training needs. Further, participation requires an application process and acceptance into the program.

- *IMH site training*—Some programs offer training sessions at a site (either at the training program's site or another convenient setting) and invite interested participants to attend. Attendees may range across disciplines and Infant Mental Health skill levels (e.g., front line caregivers, clinical practitioners, policy makers). The training may be built around broad IMH issues or specific competency issues, with a great degree of flexibility according to the needs of the participants and the community.

- *On-site training*—When agencies opt to educate multiple staff members in Infant Mental Health, many decide to host the training on-site or nearby. This arrangement is highly

flexible to the needs of the agencies and allows them to choose topics that are most beneficial to the practitioners they employ. It also encourages participation, since the training can occur during work hours in-house, eliminating travel and logistical issues.

- *Agency based consultation*—At the most flexible delivery level, agency-based consultation brings an Infant Mental Health trainer to meet with and address the questions and concerns of the agency around social and emotional development of young children and their families. The consultation may include some form of formal training, as well as guidance on many levels on how to include IMH in the agency's practice. It may or may not include issues around organizational development.

Teaching Methods

A combination of instructional modes appears to be most effective in delivering IMH training. Training programs generally employ highly interactive modes of instruction to supplement and complement traditional lecture formats. The list that follows represents current modes of teaching:

- *Lecture*—Trainers conduct lectures to relay key information on Infant Mental Health, including social and emotional development, brain development, culture and its role in the caretaking relationship, the parenting experience, and other curriculum content material mentioned above.

- *Observation*—Some element of observation of children and their caregivers was incorporated into over 20 of the training programs. The observations may take place at a center or, in the case of the Colorado and Washington, DC, programs based on the Tavistock model; the observations take place over two years in the infant's home.

- *Videotaped observation*—Along with videotaping young children and their caregivers, eight programs utilize videotaped observation including the practitioner interacting with families. The Harris Institutes in Florida and in Arizona, as well as the Center for Infant Mental Health and Development at the University of Washington all identified videotaped observation of the practitioner as an instructional mode they employ, while at least eight other programs utilize videotape of young children and their caregivers.

- *Reflective supervision and practice*—Reflective supervision offers participants opportunities for intensive reflection on their own histories and culture, as well as their personal and professional reactions to families with whom they are working, thereby supporting the development of the practitioners as they learn how to better support the young children and families that they serve. The use of reflective supervision both as a means of training participants and as a content area of the training itself is common practice among IMH training programs across the country.

Practicum Experience

Through the training process, many programs offer applied settings in which participants can practice and train. Others encourage current practitioners to apply newly acquired skills and knowledge to their current practice. This practicum experience offers the benefit of supervised,

focused interactions with young children and their caregivers while putting the content knowledge into action.

- *Internships*—Frequently a component of graduate programs in medicine, psychology, and social work, internships offer an opportunity for emerging professionals to focus on IMH competencies. Usually supervised by both the academic institution and the site, the internship provides a bridge between knowledge and independent practice.

- *Field placements*—Similar to internships, field placements provide a setting to practice the specific tools gained through the training. They may range from a shorter exposure to an agency to an internship-like, longer assignment.

- *Work applications*—Practitioners who already have access to direct work with infants, toddlers, preschoolers, and their families may be able to incorporate the IMH knowledge and skills into their existing work. The reflective supervision component of the training supports participants as they assimilate this approach into their practice. Training all levels of staff within the same agency supports integration and systems change.

Program Length

Program length ranges from short, part-day training—typically but not exclusively delivered at the training program site—to multi-year programs. Most (over 50%) of the programs cited the length of the training as one year. Not only do the lengths vary among programs, but individual programs sometimes offer varying lengths of courses depending on the proficiency level desired or the discipline of participants. For example, the Institute of Infant and Early Childhood Mental Health in Louisiana offers a one-year clinical psychology pre-doctoral internship, a two-year post-doctoral fellowship for psychiatrists, a one-year post-doctoral internship for clinical psychologists, and various one- and two-day training sessions for learning specific assessment tools. The range of program lengths the Institute offers illustrates the variance both within and among Infant Mental Health training programs.

Questions to guide discussion:

- *What agencies and service delivery settings could host and mentor IMH interns?*
- *How might training program structure and location differ according to level/type of interaction with young children and their caregivers?*

PROFESSIONAL/ACADEMIC RECOGNITION

The professional or academic recognition Infant Mental Health training participants receive ranges from knowledge enhancement or specialization (sometimes accompanied by continuing education credits) to achievement of a particular academic degree. At present, four general models of professional/academic recognition exist among IMH training programs currently operating:

- *Specialization/knowledge enhancement*
- *Continuing education credits*
- *Certification/endorsement/accreditation*
- *Professional/academic degree*

Specialization/Knowledge Enhancement

This first model of Infant Mental Health program (e.g., programs in Connecticut, Florida, Louisiana, Minnesota and New Jersey) trains participants in early child development, emotional dynamics between young children and parents, prevention, screening, assessment, intervention, promotion, and many other related content areas without conferring degrees, certification, endorsement or accreditation. For some training programs this is a conscious and intentional decision based on program resources, logistical issues, or the challenge of providing a meaningful uniform credential across disciplines. For other programs, the lack of formal professional acknowledgement may reflect a lack of consensus on just what constitutes a "specialization" or "expertise" in Infant Mental Health and how such proficiency should be recognized. Programs such as Florida State University's Harris Institute for Infant Mental Health Training award "certificates of completion". Programs that offer certificates may be awarding completion of a particular training, a non-degree program, or a practice specialization. However, this type of certificate is not equivalent to the certification other programs offer.

Certification/Endorsement/Accreditation

Training programs in Arizona, Michigan, Oregon, and Washington offer tangible evidence of proficiency in Infant Mental Health through certification, endorsement, or accreditation upon completion of a program. The length, structure, and content of courses that offer such formal acknowledgement are neither regulated nor consistent across states. However, such systems uniformly intend to indicate a trainee's proficiency in the area of Infant Mental Health.

Continuing Education Credits

Several programs utilize continuing education credits as a means of both attracting potential trainees and acknowledging their participation in training. When the programs are located within an academic setting, participants may choose the form of credit they receive. For example, Portland State University offers a training program entitled "Infant/Toddler Mental Health: A Relationship Based Approach" in which participants can opt either for continuing education credits or academic credit.

Professional/Academic Degree

A range of professional and academic degrees with a focus in the area of Infant Mental Health is available at present (e.g., AA, BA, MA, MSW, PsyD, PhD, MD). As mentioned above, students may pursue a single degree in an Infant Mental Health related field or dual degree with a related field. The vast majority of universities and colleges offer graduate degrees only.

Currently, most states with programs offering degree programs, or which offer academic credit for participation in training (e.g., California, Connecticut, Colorado, Florida, Illinois, Louisiana, Michigan, New York, Washington, Washington, D.C., and New Jersey) also have at least one training program that offers certification, endorsement or accreditation to its participants. Therefore, trainees from these states are not limited to a single training option and may have access to professional acknowledgement options that effectively suit their needs.

Questions to guide discussion:

- *What are the benefits and challenges of the following forms of recognition?*
  - *Specialization/knowledge enhancement*
  - *Continuing education credits*
  - *Certificate/endorsement/accreditation*
  - *Professional/academic degrees*
- *Which forms of recognition might work best in Massachusetts? Why?*
- *How might Massachusetts oversee and regulate such a system?*

COLLABORATIONS

Given the multidisciplinary nature of Infant Mental Health, collaborations are a common feature of training models across the country. While some Infant Mental Health training programs operate independently, 21 out of 24 programs have established creative partnerships by collaborating with universities, hospitals, provider agencies and government agencies, sometimes engaging in multiple collaborations. Frequently these collaborations are headed by public academic institutions. They may include an arrangement between two academic institutions (e.g., dual degree programs) or between an academic institution and another entity, such as a mental health clinic, hospital childcare program, Infant Mental Health Association or government agency. However, a few programs have developed other forms of partnership, for instance between a mental health clinic and a childcare program (e.g., Bank Street College Graduate School of Education/The Family Center).

Questions to guide discussion:

- *Collaborations among which types of agencies, programs, institutions, etc., would best support effective IMH training in Massachusetts?*
- *How can the systems within the Commonwealth best encourage or support these collaborations?*

FUNDING

Training programs obtain funds for start-up and ongoing operations in several ways, including:

- *Foundation grants*
- *Funding through government agencies*
- *Tuition dollars*

Foundation Grants

Foundation grants are among the most utilized funding options for Infant Mental Health training programs. A leader in the area of Infant Mental Health philanthropy and entrepreneurship, Irving B. Harris and the Harris Professional Development Network, has provided start-up and ongoing operating funds to eight programs across the country. Most of the Harris supported programs augment grant monies with funding from public agencies and tuition dollars.

Funds through Government Agencies

No single state agency consistently funds Infant Mental Health training in the United States. A few state-level departments currently contribute to IMH training. For example the Florida Agency for Health Care Administration provides some funding for training through the Harris Institute for Infant Mental Health Training at Florida State University. In California two IMH programs are publicly funded through county rather than state agencies (Alameda County Children and Families Commission; Napa County Health and Human Services; Napa County Office of Education).

Tuition Dollars

The use of tuition dollars for the funding of Infant Mental Health training is the most common method of funding ongoing operation costs (14 out of 24 programs). At present, over a dozen academic institutions utilize student fees to finance the training they provide. While these funds may be supplemented by foundation grants (often the Harris Foundation), students finance their own attendance and training.

Questions to guide discussion:

- *What are possible resources for ongoing funding (e.g., foundation grants, funding through state agencies, tuition dollars)?*
- *Ideally, what role should state agencies have in funding IMH training? Which agencies?*
- *Which colleges and universities might be most interested in collaborating and funding IMH training in Massachusetts?*

STATE EFFORTS TO DEVELOP IMH TRAINING SYSTEMS

A number of states (Michigan, Texas, Oklahoma, New Mexico, Arizona, California, Vermont, and Florida) are leading the way in developing coherent training systems to ensure that professionals working with very young children and families have the skills and knowledge they need to provide services that: promote well being, prevent problems from escalating, and intervene to address emotional distress. Implicitly or explicitly these training systems promote school readiness by strengthening early relationships, family functioning, and young children's skill in emotional regulation and social interaction. These states also recognize that promoting social and emotional well being is the responsibility of many professionals including educators, childcare providers, pediatricians, doulas, lactation consultants, and practitioners in early intervention and special education, and child welfare social workers.

Two goals are consistently articulated: 1) to identify competencies and 2) to develop a process for demonstrating competencies in keeping with the roles of all professionals, ranging from those who interact directly with babies, toddlers, preschoolers, and families to infant mental health professionals, who intervene when babies and their significant caregivers face challenges such as depression or Post Traumatic Stress Disorder. The importance of reaching the broad range of professionals who interact with very young children and families appears in every statewide formulation. The organization of the competencies and the age range specified differs across states. All of the states identified at least cover prenatal to age three. Some cover the prenatal period through ages five (Florida), six (Texas), or eight (Vermont). California outlines a framework for birth to three years of age and three to five years of age and clearly states that additional training is needed for individuals and programs interested in training across the birth-to-five age span.

Competencies and Levels of Competence

MICHIGAN*:* Michigan, through its Association of Infant Mental Health (MI-AIMH), identified eight broad competency domains for "culturally sensitive, relationship-based practice promoting infant mental health." MI-AIMH developed a system of endorsement based on practitioners' mode of contact with infants and families as well as their particular place in the promotion to intervention continuum. The process took eight years to complete. Other states including New Mexico, Oklahoma, Texas, and Arizona are using and at times adapting the MI-AIMH competencies and its system of endorsement.

The Michigan Association of Infant Mental Health is currently providing endorsement at four levels through a portfolio review process. The levels identified are:

1) *Infant Family Associate* (promotion) e.g., childcare teacher, doulas;
2) *Infant Family Specialist* (prevention/intervention) e.g., home visitor, NICU nurse, child protective service social worker, early intervention practitioners;
3) *Infant Mental Health Specialist* (intervention/ treatment) e.g., mental health clinician/supervisor, lactation consultant, early intervention specialist; and
4) *Leadership* e.g., infant and family program supervisor, administrator, researcher, faculty member, policy specialist, physician.

The minimal education requirement for each level begins with a Child Development Associate (CDA) for Level 1 and continues through masters, doctorate, and medical degrees for Level 4.

IMH sites in Texas, Oklahoma, New Mexico, and Arizona are in the process of using/adapting the Michigan system. New Mexico, Oklahoma, and Texas purchased the license and are adapting the Michigan competencies to create a system that fits the states' individual needs and environment. For example, Texas is adapting the Michigan system (focused on prenatal to age three) for a state system that will include children birth to 6 years of age and their families. Arizona is waiting to receive funding to adopt the MI-AIMH competencies and integrate them into their state systems, particularly Healthy Families Arizona.

> The core MIAIMH competencies were agreed upon by expert consensus. They are interdisciplinary and embrace professionals from multiple fields. The competencies provide a framework for best practice, the development of pre-service and in service training experiences, curricula for the promotion of infant and early childhood mental health, and acknowledge professional competency at multiple levels. The competencies do not lead to a license to practice; rather, they are used to develop an infant mental health specialization within or across disciplines. Licensing is governed by state rules, not the competencies. (D. Weatherston, personal communication, December 19, 2006)

VERMONT: Vermont released a Draft of Infant Mental Health Competencies in September of 2006 for professionals working with children from birth to age 8. The draft builds on the work of the Children's Upstream Services (CUPS) project that began identifying knowledge and practices that promote young children's social and emotional development in 1997. The competencies are organized by six categories: Philosophy and Professional Orientation, Child Development, Family Systems, Assessment, Addressing Challenges, and Systems Resources. Skill levels organize each category:

1) *Foundational*,
2) *Intermediate* skills necessary for working with children and families who may exhibit challenges,
3) *Advanced* skills for overseeing planning or providing consultation to others regarding challenges, or
4) *Expert skills* required for working with the most specialized situations and for providing leadership to the field.

The levels were created to assist current personnel preparation programs and licensing agencies to integrate these competencies into coursework and in determining whether or not providers possess the skills and knowledge recommended for particular positions. The draft report anticipates that special endorsement or certificates will be created for competencies that are beyond the existing systems to identify providers with specialized skills in early childhood and family mental health.

The important distinction in this system is the nature of services the practitioner offers and the expertise required rather than the professional's degree. For example, a pediatrician and a doula might choose to be trained at the foundational or the advanced level.

CALIFORNIA*:* California developed training guidelines and recommended personnel competencies in 2003 following a pilot study in eight counties including San Francisco, Alameda, Los Angeles, Sacramento, and Fresno. Training guidelines are divided into infant and preschool "matrices." This system identifies two groups for training: *core providers* and *mental health practitioners*.

Core providers are the professionals with the most frequent contact with very young children and their families. They are identified as the most likely individuals to provide promotion and "preventive mental health interventions" and "to partner with and make referrals to mental health practitioners, e.g., EI, Nursing, OT, PT, Speech and Language Pathology, Special Ed and Human Development. Early Childhood Educators."

Mental health practitioners are mental health providers who received significant clinical training but modest training, if any, in the provision of services to very young children and their families. The training goal for this group is to enable these professionals to do in depth clinical work with families and caregivers of very young children.

FLORIDA*:* Florida adopted a Strategic Plan in 2000 with the over-arching goal of developing "a comprehensive system to effectively prevent, identify and treat emotional and behavioral disorders in families with children birth to age five." The planning process was partially supported by a Mailman Foundation grant and explicitly called for a system of appropriate training. One of the specific goals was to build a training infrastructure for three levels of practitioners:

1) *Front line caregivers*
2) *Early interventionists*
3) *IMH therapists*.

Given that there were no licensed mental health practitioners with specialized training in infant mental health, the first priority was to provide training for this group. The effort has been successful-at the beginning of 2007 there are 100 licensed practitioners who have been trained in infant mental health principles and practices (personal communication M. Graham, January 22, 2007).

In 2004 Florida State University (FSU) in collaboration with the FSU Center for Prevention and Early Intervention Policy and the Florida Agency for Health Care Administration began the Harris Institute for Infant Mental Health Training. The Harris Institute conducts training in each of the three levels. This includes two-day introductory trainings on "What Is IMH?" for level 1; six month two-day trainings for level 2; and an intensive 10-month training for series for level 3 licensed mental health clinical professionals. A combined level-2 and level-3 class was offered in the under-served panhandle region of the state, where both levels attended on Friday and only level 3 attended on Saturday in order to address issues of diagnosis and treatment. This model was highly successful in making it possible to train in their region and in bringing together the different providers, building relationships and working partnerships.

In order to identify key competencies, staff at the Harris Institute at FSU searched the literature and handbooks including those from MI and CA, gathering a list of 100 skills and topics. They took the list to an expert panel, which added another 40.

The training institute does not endorse, credential, certify, or license participants. They may receive CEUs and receive certificates of completion. As they build capacity in the state, they may re-examine the issue in the future.

Endorsement through a Portfolio Process

Portfolios are a vehicle for organizing the process of training and allow for self-assessment and outside review. In Michigan, the Michigan Association of Infant Mental Health (MI-AIMH) provides official endorsement. Candidates must be members of MI-AIMH and present a portfolio that demonstrates achieving competency in a particular level. The portfolio review includes official transcripts from educational institutions, specialized in-service training, paid work experience, professional work as appropriate (e.g., publications, committee membership or leadership roles related to the well being of infants, toddlers, caregivers and their families, reflective supervision or consultation experiences), and three professional references. Endorsement for Levels 3 and 4 require a written exam. Michigan charges a fee for the license to use their system, which includes technical assistance over a two-three year period.

The California workgroup reached the conclusion that practitioners and potential supervisors would benefit from an organized process and a self-assessment portfolio. The workgroup developed a Personal Portfolio requirement based on the work of other states. California has a long-term goal of establishing a statewide entity responsible for personnel standards and a state endorsement or certification and specialization in infant and preschool mental health. At the time of the writing of this report, the California School of Professional Psychology at Alliant International University is offering two certificates in Infant-Preschool Mental Health. However, a state level system is still in process.

Funding, Leadership, and Coordination

As noted above, private foundations led by the Harris Foundation, state agencies, and state and private institutions of higher learning work in partnership and in various combinations in each of the states we reviewed. For example, in California, the California Department of Mental Health, WestEd Center for Prevention and Early Intervention, and California First 5 Children and Families Commission provided leadership for developing training guidelines and recommending personnel competencies (California's Infant, Preschool & Family Mental Health Initiative, 2003).

Mental Health Associations affiliated with the World Association of Infant Mental Health have played a key role in many states. In Michigan, the Michigan Infant Mental Health Association (MIAIMH) led the effort in developing competencies and promoting the state agenda for training. The Infant Mental Health affiliates in New Mexico, Oklahoma, Texas, and Arizona are taking the lead in using and adapting the MIAIMH to fit their states' missions and goals.

In Vermont, the process of developing the Early Childhood and Family Mental Health Competencies began in 1997 with Children's Upstream Services (CUPS) under the leadership of the Department for Children and Families, Child Development Division. Over time, the Child Development Division provided a grant to Vermont Northern Lights Career Development Center for Early Childhood to unify the professional development system in the state.

Each state is moving to integrate competencies into frontline practice and generally seem to begin with agencies or departments that demonstrate the most interest. For example in Arizona Health Families Arizona will probably be first to integrate the Michigan competencies into

training. In Michigan, Detroit-Wayne County Community Mental Health Agency, the largest community mental health board in Michigan, recently expanded infant mental health services in Wayne County with a $7 million initiative. The initiative requires and is paying for introductory training for all infant mental health staff (D. Weatherston, personal communication, December 19, 2006).

Funding training remains a challenge in every state. For example in Florida, a state with a strategic plan for Infant Mental Health has no regular funding allocation for training in the state budget. FSU has a large contract with Medicaid that includes IMH training and the Department of Juvenile Justice contracted with the Harris Center with some unallocated dollars at the end of the year to provide IMH training for probation officers to help them support mother-infant relationships.

THE MASSACHUSETTS INFANT MENTAL HEALTH TRAINING LANDSCAPE

Massachusetts is fortunate to have professionals from many disciplines who are devoted to working with babies, toddlers, preschoolers and their families. In this section we first identify a number of promising IMH training programs and models that reach a relatively small number of professionals. Next we identify a number of state-level initiatives, some already explicitly focused on IMH training and others with the potential for addressing this need. Finally we consider some opportunities for and challenges to developing a coordinated system for training.

Overview of Existing Training

Post-Graduate Training in Clinical Intervention

- *Infant-Parent Training Institute* is located in the Center for Early Relationships Support at Jewish Family and Children's Service (JF&CS) in Newton, MA. This is an IMH training program for both experienced and less experienced infant-parent psychotherapists, as well as others who work with young children and parents, such as Early Intervention providers. The Institute offers a two-year, post-graduate training. Courses meet bi-weekly from September to June. Year 1: Infant-Parent Development Course, Group Supervision, and Clinical Casework. Year II: Assessment, Intervention, and Consultation Course, Case Presentation, Dyadic Supervision, and Clinical Casework. Beginning in September 2007, the Infant-Parent Training Institute will offer a one-year certificate program with the option to apply for a second year. Faculty include: Director, *Peggy H. Kaufman, M.Ed.,* Director of the Center for Early Relationship Support Faculty*, Judith Arons, LICSW, Sarah Birss, MD, Ann Epstein, MD, LICSW, Susan Sklan, M.Ed., LICSW, Eda Spielman, PsyD.* and *Claudia Yellin, Ph.D.*

Post Graduate Training in Academic Leadership for Physicians

- *Boston Institute for Early Child Development* (BIECD) at the Boston University School of Medicine, directed by *Margot Kaplan-Sanoff, Ed.D*. and funded by the Irving B. Harris Foundation, trains child development pediatric fellows at Boston University School of Medicine to provide academic leadership in early child development; and pediatric clinicians to promote emotional literacy. In addition BIECD provides technical assistance to those who

care for infants and young children, with an emphasis on the training of health professionals. The Institute's goals include: development of videos, slides, and other curriculum material for directors of developmental and behavioral pediatric residency programs; developing written and video materials and training for other frontline providers in the New England area.

Training for Professionals with a Range of Educational Degrees

- *Brazelton Touchpoints Center (BTC)* in Boston, trains providers in healthcare, early intervention, social services, public health, early education and childcare. BTC offers a 16-hour training for professionals who wish to incorporate the Touchpoints philosophy and strategies into their individual practice within their early childhood settings. The *Early Care and Education (ECE)* training uses Touchpoints Developmental and Relational Frameworks, with particular attention to "elements of parent-child-provider relationships in the first six years of a child's life." The training includes continuing education credits through the National Coalition for Educational and Cultural Programs. Faculty include: Founder*, T. Berry Brazelton, MD,* Director of Special Projects*, Joshua Sparrow, MD,* Project Director*, Lisa Desrochers, M.Ed.,* Director of Site Development and Support*, Ann Stadtler, MSN, CPNP, Constance Keefer, MD, Joshua Hornstein, Ed.D., Terry Ann Lundt, MPA, Jayne Singer, Ph.D.,* and *Ed Tronick, Ph.D.*

- *The Brazelton Institute* under the direction of Kevin Nugent, Ph.D. provides training in the Newborn Behavioral Observation based on an individualized, infant-focused, family-centered approach to working with infants and families in the early months of life.

- *In-Time Mental Health Training* for Early Intervention staff developed by Thom Child & Family Services offers a 30-hour interactive training and 6 hours of on-site consulting in a peer supervision model. Participants from EI agencies include frontline staff, supervisors, and program directors. The training integrates relationship focused infant mental health principles and practices and enhances practitioners' capacity to nurture infant/toddler-caregiver relationships with an understanding of what infants and caregivers bring to relationships. The training explores the role of culture in shaping beliefs and values about raising children. Videotapes are used to develop observations skills and foster dialogue among professionals from different disciplines. Infant and caregiver screening and assessment tools are integrated into the training. *Libby Zimmerman, LICSW, Ph.D*. is the lead faculty. Other faculty include *Ann Easterbrooks, Ph.D* and *Linda Schulz, Ph.D*. The training offers Continuing Education Units for licensed social workers, nurses, and Competency Education Credits for Early Intervention practitioners.

- *Mind in the Making* will be offering a six-day training in March and April 2007, developed by the Families and Work Institute in New York, NY, and brought to Massachusetts by United Way of Massachusetts Bay and the Harvard After School Initiative. The research-based training model for early care and education staff focuses on the role relationships play in nurturing curiosity and learning. The model is a "train the trainer model" and the first training will develop a cadre of trainers for Massachusetts.

- *Together for Kids (TFK)* in Worcester,, directed by Lynn Hennigan, offers a one-year training developed and taught by *Deborah Hirschland, LICSW*. The seminar is intended for mental health clinicians working with "worrisome three- to six-year-olds and their caregivers" considered at-risk for expulsion from childcare. This seminar, funded by the Health Foundation of Central Massachusetts, is being offered in two-hour bi-weekly sessions, for a total of 16 weeks, from September to May 2007. Topics include: the impact of attachment difficulties, trauma, and neglect on early development; the nature of effective communication and growing cognitive capacity in young children; development of regulatory capacities; comprehensive family assessment; strategies for working collaboratively with parents, teachers/early care providers and other specialists; models for parent and teacher/provider training; communication and play techniques with children; and practical approaches to culturally attuned, skill-based work.

Other Training Opportunities

- Boston Institute for the Development of Infants and Parents (BIDIP) is a professional organization established in 1973 to study the dynamic interaction of the psychological, biological, social, and cognitive systems of the infant and those within the infant-parent relationship. BIDIP holds two conferences a year with topics such as: A Look in the Mirror: What We Bring To Our Relationships with The Families We Serve; Helping Caregivers Repair Attachment and Biobehavioral Problems in Young Children Who Have Been Neglected or Abused; Temperament, Life Experiences and Infant-Parent Mental Health. The Institute is affiliated with the Eliot-Pearson Department of Child Development, Tufts University, The Massachusetts School of Professional Psychology, The New England Council for Child and Adolescent Psychiatry, and the Human Relations Service.

- *Massachusetts School of Professional Psychology (MSPP)* "trains mental health professionals to deliver care to the community and equips other professionals with psychological skills to enhance their work." MSPP offers degree programs, as well as non-matriculating courses and will be offering a 10-week infant-toddler/parent intervention training starting March 20, 2007.

State-Level Opportunities

Massachusetts State-Level Investment in IMH Training

Department of Social Service

- *Massachusetts Child Welfare Institute (MCWI)* is a collaborative effort among the Massachusetts Department of Social Services (DSS), Salem State College School of Social Work and The University of Massachusetts Medical School funded by the Federal Administration for Children and Families under Title IVE. MCWI provides education, professional development, and training to DSS staff. The training is currently under review to assess the depth of its focus on very young children and the importance of their relationships with significant caregivers.

Department of Public Health

- *Early Intervention Training Center (EITC) located at the Educational Development Center* provides support and professional development to the Massachusetts Early Intervention community including those seeking certification through the Department of Public Health, Division of Perinatal, Early Childhood and Special Health Needs. A few of the competencies focus explicitly on social and emotional well being.

- *Early Intervention (EI) Inter-Agency Coordinating Council, Program Planning Committee* has been charged with discussing ways to incorporate current research and best practices regarding social and emotional well being into the EI system. A national group Individuals with Disabilities Education Act (IDEA) Infant Toddler Coordinator's Association (ITCA) issued a position paper, *Infant Mental Health Approaches and IDEA Part C* in July of 2005 calling for the integration of infant mental health into early intervention practice. One of the recommendations is to train early intervention personnel in the areas of early social and emotional development including attachment theory and parent-child interactions.

- *Maternal and Infant Mental Health Project*, within the Massachusetts Department of Public Health was funded by the US Department of Health and Human Services in 2006 to improve mental health services for pregnant and parenting women and their infants up to one year of age with a focus on the mother-infant dyad. The three-year project will reach a vulnerable population served by the Early Intervention Partnership Program (EIPP) and Early Intervention (EI) Programs including families living below 100% of poverty, minorities, those at risk for poor maternal and birth outcomes including infants at risk for social and emotional delays. The project includes a training component for practitioners.

State Initiatives Focused on Addressing Emotional Needs of Very Young Children

The following are innovative grants for addressing the problem of pre-school expulsions and responding to the emotional needs of very young children. These grants do not have a built-in investment for training and mentoring the mental health consultants.

Department of Early Education and Care

- Awarded six *Behavioral Issues: Training and Consultation Services* grants across the state. Grant recipients provide on-site consultation, training and mentoring to early childhood and school-age programs with the goal of enhancing "the ability of staff to address the social/emotional needs of children exhibiting significant behavioral difficulties" as well as to reduce early care and education expulsion rates. Grantees located throughout the state specifically target "high needs" areas.

- Awarded nine *Mental Health Consultation Services grants to provide on-site mental* health consultation to early education and care providers and parents, on-site crisis management support, develop individualized behavioral plans for children, conduct on-site observation and assessment of children's social and emotional behavioral skills. The purpose of the grants is to limit suspension and expulsions at the preschool level.

State Level Coordination Efforts with the Potential to Support IMH Training

The Massachusetts Early Childhood Comprehensive Systems Project (MECCS) works both within and outside of the Department of Public Health to coordinate services for young children birth to five. As part of this initiative, the Committee on Early Childhood Mental Health (CECMH) composed of stakeholders from the public and private sectors began meeting in April of 2005with the goal of building on the work of earlier statewide efforts to promote best practices and policies to assure the healthy social and emotional development of young children and their families. One of the top three priorities identified by CECMH was the need for birth to five mental health training for early care and education staff and other frontline providers including physicians.

Opportunities-Challenges-Possibilities

Although Massachusetts is rich in institutions of higher learning, one element missing in the training landscape in Massachusetts is a clinical graduate specialty in IMH either within an academic institution or through a dual degree between schools e.g. social work and child development. Ironically many of the leading researchers in IMH are from Massachusetts. Unlike other states with a more advanced birth to five training agenda, Massachusetts has a mixture of public and private colleges and universities. Bringing together diverse public and private institutions with a capacity to train IMH clinicians and other professionals in an IMH perspective will call upon creativity and a willingness to partner.

We do have a precedent for partnership. From 1997-2003, The University Partnership for Infant Toddler Professionals (UPITP) brought together graduate students and faculty from Boston Medical Center, Boston University School of Social Work, Boston University Sargeant School of Occupational Therapy, Simmons School of Social Work, Tufts University Eliot-Pearson Department of Child Development, Tufts University Boston School of Occupational Therapy, Wheelock College, and Lesley University. An interdisciplinary faculty developed and offered an infant mental health elective course for five years. The effort was initiated by Harris Foundation funds through Boston Medical Center and a contribution from Wheelock College. The effort was sustained through institutional actual and in-kind financial contributions.

The diverse training efforts in the state are organized around a core of knowledge that focuses on the central role relationships and culture play in development and seem to be drawing on content informed by research from a broad spectrum of disciplines. The energy present in the state suggests that we are now ready to promote a common view of research-based training that meets the needs of practitioners serving the birth to five population.

NEXT STEPS

A review of Infant Mental Health training programs across the United States allows us to glean salient features of current practice and, in turn, assists in developing appropriate next steps in the development and implementation of a comprehensive state system in Massachusetts. This research, highlighting states at various points in the coordination of an IMH training system, serves to guide a dialogue about the competencies needed to promote social and emotional well being, identify emotional distress, and intervene effectively to help children and their caregivers get back on track when problems arise. With this dialogue in mind, we embark upon a needs

assessment in Massachusetts which will entail conversations with constituents including: leaders in the field of Infant Mental Health as well as related fields, officials in state government, current and future practitioners (the pool of potential trainees), and the families who may benefit from effective IMH training.

In sum, a state system for recognizing these competencies and fulfilling the obligation to provide high quality IMH training in Massachusetts will emerge from a thorough examination of current best practice, an inclusive needs assessment in Massachusetts, and a dialogue with stakeholders. Central to this process will be answering the questions that have arisen in this report:

- *Who will the participants be and how do we best meet their training needs?*
- *How should training be structured so as to maximize communication across disciplines, level of experience and the balance among promotion, prevention and intervention?*
- *How will curriculum content, structure and service delivery reflect the diversity of practitioners, families and communities?*
- *Which key skills and competencies are essential to best practice in IMH?*
- *Collaborations among which agencies, programs, institutions, etc. would best support effective training?*
- *How do we build process and outcome evaluations into the training process?*
- *How might Massachusetts oversee and regulate an IMH training system?*
- *What resources are available for funding IMH training in Massachusetts?*

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