



Assessment of Infant and Early Childhood Mental Health Endorsement in Other States

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on behalf of the Endowment for Health and
New Hampshire Children's Health Foundation

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Purpose

To understand how other states administer and incentivize infant and early childhood mental health (IECMH) endorsement.

Methodology

Key Informant Interviews (KIIs):

15 individuals in 11 states

1-hour interviews by telephone or Zoom

Used a semi-structured interview guide

Data analyzed using thematic analysis

Limitations

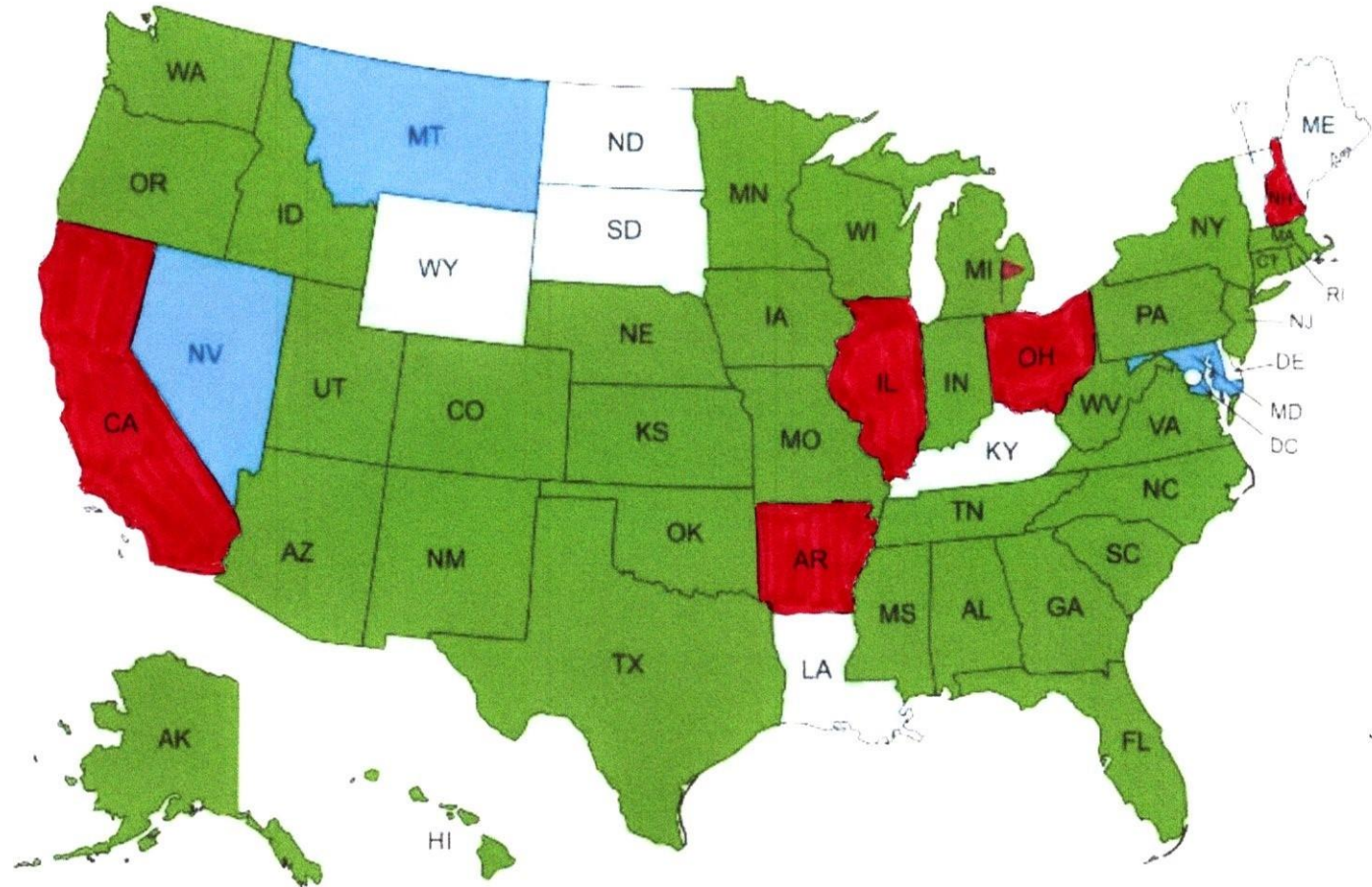
Interviewees had difficulty answering all questions due to time available and/or because of the nature and timing of their involvement with endorsement. The interviewer prioritized discussion of administration and incentivizing of endorsement and lessons learned.

IECMH Models across the U.S.

Alliance for Advancement of Infant Mental Health member (a.k.a. Michigan Model) states: 37 states **use** or are **in discovery** process.

States with no endorsement: Maine, Vermont, Wyoming, North Dakota, South Dakota, Kentucky, Louisiana

States with state-specific models: **Arkansas, Illinois, California, Ohio, New Hampshire**



From our neighbors...

Vermont: Piloted an ECFMH credential in 2011, but ultimately discontinued the credential. New head of the piloting organization is unsure why the credential was discontinued.

Maine: The Board of the Maine Association for Infant Mental Health decided not to pursue a credentialing process based on the limited number of individuals providing infant mental health services in the state. Education and training are provided to individuals, across disciplines, who are serving young children and families.

Massachusetts: An Alliance state, has worked to get some NH providers endorsed who provide care across state lines. Massachusetts is implementing endorsement in English and Spanish, offers free Reflective Practice Supervision groups in English and Spanish, and has focused strategically on DEI from the outset. In 2019, started with 7 endorsees; today 110 are endorsed.

Key Informants' States and IECMH Models

Interviews included seven states that use the Alliance model and all four states with state-specific models.

Alliance states (start date*)
Alaska (2012)
Colorado (2010)
Massachusetts (2019)
Minnesota (2008)
New Mexico (2005)
North Carolina (2021 - after having its own)
Tennessee (2017)

States with their own models (start date*)	
Arkansas (2018)	Certification for mental health clinicians
California (2003)	Trans-disciplinary endorsement for generalists and specialists, as well as supervisors and mentors
Illinois (2012)	Trans-disciplinary credential for early to mid-career (5+ years) & master's-level professionals
Ohio (2009/2020)	Trans-disciplinary credentials for BA minimum/MA preferred-level professionals

*Start dates approximated by key informants and may include initial pilot, initial cohort training, purchase/adoption of competencies, or other landmark “kick-off” events.

Alliance Model	Infant Family Associate	Infant Family Specialist	Infant Family Reflective Supervisor	IMH Specialist	IMH Mentor - Clinical, Research/Faculty, or Policy
Scope of Work	PROMOTION	PREVENTION/EARLY INTERVENTION	PREVENTION/EARLY INTERVENTION & PROVIDER OF RSC	CLINICAL INTERVENTION/TREATMENT	MACRO
Education	Any academic degree ¹	No Degree	No Degree	Masters, Post-Graduate	Masters, Post-Graduate
Work Experience	Min. 2 yrs. of infant/early childhood related work experience or volunteer experience in an applicable role ²	Min. 2 yrs. of prevention and/or early intervention services with 0-36 mo. olds & their caregivers/families; served a min. of 10 families	Min. 2 yrs. of prevention and/or early intervention services with 0-36 mo. olds & their caregivers/families; served a min. of 10 families <u>PLUS</u> provider of RSC for 1+ yr.	Min. 2 yrs. post-masters IMH practice working on behalf of caregiver-infant relationship	Min. 3 yrs. as an IMH practice leader Plus provider of RSC for 3+ yrs. (Clinical)
In-Service Training	Min. 30 hrs.	Min. 30 hrs.	Min. 48 hrs.	Min. 30 hrs.	Min. 33 hours (Policy & Research/Faculty) Min. 48 hours (Clinical)
References	3	3	3	3	3
Reflective Supervision with a Qualified Provider	Not required	Min. 24 hrs. received	Min. 24 hrs. received; 12 hours about the provision of RSC	Min 50 hrs. received	Min. 50 hrs. received; 25 hours about the provision of RSC (Clinical only)
Written Exam	No	No	No	Yes	Yes

Renewal: 15 CEUs (including 1 in DEI) annually and fee; documentation of supervision if relevant.

RSC = Reflective Supervision Consultation

Arkansas (2018)

Certification for Infant Mental Health Therapists required for Medicaid reimbursement for specialized/approved treatment for children 0-47 months and their parents/primary caregivers.

Eligibility: Master's or Doctoral level licensed clinicians

Requirements:

- Training - *DC: 0-5 and evidence-based dyadic treatment for children 0-47 months and caregivers* (e.g., Parent-Child Interaction Therapy, Child-Parent Psychotherapy) or approved graduate/post-graduate program.
- Application and required documentation related to training requirements
- Six hours of continuing education in early childhood mental health per year; renew every two years

Administrative Organization:

[Arkansas Department of Human Services Division of Aging, Adult, and Behavioral Services](#)

California (2003)

Trans-disciplinary endorsement for generalists and specialists

Three categories for Infant-Family and Early Childhood Mental Health (IFECMH) Practitioners – All must choose age group of focus (0-3, 3-5, or 0-5):

- (1) Transdisciplinary IFECMH Practitioners: Direct service providers with BA or higher
- (2) Advanced Transdisciplinary IFECMH Practitioner: Providers with Master's or higher who've met TIFECMH Practitioner criteria and have eight years of experience.
- (3) IFECMH Specialists: Providers with Master's or higher and professional license/credential from state regulatory agency.

Two Reflective Practice Facilitator (RFP) categories: Support reflective practice of IEC providers who complete additional training on reflective practice facilitation.

- RFP I - Certified at category 1 or 2 above; Can supervise those in category 1
- RFP II - Certified at category 3 above; Can supervise those in categories 2 or 3 (depending upon cross-discipline experience)

Reflective Practice Mentor: Endorsed as RPF I or II and have met requirements to train, support, and facilitate learning of others undertaking work of reflective practice facilitation. Mentor activities include program development, evaluation, supervision, training, staff development, policy development, research, and cross-systems work.

No exams; applications require documentation related to specific requirements, personal statement, recommendations, etc.

Cost: \$375

Administering organization: [California Center for Infant, Family, and Early Childhood Mental Health](#)

Illinois (2012)

Trans-disciplinary credential for mid-career & master's-level professionals –

Description: Year-long, relationship-based, professional development process to deepen and strengthen knowledge and skills of experienced practitioners. Supports development of a community of IECMH practitioners and provides a QA component to the practice of ECMH.

Eligibility:

- Education: Master's degree or higher in related field
- Experience: At least five years of relevant post-graduate degree experience
- Reflective Supervision: 60 hours of reflective supervision (48 individual required/12 can be group)

Application process: Self-assessment tool; Application with documentation of required components and \$25 fee.

Process: 10 monthly, 3-hour facilitated small group/reflective practice discussions & 5 individual sessions; each followed by reflective essay. Final assessment form completed and reviewed by panel of three and reflective practice facilitator. Cost: \$1,000.

Administering organization: [Illinois Association for Infant Mental Health](#)

Ohio (ECMH 2009 – IMH 2020)

Multiple trans-disciplinary credentials for professionals working in early childhood; separate early childhood mental health and infant mental health credentials (and several others)

ECMH Requirements:

- Personal profile on OH Professional Development Registry
- Minimum of 2 years work experience in ECMH
- Employed by an OH Department of Mental Health and Addiction Services certified agency currently/within past 2 years
- Working with children 0-6 and their families currently or in past 3 years OR supervising such persons now or within past 3 years.
- Bachelor's degree required; Master's preferred in related field
- Relevant professional license
- Training in ECMH Consultation model & 2-day DECA Program Implementation training
- 15 hours training/coursework on early childhood (0-6) in two or more core competency domains
- ECMH core competencies skills inventory self-assessment
- Renewal every two years with 15 hours of training/coursework on early childhood (0-6) in two core competency domains
- Updated ECMH skills inventory

Application process: Skills inventory, application with documentation of required components.

Cost: None and required trainings are free and required for state employees, contracted staff, and grantees. Supervision provided at org/agency level for free. Supervisors trained by Master Trainers.

Administering organization: [Ohio Professional Registry](#) at the Ohio Child Care Resource and Referral Association

Reflections on the Alliance Model

Pros

- Being part of a multi-state Alliance provides opportunities for partnership and learning from one another and influencing model.
- Alliance investments in QI and evaluation benefit all subscribers, save states time/effort.
- Offers parity/reciprocity across states that have Alliance model.
- States can purchase support for admin functions and receive TA to support implementation and ensure fidelity.
 - Allows states to focus on partnerships, marketing, etc.

Cons

- Some feel model is weighted toward MH clinicians and not multi-disciplinary enough (i.e., category 3), although others disagree.
- Upfront and ongoing costs are prohibitive for some states.
- Limits partnership and reciprocity with states that don't have Alliance model.

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Themes across all states
involved in the key
informant interviews

History/context for early work

- Most states had a very grassroots, volunteer driven path to endorsement, relying on multi-disciplinary partners to plan endorsement.
- Several had IECMH academic/research partners involved.
- A few had funders engaged.
- A couple had administration/state agencies involved in championing the effort.
- Most began with some level of assessment of early childhood services and training.
- A couple had strategic plans in which endorsement was one strategy.
- Some had an IECMH Association prior to endorsement; others created one to provide a home for endorsement.

Organizations administering endorsement

Endorsement is typically administered by a non-profit, usually an Association for Infant Mental Health.

- Some are stand-alone 501(c)(3) organizations.
- Some are housed within other non-profits (e.g., Erickson Institute in Illinois and MSPCC in Massachusetts).
- The California Center for Infant-Family and Early Childhood Mental Health lives at WestEd, a non-profit consulting group.
- The Ohio Professional Registry is part of a public-private partnership (OH Child Care Resource and Referral Association Child Care Resource and Referral Network).

Some focus narrowly on supporting endorsement. Others offer an array of services and resources (e.g., training, TA, supervision, emergency response).

Organizations administering endorsement, cont'd

Administering organizations range in size from 22 staff to a single, contracted part-time endorsement coordinator. Several rely on volunteers for some functions.

All agree that having paid staff is critical to success.



“Volunteers will burnout. You must have paid positions.”

“A paid staff person is so important.”

“If you go down this path, a paid leader is so important.”

“I suggest you start with at least two staff, one to manage the administrative functions related to enrollment and one to build relationships and do the systems-building pieces of the work.”

Organizations administering endorsement, cont'd

All have multi-disciplinary advisory groups/boards.



“It is so important that this lives in a place that has credibility, with people that really understand the work. Administrative oversight is so important, but a broad advisory board that is invested is critical.”

Some rely heavily on the board to do the work associated with endorsement, which may create risk for the organization.

“Our seven board members do all the heavy lifting...As our board ages, who knows?”

“Our board would rather be advisory not working hard to get replacements.”

Organizations administering endorsement, cont'd

- Most have annual dues (i.e., AIMHs)
- All say endorsement does not cover infrastructure; at best it covers basic administrative costs of endorsement.
- While important to start-up, for several, long-term reliance on grant funding creates vulnerability.



“Our association is pretty much the major trainer in the state. When our grant expires, we won’t be able to.”

“Our funding ended in 2016. We managed because some of us were not paid. We applied for foundation support...But they say we are not sustainable so won’t fund us. We don’t have a line item in the state budget. In 2018, we suspended the credential because we had no funding. [After raising fees and re-starting] We still have no money and are really exhausted.”

Marketing endorsement

States have used a range of marketing tactics:

- Conference presentations
- Disseminating marketing materials to association members
- Newsletters to members and stakeholders
- “101” sessions – regular and upon request
- Endorsement FAQs
- Relying on partners/endorsed individuals to talk about endorsement with others

“Partners are so important as they help market what we are doing.”

Marketing endorsement, cont'd

- Presenting to stakeholders is important but labor-intensive.

“I went around the state doing the dog and pony show to educate people.”

“In the first year, I spoke in front of more than 100 audiences.”

“There is a lot of handholding in the beginning to help professionals understand what this is.”

“Marketing is dependent upon having an endorsement coordinator who can go out and about and talk to people about it.”

Marketing endorsement, cont'd

Messaging promotes the importance of competency and having a united profession for young children and families NOT getting everyone endorsed.

“Endorsement is what we do, not who we are.”

“Improved outcomes for kids, that’s the goal.”

“The message should be that it is important for our profession, and it is big, with lots of professionals within it. Put that motto everywhere.”

“Always hold the child in mind. Remember, they are why you are doing this.”

“Endorsement is a journey toward providing relationship-based care for all young children and their families.”

Incentives to support endorsement

- Five require staff & contractors in various systems/programs get endorsement.
- Two prohibit reimbursement for MH clinicians if not endorsed.
- Two offer enhanced Medicaid reimbursement to agencies if clinicians are endorsed.
- One described general fund dollars that cover services not covered by Medicaid; must be endorsed to access those funds.



“You have to be careful when offering incentives tied to Medicaid. I worry a lot about disparities. We already have so few clinicians in the state so making it harder to get reimbursed would spell disaster.”

Incentives to support endorsement, cont'd

- One grants extra points to applicants for state contracts with endorsed staff.
- Three grant CEUs with endorsement.
- Most have registry of endorsed individuals; being in registry may result in referrals.
- All promote benefits of endorsement/professional recognition so people will see themselves in it and want it.

Addressing possible barriers to endorsement

Application/exam fees:

- Offer scholarships to those who need support
- Allow for costs to be built into state contracts

Training:

- Provide free and virtual trainings, especially for rural areas
- Offer cross-walks for trainings/certificate programs
- Work with higher ed partners to build competencies into their programs

CAUTION

“If you tie endorsement to training, you have to offer a lot of it or you’ll just create a bottleneck.”

Addressing possible barriers to endorsement, cont'd

Reflective Practice Supervision (RPS):

- Can be cost-prohibitive for the individual endorsee and difficult to find.
- Counting on volunteers (to offer free/reduced cost service) is not ideal or sustainable.



"Supervision is expensive. Some will do it on sliding scale. I used to, but I'm done with that. I now let younger practitioners do that, which means earlier career people are supervising because they are more willing to do sliding scales."

"Reflective Practice Consultation is costly. It's a job and people should get paid."

Suggestions:

- Begin with cadre of RP supervisors at outset and build consultant network over time.
- Consider use of out-of-state supervisors for virtual supervision, if needed.
- Offer/promote group supervision.
- Support organizations in developing internal capacity for RPS.
- Determine a way to ensure people are getting comparable and quality RPS.

Addressing possible barriers to endorsement, cont'd

Ensure endorsement is not seen as an exclusive club or as hierarchical is important to building the profession.

- Promote categories vs. levels of endorsement
- Talk about what is common across sectors (i.e., work with small children and families)

Build diversity into the approach:

- Ensure regional and demographic diversity in cohorts of endorsees
- Provide outreach to and engagement of organizations from across the state
- Note who isn't at the table and constantly grow representation of who is informing/influencing endorsement approach

Public Partnerships

“Endorsement can only be successful if supported by state systems so there is less burden on the individual from the beginning.”

While a couple of states had widespread engagement across child-serving agencies (i.e., Governor’s Cabinet, cross-agency strategic plan), it was more common that leadership in one agency, division, or program championed endorsement.

“While having public partnerships is key to gaining traction with endorsement, it is important that it doesn’t become so associated with any one system or profession that others don’t think it is relevant to them.”

“The state was not involved in the beginning. Later, state agencies started to sign on. It was a bumpy road. Early on, it was seen as something for clinicians so others said, ‘it is clearly not for us.’ But when DHS signed on, things turned around and every role was highlighted as relevant.”



Public Partnerships, cont'd

Multiple state agencies have a stake in endorsement.

“This work is inevitably about systems-building. We are working simultaneously with multiple partners to build their capacity for relationship-based work with young children and families.”

However, given limited staffing resources, most often do simultaneous marketing of endorsement to multiple agencies/programs while working closely with one or two around implementation.

“Be strategic. You can work closely with one, but let the others know their turn is coming.”

Public Partnerships, cont'd



Work with State partners to:

- Identify opportunities in federal grants to support endorsement (e.g., training/workforce development).
- Build into state contracts the ability for organizations to use state dollars to support training and Reflective Practice supervision to support endorsement.
- Build extra points into rubrics that reward bidders whose staff are endorsed.
- Market endorsement and professional development opportunities.

Evaluation

- Alliance tracks demographics and number of endorsees; Also doing research on perceptions of endorsement across states.
- In CA, IECMH Consultation Network got money to look at outcomes for kids, teachers, and providers. Due out next year.
- OH, in collaboration with Yale, has shown improvements in several outcomes among EC teachers, parents, and children, including significant decreases in expulsion rates.
- CO had very little money for evaluation but looked at feelings of competency and job satisfaction at all categories.

Legislative involvement

While a few noted that having legislative champions could be helpful, a couple offered guidance.

“I would be super careful if doing something legislative. Don’t get so narrow in how you define things that you deny kids the services they need.”

“Stay involved while policies are being drafted. Don’t assume partners ‘get it,’ as they may do something inadvertent that causes problems or barriers for kids.”

Other words of wisdom

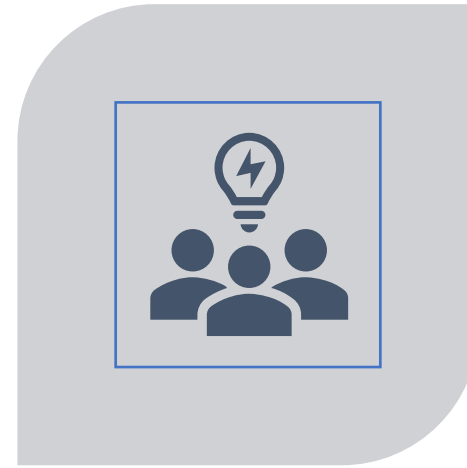


“Let your motto be, ‘What’s good enough for the babies.’ Perfect can be the enemy of getting this off the ground.”

“Stress tolerance is important. This is complex work. It is almost cliché. We talk about relationships, but this is what hold this together. There will be difficulty...always hold the child in mind. Remember, they are why you are doing this.”



QUESTIONS?



THOUGHTS?