



*Revised
Training Guidelines
and Personnel Competencies
for Infant-Family and Early
Childhood Mental Health*

California Infant-Family and Early
Childhood Mental Health Training
Guidelines Workgroup, 2009



California's Infant, Preschool &
Family Mental Health Initiative, 2003

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UNDERSTANDING INFANT-FAMILY AND EARLY CHILDHOOD MENTAL HEALTH PRINCIPLES AND PRACTICE

The field of infant-family and early childhood mental health is a broad-based, interdisciplinary field of study, research and practice that focuses on the social and emotional development and well-being of infants and young children within the context of their early relationships, family, community and culture.

Recent developments in neuroscience, infant mental health, attachment, as well as prenatal and perinatal psychology and health show us that the optimal, most cost effective time to make positive interventions in human development is from the very beginning of life. New research demonstrates that many life-enhancing or life-diminishing patterns are found to originate in the pre- and perinatal period including resiliency and health or chronic disease, self-regulation, and attachment issues. The best outcomes occur when mothers and families are supported in their mental and physical well being during pregnancy, birth, infancy and early childhood. Research and clinical practice show us that we need to erase the mental divide that has existed between prenatal and birth and redefine zero as conception or preconception in order to give our children the very best start in life.

The infant-family and early childhood mental health services emphasize the importance of parent-infant relationships on brain development, attachment and the regulation of emotions and behavior. Early parent-infant relationships provide the emotional foundations for the development of resiliency and self-esteem. Through patterns of early attachment and interaction, children develop trust and security or learn to mistrust and protect themselves against the insecurity of their world. Early mental health services promote school readiness by strengthening foundational early relationships, family functioning, the young child's emotional regulation and social competence. A strong emotional and social foundation is an essential component of school readiness. Relationships that support a child's responses to new academic and behavioral demands build resilience and provide an important key to school success.

The continuum of infant-family and early childhood mental health services includes:

Promotion: Services and supports that recognize the central importance of early relationships on brain development, learning and the emotional and social well-being of all young children. These services include a focus on positive parent-child and primary caregiver relationships within the home, child development settings and other service settings for young children and their families.

Preventive Intervention: Services that mitigate effects of risk and stress and that address potential early relationship challenges or vulnerabilities that have a documented impact on early development. Specific intervention strategies are designed to nurture mutually satisfying parent-child relationships and prevent the progression of further difficulties. Health and developmental vulnerabilities; parenting difficulties; domestic violence; family discord; and other major child and family stressors may warrant the delivery of preventive intervention services in a variety of settings.

Treatment: Services that target children in distress or with clear symptoms indicating a mental health disorder. They address attachment and relationship problems and the interplay between the child, parent and other significant caregivers that jeopardizes achieving early mental health and early emotional and social development. Specialized early mental health treatment services focus on the parent-child dyad and are designed to improve child and family functioning and the mental health of the child, the parents and other primary caregivers.

Across this continuum, infant-family and early childhood mental health services seek to facilitate a child's biological, neurological, and emotional and social development while focusing on early relationships and the "goodness of fit" among the child, the parents and other significant caregivers.

The current emphasis on evidence-based practice requires important consideration when applied to the field of infant-family and early childhood mental health. The concept of evidence-based practice comes from the medical field and needs a viable definition to fit into the field of early childhood. Buysse and Wesley define evidence-based practice for the early childhood field as a three-pronged integration of (1) the best research, (2) with professional wisdom and (3) parental values. [Buysse, V. & Wesley, P.W. (2006), *Evidence-Based Practice in the Early Childhood Field*, Washington, D.C.: Zero-to-Three Press.] An important balance is necessary among these three factors. In order to effectively utilize evidence-based approaches with infants, young children and their families, providers must have a basic foundational knowledge and core competencies in infant-family and early childhood mental health.

CONTRIBUTORS TO WELLNESS COME FROM MULTIPLE DISCIPLINES AND SERVICE SETTINGS

Practitioners working with infants, young children and their families come from diverse fields including audiology, early care and education, early intervention, nursing, occupational therapy, physical therapy, speech and language pathology, social work, special education, pediatrics and the mental health disciplines.

Every individual who touches a baby should be trained to understand the basic concepts of infant-family mental health and early development. Everyone who interacts with preschoolers and their families should be trained to understand the basic concepts of development and mental health of infants and young children, as well as the practitioner's role in supporting parents in their responsibilities to protect, nurture and guide their children.

Infant and early childhood practitioners from diverse fields must be secure in their own expertise in order to infuse early mental health concepts and processes into their specific work with infants, young children and their families. This manual describes how a practitioner might achieve infant-family and early childhood mental health competency at the level of either a core provider or an infant-family and early childhood mental health specialist.

These guidelines are based on the guiding principle that training for all professionals working with young children and their families is most effective when designed to foster family-centered, culturally competent and developmentally appropriate services. Parent-professional partnerships are crucial to the effective delivery of all services and all early mental health services must be based on the goal of strengthening relationships. The guidelines also reflect the belief that early mental health services provided to infants, young children and their families must extend across a continuum of promotion, preventive intervention and treatment services, starting even before birth. This continuum requires that the community provide a variety of services to support early mental health. Such services, aimed at strengthening parent-child relationships, may range from basic parent support and guidance to intensive dyadic psychotherapeutic interventions.

BACKGROUND OF EFFORTS IN CALIFORNIA

During the last decade, professionals in California and throughout the country have worked to clarify the knowledge, skills and competencies needed to provide effective infant-family and early childhood mental health services. In California, an initial set of recommendations and personnel competencies were identified in 1996 through a leadership training grant funded by the U.S. Department of Health and Human Services, Maternal and Child Health Bureau, under the direction of the University of Southern California, University Center for Excellence in Developmental Disabilities at Childrens Hospital Los Angeles.

Based on these initial recommendations, a State workgroup was established in 2001 in association with California's Infant, Preschool & Family Mental Health Initiative. This statewide special project, funded by the First 5 California Children and Families Commission through the Department of Mental Health, and coordinated by the WestEd Center for Prevention and Early Intervention (CPEI) in partnership with eight county teams, provided a new venue and renewed interest in personnel competencies and staff development in the field of infant-family and early childhood mental health.

The 2001-2003 interdisciplinary workgroup was comprised of representatives from Alliant International University, the California Department of Health Services (now called the California Department of Health Care Services), the California Department of Mental Health, Children's Hospital & Research Center at Oakland, the University of Southern California University Affiliated Program at Childrens Hospital, Los Angeles, and WestEd CPEI. The workgroup reviewed materials and recommendations from other states, consulted with field leaders and gathered information from organizations to address the need for training guidelines and personnel competencies in the interdisciplinary field of study, research and clinical practice. The 2003 workgroup developed training guidelines that were published and disseminated through the California Early Intervention Technical Assistance Network (CEITAN) at WestEd.

The 2007-2009 interdisciplinary workgroup is comprised of infant-family and early childhood specialists who conduct training programs throughout the State of California, working with practitioners from several disciplines and systems of care. The training programs are based in universities, mental health clinical services programs and interdisciplinary training institutes. The workgroup also included representatives from the California Department of Mental Health, CEITAN and the Infant Development Association of California. The workgroup reviewed updates from the literature and from other regions that are addressing infant-family and early childhood mental health competencies and endorsement processes. A draft of the Guidelines was sent to infant and early childhood mental health professionals throughout the country for review.

This manual represents the next generation of thinking and guidance in the development of professional competencies and will provide a basis for infant-family and early childhood mental health in-service and pre-service training programs. These guidelines provide a framework for programs and individuals interested in obtaining specialized training in infant-family and early childhood mental health. The manual presents the refined set of training guidelines and recommended competencies for core providers, infant-family and early childhood mental health specialists and reflective practice facilitators. Training, experience and desired competencies for reflective practice facilitators (see definition below) have been delineated to ensure that core providers and mental health specialists receive the appropriate facilitated reflective experiences needed to develop infant-family and early childhood mental health reflective practice. It is hoped that guidance for obtaining additional knowledge and skills, along with appropriate supervision by qualified personnel, results in a better-trained and more effective work force providing enhanced services for infants, very young children and their families.

PLANS FOR THE FUTURE

A comprehensive system for addressing and supporting the infant-family and early childhood mental health training needs of all providers who work with infants and very young children and their families would also include a set of competencies for those who work in early care and education. The 2007-2009 interdisciplinary workgroup recognizes this need and has begun discussions with leaders of training programs in the early care and education field. Plans are for a new workgroup to develop infant-family and early childhood mental health competencies for early care and education within the next year.

The 2007-2009 workgroup is planning for the development of a formal endorsement process, which would require applicants to document completed requirements through creation of a portfolio. The organization administering the endorsement process would collaborate with infant-family and early childhood training programs throughout California to ensure alignment of trainings with the competencies.

DEFINITION OF TERMS AND KEY CONCEPTS

For the purposes of this document, the following concepts are defined to provide the reader with a unified understanding of words and phrases used therein.

- **Infant-Family and Early Childhood Mental Health** is defined as “the state of emotional and social competence in young children who are developing appropriately within the interrelated contexts of biology, relationships and culture. The field of infant mental health may be defined as multidisciplinary approaches to enhancing the social and emotional competence of infants in their biological, relationship and cultural contexts” (Zeanah & Zeanah, 2001, 14).
- **Core Providers** include professionals from multiple human development and education disciplines, including early intervention, nursing, occupational therapy, physical therapy, speech and language pathology, special education, human development, audiology, social work and pediatrics, who work with pregnant women, infants, toddlers and preschoolers and their families, and who have achieved the core provider mental health competencies described in this manual.

Core providers are the professionals with the most frequent contact with infants and very young children and their families and are the most likely individuals to provide promotion and preventive mental health interventions and to partner with and make referrals to mental health specialists. Core provider guidelines are also appropriate for infant and early childhood researchers, policy analysts and advocates.

- **Infant-Family and Early Childhood Mental Health Specialists** include individuals from relevant professional practice disciplines who have a Masters Degree or higher and/or a license/credential and who have achieved the mental health specialist competencies described in this manual. Infant-family and early childhood mental health specialists include, but are not limited to, professionals in the mental health fields. 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.

- **Reflective Practice Facilitation** is an individual or small group integrative experience that supports the practitioner to explore ways to apply relevant theories and knowledge bases to clinical situations; to model an appreciation of the importance of relationships that are at the core of infant-family and early childhood mental health; to reflect the experiences, thoughts and feelings involved in doing this work; to understand the family's culture and the parents' and infants' interpersonal perspective; and to explore possible approaches to working effectively with infants and families. It is acknowledged that the dynamics of the reflective practice facilitation relationship will in turn influence practitioner/family relationships, and thus the reflective practice facilitator must embody ways of being that are considered best practice for infant-family and early childhood mental health practitioners.
- **Reflective Practice Facilitators** are those who support the reflective practice of individuals working with infants, toddlers, young children and their families, and who themselves have training and experience as infant mental health specialists or core providers, as well as an additional set of trainings and competencies focusing on the reflective practice facilitation process. This role is similar to that of a clinical supervisor, but does not necessarily involve the same set of responsibilities, as discussed in the final section of this document.
- **Parent** refers to a biological or adoptive parent; a person acting in place of a parent (such as a grandparent or step-parent with whom the child lives or a person who is legally responsible for the child's welfare); or a surrogate parent who has been assigned by a lead agency (CEITAN, Early Start Personnel Model, 2004).
- **Caregiver** refers to anyone in the above definition of **Parent** as well as any individual who is providing primary caregiving for an infant or young child, such as early care and education providers, preschool educators and nannies.
- **Multidisciplinary** refers to the coordinated efforts of several disciplines to achieve a common goal. Practitioners from different disciplines collaborate and share results. Contributions from different disciplines are complementary, not integrative.
- **Interdisciplinary** refers to the integration of several disciplines that creates a unified outcome that is sustained and substantial enough to enable a new discipline to develop over time. Integration of multiple disciplines requires collaboration at the level where practitioners combine methods and concepts from their different disciplines.

THE TRAINING MATRICES

All professionals working with young children and their families need to be grounded in the core knowledge and training necessary to provide family-centered, culturally competent and developmentally appropriate services across the continuum of infant-family and early childhood mental health. The matrices for **core providers, infant-family and early childhood mental health specialists and reflective practice facilitators** outline a framework for building a coherent foundation of the knowledge and training necessary to work with very young children and their families with a focus on early relationships and early mental health. The matrices are designed to guide programs and training institutions to develop coursework, workshops and special certifications. They are also intended to guide professionals seeking specialized training in infant-family and early childhood mental health. The matrices are not intended to specify objectives of individual

training curricula, but to provide an overview of critical core material. An example of developed module topics is in Appendix A.

Two training domains are described in this document. One domain covers the key concepts and competencies needed by providers. The second domain delineates the clinical experience and reflective practice facilitation needed for a minimum level of expertise. The hours noted for each domain are considered minimum amounts of training needed to gain a basic understanding in each area. It is assumed that working with children birth to 5 and their families is a lifelong learning process. Most individuals will develop a portfolio of coursework and workshops far exceeding these basic requirements. A second phase of the Workgroup will be to refine an endorsement process for professionals in the State of California.

KEY AREAS OF KNOWLEDGE AND RELATED KEY CONCEPTS

The following is an overview of the range of topics recommended within each knowledge domain. The lists are not meant to be exhaustive; some programs may include additional topics within the domains. However, within each domain, consideration should be given to a variety of areas. Quality training should focus on multiple topics within the domains that prepare practitioners to provide core services or more specialized mental health services.

The focus of the training for core providers is on providing an overview and application of the core concepts within each broad domain of knowledge. Training for mental health specialists is focused on using basic knowledge as a building block for more in-depth assessment and intervention. Thus, effective trainings focus on building upon the mental health specialist's understanding of core concepts, with the goal of developing appropriate interventions to enhance all services designed to meet individual child and family needs. In addition, extensive training of the mental health specialist is required in *Domains E and F — Observation, Screening and Assessment, and Diagnosis and Intervention* — since these areas are critical components of the mental health specialist's practice and focus on early relationships between parents and children.

KEY CONCEPTS WITHIN EACH DOMAIN

DOMAIN 1 - KNOWLEDGE

A – Parenting, Caregiving, Family Functioning and Parent-Child Relationships

- Range of family structure
- Pregnancy and childbirth
- Postpartum period
- Attachment issues
- Parenting as a developmental process
- Family dynamics
- Family expectation regarding child development
- Providing family-sensitive services
- Cultural issues in parenting and family development
- Goodness of fit between parents and young children
- Importance of relationships to development
- Family systems

B – Infant, Toddler and Preschool Development

- Typical development in infancy, toddler and/or preschool periods
- Milestones of development
- Peer relationships
- Expectations of children in groups
- Cultural variations in development and family expectations

C – Biological and Psychosocial Factors Impacting Outcomes

- Temperament
- Regulatory and sensory issues
- Brain research
- Neuro-developmental issues
- Prematurity and low birth weight
- Child abuse
- Child neglect
- Nutrition
- Poverty
- Community issues
- School and community services
- Impact of such factors upon development and relationships

D – Risk and Resiliency

- Atypical development
- Maternal depression
- Teenage parenting
- “Ghosts” in the nursery
- Chronic physical illness
- Chronic mental illness in parent
- Developmental disabilities
- Prematurity
- Communication and interaction problems
- Substance abuse in families
- Family violence
- Working with challenging caregivers
- Foster care
- Institutional care
- Protective factors that promote family resiliency
- Promoting resiliency in young children and families

E – Observation, Screening and Assessment

- Development of observational skills with infants and young children
- Use of observational information
- Use of screening tools
- When to make referrals for more comprehensive assessment
- How to make a referral, including following through or assisting family with initial contacts
- Introduction to major assessment instruments and processes

F – Diagnosis and Intervention

- Diagnostic systems for infants, toddlers and young children
- Linking assessment and diagnosis to intervention
- Development of intervention goals
- Effective communication with caregivers and others
- Concrete assistance
- Community resources
- Developmental guidance
- Strategies to promote infant-family and early childhood mental health
- Strategies for preventive intervention addressing social-emotional-behavioral vulnerabilities
- Intervention strategies
- Therapeutic options, including current knowledge of evidence-based practice
- Developing reflective practice skills
- Use of self in provision of services

G – Interdisciplinary/Multidisciplinary Collaboration

- Understanding the roles of other professionals in working with young children and families
- Respecting boundaries of practice
- Community resources
- Working together with other professionals to create an integrated plan
- Collaborating to prioritize child and family needs

H – Ethics

- Ethics of scope of practice
- Working ethically in family settings

DOMAIN 2 - EXPERIENCE

- Clinical experience with families and children prenatal to age 3 and/or
- Clinical experience with children 3 to 5 and their families
- Reflective Practice Facilitation

RECOMMENDATIONS FOR CLINICAL EXPERIENCE/REFLECTIVE PRACTICE FACILITATION

There has been a paradigm shift from solely administrative supervision towards reflective practice facilitation and practice in work with very young children and their families. This is differentiated from the previous field emphasis on administrative supervision, accountability, documentation and the mechanics of “case management” and is based on practice issues and service provider needs. Reflective practices and related facilitation involve a focus on relationships, qualitative improvement, support and the investment of self in the intervention and treatment process.

Competent infant-family and early childhood mental health practice needs the triad of knowledge, skills and mentorship through reflective practice facilitation. Effective application of basic concepts involves the development of interventions at a variety of levels. Such application also requires oversight and feedback, which may occur in the context of an academic setting for coursework (e.g., assessment training) or in supervised clinical settings where the application of information learned in workshops or the academic setting can be more fully developed. This need for reflective practice facilitation is particularly evident as assessment, diagnostic, reporting and intervention skills are developing. An experienced **reflective practice facilitator** at Level I is able to guide **core providers** while infant-family and early childhood **mental health specialists** will be guided by Level II reflective practice facilitators.

Within the context of these training guidelines, facilitation is focused around principles of reflective practice. Reflective practice facilitation of core providers and infant-family and early childhood mental health specialists may be done either individually or in small groups (up to eight participants). Within each set of matrices, clinical experience and reflective practice facilitation practices are outlined with the number of hours required for a minimum level of expertise and for application for the proposed endorsement.

GUIDELINES FOR COURSEWORK, TRAINING AND REFLECTIVE PRACTICE FACILITATION

The matrices were designed to guide the development of both university-based academic coursework and comprehensive infant-family and early childhood mental health training programs, as well as applied workshops through continuing education, in-service training and clinical practice settings. Because academic coursework and comprehensive training programs are generally more rigorous, requiring extensive time beyond classroom assignments, including readings and practice application, hours would be counted as 1.5 clock hours for every course hour.

The following are samples of how training might be provided across a range of programs and options offered by colleges/universities and free standing infant-family and early childhood mental health training programs:

- **Graduate Level Academic Coursework and Comprehensive Training Programs**
- **Workshops and Continuing Education Courses**
- **Supervised Clinical Practica, Internships and Post-Doctorates**
- **Combination of Options**

MATRICES AND GUIDELINES FOR THE INFANT-FAMILY AND EARLY CHILDHOOD MENTAL HEALTH CORE PROVIDER

PROVIDING INFANT-FAMILY AND EARLY CHILDHOOD MENTAL HEALTH SERVICES

CORE PROVIDERS

Domain 1: Knowledge		
A: Parenting, Caregiving, Family Functioning and Parent-Child Relationships		
Key Concepts	Hours	Competencies
<ul style="list-style-type: none"> • Range of family structure • Pregnancy and childbirth • Postpartum period • Attachment issues • Parenting as a developmental process • Family dynamics • Family expectation regarding child development • Providing family-sensitive services • Cultural issues in parenting and family development • Goodness of fit between parents and young children • Importance of relationships to development • Family systems 	20	<ul style="list-style-type: none"> • Demonstrates an understanding of optimal health during pregnancy. • Demonstrates an understanding of the birthing process and impacts on the family. • Demonstrates an understanding of healthy attachment after birth and the importance of the postpartum period on the newborn. • Demonstrates an understanding of family and parenting function as a lifelong developmental process beginning before conception. • Demonstrates an understanding of different patterns of parent-infant interaction and attachment and their impact on child outcomes. • Is knowledgeable about the emergence of communicative intent and gestural communication in dyadic interaction during the first year of life. • Understands the complexity of interrelationships between infant and caregivers within an environmental context and demonstrates a variety of appropriate strategies to support and promote family well-being. • Uses a variety of techniques to facilitate and reinforce positive parent-infant interaction and enhance parents' capacity to be responsive and sensitive to their baby. • Is aware of the potential negative impact of multiple separations and/or multiple family placements on early development. • Is aware of a wide range of family structures, family dynamics and cultural influences on family functioning.
B: Infant, Toddler and Preschool Development		
Key Concepts	Hours	Competencies
<ul style="list-style-type: none"> • Typical development in infancy, toddler and/or preschool periods • Milestones of development • Peer relationships • Expectations of children in groups • Cultural variations in development and family expectations 	24	<ul style="list-style-type: none"> • Demonstrates knowledge of sequences of development and effects of risk factors on early development, beginning prenatally and including sensory, motor, communication, cognitive, play, social, emotional, self-help and adaptive behavior. • Demonstrates knowledge of social and emotional development and resiliency, including the development of attachment and trust. • Demonstrates understanding of importance of development of self-regulation, early childhood social relationships, communication and representational skills, and executive function abilities for school readiness.

		<ul style="list-style-type: none"> • Successfully initiates and sustains an effective working relationship with parents that nurtures their strengths and emerging capacities. • Collaborates with parents in devising early intervention activities to promote development and identity, and to reduce risk of delay or disorder. • Actively involves parents to implement strategies to facilitate emotional and social development. • Provides guidance and information in a manner timed and suited to the parent's strengths, concerns, priorities and cultural values.
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C: Biological and Psychosocial Factors Impacting Outcomes

Key Concepts	Hours	Competencies
<ul style="list-style-type: none"> • Temperament • Regulatory & sensory issues • Brain research • Neuro-developmental issues • Prematurity and low birth weight • Child abuse • Child neglect • Nutrition • Poverty • Community issues • School and community services • Impact of such factors upon development and relationships 	12	<ul style="list-style-type: none"> • Demonstrates knowledge of the effects of cumulative risk factors such as genetics, medical complications, prematurity/low birth weight, substance exposure and other teratogens and the impact of familial, cultural, social, physical and/or economic factors including poverty, abuse and neglect on growth, development and relationships. • Demonstrates knowledge of the effects of medical risk factors, health and nutritional concerns for the infant and toddler with disabilities or risk concerns. • Demonstrates knowledge of neurological and physiologic systems, and their interdependence with the psychosocial and caregiving environments. • Considers the impact of stress and trauma on development and learning. • Supports family/caregivers to respond to child's cues and preferences including sensory processing needs. • Recognizes the significance of socio-cultural and political contexts for development of infants and young children from diverse backgrounds, including the impact of poverty.

Domain 1D: Risk and Resiliency

Key Concepts	Hours	Competencies
<ul style="list-style-type: none"> • Atypical child development • Maternal depression • Teenage parenting • "Ghosts" in the nursery • Chronic physical illness • Chronic mental illness in parents • Developmental disabilities • Prematurity • Communication and interaction problems • Substance abuse in families • Family violence • Working with challenging caregivers 	30	<ul style="list-style-type: none"> • Demonstrates knowledge of the effects of risk factors such as genetics, medical complications, prematurity/low birth weight, substance exposure and teratogens, and the impact of familial, cultural, social, physical and/or economic factors including poverty, abuse and neglect on development and relationships. • Is aware that practices should be responsive to developmental protective factors. • Considers the concept of resilience and the protective factors that influence it. • Demonstrates the ability to select strategies based on parent concerns, priorities and resources, including consideration for culture, language and education. • Recognizes and supports cultural beliefs and values of families. • Is aware that practices should be responsive to risk factors. • Demonstrates knowledge of the impact of familial, economic or social factors on relationships and social-emotional development.

<ul style="list-style-type: none"> • Foster care • Institutional care • Factors that promote resiliency and help to insulate families from risk • Promoting resiliency in young children and families 		
E: Observation, Screening and Assessment		
Key Concepts	Hours	Competencies
<ul style="list-style-type: none"> • Development of observational skills with infants and young children • Use of observational information • Use of screening tools • When to make referrals for more comprehensive assessment • How to make a referral, including following through or assisting family with initial contacts • Introduction to major assessment instruments and processes 	12	<ul style="list-style-type: none"> • Selects and uses a variety of formal and informal observation and screening tools and practices appropriate for infants, young children and their families. • Conducts observation and other informal assessment procedures in a variety of settings natural to the family, as appropriate. • Selects and uses screening and assessment practices appropriate to pregnant and postpartum parents, including screening for depression. • Interprets and links assessment results with needed outcomes and services based on infant, young child and family needs and perspectives. • Integrates assessment results with information from parents and other agencies/professionals. • Recognizes when further assessment is warranted and collaboratively makes appropriate referrals. • Assists family to make initial contact with appropriate professionals and/or agencies.
F: Diagnosis and Intervention		
Key Concepts	Hours	Competencies
<ul style="list-style-type: none"> • Diagnostic systems for infants, toddlers and young children • Linking assessment and diagnosis to intervention • Development of intervention goals • Effective communication with caregivers and others • Concrete assistance • Community resources • Developmental guidance • Strategies to promote infant-family and early childhood mental health • Strategies for preventive intervention addressing social-emotional-behavioral vulnerabilities 	12	<ul style="list-style-type: none"> • Demonstrates knowledge of the distinctions among difference, delay and disorder and appropriate referral for each. • Integrates information and formulates plans together with the family. • Selects and implements evidence-supported relationship-based intervention strategies that are appropriate to support and promote the infant or young child's strengths and needs. • Ensures that families are primary members of the IFSP/IEP team. • Assists parents in identifying community resources for services that parents identify as important. • Provides resources for related services such as primary care, child welfare, mental health or social services and provides guidance regarding child's development. • In partnership with the family and other team members, develops, uses and analyzes ongoing observation and assessment data to achieve child and family outcomes.

<ul style="list-style-type: none"> • Intervention strategies • Therapeutic options, including current knowledge of evidence-based practice • Developing reflective practice skills • Use of self in provision of services 		
G: Interdisciplinary/Multidisciplinary Collaboration		
Key Concepts	Hours	Competencies
<ul style="list-style-type: none"> • Understanding the roles of other professionals in working with young children and families • Respecting boundaries of practice • Community resources • Working together with other professionals to create an integrated plan • Collaborating to prioritize child and family needs 	6	<ul style="list-style-type: none"> • Coordinates early intervention services across a variety of agencies. • Facilitates relationships, communication and collaboration among family and all other team members. • Works cooperatively with fellow team members and other agencies. • Respects and incorporates information and feedback from other team members. • Provides resources to families for services and supports in collaboration with Early Start and/or Early Head Start. • Demonstrates knowledge of the limits of one's own discipline's scope of practice and the need for referral for issues beyond one's own discipline's expertise.
H: Ethics		
Key Concepts	Hours	Competencies
<ul style="list-style-type: none"> • Ethics of scope of practice • Working ethically in family settings 	4	<ul style="list-style-type: none"> • Considers and reflects on the interpersonal nature of the family-provider relationship. • Conducts early intervention practice in accordance with state and federal laws and regulations and in observance of discipline-specific requirements and principles. • Maintains professional ethics, including recognizing scope-of-practice parameters of one's own discipline. • Maintains appropriate boundaries in interactions with co-workers and families. • Develops and implements a professional development plan recognizing a continuum of lifelong professional development. • Establishes effective supervision/mentoring relationships. • Recognizes and supports the cultural beliefs and values of families. • Recognizes the significance of socio-cultural and political contexts of children from diverse backgrounds.

Domain 2: Clinical Experience/Reflective Practice Facilitation		
Key Concepts	Hours	
<ul style="list-style-type: none"> ▪ Clinical experience with families and children prenatal to age 3 and/or ▪ Clinical experience with children 3 to 5 and their families ▪ Reflective Practice Facilitation 		60 hours of supervised clinical work prenatal to age 3, and <ul style="list-style-type: none"> • 12 hours minimum of either individual RFP or group RFP up to eight individuals and/or 60 hours of supervised clinical work age 3-5* and <ul style="list-style-type: none"> • 12 hours minimum of either individual RFP or group RFP up to eight individuals
Summary: Domains 1 & 2 Competencies		
Key Concepts	Hours	
<ul style="list-style-type: none"> • 120 hours Knowledge/Training • 60-120 hours Clinical Experience with Reflective Practice Facilitation 	180-240	180 hours prenatal to 3 or 3 to 5 only endorsement 240 hours prenatal to 5 endorsement

**Reflective Facilitation at the Core Level may be provided by an infant-family or early childhood mental health core provider or specialist at the Reflective Facilitation level and may be provided in small groups.*

MATRICES AND GUIDELINES FOR THE INFANT-FAMILY AND EARLY CHILDHOOD MENTAL HEALTH SPECIALIST

PROVIDING INFANT-FAMILY AND EARLY CHILDHOOD MENTAL HEALTH SERVICES

INFANT-FAMILY AND EARLY CHILDHOOD MENTAL HEALTH SPECIALIST

Domain 1: Knowledge		
A: Parenting, Caregiving, Family Functioning and Child-Parent Relationships		
Key Concepts	Hours	Competencies
<ul style="list-style-type: none"> • Range of family structure • Pregnancy and childbirth • Postpartum period • Attachment issues • Parenting as a developmental process • Family dynamics • Family expectation regarding child development • Providing family-sensitive services • Cultural issues in parenting and family development • Goodness of fit between parents and young children • Importance of relationships to development • Family systems 	32	<ul style="list-style-type: none"> • Demonstrates an understanding of optimal health during pregnancy. • Demonstrates an understanding of the birthing process and impacts on the family. • Demonstrates an understanding of healthy attachment after birth and the importance of the postpartum period on the newborn. • Demonstrates an understanding of family and parenting function as a lifelong developmental process beginning before conception. • Demonstrates an understanding of different patterns of parent-infant interaction and attachment and their impact on child outcomes. • Is knowledgeable about the emergence of communicative intent and gestural communication in dyadic interaction during the first year of life. • Understands the complexity of interrelationships between infant and caregivers within an environmental context and demonstrates a variety of appropriate strategies to support and promote family well-being. • Uses a variety of techniques to facilitate and reinforce positive parent-infant interaction and enhances parents' capacity to be responsive and sensitive to their baby. • Is aware of the potential negative impact of multiple separations and/or multiple family placements on early development. • Is aware of and able to competently engage with a wide range of family structures, family dynamics and cultural influences on family functioning. • Understands assessment of difficulties in parent-child relationships as outlined by Axis 2 and PIRGAS of DC:0-3R, and the implications for relationship-focused interventions. • Understands strategies for facilitating change and growth processes in families with significant problems in relationships — at the representational, dyadic and systemic levels. • Demonstrates reflective insight into personal relationship history and dynamics, and understands importance of one's own awareness in context of therapeutic relationships with families.

B: Infant, Toddler and Preschool Development		
Key Concepts	Hours	Competencies
<ul style="list-style-type: none"> • Typical development in infancy, toddler and/or preschool periods • Milestones of development • Peer relationships • Expectations of children in groups • Cultural variations in development and family expectations 	36	<ul style="list-style-type: none"> • Understands the developmental sequences and range of variation across multiple dimensions of child development, beginning prenatally and including sensory, motor, cognitive, communication, play, self-regulatory and social-emotional domains. • Demonstrates an understanding of the importance of development of self-regulation, early childhood social relationships, communication and representational skills, and executive function abilities for school readiness. • Understands social-emotional development in a dyadic relationship context, as outlined by Axis 5 of the DC:0-3R and exemplified as social-emotional milestones, which may begin prenatally, and the implications for treatment of atypical dyadic emotional development. • Accurately interprets information from direct and reported information, observations and assessments in a range of settings to identify capacities and strengths, as well as developmental delays and/or emotional disturbances in infants and young children served. • Uses collaborative approaches to explore appropriate family expectations and provides developmental guidance in achieving strategies that support those expectations. • Suggests, demonstrates and coaches families on strategies to nurture a child's development across all domains, including their strengths, emerging capacities and cultural values. • Understands social-emotional development and the role of peer and group interactions and can utilize a range of strategies for promoting optimal interactions.
C: Biological and Psychosocial Factors Impacting Outcomes		
Key Concepts	Hours	Competencies
<ul style="list-style-type: none"> • Temperament • Regulatory and sensory issues • Brain research • Neuro-developmental issues • Prematurity and low birth weight • Child abuse • Child neglect • Nutrition • Poverty • Community issues • School and community services • Impact of such factors upon development and relationships 	24	<ul style="list-style-type: none"> • Accurately interprets the bi-directional nature of biological and psychosocial circumstances that influence infant brain development, parent-child relationships and the regulation of emotions and behavior, including genetics, low birth weight, undernutrition, substance exposure, disability and the impact of family discord and trauma. • Can identify and address family and child health factors, including nutrition, and their role in child and family outcomes from preconception onward. • Can identify and assess infant/child/adult states of arousal and how they are regulated and modulated. • Understands the concept that prolonged unaddressed stress in the infant/child/parent or dyad affects all domains of development and that chronic stress may lead to subsequent interference with brain development and emotional regulation. • Identifies and addresses prolonged stress as a focus of intervention. • Comprehends that over-reactivity, under-reactivity or a combination of both to sensory information can disrupt typical development, and is able to provide appropriate intervention where there is a mismatch between the parent and the infant or child. • Recognizes and works to combat the adverse effects of poverty and marginalization.

D: Risk and Resiliency		
Key Concepts	Hours	Competencies
<ul style="list-style-type: none"> • Atypical development • Maternal depression • Teenage parenting • “Ghosts” in the nursery • Chronic physical illness • Chronic mental illness in parents • Developmental disabilities • Prematurity • Communication and interaction problems • Substance abuse in families • Family violence • Working with challenging caregivers • Foster care • Institutional care • Factors that promote resiliency and help to insulate families from risk • Promoting resiliency in young children and families 	36	<ul style="list-style-type: none"> • Demonstrates a theoretical understanding of the cumulative risk factors that affect family well-being and parent-child relationships for infants and young children and their families and communities stemming from a variety of sources. • Demonstrates a theoretical understanding of the resilience factors that allow infants, toddlers and preschoolers to positively adapt despite significant life adversities. • Applies concepts of resilience to guide treatment planning assessment and interventions with children and families. • Demonstrates an ability to modulate intervention style and strategies in response to specific strengths and vulnerabilities of each infant, child and family. • Demonstrates an ability to consider culture and context as well as risk factors in planning assessment and interventions. • Demonstrates the ability to identify and address parent-family difficulties that negatively impact the parent-child relationship and infant or child’s social-emotional development.
E: Observation, Screening and Assessment		
Key Concepts	Hours	Competencies
<ul style="list-style-type: none"> • Development of observational skills with infants and young children • Use of observational information • Use of screening tools • When to make referrals for more comprehensive assessment • How to make a referral, including following through or assisting family with initial contacts • Introduction to major assessment instruments and processes 	60	<ul style="list-style-type: none"> • Demonstrates an understanding of assessment as intervention. • Successfully uses a wide range of strategies in varied settings to reach and engage families. • Demonstrates an understanding of how to use observation, screening and assessment to determine necessary components for the individual infant, young child and family. • Selects and uses screening and assessment practices appropriate to pregnant and postpartum parents, including screening for depression. • Incorporates observations of the infant and young child in multiple settings including play, child-parent interactions, early care and education settings and home into every assessment of the child. • Demonstrates an understanding of and ability to integrate a multidimensional assessment of an infant or young child, utilizing information from other providers and caregivers as appropriate, inclusive of health, physical, social, emotional, psychological and cultural aspects from a developmental and relational perspective. • Understands how to select and use specific components of assessments for birth-5-year-olds and their caregivers within scope of practice and training.

		<ul style="list-style-type: none"> • Uses components of assessment including observations, interviews, standardized and non-standardized tests and other professional reports, as appropriate, to provide multidimensional assessment with appropriate interpretation and application of findings in the design of interventions. • Can, through observation and interview, recognize challenges to adults functioning as parents, including signs of substance abuse, developmental delay, mental illness, etc., and provide appropriate referrals and interventions. • Demonstrates an ability to integrate multiple sources of information into a cohesive, family friendly report.
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F: Diagnosis and Intervention

Key Concepts	Hours	Competencies
<ul style="list-style-type: none"> • Diagnostic systems for infants, toddlers and young children • Linking assessment and diagnosis to intervention • Effective communication with caregivers and others • Concrete assistance • Community resources • Developmental guidance • Strategies to promote infant-family and early childhood mental health • Strategies for preventive intervention addressing social-emotional-behavioral vulnerabilities • Intervention strategies • Therapeutic options, including current knowledge of evidence-based practice • Developing reflective practice skills • Use of self in provision of services 	60	<ul style="list-style-type: none"> • Uses the DC: 0-3R and DSM-IV to diagnose problems in very young children and can provide the “cross-walk” diagnosis between the two systems within their scope of practice. • Recognizes intervention must be developed immediately following recognition of a child’s developmental risk in order to minimize the likelihood of failure to progress. • Integrates information and formulates plans together with a family. • Understands and addresses the importance and need for concrete assistance, developmental guidance, crisis management and advocacy in therapeutic and developmental work with families of infants and toddlers. • Demonstrates an understanding of basic principles of a variety of individual, dyadic and family therapeutic approaches to promotion, preventive intervention and intervention (treatment). • Demonstrates knowledge of and skill in implementing developmentally appropriate, evidence-based and best practice interventions. <ul style="list-style-type: none"> ▪ Provides developmental guidance and implements developmentally appropriate strategies for common problems in early childhood (tantrums, sleeping, eating, crying, regulation). ▪ Provides resources for related services, such as primary care, child welfare, mental health or social services. • Is able to monitor progress and problems with intervention in writing, make adjustments as needed and maintain ongoing communication and collaboration with family and other agencies or providers regarding their perceptions and concerns.

G: Interdisciplinary/Multidisciplinary Collaboration

Key Concepts	Hours	Competencies
<ul style="list-style-type: none"> • Understanding the roles of other professionals in working with young children and families • Respecting boundaries of practice 	8	<ul style="list-style-type: none"> • Demonstrates an ability to assemble an interagency and interdisciplinary team in which team and family members exchange information and learn from one another. • Demonstrates awareness that relationships with other providers will have an effect on their relationships with the child and family.

<ul style="list-style-type: none"> • Community resources • Working together with other professionals to create an integrated plan • Collaborating to prioritize child and family needs 		<ul style="list-style-type: none"> • Demonstrates the importance of sensitive, respectful and effective communication with other providers of services to the child and family. • Demonstrates knowledge of the existence of a wide variety of resources and systems providing services to young children and families. • Understands limits and boundaries of practice and makes appropriate referrals.
H: Ethics		
Key Concepts	Hours	Competencies
<ul style="list-style-type: none"> • Ethics of scope of practice • Working ethically in family settings 	4	<ul style="list-style-type: none"> • Demonstrates self-awareness and the ability to reflect on one's impact on families and vice versa. • Demonstrates a clear understanding of scope of practice as defined by license, certification, and/or position/role, and seeks consultation when questions arise. • Demonstrates a clear understanding of scope of areas of personal competency as determined by training and experience, and seeks consultation when questions arise. • Maintains appropriate boundaries with families and other professionals. • Keeps abreast of new scholarship and evolving notions of best practice in areas of competence through reading, continuing education, consultation, etc. • Recognizes and supports the cultural beliefs and values of families. • Recognizes the significance of socio-cultural and political contexts of children from diverse backgrounds. • Makes effective use of reflective practice facilitation and/or supervision.
Domain 2: Clinical Experience/Reflective Practice Facilitation		
Key Concepts		
<ul style="list-style-type: none"> ▪ Clinical experience with families and children prenatal to age 3 and/or ▪ Clinical experience with children 3 to 5 and their families ▪ Reflective Practice Facilitation 		<p>500 hours of Clinical Experience prenatal to age 3, including</p> <ul style="list-style-type: none"> • 60 hours Reflective Practice Facilitation for prenatal to age 3 <ul style="list-style-type: none"> • 10 hours minimum of 1:1 reflective practice facilitation • 10 hours minimum of 1:group supervision of up to 8 reflective practice facilitation • 40 hours of either individual or group facilitation and/or <p>500 hours of Clinical Experience for 3-5-Year-Olds, including</p> <ul style="list-style-type: none"> • 60 hours Reflective Practice Facilitation for 3-to 5-Year Olds <ul style="list-style-type: none"> • 10 hours minimum of 1:1 reflective practice facilitation • 10 hours minimum of 1:group supervision of up to 8 reflective practice facilitation • 40 hours of either individual or group facilitation

Combined Competencies: Domains 1 & 2		
Key Concepts	Hours	
<ul style="list-style-type: none"> • 260 hours Knowledge • 500-1000 hours Clinical Experience with Reflective Practice Facilitation 	760-1260	760 hours prenatal to 3 or 3 to 5 only 1260 hours prenatal to 5 endorsement

COMPETENCIES AND GUIDELINES FOR THE INFANT-FAMILY AND EARLY CHILDHOOD REFLECTIVE PRACTICE FACILITATOR

Working Definition of Reflective Practice Facilitation:

Reflective practice facilitation is defined as an individual or small group integrative experience that supports the practitioner to explore ways to apply relevant theories and relevant knowledge bases to clinical situations; to model an appreciation for the importance of relationships which are at the core of infant-family and early childhood mental health; to reflect on the experiences, thoughts and feelings involved in working with infants, young children and families; to understand the parents' culture and the parents' and infants' interpersonal perspectives; and to explore possible approaches to working effectively with infants and families. It is acknowledged that dynamics in the reflective practice facilitation relationship will in turn influence practitioner/family relationships, and thus that the reflective facilitator embodies ways of being that are considered best practice for infant-early childhood mental health practitioners.

Infant-Family and Early Childhood Mental Health (IFECMH) is an interdisciplinary field that inherently challenges the traditional boundaries of discrete disciplines. The endorsement process is designed to establish standard training guidelines to expand competence in infant-family and early childhood mental health principles for practitioners coming from a range of disciplines. In this document, the clinician/trainee/person receiving reflective practice facilitation is referred to as "practitioner." The agency or institution at which the practitioner is working/training is referred to as the "practice setting." The reflective practice facilitator may be situated in the same or a different setting. Reflective practice facilitators must be able to competently support practitioners working in a range of disciplines to apply infant mental health principles in their work. While it is hoped that practitioners will learn new skills and adopt new sensibilities, it is important that both practitioner and reflective practice facilitator attend to the scope of practice parameters appropriate to the practitioner's field/license/credential/role and practice setting.

Three categories of endorsement are possible for Reflective Practice Facilitators. A person endorsed as a Reflective Practice Facilitator I has attained endorsement as a P-60 Core Provider and has also met the training requirements and facilitation competencies delineated here, and is endorsed to provide reflective practice facilitation for Core Providers. A person endorsed as a Reflective Practice Facilitator II has attained endorsement as a P-60 Infant Mental Health Specialist and has also met the training requirements and facilitation competencies delineated here, and is endorsed to provide reflective practice facilitation to Infant Mental Health Specialists and/or Core Providers. A person endorsed as a Reflective Practice Facilitator III has attained endorsement as a Reflective Practice Facilitator II and has also met the requirements delineated here to be able to train, support and facilitate the learning of others in undertaking the work of reflective practice facilitation.

The endorsement process for reflective practice facilitators includes both curriculum-based and integrative experience-based learning components focused specifically on the challenges and responsibilities of this role. This includes training in reflective practice facilitation and participation in one-on-one meetings with a Reflective Practice Facilitator III or in a group of reflective practice facilitators led by a Reflective Practice Facilitator III.

Training for Reflective Practice Facilitators includes:

1. Reading a basic set of articles/books related to reflective practice facilitation.
2. Viewing a set of videos and DVDs detailing reflective practice facilitation skills.
3. Completing a minimum of 12-hours of didactic training with a curriculum built from reflective practice facilitator competencies.
4. Participating in one-on-one reflective practice facilitation meetings with a Reflective Practice Facilitator III or in a reflective practice facilitation group of eight participants or fewer led by a Reflective Practice Facilitator III. Participation involves a minimum of 36 hours of contact over a period of nine months or longer, with the frequency, duration and number beyond the minimum to be determined by the candidate's progress and satisfactory demonstration of the reflective practice facilitation competencies. Contacts must be monthly at a minimum; weekly contacts are encouraged. Contacts may be in person or in real time electronically supported modes.
5. Conducting a reflective practice facilitation meeting under the observation of a Reflective Practice Facilitator III in person, by audiotape or by videotape.

A qualified reflective practice facilitator possesses, IN ADDITION, the competencies that follow.

REFLECTIVE PRACTICE FACILITATOR COMPETENCIES

I. Clarity Regarding Roles and Ethics	
1.	Demonstrates the ability to articulate and communicate directly and explain to the practitioner and any involved agencies or institutions his or her role as reflective facilitator, which may or may not include or overlap with additional roles in relation to the practitioner, such as clinical supervisor, administrative supervisor, consultant, mentor, tutor, proctor, etc.
2.	Evidences accomplishment within a particular Infant-Family and Early Childhood Mental Health orientation or conceptual framework as well as awareness of alternative Infant-Family and Early Childhood Mental Health orientations or conceptual frameworks with which she or he may be less familiar.
3.	Understands and can explain the legal and ethical issues pertinent to the role of the facilitator, such as when issues presented in reflective practice facilitation sessions must be referred back to program supervisors or discussed with program administrators. This entails specifically the ability to manage complex intra- and/or interagency issues around boundaries, confidentiality, personnel matters and agency culture and politics in ways that promote practitioners' development, practice setting integrity and families' well-being.
4.	Understands that a variety of legal and ethical issues exist pertinent to a scope of practice and is able to support the practitioner in seeking clarity about these issues as needed.
5.	Is able to sensitively assist the practitioner in reflecting on his or her disciplinary scope of practice and the interdisciplinary nature of Infant-Family and Early Childhood Mental Health work, including, on the one hand, identifying times when additional referrals or consultation are needed for a child or family and, on the other hand, considering when there may be more professionals or agencies involved with a family than may be helpful or welcome.
6.	Is able to help the practitioner recognize and maintain professional boundaries in a variety of intervention/treatment settings such as home, child development center, social service system, health facility or other community setting.
7.	Is able to help the practitioner assess the strengths and limitations of their practice setting, and to consider best ways to provide services given family needs, relational and practical possibilities as well as limitations, and the need to consider interagency referral and/or collaboration.
8.	Can help the practitioner learn to listen closely to the family and discover the things that are important to them about their child and themselves and then collaborate with the family on behalf of the child. This means embracing the idea that intervention must be rooted in a worry or a wish that a family has in relation to a child, rather than in some motivational system entirely external to the family.
9.	Possesses the ability to assist the practitioner to learn how to set the frame for the work as focused on parent-child relationships in spite of multiple needs and distractions.
II. Understanding of Interpersonal Influence Issues	
1.	Demonstrates an appreciation of the importance of relationships that is central to infant and early childhood development and mental health, as reflected in a strong commitment to consistent reflective practice facilitation meetings and attentiveness to the practitioner-reflective practice facilitator relationship.
2.	Possesses a basic set of skills that is both embodied by the reflective facilitator and promoted in the practitioner. These include a nonjudgmental, accepting stance; facility with interpersonal understanding and inquiry; and promotion of positive change.
3.	Has the ability to consider and address issues of culture, including the impact of racism, class, immigration-related issues, socioeconomic issues, etc. on families, practitioners and the practitioner-reflective practice facilitator relationship.

4.	Expands practitioner's understanding of how to create a feeling of reciprocity and comfort/friendliness with a family by allowing for normal everyday social interactions without losing a sense of purpose and safety about role and reason for involvement with the family (e.g., the ability to consider the costs and benefits of accepting offered tea and cookies on a home visit, ability to understand parents' worry that their children's developmentally inappropriate needs/behaviors will reflect badly upon them, etc.).
5.	Works with the practitioner to understand that personal characteristics, clinical context, culture, style and professional role may unconsciously influence the interactive process with families.
6.	Helps the practitioner learn to observe and reflect on individual behavior and the interactive exchange with others, reflect on these processes and attribute relational meaning.
7.	Expands the practitioner's capacities to consider, observe and monitor impact of interactions on the family and talk with the family about this in a way that is potentially meaningful for them. In addition, facilitators should have the ability to help the practitioner expand these concepts to staff and collateral contacts and consultation relationships.
8.	Expands the practitioner's capacities to use self-knowledge and the ability to think about the client's experience to help formulate therapeutic responses and to act on the family's behalf in the context of collateral relationships.
9.	Expand the practitioner's capacity to understand and accept that each family is unique and will perceive the clinician and the intervention through the lens of their own experience and to extend this idea to work with staff and collateral contacts.
10.	Supports the practitioner to be able to tolerate strong affect and situations that are ambiguous realizing that these situations may involve not knowing or not understanding behaviors and motivation of the family.
11.	Helps the practitioner to recognize and think about experienced internal pressures that can "press" toward an emotional response and urges or wishes to act before adequate reflection or assessments are made. (As Clinical Professor in Psychiatry and Director of the Infant/Parent Program at the University of California-San Francisco Jeree Pawl has said, "Don't just do something, stand there!")
III. Facilitation Skills	
1.	Has an ability to understand the developmental level of the practitioner and tailor reflective practice facilitation sessions to individual needs.
2.	Is able to set a tone, plan and sequence the use of time in the reflective practice facilitation sessions that helps the practitioner regulate his or her thoughts and emotions so they can think about and experience their work in new ways.
3.	Possesses basic group skills that support and develop practitioner abilities. Such skills include awareness of and the ability to address unconscious group dynamics, patterns of role assumption in groups, challenges of "airtime" sharing and other group resource sharing issues, group/infant family parallel process possibilities and the healing/transformational potential of collaborative processes.
4.	Inspires confidence in Infant-Family and Early Childhood Mental Health principles and practice that lead to the practitioner's ability to be effective at outreach and relationship-building, successfully engaging families that might otherwise miss needed services.
5.	Helps practitioners working in nontraditional settings, such as shelters, medical facilities and early care and education and in developing ways to integrate Infant-Family and Early Childhood Mental Health principles into a variety of settings.

Note: Many of these competencies are adapted from those described in *Finding an Authentic Voice*, Heffron, Ivins, Weston. *Infants and Young Children*. Vol. 18, No. 4, 2005.

SUMMARY OF ENDORSEMENT CATEGORIES AND THE RELATED KNOWLEDGE, TRAINING, CLINICAL EXPERIENCE AND REFLECTIVE PRACTICE FACILITATION REQUIREMENTS

California Revised Training Guidelines and Personnel Competencies for Infant-Family & Early Childhood Mental Health - 2009

Summary of Endorsement Categories and the Related Knowledge, Training, Clinical Experience and Reflective Practice Facilitation Requirements

NOTE: The Knowledge, Training, Competencies and Reflective Facilitation Hours for Early Childhood Education Professionals is under development and expected to be released in 2010.

	CORE PROVIDER	SPECIALIST	REFLECTIVE PRACTICE FACILITATOR		
Definition	Professionals from multiple human development and education disciplines, including early intervention, mental health, nursing, occupational therapy, human development, audiology, physical therapy, speech and language pathology, special education, social work and pediatrics, who work with pregnant women, infants, toddlers and preschoolers and their families, and who have achieved the core provider mental health competencies described in this manual.	Individuals from relevant professional practice disciplines who have a Masters Degree or higher and/or a license or certificate/ credential and who have achieved the mental health specialist competencies described in this manual. Infant-family and early childhood mental health specialists include, but are not limited to, professionals in the mental health fields. 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.	Those who support the reflective practice of individuals working with infants, toddlers, young children and their families, and who themselves have training and experience as infant mental health specialists or core providers, as well as an additional set of trainings and competencies focusing on the reflective practice facilitation process. This role is similar to that of a clinical supervisor, but does not necessarily involve the same set of responsibilities as discussed in the final section of this document.		
Degree Minimum	BA/BS in field related to IFECMH	Masters Degree or higher in field related to IFECMH	DESIGNATION →	RPF-I	RPF-II
Professional License or Credential	None Required	Required in Field Related to IFECMH Field	Endorsement at time of Application to become a RPF	IFECMH Core Provider or Specialist	IFECMH Specialist
DOMAIN 1 KNOWLEDGE & TRAINING <i>A: Parenting, Caregiving, Family Functioning & Parent-Child Relationships</i>	20	32	Experience in Endorsed area at time of application to become a RPF	Equivalent of 1 year of full-time work	Equivalent of 1 year of full-time work
<i>B. Infant, Toddler & Preschool Development</i>	24	36	Basic Training Workshop	12 hours	12 hours
<i>C. Biological & Psychosocial Factors Impacting Outcomes</i>	12	24	Reading Component	18 hours	18 hours
<i>D. Risk & Resiliency</i>	30	36	Video/DVD viewing	2 hours	2 hours
<i>E. Observation, Screening & Assessment</i>	12	60	Reflective Facilitation with an RPF-III*	≥48 hours ¹	≥48 hours ¹
<i>F. Diagnosis & Intervention</i>	12	60	Practice Observation by RPF-III*	≥ 1 session ²	≥ 1 session ²
<i>G. Interdisciplinary/ Multidisciplinary Collaboration</i>	6	8	Can provide qualifying RF hours for	Core Providers only	Core Providers & Specialist
<i>H. Ethics</i>	4	4	¹ Reflective Facilitation by the RPF-III can be provided 1:1 or in a group of 1:≤8 over at least 9 months with at least monthly contact (weekly contact encouraged). RF hours can be completed face-to-face, by phone.		

TOTAL DIDACTIC TRAINING	120			260		
Endorsement Category	Prenatal-35 mos	36-60 mos	Prenatal-60 mos	Prenatal-35 mos	36-60 mos	Prenatal-60 mos
Clinical Hours	60	60	120	500	500	1,000
Reflective Facilitation	12*	12*	24*	60*	60*	120*
Endorsement Designation	IF-CP	ECMH-CP	IFECMH-CP	IF-S	ECMH-S	IFECMH-S
	*Reflective Facilitation must be provided by a qualified Reflective Practice Facilitator/RPF (see training guidelines for recommended competencies). After 2015, all Reflective Facilitation must be provided by an <u>endorsed</u> RFP I, II or III. RF may be provided 1:1 or in groups of 1:≤8			*Reflective Facilitation must be provided by a qualified Reflective Practice Facilitator/RPF (see training guidelines for recommended competencies). After 2015, all Reflective Facilitation must be provided by an <u>endorsed</u> RFP II or III. Of the RF hours, there must be at least 10 hours of 1:1 RF and 10 hours of group 1:≤8.		

least monthly contact (weekly contact encouraged). RF hours can be completed face-to-face, by phone, Skype or other "real-time" electronic technologies.

2 Practice observation by the RPF-III of the candidate conducting a RF session may be accomplished by audiotape, videotape, or direct observation in the session.

The frequency, duration, and number beyond the minimum Reflective Facilitation hours and Practice

Observations with the candidate and the RFP-III will be determined by the candidate's progress and satisfactory demonstration of the RPF competencies.

On or before July 1, 2010, the IFECMH Endorsement website will have information on Basic Training workshops reading lists, and video/DVD titles.

After 2 years of providing both group and individual RF, an endorsed RFP-II is eligible to apply to complete the professional development requirements to be endorsed as an RPF-III. The application process and professional development activities will be published before 2012.