ADELPHI UNIVERSITY
INSTITUTE FOR PARENTING

Feasibility Study
Addressing the Implementation of
Infant Mental Health Competencies, Standards and Credentials
for Professionals in New York State

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I Introduction

This study was conducted to assess the need and feasibility of implementing a system of Infant Mental Health (IMH -sometimes referred to as Infant and Early Childhood Mental Health) competencies, (standards and/or specifically The Michigan Association of Infant Mental Health Endorsement System) in New York State. The Michigan Endorsement is currently at different stages of implementation in 18 states.

Funded by the FAR Fund and implemented at the Adelphi University Institute for Parenting (AUI for P), this needs assessment and feasibility study examined the workforce capacity and current status of competency standards of multidisciplinary professionals providing programs and services to children birth to five-years-old and their parents within the State of New York. In order to provide a context and standard for comparison and analysis, the current status of competencies, standards and credentialing throughout the United States was also canvased and examined.

This needs assessment included an analysis of information, reports and statistics pertinent to assessing the need for and availability of IMH services in New York State and the capacity (both in quantity and quality) of professionals available to provide those services. The appetite for the implementation of any system of standards and competencies; and specifically the Michigan system, was examined through interviews with respected experts in the field in New York State. In addition, key experts from around the country possessing in-depth knowledge and experience of the major competency/endorsement systems were interviewed at length to gain knowledge of the major existing competency/endorsement systems, answer specific questions and be prepared to provide accurate information to New York State professionals This report is a detailed and synthesized description of the information gathered. Finally, recommendations have been included with regards the original goal:

What is the need and feasibility of implementing the Michigan Association of Infant Mental Health Endorsement System in State of New York.

A. What is Infant Mental Health?

The term Infant Mental Health (IMH), sometimes referred to as Infant and Early Childhood Mental Health (I-ECMH), is synonymous with healthy social-emotional development. IMH refers to the developing capacity of the child from birth to five to experience, regulate and express emotions; form close personal relationships; explore the environment and learn, all in the context of family, community and culture (National Zero to three, 2004). Recent decades of infant research and clinical practice have dramatically changed our understanding of IMH. It is now known that during the first few years of life, from birth through age five, the brain develops at its most rapid and can be regarded as a crucial phase, during which children develop the foundational capacities on which all subsequent development builds and in part depends. Infants require a secure attachment to a primary caregiver, positive caregiver emotional responses, and experiences and activities that foster social-emotional, cognitive, physical and language development (National Scientific Council on the Developing Child, 2005). When infants and young children do not experience positive caretaking they lose critical social, emotional, and intellectual skills, including the ability to trust, to relate to others, to empathize, to have a positive sense of self, to explore and develop cognitively, to regulate emotions and behavior and to develop executive function and as such, school readiness skills.

B. What is Infant Mental Health Practice?

Infant Mental Health (IMH) practice, encompasses the birth through early childhood age spectrum, is an interdisciplinary field that represents a dramatic shift in clinical practice. It acknowledges the early parent-child *relationship* as the foundation and center of healthy social-emotional, cognitive, language and physical development. Infant Mental Health (IMH) practitioners believe in the centrality of the parent-infant relationship and see that relationship as the key to the healthy

development of young children. They understand that these relationships are influenced by parent/caregiver experiences and history, the characteristics and responses that the infant brings to the relationship and the environment which surrounds them (MA-IMH, 2014). The emotional and behavioral challenges seen as children grow older are often related to gaps and lapses in this foundation of their development.

The IMH workforce is multidisciplinary, and encompasses all those who care for infants and toddlers including early care and education providers, home visitors, child health providers, early intervention specialists, speech, occupational and physical therapists and mental health clinicians from a range of disciplines. Understanding the impact of early experience on development and the interdependence and interrelatedness of developmental lines is essential for multidisciplinary IMH practitioners whose work impacts the lives of parents in relationship with their young children.

II. Evidence of Critical Shortages of trained IMH Practitioners:

A. Nationally

The increased demands to meet the needs of infants and young children who have a range of developmental challenges and their families has precipitated national concern about the states' capacity and ability to address the service delivery mandates with a high standard of competence. Between 2000 and 2013 the number of infants and toddlers receiving Early Intervention services has increased by 62%.The number of preschoolers with disabilities receiving Special Needs Preschool (CPSE) services increased by 35% between 2000 and 2013 (Lucas, Gillaspy, Hurth & Kasprzak, 2012). Within those broad parameters the increase of young children with a diagnosis of Autism Spectrum Disorders (ASD) has doubled in the last four years from 1 in 110 in 2009 to 1 in 50 in 2013 creating the demand for infant and early childhood professionals with a relational perspective and specialized skills and knowledge in developmental practice. In addition, it has been estimated that if all children investigated for maltreatment were referred to Early Intervention via the Child Abuse Prevention and Treatment

Act (CAPTA), EI would experience a 70% increase over the number of children served which would severely strain the capacity of most EI programs (Rosenberg & Smith, 2008).

The projected increase in the need for Social Work professionals from 2012 to 2022 is 19% and the anticipated growth in the demand for Social Workers who specialize in child, family and school in the same period is 15% (Bureau of Labor Statistics Employment Projections 2012-2022). In light of increasing numbers of children to be served, coupled not only with current shortages but also the expected increase in retirement of professionals currently in the field, The National Association of Social Workers (NASW) and the American Speech-Language-Hearing Association (ASHA) emphasize the importance of expanding the capacity of current training programs to meet the demand for new, highly qualified professionals.

There is a specific national need and shortage of personnel with expertise in social-emotional development and infant mental health across disciplines.

Mental health in Early Intervention, Preschool Special Needs Services (CPSE) systems and other child serving systems such as child welfare has been identified as an under addressed domain and the need for infant and early childhood professionals with infant mental health expertise is underscored (Foley & Hochman, 2006). The framework of the 'Pyramid Model" has often been chosen by policy advising and technical assistance agencies for structuring systems that support the promotion of social and emotional competence in infants and young children (Azzi-Lessing, 2010; Colorado's Center for Social Competence and Inclusion, 2009; Perry & Kaufman, 2009; Pennsylvania Early Childhood Mental Health Advisory Committee, 2009). Acknowledged in this choice is that the foundation of the service delivery pyramid is dependent on building an effective workforce that is well-trained on best-practices of Infant Mental Health and development. A study by the National Center for Children in Poverty identified promising approaches to supporting social-emotional wellbeing of infants and toddlers through early Intervention Programs and concluded, "Perhaps the most important factor affecting the quality of interventions that infants, toddlers and their families receive in Early Intervention is the

knowledge and skills of the professionals who provide early intervention services" (Woods, Smith, & Cooper, 2010, p.7). That said, national surveys have identified shortages in the number of professionals with adequate proficiency in infant mental health knowledge and intervention skills and more pointedly a paucity of programs available to train them (Meyers, 2007; Korfmacher & Hilado, 2008). An Illinois statewide survey found that 70% of early intervention providers felt unprepared to identify and intervene to meet the social-emotional needs or to respond to parental concerns (Onunaku, Gilkerson, & Ahlers, 2006). In an issue of the American Psychologist devoted to IMH, Nelson and Mann state, "There is a shortage of psychologists and other practitioners qualified to provide intervention and treatment with infants, toddlers and their families, let alone to provide the training programs needed to increase capacity" (2011, p. 133). Building workforce capacity with competence in infant mental health and expanding professional programs to train infant and early childhood mental health practitioners continues to be a recurrent and central theme in the advocacy literature. The Center for the Study of Social Policy in its Results-Based Public Strategies for Promoting Children's Social, Emotional and Behavioral Health Statement (2012) identified having well-trained staff as critical and recommended an expansion of staff training and development. National Zero to Three in Nurturing Change: State Strategies for Improving Infant and Early Childhood Mental Health (2013) in its recommendation to states, identified building capacity and expanding professional development as among the core components for addressing the promotion, prevention and treatment of social-emotional health. The National Center for Children in Poverty (NCCP) in its report Building Strong Systems for Young Children's Mental Health: Key Strategies for States and a Planning Tool (2013) identified developing a better-trained workforce to address early social-emotional problems as essential. Without well-trained professionals the entire service delivery system for 0-5 year olds with developmental and psychosocial disabilities and their families falters, which underscores the urgency for action as expressed by the Pennsylvania Early Childhood Mental Health Advisory Committee's Immediate Recommendation to: "force transformation by adopting and promoting a set of early childhood mental health competencies

for all professionals and across all levels of service provision for families with children from conception through age five" (2009, p.11). The same committee also recommended, "Increase the number of university programs providing specialized attention to early childhood mental health" (2009, p.8). Such sweeping and urgent recommendations speak to the magnitude of the need not only for all infant and early childhood professionals to be mental health informed but also and specifically the need to prepare early intervention professionals with expertise in infant and early childhood mental health and development, able to practice across service delivery systems. The need in the field is two-fold: quantity and quality of expertise. These are addressed together as the needs are interrelated.

An analysis of Child and Family Services Reviews and Program Improvement Plans from 32 states found that 97 % of the programs failed to meet standards of care with the most common challenge reported (11 states) as lack of service capacity and poor quality (McCarthy, Marshall, Irvine, & Jay, 2002). The need was echoed in the recommendation of the Florida Mental Health Plan work-force development goal to build capacity in IMH (Meyers, 2007).

The notion that developmental professionals (educators, speech language pathologists, occupational therapists, physical therapists, etc.) are frequently underprepared in mental health and that mental health professionals (psychologists, social workers, psychiatric nurses and psychiatrists) are underprepared in child development, speaks to the qualitative dimension of the need (Cooper, Banghart & Aratani, 2010; Foley & Hochman, 2006; Foley, Hochman, & Murch, 2011). A policy document from the National Center for Children in Poverty (NCCP) (Cooper, Banghart & Aratani, 2010) addressing the mental health needs of young children in the child welfare system identified under-recognition of developmental problems by child welfare workers as first among the most important barriers to care. The NCCP report recommended, regarding Social-Emotional Development in Early Childhood (Cooper, Masi, & Vick, 2009, p. 6-7), the need to "Address the lack of trained providers in health, mental health and early care settings… and for the…implementation of a bold training and human resource development initiative." Again in 2010 (Cooper, Banghart & Aratani, p.-17)), NCCP in its

report Addressing the Mental Health Needs of Young Children in the Child Welfare System recommended, "enhanced resources for provider capacity… offer opportunities to increase the number of service providers with competencies in early childhood development and behavioral health, child maltreatment and young children….." In keeping with the theme to break down "silos" and for professionals to have the capacity to provide services across mental health and development, diagnoses and systems of service delivery, Osofsky & Lieberman (2011, p.126) recommend, "creating capacity by including infant mental health in the standard curriculum of training programs in clinical, developmental, educational and counseling psychology."

The need for not only building professional capacity in numbers but also for training a new kind of mental health professional is critical. The need for professionals with an expanded scope of expertise and practice encompassing knowledge and skill specific to infant-early childhood mental health and child development able to practice across service delivery systems is expressed in terms of service delivery gaps as well as in shortages of specific numbers of professionals as it underlines not only the lack of capacity but also expertise.

Within the Early Intervention system, only 16 states (34%) reported that they required an individual with social-emotional developmental expertise on multidisciplinary evaluation teams that determined eligibility for Early Intervention services (Cooper & Vick, 2009). While only four percent of children receiving EI services nationally were identified as having social-emotional problems by EI providers, more than 25% of parents of a child receiving EI services reported them to be anxious, hyperactive, exhibiting signs of depression and/or having problems with social interaction. More than 30 % of parents of children receiving EI services report problems managing their child's behavior (Cooper, Masi, & Vick, 2009). The relationship between maltreatment and developmental disabilities is large. Thirty to 62% of children younger than 3 entering the foster care system are reported to have developmental delays. Of those, 47% would be likely candidates for Early Intervention services. Yet, in spite of The Child Abuse and Prevention Treatment Act (CAPTA) which requires child welfare

agencies to have provisions in place to identify and refer young children to early intervention services, only 20 % of children birth to two used the EI system (Cooper, Banghart & Aratani, 2010; Rosenberg & Smith, 2008). A shortage of professionals well trained in both Infant Mental Health and Developmental Practice able to work across the child welfare and early intervention systems is at the heart of the capacity barrier.

In the Preschool Special Needs system (CPSE), only one to three percent of the children ages 3 to 5 served are identified as having mental health needs and receive mental health mandates on their IEPs. However by age nine, the proportion of children receiving services for emotional challenges increases to between 5 and 15 percent, suggesting a sizable gap in early identification and treatment (Cooper, Masi & Vick, 2009). Preschool children face expulsion rates three times higher than children in kindergarten through 12th grade, due in part, to a slippage in addressing social-emotional needs (Gilliam, 2005).

In general, the preschool population presents with a large magnitude of mental health concerns. Nearly two to three more preschool children exhibit symptoms of trauma-related impairment than are diagnosed (Scheeringa, Zeanah, Myers, & Putnam, 2005). Almost two-fifths of two year olds in early care and learning settings had insecure attachment relationships with their mothers (Chernoff, Flanagan, McPhee, & Park, 2007). Even in structured early learning settings such as Head Start, 80 % of children needing mental health services did not receive them (Razzino, New, Lewin, & Joseph, 2004). If these children were identified and entered the Early Intervention system, the IMH workforce would be inadequate in quantity and quality of skilled IMH professionals, to serve them.

B. New York State

New York State ranks 29th in terms of a range of child well-being indicators covering health, economic, education, community and service delivery variables (Annie E. Casey Foundation, 2013). Sixty-one percent of New York infants and toddlers have at least one risk factor that increases the chances of poor outcomes and 12% of New York's babies are born pre-term and 58% low birth

weight, scoring New York a grade D by March of Dimes (Zero to Three, 2011). Twenty-one percent of New York's maltreated children are under age 3 and 27% of those enter foster care under the age of three (Zero to Three, 2011). Given the cumulative nature of risk and the fact that infants and toddlers who have been maltreated are six times more likely than the general population to have a developmental delay and 50% of children in early intervention services had two or more risk factors, it is consistent that 33 % of children four months to five years in New York are determined to be at moderate risk for developmental or behavioral problems. However, only 4.09% of New York's infants and toddlers receive IMH services (Zero to Three, 2013). Shortages of professionals trained as Infant Mental Health practitioners, lack of knowledge and policy gaps are all contributing factors in the service delivery shortfall.

Relative to expertise, at a recent New York Infant Mental Health Summit (Early Care and Learning Council, 2013), 34.5% of the professional attendees reported they had the lowest level of knowledge in providing direct IMH services. Across the US, of the twelve states with the highest numbers of 0-3 year olds receiving Early Intervention (300,000 to over 1 million children each year per state), New York is only one of three that does not have a system of IMH standards or the Endorsement, yet has the third highest number of children served each year (750,000) across the US (U.S. Department of Education, Office of Special Education Programs, 2013). Only Texas and California serve more children and both have systems of standards and competencies. In that light, the New York Strategic Work Force recommended that, "Early Intervention services and assessments should be administered by professionals trained in early childhood development and social/emotional domains."

In terms of service delivery gaps, New York State has no policy that requires mental/behavioral health assessments for all maltreated infants and toddlers; does not require developmental monitoring/screening for all maltreated infants/toddlers; does not require referral to specialists within one week of identifying health or developmental problems for infants/toddlers in foster care; nor

requires training on developmentally appropriate practices for maltreated infants/toddlers for all agency staff (Zero to Three, 2013).

National Zero to Three noted in a policy paper on workforce development, that "policymakers must create and sustain an integrated professional development system that: incorporates infant-toddler workforce preparation and ongoing professional development; aligns with and articulates into college degree programs; includes alternative pathways to credentials; connects various service delivery programs; and provides appropriate compensation." Taken together, the profile of need and shortage of Infant Mental Health expertise across systems and professionals serving infants and young children nationally and specifically within New York State is a message of moment and urgency. The data supports the relevance and value of this needs assessment and feasibility study.

III. Standards, Competencies and the Endorsement System

As previously explained, this study was undertaken to determine the need and feasibility of implementing the Michigan Endorsement® System in New York State. As the study progressed, it became evident that it was important to understand all viable systems in order to answer this question.

There are three prominent systems of standards and competencies used throughout the United States pertaining to Infant Mental Health. Specifically the Michigan Association for Infant Mental Health Endorsement System (MI-AIMH Endorsement®), which is currently used by 18 states including Michigan; the California Center for Infant Family and Early Childhood Mental Health Endorsement, used in California; and the Vermont Early Childhood and Family Mental Health Credential and Competencies, used in Vermont. Vermont and California have developed individualized state systems. In addition to Michigan's use of its own system which was developed in the 1980's, 17 additional states across the country have embraced the Michigan system through the purchasing of a specialized license to implement the system in their state. The States which have the MI-AIMH Endorsement® are called the League of States and include: Alaska, Arizona, Colorado,

Connecticut, Idaho, Indiana, Kansas, Michigan, Minnesota, New Jersey, New Mexico, Oklahoma, Rhode Island, Texas, Virginia, West Virginia and Wisconsin. Florida has implemented the Michigan competencies, but not the entire Endorsement. Seven of these states will be discussed further in this report as their experiences have implications for NYS.

A. What is a Competency-Based or Endorsement System?

A competency-based or endorsement system for IMH practitioners provides a set of standards or competencies that must be attained through professional training of multidisciplinary providers who work with infants, young children and their caregivers across a range of roles and responsibilities. The system assures that those who work with infants, young children and their caregivers can provide, relationship-based, culturally sensitive services, rooted in strong theoretical foundations and operationalized to demonstrate the effectiveness of their skill and knowledge. Regardless of whether or not a state has implemented its own individualized system , the three identified systems of standards all incorporate extremely similar specialized core areas of knowledge that are critical to working with 0-5 year olds and their parents. These standards/competencies/knowledge areas are recognized by national and international professional organizations committed to promoting IMH with a high level of integrity, quality and with assurance of best practices. The ultimate goal is a network of high quality service providers along with high quality service delivery systems; a skilled and competent workforce and strong commitment and partnerships with the organizations that make-up that service delivery system.

B. Summary and Comparison of Competency Systems in California, Vermont and Michigan

The states represented in this study have developed high quality comprehensive education and training programs that reflect the competencies and support multi-disciplinary workforce development. Each state reported that its primary objective in developing and implementing a competency system

was to create a trained, skilled, and effective IMH workforce. This portion of the report details and summarizes three successful competency systems; first California then Vermont and finally the Michigan system which is currently used in 18 states. A comparison chart follows this discussion. This study explores the challenges and benefits of developing a new system for New York as was done in California and Vermont each for their own use, borrowing one of those systems or implementing the MA-IMH system as Michigan and 17 others have done to-date. The information included in this section was obtained through interviews with leaders in the field of Infant Mental Health and developers/administrators of competency and endorsement systems in California, Vermont and Michigan.

1. California

The California Center for Infant-Family and Early Childhood Mental Health in partnership with WestEd Center for Prevention and Early Intervention created a system of competencies and standards that address IMH practitioners from diverse fields. These standards are multidisciplinary and development of this system started in the 1990's with the most recent revision in March 2012.

California opted to create its own system of competencies and standards instead of purchasing the license for the MI-AIMH Endorsement® for a variety of reasons.

There were legal issues in terms of delivery of mental health services. Two class action lawsuits, in 1993 and 2002, authorized state funding for mental health services for children; children with developmental delays no longer needed a diagnosis to receive Early Intervention services. CA wanted to promote birth to five year olds and at the time, the Michigan endorsement focused on birth to three year olds. CA also did not want to include an exam in their endorsement, a requirement of the Michigan endorsement. They also felt that their significant immigrant population required tailored delivery of services. In addition, Medicaid funding already paid for dyadic work in CA and separate competencies and standards for early care and education already existed.

An interdisciplinary work group comprised of representatives from universities, Department of Health, Children's Hospital and Research Center, and WestEd Center for Prevention and Early Intervention developed training guidelines that were published through the CA Early Intervention Technical Assistance Network (CEITAN) at WestEd. Since then, infant family and early childhood specialists conduct training programs throughout the State, working with practitioners from several disciplines and systems of care. The comprehensive training model includes a framework for building a foundation of knowledge and training necessary to work with very young children and their families. The training matrices guide programs and training institutions to develop coursework, workshops and special certifications. The key concepts included in the statewide training are: 1) Parenting, caregiving, family functioning and parent child relationships; 2) Infant, toddler and pre-school development; 3) Biological and psychosocial factors impacting outcomes; 4) Risk and resiliency; 5) Observation, screening and assessment; 6) Diagnosis and intervention; 7) Interdisciplinary/multidisciplinary collaboration; 8) Ethics.

The initial training has been expanded to a three year training program. Tracked training includes undergraduate and graduate course credit – with approved curricula and programs. Curricula are approved by a review panel and in collaboration with national experts in the field. Individual trainers are also approved by the panel. Webinars have been created through WestEd (funded by Race to the Top) and have been particularly effective for training the rural workforce. CA has developed a training database which allows individuals to track the training programs, hours and trainers and in addition, a database funded through the SAMHSA System of Care grant provides a self-assessment tool in which workers identify their knowledge, skills, and strengths. Using "tobacco money" California has been able to offer this professional development for free.

The California Endorsement integrates the comprehensive training programs and graduate level academic coursework, workshops and continuing education courses, with supervised clinical practice. The following designations highlight skills, knowledge and experience required to support children zero

to five and their families. These levels of skill and knowledge are designed to be flexible to meet the different needs of different populations in this interdisciplinary field. There are no tests required. The endorsement is voluntary – not mandated. At this time, 125 people, mostly mental health practitioners, have been endorsed.

The endorsement designations are as follows:

Transdisciplinary Infant-Family and Early Childhood Mental Health Practitioners

Have the most frequent contact with infants and very young children and their families and are the most likely to provide promotion and preventive mental health interventions and to make referrals to Infant Family or Early Childhood Mental Health Specialists. This designation is also used for I-EC researchers, policy analysts and advocates.

The **Advanced Transdisciplinary Mental Health Practitioner** has a Master's degree and/or 8-10 years of experience in the field.

Infant Family and Early Childhood Mental Health Specialists

Include individuals from relevant professional practice disciplines who have a master's degree or higher and a professional license or credential from a state regulatory agency. They provide prenatal, infant-family and early childhood mental health services within their scope of practice in the areas of promotion, preventive intervention and treatment.

Infant Family and Early Childhood Mental Health Reflective Practice Facilitators

Support the reflective practice of individuals working with infants, young children and their families, and who have training and experience as I-ECMH Practitioners or I-ECMH specialists as well as training in reflective practice. This role is similar to a clinical supervisor. There are two levels within the Reflective Practice Facilitator designation based on the positions they supervise.

Infant-Family and Early Childhood Mental Health Reflective Practice Mentors

Have attained endorsement as a Reflective Practice Facilitator I or II and are able to train, support and facilitate the learning of others in undertaking the work of reflective practice facilitation.

As a result of implementing the endorsement, "people are better able to do the work", agencies have been able to pay more and promote workers as a result of their enhanced skills and knowledge, and there has been a lower rate of attrition among endorsed individuals. In California, mental health services are county driven. Consequently, measurement of outcomes is computed on a county by county basis with the County Department of Health responsible for the measurement. In Los Angeles County, for example, evaluation data reflect family satisfaction, training, workforce mobility and attrition.

The California Center which oversees the endorsement is not funded by the state, but receives small working grants. WestEd is the holding body. The monitoring of the standards and competencies is done on a volunteer basis by "people who believe in it". People across the state also serve on committees and in that capacity, work as volunteers. Consultants who review applications and portfolios are paid, with a specified fee structure.

2. Vermont

The Vermont Competency System, entitled the Early Childhood and Family Mental Health Competencies was developed by a collaborative workgroup including representatives from early intervention, mental health, special education, and state universities. Managed by Vermont Northern Lights Career Development Center the competency system supports all professionals working with Children Zero to Eight or "any child, anytime, anywhere". Vermont looked at the Michigan model and decided to create a different system, not focused on just mental health but more all-encompassing. The VT competency system includes all disciplines – child care providers, nurses, special educators for 0-5, developmental disciplines, home visitors, program directors, etc. The competencies mesh with competencies for Home visitors, Head Start and Early Childhood Consulting. They have been "cross walked" with curricula including Touch Points, Center of the Social Emotional foundations of Early Learning (CSEFEL) and Devereux Early Childhood Assessment (DECA). This system was developed for Vermont specifically.

The competencies form a framework for the Early Childhood Career Ladder and are based on 6 competency or core knowledge areas which are: 1) Philosophy and Professional Orientation; 2) Family Systems; 3) Child Development (0-8); 4) Child Assessment; 5) Addressing Challenges; and 6) Systems Resources. Training and coursework related to these Core Knowledge areas are available throughout the state and are reported on the Bright Futures Information System (BFIS) This database includes the professional development plan and assessment tool for individuals to track their skills, knowledge, training, work experiences and supervision regardless of work setting or job requirements. These core competencies have also been cross walked with existing credentials. For example, the National Child Development Associate Credential (CDA) is included in the Northern Lights Career Ladder as equivalent to Level II competencies.

Vermont also created an Early Childhood and Family Mental Health Credential, which was implemented in 2011 and based on the Early Childhood and Family Mental Health Competencies. The levels of the ECFMH Credential are:

Foundation Professionals

The Competencies required at this level are the foundation for working with young children and their families. This includes childcare providers, head start personnel and home health workers.

Intermediate Professionals

Candidates at this level must be knowledgeable in competencies that require skills needed to work with children and families who exhibit challenges. This includes childcare directors, kindergarten teachers and registered nurses.

Advanced Professionals

Professionals at this level must have skills in planning or providing direct services or consultation around early childhood mental health challenges. This level includes special education teachers, and mental health consultants.

Specialist professionals

Competencies at this level reflect the expert skills that are needed in working with the most challenging situations as well as provide leadership in the field. Included in this category are licensed therapists, professors, agency directors and those holding medical degrees.

All professional development and training in the multidisciplinary field of early childhood is directed by Vermont Northern Lights, a state funded organization hosted by the Community College of Vermont. Training, which is done in cohorts consisting of people in different roles and from different agencies, is based on the competencies and has been integrated into all early childhood programs, Children's Integrated Services, early intervention, home visitation programs and early education.

3. Michigan - MI-AIMH Endorsement®

Best described by the Michigan Association of IMH itself, "The intent of the MI-AIMH Endorsement (IMH-E®) is to recognize and document the development of infant and family professionals within an organized system of culturally sensitive, relationship-based, infant mental health learning and work experiences. Endorsement by the Michigan Association for Infant Mental Health (MI-AIMH) will verify that an applicant has attained a level of education as specified, participated in specialized in-service trainings, worked with guidance from mentors or supervisors, and acquired knowledge to promote the delivery of high quality, culturally sensitive, relationship-focused services to infants, toddlers, parents, other caregivers and families. The MI-AIMH Endorsement (IMH-E®) will provide information of significant benefit to employers, referral sources, and the courts seeking expert witnesses related to the social and emotional development of infants and young children and their families. Of additional importance, the MI-AIMH Endorsement (IMH-E®) will be useful in developing individual professional development plans" (MI-AIMH 2014).

The Michigan competencies and Endorsement evolved over a 30 year timeframe. In 1983, leaders in the field of Early Childhood developed an initial outline of knowledge, clinical assessment and intervention skills specific to infancy and early parenthood and included reflective supervision.

This evolved into the MI-AIMH training guidelines which included pre-service, graduate and in-service training. In 1990, specialized knowledge skills and experiences were identified for people working with infants, young children and families and in 1996 the Michigan Department of Education recognized five areas of competency for early intervention across disciplines (based on Individuals with Disabilities Education Act – IDEA Part C). In 1997 the competencies were linked with the training guidelines and IDEA, and in 2000 competencies were expanded to include practice from multiple disciplines in a variety of service delivery areas. In 2002 the MI-AIMH Endorsement® was created based on four levels of competencies, primarily for individuals working with children birth to three years of age but now is applicable for those working with children up to five years of age.

The Michigan Endorsement is multidisciplinary and recognizes specialized knowledge, training and experience across disciplines in the infant, early childhood and family fields. It includes the following disciplines: developmental psychology, clinical psychology, human development, social work, occupational therapy, physical therapy, pediatrics, nursing, counseling, psychiatry, early childhood education, and special education with practitioners coming from diverse settings such as home visiting, hospitals, mental health agencies, public health clinics, child care centers, and early childhood programs. The four levels of MI-AIMH Endorsement® are:

Infant Family Associate – Level I

Focus is on promotion and prevention, mainly in early care and education settings including Early Head Start teachers. A significant number of fields are represented at Level I including professionals who are committed to the standards, but have not had access to reflective supervision or those who have competency based training and education but who volunteer and do not have paid work experience.

Infant Family Specialist – Level II

Focus on early intervention with most having a Bachelors or Master's degree. In Michigan the majority endorsees are Masters prepared. Many endorsed at this level come from home visiting programs such as Early Head Start home visitors, Parents as Teachers, Nurse Family Partnership, Healthy Families

America, maternal-child health staff and Part C coordinators. In Michigan, there are many home based therapists from Community Mental Health funded agencies who provide IMH home visiting to families of the "zero to six" population. Many individuals who move on to Level III endorsement begin at Level II, which is the minimum required for Medicaid reimbursement in Michigan.

Infant Mental Health Specialist – Level III

Focus is clinical intervention with a very specialized work requirement. Most Level III candidates have a mental health background such as clinical psychology, social work or counseling. Many come from child development backgrounds or other disciplines and have pursued specialized in-service training and reflective supervision that has strengthened their ability to practice infant mental health therapies such as Child Parent Psychotherapy (CPP). A test is required to receive Level III endorsement.

Infant Mental Health Mentor – Level IV

Focus is on the clinical, policy and academic concentrations. The clinical group includes the same professionals as included in Level III with additional training and paid work experience as providers of reflective supervision or consultation. IMH Mentor – Policy are usually leaders at a regional, state or national level who are influencing program design, funding and policies in a way that promotes IMH. They come from a broad range of disciplines, but must have at least a Master's Degree. IMH Mentor – Research/Faculty can be Masters but most are at a Doctorate level. They conduct research related to IMH and/or teach on topics related to IMH and can be nurses, social workers, developmental and clinical psychologists, psychiatrists, early childhood educators. A test is required to receive Level IV Endorsement.

MI-AIMH Endorsement® is based on attaining levels of knowledge in eight core competency areas. These are: 1) Theoretical foundations; 2) Law, regulation and agency policy; 3) System expertise; 4) Direct service skills; 5) Working with others; 6) Communicating; 7) Thinking; and 8) Reflection. This creates the foundation for training Infant-Early Childhood Mental Health professionals throughout Michigan. MI-AIMH has created intensive trainings and workshops, conferences and

certificates. One notable degree program is the Wayne State University Infant Mental Health dual title degree integrating IMH theory, assessment, treatment and practice. Graduate students working toward degrees in Nursing, Social Work and Education are eligible for this dual-title.

As part of the endorsement, Michigan has developed the Endorsement Application System, a web based system, which is a professional development database designed to track skills, knowledge, training, and application process. The Michigan Association for Infant Mental Health receives revenues through their publications, training workshops and conferences, and through licensing their Competency Guidelines and Endorsement. These fees support the MI-AIMH organization, the coordination of the Endorsement, management of the League of States (described below) and payment for portfolio and test review by professionals. The MI-AIMH has also influenced legislation that has ensured reimbursement from Medicaid for Endorsed individuals at Levels II, III and IV. The fee to purchase the license to use the MI-AIMH Endorsement is $45,000 for the complete endorsement package including the competencies and data base.

League of States

To date, seventeen states have purchased and implemented the Michigan Endorsement. This group, called the League of States includes: Alaska, Arizona, Colorado, Connecticut, Idaho, Indiana, Kansas, Michigan, Minnesota, New Jersey, New Mexico, Oklahoma, Rhode Island, Texas, Virginia, West Virginia and Wisconsin. By year end, Washington State will be added to the League of States. Internationally, the West Australia Association of Infant Mental Health and the Ireland AIMH are researching the feasibility of implementing the Michigan Endorsement®. To date, the number of individuals endorsed throughout the United States since inception of the MI-AIMH Endorsement® through 2013 is 1007 with another 906 in the process. From 2011-2012, growth was 49% and from 2012-2013 the numbers endorsed grew by an additional 14.7%.

Competency Systems - Comparative Data

	MICHIGAN	CALIFORNIA	VERMONT
Children's Ages	0-3. Recently expanded to include 0-5	0-3 3-5 0-5	0-8
Credential or Endorsement Structure	Four levels: I Infant Family Associate II Infant Family Specialist III Infant Mental Health Specialist IV Infant Mental Health Mentor	Multiple levels: Transdisciplinary Practitioner, I and II Mental Health Specialist Reflective Practice Facilitator, I and II Reflective Practice Mentor	Four levels: • Foundational • Intermediate • Advanced • Specialist
Organization	MI-AIMH –Michigan Association for Infant Mental Health A state-wide IMH Association structure is required before purchase and implementation of the competency system	California Infant Family and Early Childhood Mental Health Center partners with West Ed who coordinate the competencies.	Vermont Northern Lights Coordinates and oversees all early childhood professional development programs. Hosted by Community College of Vermont
Participation:	17 States included in the League of States. This consortium discusses endorsement process and coordination, policies and procedures, and strategies for creating programs and services supporting Early Childhood nationally.	Pennsylvania unsuccessfully attempted to adopt the California competencies. The CA credential is not used outside of CA	New Hampshire has implemented the VT competencies. The VT Early Childhood and Family Mental Health Credential is not used outside Vermont
Cost	$45,000 for endorsement including Endorsement Application System. $1,000 renewal every 3 years	Not for sale	Not for sale Bright Futures Information System is proprietary.

Training	Training programs have been developed throughout MI. Wayne State has developed a dual title program for Infant Mental Health – including clinical and research training within Nursing, Social Work and Education Graduate programs. Other states have individualized approaches to training.	Comprehensive undergraduate and graduate programs at various universities as well as a specialized three year training program.	All early childhood professional development programs are coordinated by Northern Lights. 45 hour course for child care offered in 12 regional locations. There are ECMH certificate and degree programs at Community College of VT and Springfield College.
Database	Endorsement Application System, a professional development database, tracks skills and knowledge, training and application process in each state where the endorsement is implemented.	Training database and on-line system for application process is in place throughout CA.	Bright Futures Information System tracks all professional development, courses, and programs in Vermont.
Numbers endorsed	1007 endorsed throughout the United States/League of States members 906 are in process	125 – mostly mental health practitioners	5 at the Intermediate level

IV. Needs Assessment and Feasibility Study Methodology and Process

Professionals with expertise in infant mental health within both New York State and nationally were identified to be interviewed as part of this feasibility study. Additionally, as interviews progressed, introductions were made to other professionals and key decision makers in the 0-5 serving systems, with a final total of 57 individuals interviewed both in person and via telephone.

Individuals working in the following organizations outside of New York State were also contacted for interviews: National Zero to Three, the World Association of Infant Mental Health (WAIMH), Michigan Association for Infant Mental Health MI-AIMH), and Harvard Center on the Developing Child. Information was gathered through attendance at the Michigan Association of

Infant Mental Health (MI-AIMH) statewide conference, The Zero to Three National Training Institute (NTI), the World Association of Infant Mental Health (WA-IMH) World Congress, other workshops and meetings. The list of experts was comprehensive in representation by region, constituencies served, child serving systems, professional disciplines, administrators and policy makers.

A review of literature, policy statements, white papers, and materials pertinent to this study was undertaken.

A. Demographics

Those interviewed included individuals in a range of positons and functions supporting young children such as: Executive Directors, policy makers, clinicians, educators, experts in varied disciplines such as nurse home visitors, child care directors, pediatricians, and academicians/researchers. Interviews have been summarized and compiled in the following document for discussion.

The demographics of those interviewed are:

Position of Infant Mental Health Professional	New York State	Other States
Government/State Agency	**8**	
Center Directors	**3**	**8**
Directors, Community Agency	**3**	**2**
Program Directors	**5**	
Staff - Community Agency	**4**	**1**
Policy Research and Advocacy	**4**	
Nursing/Nurse Family Partnership	**2**	
Medicine	**2**	
Academic Center Director, Researcher, Professor	**7**	**6**
Private Practice Clinician	**2**	
Total	**40**	**17**

B. Interview Questionnaire

Three interview questionnaires, attached in Appendix A, were developed focusing on the areas of expertise and the role of the individual as it relates to this project. They include:

- Questionnaire for key stakeholders, leaders in the field of IMH or related professions within New York State. Topics included workforce capacity and development, training, competencies and standards, policy, funding, and implementation issues.
- Questionnaire for individuals who have implemented the Michigan Endorsement, members of the League of States followed a similar format and addressed history of IMH, benefits of Endorsement, funding, policy, training, implementation process and issues.
- Questionnaire for individuals in states which have developed specialized systems of competencies and standards for IMH; Vermont and California, focusing on the design and implementation of their competences/credential and the measurement of its success within their organizations and state.

C. Interview Process

Key stakeholders were identified and contacted requesting an interview to specifically discuss the competencies and standards. Each person responding was sent an article entitled "Strengthening and Recognizing Knowledge, Skills and Reflective Practice: The Michigan Association for Infant Mental Health Competency Guidelines and Endorsement Process" (Weatherston, Kaplan-Estrin, Goldberg, 2009) a summary of the California competencies, if requested, although most were already familiar with these. Individuals were asked to read the article and were told that the interview would address the following topics: Workforce capacity and development; training; competencies and standards; policy; funding and long term sustainability; implementation issues; and suggestions for next steps. Each person interviewed was asked to identify other candidates they felt should be interviewed for this assessment. . Names were compiled and introductions made where necessary.

Interviews were scheduled and were designed to last not more than one hour. As the interviews progressed, the process became organic and additional topics and questions were incorporated into the initial questionnaire. Specific questions were included that focused on the interviewee's knowledge and experience. Each person interviewed was told that her/his comments

would be compiled into a report with recommendations and that her/his comments were confidential and would only be summarized, with no identifying information. Interviews were held in person or via telephone with approximately one-third from out-of-state. Detailed notes were taken at each interview, and summaries of each interview were compiled afterwards. Findings are summarized by topic areas and are reported for both the New York State stakeholders and for those from other states.

The individuals interviewed were not only familiar with the topic but many also had extensive knowledge about IMH competencies. In total, those interviewed both in New York State and outside the state were pleased to be included in this effort and offered ongoing support throughout the process. The support for this needs assessment/feasibility study was strongly positive as was overall interest in an IMH initiative in New York State. Everyone included in this study was supportive of implementing a system of competencies and standards within New York State. As the interviews progressed, it became clear that the greater gap and need for implementing standards and competencies was at the clinical and supervisory levels as a current system of competencies, the Child Development Association (CDA) system, is already in place for child care professionals. A clear desire and readiness to be endorsed was also indicated by childcare professionals working in the Healthy Families Program in NYS. Those interviewed acknowledged that the work that has been done to date in New York State should be integrated into any new IMH system. Many requested to be included in developing an implementation strategy. All identified the need for more coordinated efforts statewide.

This study had an additional unintended benefit – it increased awareness and educated those interviewed with regard to the process and benefits of the implementation of competency systems in other states. Those who had been skeptical about implementing a competency system in New York State, were informed about approaches to implementation in a variety of states and how challenges were overcome. In general, where there might have been initial reservations these tended to give way as the interview unfolded and information was exchanged and discussed. Innovative ideas were generated and deliberated and have been incorporated into the recommendations.

V. Summaries of recurrent and emergent themes

A. League of States Representatives

Representatives from seven states, all members of the League of States, who have implemented the MI-AIMH Endorsement®, were interviewed for this study. They reported on the benefits of the endorsement, their implementation strategies, funding, training, and post implementation issues. The following narrative summarizes their recommendations regarding the process and outcomes of the MI-AIMH Endorsement® in each state. These states were chosen at the suggestion of Deborah Weatherston, the Executive Director of the MI-AIMH, who identified these as states that had a range of implementation strategies and challenges.

1. Benefits of Michigan Endorsement

Benefits of implementing the Michigan Endorsement reported by a majority of League of States representatives focused on the following areas: workforce knowledge and skill development; interdisciplinary delivery of programs and services; policy changes and long term cost effectiveness.

Workforce development

Regarding Workforce development, League of States representatives explained that the Endorsement ensures that all professionals working with infants and young children, birth to five, provide relationship-based, family-centered, developmentally appropriate, culturally competent services that are consistent and meet a standard of care that is evidence based. At each level of Endorsement a skilled cadre of professionals is created who are able to prevent negative outcomes, identify, support and/or treat young children and their families. The Endorsement creates a foundation which improves personal and professional job performance and satisfaction, resulting in better and more targeted services to families and children. Long term professional opportunities, professional status, and advancement potential are improved. In addition the Endorsement provides for professional

reciprocity across state lines. Endorsed professionals are able to bring their Endorsement to other states within the League of States.

Delivery of Services

Regarding service delivery, League of States representatives explained that the Endorsement fosters the creation of an integrated cross-disciplinary system focusing on prevention, building resilience, early identification of social-emotional problems and trauma related behaviors, and treatment. It provides the foundation for extensive coordination of the delivery of services across service systems. It supports the creation of "a team dynamic" to address individual children's needs. The endorsement promotes uniform and consistent delivery of services and sets a standard of care for all practitioners working with 0-5 year olds and their parents.

Cost Effectiveness

Regarding its cost effectiveness, League of States representatives explained that although the cost of the purchase and sustainability of the endorsement were viewed as expensive by some, all agreed that the initial start-up investment proved cost efficient in the long run in terms of significantly improving outcomes for children. Cost benefits resulting from improved delivery of services, improved job performance and job satisfaction are perceived as significant although not quantified. A number of those interviewed referred to the statistics reported by James Heckman who demonstrated that investing in early childhood development and early intervention results in dollar returns of $7 to $9 for every dollar invested, and that expenditures in early childhood interventions and programs accrue significant benefits to society many years afterwards in terms of educational achievement, and work success, and reduced costs in educational interventions and criminal justice involvement (Heckman. 2009).

Policy Changes

The endorsement has facilitated Medicaid reimbursement for assessment and provision of evidence-based treatments for children, birth to five in several states, i.e., Michigan and New Mexico. A

number of states now require that professionals be endorsed at the minimum of level II and at levels III and IV in other states. The Endorsement is required in order to receive Medicaid payment for dyadic and in-home (EI and home-visiting) services to young children and their families. The endorsement along with its League of States membership has begun to shape a national standard regarding Infant Mental Health and professional competencies. The League membership is viewed as carrying more weight and opening more doors than an individual state program and has done and can do more to influence national policy initiatives.

2. Implementation

League of States members have taken very different approaches to implementing the endorsement and competencies based on state needs, existing organizational structures, and leadership support and commitment. "There is no one way to implement the endorsement". "We built on our strengths and implemented the endorsement where need was most evident, and where support and funding were most available".

Some states addressed Levels I and II of the Endorsement, focusing on child care providers, while other states addressed Levels III and IV focusing on clinical and supervisory professionals. For example, Texas started its endorsement implementation with Levels I and II where the greatest gaps existed in infant mental health training. Virginia focused initially on Levels III and IV because it was able to receive funding for reflective supervision and home visiting. Colorado implemented the endorsement across all levels within one county, Weld County, as a result of receiving Project Launch funding. The Weld County pilot became the model for the statewide roll out of the endorsement. Michigan focused on levels III and IV with more emphasis on Level IV initially. The Infant Family Associate, Level I was the last group to be addressed.

Every interviewee identified leadership as the single most important component in the implementation process. Every state leader said that success in implementing the Michigan Endorsement or any system of competencies was due to the active involvement of strong supporters or

"Champions" throughout the state. Most states reported that they worked on laying the foundation for the Endorsement or competences years in advance of actually implementing the Endorsement. In Colorado, for example, work on the Endorsement started in 2004/2006. At that time there was little momentum but a large number of stakeholders from child care systems, community mental health centers, departments of education, and universities. "There were a lot of decision makers. At that time the initiative was stopped due to financial considerations. The project needed more support from the stakeholders and funding." Colorado's purchase of the endorsement was unique among the League of States. Before the statewide infrastructure was in place, Weld County used Project Launch funds to pilot and evaluate the endorsement within one agency, Northrange Behavioral Health. The final operational details for a statewide implementation were put in place in 2011, including the creation of the Colorado Association of Infant Mental Health infrastructure. At this time there are 22 people who have completed their endorsement in Colorado.

Wisconsin started work in 2002 and 2003 to develop an Infant Mental Health system, organizing IMH summits in collaboration with the Georgetown University Center for Children and Families. Communicating the Science of Infant/Child Development throughout the state created awareness of the need and formed a foundation for the Endorsement. Wisconsin felt it was important to first highlight the basic assumptions, the science, and values which underpin this work. "The 'mantra' that aligns all disciplines and has become the framework in Wisconsin for IMH is that children grow in the context of relationships and that social/emotional development is the foundation of all later learning". Focus on defining healthy development and clarifying what is in the best interest of the child and family has helped build support for the Endorsement.

3. Challenges in Need of Specific Planning

The endorsement process for an individual takes time and requires up to one year for the candidate to create a portfolio and prepare for the Level III and IV exams. Most states reported that it took at least a year before the endorsement system was in place within a state, and it takes significant

time for the Endorsement to become multi-disciplinary. Many League of State representatives suggested that it is important to make change wherever it is possible, "Bring the Endorsement into the most likely and receptive place and not worry about the resistance that might exist in other areas". "Once the Endorsement is integrated into one area, it becomes easier to integrate it into other areas as well." "Start with an initial area of support, move to intra-silo connections and then broaden the reach to include inter-disciplinary programs".

In Connecticut there were champions in the legislature and in state agencies. Work on the Endorsement had been ongoing there since 2002. The Association for Infant Mental Health (AIMH) was incorporated in 2008. The Endorsement was implemented afterwards and at this time 18 people have completed their endorsed in Connecticut, of which 11 are Level IV.

New Jersey, a recent member of the League of States (May 2013), has been doing significant work to lay the ground work for the Endorsement. The Early Learning Commission, an interdepartmental working group that consists of Commissioners of the Department of Health, Department of Education, Human Services and Children and Families, was supportive. A strategic plan was created in New Jersey addressing Early Learning Standards, birth to three, Quality Improvement, QRIS Quality Rating Improvement System and workforce development prior to purchasing the endorsement. New Jersey identified champions for the infant mental health initiative to facilitate funding, and raise awareness for the endorsement across disciplines. They held a statewide, multidisciplinary conference to kick off the endorsement in April 2013, explain its benefits and outline the process. A statewide grant has provided funding to train and endorse approximately 100 childcare providers at level I.

Virginia is one state that adopted the endorsement without having laid an extensive statewide foundation. Because the implementers were able to get funding at Level III, they proceeded to bring the Endorsement to the clinical levels III and IV, without having the structure in place beforehand. It was felt that the impact of the Endorsement on job functions and job content would be significant at

that level and the competencies would then infuse all existing credentials. At this time there are 10 people who have completed their endorsement in Virginia in levels III and IV. The Endorsement is presently being rolled out to Levels I and II.

Interviewees addressed the importance of marketing and communication in the successful implementation of the endorsement. It was suggested that sponsoring Early Childhood conferences would raise awareness and that by reaching out to different groups and cultivating relationships, more interest would be generated. It was suggested that messaging is also very important and that such communications include the science and values of Infant Mental Health as a framework. It was also suggested that a useful approach to training and portfolio development be provided for groups or cohorts within or among agencies to foster peer support and commitment from supervisors.

4. Statewide Mandate for Endorsement-Policy

Most States did not have a statewide mandate for professionals to become endorsed. However, some states suggested that Infant Mental Health providers be required to receive a Level III endorsement within three years. Michigan has a statewide mandate that all people working with 0-5 year olds and their families need to be endorsed at the level appropriate for their position.

5. Policy

All League of States members interviewed stated that the Endorsement was helpful in implementing state policies and procedures and advocating for children ages 0-5. Few states mentioned that specific legislation in their state had been implemented. All representatives suggested that emphasis should be placed on educating legislators and key decision makers on the latest science relating to infant and early childhood development and mental health. Programs and services need champions within state legislatures as well as nationally. All agreed that together the League of States has more clout and impact nationally than individual states do. This year the League of States members collectively have begun to tackle Medicaid issues as a national organization.

6. Relationship between Medicaid reimbursement and The Michigan Endorsement

Medicaid reimbursement for services appropriate for infants and young children including dyadic therapy and in-home treatment has been a significant concern in every state. The Endorsement at Levels II, III or IV is required for a range of services that are reimbursable by Medicaid in a number of League member states. Other states including California, Florida and Vermont have implemented policies in this area as well. Florida, which uses competencies based on the Michigan Competency Guidelines, created a crosswalk of diagnostic codes from the DC: 0-3R, Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition; DSM-IV TR, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition; and ICD-9-CM, International Classification of Diseases, Ninth Revision, Clinical Modification. This crosswalk has resulted in reimbursement for IMH services including dyadic therapy from third party insurers and Medicaid.

7. Initial Funding and Sustainability

Each state included in this study has different sources of support for the Endorsement. This support consists of a combination of state and private funding and portfolio fees for the purchase and ongoing sustainability of the endorsement. Endorsement application fees were not sufficient to cover ongoing expenses including staffing and organization infrastructure in any state. Most states reported that they use volunteers (endorsed at Level IV) to oversee the IMH organization, to coordinate the endorsement, and in some cases to review portfolios and tests. Every leader mentioned that creative funding strategies are key to the successful implementation including marketing, communication and ongoing training. West Virginia and Wisconsin both received funding from the Early Childhood Fund and created their AIMH through an existing organization. Oklahoma funded the endorsement through different state departments. Other states received funding for training from grants and private foundations. Funding also has been obtained from conference fees, AIMH membership fees, webinars,

child welfare and mental health grants. Colorado received initial funding from a Project Launch grant and ongoing funding from State Health and Human Services. In New Jersey, the endorsement was paid for by the New Jersey Council for Young Children, which has an Infancy and Early Childhood Mental Health Committee.

Interviewees from Wisconsin stated, "It was important to have the funds come from at least two different sources, since we did not want one agency or system to see the competencies and Endorsement as their own". "We were able to get the funds from a mental health block grant, (MHBG) which funds prevention, early intervention and treatment and from the Children's Trust Fund".

Other funding ideas suggested by individual states included federal grants such as Early Childhood Comprehensive System (ECCS), Project LAUNCH, and child welfare grants. It was also suggested that public/private partnerships be created to fund the Endorsement long term. In Connecticut an Early Childhood Mental Health partnership was created that included the Child Health Development Institute and Head Start. Together they applied for and received a grant which paid for the purchase of the Endorsement. Afterwards a SAMHSA Transformation Grant paid for the license and training series on reflective supervision for Child Welfare and Head Start.

8. Evaluation

In Colorado, a qualitative evaluation of the MI-AIMH Endorsement® was completed by Northrange Behavioral Health as part of their Project Launch grant. Professionals who were endorsed at Levels I through IV within the agency were interviewed individually, in focus groups, and completed surveys regarding their experience with the Endorsement process and personal and professional outcomes. They reported the following significant job related benefits: increased knowledge; improved confidence; enhanced professional status; increased credibility among families and peers; improved ability to work with other agencies and positive impact on parents, through improvement of family support.

At this time, there is little evaluative data gathered from the states which have implemented the Michigan Endorsement. Due to funding challenges, individual members of the League of States and the group collectively, have not formally evaluated outcomes resulting from implementing the Endorsement. Michigan MI-AIMH has recently requested funding for a master evaluation of the Endorsement which will be facilitated by the creation of their web based data system, EASy. The Endorsement Application System will provide numbers, levels of satisfaction and a summary of early childhood initiatives in each state. EASy is designed to manage the application process and all portfolio information including skills, knowledge, and experience.

Other interviewees mentioned that it is difficult to measure the outcomes of the Endorsement since the interdisciplinary nature of this work makes evaluation complex and challenging. . It was suggested by a majority that prior to implementing the Endorsement it is desirable to identify the possible impacts, and how these can be measured. "Building evaluation into the implementation strategy is essential and it is important to engage the diverse professions such as early intervention, nurse/family, and child welfare in the evaluation process".

9. Workforce Development

Concern with workforce skills and professional development across disciplines was the primary impetus for all states to purchase the Endorsement. In both Colorado and Connecticut, the objective was to increase awareness and knowledge of early childhood development and attachment theory specifically in Level I and II professionals, encourage the asking of questions, and provide for appropriate referrals to supervisors and skilled professionals. The intent was not to change job content. "There was no change in job content, but how infant mental health principles and information are integrated into the work that is done". "The work is done differently. It enhances work, does not add more work". The result of the Endorsement is that "it makes work 'better' and more meaningful to both the workers and the children with their families." In addition, the endorsement dovetails nicely with other initiatives. "Children get evaluated and treated in a timely manner". "The endorsement

builds capacity". Regarding compensation, the endorsement has not automatically resulted in increased compensation in every state, but has created specialization, career choices and advancement opportunities for endorsed professionals.

10. Training: Existing Degree Programs and Post Degree Training

Every state mentioned the need to identify existing IMH training or develop and implement new training through the undergraduate, graduate, post graduate and continuing education levels to ensure that required training for professionals is available, consistent, and thorough. States each had their own unique approaches. In Connecticut as in some other states, training for the Endorsement is not specified in terms of "required courses," although courses need to be approved in order to meet specific competencies. Individuals are able to take a range of workshops, courses and conferences that apply to this work. Professionals interested in the endorsement are not required to get "new training" or additional academic training. In-service work experience may count toward the endorsement. Connecticut AIMH created a DVD listing all programs offered in the state. At present they are working with the community colleges to create a course and curriculum addressing infant and early childhood mental health. This proposed curriculum is similar to the CDA which is equivalent to the level one endorsement offered at many community colleges in other states. It was suggested that a number of contiguous states such as Connecticut, New Jersey and New York collaborate in the creation of a regional database of trainings offered for infant and early childhood professionals to meet endorsement requirements.

In Pennsylvania, an effort to implement the California Competency System was unsuccessful because the infrastructure was not available to support the implementation of that system. More recently, Pennsylvania started an Infant Mental Health Association and is in the process of reviewing the implementation of the Michigan Endorsement. In addition, the State Department of Early

Intervention, Department of Health, contracted with Chatham University to create a graduate certificate and Master's degree program in Infant Mental Health Counseling. To date, 300 staff from Early Intervention were paid under a statewide grant to complete the certificate which will make them Endorsement-eligible, when the Endorsement is enacted.

The University of Wisconsin in partnership with the WI-AIMH has developed a post graduate certificate with two paths, Foundational, which is the educational requirement for Level II and Clinical, which is the educational requirement for Level III. Colorado has implemented IMH training at the University of North Colorado. In Michigan, Wayne State University, in collaboration with its affiliated Merrill, Palmer, Skillman Institute for Child and Family Development has created a dual title program combining Infant Mental Health with degree programs in Nursing, Psychology and Social Work. The University of Michigan, Eastern Michigan University and Michigan State University have significant IMH coursework in their MSW and Psychology graduate school curricula.

Other states have instituted programs of IMH science in their Education and Clinical Social Work and Nursing programs as well. Florida and California (not League of States members) have both developed their own specialized training programs which are offered throughout the state to cohorts of professionals. All programs are based on clearly defined competencies and standards developed for infant mental health professionals.

New Jersey and several other states are exploring the possibility of giving those who receive the Infant Toddler Credential a Level I Endorsement. They have received a grant to provide training to all Infant Toddler specialists to address the knowledge gaps. "Resistance can be overcome by simplifying and by working with the existing credentials and licensing structures within the state, identifying both disparities and compatibility."

11. Organizational Structure

Every state considering the purchase of the MI-AIMH Endorsement® created an Association of Infant Mental Health prior to the purchase to oversee the Endorsement process. This is a

requirement of the MI-AIMH license and is viewed as essential structure to manage the Endorsement, to review portfolios and to facilitate ongoing communication. Each AIMH must use the World Association of Infant Mental Health by-laws in the creation of its organization. These guidelines for the creation of the AIMH organization are available on the WA-IMH website. There is agreement that the Endorsement benefits by being housed in a university setting, or in collaboration with another association or agency.

Volunteers staff the Associations of Infant Mental Health in Idaho, Connecticut, New Mexico, Arizona and Colorado. In Wisconsin, salaries are paid by a combination of revenue from training, membership fees, endorsement fees, grants and private donations. It was recommended by a number of state representatives that a paid position of coordinator be included in the short and long-term financial projections for the AIMH. Many of the heads of the AIMH organizations, who are volunteers, have positions with another agency.

Collaboration between states is encouraged. Interviewees suggested that contiguous states would benefit by working together to review portfolios, score exams and provide training. MI-AIMH requires that each state must purchase the endorsement individually. Historically, successful implementation of the endorsement has depended on the collaboration of all organizations serving infants, toddlers and young children, including early care and education, early intervention and home visiting programs.

12. Expected Post Implementation Challenges

As with any new system which recommends changes in skill and knowledge for licensed professionals, there has been some push back. Some professionals have complained that the tests at Levels III and IV are daunting. They have been overwhelmed by the amount of information required, and were not aware of how complex the test is, even though there is significant information provided to prepare test-takers. . Everyone spoken to, endorsed at a Level IV and experienced in the field, found

the portfolio application process to be thorough and the test "difficult enough and *not* something that anyone can take without adequate preparation and experience".

There was initial concern that the Endorsement would change job functions and job responsibilities so significantly that additional compensation would be justified for the enhanced skill and knowledge required especially in positions requiring Levels I and II endorsement. However, it was reported that the endorsement has actually resulted in a change in the way professionals perceive their jobs and their interactions with families. "Professional development has been infused with new concepts, not additional work requirements that require additional compensation."

Reflective Supervision

The capacity of states to provide consistent reflective supervision was another challenge raised. There was particular concern in states with large rural and remote areas where there are not always enough Level IV mentors available to provide ongoing reflective supervision. Interviewees explained that this problem can be addressed by using telephone, Skype, group supervision, etc.

Management support

Because of the time needed for professionals to complete the training and portfolio requirements, interviewees made clear that the most successful implementation of the Endorsement is realized only with the support of managers and agency directors, as significant time is required for professionals to complete training and portfolio requirements. It was recommended that agencies and other organizations need to not only "buy in" but also actually provide necessary time and assistance for employees to meet the endorsement requirements. In some states, training takes place in cohorts. Groups from a county or agency attend required workshops and programs together, sometimes during the work week and at other times over weekends. State policy mandates in some states have helped to motivate organizations that might not otherwise have been supportive of the need for training.

The Age Range of the IMH Endorsement

The Michigan Endorsement has traditionally focused prenatally to three years old. However, it has now been extended to include the age range prenatal to five years old. Deborah Weatherston, Director of MI-AIMH, acknowledged that the endorsement needs to be inclusive and "we will be addressing the added competencies, skills and knowledge required for professionals working with children to age five".

"Grandfathering"

"Grandfathering" is not allowed by the Michigan Endorsement and has resulted in some dissatisfaction among professionals in a few states. There have been requests to endorse professionals who have had extensive experience in the field. League of States members determined that in order to ensure reciprocity among states that "grandfathering" could not be permitted. To date, there have been no exceptions to this rule.

B. New York State Representatives

1. Need and Readiness in New York State to Adopt the Endorsement

The general tone on the part of NYS stakeholders is that there is a need and readiness to embrace the Endorsement as a viable credential and standard in New York State. Although there was initially some question as to which levels of the endorsement to address initially, over the course of the study it became clearer that there is a need and readiness at all Levels (I, II, III, IV). The following report of the results of the investigation (recurrent and emerging themes), analyzes the "need and readiness question" in greater detail from both formative and summative perspectives and serves as the data base on which the readiness inference is supported.

A sample of forty individuals representing organizations and agencies working with infants and young children and their families throughout New York State were interviewed for this part of the study. ***Support for the adoption of a competency system/endorsement for IMH professionals***

in New York State was universal. That does not preclude, however, that many issues and challenges were identified, including: current workforce limitations, training, implementation, evaluation, policy, sustainability and reimbursement.

2. Current Workforce Limitations

A weakness in training, knowledge and skill in the domain of social-emotional development among providers and related service professionals, both those who are not licensed as well as those licensed as mental health professionals, was consistently identified as a concern and a need. One interviewee captured the overall sentiment, "There is an urgent need to increase the numbers of professionals providing services to the birth-to-five age group and the greatest need is at the clinical level."

One hundred percent (100%) of those interviewed regardless of their position or discipline, expressed the need for improving the skills and understanding of IMH (i.e., a relationship-based, developmentally informed perspective when working with very young children and their caregivers) among the NYS infant and early childhood workforce. Another perspective taken by a sizable majority of those interviewed was that service providers and teachers who work directly with very young children in New York State are not sufficiently knowledgeable in many aspects of child development, specifically social-emotional development preparation to identify potentially at-risk infants and young children and to make appropriate referrals to IMH clinicians. Another interviewee said, "There are significant workforce issues that require that we build capacity and identify the skills required in various positions across disciplines." Knowledge and skills are needed across a variety of disciplines serving in early care and education settings; i.e., early care providers, preschool teachers, and infant toddler specialists. The same pattern of need was identified among those who work in the CPSE and Early Intervention systems providing services either on-site at early care and education centers or as Special Education Itinerant Teachers (SEIT) or through home visiting; such as parent educators or nurses, including those who provide services at school and/or home; such as speech pathologists and

occupational therapists. This point was also made with regard to related "helping" professionals who provide services to young children in other systems; such as child welfare workers. Likewise, directors and supervisors of preschool and other center based services from across all disciplines were identified as having similar gaps in training, knowledge and skill in the area of social-emotional development and intervention. In addition, other programs in New York State developed with a prevention focus for infants and toddlers, such as Healthy Families and the Nurse Family Partnership, were also identified as having a workforce with gaps in knowledge specific to the social-emotional domain and understanding development from a relational perspective.

It was strongly suggested that IMH knowledge and practices be integrated into the day-to-day activities of all who touch the life of infants, young children and their families. An example of the need for competencies across disciplines is reflected in the Early Intervention system. A majority of those interviewed expressed that Early Intervention professionals are often unable to recognize mental health "red flags" and other social-emotional delays and are ill prepared to make appropriate referrals.

Some selected comments highlight the need and provide support for improving the knowledge and skills of the non-licensed mental health workforce. "There is variability and lack of consistent knowledge and skills among the professionals who provide services to children birth to five particularly as it relates to screening, assessment and early intervention services". "Because of the lack of skilled professionals, referrals to clinicians skilled in this area are limited" Also, concern was expressed that if more referrals were made, there would be very few skilled IMH professionals to provide the necessary treatment. Interviewees agreed that even among trained mental health professionals, a significant number including psychotherapists from the fields of psychology, social work and psychiatry do not have specialized training in early childhood development. Further, they often lack training in relationship-based interventions, trauma treatment and the promotion of awareness, prevention and intervention regarding social-emotional problems in young children in a family context.

3. Training

Training and professional development were key concerns expressed by all those interviewed for this study. Regardless of discipline or position, all mentioned that training for professionals working with 0-5 year old children needed to be enhanced to reflect the latest science of child development as well as evidence-based practices. As was corroborated by a majority of experts interviewed, "many therapists, supervisors and other workers in the mental health system lack specialized, in-depth knowledge of early childhood development and have not been trained to use the relationship-based perspective that should infuse all treatment of infants, toddlers and preschoolers."

It was universally agreed that undergraduate degree programs, such as early childhood education or the BSW in New York State, do not provide the requisite skills and knowledge in the latest science of infant and early childhood development necessary to teach or work with children aged 0-5 and their families. Interviewees stated that graduate programs for psychologists, social workers, nurses and early childhood educators do not specifically address IMH. "These programs need to be infused with the latest science as well as the most recent evidence based, evidence informed, clinically validated practice for this age group". In addition, assessment and observation skills, attachment theory, family structure and ecological impacts of early childhood development should be included as well. It was mentioned by a significant majority of interviewees that it is important to align competencies with training. "Training in this field must be an ongoing process and include post-masters certificates, continuing education programs, lectures, workshops, and webinars".

One hundred percent (100%) of those interviewed recognized IMH as a multidisciplinary specialization. The interviewees expressed that there is a need for foundational training across disciplines, effective preparatory training specifically for clinicians and reflective supervision for all. Information about IMH should be provided to occupational therapists, physical therapists, speech and language pathologists, pediatric providers, psychiatric and pediatric residents, nursing and health care professionals working with infants and young children. "IMH and child development content is not just for (mental health) clinicians." Individuals working in these various disciplines confirmed that

training in IMH is essential and would be welcome. It was suggested that NYS promote a cross disciplinary approach to IMH, including integrating IMH into existing training offered in all the child-family serving professions. The Healthy Families Program core and foundational training for its home visiting staff was cited by a few interviewees as an independently designed example of an existing national program model that integrated a relational perspective and other core IMH concepts into its curriculum and foundational training. The content includes: early brain development; the impact of childhood trauma on the brain, attachment and adult functioning; assessment, nature of parent/infant relationships; temperament, and protective factors pre-natal to 5. Still others raised concern that even the training for Healthy Families did not adequately address social-emotional development, trauma or have a deeply relational perspective.

Some raised concern that both confusion and stigma remain associated with the term Infant Mental Health. Others disagreed with the attribution of stigma and saw IMH as strength-based in terminology and practice. A majority of those interviewed stated that it is important to engage parents, promote understanding of social-emotional and cognitive development of infants and to de-stigmatize the term IMH.

4. Implementation

Interviewees indicated that the time is right for the implementation of an IMH endorsement in NYS. "There is a level of readiness now that has not existed prior". It was viewed by 100% of those interviewed that it is not practical or possible for NYS to design its own system of specific standards at this time. Using an existing and tested system of standards tailored to support NYS systems and structure was viewed as both time and cost efficient. It was suggested that the Michigan competencies and Endorsement offered the most benefits including: the League of States partnership, the Endorsement database, as well as structure and support from Michigan and the other League of States members which could be offered throughout the implementation process. Issues raised included: concern that the Michigan Endorsement addressed only children zero to three year olds. However, this

is no longer a concern as Michigan has expanded the competencies and endorsement to include professionals working with children prenatally to age five. In addition, there were concerns raised about the upfront costs to become part of the Michigan system. California and Vermont competencies do not have associated fees as they were not designed for use outside their own states. The benefits of the League of States include the supporting structure and the database which were viewed as critical to moving any successful credentialing system forward in New York State.

A number of those interviewed suggested that the system of competencies, guidelines and credentialing for IMH professionals should be consistent with the Pyramid Model developed by the Center on the Social and Emotional Foundations for Early Learning (CSEFEL) and reflect the public health model of promotion, prevention and intervention. The foundation of the CSEFEL pyramid model is the "creation of an effective workforce". Building on that foundation are universal programs supporting optimal development; targeted support to children and families; and finally intensive intervention.

Everyone agreed that there are numerous child serving systems and programs including early care and learning programs (center based and family and group programs); home visiting, early intervention, mental health agencies, public health clinics, the child welfare system (specifically for 0-5 year olds) which would all be positively impacted by the implementation of a competency/endorsement system. Because of this breadth, they stressed that the Endorsement will overlap with some existing programs and competency models such as the Child Development Associate (CDA). In order to ensure that there will not be redundancy among existing credentials, it was suggested by all interviewed that these existing competencies be integrated into (and cross-walked with) any IMH endorsement system adopted in NYS.. Missing core competencies required by an adopted IMH endorsement could be acquired through training and continuing professional education as was successfully accomplished in many states which have implemented the MI-AIMH Endorsement®. Quality Stars was specifically mentioned as an existing structure that supports professional development in NYS. A suggestion was

that the Endorsement competencies be cross walked with the rating criteria used in Quality Stars as a possible way to construct a coordinated, consistent and comprehensive competency system applicable across child serving systems.

Interviewees stressed that in order to ensure a successful implementation of any professional credentialing system it must be established and perceived by potential applicants as an advantage (and eventually a requirement) to employment. The endorsement is no exception. By making the Endorsement an employment advantage and ultimately an employment requirement among the disciplines serving the birth to five population, its path to survival and growth will be vastly strengthened. It will be necessary to "market" the Endorsement and demonstrate to professionals that there is a real benefit to earning the credential. It will need to positively impact job satisfaction and outcomes; professional retention and advancement opportunities; hiring and supervision if it is to be embraced as an integral part of one's professional development and identity. "The system of competencies and endorsement will build a sense of professionalism in multidisciplinary fields, create career development opportunities and improve job satisfaction".

5. Evaluation

Identification and evaluation of measurable outcomes through ongoing data collection were targeted by interviewees as important components for a successful endorsement implementation. It was the majority opinion that if the MI-AIMH endorsement were to be adopted in New York State that it would be critical to build in an evaluation component and assess efficacy from the start. "Benefits to children and families should be defined and measured as they relate to improved service delivery, treatment and behavior change both for the child and the family". Measures of job satisfaction and performance of professionals within the IMH fields should also be part of the implementation strategy. A number of interviewees felt that the benefits of the endorsement may be hard to quantify but thought it important to collect data. There were a variety of suggestions as to the type of information that might be desirable to glean as part of an ongoing formative and summative outcome evaluation.

6. Policy

A majority of those interviewed mentioned that legislators, policy-makers and key decision makers need to be made aware of the needs of infants, young children and their families and be educated in the science that informs programs and services dependent on government support and funding. Quantifying the long term financial impact and societal benefits of IMH services must be communicated to policy makers. Advocacy organizations such as National Zero to Three and NY Zero to Three Network, National Center for Children in Poverty and the Schuyler Center have all published policy papers advocating for IMH. However, policy alone will not drive the implementation of the Endorsement. The Endorsement needs to have champions throughout the state, both leaders in the field and in the legislature.

7. Sustainability

Sustainability issues were identified by the majority of interviewees as their primary concern with regard to implementing the Endorsement in NYS. In addition to the purchase price of the Michigan Endorsement ($45,000), ongoing sustainability was mentioned by a majority as a potential challenge. Concerns included the creation and maintenance of a New York Association of Infant Mental Health (NY-AIMH) and the ability of professionals to pay for the initial endorsement/portfolio review and renewal fees. In addition, concerns about potential costs for marketing of the endorsement were identified. Compensation for reviewers of portfolios was raised as a potential expense (although in many states this is accomplished on a voluntary basis, at least initially). The importance of an "up-front" sustainability plan was emphasized by one interviewee, "It is not enough to look at implementation now without a long term focus addressing sustainability".

There were a range of views articulated about funding and sustainability options. One interviewee felt strongly that limited public funds should not be dedicated to training clinicians and agencies in up-to-date-science and that if there were money designated for children zero to five, it would be better expended to treat emotional difficulties in very young children. Most felt that

systematic training would yield increased capacity to provide that needed treatment and would yield more effective services and outcomes. Other interviewees suggested that if insurance reimbursement including Medicaid was more available to agencies or home visiting programs, then other funding could be allocated to the training and development of IMH specialists.

It was also suggested by a few interviewees that the long-term return-on-investment (ROI) should to be considered when strategizing the promotion of the Endorsement. "Investments in early childhood programs have been shown to have significant long term benefits". It was suggested that a consortium linking foundations and public funding sources might address the initial purchase and sustainability costs. Interviewees offered a range of thoughts and ideas that could be explored to solve the funding problem in order to bring the Endorsement to New York State.

8. Medicaid reimbursement

Although not a predetermined part of the interview, concerns about problems with the current status of Medicaid reimbursement in New York State were raised by a significant number of those interviewed. Interviewees were concerned that these problems could be an impediment to the implementation of IMH competencies and standards. Several interviewees offered their views of the problems and potential solutions to the Medicaid problem. It was mentioned by many that a structured reimbursement process which "acknowledges the need for specialized treatment for children zero to five that includes the caregiver" is key. Dyadic therapy such as Child-Parent Psychotherapy (CPP) was identified as the most effective treatment for children 0-5 and that this intervention is not reimbursed by Medicaid in NYS to individual providers or article 28 and 31 clinics. As explained by a few interviewees, the system used for Medicaid payments in NYS is based on the medical model of a designated "identified patient." All communicated that the entire family unit, even system, needs to be considered when dealing with children. It was suggested by a majority that NYS needs to expand eligibility criteria for mental health services to include interventions provided to children under age five

and their families and that funding streams should reimburse mental health services provided in primary care settings.

It was communicated to the interviewees that in states where the Michigan Endorsement has been implemented, the clarity of the Endorsement/licensure criteria/competencies for IMH specialists has actually served to reify and solve most of the issues raised and been a port of entry to working collaboratively not only with Medicaid but other insurers as well. It was suggested by one interviewee that it is important to "build teeth behind the credential". The Endorsement/licensure has served this purpose in other states where only endorsed IMH specialists are eligible to receive Medicaid payments, thus providing an incentive to professionals to pursue the requisite training needed for the Endorsement. Historically, in NYS reimbursement has not been tied to professionals having specialized knowledge, training and skill to work with young children. Early Intervention and Preschool Special Needs Provider (CPSE) qualifications and eligibility standards have also been addressed by the Endorsement in states where it has been implemented.

9. **Other Related Concerns**

A minority of those interviewed questioned whether the implementation of competencies and the Endorsement would impact job content, case loads and work responsibilities for professionals. It was suggested that the competencies should infuse the workforce with raised awareness, new knowledge and expertise but should not change position content or increase work-loads. It was also suggested that additional research is needed to determine how the Endorsement would impact roles and responsibilities, supervision, compensation, career choices and advancement opportunities across disciplines.

A number of interviewees identified the fragmented service delivery system in NYS - described as "silos" with "limited interconnections between disciplines"- and wondered if this splintering might hinder the creation of a multidisciplinary system of competencies and standards. Experiences collected from outside New York State suggested that adopting the Endorsement actually fostered the creation

of an integrated and coordinated cross-disciplinary system that promoted the uniform and consistent delivery of services as well as the development of evidence-based standards of treatment and care.

A few interviewees were concerned that reflective supervision may be difficult to implement especially outside urban areas. "Effective, ongoing reflective supervision must consistently be provided in both urban and rural areas". League of States members addressed this issue in a variety of ways (skype and telephone conferencing) that could also be replicated in NYS.

A significant concern voiced by a number of those interviewed was how the implementation of an IMH endorsement or credential will both impact and be impacted by the implementation of a Managed Care system in New York State. It was suggested that additional research be conducted to assess the long term impact of this method of health care delivery and reimbursement. However, there is evidence, from Louisiana, for example, that managed care systems have chosen to reimburse endorsed IMH specialists for mental health treatment of 0-5 year olds and their parents.

Conversations with representatives of the Early Childhood Advisory Council (ECAC) the Parent Education Partnership (NYSPEP), Early Intervention Coordinating Committee (EICC), Early Care and Learning Council, and the Child Care Coordinating Council have revealed that several initiatives focused on training care providers and educators of young children have already been set in motion in New York at both the state and in some cases county levels. These initiatives have developed from the recognized need for standards of care and capacity building through the infant and early care and education arenas. As examples, interviewees identified the Early Learning Guidelines, the Infant Toddler Credential, Quality Stars, a quality rating system for family and group day care, Child Development Associate (CDA), the Common Core and the Parent Educator Credential, which addresses prenatal to age 18, all of which have competencies that include development from ages 0-5.

These important initiatives have focused on improving the quality of the service provided by early care and education providers. These competencies, credentials and programs address a percentage of individuals who work with children zero to five. Still, virtually everyone interviewed stated that skills

and knowledge deficiencies regarding social-emotional development and evidence based treatment for children zero to five, exist among early care and education providers, teachers and directors.

10. Initiatives in New York addressing the IMH needs of young children and their families through changes in structure and systems of care

Interviewees highlighted several important systems change initiatives that have been implemented across New York State to address a range of problems related to the quality of services for children. The Children's Mental Health Act of 2006 created a statewide Children's Plan which contained both short-term and long-term recommendations to provide comprehensive, coordinated mental health prevention, early intervention, and treatment services for children through age 18. Project Launch in Westchester County at the Open Door Family Medical Centers integrates physical and mental health services for children within one agency. The Healthy Steps Program at Montefiore Medical Group Comprehensive Family Care Center addresses physical, mental and behavioral needs of young children and their families, providing referrals to specialists, parenting support, educational information and mental health treatment. New York State Success, is a SAMHSA funded program implemented in 55 Upstate New York Counties which creates a coordinated network of community based services and supports, organized to meet a range of developmental needs of children and their families.

Interviewees identified a variety of organizations that have developed Post Graduate training programs specifically focused on training multidisciplinary licensed professionals to gain specialized knowledge in working with Infants, Toddlers and Preschoolers. The Jewish Board of Family and Children Services (JBFCS) in NYC developed an Infant Mental Health Training Program, Adelphi University Institute for Parenting developed two Post Graduate Certificate Programs; one for Parent Education and one for Infant Mental Health. Columbia University offers the Parent-Infant Psychotherapy Training Program. Although the quality of these programs is excellent, they have all had challenges with enrollment. Interviewees attributed enrollment problems to the fact that there is no

mandate or incentive for professionals in New York to pursue the level of competency endorsed by these programs and that most agencies do not support additional training with either release time or money.

Interviewees identified a variety of initiatives designed to train early care and education providers regarding the social emotional needs of young children. Child Care Councils across the state have received mini-grants to foster collaboration across different disciplines. The Educational Incentive Program (EIP), a scholarship program, has been in place in NYS helping providers pay for training such as the CDA to enhance knowledge and skills and improve competencies of child care professionals. Quality Stars, a quality rating and improvement system, impacts 400 family and group childcare programs throughout the state. This system provides a structure and incentives to promote and support additional training for childcare providers. The Early Care and Learning Council offers the "Program for Infant Toddler Care" (PITC) which focuses on social emotional development of infants and children. Over 200 childcare providers were trained in 2013. The Healthy Families program has infused IMH concepts into the training provided to home visitors. Up to 120 people are trained annually in this program and many have expressed interest in becoming endorsed at Level I. In addition, organizations like Docs for Tots provide education and training to professionals who work with young children in a variety of settings including hospitals and schools.

Most recently, the Early Childhood Advisory Council (ECAC) and the Early Intervention Coordinating Council (EICC) have created a collaborative partnership to address the challenges of IMH needs in the NYS Early Intervention System. A wide range of issues are being addressed. One is the need for trained professionals who understand and are able to identify social-emotional concerns in young children from a relational perspective to screen and refer to skilled professionals for necessary treatment. Another is the need for capacity building in both quality and quantity of IMH providers.

These initiatives have created a foundation as well as illuminated and identified specific impediments in New York State to providing quality IMH services. Regardless of the organization or

system of care, interviewees mentioned the lack of a coordinated system of standards and competencies with state-of-the-art training grounded in the most current science of IMH. The existence of such a system would ensure that an increased quantity of licensed and non-licensed Infant Mental Health professionals of high quality would be available to address the IMH needs of the very young children. "Effective delivery of services to children zero to five requires that there be an integrated system of training that focuses on social emotional development. This should provide information and guidance to professionals and others who work with young children in various systems that are outside of but relevant to the field of mental health" (NYC EMH Strategic Work Group).

Interviewees universally stated that decisions need to be made to create the systems and structures that would support the realization of the Endorsement in New York State. The Endorsement should not be viewed as just another credential but rather as an infrastructure for training, professional development, comprehensive service delivery, quality assurance, policy advancement as well as a superordinate coordinating system under which all other credentials could be unified. The Endorsement would provide oversight for the quality and effectiveness of efforts towards promotion, prevention, and intervention for infants, young children and their families. The Endorsement holds the potential to activate a unifying force and structure to move the system beyond the "silo mentality" and toward a new holism among the diverse disciplines, agencies and governmental departments serving the birth to five populations. Ultimately, the Endorsement holds the potential to knit together all the infant and early childhood/family serving systems of New York State into a comprehensive and coordinated system of care.

VI. Recommendations

1. Adopt, implement and promote the Michigan Endorsement® of Infant Mental Health standards and competencies for professionals who work with children birth to age five and their families in New York State, across all endorsement levels, I, II, III and IV.
2. Establish a statewide Infant Mental Health committee composed of experts and champions in the field, committed to bringing the Endorsement to New York State.
    - Initial issues to be addressed by the committee may include but are not limited to the funding to purchase the Endorsement, the ongoing sustainability of the Endorsement process and the development of a New York State Association of Infant Mental Health.
    - Potential members of this committee will include representatives from state agencies, parents and professionals from universities, hospitals, community organizations; service delivery organizations such as Head Start, etc.; professional organizations such as New York Zero to Three Network (NYZZT), New York Association for the Education of Young Children, Association of Early Childhood and Infant Psychology and so forth, advocacy organizations, policy organizations such as Early Childhood Coordinating Council , etc. and representatives of stakeholders and constituencies.
3. Create an Association of Infant Mental Health as a preliminary step to bringing the Endorsement to New York State. The NYS-AIMH must be a 501(c)(3) with its by-laws based on those of the World Association of Infant Mental Health (WAIMH).
    - Within NYS, an Association of Infant Mental Health chapter is housed within the Capital District Child Care Coordinating Council, with by-laws based on the WAIMH guidelines. It is important to determine if this could be the foundation of a statewide AIMH and if it could be expanded to include other chapters.

- Address ongoing issues such as funding streams which will ensure the long term sustainability of the endorsement, including costs of portfolio reviews, communication and marketing, and revenue streams associated with endorsement fees.
- Maintain a keen awareness that professionals who serve 0-5 year olds and their parents work across diverse agencies including health, education, child care, disabilities, mental health and social services and the coordination of the endorsement will require collaboration with both individual providers and across state agencies.
- Explore, over time and in conjunction with the statewide IMH Committee, potential legislative changes, licensure potential, Medicaid and other insurance issues.
- Develop an evaluation process that may include: improvement in school readiness, and educational attainment, quantify long term cost savings in treatment, as well as other outcome measures such as professional satisfaction, reduced staff turnover and performance improvement.

4. Ensure all levels of professionals working with children birth to five understand the "Science of Child Development" and provide services to young children within the context of family/caregiver relationships.
    - Identify current training programs in NYS including Graduate, Undergraduate and Continuing Education Programs that include multidisciplinary Infant Mental Health curricula and support the standards and competencies of the Endorsement.
    - Create new training programs in a variety of areas including education, health care, social services, and developmental services including programs for professionals from non-mental health disciplines.
    - Examine and expand existing content of programs to ensure up-to-date science in the field of IMH is offered to licensed mental health professionals and other

multidisciplinary professionals in the form of continuing education units to meet recommended competencies and standards. Broadly this includes Clinical Psychologists, School Psychologists, Licensed Social Workers, Mental Health Counselors, Family and Marriage Therapists, Psychoanalysts, Psychiatrists, Psychiatric Nurses, Creative Arts Therapists, Physical and Occupational Therapists, Child Life Specialists, Nurse Home Visitors, Family and Community Workers, Speech and Language Pathologists, Audiologists, Vision-Mobility Specialists, Pediatricians and Developmental Pediatricians , Nutritionists, Feeding Specialists, and the Professional Infant/ Early Education Community including but not limited to Early Childhood Educators, Early Childhood Special Educators, Child Development Specialists, Parent-Infant Specialists, Parent Educators, Assistant Teachers, Early Care and Education Consultants etc.

- Expand training in Child Care Consultation skills, as well as in the area of trauma identification and treatment for children birth to five.
- Include not only developmentally informed but trauma focused training as well, for all who work with children birth to five.
- Crosswalk existing credentials for professions and providers against the Endorsement, addressing gaps in training and knowledge. Identify the Endorsement Levels most closely matched with existing credentials, including: Early Learning Guidelines – Core Body of Knowledge for Early Childhood Educators, Child Development Associate (CDA), Infant Toddler Credential, Family Child Care Credential, Infant Toddler Care and Education NYSAEYC), Family Development Credential (FDA) and the New York State Parent Education Credential.
- Integrate information about the science of Infant Mental Health into parenting programs and communications with families in pre-natal, postnatal, and pediatric outpatient/well baby and inpatient settings where possible.

5. Collaboratively, the Statewide IMH Committee and NYS-AIMH should:

    - Explore the impact of Managed Care, Medicaid and other medical insurance options on the provision and payment for services to children birth to five and their families as it relates to infant mental health, pediatric services etc.
    - Review mandates for licensure/certification as an IMH specialist in NYS (leverage and incentive) as they are related to insurance, workforce capacity and quality and their impact on improving the quality of services available to 0-5 year olds and their families in New York State.

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