ASSOCIATION OF UNIVERSITY CENTERS ON DISABILITIES (AUCD)
HOW DOES INFANT MENTAL HEALTH SUPPORT THE WORK OF PART C/EARLY INTERVETION?
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>> Anna Costalas: Hello, everyone. We will be starting in five minutes. You can download the slides above the chat box. You can download the file. Presenters, can I have a quick mic check?

>> >> Nichole Paradis: This is Nichole.

>> Anna Costalas: Mary Beth, can you hear me?

>> >> Mary Beth Bruder: I can.

>> Anna Costalas: And Peggy, just so I can get her volume?

>> Peggy Kemp: Yes, I'm here. All right. We'll be starting shortly.

>> Anna Costalas: Hello. And welcome to how does mental health support the health of -- I'm Monica and I'm the resource manager at the Association of University Centers on Disabilities, AUCD. Thank you for joining us today. Before we begin, I would like to address a few details. We'll provide a brief introduction of speakers. Because of the number of participants, your telephone lines are muted throughout the call. We will unmute during the Q and A at the end. Press star and pound on the phone to request to be unmuted to ask your questions.

If you're using your microphone on your computer, you can raise your hand by clicking the little icon on the -- very top of the screen. It looks like a person raising their hand. And you can submit your questions at any time via the chat box on your webinar console. You may send a chat to the whole audience or the presenters only. We will compile the questions throughout the webinar and address them at the end.

Please note we may not be able to address every question and may combine some questions. This is being recorded and will be available on the AUCD library. There will be a short survey at the end of the webinar. We ask for feedback and suggestions for future topics. Now please join me in welcoming Dr. Mary Beth Bruder.

Mary Beth: Thank you everyone for tuning in. I'm happy to introduce our topic on behalf of myself and Corey Rosenberg who is unable to join us. She is the other co-chair of the SIG. And the topic was brought up by our membership last year, which sounds so far away at the SIG meeting at the AUCD national conference. We had a number of folk there is representing the mental health community and wondering how we can integrate the mental health credentials and endorsements with all the other state initiatives that were happening.

And as a result, it started a dialogue, I'm very happy to say, with The Alliance for the advancement of infant mental health and how we could bring their work to the AUCD community and the SIG, the special interest committee. So, it's my pleasure to have two speakers today. Nichole Paradis who is the executive director for The Alliance at this point has done international work and actually started out in direct service.
She has authored a number of publications on infant mental health. Her most recent, early childhood mental -- actually, it's building competency for providers in the early childhood mental health feed and early childhood mental health endorsement that was in the 2017 issue as well as a number of chapters that she's done. She certainly brings this expertise to this whole field and our community and we look forward to hearing from her. We also have Dr. Peggy Kemp who is presenting with her. And her current role is the executive director for the counsel for exceptional children and has a long history in direct service for infants and toddlers and their families and was the part C coordinator for the State of Kansas. As well as co-authoring a number of curricula for early childhood interventionists. The early years curricula in particular.
And she has an endorsement in early -- in early childhood mental health and she's going to share with you how that fits into part C. So, Nichole, I'm going it turn it over to you and look forward to learning from you. Thank you.

>> Nichole Paradis: Thank you. Hello, everyone. I'm Nichole Paradis. And I'm really excited and was really pleased to be invited to talk about our competencies and specifically how early childhood and infant mental health really will help in terms of the intervention. It can be seen as a way to help in early intervention. I should say more specifically, how to help the workforce in early intervention.

Going to advance to the next slide. This is an actual map of me getting lost in Dublin, actually. But used this slide to sort of talk about the Competency Guidelines as we see them like a map. It's important to know where you have been, but it's equally important to know where you have not yet been. What are the critical knowledge and skill areas that maybe you have not yet fully acquired to the degree that would be most

helpful not just to you, but certainly to the infants and the families that you're serving.

So, I point out on this map, I saw a lot of great things while I was in Dublin, right? I saw that I went to Trinity College and I went to Steven's. green, but I completely missed the whiskey distillery. Maps are particularly important. Something that's important to know about these competencies, I'm speaking on behalf of The Alliance for the Advancement of Infant Mental Health. And we've been contacted by the Michigan Association for Infant Mental Health to manage our licensing of and the accompanying endorsement credential. But these competencies come from the Michigan infant mental health. They're intellectual property.

The other thing that would be really important for all of you to know is that they evolved from some competencies that were originally developed for the early intervention community. At that time the Michigan Department of Education was I believe at that time I believe it was still being called part H, now we know it's part C. The Michigan Department of Education wanted to develop competencies for that segment of the workforce and helped them to help develop competencies. Then after some time evolved, those competencies as well as some other work that had been done were pulled together to help describe more -- more specifically about a specialization in infant mental health across early intervention, but also other service sectors and other disciplines that work with infants and families.

But I thought it would be helpful for you to know that the roots come from early intervention and from part C. So, the competencies are comprised of really eight domains. And then within each domain there are knowledge or skill areas that are identified. And then what you can't see, because it's just a slide, that then for each knowledge or skill area, there's an as demonstrated by that really help practitioners really understand what's meant by each of these. The knowledge and skill areas and the domains themselves have pretty consistent across practice sectors, across scopes of practice. Where you might see differences are in that as demonstrated by column that you don't see here. That really might change for somebody perhaps in early care and education versus somebody in early intervention versus somebody working in a behavioral health setting.

The other thing that I think is helpful to notice about these domains is you see there are three areas that are bolded there. Those are what we sometimes refer to as the big three. We think that the -- they're all critical, but we -- if we think about, to use a term from Jerry Costa, think

about ways of knowing, ways of doing and ways of being as important to professional development, or as Jerry would say, professional transformation, we think there's an alignment here. The theoretical foundations represent knowing things. What do we know about infant development? What do we know about family relationships and what do we know about disorders of infancy and early childhood, for example, And ways of doing. I think this is like observation and listening, screening and assessment. And then the ways of being are represented for the most part in the reflection domain. So, our capacity for self-awareness, our capacity for curiosity, for contemplation. Now, this slide is really just a thumbnail. There's only a selection of the knowledge and skill areas listed here so that we didn't overwhelm the slide. But I encourage you to look at the full document which is like I think a 60-page brochure. But many infant mental health associations post these on their website. You would be welcome to go to your state's infant mental health association to look at these or email me and I can direct you to them. My email address will be on the last slide.

You heard me mention Endorsement. It's a credential offered to those who document their competency in those domains we just looked at and who have also participated in a set of specialized experiences. So, in addition to meeting the competencies, people who are in Endorsement have to have paid work experience in the field for the most part. There's one exception for that for infant family associate. For folks who have the education but have not yet had the opportunity to gain work experience. But for the most part, paid work experience is required with infants and families. As well as participation in a minimum amount of specialized in-service training and for many people participation in reflective supervision.

That's not true for all the categories of Endorsement, but it's true for many of them. And I'll say a little bit about that in a moment. But the endorsement is really meant to indicate that a professional has specialized. So, for instance, we were speaking with a group of -- a national group that represents home visitors recently. They have some sort of foundational competencies that they expect home visitors to have. Then they would like to see home visitors be able to specialize further in a field such as infant mental health So, this could be a secondary credential for some professionals that would complement another credential they want to earn. Or more typically a license that someone has earned in their field.

So, someone can be a licensed -- in my case, I'm a licensed mental health practitioner, but I've chosen to specialize in infant mental health. That documents that I've met the competencies and I do apply infant and

early childhood mental health principles to my practice.

At categories of endorsement, there are actually at this point -- it's a little complicated. It isn't just one credential, really. There are a number of different categories of Endorsement and each one is specific to an individual's scope of practice. You see folks that work primarily in promotion, the most appropriate category would be infant family associate. Those in prevention and early intervention typically fit best into the infant family specialist category. Those in treatment and intervention -- inside case we mean the kind of intervention that addresses relationship concerns.

So, things like infant/parent psychotherapy, child/parent psychotherapy, minding the baby. There are a number of interventions that are relationship-focused in that way. Those are interventions that best fit in the infant mental health specialist category. And then in leadership, we have three sub category, clinical for infant mental health. Those provide supervision and consultation to other practitioners. There's infant mental health policy for program and policy leaders promoting mental health within and across systems. And then the research/faculty sub-category for people who work in higher education teaching and/or conducting research about infant mental health.

You see on the column to the far right is the coming soon column. Our competency guidelines that are sort of the basis for this Endorsement, the competencies themselves cover work with pregnant women up to children age 6 and their families. However, the infant mental health endorsement always required work experience 0-3. We were hearing from a lot of people in the workforce whose work was informed by both infant and early childhood mental health principles but who worked primarily in the 3-6 age range.

So, think about people in Head Start, for instance. They wanted a pathway to endorsement. So, we have launched, as a pilot, an early childhood mental health endorsement. We have completed the pilot for the first two categories, early child family associate and family specialist and midway through the other categories for infant -- sorry -- early childhood mental health specialist and early childhood mental health mentor. So, those will be more broadly available in 2019.

So, just a little bit more about the requirements for endorsement. I mentioned this before, but this kind of give use a little bit of a visual side-by-side comparison. You'll see for that first category the infant family association or early childhood family associate, the promotion category. That is the only one that is an education and/or work

experience category. So, for folks who have a lot of work experience but don't have a higher education degree, there's a pathway for them to earn endorsement. For those who have had the education but haven't yet had an opportunity to get paid work experience, that category is the best fit for them as well.

And then if you go across the education and work experience rows there you'll see that the educational experiences change a bit from one category to another. And here -- this is just a thumbnail of the work experience. The endorsement criteria give a far more detail about the scope of practice in terms of work experience for each category. But just know that it varies from one to the other. You'll see that 30 hours is the minimum amount of in-service training. That's career-wide training. So, an individual can use training as long as it was related to the competencies, they can use training as far back as they can recall on their Endorsement application.

But you'll see in order to document that they've really met all of those knowledge and skill areas that fall under those eight domains, most people need more than 30 hours to document that. You can see the averages are listed there as well. So, 40 for infant family associate all the way up to 90 is what's typical for folks applying for infant mental health mentor. And, again, that's lifetime. That's not within a year. That's over the course of your career.

For the Endorsement we require three reference ratings. That's our way to document some of the things not easily documented through education or training. Again, if you think about that domain of reflection, those ways of being. We use the references to document an applicant's capacity for self-awareness, for curiosity, for understanding of parallel process, things like that.

Reflective supervision is something that we consider to be really important and a big part of best practice for folks who are working in the infant and family field. And so, it's required for the infant family specialist, infant mental health specialist and for infant mental health clinical. It's recommended for the infant family associates and for the mentors at the policy and research/faculty levels but not required for those categories of endorsement. Endorsement applicants sign a code of ethics and an Endorsement agreement. There is a written exam that is required for infant mental health specialist and mentor. It's not required for infant family associate or infant family specialist. And then membership in the infant mental health association is required for all categories.

And this is really to drive home the point about we want Endorsement to be a way of really professionalizing those who special in infant mental health. And membership in an infant mental health association is a part that have. And so that's why membership is a required part of the Endorsement.

So, a little bit more about reflective supervision or consultation. Many of you I'm sure are doing it, receiving, read about it, conducting research in it. But just to sort of be on the same page about it. We define it as really a trusting relationship between the supervisor and the practitioner. What we're looking for here is to parallel for the practitioner the experience that we hope that they are providing to the families and hope that then the families can do the same for the infant or toddler who is in their care.

So, wept the supervision or consultation that they receive to be consistent and predictable. We want to encourage questions that will help us understand a little bit more about the infant and the parent and their emerging relationship. Some things that I often find I need to say here and probably isn't news for any of you who have ever had to do a home visit.

When we're with families that are really vulnerable, it can be very easy to lose sight of why you're there. And so, these questions during reflective supervision are intended to help always keep the baby at the center. The relationship that the baby has with their parent or care giver as the reason we're there. Whether we're there to do an assessment or to check in on IFSP. Or if we're part of a child welfare check. We're there for the baby. And so, it's intended to help bring our focus back there because it can be very, very easy to be pulled in, whatever else might be going on during the session or during the home visit.

Again, the hope is that then both -- again, to help parallel the experience that the practitioner will be providing to the family is a commitment that both practitioner and the supervisor remain emotionally present during the session. There is a certain amount of teaching and guiding that may happen. And depending on the professional development sort of stage that the practitioner is in, there might be more that have as the person is learning more about the scope of practice, as they're becoming more experienced.

But always there's the element of providing nurture and support. We are Hoping that we're helping the practitioner apply the integration of emotion and reason to really make sense of the feelings that are arising when they're with a particular baby or family or in a particular setting. And to

try to make sense of why are those feelings arousing in you and why? What is that information telling us about the baby's experience in this family? What can we learn about the baby's experience by paying attention to the emotions and the feelings that are aroused in you when you're with them?

And all that, again, is a part of the exploration of the parallel process. We really want there to be sort of slowing down and a stilling that happens during reflective supervision and consultation. I don't have the image here, but we think about -- when you're looking into the water. Say there's a lake or a pond. When things are still, you're very much able to see the reflection. Things become much clearer. When there's a lot of churning, when there's waves, when there's wind, the image is very fuzzy and very hard to see. And so, we think about the practitioners that we send out in the field.

Often, they feel rushed. The water doesn't often have the opportunity to calm and to still so that the image can become clearer. So, we think of reflective supervision as a metaphor for that time. A time of stillness and a time to really think about what's really happening for the baby and for the family.

Those are just some of my favorite quotes about reflective supervision and consultation. Many of you are familiar with them, but Rebecca Shamoon Shanok, when it's going well, supervision is a holding environment. A place to feel secure enough to expose insecurities, mistakes, questions and differences. I use this quote for a couple of reasons. One is that the other role that reflective supervision plays is that for a practitioner to come in and admit they might have made a mistake.

I can give an example, most recently a practitioner came in and said, I went out to see the family. I had an intention to go over the curriculum. They were about to have their lights shut off, and I drove them to the power company and paid part of the bill to keep the power from being shut off. But I think I did the wrong thing. Can we talk about that? We want there to be a safe place where they can talk about, was there a boundary that was crossed that shouldn't have been?

Was there a judgment call made that should have been made differently? If they don't feel safe enough to admit that they've made those mistakes, then there isn't an opportunity to explore with them why they made the decision that they did and how maybe it should have gone instead. And more importantly -- and equally important -- how to go back and repair things if there's been a misstep along the way. But they have to have a

place that feels safe enough to admit that they may have made a mistake to begin with.

The other part of that quote that I think is important is the piece about differences. What I think is particularly helpful about reflective supervision, consultation and the safety that it hopefully provides is it's a chance to address our personal biases. If we want to be a culturally-responsive field, we need a place to think about our bias and how it might be affecting families that we might be working with. Cultural differences, parenting differences, value differences. It's very helpful we believe if there's a safe place to explore that to prevent that from interfering with the work. And to also promote better self-understanding on the part of the practitioner.

So, the second quote there is, "Supervision is the place to understand the meaning of your work with a family and the meaning and impact of your relationship with the family." I said before that we want there to be a place to understand what -- when feelings are evoked when you're with a family, what does that mean? What does that tell us about the family? But also, to think more particularly about what the practitioner might mean to the family. Who do they represent? What is the relationship that they're offering the family? How is that helping them form a stronger relationship with their infant? With their young child?

And then the last quote is also from Jeree Pawl. And I think she refers to this one as the platinum rule. The golden rule is do unto others as you would have them do unto you. And the platinum rule is "Do unto others as you would have others do unto others." Meaning, again, we want to provide for the practitioner that kind of safe, inviting, sensitive, responsive experience that we hope that they'll -- they will then provide to the parent which then we hope in turn the parent can then provide to the infant and the young child.

So, I mentioned they work for The Alliance for the Advancement of Infant Mental Health. But I mentioned that this system was actually born in Michigan. So, Michigan was licensing the use of the Competency Guidelines and the Endorsement to other interested mental health associations. And as the numbers of states who were interested in doing so grew, Michigan's capacity to attend to all of those associations was growing limited.

And they were being taken away from their own members. And so, The Alliance for the Advancement was formed. And we are contracted to manage the licensing, to deliver the training and technical assistance about how to implement these competencies, how to implement the

Endorsement system and ensure quality. There is reciprocity of Endorsement for all the members of The Alliance. That's an important piece.

It's not me, it's not the people who work for The Alliance. It's all the mental health associations represent on this slide and the next slide. Those in green are using this set of Competency Guidelines and Endorsement through their infant mental health association. The ones that you see in blue -- by the way, there's a total of 29 of them right now. 29 U.S. infant mental health associations. Those that are in blue are actively pursuing or considering adopting this set of competencies as well as the Endorsement credential.

And then you'll see on this next slide, we've kind of gone international. Not kind of, we have got international. Sorry, Ireland got really, really tiny. They're not intended to be so small. I just see that. Western Australia and Ireland are both using the competencies and Endorsement. And the other regions of Ireland are considering doing so as well as the country of Japan. Japan bought a limited license to translate the competencies into Japanese, so they can more carefully consider how they might be adopted in Japan.

So, I'm just going to talk about some of the benefits of the -- this particular set of competency guidelines as we see them. One of the things that we feel is helpful for infant mental health associations, again, thinking about that map, is to take a look at what's already being provided in terms of professional development. Not just by the infant mental health association, but by the state department that looks over part C or folks in the behavioral health system and other like-minded organizations. Right?

So, things like the National Association for the Education of Young Children. Kind of do -- what associations can do is an environmental scan. What kind of specialized training is out there that relates to this set of competencies and then what's missing? That gives guidance about what the infant mental health association can provide themselves or who they might partner with like their Part C department around making sure that in-service training that meets that particular knowledge area is available.

So, the example I use here is that in Michigan we found that there were very few if any trainings that had been offered in the last five or six years related to pregnancy. And so, as a result of that we partnered with a nursing organization to provide a three-day long three-part training in the developmental tasks of pregnancy and issues around pregnancy and

substance use and pregnancy and interpersonal violence. And this is really valuable training that filled a gap. But we wouldn't have, I don't think, really have noticed that if we hadn't take an look at that map like I was describing earlier.

Some of the other benefits of using this set of competencies. They've led to some really terrific university partnerships. And this is just a small sample of they will. But the University of Minnesota, their center for early education and development has several infant mental health online modules that they offer. They also did a terrific project, University of Minnesota, with their infant mental health association. They created modules that can be used in any discipline, in any college or university setting in Minnesota.

They developed -- within each module there are slides, a suggested reading list, a suggested discussion topics, talk points. So, that any instructor in any field in any discipline could integrate them into mental health principles into the courses that they were offering And that this has been really popular. And I just learned this is being duplicated in other places. Connecticut is the one I heard about most recently.
And then in terms of graduate certificate programs. Ball State University in Indiana has an undergraduate certificate in infant toddler specialization that is aligned with the infant mental health competency. And the University of Wisconsin used this set of competency guidelines to develop their early childhood and family mental health capstone certificate practice there.

And then in terms of degrees, Rhode Island College has an early childhood education. Their new birth to 3 bachelor's degree program is aligned with the competency guidelines. Many others, Field and Graduate University, many others that aren't listed here. But this is just to sort of give you an example.

In terms of the benefits around availability of reflective supervision and consultation. A couple of examples here. The Alliance has a strategic partnership with healthy families America. As you may know, healthy families offers an evidence-based home visiting model that's used widely across the U.S. and in the territories as well. And they really value reflective supervision. But knew that even though they were requiring reflective supervision and recommending it, not all of their program supervisors had enough training to feel like they could provide reflective supervision. We are partnering with them and there's a training series launching in October.

It will be held in Philadelphia. That's really helping supervisors gain skill

in the area of reflective supervision. And the Wisconsin partnered with a train the trainer series around reflective supervision because they found they didn't have enough capacity for reflective supervision in the rural parts of the state and the tribal communities. And so, this was a special outreach program that helped build capacity there. Especially for the home visiting program in those rural parts of the state.

One of the other benefits to the competencies and for the Endorsement system we believe is it helps address a barrier to expanding services. So, for instance, in Alaska right now they actually have a very, very strong -- you probably know, and some of you are probably from Alaska -- they have a really strong early intervention system there that reaches far and wide which is saying something because Alaska is really far and really wide. But what they discovered is they didn't have enough folks in the behavioral health system who felt qualified to deliver early infant and childhood services, relationship-based services to that population.

And so, they're using the Competency Guidelines to see what's missing. What did their existing behavioral health staff, currently serving older children, it's what the training they need so that they can skillfully provide services to the pre-verbal kids, that birth to 6 population? In other places, in South Carolina comes to mind, they've had a very strong history of quality in their early care and education system. But they haven't yet had an opportunity to have as much infant and early childhood mental health in some of the other elements of their service delivery system.

Some, but not as much as they would like. So, they're using the Competency Guidelines to drive some of that system expansion. I have been talking with folks at Georgetown and those who delivered the competencies for the infant and child health consultation, they're very much aligned with our mental health competencies. And thinking about a way we could provide our competencies to come up, perhaps, with a new category of Endorsement that would be specific to infant and early childhood mental health consultation. That's been another benefit in terms of thinking about that map from a systems perspective and not just an individual perspective.

Promoting infant and early childhood mental health principles across systems. As my colleague Therese Ahlers would say, the goal is for everyone who touches the life of an infant, toddler, young child and family to be informed by infant and early childhood mental health principles. So, again, this idea that you can have a license, or you might have another credential in another system. But demonstrating a specialization

in infant and early childhood mental health is important.

And, again, with the number of different fields here, including early intervention where we think that can be -- it can play a real role in helping those who wish to specialize and indicate that they specialize. The competencies that you've seen have been cross so far to the zero to three critical competencies for infant-toddler educators. They have been across to the training through the baby family at Erickson Institute in Illinois to their facilitating attuned interactions model. They are in development with the current Healthy Families America training series. What is it that HFA folks, when they complete the training, where do they stand with the competencies and the gaps?

And I mentioned the Center of Excellence were their infant childhood mental health competencies. And been in long discussions with folks at the Pyramid because our systems and approaches are also closely aligned and there are many people using both and this would be helpful. And now I'm going it turn things over to Peggy, so they can talk a little bit about how they have been integrating infant mental health in Kansas.
>> Peggy Kemp: Thank you, Nichole. As Nichole said, my job today is to reflect on the work we have done in Kansas. In Kansas, the Part C leadership team in Kansas really came together around 2008 and focused with a group of professionals in Kansas to look at the prospect of how we could increase the already existing work of the campus association for infant and early childhood mental health. The group was really formed around 1995. But in 2008 the team, including Part C representatives, the Part C coordinator at the time.

I served as the professional development support to the University of Kansas, our Kansas in-service training program. We had Head Start representatives, Part B representatives. Many of us came together with really the idea of looking towards achieving -- bringing the Endorsement process to Kansas.

And so, we looked towards the Michigan group for extensive mentorship and what we could do to bring that program to Kansas. And so, with the -- at the same time it was the ARRA dollars had come to Kansas and to the Part C program to it seemed like a nice match between an already-existing goal and some funding to support that.

So, we were fortunate to know also that the Competency Guidelines and Endorsement process to Kansas was a good match with Part C who had a philosophy of relationship-based early intervention practices already in place and really saw partners as critical -- or the critical partners in early intervention. As well as a goal at the time of really increasing

professional understanding of social/emotional development and of infant mental health. So, with that, the 37 programs in Kansas that cover the entire state of Kansas were -- received information about -- came about the competencies, about the Endorsement process.

And many of the programs chose to put forth their providers in one of the pathways. For a lot of the policy providers, most of them fall into the infant family associate or infant family specialist. But others actually fit into some of the other categories as well. There were some reflective supervision folks that were ready to actually provide reflective supervision at the time from within Part C. But also, from other partners across the state.

And so, we had a variety of reflective supervision groups going in. It seemed like an excellent fit with the work of a Part C home visitor, early interventionist. The eight competency domains were also a fit for many of the competencies that the professional development pre-service and in-service of the various disciplines. As Nichole talked about earlier, it seemed like a good second specialization, or a second endorsement to really recognize the work someone has done in the competencies around infant mental health and to help them build their capacity in those competencies.

So, we really worked together for professional development opportunities that already existed in the state -- in the Part C system or the partner programs that would align with the skills or the knowledge that were needed to support -- to complete the Endorsement process in the portfolios. What was really helpful is that we began to develop a web of mentors as well as a web of reflective supervision folks that could really help people reflect and in a lot of ways measure the work towards knowledge and skills in these competency areas.

After the ARA funds were exhausted, we -- sustainability was through the Kansas in-service training system program. And that's at the Life span Institute at Parsons. It's our university-affiliated program. There were a variety of ways that we looked to sustain that after -- with our Part C lead agency. And so, many of the things were keeping professional development leaders endorsed and came through serving on the board. Keeping our Part C coordinator almost consistently as part of the board so that they could bring information as ex officios to the group about Part C and the need for Part C, et cetera.

And we looked at the competencies for the infant mental health and were noted where there were offerings that could help support people who were moving towards their endorsement and help fill out their portfolio.

Currently KAIMH -- the Kansas Association for Infant and Early Childhood Mental Health is refocusing on a partnership with three identified program and Part C is one of those. It's been a while, since 2008. We felt the need to sort of refresh. And relook at the way that we were really supporting part C providers to look at the competencies and/or move forward for Endorsement. And so, right now we're looking at a lot of the existing -- the trainings that are a part of the Part C system and how do they crosswalk with some of the Endorsement?

What can we, in essence, sort of mark off because someone's a part of the system and already has certain pieces in place or pieces in place from their pre-service training. And so, we're also looking towards building internal mentors within the Part C system. And rebuilding some of the reflective supervision within the Part C system to, again, reestablish that idea of sustainability over the long haul in partnership with the KAIMH program. Many of the programs have continued to use the reflective supervision. It's been a good match with the work of early interventionists as well as the KAIMH work sitting nicely into Kansas' state system improvement plan which puts focus on the social/emotional well-being of children and how relationships are supported with their families.

So, just today we in Kansas absolutely seat connection between the infant mental health, the competencies and the Endorsement. And as a very nicely aligned and critical component of the work that we do.

>> Anna Costalas: Thank you. We now have time for some questions. So, what I'm going to do is I'm going to go ahead and open the phone lines if folks want to answer a question via the phone, they can press star and pound. If you want to ask a question on your march you can just raise your hand by clicking the little guy above the slides that has his hands raised. Or you can also ask a question via the chat box and I'll be happy to read them out to our presenters.

Mary Beth: Hi, everybody. This is Mary Beth and I'm just going to start by the fact that most of us who have been working with personnel for a lot of years are very, very happy about the focus on competency-based education. Whether it's pre-service or in-service to better prepare our workforce. We have a plethora of competencies out there. And I was happy to see your slide showing the alignments. Because at the early childhood personality center, another center I have, we are spending a lot of time doing alignment. The question I would make it specific, into mental health competencies.

Do you guys have it tied to an evidence-based? That is either linked to literature that supports the competencies? What are the results of the

competencies? What type of family and child? Or do you have plans for doing that? And then I can also have Peggy address it.

>> Nichole Paradis: Sure, I'll say at the more national level there are a total of I think three research committees among The Alliance who are looking at this. Exact question, what difference does it make to families and infant and children's outcomes if they're receiving services from an Endorsed practitioner? Right now, the data that we have is really just qualitative data about what the endorsed professional's perception is about that. But there are -- there's an IRB actually pending in the next couple of days, I hope, that will allow at least one person to do a more thorough dive into that.

Actually, her question will be also around looking at does it make a difference in terms of staff turnover and staff burnout if the staff person's endorsed versus not endorsed? There is -- in terms of the reflective supervision, there's a little more data. But, again, more is being gathered as we speak. But there's a really great study that was in 2016, infant mental health journal issue that was about reflective supervision, but it was specific to an early intervention group who had been receiving group-reflective consultation over a period of time and what they had to say about the effect on their work. There was great stuff in there, but with the one that stuck with me was they felt they had so much more efficacy in their work because they were getting reflective consultation. Before the reflective consultation, they were doing their work, but felt at times they were banging their heads against the walls.

These family have so many risks and needs. I'm here to talk about the developmental needs of one child of this family of children. I don't think I'm making a difference here. That was kind of the consensus. But by participating in reflective consultation over time, they were invited to see the ways that they were really making a difference and they had to find that time to sort of quiet and to think carefully about the changes that you were seeing. And that an invitation to do that through reflective consultation really made them feel they had a lot more efficacy in their work. The finding isn't there, but I would suggest they would say they were sticking around longer, and the turnover was less because they felt like they had more efficacy around their work.

I would say stay tuned, we're hoping to have more data. Those are the highlights we have so far. Again, most of it's qualitative at this point.

Mary Beth: Thank you. That sounds very encouraging.

>> Anna Costalas: We have a question in the chat box from Charlotte Porter if you can give some specific examples of how integrated IMH competencies or family objectives into the ISSP, individual objectives

rather than underlying foundation.

>> Nichole Paradis: That's a great question. I'm trying to think how exactly it might get included into an ISSP. But generally, the way I think about it is, I used to oversee a very, very small Part C program that was within a child welfare department. This would have been in the 1990s, so, we're talking a long time ago. But what was helpful, what we thought we'd brought because we had an infant mental health perspective that some of the other folks who were working with the family around a child, whether there was a concern that they might not have brought was that perspective because of the training specifically around attachment, separation, trauma, grief and loss. Nowadays many more people are using a trauma-informed approach.

But at that time, it was really helpful for there to be a voice in the room when the IS SP was being developed about what impact does the parent's grief have on the relationship of what's happening with this child and their capacity to really encourage their development. And it wasn't always the grief about -- a lot of times it might have been grief about the child's diagnosis in general. But sometimes it was something else. There might have been another sort of ghost in the nursery. A pregnancy and loss. A worry that another child that they might be pregnant with or hoping to become pregnant with might have the same experience as this child who is in need of an ISSP. Sort of bringing that perspective to thinking about as services were being coordinated what's helpful.

Again, I think that's happening more now maybe than it was back in those days but that's one example that comes to mind.

Mary Beth: Hi, this is Mary Beth, if I could jump in It could be turned into an ISSP objective by stating if you are working with a family who has some very concrete mental health needs forward to grief that you have been able to identify, one of the ISSP objectives could be to help that mother -- connect that mother to counseling. Or a psychologist who is licensed to work in that area.

Because many of our Part C folks are not licensed to do counseling or therapy. So, I think that I would turn it into that type of an objective since our ISSPs are to really look at family resources and what their needs are. I don't know if that helps make it that concrete. But I think that's how you would take the information to inform some measurable outcomes on the ISSP which is really continuing on that path to help that mom get her mental health needs met which is then in turn going to be realized by not just better outcomes for her, but for how she parents. And then you

could turn it into a parenting outcome also.

>> Anna Costalas: We have another question.

>> Nichole Paradis: Sorry, I was just going to add a quick clarification. I was so glad you added that, Mary Beth. I think it's also important that everyone's working within their scope of practice. I think just because someone has a mental health-informed approach doesn't mean they're qualified to treat postpartum depression, for example. It's the awareness, I think, that one brings. And then knowing that means a referral to a qualified person who can -- it does fall in the scope of practice. It's important. So, thank you for adding that.

>> Peggy Kemp: And that's what I would add. The ISSP goals would be individualized and sometimes it may be about a parent. Sometimes it may be about a young child who already has a diagnosis. However, I think the point of this work is that awareness piece. That understanding by the professional, a specialization that -- about what could be going on, as you've said, you know, in the current, in the past, for parents. And really having a different perspective on supporting families while they're so -- during home visits and thinking about during assessment, during the ISSP process. Being able to have conversations about perhaps if there is a concern about depression how to really know where the specialists are and how to support that.

I think that it's -- there are a lot of reasons that really help inform the ISSP process that may not always end up as an outcome.

>> Anna Costalas: Great. Can you speak to how the social/emotional growth supports in all areas of development and why the competencies might be important to keep this growth going?

>> Nichole Paradis: Yeah. I think -- a lot of folks have expressed to us what they find helpful about the infant mental health competencies is that focus on social/emotional development. I alluded before how when you're -- sometimes you're on a home visit and your attention can be pulled in a bunch of different directions around the other needs that the family might have. I think that's also true when we're looking at a child who may have some deficit or diagnosis of disability. That sometimes we need to be pulled back to think about the social/emotional development. And as the question suggests, its role in supporting all the other development.

We know that children who feel secure, who have predictability and reliability in their care giving environments are going to do better developmentally across all the domains. But that it can be hard to move the focus on that at times when the other things are far more -- well, just

squeakier wheels, maybe. And so, to me I think that's a part of the value of the competencies. To really help us turn our attention back to the social/emotional needs and their role that they play in supporting the rest of the development.

>> Anna Costalas: Great. Thank you so much. Looks like that was our last question. So, I would like to thank our presenters, again, for a fabulous presentation. I thank everyone for attending this webinar. This webinar has been recorded and will be in our webinar library at AUCD.org. If you would like more information about AUCD's early childhood special interest group, email Mary Beth or us here at AUCD. Please take a few moments to complete the survey that will pop up on your web browser once I close out. Thanks, again, everyone, and have a great rest of your week.

>> Thank you, Anna.

>> Thanks, everybody.

>> The meeting is now over. All the participants have been disconnected.