CHAPTER 35

Infant and Early Childhood Mental Health Training

Updates, New Directions

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Increasing awareness of the importance of early experiences on brain development, mental health, and later physical health has fueled ongoing efforts to expand the field of infant and early childhood mental health (IECMH) and to increase the reach of child- and family-serving disciplines to support healthy early development. This explosion of interest is reflected in the expansion of training opportunities designed to prepare a workforce to engage in infant and early childhood mental health practices in the wide range of settings in which it may be addressed—early childhood education, obstetric and pediatric health care, home visiting, mental health, child welfare, and the legal system. A significant challenge for the field is how to prepare a diverse workforce, including those without training or experience in mental health, to engage in IECMH practice in settings with differing goals, priorities, strategies, and resources, and driven by differing professional parameters. Like the rapid proliferation of brain cells in the early years of life, the field of IECMH is experiencing rapid expansion of training opportunities and efforts, which is exciting but may also be overwhelming and lack efficiency. As professionals across child-serving disciplines learn and practice IECMH, over time, successful methodologies and pathways to effective practice will become clearer—a process of "pruning," in effect.

The field of IECMH focuses on promotion, prevention and intervention activities. As noted by Zeanah and Zeanah (Chapter 1, this volume), this includes a range of IECMH services beginning with health promotion; universal, targeted, and selective prevention; case identification and diagnosis; treatment; and continuing support through parents' aftercare and recovery (posthospitalization or intensive treatment programs). Services in the field address healthy, well-functioning infants and families, those at risk or with emerging symptoms, those with diagnosable disorders in need of treatment, and those who are recovering after an intense treatment episode such as posthospitalization or substance abuse treatment. This continuum reflects potential points of entry through which services may be provided; it therefore provides a framework to consider workforce development efforts and needs.

We have proposed three overarching goals to meet training needs in this multidisciplinary field (Hinshaw-Fuselier, Zeanah, & Larrieu, 2009):

1. To *define and promote a core set of principles pertaining to the understanding of infant development in context* that is relevant to the training of all practitioners who work with young children.
2. To *develop and refine training experiences that differentially incorporate the knowl-*

edge and skills appropriate to "discipline of origin" (scope of practice) and the degree to which professionals are involved with infants, young children, and their families.

3. To *provide a supervision and/or consultation process that promotes professional development aimed at promoting supportive relationships between parents and infants, parents and professionals, and between professionals.*

We believe that these goals provide a framework for navigating the current landscape of training in IECMH. In this chapter, we assess progress that has been made in each of the three areas associated with the goals and consider the intersection of training and the continuum of services (e.g., promotion, prevention, intervention) in each of the areas. We highlight examples of training efforts, discuss challenges in training the multidisciplinary workforce of IECMH, examine gaps and next steps, and suggest future directions in this evolving field.

Goals of IECMH

Promote Infant Mental Health Principles: Incorporate IECMH Principles in Training

It is essential that practitioners across IECMH disciplines share an understanding of the interplay among the biological, relational, and cultural contexts that shape infant development and give meaning to children's relationships and behaviors, whether healthy or symptomatic. The core IECMH principles that have been identified (see Zeanah & Zeanah, Chapter 1, this volume) describe the range of basic concepts that underlie and can guide all promotion, prevention, and intervention approaches. Furthermore, a shared understanding of these principles may facilitate a shared language and perhaps even complementary goals for families among those serving very young children and their families.

For instance, in the provision of routine care, pediatric professionals promote healthy development through attention to physical wellness, children's growth and development, and families' knowledge of basic parenting skills and practices. Moving along the continuum, practitioners who work in the area of prevention and early intervention serve families who are at risk for poor developmental outcomes and provide additional targeted interventions to keep families on a healthy trajectory. Home visiting programs serving families in poverty, for example, can reinforce the health and developmental information that parents learn from the primary care provider, and help parents navigate the health care system. When armed with knowledge about potential contributions to and buffers against deviations in healthy development and with the intentional incorporation of key IECMH principles in their work, such as the importance of relationships (e.g., the parallel process) and reflection (for professionals and for parents), they can help families to identify and develop protective factors and resilience. For families who need mental health intervention, primary care and prevention practitioners need awareness of when and how to refer for more intensive services. Mental health clinicians need knowledge and skills in assessment of infant and early childhood psychopathology, as well as the specific treatments and interventions geared to the developmental needs of the child and the relationship needs of the dyad (or extended caregivers). Promotion, prevention, intervention, and recovery activities may occur simultaneously—for example, a young child who has experienced abuse or neglect may need treatment for trauma symptoms, physical health, or educational services aimed at prevention of further sequelae of trauma, and promotion of caregiving that will facilitate the child's current and future well-being. In this case, services that address the caregiving needs of the child while outside of parental custody, and aftercare/recovery services for the parent and dyad when the child is returned to the parent, are also needed.

From an IECMH perspective, integrating core principles into every level of intervention will facilitate better outcomes for the child. Above are just a few of the countless possible examples across the continuum of services that illustrate the ways cross-disciplinary and cross-system recognition of core IECMH principles can inform practitioners to better serve infants and young children. A further question for the field, then, is how to effectively promote awareness and provide ample training opportunities for practitioners from diverse fields to develop a keen understanding of these principles and how to apply them to their work. This question dovetails with the second stated goal regarding training, discussed below.

Differentially Develop Training: Determine Differential and Shared Training Approaches

In a previous discussion of training, we proposed that the field should "develop and re-

fine training experiences that differentially develop the knowledge and skills appropriate to the degree to which professionals should be involved with an infant's state of being based on their discipline of origin" (Hinshaw-Fuselier et al., 2009, p. 534). An overview of developments in the field since that time suggests that training is indeed proliferating, and with that proliferation come many new questions for the field. Current training efforts span a vast range, from "stand-alone," content-focused, one-time trainings on a specific topic (e.g., nurturing language development, developing observational skills) to protocols for evidence-based practices targeting one or multiple disciplines (e.g., Video-Feedback Intervention to Promote Positive Parenting [VIPP], Minding the Baby [MTB], child–parent psychotherapy [CPP], Attachment and Biobehavioral Catch-Up [ABC]), to specialized IECMH training offered in certificate or graduate programs that are affiliated with universities. Numerous organizations offer conferences that target a range of topics for a range of professionals who may be involved with IECMH in varying capacities (e.g., see *www.waimh.org, www.zerotothree.org, www.postpartum.net, www.naeyc.org*). Finally, professional development opportunities exist to cultivate expertise in IECMH, such as Zero to Three's Fellowship Program (*www.zerotothree.org/resources/59-zero-to-three-fellowship-program-description#chapter-24*), which targets emerging leaders from various disciplines and geographic areas, and various competency structures that can help guide an overarching strategy for training efforts by outlining content areas that are thought to be necessary for competent practice across domains (see below).

Sorting through the possibilities to determine which training options are best for whom and how to choose among similar options can be perplexing. Such decisions may be made by individual practitioners, but often the larger systems within which they practice influence the extent to which resources (e.g., time, money) will be spent on training. Ideally, baseline training that addresses the core principles of IECMH would be a requisite part of preparation across disciplines involved in IECMH, thereby increasing the likelihood that health, mental health, education, and related services would be delivered in a developmentally sensitive way, and that providers of those services would have a common language and understanding of IECMH. Such a universal approach to training might also help alleviate some of the confusion and costs associated with professionals trying to acquire basic IECMH skills. However, potential challenges in incorporating this kind of baseline training across disciplines include philosophical issues, such as each discipline's commitment to its special focus and expertise, historical traditions and current identity, professional values within the respective fields, and more practical issues such as securing education credits across multiple disciplines. In spite of these challenges, efforts are under way to stretch across disciplines to train individuals to practice IECMH within the scope of their profession.

Competency Frameworks

Competency frameworks provide salient examples of both the efforts and the challenges in being comprehensive, multidisciplinary, and differential in IECMH training. Different competency approaches allow practitioners to select an approach that best fits their goals and resources, which is arguably advantageous. However, separate structures are potentially duplicative, and there is no overarching authority to help practitioners determine what professional development approach is best for whom. While not comprehensive, the discussion that follows provides examples of approaches to competency-based training that illustrate current approaches, issues, and dilemmas.

The Michigan Association for Infant Mental Health (MI-AIMH, 2002, 2011) developed competency guidelines for infant mental health providers from multiple disciplines (e.g., child care providers, mental health clinicians, researchers, administrators), as well as a procedure for professional endorsement that is now being administered by several states and Infant Mental Health Associations (approximately 23 at this time), including Ireland and Australia (Priddis, Matacz, & Weatherston, 2015; Weatherston, Kaplan-Estrin, & Goldberg, 2009; Weatherston, Moss, & Harris, 2006). The MI-AIMH competency framework includes eight core areas: theoretical foundations; law, regulation, and agency policy; systems expertise; direct service skills; working with others; communicating; thinking; and reflecting. The MI-AIMH system recognizes professional competency in five categories: infant family associate, infant family specialist, infant mental health specialist, infant mental health mentor, and early childhood family specialist. MI-AIMH's *Endorsement of Competency* verifies that the individual

has the appropriate professional education, experience, and licensure (if needed), and has successfully completed the competency-specific training and reflective practice experiences specified for each endorsement. Training and supervision requirements vary by endorsement, and because the requirements are extensive, the process may take several years to complete; training (continuing education) is also required for maintenance of the endorsement. This approach is clearly comprehensive and requires a significant investment of resources and infrastructure.

Similarly, Zero to Three has partnered with First 5 LA in California to tackle the issue of universally shared competencies; they recently produced the "Cross-Sector Core Competencies for the Prenatal to Age 5 Field" ("P-5 Project"; Zero to Three, 2015) to outline the fundamental competencies across the disciplines of early care and education, early intervention, social services/child welfare, physical health, and mental health. They identify eight core competency domains: Early Childhood Development; Family-Centered Practice; Relationship-Based Practice; Health and Developmental Protective and Risk Factors; Cultural and Linguistic Responsiveness; Leadership to Meet Family Needs and Improve Services and Systems; Professional and Ethical Practices; and Service Planning, Coordination, and Collaboration. No certification or endorsement is offered, and the training process can require as little as 8 hours of online lessons, though more extensive learning is available through optional fieldwork and peer interaction.

Like the MI-AIMH Endorsement, the P-5 Project assumes that discipline-specific training and licensing requirements are met; these efforts strive to offer something beyond typical professional education and training. The emphasis of the endorsement leans toward in-depth professional development to help individuals subspecialize within their discipline, recognizing that disciplines will differentially engage with families depending on where their services fall along the continuum of promotion, prevention, and intervention. The P-5 Project seeks to develop common understanding across sectors, so that the needs of families and young children can be met more holistically across the service spectrum. While both the MI-AIMH Endorsement and P-5 Project aim to enhance the developmental appropriateness of services across the continuum of IECMH, their approaches are quite different. They do not seem to be mutually exclusive approaches, but these examples highlight questions around training: What training is most appropriate for whom? What training/experience qualifies a professional to engage with families and young children around IECMH? When is a person "qualified enough" to provide promotion, prevention or intervention services? What body or bodies monitor or should monitor professional qualifications, certifications, and endorsements?

Evidence-Based Practices

Another avenue for developing differentiated expertise is through training in evidence-based programs and certification/rostering in evidence-based practices (EBPs). While there is a wide array of EBPs, some have similar protocols or overlapping approaches. There is not a singular entity that determines which protocols are considered "evidence-based," or determines how much and what quality of evidence defines the continuum of evidence-informed practice to EBPs. However, some guidance is available to help practitioners and service delivery programs navigate the growing landscape of EBPs across the continuum of services.

At an individual level, practitioners from many disciplines can look to their professional organizations for guidance. While specific EBPs may not be endorsed, guidance about practice can be found in the form of policy statements (e.g., the American Psychological Association's Evidence-Based Policy and Practice [Levant, 2005]), practice parameters (e.g., the American Academy of Child and Adolescent Psychiatry's Practice Parameters for the Psychiatric Assessment of Infants and Toddlers [Thomas, 1997]), and guidelines for practice (e.g., the National Association for the Education of Young Children's Developmentally Appropriate Practice [Copple & Bredekamp, 2009]). At a programmatic level, practitioners across the service continuum may find that specific protocols are required, such as use of a particular treatment manual or service model.

Administrators and funders can look to policymakers for guidance about evidence-informed practice. The Department of Health and Human Services Home Visiting Evidence of Effectiveness (HomVEE), for example, reviews maternal child health home visiting programs and rates programs using clear and stringent criteria to determine whether programs have suf-

ficient evidence of effectiveness to qualify for federal funding. Evidence considered includes the quality of research approaches and outcomes measured; the duration, sustainability, and replicability of impacts; and subgroup findings, unfavorable outcomes, the evaluator's independence, and the magnitude of impacts (Sama-Miller et al., 2016). Thus, though HomVEE programs include models whose practitioner requirements range from a high school degree to a professional license and span the service continuum from prevention (e.g., universal delivery of parent education) to intervention (e.g., mental health treatment providers working with a specifically targeted population), all approved programs have met the HomVEE evidence-based criteria. Other efforts are occurring at a state level; Herschell, Lindhiem, Kogan, Celedonia, and Stein (2014) identified sites that detail initiatives for dissemination of EBPs at a statewide level (e.g., the California Evidence-Based Clearinghouse for Child Welfare, the New York State Office of Mental Health's Evidence-Based Treatment Dissemination Center, and Pennsylvania's Evidence-Based Prevention and Intervention Support Center).

On a practice level, EBPs vary in terms of outcome targets and which types of practitioners may engage in the protocol. For example, Video-Feedback Intervention to Promote Positive Parenting (VIPP) has been used successfully in parenting education programs serving different types of families, in day care settings (Juffer, Struis, Werner, & Bakermans-Kranenburg, 2017), and in pediatric clinics (Cates et al., 2016). Other models offer gradations of training along the prevention–promotion–intervention continuum, based on the trainee's professional background (i.e., prior education and training) and the limits of the profession. For example, Circle of Security (Powell, Cooper, Hoffman, & Marvin, 2014) has both a parent education model and a therapeutic model based on the same principles; training for the models is different and reflects the level of engagement a professional is expected to have with families. Still other EBPs, particularly those addressing mental health interventions, are developed for use by specific disciplines or groups of disciplines, such as licensed mental health providers. For instance, the rostering process for CPP prepares mental health clinicians to treat significant problems and pathology in the relational context of children's development (Lieberman, Ghosh Ippen, & Van Horn, 2015). Finally, some EBPs target multidisciplinary intervention in specific delivery contexts, such as home visitation models. Examples include different approaches, even within this highly circumscribed context; Moving Beyond Depression (Ammerman et al., 2013), for example, promotes a collaborative relationship between home visitors and mental health clinicians treating maternal depression, whereas Minding the Baby (Sadler et al., 2013) pairs mental health clinicians with pediatric nurse practitioners to provide integrated primary and mental health care in a home visiting model designed to enhance the attachment relationships between parent and infant.

Training Challenges. While the efforts to develop and disseminate EBPs are laudable and represent advances in increasing the skill of the IECMH workforce, there are challenges that must be considered as we strive to grow a workforce that is able to make effective practices accessible to children and families in communities of need. Whether one is pursuing formal training in infant and early childhood mental health (e.g., university-based certificate or degree programs), achieving an endorsement for an identified level of infant mental health practice (e.g., MI-AIMH endorsement process), or certification/rostering in an evidence-based therapy (e.g., CPP), the process often entails a considerable amount of time, effort, and cost. Similarly, though evidence-based IECMH prevention and intervention programs do not usually confer certification, they do require program-specific training and infrastructure to implement models with fidelity and maintain high-quality service delivery (e.g., the Maternal, Infant, and Early Childhood Home Visiting [MIECHV] evidence-based home visiting models). Acquiring the requisite knowledge, skills, and applied practices can be a long process. Many specific therapies (e.g., CPP, ABC), specific types of assessment (e.g., Nursing Child Assessment Satellite Training [NCAST] Parent–Infant Interaction Scales), or evidence-based intervention programs (e.g., home visiting models) require supervised, hands-on practice prior to completion of the training program, and several assessment and treatment models have established mechanisms to maintain fidelity to the intervention following completion of the training (e.g., ABC: Dozier et al., 2006; CPP: Lieberman et al., 2015; NCAST Parent–Infant Interaction Scales: Kelly & Barnard, 2000).

Undoubtedly, practitioners want to deliver high-quality, effective services to infants and families. In fact, community behavioral health care providers describe preferences about training and implementation of EBPs, suggesting that hands-on, interactive training, followed by ongoing training support, peer support, and supervisory/agency support is essential for successful implementation into practice (Herschell et al., 2014). The difficulty is in the availability, accessibility, and cost of training. Finding the time, funding, and support necessary to develop skills and/or acquire specific program materials is challenging. Beyond this, logistical challenges may interfere with access to training. For example, many trainings are only offered at certain times and in certain locations, and many locations lack access to training professionals with expertise in IECMH. Thus, despite interest in and options for differential training, availability and accessibility remain barriers to workforce development.

In addition to the logistical issues described above, there are also challenges with implementation of best practices, including how to determine which practice is most relevant for a given agency or population, the availability of approaches that are expected to lead to the desired outcomes, the "fit" between the practice and the child or family, including sensitivity to the cultural and community needs and readiness for particular approaches, and agency/workforce readiness to successfully replicate (or adapt) models in clinical settings (Finello, Hampton, & Poulson, 2011). These issues are not unique to the field of IECMH. Marchette and Weisz (2017) outline similar challenges in providing evidence-based psychotherapy for youth. They argue for reconceptualization of treatment from focal (e.g., diagnosis or symptom-specific) methods to transdiagnostic interventions, placing focus on core dysfunction (dysfunction that is associated with multiple diagnostic categories), common elements approaches (therapeutic use of activities that are beneficial across therapies), or principle-guided approaches (addressing core principles of therapeutic change) (p. 971). Similarly, within the intervention/behavioral health part of the continuum of services, researchers have been studying approaches to matching EBPs to particular client populations and communities (Chorpita, Bernstein, & Deleiden, 2011), as well as mixing strategies from across multiple EBPs to create a more effective treatment for individual clients (Weisz et al., 2012). While these examples are specific to behavioral health intervention, perhaps the IECMH field can learn from them in terms of developing ways to identify underlying issues that can be addressed by cross-diagnostic and/or cross-discipline intervention approaches. These approaches are worth exploring and may provide a more specific path for multidisciplinary workforce development, including greater accessibility and reduced training costs.

Provide Supervision/Consultation: Provide Appropriate Levels of Supervision and Consultation

Whether or not IECMH practitioners are engaging in specific EBPs, the field has long recognized the importance of supervision for effective practice, and there is general agreement that inclusion of reflective practice is essential to the development and sustenance of effective infant and early childhood services across the continuum of care (Weatherston & Osofsky, 2009). Including ongoing supervision/consultation as part of promoting effective assimilation and implementation of training material remains a central consideration for training in IECMH. We recognize that reflective supervision, in particular, has extensive support in the field of IECMH (Heller & Gilkerson, 2009), and increasingly, consultation is also developing broad support in the field (Wotherspoon et al., 2010). Given the growing interest in these areas, consideration should be given to how the field prepares supervisors and consultants.

Reflective supervision has grown out of the mental health supervision model, with emphasis on establishing a relationship between service provider and supervisor that supports professional growth through reflection, collaboration, and regularity (Shahmoon-Shanok, 2009; Van Berckelaer, 2011). Specifically, the major goal of reflective supervision is to improve the provider's practice with children and families by increasing professional competence and awareness of the parallels between the parent and the provider, as well as the parent and the child. The clinical work of the provider is considered from many perspectives, including the provider's thoughts, feelings, and observations (Shahmoon-Shanok, 2009). The discussions that occur during reflective supervision provide safety for the provider to explore his or her own motivations, thoughts and behaviors;

explore uncomfortable or distressing thoughts and feelings, and set the stage for being open to exploring those same feelings or thoughts in parents and children. Experience with reflective supervision may vary in length and quality. For example, it may be a finite part of training (e.g., fulfilling a requirement for endorsement) or an ongoing part of a job (e.g., as required in some home visiting and consultation models). As for quality, there is not a defined curriculum for preparation to be a reflective supervisor; in other words, training experiences vary, and there is not a governing body that sets requirements for who can be a reflective supervisor. However, training opportunities abound, from books and guides (e.g., Heller & Gilkerson, 2009; Parlakian & Seibel, 2002), to programmatic training (e.g., reflective supervision for supervisors in Nurse–Family Partnership), to in-person training at conferences (e.g., Zero to Three Annual Conference).

Like reflective supervision, consultation is recognized as a means for professional development and a path to providing effective service delivery for young children and their families. Information and resources for IECMH consultation are growing. Early Childhood Mental Health Consultation (ECMHC) "aims to strengthen the capacity of staff, families, programs, and systems to promote positive social and emotional development as well as prevent, identify, and reduce the impact of mental health problems among children from birth to 6 years old and their families" (Kaufmann, Perry, Hepburn, & Hunter, 2013, p. 6).

Research conducted by Georgetown University Center for Child and Human Development (GUCCHD; Duran et al., n.d.) identified that having a strong program infrastructure, using highly qualified consultants, and providing high-quality services results in positive outcomes for children, families, staff, and agencies. For example, the U.S. Departments of Health and Human Services and Education (2014) recently recognized high-quality ECMHC as vital to successfully addressing suspensions and expulsions from early childhood settings. While much of the attention on ECMHC has been on child care consultation (including licensed child care centers, family child care homes, and Head Start and Early Head Start), the reach of ECMHC is actually quite broad and includes consultation to Part C Early Intervention in IDEA, primary care, child welfare, and home visiting.

Thus far, there is not a consensus on a prescribed training curriculum or mandatory activities for training IECMH consultants, and there appears to be some variation among programs as to who can provide this kind of consultation and what components are part of IECMH consultation (Kaufmann, Perry, Hepburn, & Duran, 2012). Efforts are under way to provide guidance and further develop resources for IECMHC. In 2015, the Substance Abuse and Mental Health Services Administration (SAMHSA), under the auspices of the U.S. Department of Health and Human Services (DHHS) and in collaboration with the Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF), launched the National Center of Excellence in Infant and Early Childhood Mental Health Consultation (IECMHC; *www.samhsa.gov/iecmhc*). The Center of Excellence strives to build effective, sustainable mental health consultation systems throughout the United States. This initiative is a prevention-based service that pairs a mental health consultant with families and individuals who work with infants and young children in a variety of settings, including child care, preschool, and families' homes. The goal is to increase the capacity of caregivers to support and facilitate the healthy development of children before intervention is needed. Some of the goals of this initiative are to reduce young children's challenging behaviors, increase collaboration and positive relationships, reduce staff burnout and turnover, and address racial disparity and inequities in child-serving systems. The center offers a toolkit to support building infrastructure, adoption, and implementation of best practices for IECMHC in infant and early childhood settings in which consultation occurs, including home visiting, early child care, and education. Similar efforts and resources can be seen through the work of Project LAUNCH (Linking Actions for Unmet Needs in Children's Health (*www.healthysafechildren.org/grantee/project-launch*), a component of which is early childhood mental health consultation. Some consideration has been given to identifying training needs for consultants (Johnston & Brinamen, 2005), though as IECMHC grows in and across settings (e.g., child care, primary care, home visiting), further consideration will need to be given to the preparation and qualities necessary for effective consultation. Emphasis should be placed on delineating key content knowledge areas and refining how consultants are trained

to consult (i.e., the process, itself) with professionals outside of their discipline.

While there is widespread advocacy for reflective supervision and IECMHC, there is a lack of research about their effectiveness. Several initiatives promote reflective practice and underscore its importance, regardless of discipline, professional role, years of service, and position within an agency or organization (Eggbeer, Shahmoon-Shanok, & Clark, 2010). Examples include reflective supervision requirements in some evidence-based practices (e.g., many home visiting models) and engaging in reflective practice as part of the competencies necessary to achieve fidelity to an intervention model (cf. CPP; Lieberman et al., 2015). Numerous educational offerings are available for professionals to gain knowledge and skills in reflective practice. For example, Zero to Three disseminates education through online offerings, educational briefs and publications, workshops, and customized training programs in reflective supervision (for more information, see *www.zerotothree.org/reflectivesupervision*). Lagging behind is the evidence to support the initiatives.

Systematic evaluation and research on the implementation and impact of reflective practices are needed to determine how reflective supervision and consultation contribute to developing a competent workforce, justify funding to support reflective practice in IECMH agencies and organizations, and to inform policy in infant and early childhood (Tomlin & Heller, 2016). Recently, promising work has emerged regarding reflective supervision, focused on the measurement of knowledge and skills of clinicians participating in reflective supervision (e.g., capacities to mentalize and reflect), as well as how the structure and process of supervision sessions build reflective capacity in professionals and supervisors (Finello, Heffron, & Stroud, 2016; Gallen, Ash, Smith, Franco, & Willford, 2016; Heller & Ash, 2016; Watson, Harrison, Hennes, & Harris, 2016). Similarly, several states have begun to evaluate consultation to facilitate the effective implementation of IECMHC and establish its use as an EBP (Zero to Three, 2015). Under consideration are questions such as the following: What types of activities are most important for the consultant to provide? Which outcomes should be considered? How should these outcomes be measured? What is the cost–benefit of IECMHC? Continued evaluation and research efforts such as these will help strengthen our understanding of supervision and consultation, and refine training as the field prepares supervisors and consultants for their roles.

Additional Training Considerations

Revisiting the goals set forth regarding training in IECMH highlights the progress that has been made in recent years. Not surprisingly, this growth has also led to more questions. In this section, we discuss other important issues that we believe must be central considerations as the workforce is developed in the field.

Diversity-Informed Training and Practice

Discussion of training in IECMH would be incomplete without addressing the role of culture in the lives of young children and families (see Ghosh Ippen, Chapter 8, this volume, for a discussion of the cultural context in IECMH), and the professionals who provide the continuum of services for them. Across health, mental health, and health-related fields, recognition of the need for cultural competence abounds. Examples range from the personal reflections of trainers in social service fields (see Williams, 2017) to evaluation of patient satisfaction of those treated by nurses and physicians who participated in cultural competence training (see Govere & Govere, 2016) and federal recognition of emerging evidence in culture-centered practice (see *https://nrepp-learning.samhsa.gov/emerging-evidence-culture-centered-practices*). More specifically, in the world of IECMH, competency structures include knowledge, skills building, and reflection regarding work with diverse populations. Many EBPs also address cultural understanding in their training.

Questions for the field of IECMH are what training is necessary and sufficient for competent culturally sensitive practice, and how it is determined that a practitioner meets basic competence? Self-awareness, other-awareness, and reflection are integral and ongoing parts of being a competent practitioner who is appropriately sensitive to issues of diversity, but what are the mechanisms for ensuring reflective practice in an ongoing way? How does this vary across the service delivery continuum and across the many disciplines that make up the field of IECMH? Furthermore, what is the scope of cultural competence? Is it enough to

recognize and respect diverse cultural practices and viewpoints, or do IECMH practitioners have an obligation to intentionally address systematic barriers to good mental health for all young children and families?

Efforts to address these questions are apparent through avenues such as the promotion of reflective supervision throughout much of the field and the inclusion of cultural considerations in training content across programs and service/treatment models. Nevertheless, routine and universal application of consensus ideas around cultural competence remains a challenge. A workgroup supported by the Irving Harris Foundation Professional Development Network delineated 10 diversity-informed tenets of infant mental health (Table 35.1; St. John, Thomas, Norona, & the Irving Harris Foundation Professional Development Network Tenets Working Group, 2012) that illustrate the challenges the field faces to become culturally competent in practice and to promote the healthy development of all young children. The tenets suggest that practitioners in the field of IECMH must act individually and collectively, from responsibility for their own education and awareness, to enacting systemic change to promote diversity and inclusion for families and professionals. It is our belief that broad adoption of these tenets in professional preparation (e.g., academic settings, fieldwork) and service programs could help shape and support current and future efforts to integrate training that adequately prepares a diversity-informed IECMH workforce.

Technology and Distance Training

Accessibility of training and services remains a challenge for IECMH. Technology is emerging as a way to bridge the gaps in health and mental health care (see, e.g., Alicata et al., 2016). Though imperfect in many ways (see Newman, Bidargaddi, & Schrader, 2016), telemedicine has advanced thinking about service delivery, particularly to remote and underserved geographical areas. Similarly, distance training has the potential to provide professional development to individuals who are less easily able to access training opportunities. Numerous examples of the use of technology in professional development exist, from the rapidly increasing use of webinars and asynchronous online courses to deliver content to the use of telephone and video conferencing for supervision and consultation. Technology allows for interdisciplinary collaboration in ways such as making the same learning materials available to practitioners from different disciplines (e.g., Zero to Three P-5) and offering access to mentors with different expertise through multisite training opportunities, such as the clinical research fellowship offered by Veterans Affairs (O'Hara et al., 2010). While these examples are by no means exhaustive or exclusive to IECMH, they illustrate the plentiful potential benefits of using technology in training. At the same time, we must carefully consider how to mitigate some of the potential pitfalls of the format.

Foremost on the minds of many IECMH practitioners may be the seemingly impersonal nature of long-distance training. IECMH has a rich history of valuing relationships; parent–child and professional relationships are, in fact, centerpieces of IECMH practice and training. Traditionally, we think of relationship-building experiences as occurring when individuals are together physically, and we are particularly dependent on observation of nonverbal communication when working with young children. Hands-on elements in training are a natural fit within this context, as practitioners learn to interpret cues and behaviors, and create safe environments in which families can grow. Moreover, practicing newly learned skills while being observed by a supervisor is an integral part of training for health, mental health, and allied health professionals, in their respective disciplines. Despite having become more comfortable with the use of video across the service delivery continuum (e.g., VIPP, Interaction Guidance), clinicians typically prefer to use technology while sitting together with clients. Some training programs may even record trainees' work with clients and review those recordings as part of supervision, but, again, that experience often occurs in person. Thus, there may be some discomfort in employing distance learning training options in the field of IECMH.

While these concerns are reasonable, they are juxtaposed with a rapidly evolving world of technology and the ongoing shortage of practitioners who are trained to provide appropriate services for very young children and their families. Take, for example, the push for increased use of EBPs. As noted earlier, training in EBPs is a desirable, yet resource-rich endeavor. McMillen, Hawley, and Proctor (2016) began to explore Web-based alternatives to traditional training formats in EBPs as a cost-effective

TABLE 35.1. Diversity-Informed Infant Mental Health Tenets

1. *Self-awareness leads to better services for families.* Professionals in the field of infant mental health must reflect on their own culture, personal values, and beliefs, and on the impact that racism, classism, sexism, able-ism, homophobia, xenophobia, and other systems of oppression have had on their lives in order to provide diversity-informed, culturally attuned services on behalf of infants, toddlers, and their families.

Stance toward infants and families

2. *Champion children's rights globally.* Infants are citizens of the world. It is the responsibility of the global community to support parents, families, and local communities in welcoming, protecting, and nurturing them.

3. *Work to acknowledge privilege and combat discrimination.* Discriminatory policies and practices that harm adults harm the infants in their care. Privilege constitutes injustice. Diversity-informed infant mental health professionals work to acknowledge privilege and to combat racism, classism, sexism, able-ism, homophobia, xenophobia, and other systems of oppression within themselves, their practices, and their fields.

4. *Recognize and respect nondominant bodies of knowledge.* Diversity-informed infant mental health practice recognizes nondominant ways of knowing, bodies of knowledge, sources of strength, and routes to healing within diverse families and communities.

5. *Honor diverse family structures.* Families define whom they comprise and how they are structured; no particular family constellation or organization is inherently optimal compared to any other. Diversity-informed infant mental health practice recognizes and strives to counter the historical bias toward idealizing (and conversely blaming) biological mothers as primary caregivers while overlooking the critical contributions of other parents and caregivers including fathers, second mothers, foster parents, kin and felt family, early care and educational providers, and others.

Practice/research field principles

6. *Understand that language can be used to hurt or to heal.* Diversity-informed infant mental health practice recognizes the power of language to divide or connect, denigrate or celebrate, hurt or heal. Practitioners strive to use language (including "body language," imagery, and other modes of nonverbal communication) in ways that most inclusively support infants and toddlers and their families, caregivers, and communities.

7. *Support families in their preferred language.* Families are best supported in facilitating infants' development and mental health when services are available in their native language.

8. *Allocate resources to systems change.* Diversity and inclusion must be proactively considered in undertaking any piece of infant mental health work. Such consideration requires the allocation of resources such as time and money for this purpose and is best ensured when opportunities for reflection with colleagues and mentors, as well as ongoing training or consultation opportunities, are embedded in agencies, institutions, and systems of care.

9. *Make space and open pathways for diverse professionals.* Infant mental health workforces will be most dynamic and effective when culturally diverse individuals have access to a wide range of roles, disciplines, and modes of practice and influence.

Broader advocacy

10. *Advance policy that supports all families.* Diversity-informed infant mental health practitioners, regardless of professional affiliation, seek to understand the impact of social policies and programs on diverse infants and toddlers and to advance a just policy agenda for and with families.

solution to address problems with scalability of EBPs; they offered free distance learning of trauma-focused cognitive-behavioral therapy for children. Though they encountered problems with participation due to issues such as lack of accountability and lack of motivation, they also found that some clinicians responded well to the flexibility of asynchronous learning. However, many of those who completed the course did not make use of many of the learning activities designed to be interactive. This study highlights the need for multimodal and active strategies for learning, with careful attention to clinician engagement, the recognition of which is an important part of designing distance training. The authors provided several options to address the kinds of problems that may be encountered in distance training, such as offering a combination of online and in-person training or having deadlines set by employers. Similarly, distance consultation may offer a way to reinforce learning and enhance application of material from online courses.

It is certainly understandable that there may be reluctance to embrace the use of technology in the field of IECMH given that so much of our work is predicated on the importance of relationships, and distance can feel like a barrier to relationship building. However, there are already numerous opportunities for distance learning in IECMH through universities, as well as mental health practices and associations. A brief search of programs finds more options for training along the prevention and promotion end of the service continuum, but opportunities are available for those wishing to pursue clinical mental health training; several entities offer certificate programs. As noted earlier, little research exists about training effectiveness and even less so about Web-based training. The challenge for the field is learning to effectively integrate technology into training, as we try to reconcile what sometimes seem like competing demands: the need for high-quality services to be provided by a well-trained and well-supported workforce and for professionals and families to be developed and served in an inclusive, accessible, and affordable way, while preserving the core principles of IECMH practice.

Research on Training

The rapid proliferation of training opportunities in IECMH reflects the growing base of evidence of the importance of early experience and the resulting urgency to develop a workforce that can make available prevention and intervention services to vulnerable infants, children, and families. As we have noted throughout this chapter, evidence of effectiveness of training content and methods is lacking.

Primary questions center on the who, what, and how of training: Who needs training and for what purposes or outcomes? What preparation is necessary and sufficient for whom, and in what setting, in order to provide infant and early childhood mental health services? What can be considered shared practices (e.g., useful across disciplines), and what can be considered specific to a particular professional discipline? For example, how do "usual care" practices of various professionals (e.g., anticipatory guidance by pediatric professionals) correlate with infant mental prevention practices (e.g., developmental guidance)—are they essentially the same, are there identifiable differences in practice, and do these differences make a difference in outcomes? Such questions have implications for who needs to learn what.

While competency-based learning and credentialing in IECMH are gaining popularity, evidence that such efforts are effective at ensuring the expected outcomes is generally weak (Ogolla & Cioffi, 2007). Given the investments required to achieve credentialing or endorsement, future research should examine the evidence base on which competencies are established, recognized, and maintained, and equally important, the impact of such credentialing on clinical and service outcomes.

Training in EBPs presents unique evaluation challenges. By definition, EBPs have research that supports the approach to obtain specific clinical outcomes. Few data are available about the threshold of information or skills necessary for different levels of clinician competence, how various components or intensities of training impact learner or client/family outcomes, and the amount of ongoing support or supervision needed to create and sustain necessary and sufficient competence (Lyon, Wiltsey-Stirman, Kerns, & Bruns, 2011). Furthermore, because many EBPs target specific behaviors or problems, clinicians may need to learn multiple evidence-based therapies or interventions to address a wider range of clinical issues. As noted earlier, because of the challenge of investment of time and resources needed to gain and maintain skills and expertise in a variety of EBPs, research is needed to determine how

well clinicians identify an appropriate target of treatment, select the appropriate intervention, determine how and when to adjust a therapy, assess the impact of adherence to the model, or determine when to end therapy (Finello et al., 2011; Marchette &Weisz, 2017).

Turning toward the process of training professionals, more research is needed on the application and effectiveness of teaching strategies. As we have noted, IECMH training incorporates traditional methods of teaching such as didactic, face-to-face, classroom-based approaches, and reflective supervision. Additionally, innovative methods, including consultation (Brennan, Bradley, Allen, & Perry, 2008; Cohen & Kaufmann, 2005), learning collaborative models (e.g., Norona & Acker, 2016), web-based programs (e.g., McMillen et al., 2016), and self-instructional modules (e.g., see *www.zerotothree.org*) are developing rapidly. Each of these approaches has benefits, but how best to apply the approaches still needs to be determined. For example, while online, web-based programs allow for convenience and flexibility for the learner and provide a platform that delivers information in a consistent, replicable manner, technology problems, learner motivation and accountability, contact with the facilitator, and certain types of learning activities can be barriers (Hogan, Dillon, Fernandes, Spieker, & Zeanah, 2012; McMillen et al., 2016). Similar concerns may apply to other training approaches; of course, how newer strategies translate into relationship-based work has not been explored adequately.

There is growing recognition of the impact of individual and agency/program readiness for training. Commitment of agency infrastructure and resources (e.g., time, place, personnel), recognition of the need and motivation for undertaking a particular training or approach (content fit), and acknowledgment of need for and provision of support for appropriate formal evaluation or quality improvement activities can support or impede training efforts (Finello et al., 2011).

It is clear that much work remains in determining the most effective approaches and principles for generating and maintaining IECMH knowledge and skills in cost-effective ways. Large-scale dissemination of evidence-based models is under way (e.g., see *nctsn.org*), but collecting and synthesizing results of these efforts remain long-term goals. Investment in research on best practices for IECMH training is urgently needed to identify foundational knowledge, as well as specific and shared skills and competencies, training methods and strategies, provider and program readiness, and methods for dissemination and maintenance of skills and knowledge. Better data should help refine IECMH training approaches and propel best practices for the future.

Ethics

Ethics in IECMH is an area that has received surprisingly little explicit attention. This may be in part because of the transdisciplinary nature of the field, and practitioners adhere to their specific profession's code of ethical conduct. Ethical codes serve to identify a profession's core mission and values, establish principles and standards to guide professional practice, identify considerations when professional obligations or uncertainties arise, and provide standards to which the general public can hold the professional accountable (e.g., American Psychological Association, 2017; National Association of Social Workers, 2008). IECMH does not have a unique licensing body, so there is not an organization to which the public can turn when problems arise.

Although the field of IECMH does not have an agreed-upon set of ethical standards, many standards identified by professions of IECMH are relevant to current practice (Zeanah, 2016). Notably, the MI-AIMH has developed a code of ethics that emphasizes core values: importance of relationships; respect for ethnicity, culture, individuality and diversity; integrity; confidentiality; knowledge and skill-building; and reflective practice (MI-AIMH, 2017). Such values are embedded within many IECMH training programs and areas of practice. An in-depth discussion of the ethics of IECMH is beyond the scope of this chapter, but several related ethical issues in clinical IECMH underscore impact on training.

IECMH emphasizes the importance of early identification and early intervention, and places high value on providing services in settings where families are located to improve access and decrease stigma. There is increasing pressure to provide screening for a variety of risk factors and symptoms in settings even when referral services may not be available (e.g., early childhood centers, home visiting). When professionals are asked to assess behaviors, interactions, or symptoms for which they have

not had adequate preparation, or when such screens are considered, perhaps, tangential to the primary purpose of the setting or program, *lack of role clarity* can result. When *complex clients and families* are identified, the appropriate boundaries or professional limits are often unclear. This conflict can be heightened when there is a *lack of resources*. By default, professionals can be put into situations in which there is "no one else" to provide services, so underprepared practitioners may feel compelled to act (see Zeanah & Korfmacher, Chapter 38, this volume).

Approaches such as reflective supervision, integrated behavioral health services, and consultation to extend provider knowledge and skills are increasingly used to address such dilemmas, but there is little discussion about how such practices impact licensing and reimbursement. The multidisciplinary nature of the field also raises questions about who can train (or supervise) whom: Do professionals learn best from their own profession? When one is training professionals outside of one's own domain, what are the implications for practice, responsibility of care, and ensuring that others work within their appropriate scope of practice? For example, when non-mental-health providers learn skills that enable them to explore more deeply a parent's experience of trauma that may impact parenting, when does "being therapeutic" become "doing therapy"? Who decides, and how, when the professional has enough knowledge or skills to carry out such work, or when the professional, or the program, has "done enough"? How are limits of practice explained to families? A parent may be relieved to talk to a pediatrician about his or her young child's behavior problems but may not be aware of the type of skills the physician has, or what constitutes an adequate evaluation and treatment. Such dilemmas also take a toll on the professional and can manifest as burnout or compassion fatigue (Hayes, 2013). As the field evolves, best practices in providing IECMH care will become clearer. Meanwhile, critical, vigorous discussions are needed to further clarify and identify appropriate ethical practice in IECMH, and how such considerations should be incorporated into IECMH training.

Leadership and Coordination of Efforts

The field of IECMH is enriched by its multidisciplinary nature. As we and others (Finello et al., 2011; Hinshaw-Fuselier et al., 2009; Hogan et al., 2012; Priddis et al., 2015) have highlighted, this also contributes to a complicated picture of training and professional development. The efforts to prepare this workforce are often overlapping; sorting through the options can be confusing. Currently, there is no unifying infrastructure to address training questions with which the field needs to grapple, to help provide direction for training in the field, and to ensure that minimum standards of quality are met by trainers and training programs. In their review of infant and early childhood training programs in the United States, Canada, the United Kingdom, Europe, and Australia, Priddis and colleagues (2015) argued that coordinating training through an association or organization that focuses on IECMH is essential. Programs that emphasize cross-professional and cross-sector training typically include collaborations of universities, government, IECMH organizations, and practitioners.

We believe the field may benefit from a comprehensive and coordinated approach to transdisciplinary training in IECMH. A coalition of leaders in the field of IECMH could elicit and consolidate input from stakeholders regarding professional development and training in IECMH, as it relates to the needs of families, practitioners, and larger organizations and systems (e.g., professional licensing boards, universities). Such a coalition could also develop informed positions on ethical and practical questions regarding training in the field, potentially resulting in the development of guidelines and resources on best practices for professional development in IECMH across child and family-serving disciplines. Furthermore, an IECMH training coalition could spearhead needed research regarding the effectiveness of training in the field, particularly as it relates to the effectiveness of services for families. Major goals of these efforts would be to clarify which avenue(s) of professional development is best for whom and reduce redundancy and confusion about training, to set training standards to ensure professional and public accountability of services, and to ensure the best outcomes for young children and their families.

Hogan and colleagues (2012) pointed out that leadership in IECMH professional development is needed at several levels: clinical expertise; systems development; policy development; and IECMH professional development methods. To this end, an IECMH training coalition could

nurture a multilevel approach to addressing training needs in the field. Though some current competency approaches address the areas of research, administration, and policy, training opportunities overall tend to lean toward the clinical activities of promotion, prevention, and intervention. The field could certainly benefit from elevating systems-level training needs to a more central focus of training and professional development efforts, facilitating the growth of IECMH professionals working on infrastructure development to recognize the need for and refine services for families and young children across the behavioral health continuum. From promotion, prevention, and intervention to systems and policy, a coalescence of leadership in IECMH training would encourage states and/or other entities to work together to increase accessibility and availability of professional development by sharing resources and opportunities that they may not be able to access or afford on their own. The potential benefits of this kind of leadership effort are plentiful. Creation of a coalition of leaders would be timely, as training efforts continue to proliferate at a pace that makes the landscape challenging to navigate. Increasing clarity and focus of training efforts at these multiple levels would enable efficient use of resources for training and professional development at this time, when the costs of the undertaking are measured against the resulting benefits.

Summary and Conclusion

A review of current training in IECMH reveals an environment that has encouraged proliferation of efforts across and within clinical settings, disciplines, programs, and systems. Traditional and innovative approaches widen the availability of professional development, yet despite the activity, data about the effectiveness of the various training approaches on clinical practice and outcomes are limited. There are major areas in need of development: cultural competency, ethics, leadership development, and research on training. As the field continues to mature, pruning of efforts will enable delineation of the basic professional development needs for practitioners engaged in clinical work across the behavioral health continuum. Systems that support this work—research, policy, administration, advocacy (among others)—require a community to define, refine, and nurture their development as well. Creation of a Center of Excellence in IECMH Training could afford the field an organized opportunity for myriad training efforts to coalesce into a more coherent landscape for IECMH providers, programs, and relevant systems-level personnel to navigate as they contribute to the rapidly expanding field of IECMH.

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