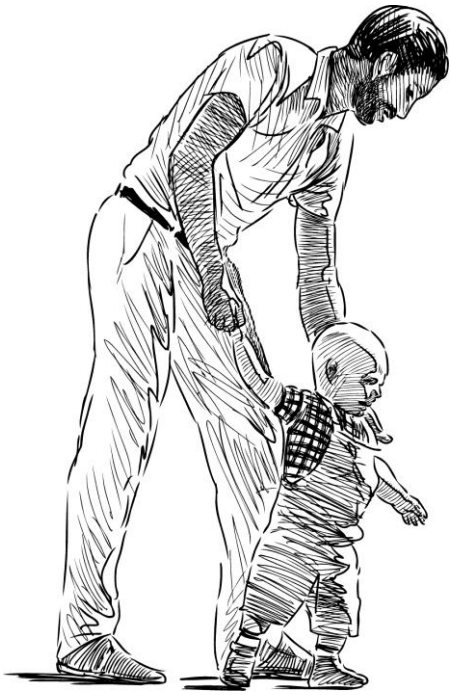
Building the Mental Health of Infants and Young Children in WA

Workforce Competency based Training Project

October 2013



The WA Mental Health Commission (MHC)

Australian Association for Infant Mental Health West Australian Branch Incorporated (AAIMHI WA)

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EXECUTIVE SUMMARY

The Workforce Competency Based Training Project (The Project) is an innovative response to the growing awareness in the professional community of the need to up skill those working with infants, young children and their families. The workforce ranges from those providing services in preventative health and support agencies to those delivering clinical interventions.

The Project has its genesis in collaboration between The Western Australian Mental Health Commission (WA MHC) and the Australian Association for Infant Mental Health West Australian Branch Incorporated (AAIMHI WA). The Project commenced on 17 March 2013.

The Project is one of a range of related activities facilitated by the WA MHC in keeping with the Mental Health 2020 Strategic Policy to progress the healthy social and emotional development and mental health of infants, young children and their families.

The aims of The Project are to:

(1) identify a framework of Infant-Early Childhood Mental Health (I-ECMH) workforce competencies to articulate core knowledge skills and abilities for all levels of the workforce who work with infants and young children to five years of age;

(2) identify current accredited training programs in I-ECMH that align with the framework; and

(3) prepare a draft structure for training delivery and for supervision for the workforce.

The Project engaged with major stakeholders at practitioner and management levels leading to shared discussions across:

- levels of service (promotion, prevention and intervention);
- the diverse range of disciplines represented by the workforce (Education, Nursing, Occupational Therapy, Medical Officers and General Practitioners, Paediatrics, Physiotherapy, Psychiatry, Psychology, Social Work, Speech Therapy) and of practitioners who work with infants and young children and their families (Case Workers, Parent Educators, Policy Makers, Playgroup Facilitators, Early Childhood Educators, Home Visitors, Therapeutic Skill Educators and Allied Health Professionals);
- a diverse range of stakeholder groups (Government Departments including - Health, Education, Child and Family Services, Communities, Disabilities; Non-government organisations; private practices; Early Learning Centres, community support groups; Registered Training Organisations.

The Project team interviewed experts across Australian states as well as international experts in the policy and practice of I-ECMH. International competency based frameworks and training models that are designed to operate in a similar context to that in Western Australia were investigated. The extensive consultative process brought the potential of this project into focus locally, nationally and internationally.

Significant Findings

1. The field of I-ECMH is developing rapidly in Western Australia. At the same time increased pressure is being placed on the workforce to manage higher caseloads and more complex presentations. There is a need to clearly identify population parameters, develop the infrastructure for the workforce, develop clear clinical pathways, harness workforce capabilities, and build workforce capacity.
2. Western Australia has a dedicated workforce that is open to change and is aware of the need to develop best practice guidelines for working with infants, young children and families.
3. Allocated funding is not used in an informed, co-operative and coordinated fashion to build capacity in the I-ECMH workforce.
4. There are no competencies or standards currently in use that cover the range of the I-ECMH workforce in Australia which spans preventative health agencies, support groups through to those offering clinical interventions.
5. There is unanimous support in the field for a coordinated and inclusive approach to building workforce capacity through a competency based model in Western Australia.
6. A limited number of competency based models for the I-ECMH workforce exist. Review of these recognises The Michigan Association for Infant Mental Health, (MI-AIMH) Competency Guidelines(2002a) and Endorsement for culturally sensitive, relationship-focused practice promoting infant mental health (2002b) to be the international gold standard.
7. Gaps exist in knowledge and skills of I-ECMH in promotion, prevention, intervention and policy as well as in reflective practice across all levels of the workforce. These gaps contribute to tensions in the field over ownership of I-ECMH. For example, a common misperception is that any type of intervention that occurs early in life is preventative. In I-ECMH some interventions are preventative; some targeted and for those infants who have a complex presentation a range of specialist clinical interventions are required.
8. Current local education and training programs in I-ECMH do not reflect best practice for the subsequent service. These are mostly discipline specific and neglect the inter-professional collaborative skills required for working in the field of I-ECMH.
9. There is awareness of the need to develop structures to maintain knowledge and skills in I-ECMH; currently structures and processes for the maintenance of competency are in the main adhoc, poorly supported and uncoordinated. One way that is recognised in the international literature to maintain competency is through ongoing reflective practice.
10. There is no defined, state based I-ECMH training structure. Professional development and training is identified to be an essential vehicle for constructive collaboration between metropolitan and rural workers; between disciplines and services; and it is desired by the workforce.
11. There are a range of agencies, organisations, and government departments involved in providing services to infants, young children and their families. The workforce is characterised by a cross professional and cross sector profile. Building capacity across this diversity will require a coordinating body that has I-ECMH as its central focus at all times.

Recommendations

1. To ensure quality of the training framework and build a sustainable workforce, the state purchase the *Michigan Association for Infant Mental Health, (MI-AIMH) Competency Guidelines and Endorsement for culturally sensitive, relationship-focused practice promoting infant mental health®*,

2. Work to begin immediately to build the competency based training and supervision framework that aligns with the MI-AIMH Competency Guidelines.
3. The MI-AIMH Framework to be implemented in incremental phases over five years, whilst the infrastructure is developed to support it. Recommendations for the process of implementation are outlined in the body of the report.
4. Specialist intervention capacity in the I-ECMH workforce needs to be developed and occur concurrently with building workforce capacity in promotion, prevention and policy development.
5. The I-ECMH competency based training and supervision framework needs to be cross professional and cross-sector. The suggested framework is to:
    a. Be further developed and delivered in collaboration with stakeholders.
    b. Include substantial components that are deliverable to the rural workforce.
    c. Include the incremental development and delivery of interdisciplinary postgraduate university level modules that align with levels 2-4 of The MI-AIMH Framework.
    d. Include the development and integration of I-ECMH material for interdisciplinary undergraduate university courses in alignment with Level 2 of The MI-AIMH Framework.
    e. Include the development and delivery of certificate level modules that align with Level 1 of The MI-AIMH Framework.
    f. Develop structures to support reflective practice in I-ECMH across all levels of the workforce.
6. The funding body resource an independent agency or agencies to coordinate and deliver training in Western Australia. To purchase The MI-AIMH Framework it is a requirement that one collaborative partner is affiliated with the World Association for Infant Mental Health (WAIMH). AAIMHI WA is one body that meets this requirement. It is affiliated with WAIMH and it is also an independent agency representing multidisciplinary professionals that holds the emotional wellbeing of infants and young children as its central focus and core business.
7. The state to implement structures for supporting reflective supervision in line with The *Michigan Association for Infant Mental Health, (MI-AIMH) Endorsement for culturally sensitive, relationship-focused practice promoting infant mental health®*.
8. The operational infrastructure for developing and delivery of a I-ECMH competency based training framework in Western Australia should have the following components:
    a. MHC and AAIMHI WA partner to manage funding and The MI-AIMH Framework.
    b. A Training and Supervision Committee to be established that comprises representation from AAIMHI WA and includes state funded specialist I-ECMH

positions including: Endorsement Coordinator (EC), Service Development Leader (SDL) and a part-time administration assistant.

c. The Training and Supervision Committee partner with key stakeholder groups that represent the universal, targeted and selected levels of I-ECMH service delivery. Key stakeholder groups identified are: WA Association for Mental Health (WAAMH); WA Council of Social Service Inc, (WACOSS); The Department for Communities; The WA Department of Education (DoE); The WA Department of Health (DoH); Department for Child Protection and Family Support (CPFS); The Disability Services Commission (DSC).

9. The Training and Supervision Committee establish creative partnerships with universities and education providers of certificate level courses. The Training and Supervision Committee collaborate with representatives from relevant stakeholder groups, to inform the development of training modules appropriate to the level of service delivery.
10. The training framework be phased in over a five year period in order to provide opportunity to build workforce capacity, align with The MI-AIMH Framework and ensure sustainability.

We have made the process of inquiry explicit in the report while at the same time ensuring the report is helpful for decision-making by all the stakeholders. The Project recognises the importance of supporting each newborn infant to reach his/her potential by building capacity in all spheres of influence. The specific focus of this competency based training project is on the considered planning and action required to bring new knowledge and skills to all those who work with infants, and young children in Western Australia. The implementation of this initiative will bring positive outcomes to the I-ECMH workforce and ultimately the community of Western Australia.

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INTRODUCTION

This section of the report sets out the aims of The Project, defines the field of Infant-Early Childhood Mental Health (I-ECMH) and describes the I-ECMH workforce. We draw attention to the political context including examples of strategic initiatives in IMH in Western Australia.

Aims of The Project

The aims of this project as per the Grant agreement (MHC & AAIMH WA, 2013) are to:

(1) Identify a framework of workforce competencies in Infant Mental Health to articulate core knowledge skills and abilities across all levels of the workforce who work with infants and young children up to five years of age and their families (the workforce)

(2) Identify current accredited training programs in Infant Mental Health for the workforce that align with the framework

(3) Prepare a draft structure for training delivery and supervision for the workforce

What is Infant-Early Childhood Mental Health?

Infant mental health (IMH) is an interdisciplinary field that has steadily grown internationally over the past 35 years. One definition commonly accepted is 'the healthy social and emotional development of a child from birth to 3 years; and a growing field of research and practice devoted to the:

- promotion of healthy social and emotional development;
- prevention of mental health problems; and
- treatment of the mental health problems of very young children in the context of their families. (Zero To Three, 2012). See Figure 1 The range of I-ECMH".

Other definitions include the age range to be 0-5 years, for example:

> *Infant-early childhood mental health (I-ECMH), sometimes referred to as social and emotional development, is the developing capacity of the child from birth to 5 years of age to form close and secure adult and peer relationships; experience, manage, and express a full range of emotions; and explore the environment and learn—all in the context of family, community, and culture (Zero To Three, 2012).*

There exists a current move to redefine the field in terms of infant and early child behavioural health (I-ECBH) in order to appeal to policy makers and those who find it difficult to reconcile an infant or toddler as having mental health issues. In most cases the field is resisting this for fear that the underlying relationship aspects that contribute to emotional and social well-being in infants will be neglected in favour of behavioural strategies that focus on the child only. Other reasons include

maintaining the current growth of the identity of the field which has a developing international profile (Zero To Three, 2012).

The parameters of this project include young children aged 0-5 years, therefore we use the term Infant-Early Childhood Mental Health (I-ECMH) throughout and IMH when specifically referring to the 0-3 year population.

The field of I-ECMH has provided significant clinical and research contributions towards understanding social and emotional development in infancy and toddlerhood and the critical role this developmental stage plays in psychosocial development throughout the lifespan. The term 'infant mental health' was first coined by Selma Fraiberg in her seminal article 'Ghosts in the Nursery' (Fraiberg, Adelson, & Shapiro, 1975). Fraiberg and her colleagues considered disturbances in early relationships and asked important questions about clinical interventions that address disturbances in both the mother and infant's clinical presentation. Fraiberg's (1975) ground breaking work was distinctly different from other models of intervention for childhood and adulthood psychological disturbances in that the model conceptualised presenting concerns within the care giving relationship rather than attributing problems to either the individual child or parent.

Since these beginnings, I-ECMH has developed to incorporate many theoretical frameworks including developmental psychology, attachment theory, developmental neurobiology and psychoanalytic theory. It has grown rapidly over the past 25 years due to:

- increase in research investigating infant development and the importance of the parent-infant relationship on developmental outcomes;
- advances in brain research on early development and the impact of early life experiences on brain development. Infancy is now considered a critical period of brain development that is 'experience dependent', relying on sufficient stimulation from the caregiving environment to ensure optimal development (Mares, Newman, & Warren, 2011, p. 9);
- the development of theoretical frameworks that understand social, emotional and behavioural difficulties in the context of the caregiving relationship. These in turn have shaped clinical interventions to target the infant-caregiver relationship; and
- the work of economists who provide clear evidence of the cost benefit to society of investing in the infant and toddler years.

It is important to distinguish I-ECMH from perinatal mental health in terms of both definition and service delivery. I-ECMH maintains focus on the mental health and wellbeing of the baby or young child as having precedence in the context of the parent child relationship. Indeed, some use the term 'infant-parent' rather than 'parent-infant' to emphasise the priority of the infant in the relationship. Perinatal mental health overlaps with I-ECMH somewhat in that the perinatal period extends from pregnancy to the first year after the baby is born. However, perinatal mental health, by definition as well as according to parameters of service delivery, prioritises the mental health of the mother followed by the emotional well-being of the child, partner and family.

Clinical Presentations and Intervention in I-ECMH

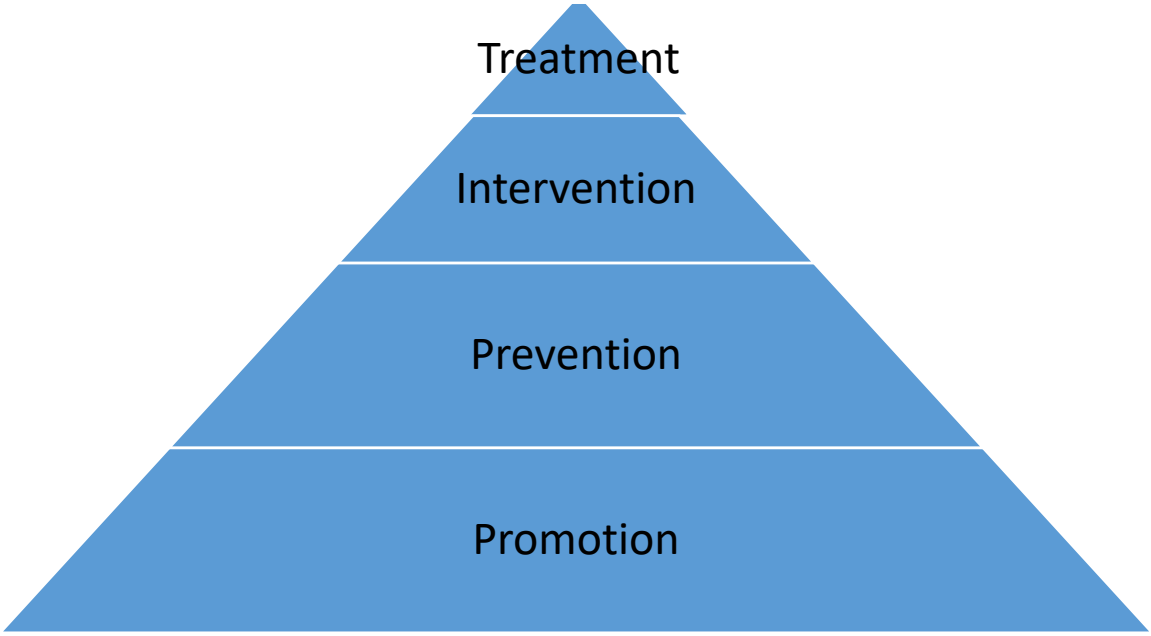
Disorders in infancy and early childhood exist. These are expressed in a multitude of ways, including disturbed infant-caregiver interactional patterns, early developmental or medical problems in the infant, and/ or chronic functional disorders (crying, sleeping, and feeding). Exposure to trauma, abuse, neglect and parental mental illness are established factors that contribute to the development of clinical disorders in infancy and early childhood. Typically, 'disturbances to early development are seen as arising from an interplay of factors in the infant, parent and their environment' (Mares, Newman & Warren, 2011, p. 20). There is a need for comprehensive approaches to interventions for identified clinical disorders in this developmental period. These interventions require a highly skilled workforce to provide specific relationship based intervention strategies in addition to simultaneously paying attention to the developmental trajectory of the infant or young child to ensure prevention of future development disturbances (Zeanah, 2009).

In Western Australia, there is no dedicated IMH or I-ECMH service and there are very few clinical pathways for infants and young children who have established clinical disorders or present with significant social, behavioural and emotional disturbances. In understanding the broad scope of I-ECMH it is crucial to develop clear clinical pathways. This ensures that in a setting where the focus is on promotion and prevention, practitioners will detect the emergence or presence of clinical disorders in infancy and early childhood and have a clear referral pathway to services which provide clinical interventions specific to infant and early childhood mental health. Building workforce capacity in I-ECMH is an important way of developing a specific skill set at each level of service provision and in the long term will contribute to the establishment of clear clinical pathways for I-ECMH across promotion, prevention, intervention and treatment services.

The I-ECMH Workforce

The I-ECMH workforce encompasses the diverse range of practitioners and professionals who work across promotion, prevention and intervention services, see Figure 1. These include services with duty of care to children aged 0-5 years, maternity services, mental health services (adult, child and adolescents), child development services, child protection and support services for vulnerable families, public health and early childhood education and parenting services. The diversity of the workforce reflects the range of disciplines and services that play a role in supporting the social and emotional well-being of infants, young children and their families from fostering healthy early attachment relationships to intervening with significant clinical disturbances in the infant-caregiver relationship.

Figure 1 The range of I-ECMH



The diversity of the I-ECMH workforce is such that it is often difficult to delineate and is "not clearly defined by professional discipline, service settings, or traditional academic training programs" (Huang, Macbeth, Dodge, & Jacobstein, 2004, p. 168). It is often fluid and crosses traditional siloed departments. In addition, mental health issues in infants and young children are often first identified in primary health care, child protection, community based interventions, parenting programs, and early learning centres rather than in tertiary mental health services. Typically these settings are not organised around provision of mental health services (Huang et al.).

The workforce must have the capacity to provide a service that can focus on the infant-parent relationship across the range of settings. *"Infant mental health work is complex, and requires a range of skills, knowledge and competencies including the ability to assess risk both to mothers and infants and the ability to take appropriate action so as to safeguard individuals and families, many of whom are extremely vulnerable. It is essential that everyone working in this area of care keeps up to date with the required levels of knowledge and practice in relation to safeguarding procedures (*NHS North West, 2011, p. 32*)."*

For the scope of this report and in line with the definition of I-ECMH, the workforce includes universal and targeted services as well as tertiary level specialist intervention services. Attention to primary and secondary service providers (examples include and are not limited to Child Health, General Practitioners, Community Parenting Services and Early Childhood Educators) is an important factor when considering a workforce development plan in I-ECMH. This is in keeping with current shifts to create a wider sense of responsibility for I-ECMH that includes services involved in promotion and prevention and understanding of the importance of proportional universalism.

Studies of proportional universalism, have identified that to 'reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to

the level of disadvantage' (Solihull Director of Mental Health, p. 1). This concept has particular relevance to I-ECMH and highlights the importance of investing in universal and targeted programs that support infant-caregiver relationships which will in the long term reduce the risk of developing more serious mental health concerns in childhood and adulthood and produce significant financial savings for the community. For a flow chart of projected benefits of up skilling the I-ECMH workforce see Appendix C.

Political Context

It has been widely acknowledged by economists including The World Bank (2013) that "failure to invest in early child development is costly to individuals and society and difficult to compensate later in life." Investments that focus on fostering healthy early parent-child relationships yield the greatest benefits for later overall development. Where these are supported greater cognitive development, educational success, and increased productivity in later life follow. There now exists solid empirical evidence from multiple research disciplines including economics, neurobiology, developmental psychology, epigenetics, attachment theory, longitudinal studies, evaluation of international head start interventions, cross cultural studies and child development that investment in the social and emotional well-being of young children from the prenatal stage through the transition into the early school years is of paramount importance for both the individual and for well-functioning society.

Entry points to influence the social and emotional development of infants and young children are diverse and involve multiple stakeholders. Policies and programs in a number of sectors affect infant and child outcomes, including: education, child protection, community, distribution of wealth, health, and indigenous affairs. These policies and programs may be aimed at the pregnant woman, the infant and young child, the caregiver or the family as a whole. Interventions may take place in a variety of environments, including: the home, child care centres, child and community health centres, preschools, hospitals, medical centres, and community agencies (The World Bank, 2013).

In Australia awareness of the importance of the young child's earliest relational environments has slowly become incorporated into policies over the last decade. Organisations such as the Australian Association for Infant Mental Health (AAIMHI), established 1988, followed an international movement to advocate for the mental health of young children and their families (Warren, 2007). AAIMHI is now well established across Australia and influences a large contingent of Australian Infant Mental Health (IMH) workers who attend annual National and bi-annual World Congresses in IMH. In 1999, the National Investment for the Early Years (NiFTeY) was established to disseminate research information on children in their early years and contribute to the growing awareness of infant and child well-being in policy making and in 2002 a research alliance was established Australian Research Alliance for Children and Youth (ARACY). These two organisations amalgamated in 2012. The importance of the early years was highlighted in the National Early Childhood Development Strategy (NECD) that was endorsed by the Council of Australian Governments (COAG) in 2009 (Australian Government, 2013b). This collaboration aimed to ensure that "By *2020 all children have the best start in life to create a better future for themselves and for the nation".* A consortium of organisations concerned at the service gaps for the wellbeing of infants and young

children within Australia jointly badged a National Coalition for Children to advocate in the Federal election of 2010 for increased spending on the mental health of children from early life.

Mental Health became a key issue of the 2010 election and the newly elected Prime Minister Gillard reflected this by changing the emphasis of the portfolio of ageing to become that of 'Mental Health and Ageing' and followed this by establishing Australia's first National Mental Health Commission in 2012.

Publication of annual results from the Australian Early Developmental Index (AEDI); a population measure initiated by the Federal Government in 2009 to understand how the nation's children were developing in their various communities has highlighted how children entering Australian schools do NOT do so from a level playing field, highlighting the need for interventions well before school entry. In Western Australia, the Education Department has recognised the importance of the early infant, toddler and childhood years for later mental health and have implemented an exciting new initiative in the introduction of the Child and Parent Centres which cater for 0-8 year olds with a strong emphasis on the social and emotional development of 0-4 year olds.

The current project recognises the importance of building secure relationships for *all* children to maximise their potential. The Project also recognises that where infant-parent relationships are derailed then having a competent workforce who can identify that an issue exists, competently assess the relationship in all its complexity, and collaboratively and skilfully intervene, may change trajectories for the infant, family and community. The focus of this project is to build both capability and capacity in the Western Australian I-ECMH workforce.

Western Australian Context

Over the last two decades epidemiological research has identified that a growing number of young children in Western Australia have clinically significant mental health problems. Nearly two decades ago a Western Australian study identified that one in four children aged 4-17 years had significant mental health concerns (Zubrick et al., 1995; Zubrick, Silburn, Burton, Blair, & Eve, 2000) and that for indigenous children the figures were considerably higher (Zubrick et al., 2005). These reports resulted in activity across sectors such as Justice, Education, Child Protection, and Health. Most epidemiological reports of this nature identify the prevalence of mental health disorders in the 4-11 years age bracket to be in the order of 16-20% with mental health issues continuing to rise as children develop, peaking at 25-40% between the ages of 18-24. In line with international research, these significant epidemiological Australian studies identified that precursors to mental health issues in children and young people were evident in the antenatal, perinatal and postnatal periods (Robinson et al., 2008; Zubrick et al., 1995). We know that many precursors such as disorganised attachments will have been observable and identifiable by trained clinicians in infancy (Lyons-Ruth, 2011; O'Connor, Bureau, McCartney, & Lyons-Ruth, 2011).

In the face of such evidence it is disturbing that there is a dearth of quality data on the prevalence of relational disorders in infancy and associated population parameters for Western Australia. There is no workforce data on how, where or how many infants and their families present for help or indeed any data on the gaps between prevalence of relational or mental health needs and interventions for this population. Australian Bureau of Statistics census data shows that over 32000 births were

registered in WA in 2011; 7, 500 of these were to rural families; 1,460 were to teenage mothers, 526 to teenage fathers; and 2506 were indigenous births. Based on the prevalence rates of mental health disorders in four-year-olds and these population statistics we might expect around 6000 children to have an identifiable mental health disorder by 2015 as they enter formal schooling. We have opportunity today to prevent future mental health illness by raising workforce competence state-wide to recognise and intervene early to halt the trajectory of mental illness.

Studies such as those cited provided impetus to a growing national movement to address such issues and in Western Australia political initiatives have been launched recently to address the mental health of infants and young children.

In 2006 the WA Parliament passed the Commissioner for Children and Young People Act and appointed Commissioner Michelle Scott. In 2010 a Mental Health Commission was established to lead reforms of the mental health system throughout WA headed by a Commissioner responsible to the Minister for Mental Health. Mr Eddie Bartnik was appointed to lead this and within his first term in office announced a mental health strategy to take WA to the year 2020.

In "*Mental Health 2020*", the Mental Health Commission recognised perinatal, infants and children as a population with specific needs (Mental Health Commission, 2012). The Commission established the Infant Mental Health Planning Group in late 2010 to provide expert advice. Representatives were invited from Departments of Health, Communities and Child Protection and the Australian Association for Infant Mental Health West Australian Branch (AAIMHI WA).

Following the release of the Commission's strategic plan and foundation of the IMHPG, the Commission for Children and Young People (CCYP) completed an Inquiry into the mental health and wellbeing of children and young people in WA, 2011 (Commissioner for Children and Young People Western Australia, 2011).

The inquiry found that 'services to promote strong mental health among children and young people, to prevent problems and disorders from arising and to treat those who are in need in Western Australia are seriously inadequate' (pg. 2). A number of specific recommendations were made to improve outcomes for infants and children. Specifically, these recommendations included:

Recommendation 36: A comprehensive, specialist infant mental health service be developed that can provide early intervention and treatment services for very young children and their parents.

Recommendation 16: A comprehensive mental health workforce strategy be developed by the Mental Health Commission in collaboration with the Commonwealth Government. This strategy to include cultural competency training and specific planning for the recruitment, training and retention of Aboriginal mental health professionals.

Recommendation 28: Training be provided at university and TAFE as a part of relevant undergraduate and certificate courses (for example: for general practitioners, teachers, allied health professionals, youth workers and child care workers) to improve the understanding of the mental health needs of children and young people.

Further reviews of the health system have been undertaken that have identified recurring issues relating to services for young children and workforce sustainability (Stokes, 2012). With the

recommendation of the IMHPG, the Mental Health Commission has undertaken or participated in a number of strategic projects to investigate the best service options and workforce strategies for perinatal, infants, children and their families (see box titled MHC Strategic initiatives in IMH in WA).

The current project, Infant Mental Health Competency Based Training Framework, is aimed at further developing the knowledge base of the infant mental health workforce across the prevention/treatment spectrum. In conjunction with the other strategic projects listed that are currently underway or recently completed, the Competency Based Training Framework will provide a comprehensive plan for progressing the sector in a sustainable way.

MHC Strategic Initiatives in Infant Mental Health in WA

Infant Mental Health Scholarships

From 2011-2013, the Commission provided over $600,000 in infant mental health scholarships across disciplines throughout the State. The scholarships were enthusiastically received and funds were provided for the completion of a workforce scoping project with the aim of identifying sustainable strategies for an infant mental health workforce.

Case illustration

Mother and seven-month-old infant present to an occupational therapist with feeding issues, a delay in achieving milestones and overall low muscle tone. Over a number of sessions, the Occupational therapist is unable to address the concerns due to the infant's high level of distress and refusal to leave her mother's lap. The occupational therapist has completed some introductory training on IMH highlighting the importance of the parent-child relationships and developing awareness of the key social and emotional developmental milestones in infancy. She is concerned that the infant's reluctance to engage in activities with her in the therapeutic sessions is related to emotional difficulties and perhaps a struggle in the mother-infant relationship. The occupational therapist shares her concerns with the clinical psychologist on the team and with the mother's permission the clinical psychologist attends the next occupational therapy session.

Allied Health Professional became aware of Infant Mental Health approach to casework through a seminar series and this facilitated capacity to notice IMH issue.

Community Based Integrated Service Models

In 2012/13, the Commission funded two community based service integration projects in Swan and Cockburn to articulate and demonstrate an integrated service model to address the mental health needs of children in the early years, as well as their families and carers.

Since 2012, the Swan project has completed extensive local service scoping and community consultation. The project officer has brought together key people across child development, primary care and mental health (infant and adult) who are highly committed to improving perinatal and infant mental health services and support in the area and a new local perinatal and infant network has been established. A Community Assessment: Gaps, Recommendations and Strategies exercise has been completed which documents the work to be undertaken in Phase 2 to embed improved and integrated perinatal and infant mental health practices within agencies in the Swan area in a sustainable way.

The Cockburn project has produced a preliminary report "Integrating services to support the mental health of infants and young children: developing the concepts" (WACOSS, 2013) based on an extensive literature review. A second report is being prepared following extensive consultations with the local service sector to consider practical implementation of the model.

Perinatal and Infant Model of Care

Lead by the Women's and Newborn Health Network and the WA Perinatal Mental Health Unit, Women and Newborn Health Service, a reference group was established to develop a model of care with representation from over 25 government, non-government, and private practice based health professionals. The model of care aims to define evidence based best practice and service delivery across the perinatal and infant continuum of care from prevention to treatment and management in ways that are respectful to families' knowledge of their babies and children.

National Perinatal Depression Initiative (NPDI) Clinical Nurse Specialists

In 2011, 5 metropolitan and 4 rural Clinical Nurse Specialists were employed across the state to improve the patient/ client journey for women with postnatal depression, reduce service barriers, and encourage better communication pathways between service providers. The service model focused on integrating services, enhancing relationships and providing support and training to clinicians. The service was evaluated at 18 and 36 months and found to have many positive outcomes for service to women with PND and their families. This service no longer exists.

COMPETENCY FRAMEWORKS

This section of the report details the method of investigation into competency frameworks for the I-ECMH workforce. A summary of the literature review on I-ECMH competency frameworks provides background for findings from the international and national consultation process, followed by a report of consultations within Western Australia. This section of the report closes with conclusions and recommendations.

Method of Investigation

The Project team searched library data bases and sourced established competencies from experts in the field both within Australia and overseas to review the available literature on I-ECMH competencies. In accordance with specific requirements of The Project the team included those of the NSW competency Framework, Wisconsin initiative for Infant Mental Health and Michigan Association for Infant Mental health (MI-AIMH).

The Michigan Competency Guidelines and Endorsement Framework were specifically identified by the IMHPG as a framework of interest that was to be thoroughly assessed. Telephone and Skype interviews were conducted with I-ECMH policy makers and practitioners in three The USA States: New Mexico, Connecticut and Michigan all of which were in positions to comment upon The Michigan Framework.

Telephone and Skype and email were used to interview academics, policy makers and practitioners in a number of Australian States.

A list of stakeholders and potential participants was compiled from recommendations from the MHC Infant Mental Health Planning Group (IMHPG). Over 60 interviews were conducted with individual or small groups of practitioners from all disciplines and levels of service, managers, trainers, academics, policy officers, administrators between March and September 2013. See Appendix A for the list of stakeholder groups represented.

The following questions were asked:

1. When you think about your professional development and training do you have a set of competencies in mind? Do you operate from a set of competencies?
2. What do you understand to be core principles and skills when working in the field of I-ECMH?
3. Would a set of competencies in I-ECMH be useful?
4. How would a set of I-ECMH competencies complement your decision making about training?

Interviews and questionnaires were then analysed for themes and presented as a summary of perspectives from those responsible for service delivery and training across levels of service delivery (promotion, prevention and intervention), and of practitioners across disciplines.

Findings on Competency Frameworks

Summary of literature review on I-ECMH Competency Frameworks

The literature review details I-ECMH competency based frameworks in the USA, Europe, Australia and New Zealand. This section will briefly outline the competencies found in each of these countries before giving an overview of the Michigan Framework. Further details are to be found in the full literature review.

In the USA there is growing momentum to develop and define descriptors that link with competence in the broad based interdisciplinary field of I-ECMH (Johnston, Steier, & Scott-Heller, 2013). In 2008 there were six different competency systems developed in the following states, Michigan, California, Vermont, Florida, Indiana and Connecticut. Currently only three of these remain since 17 states including Wisconsin have adopted the *Michigan Association for Infant Mental Health, (MI-AIMH) Competency Guidelines and Endorsement for culturally sensitive, relationship-focused practice promoting infant mental health®*. Details of the three other competency systems are as follows:

1. California maintains a Competency Guidelines and Endorsement process that is comprehensive with detailed competency areas and behavioural descriptors (California AIMH, 2003). This system is more limited than the MI-AIMH set in that it only covers professionals in the field who have upwards of a Bachelor degree qualification and the endorsement requirements provide limited flexibility in how training is acquired.
2. Vermont has recently produced a credentialing system that has been under development for four years (Vermont Northern Lights Career Development Center, 2013). This system has four levels similar to those of The MI-AIMH Framework, however, it does not include reflective practice and to date only has credentialing for practitioners at level two.
3. Florida developed a tri-level set of competencies for I-ECMH from competencies identified by the field to be significant (Quay, Hogan, & Donohue, 2009). The competencies are not accompanied by any behavioural descriptors and are not used universally in the state of Florida with one large agency having purchased the MI-AIMH competency and endorsement process.

In the United Kingdom and Europe there are no comprehensive competency frameworks specific to I-ECMH. Whilst there exist some well-established training programs in the UK these have been developed from a small set of core competencies. Currently the newly amalgamated International Training School In the Early Years (ITSIEY, 2013) is working toward further developing the competencies. The United Kingdom has developed a competence framework for Child and Adolescent Mental Health Services. This is a competency framework specific to practitioners working within Child and Adolescent Mental Health Services and hence, is limited in its applicability for the I-ECMH workforce, as it does not cover all levels of service, has minimal reference to infancy, and does not support a relational approach or reflective practice.

In New Zealand the Real Skills plus CAMHS Competency Framework (Real Skills Plus CAMHS Training Compendium, 2011) offers a set of competencies in IMH specifically designed for clinicians working within a CAMHS setting. The competencies reflect many of the principles and practices of I-ECMH

and include relationship based assessment and intervention, use of the DC: 0-3R, understanding of attachment principles and using therapeutic relationship as the basis of intervention. This framework also highlights the importance of working in partnership and collaboration with other sectors such as education, maternal services and social services (Child Protection). It does not address the needs of the broader I-ECMH workforce and nor are they as comprehensive as The MI-AIMH Framework. All the same, the New Zealand model complements that of I-ECMH well particularly with their emphasis on building relationships with a broad range of agencies.

In Australia, a number of important practice standards exist that have relevance to the I-ECMH workforce. Those examined in detail in the literature review include: (1) The National Practice Standards for the Mental Health Workforce, (2) NSW CAMHS Competency Framework and (3) Early Years Learning Framework and Classroom Strategy.

- The National Practice Standards for the Mental Health Workforce (Australian Government, 2002) include 12 standards to be used across the lifespan from infancy to old age for five professional groups: Mental Health Nursing, Occupational Therapy, Psychiatry , Psychology and Social Work. Standard five focuses on promotion and prevention strategies for the mental health workforce and includes some limited references to the importance of working with children as a vulnerable group. In keeping with I-ECMH principles these standards have an overarching framework that includes supporting the interdisciplinary nature of the work and consideration of culture.
- NSW Child and Adolescent Mental Health Services (CAMHS) Competency Framework (NSW Health, 2011) identifies an Infant and Early Childhood (0–4 yrs) cohort, similar to the Real Skills Plus CAMHS New Zealand Model. There is, however, no dedicated skill set identified for working with infants and young children in the 12 identified competency areas. The framework adopts a bio-psychosocial model of conceptualising mental health in children and adolescence and offers a comprehensive set of competencies, an implementation plan and accompanying tools to guide workforce development across CAMHS services in NSW. The target group of professionals is narrower than that in the field of I-ECMH, covering Psychiatry, Nursing, Social Work, Psychology and Occupational Therapy. The Framework provides a range of tools (Competency Review Tools) that can be used to measure whether competence in a particular area is been achieved. These tools are to be used in conjunction with structures such as reflective practice, clinical supervision, and professional development and performance appraisals. The various structures offer a way in which the competency framework can be embedded in everyday practice for clinicians, managers and supervisors. As with the New Zealand model the NW competency Framework complements that of I-ECMH well but not completely. Its lack of a dedicated skill set for those working with infants and young children limits its applicability across the I-ECMH workforce.
- Early Years Learning Framework (EYLF) and Classroom Strategy (Australian Government, 2009) was developed to 'extend and enrich children's learning from birth to five years and through the transition to school'. The EYLF contains five principles with associated classroom practice and outcomes. These are: secure, respectful and reciprocal

relationships; partnerships; high expectations and equity; respect for diversity; ongoing learning and reflective practice. The EYLF contains behavioural descriptors of the skills and knowledge required by staff in an educational setting to respond to the social and emotional needs of young children. It complements well the principles of I-ECMH and if used in conjunction with The MI-AIMH Framework, The Mi_AIMH competency guidelines may inform training and program development in I-ECMH for early childhood educators.

Michigan Association for Infant Mental Health, (MI-AIMH) Competency Guidelines and Endorsement for culturally sensitive, relationship-focused practice promoting infant mental health®(2002a, 2002b).

The MI-AIMH Framework is the most widely documented and reviewed set of competencies and endorsement framework for credentialing professionals working in the I-ECMH field. It is grounded in Michigan's long history of providing a range of infant mental health services to infants, toddlers and their families and offering support to practitioners working in the field. After taking six years to develop both The MI-AIMH Competency Guidelines and Endorsement Framework is now used in 17 states across The United States of The USA with international collaborations in Ireland and Japan in progress. It is a requirement of purchase of the Michigan Framework that the buyer be affiliated with The World Association for Infant Mental Health (WAIMH), since the Michigan founders of the Framework found that it is typically WAIMH affiliates that have the social emotional wellbeing of infants as their core business, irrespective of other demands of the times.

The competencies include detailed behavioural descriptors demonstrating these competencies across a four level system (Weatherston, Kaplan-Estrin, & Goldberg, 2009). The four level system includes:

- **Level I: Infant Family Associate**

Practitioners who provide universal services fall within this category and include early learning childhood educators (certificates 3 or 4), home visitors, family day care providers, play group facilitators, teacher assistants and parenting educators.

- **Level II: Infant Family Specialist**

Practitioners need to have a minimum of a Bachelor's degree and provide universal, promotion, prevention and/or intervention services and include but not limited to Social Worker, Physiotherapist, Speech and Language Therapist, Nurses, Early Childhood Educators, General Practitioners and Occupational Therapists.

- **Level III: Infant Mental Health Specialist**

Practitioners are required to have a minimum of a Master's Degree or Equivalent and include but not limited to mental health clinicians, clinical nurse practitioners, early intervention specialists, clinical and counselling psychologists and psychiatrists.

- **Level IV: Infant Mental Health Mentor (Clinical, Policy, or Research/Faculty)**

Practitioners are required to have a minimum of a Master's Degree and include clinical supervisors, researchers, academic faculty members and policy specialists.

The four levels include the same set of competency areas with 'increased complex behavioural and/or skills at each of the four levels'. Accompanying each level of competency is an 'impact map' which describes infant mental health service goals, objectives, responsibilities and competencies'(Weatherston et al., 2009, p.652).

The MI-AIMH Endorsement Framework was developed in conjunction with the Competency Guidelines in order to satisfy both the demand for accountability in the workplace and in response to the growing need for develop a pathway for building workforce capacity in the field of I-ECMH. The endorsement process requires ongoing reflective practice, which serves to maintain the competencies.

The MI-AIMH Endorsement Framework includes four levels, each requiring acquisition of knowledge and skills pertaining to the I-ECMH field, clinical experience in the field, in service training experiences and reflective supervision or consultation experiences. Practitioners applying for Endorsement are required to provide a signed I-ECMH code of ethics, provide reference ratings (linked to competencies and practice guidelines) from teachers, employers, supervisors who have provided reflective supervision or consultation; and at Level 3 and 4, successfully complete a 3 hour written exam (Weatherston, Moss, & Harris, 2006, p.6). Progress towards earning The MI-AIMH Endorsement provides a professional development plan for those working in the I-ECMH field.

The MI-AIMH Framework addresses the following workforce needs:

1. Direction for building a knowledgeable, skilful and reflective workforce that is grounded in theory and best practice guidelines;
2. A framework for developing local systematic training in I-ECMH, through alignment of training with the competencies in I-ECMH;
3. A framework for maintaining increased competency in the I-ECMH workforce;
4. A model for workforce development to promote I-ECMH which can be delivered across services and disciplines at a universal, promotion and prevention level;
5. A foundation for the establishment of recognised qualifications for I-ECMH practitioners;
6. A developmental pathway for professionals across disciplines to integrate knowledge, skills and practice within a reflective practice model;
7. Quality assurance for consumers, and
8. It opens the door for those working at a policy and research levels to obtain knowledge, skills and expertise in I-ECMH within a reflective practice framework.

Identified outcomes for those states in The USA who have implemented the MI-AIMH Framework include:

1. Influence on the development of services that promote social and emotional well-being; relationship based practice, and I-ECMH;
2. Creation of workforce positions for 'Early Childhood Mental Health Practitioners';

3. Development of reflective supervision and consultation groups in mental health and non-mental health settings to support reflective practice;
4. Shaping of pre-service, in-service, and professional development delivery for the workforce. Development of dedicated interdisciplinary postgraduate programs of study in I-ECMH. For example, Wisconsin established a post graduate Infant, Early Childhood and Family Mental Health Certificate Program at the University of Wisconsin (2010), that is aligned with the MI-AIMH Competency Guidelines;
5. Career incentives for those who achieve endorsement;
6. Increased numbers of endorsed practitioners in the workforce, for example, Michigan have 530 practitioners who are endorsed as of December 2012 with 283 working towards endorsement;
7. Across the state of Michigan, universities are cross-walking the competencies with existing curricula in order to streamline application for endorsement after graduation (Michigan Association of Infant Mental Health, 2012; Zero to Three, 2013).

To illustrate how the MI-AIMH Framework fits the West Australian workforce a profile of the WA workforce according to the MI-AIMH levels of competency is detailed in Table 1.

International View of I-ECMH Competency Frameworks

1. The *Michigan Association for Infant Mental Health (MI-AIMH) Competencies and Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health®* are the gold standard[1].
2. Those interviewed in New Mexico and Connecticut reported positive experiences and gave unconditional references for the MI-AIMH framework. They also reported the benefits of participation in the monthly support conference calls with the "League of States" (Michigan Association of Infant Mental Health, 2012) that have purchased The MI-AIMH Framework.
3. In Connecticut, as in Michigan and New Mexico once the competencies were established, training in I-ECMH began to develop in a more coherent fashion and more intersectoral collaborations around I-ECMH were initiated. Both Connecticut and New Mexico recommended that endorsement follow purchase of the competencies in a measured and incremental fashion.
4. In Connecticut, a list serve is used to keep the growing list of stakeholders informed of I-ECMH issues, developments and events. Interestingly, the upcoming AAIMHI/ARACY conference advertised through WAIMH had found its way to the Connecticut list serve.

[1] The *Michigan Association for Infant Mental Health, (MI-AIMH) Competency Guidelines and Endorsement for culturally sensitive, relationship-focused practice promoting infant mental health®*, will be referred to as "The MI-AIMH Framework" for the remainder of this document. Where specific reference is made to the competencies they will be abbreviated to The MI-AIMH Competency Guidelines and where it is Endorsement that is referred to it will be known as The MI-AIMH Endorsement Framework.

5. In New Mexico and other US States, it has proven essential that initiatives to establish I-ECMH competencies are financially supported by the State government but "housed" outside of State government. The collective experience in the USA is that the WAIMH affiliate is constant in maintaining focus on IMH work force development even when various arms of state government might lose this focus/priority due to competing demands, changes in political priorities, etc. (personal communication New Mexico Association for Infant Mental Health-NMAIMH).

6. The World Association for Infant Mental Health (WAIMH) affiliate in many US states has restructured in order to better manage the training and endorsement demands of the field. For example, In New Mexico a NMAIMH strategic plan included hiring an Executive Director to support the endorsement coordinator and part time administrative assistant. Recommendations from this affiliate are to have suitable infrastructure in place prior to rolling out the endorsement process since "*the NMAIMH has, from the beginning had some level of government funding to support the use of the competencies and the endorsement process, there have been disruptions and decreases in funding for staffing the process, which cannot run effectively on all volunteer time. This is a very detailed, comprehensive process that has to be carefully managed and implemented carefully and consistently or it loses credibility*" (NMAIMH communication).

National View of I-ECMH Competency Frameworks

1. There is no I-ECMH competency based framework in existence in Australia that informs the training for the breadth of the workforce who work with infants, young children and their families.

2. Interviews with I-ECMH practitioners, academics and policy makers in The Australian Capital Territory, South Australia, Queensland, Victoria, New South Wales and Western Australia identified that the lack of an I-ECMH competency based framework is a current issue in all states of Australia. Building a competency based training framework was a topic of discussion in the 2011 National conference in Infant Mental Health and is a planned topic again in the combined ARACY/ AAIMHI conference to be held in Canberra in November 2013.

3. Those interviewed all expressed interest in the recommendations of this project as well as the nature of uptake of the recommendations and independently suggested that WA via this project has capacity to produce a blue print for an Australian process for building I-ECMH workforce capacity.

4. All the interstate interviewees were familiar with *Michigan Association for Infant Mental Health, (MI-AIMH) Competency Guidelines and Endorsement for culturally sensitive, relationship-focused practice promoting infant mental health®*. Two senior practitioner/ academics had been involved in discussions of competencies with world leaders in I-ECMH over a decade ago as Michigan begun formative processes to establish a set of competencies and endorsement process. Whilst no interviewee had intimate knowledge of the MI-AIMH Framework detail: All were very respectful of the collective knowledge and wisdom that

contributed to the Michigan Framework. They were also aware of the order of the costs involved, and were mostly aware of copyright issues.

Interview Data WA context with regards to I-ECMH competencies

1. Participants expressed enthusiasm for a set of competencies to inform workforce training about I-ECMH issues. For those responsible for training programs the idea of having a blue print to follow was a relief. Most trainers were aware of the importance of 'the early years' and make creditable attempts to notify staff of and plan for staff to attend training pertaining to work in the early years whenever it is offered. Participants, however, identified that they didn't have a map for building capacity in a systematic way for their workers. There was clearly expressed desire for guidelines and direction to assist the development of training programs.

"If staff had a competency matrix we could identify what skills they need"

Manager NGO

"Oh! It would such a relief to have a set of competencies so we knew what we should put into our training, instead of me having to work out what I think they should have"

Manager Training in a government organisation

2. Participants expressed concern that services for children and young families in Australia was becoming overly regulated and that another set of competencies may overload those in the field. For example, National initiatives introduced to improve focus on quality and consistency in early childhood education programs across the country as per The Early Years Learning Framework (EYLF) and the National Quality Framework whilst ideologically in keeping with sound I-ECMH practice have had strong regulatory components that have taken precedence over a more holistic approach. One of the core areas of the EYLF is 'Relationships with Children', however, several interviewees made the point that this area often falls into the background against competing pressures. At senior policy level the idea of competencies that would specifically focus the work force on building better relationships with children as per this core area was especially appealing.

I can see how the coordinators would benefit by some training that is informed by a coordinating competency framework – while they are coordinators they certainly need to be able to relate to the target community of pre-birth to 8 year olds – I can also see how the framework could inform a systematic approach to improving the quality of work with infants.

3. Several senior training and policy makers were keen to examine more closely how the competencies they were already required to deliver training for matched those suggested for I-ECMH. From the interviews, it appeared that the MI-AIMH competencies overlapped

Quote from a senior educator: "Literacy and numeracy have taken over in Australia. When will people understand if a child is secure and feels settled these will improve?"

significantly with those of most organisations in WA. This will require further investigation. A start has been made in this document in the full literature review further in this report.

4. Interviewees from all professional backgrounds, notably GP's, Nursing, Early Childhood Education, Paediatrics, identified that the competencies required for accreditation in specific professions did not adequately recognise the importance of the social and emotional relationships that are formed with infants and young children and that are likely to influence development over their lifetime and that these must be given explicit attention.
5. Individual practitioners in the main also expressed the desire for a set of competencies that had capacity to both direct their own professional development and contribute to career progression.

Nurse practitioner: "I want to up skill but I can't afford to do any more training that has no influence on my job prospects. I don't mind studying in my own time and looked in to Eastern States courses but that won't progress my career here."

Interview data with regard to an I-ECMH Endorsement Framework

All but one Western Australian participant recognised the essential nature of an endorsement process to sustain the building of workforce capacity. In keeping with The USA experience participants articulated a desire for endorsement to guide higher education and professional development in the I-ECMH field. Endorsement that is grounded in a competency framework will provide a vehicle for practitioners and stakeholder groups to plan training in an organised and coherent fashion that has clear and objective parameters.

It is important to acknowledge the tensions articulated by interviewees in regards to the endorsement process and how it would translate into practice. These include:

1. Request for clarity as to how an experienced clinician with an undergraduate tertiary qualification and no postgraduate qualification who has attended professional development seminars over the years is recognised within The MI-AIMH Framework.
2. Confusion as to whether The USA qualifications system mirrors the Australian context? For example, is a Bachelor's Degree in Australia equivalent to that in The USA? What are the prevalence rates for postgraduate qualifications in the two countries?
3. Experience that endorsement in competencies that are very specific can become unwieldy,
4. Curiosity as to the possible effects of endorsement upon employment.
5. Desire for transparency of administration of the endorsement process.
6. Concern as to cost to individuals of endorsement.

Conversations with those who have managed this process in the USA suggest that there may be unforeseen challenges if AAIMHI WA becomes in a position to take on this process since often *the IMH organisation may not have known what they didn't know about endorsement at the time so could not fully understand the infrastructure and sustainability needs related to endorsement* (NMAIMH). Information gathered by The Project team that pertains to the identified issues is summarised below:

1. Consultation with overseas organisations who have adopted the MI-AIMH Framework in their states as well as gathered from documented literature identified similar **workforce tensions** in the early stages. For example, New Mexico reported that "*it was touchy and uncomfortable initially as those advanced in their careers came slowly to realise the value of updating their qualifications…many updated, some chose to remain in the field but not apply for endorsement and ultimately the field came to accept that the short-term discomfort was worth the long term clarity*".

1.1 Flexibility in the endorsement process is possible in that a Master level practitioner who is endorsed at Level II can provide training and supervision to a Level I or II practitioner with a Bachelor Degree, although the endorsement would recommend that a Level III practitioner do this. There is a precedent for flexibility in reflective supervision where requirements can be met via Skype or teleconferencing and in groups of up to 6 persons. The endorsement also offers a framework in which practitioners can build their capacity without necessarily having to participate in the endorsement process.

2. With regards to **comparisons of prevalence and equivalence of postgraduate degrees** across the USA and Australia the following information provides a trend that suggests a degree of similarity between the countries.

2.1 A 2010 fact sheet from the Allied Health Professions Australia (AHPA) website states that "*The vast majority of allied health professionals have minimum of 4 years of university training. Many allied health professionals also have higher degrees at Masters and Doctorate* levels."
http://www.ahpa.com.au/Portals/0/2010%20Allied%20Health%20Fact%20Sheet.pdf

2.2 According to the 2006 US Census, 38.54 per cent of all US citizens over the age of 25 had obtained an Associate or Bachelor's degree. More than 59 per cent of Australians had obtained an Advanced Diploma or Bachelor's degree by 2006.
http://www.news.com.au/national-news/how-would-your-life-compare-australia-vs-us-where-it-counts/story-e6frfkvr-1226196606062)

2.3 In both the USA and Australia students complete 12 years of primary and secondary education before being eligible to enter a university undergraduate program. In both countries, a four year degree is called a Bachelor's degree. Two years post bachelor degree earns one a Master's degree and a PhD can take 3-6 years to complete. Both countries have accreditation processes undertaken by independent agencies. Semesters in both countries are typically 12 weeks in length. Both countries use systems of continual assessment and assign grades for courses and students in both countries complete degrees with a grade point average taken over all units throughout the degree program.

2.4 There is change in process at several universities in WA that bring them further in line with course content in the US where the first year of a course is of a generalist nature and serves as an introduction for a chosen major. In Australia, students previously have not completed general education requirements.

3. The MI-AIMH Competencies Guidelines are **worded in general terms** rather than in specific tick box style. See example in Appendix B.

4. The **effect of endorsement upon employment** is unknown in the Australian context. From the interviews conducted it seems that there has only been one position advertised across Australia specifically for an Infant Mental Health practitioner.

4.1 In Michigan where the endorsement process has been established over a decade upward movement through levels of endorsement attracts a salary bonus in organisations in that State. By the end of 2012, '530 practitioners across all levels, systems and programs had earned endorsement in Michigan, and 287 are working toward endorsement' (Zero to Three, 2013a, p. 9). In New Mexico, the competencies have been tied to a Federal Government Act (IDEA, Part C) and strategic plans that require endorsement in order to be eligible to bill for work with infants in the Home Visiting programs as well as in the Special Education for Infants and Toddlers service. "*The Training and Technical Assistance (T & TA) programs that are funded to support those programs are expected to integrate and support the IMH competencies as well as reflective supervision into their work. Many of the T & TA providers have earned endorsement* (personal communication New Mexico IMH)". Advice from this organisation was to build endorsement over a five-year process, in order to develop a shared language as a developmental early step and to build infrastructure to support such a commitment. They identified that it can take people many years to earn endorsement. The endorsement process was found to be protective since "*often people who claimed to have expertise in working with IMH actually had little experience in working with infants and babies but worked with 3-4 year olds and it took them a while to build up their competency since the service required is very different for babies*."

5. With respect to the **transparency of the endorsement process** this appears to be a non-issue for the states who have incorporated the MI-AIMH Framework. The support given by MI-AIMH is recognised to be such that the process of review, tests and procedures for decision making endorsement are well regulated, fair, equitable and transparent. These characteristics appear to be markers of the integrity of the MI-AIMH Framework.

6. **Costs to individuals** will depend in part upon the funding structure adopted by Western Australia for training costs associated with achieving competencies. For the endorsement itself, the exam at Level 3 and 4 costs US $250. Typically, in the USA, states that have adopted the MI-AIMH Endorsement Framework individuals have been financially supported for some but not all of the training.

Table 1 profiles the Western Australian workforce into four groups that are provisionally aligned to the MI-AIMH competency levels. These levels indicate a natural progression based on the type of professional qualification, the extent of reflective practice undertaken as well as the type of work the practitioner engages in. The levels are not based solely on profession or service provision instead they recognise a professional's I-ECMH learning, and work experiences. The four level system is inclusive of workforce capacity across promotion, prevention and intervention services. It provides a framework which encompasses service providers, policy makers and academic staff working in the I-

ECMH field. In Table 1 below service providers and professions may be represented across multiple levels depending on the nature of the I-ECMH work and extent of reflective practice undertaken.

Table 1. Representative Western Australian workforce profile as per The MI-AIMH Framework

Level 1 Service Providers	Level 2 Service Providers	Level 3 Service Providers	Level 4 Service Providers
Private Early Learning Centres	**Private** Early Learning Centres Private kindergartens GP's, Family Therapists, nurses, Psychotherapists, Paediatricians, Child Health Nurses	**Private** Early Learning Centre Private professionals e.g. GP's, Family Therapists, Allied Health Professionals Psychotherapists, Psychiatrists, Paediatricians Clinical Psychologists	**Clinical**
NGO Playgroup Australia, WACOSS, WANSLEA, Marr Mooditj, RUAH Community Services	**NGO** Ngala, Communicare Mercy Care Anglicare WANSLEA RUAH Community Services	**NGO** Ngala, Communicare Mercy Care Anglicare WANSLEA RUAH Community Services	**Policy**
Rural Private e.g. Amity Health Govt rural link (help line) Collaborative interagency projects	**Rural Workers** Private, NGO and Government	**Rural Workers** Private, NGO and Government	**Research**
Government Dept. Communities, Parent Child Centre staff, Mental Health workers, Community support workers	Government Health: Child Health Nurses; Allied Health Professionals; Adult Mental Health; CPFS: Case Worker, Best Beginnings ; Disabilities Services Commission DoE: Preschool Teachers; Parent Child Centre staff	**Government** Hospitals, MBU, Adult Mental Health Early Childhood Intervention Services such as CDS & CAMHS	

Conclusions

1. The workforce in Western Australia is poised to welcome and work with a credible set of competencies that will inform training in I-ECMH.

2. The most authoritative and comprehensive set of competency guidelines currently in existence is that of the *Michigan Association for Infant Mental Health (MI-AIMH) Competencies and Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health®*.

The MIAIMH Endorsement successfully addresses these important workforce issues in the identification of core competencies and criteria that professionals across disciplines must meet to promote social and emotional well-being or to treat mental health

3. The MI-AIMH Endorsement Framework successfully addresses important workforce issues including the sustainability and maintenance of competencies.
4. The idea of an I-ECMH endorsement process is new to WA and while most of the workforce cautiously embraced the concept some tensions exist.
5. The *Michigan Association for Infant Mental Health (MI-AIMH) Competencies and Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health®* are only available for purchase by an affiliate of WAIMH.

Recommendations for I-ECMH Competency Frameworks

1. Purchase of *The Michigan Association for Infant Mental (MI-AIMH) Competencies and Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health®* framework be financially supported by the State.
2. The MI-AIMH Competency Guidelines framework to be embraced as soon as is practically possible.
3. The MI-AIMH Endorsement Framework to be implemented in stages.

TRAINING MODELS IN I-ECMH

This section of the report describes the method of investigation into training models in I-ECMH followed by an examination of the literature on international and national training models in I-ECMH. A summary of the main themes obtained from the interview data in the consultation process with WA stakeholder groups is offered and conclusions and recommendations are presented.

Method of Investigation

The list of stakeholders and potential participants compiled in collaboration with the MHC Infant Mental Health planning group was used as a basis to begin interviews with local stakeholders. Over 70 interviews were conducted with individual or small groups of practitioners from all disciplines and levels of service, managers, trainers, academics, policy officers, administrators between March and September 2013.

In these interviews the following questions were asked of individuals:

1. What training in I-ECMH do you bring to your current role?
2. How has this training or lack of training impacted on the way you work with infants, toddlers and families?
3. What areas of training are important to you in your current role and how do you access training?

The following questions were asked of training officers:

1. What training in I-ECMH do you provide to your staff?
2. What training would you like to offer to your staff?
3. What restrictions are there for developing further I-ECMH training in your workplace?
4. Would it be useful to have a central body responsible for the coordination of training in I-ECMH?

Interviews and questionnaires were then analysed for themes and presented as a summary of perspectives from those responsible for service delivery and training across levels of service delivery (promotion, prevention and intervention), and of practitioners across disciplines.

The Project team interim report to the MHC Infant Mental Health Planning committee identified that The MI-AIMH Framework was the gold standard for the I-ECMH field. With this in mind, additional interviews were conducted with national providers of post graduate training in I-ECMH, and with I-ECMH experts in other Australian States.

In addition, The Project team conducted a search of data bases for literature pertaining to training models as they related to the MI-AIMH competencies.

Findings on Training Models in I-ECMH

The International Landscape for Training the I-ECMH workforce

A literature search of international training programs and models of delivery in Infant Mental Health identified a series of initiatives in the USA, Canada, UK and Europe. The majority of these initiatives were influenced by or in joint collaboration with the respective Associations for Infant Mental Health and many have university affiliations.

The World Association for Infant Mental Health (WAIMH)

WAIMH takes a clearinghouse approach to developing training in I-ECMH.

- WAIMH maintains an active website linking affiliate associations in Africa, Asia, Australia and Oceania, Europe, the Middle East, Canada, The USA, and South The USA with relevant ideas, questions, innovations and issues in the field of I-ECMH.
- WAIMH hosts an international biennial congress that attracts around 1000 participants where exchange of ideas, methods and debates on current issues are encouraged. Reflective Supervision and competency based models for training are currently topical on the international scene along with "The Rights of the infant".
- WAIMH publishes a peer reviewed bimonthly journal *Infant Mental Health Journal* that has a respected citation factor and is dedicated to interdisciplinary I-ECMH approaches, including diverse theoretical views, to the optimal development of infants and their families.

Briefly around the globe,

The United Kingdom

Up skilling of the I-ECMH workforce is a current topic across the UK. As in Australia, training in I-ECMH occurs in an adhoc fashion. See Table 9. Summary Table of UK Training models.

Examples include:

- AIMH UK is a source of expertise and provides advice to governments and organisations on I-ECMH issues. Its members have made training videos and vignettes for dissemination. Delivery of training primarily remains with the respective recognized agencies who buy in training or through individuals who access training independently.
- The 'Windscreen Training Model' of the National Health Service in the North West region (NHS North West, 2011) was developed for the Perinatal and Infant Mental Health (PIMH) workforce of that region. It emphasises joint cross professional training and cross-sector training with a focus on training for emerging and developing practices in order that new skills are recognised and accredited and to support cross-sector mobility. The comprehensive training package is presented within a mental health framework across universal, targeted and indicated trainings.
- The International Training School for Infancy and Early Years (ITSIEY) provides training at a more intensive level or levels 3 and 4 (The MI-AIMH Framework). This Training Framework

was established in 2012 and comprises collaborations with three established leaders in the field of I-ECMH: Anna Freud Center (UK), Yale University Child Study Center (USA) and Tavistock and Portman NHS Foundation Trust (UK)(ITSIEY, 2013). The ITSIEY courses are typically offered in modules so that health service workers can build upon their learning to gain a postgraduate certificate.

- In Scotland, a Pre-Birth to Three National Guidance and Multimedia Resource was created by an "Early Years Team" in collaboration with the Scottish Government and I-ECMH practitioners, universities, colleges and MHS Health Scotland. It is a five-hour DVD supported by case studies of 'practitioners at work' with links to websites and policy and research evidence. It is not all mental health focused (teaching and learning oriented parts) and includes information for parents and carers (Galloway, 2012).
- Ireland has an I-ECMH strategy that aims to support every child (with extra support for vulnerable populations) in order to build protective and resilience factors within population to create gradual reduction in number of children and families in crisis (Hosking, 2011). Correspondence with an international supervisor, along with international experts and colleagues in the field of IMH coupled with a review of the extensive evidenced based literature, enabled leaders of the North Cork IMH Project to devise the guiding principles required to develop and deliver an interdisciplinary Infant Mental Health Training Model (Maguire & Matacz, 2012).

Europe

The WHO Regional Office for Europe published a 10 year action plan for mental health reform in 2005 (World Health Organisation, 2005). This group included representation from WAIMH (Tuula Tamminen, President) and while not directly focused on infant or child mental health issues it has needs that are in line with those in WA to build workforce capacity, retain trained workers, include mental health in in the curricula of all health professionals, and to maintain competency. This document give examples from throughout Europe including:

- Innovative approaches to mapping the I-ECMH consumers in Germany and in Norway
- A national prevention strategy implemented in Sweden
- A multi-sectorial funding partnership between three sectors of society: "state, private and civil in Iceland that merged the top down and bottom-up approaches, with the policy aims of the top-down approach and the action –oriented bottom up perspective (pge 121)."
- Awareness of poor curricula for most professionals who train in child and adolescent mental health (Braddick, Carral, Jenkins, & Jané-Llopis, 2009).

Canada

Many I-ECMH initiatives in Canada occur through the Hospital for Sick children in Toronto and through the Hincks-Dellcrest Institute in collaboration with WAIMH affiliates.

- The Hincks-Dellcrest Institute was established in 1986 to improve the training of professionals involved in the mental health care of children, it exists alongside a clinic service. It offers a clinical infant mental health program that provides workshops, consultation and supervision services and certificate courses and provides training for professionals working with infants, young children and their families.
- Training for professionals and front line practitioners in infant mental health principles in Canada is in the main ad hoc, depending on staff expertise and hospital conditions, philosophy and politics.
- A coordinated approach to training is called for. This is developing in Quebec through partnerships with universities, professional organisations and field organisations that organize workshops, course and educational programs and congresses.

The USA

There is a wealth of literature on the growth of I-ECMH training in the USA that is beyond the scope of this paper to review. More details are given in the literature review section and much of this is taken from an informative paper titled "Lessons for Massachusetts from the National Landscape" (Bartlett, Waddoups, & Zimmerman, 2007). The main points include:

- Rapid growth in the number of training programs dedicated to I-ECMH;
- Today 18 States have competencies and training programs in existence;
- All states have had the support of either a philanthropic organisation, a supportive university or a committed non-government organisation as well as collaboration with government for training;
- Collaborations and multi-collaborations are the norm and frequently these are headed by academic institutions or between an academic institution and another entity such as a mental health clinic, hospital childcare program, IMH association or government agency;
- Challenges for those developing training programs include balancing breadth and depth as well as a prevention, promotion and intervention;
- Maintenance of training occurs through models of reflective practice.

The full literature review gives further details of three USA training models

1. Minnesota (Graham, Nagle, Wright, & Oser, 2012) where longitudinal university based research informed the population of the importance of I-ECMH for later development and resulted in increased awareness of the need to up skill the workforce. Local foundations and the early childhood community developed the Infant and Early Childhood Certificate program at the University of Minnesota in 2007. In addition, the university and other local partners lent resources to the Children's Mental Health Division to develop the clinical capacity to provide interventions to children under five years old and their families.
2. DIR Institute Certificate Program (DIRC) initiated by Serena Wieder and Stanley Greenspan to support the DIR model of Infant Mental Health (Wieder, 2005).

- The training program DIRC originated from a six-year longitudinal (NIMH) research based protocol for the DIR intervention. Research staff found they required intensive reflective supervision to be essential to sustain the staff and the program.
- DIRC began with case conferences at interdisciplinary meetings and annual conferences. In 1999 they invited interested senior clinicians to be trained and these people later became trainers.
- The issues DIRC faced are very similar to those in Western Australia today. Who to train? How to offer training when they were not a clinical service or an educational service and had only done seminars and conferences until that point; What sorts of numbers would they attract, locally, nationally and internationally; How to offer mentorship; How to determine levels of competence; how to use technology without lessening quality of clinical training? How to cater for distance and for those who had limited time due to work, how to make it self-paced? And how to leave room for expansion.

3. Zero To Three a "non-profit organisation that provides parents, professionals and policy makers the knowledge and know how to nurture early development" (Zero To Three, 2013b). Zero To Three offers:
   - Many free of charge on-line training modules, webinars for professionals working with maltreated infants, toddlers and their families in a range of settings.
   - Extensive variety of training for supervisors, trainers and for mental health clinicians.
   - A National Training Institute each year for experienced professionals in the field of I-ECMH.

One constant factor in the coordination of training services around the globe is the presence of an association that has the focus of I-ECMH as its priority. Organisations that have this role include The World Association for infant Mental Health and Affiliates and The Zero to Three organisation. Both organisations provide a clearinghouse of information as well as development and co-coordination of training. Common features of the international programs that deliver training in I-ECMH include:

1. A focus on developing coherent training that emphasise joint cross professional training and cross-sector training.
2. Collaborations with universities, colleges, government, I-ECMH practitioners, organisations and community based services to provide I-ECMH training in the curriculum of allied health professionals and educators; to provide continuing professional development and post graduate training.
3. Recognition of the importance of specific training for in I-ECMH principles including that of reflective practice across all levels of the workforce.
4. Training for professionals and front line practitioners in I-ECMH principles is in the main ad hoc with institutions in the UK, USA and Canada continually making calls for coordinated training.
5. The most coordinated systems of training exist in the USA where competency based trainings supported by philanthropy, universities or committed NGO's and government exist.

The National Training Landscape for Training the I-ECMH workforce

Currently no national training model for I-ECMH exists in Australia. The Australian Association for Infant Mental Health (AAIMHI) is the only body to coordinate training specifically for this purpose.

There are a number of national organisations which provide training that is attended by many who work in the I-ECMH field. Along with AAIMHI, these include the Australian Research Alliance for Children and Youth (ARACY), MARCÉ, Beyond Blue, Australian Childhood Foundation (ACF) and Triple P- Positive Parenting Program. Of these only AAIMHI has as its core business a relational approach to the social and emotional wellbeing of infants, young children and their families'.

NSW and Victoria have histories of formal training in perinatal and infant mental health. They are the only states in Australia and New Zealand to offer nationally accredited tertiary training for professionals from a range of disciplines in the specific field of perinatal and infant mental health. Training in these states is discussed in detail in the literature review alongside that in Queensland and South Australia since these are closest to or ahead of WA in terms of numbers of professionals in the I-ECMH field and associated resources.

Briefly in Australia,

- NSW's history of training in I-ECMH is built on a foundation of collaboration across adult and child psychiatry, psychotherapy, occupational therapy, speech pathology, social work and child psychology as well as child protection, social work, nursing, paediatrics and physiotherapy.
    - Professional development continues to be provided by the range of organisations listed above and local community agencies such as Karitane and St John of God (SJOG). There is no coordinated cross disciplinary training strategy for the I-ECMH field outside of the tertiary sector.

The NSW Institute of Psychiatry (IOP) offers a postgraduate degree program in perinatal and infant mental health that today is offered at both undergraduate and post graduate levels. Essential requirements for acceptance into this program include working in the I-ECMH field. These course are available to interstate students. A number of MHC/AAIMHI WA scholarships supported WA practitioners to access this training in 2012/13. See Table 10. NSW Postgraduate Degree Programs.

- Victoria has a number of distinctive training events in I-ECMH.
    - The Queen Elizabeth centre provides support for children aged 0-5, and hosts an annual conference that frequently includes I-ECMH as a focus.
    - The state has a very active branch of AAIMHI that have regular weekend training days and seminars.
    - The first Australian dedicated Postgraduate Degree program in Mental Health Science (Infant and Parent Mental Health) was developed from clinical teaching work of the Infant Mental Health Group at the Royal Children's Hospital and draws on the disciplines of psychiatry, developmental psychology and psychoanalysis for its theoretical basis. This course is available to interstate students. A number of

MHC/AAIMHI WA scholarships supported WA practitioners to access this training in 2011-13. See Table 11. Victoria Postgraduate Degree Programs.

- Queensland has a state funded Centre for Perinatal and Infant Mental Health (QCPIMH) that has responsibilities across four key areas: (1) Service Development and Implementation, (2) Workforce Development, (3) Mental Health Promotion and Prevention, and (4) Research and Evaluation. This centre is staffed by recognised experts in I-ECMH. The unit has produced 4 learning units that include one on I-ECMH and another on screening tools. Staff at this centre who were interviewed expressed considerable interest in the MI-AIMH Framework as a vehicle for developing training. See Table 12. Queensland I-ECMH training.
- South Australia has a very active AAIMHI affiliate branch that provides active training in the field of I-ECMH, providing regular seminars and frequently hosting overseas IMH clinicians to train in specific assessments and interventions and to run workshops. As with other Australian States there is no coordinated cross discipline or cross sector training in I-ECMH.
    - The South Australian Health Department through the Women and Children's Hospital differentiates between IMH and Perinatal Mental Health and offers a Certificate in Infant Mental Health as well as an innovative program for perinatal mental health that includes some material specific to I-ECMH in South Australia. See Table 13. South Australia Health Department Training.
- The West Australia Branch of AAIMHI has one of the largest memberships in the country with over 170 members. It plays an ongoing and active role in up skilling the workforce through a regular seminar series, professional development days, and through national and international links and conferences. It maintains representation to the National AAIMHI executive as well as to the international organisation WAIMH affiliates committee and encourages a large contingent of West Australians to attend the world congresses in Infant Mental Health. AAIMHI WA is also building capacity to teleconference training to the rural workforce. For a comprehensive list of training in I-ECMH that is delivered in Western Australia. See Table 2 and Table 3 for a description of recurrent and periodic training in I-ECMH that is available in WA as it aligns with the MI-AIMH Framework.

  There is a great deal of interest in the Australian states around a training model that is tied to competencies in I-ECMH and which is sustained by a cohesive reflective practice model. The postgraduate programs currently available in NSW and Victoria each have very differ flavours that reflects the history and culture of their states in I-ECMH. Those interviewed for this project indicated willingness to contribute to the development of post graduate training In I-ECMH in WA thus integrating Australian perspectives to the unique history, culture and challenges of WA.

Interview Data WA context with regards to I-ECMH Training

1. Current training in I-ECMH is sporadic and there exist few opportunities to consolidate the training that is offered. Participants specifically identified poor integration of skills into their practice due to: lack of time; lack of importance placed on continued professional development or training; and lack of career progression for any I-ECMH training undertaken.

   "There is a need for more formalised training in IMH and opportunities for consolidation of new skills… the challenge is ensuring clinicians have the confidence and ability to use the skills in their everyday practice once training is completed" (NGO Manager)

2. There is widespread dissatisfaction with the lack of I-ECMH content in tertiary training courses. In Western Australia, tertiary training at undergraduate level in the health sciences and related disciplines rarely includes any focus on the emotional and social development and well-being of infants, toddlers and young children, let alone interventions to support development where it has been derailed. A search of the units offered across all undergraduate degrees at one major WA tertiary institution that offers degrees in teaching, nursing, occupational therapy, speech pathology and psychology found only two units with the keyword 'child' and none with 'infants' or 'family'. The two units were in child development with very broad coverage such as, physical, social, emotional and cognitive development in children aged 0-12 years and 0-18 years. The tuition pattern was a one hour lecture and 2 hours tutorial for 12 weeks and a multiple choice exam as assessment of competency. Further searches at other universities show that in teacher education a few units explore the development of the child aged 0-4 years in the context of family, community and culture. One university partners with TAFE to make available to students a unit on working with infants and toddlers in which one component is titled "working in partnerships with families to care for the child."

3. There is a sense of indignation that no local postgraduate courses currently exist in I-ECMH. Those Western Australian practitioners who accessed Eastern States University courses reported making significant sacrifices to cover associated costs to attend the courses. Even those who received MHC/AAIMHI WA Scholarships reported significant costs associated with travel and leave.

4. Training in I-ECMH is virtually absent in certificate level courses in the TAFE system. The unit described above is a practical based unit that has minimal content on I-ECMH. Participants identified that in courses specifically designed for early childhood learning centre workers, such content is virtually absent. It is also absent from certificate courses designed to up skill workers in the indigenous workforce, such as Aboriginal Health workers. Several senior administrators and educators in these industries expressed willingness to include material relevant to I-ECMH in current courses, however, they also identified a tension due to how new units might fit into the packages where available course hours were already taken by established compulsory requirements.

   You write a course on that and we'll teach it .. It's vital for our people, for them to think about bringing up kids (Indigenous Educator).

5. There is misunderstanding of the nature of the field of mental health and of the training required in I-ECMH for practitioners who work with infants, young children and their families and this is contributing to tension in the field. Examples include:

    a. There was misunderstanding of the breadth and diversity of the field and of who comprises the workforce in I-ECMH. For example, those who provide intervention services frequently omitted those who work in promotion and prevention services from their awareness of the I-ECMH workforce. Similarly, some clinicians who provide services to mothers and who do not include parent-child relationship work in their practice described themselves as an I-ECMH practitioner. Policy makers in stakeholder groups who actively work to improve parent child relationships in promotion and prevention articulated how they are not perceived as serious players in the I-ECMH workforce by some who provide tertiary services. Tension also exists around who does and does not provide a tertiary service in the I-ECMH field.

    b. At Level 1, some service providers at the universal level had not considered the different philosophies and practices that underpin parenting programs. For example, some programs are structured, packaged and directive and primarily focussed on intervening with parents around the behaviour of their children in the context of relationships, and others focus primarily on the nature of the parent-child relationship and are less structured. All have a place in the context of parent training and I-ECMH trained practitioners are expected to develop thoughtful understanding of the applicability of the different programs.

    c. At Level 2 and 3 some interviewees understood psycho-educational parent groups and parent focussed programs to be all that was required in training for infant and young childhood mental health. Others considered that participating in a placement in an agency where the work focussed on children equated to training in I-ECMH.

6. Calibration of competency across the field is ad hoc. Some interviewees who clearly articulated sound principles of I-ECMH in the interviews described themselves as having modest levels of knowledge and skill, whilst others assumed a degree of confidence that was not evident in their conversations or in their work history. Observations of this nature are in keeping with the Dunning-Kruger research on the miscalibration of competency and offer further evidence of the need for an endorsement process and quality training to up skill the field across all disciplines and levels of service (Ehrlinger, Johnson, Banner, Dunning, & Kruger, 2008). Examples include:

    a. At levels 2 and 3 several interviews with highly trained professionals were dominated by a parent or perinatal focus and frequently these interviewees were confused when asked how they would include the infant in their work. This was observed in interviews with some who claimed to understand the concept of Infant Mental Health.

    b. At levels 1 and 2 sophisticated understanding of the nature of the importance of infant-parent relationships and also of reflective practice was articulated by some interviewees who experienced themselves as under-skilled in IMH practice.

7. Most agencies and organisations have purpose designed pre service and in-service training models. One such example is the "People Development Framework "from the Department for Child Protection and Family Support (CPFS). This framework offers a range of learning modalities and clearly outlines a pathway of learning for practitioners in the agency and stakeholder groups. Employees in Residential Care and Responsible Parenting Services receive programs such as Impact of Trauma, Therapeutic Crisis Intervention, Introduction to children in care, Introduction to responsible parenting services and Introduction to child development. Their model includes compulsory components as well as modules for up skilling and upgrading. Few of these agency-based models of training included I-ECMH content although many training officers expressed willingness to include such material as it was explained to them via the interview process.

8. Some agencies and organisations have implemented supervision as part of their training framework. Supervision models include team conferencing, clinical, administrative, case management and appreciative enquiry. One NGO has employed a project officer to research models of supervision with a view to implementing a comprehensive supervision framework in the agency. Other agencies reported that they were using a reflective practice model, however, further discussion and clarification identified this was more likely to be classified as a clinical model since focus was on diagnostic and case discussion rather than parallel process and relationship based learning. Across professions there was varying acceptance of supervision as a core component of training required in I-ECMH. For example, 'corridor conversation' was considered supervision by one senior professional.

'Structured reflective practice supervision can get bogged down in requirements and there is less flexibility ….. for some it is more instinctual and there is no need for reflective practice' quote by interviewee at senior level

9. A number of government departments, organisations and NGO's have offered in-house specialist training in I-ECMH for their workers on an ad hoc basis. Recent examples include:

    a. Psychologists in the Department for CPFS have had many professional development trainings on clinical interventions with high risk families with infants and young children. The Department for CPFS has also funded overseas clinicians such as Daniel Hughes to make return visits for the purpose of training staff in a model of clinical intervention that fits with I-ECMH principles.

    b. The Child and Adolescent Health Service (CAHS) in the Department of Health took the initiative to provide professional development that was specifically focussed on IMH over three days in 2012. Topics included introduction to attachment theory, working with sick infants and their families and was opened to the workforce in CAMHS and CDS and delivered by educators from the University of Melbourne postgraduate courses. This training stimulated considerable discussion around workforce ownership and delivery of specialist interventions in the I-ECMH field in WA.

c. The SJOG team at the Raphael centre have developed professional collaborations with the co-originators of the Circle of Security from Spokane in The USA and have introduced this model of intensive intervention to the workforce at SJOG as well as to the wider workforce through a series of 1, 2, 4, and 10 day professional development trainings over the past decade. Tensions around this for the workforce include cost and sustainability.

d. AAIMHI WA provided a well-attended three days of training in I-ECMH psychotherapy using the London based Tavistock model conducted by Rikki and Louise Emmanuel in 2012. This professional development focussed specifically on psychotherapeutic interventions with children traumatized in infancy as well as on the Tavistock model of psychotherapeutic intervention with the under-fives. Ongoing supervision and sustainability across workplaces was a topic discussed at this training event.

I-ECMH Training that has been delivered in WA

Practitioners in Western Australia have accessed a range of trainings in I-ECMH some of which have been financially supported by MHC funding. Below is a summary of various recurring trainings practitioners have attended in recent times in Western Australia. The lists in Table 2 and in Table 3

of recurring and of periodic trainings are not recommendations but simply a list of trainings identified through project interviews. To The Project team it highlighted the small range available some of which is expensive and relies on overseas expertise.

Table 2. Recurrent Training Specific to I-ECMH in Western Australia as per The MI-AIMH Framework

Level 1	Level 2	Level 3	Level 4
Family Partnership Training (2 days)	Family Partnership Training (2 days*)	Family Partnership Training	Family Partnership Training
	Sensitive Parenting	Sensitive Parenting	Sensitive Parenting
Edinburgh Postnatal Depression Scale	Edinburgh Postnatal Depression Scale	Edinburgh Postnatal Depression Scale	Edinburgh Postnatal Depression Scale
Working with Aboriginals in Perinatal Period	Working with Aboriginals in Perinatal Period	Working with Aboriginals in Perinatal Period	Working with Aboriginals in Perinatal Period
1 and 2 day COS	1, 2, and 10 day COS	10 day COS	1, 2, and 10 day COS
	AAIMHI WA Workshops**	AAIMHI WA Workshops**	AAIMHI WA Workshops**
	Australian Childhood Foundation (ACF)**	Australian Childhood Foundation (ACF)**	Australian Childhood Foundation (ACF)**
	NSW IOP Post Grad Studies in IMH	NSW IOP Post Grad Studies in IMH	NSW IOP Post Grad Studies in IMH
	Uni of Melbourne Post Grad Studies in IMH	Uni of Melbourne Post Grad Studies in IMH	Uni of Melbourne Post Grad Studies in IMH
	National Conferences (AIMHI, Marcé, QEII)	National Conferences (AAIMHI, Marcé, QEII)	National Conferences (AaIMHI, Marcé, QEII)
Beyond Blue Training Matrix	Beyond Blue Training Matrix	Beyond Blue Training Matrix	Beyond Blue Training Matrix
WAPMHU EPDS	WAPMHU EPDS	WAPMHU EPDS	WAPMHU EPDS
COPMI e learning	COPMI e learning		
Ngala Building Brains: Engaging and working with fathers; Understanding and managing children's sleep	Ngala: Building Brains: Engaging and working with fathers; Understanding and managing children's sleep		

*quarterly follow up with reflective practice review sessions

**provides training opportunities annually covering a range of topics relevant to IMH and recently addressing Reflective Practice in the field

Some structured parenting programs are offered as core training by Department of Communities. These typically provide active skills training based on social learning models with the focus on parental and child behaviours.

Table 3. Periodic Training in I-ECMH that has occurred in Western Australia as per The MI-AIMH Framework

Level 1	Level 2	Level 3	Level 4
	Infant Observation	Infant Observation	Infant Observation
	COS 4 day DVD Training**	COS 4 day DVD Training**	COS 4 day DVD Training**
Commissioner for Children Thinker in Residence Program (Shanker)	Commissioner for Children Thinker in Residence Program (Shanker)	Commissioner for Children Thinker in Residence Program (Shanker)	Commissioner for Children Thinker in Residence Program (Shanker)
		Infant Strange Situation	
		Parent Development Interview / AMBIANCE training	
Uniting Care West Attach: PUP(parents under pressure)		Infant related modules within sectors (CAMHS, DCFS, CDS,)	
RUAH : Working with a family under pressure series of three one day events, funded by MHC so free across sectors Perspectives @ Ruah	RUAH : Working with a family under pressure series of three one day events, funded by MHC so free across sectors Perspectives @ Ruah	Infant related modules within NGO's (Anglicare, Ngala, SJOG)	
COPMI: e- learning packages Family Focus Keeping Families and children in Mind			

Close examination of both periodic and recurrent training in I-ECMH in WA identifies a variable and idiosyncratic pattern of available trainings depending on current trends, some of which is not economically sustainable. The need for an integrated and consistent model of training was identified and the majority recognised the AAIMHI WA Seminars as the one training organisation that provided recurring opportunities for up skilling in the field.

Case Illustration (continued)

The clinical psychologist is an experienced IMH practitioner and participates in a continuous interdisciplinary reflective practice training group with the occupational therapist. In the joint session, the clinical psychologist observes a marked struggle in the relationship between mother and infant, characterised by out of synch parent-infant interactional patterns and high levels of distress. She begins to integrate her relationship based IMH training with what she has learned from the occupational therapy input in the reflective practice sessions. Later as part of their reflective practice the clinical psychologist shares her thoughts with the occupational therapist "It was difficult to observe the constant crying and high level of distress in the infant. Did you notice that the infant became more distress when her mother tried to place her on the floor? During these attempts at separation, I observed that the mother was unable to establish eye contact with her daughter as she placing her on the floor and in response the infant's distress was heightened. What was it like for you observing the infant-parent interactions during this joint session?

The occupational therapist shares her experiences of the session with the clinical psychologist and reflects that she found these sessions particularly challenging as she felt 'at a loss of how to manage the infant's constant crying'. In the session, she noticed how the clinical psychologist was able to give words to the infant's distress and this seemed to help in calming both the mother and infant. The occupational therapist and clinical psychologist began to wonder about the mother's experience of her infant and why she found it difficult to soothe her infant in times of extreme upset. It also provided opportunity to think about the infant's clinical presentation and explore more deeply the physical delays in development and how these are connected to struggles in the developing infant-parent relationship.

An interdisciplinary reflective practice group and attendance at IMH training events facilitated consultation between professionals from different disciplines.

Conclusions

1. There is a worldwide movement to establish systematic training In I-ECMH for the workforce for pre-service, in-service and professional development as well as postgraduate training.
2. The most coordinated systems of training exist in the USA where competency based trainings supported by philanthropy, universities or committed NGO's and government exist.
3. Best practice models are those that emphasise joint cross professional training and cross-sector training and where maintenance of training is supported by reflective practice.
4. One constant factor in the coordination of training services around the globe is the presence of one Association that has the focus of I-ECMH as its priority

5. Formal training in I-ECMH exist in two Australian states, namely Victoria and NSW. As I-ECMH education and training has developed to meet practice demands in these states then advertised positions in I-ECMH related fields have developed to specify "infant mental health training" as an advantage or a desirable criteria.

In Western Australia:

6. Gaps exist in knowledge and skills of I-ECMH in promotion, prevention, intervention and policy and in reflective practice as well as tensions around who constitute the I-ECMH workforce. There are a multitude of training events available on an ad hoc basis to the WA workforce with some notable gaps for all disciplines (Education, Nursing, Occupational Therapy , Medical Officers and General Practitioners, Paediatrics, Physiotherapy, Psychiatry, Psychology, Social Work, Speech Therapy) and practitioners who work with infants and young children and their families (Case Workers, Parent Educators, Policy Makers, Playgroup Facilitators, Early Childhood Educators, Home Visitors, Therapeutic Skill Educators etc).
7. Training is identified to be an essential vehicle for constructive collaboration between metropolitan and rural workers; between disciplines and between stakeholder groups; and it is desired by the workforce.
8. There is diverse understanding of the nature of I-ECMH training and practice at all levels of service provision.
9. There is dissatisfaction with the lack of follow up to training events. New knowledge and skills are often not competently integrated into practice as a result.
10. Current local education and training programs do not reflect best practice in delivery of service to infants and children. These are mostly discipline specific and neglect the interprofessional collaboration required for working in the field of I-ECMH.
11. There is no formal tertiary level training in I-ECMH involving either TAFE or university collaboration in Western Australia and there is an identified need for coordinated training at all levels of service delivery.

Recommendations for Training in I-ECMH

1. The state to support development of a structure for training delivery and supervision that aligns with The MI-AIMH Framework
2. Training for specialist I-ECMH intervention to occur concurrently with building I-ECMH workforce capacity in promotion, prevention and policy.

A sustainable training framework of activities be developed. See Table 3 and Table 4. This to include:

- Development of university based interdisciplinary training modules in I-ECMH that are delivered locally.
- Introduction of I-ECMH principles into certificate level training courses

REFLECTIVE SUPERVISION IN I-ECMH

This section of the report details the method of investigation and includes a literature review on reflective supervision and reflective practice in I-ECMH. Findings from the consultation process with international and national experts in reflective supervision in I-ECMH are provided and interview data gathered from WA stakeholder groups is discussed.

Method of Investigation

A review of the available literature on reflective practice and reflective supervision in I-ECMH was conducted. Keeping in line with the finding that The MI-AIMH Framework is the gold standard for building workforce capacity in the I-ECMH field, the literature review and consultation process also focussed on understanding how The MI-AIMH Framework has supported building workforce capacity in reflective practice and the sustainability of these skills in the workforce.

The Project team reviewed the interview material gathered from Stakeholders in Western, Australia, national experts in the I-ECMH field and International practitioners and policy makers in the USA: New Mexico, Connecticut and Michigan.

The following questions about reflective practice were asked:

1. What sort of supervision do you participate in?
2. What is your understanding of reflective supervision?
3. Do you see reflective supervision as an important part of clinical work with infants, young children and their families and if so why?

Themes from interviews and questionnaires are presented below. Perspectives have been summarised from those responsible for service delivery and training as well as practitioners across all levels from of promotion, prevention and intervention, and from practitioners across disciplines.

Findings on Reflective Supervision in I-ECMH

A number of definitions of reflective supervision/practice are quoted in the literature review. Briefly, Reflective supervision is a way of supporting practitioners in their therapeutic work with infants, young children and their families, maintaining practitioner skills, and of ensuring a quality service is provided. The central premise is that development occurs within a relationship context. It provides the practitioner with 'the continual conceptualisation of what one is observing, doing and feeling' (Gilkerson & Ritzler, 2005, p.434). An important feature of reflective supervision is paying close attention to the parallel process that occurs between supervisor and supervisee, supervisee and family, child and family, service and practitioner or service and family.

Summary of Literature Review on Reflective Supervision in I-ECMH

An extensive literature review identifies reflective supervision as a core competency required for all professionals working in I-ECMH across all settings. Reflective supervision is consistently recognised as a core component of any training program in I-ECMH and an on-going requirement for sustainable I-ECMH practice.

There have been rapid advancements in reflective practice and reflective supervision across mental health and non-mental health settings in recent times. Reflective supervision models in practice are reviewed and examples from The USA, Ireland and Australia are provided.

The NSW post graduate training programs highlights how reflective supervision can be integrated into a training program, using a reflective practice relationship based framework to foster growth and development of IMH skills. Reflective supervision is a core component of the course over the two years of study including reflective supervision for infant observations in the first year followed by group reflective supervision in the second year.

Ireland has developed an interdisciplinary training model which includes a continuing reflective practice group following the completion of an intensive three day training program. There are now six reflective practice groups across the country and they have ensured sustainability of skills gained in the intensive training experience and on-going consolidation of skills and reflective capacity in I-ECMH.

Detailed attention is given to The MI-AIMH Framework. As an association it is internationally recognised as a leader in the field with a long history of writing about reflective practice, delivering training in reflective practice and reflective supervision and identifying reflective supervision as a core area of expertise in IMH. Below is a brief summary of components of The MI-AIMH Framework pertaining to reflective practice and reflective supervision.

a. MI-AIMH League of States have developed best practice guidelines for reflective supervision and continue exploring how to develop specific training to build reflective capacity and ways of sustaining reflective practice skills in everyday practice.

b. At level two, three and four of The MI-AIMH Framework it is a requirement to engage in a minimum number of hours of reflective supervision over a two year period.

c. MI-AIMH offers support in building workforce capacity in reflective practice to those states and organisations who adopt the *Michigan Association for Infant Mental Health, (MI-AIMH) Competency Guidelines and Endorsement for culturally sensitive, relationship-focused practice promoting infant mental health®*.

Finally, a review of Early Childhood Mental Health Consultation using an IMH is discussed. This is an important domain within I-ECMH and provides a framework in which reflective supervision is delivered in non-mental health settings such as childcare. This is an important model for thinking about how to infuse I-ECMH principles and skills into settings that focus on promotion and prevention. Furthermore, it highlights the strength of the *Michigan Association for Infant Mental Health, (MI-AIMH) Competency Guidelines and Endorsement for culturally sensitive, relationship-focused practice promoting infant mental health®* as a

model for building workforce capacity in reflective practice in non-mental health settings that play a significant role in prevention and early identification of social and emotional difficulties in infants, toddlers and young children.

International View

Extensive literature review identifies reflective supervision as a core competency required for all professionals working in I-ECMH across all settings. It is consistently recognised as a core component of any training program in I-ECMH and an on-going requirement for sustainable I-ECMH practice.

The *Michigan Association for Infant Mental Health (MI-AIMH) Competencies and Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health®* identifies reflective practice supervision and consultation as a core area of expertise in I-ECMH practice across four levels of endorsement. The competency based endorsement system is a way of building reflective capacity across all disciplines and levels of service.

The MI-AIMH League of States has developed best practice guidelines for reflective supervision and as a tool it can provide a guide for reflective supervision requirements across all four levels of endorsement. States that have adopted the *Michigan Association for Infant Mental Health (MI-AIMH) Competencies and Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health®* have developed reflective supervision experiences which were not available previously. Examples include providing groups for front line practitioners, groups for supervisors giving reflective supervision, offering live supervision opportunities for practitioners and using technology to provide reflective supervision experiences to those in remote areas.

Those interviewed in Connecticut reported a key milestone in building workforce capacity in I-ECMH was developing a number of reflective supervision groups. These groups are facilitated by the Connecticut AIMH and open to a range of practitioners across services and disciplines, continuing for at least one year and some groups continuing into their second year.

In Connecticut as well as a number of other states who have adopted The MI-AIMH Framework, reflective supervision groups have resulted in the strengthening of relationships across disciplines and sectors, increasing collaboration between sectors and integrating IMH principles into everyday practice.

A National View

1. There is no I-ECMH competency based framework that includes developing reflective capacities in existence in Australia that informs training and ways of sustaining skills for those who work with infants, young children and their families.
2. Reflective supervision is a core component of the two nationally accredited tertiary training programs in IMH offered in NSW (NSWIOP Degree programs) and Victoria (University of Melbourne Graduate Diploma).
3. Both national programs offer reflective supervision on site and externally for those students completing the course in a distance education mode. This mode of delivery enables a range

of professionals' access to reflective supervision and teaching including students from rural and country areas, different states and countries.

4. There is a dearth of research investigating the impact of receiving reflective supervision in a distance mode and how this mode of supervision impacts on areas such as quality of the supervision, facilitating group processes, and capacity to build relationships over mediums such as telephone and skype.
5. Reflective practice and reflective supervision are identified as important considerations in building workforce capacity in mental health and early education and are cited in the following national documents, The National Practice Standards for the Mental Health Workforce, The NSW CAMHS Competency Framework and The Early Years Learning Framework (EYLF). These national frameworks do not provide detailed competencies or behavioural descriptors pertaining to reflective practice in I-ECMH due to their specificity to mental health, child and adolescent mental health and early education.
6. Interviews with I-ECMH practitioners, academics and policy makers in The Australian Capital Territory, Canberra, South Australia, Queensland, Victoria and New South Wales identified a lack of understanding of reflective practice and limited use of reflective supervision for practitioners working in the I-ECMH field as a current issue in Australia. In response to this significant skill deficit in the Australian I-ECMH workforce the combined ARACY/ AAIMHI conference to be held in Canberra in November 2013 is providing a pre-conference workshop in reflective practice delivered by Dr Deborah Weatherston, Executive Director of MI-AIMH. She will also present a key note presentation outlining how The MI-AIMH Framework addresses building workforce capacity in reflective practice.
7. Those interviewed all agreed that reflective practice and reflective supervision needed to be an integral part of any I-ECMH training.
8. There was widespread support for a training framework which included reflective practice in trainings targeting practitioners working in promotion, prevention and intervention
9. There is awareness in Australia that reflective practice and reflective supervision are essential components of practitioners sustaining skills in the workplace. However, there are no national or state frameworks that guide how this can be carried out or any practice parameters to ensure supervisees are receiving reflective supervision that is of high quality.

Interview data WA context with regards to reflective practice and supervision

1. Participants' knowledge and experience of supervision is varied. When asked to describe their knowledge and application of models of supervision, practitioner's responses included administrative, case management and clinical models, and these were not always differentiated. Implementation into practice was limited and those engaging in supervision were mainly representative of practitioners providing therapeutic interventions in services such as Child and Adolescent Mental Health Services and Child Development Services and primarily in Psychology and Psychiatry disciplines. It became clear that primary and secondary service providers did not have a supervision structure for practitioners, however, some were beginning to think about supervision models and what that would look like in their services.

"Practitioner's own stuff has been getting into the decisions they have been making" (Senior Clinician).

"I need reflective practice to help me see patterns in a mother and her baby…. I would like supervision formally included in my workplace since I have only done it informally with colleagues" (Allied health professional).

2. There is limited understanding of reflective supervision. Only a few interviewees were able to provide a detailed, accurate description of what reflective supervision is and how it can be applied to the I-ECMH field. Participants often reported having a working knowledge of reflective practice but when asked to provide a description it did not represent an accurate understanding of reflective practice.

3. Participants are motivated and eager to learn more about reflective practice as a supervision model and how it applies to the I-ECMH field. It was universally acknowledged as a new concept in Western Australia. All practitioners and the majority of interviewees in managerial roles acknowledged the importance of reflective supervision in working with infants, young children and their families. Some but not all were aware of the large body of international literature documenting that reflective supervision as an essential component of I-ECMH practice across promotion, prevention and intervention. Participants were quick to describe many barriers to implementing reflective practice into their current work roles. Barriers included

Lack of support from management to engage in supervision within working hours, competing demands in the service and need to respond to day to day activities as a priority. On a number of occasions when considering the inclusion of reflective supervision into practice, practitioners and managers reported "we are already a time poor service".

"There is a need to normalise that reflective practice is part of everyday practice … and have it built in by management" (Child Health Nurse)

Insufficient financial assistance from organisations to contribute to the cost of participating in reflective supervision.

Limited understanding in organisations of the importance of reflective supervision in working with young children and their families. This was particularly evident in adult services where the identified client is the parent.

"Building reflective practice capacity in an organisation requires building skills over time, however, the challenges are that managers expect everyone to have the skills immediately and be ready yesterday to deliver a reflective practice model of practice" (service manager of a family support service)

Lack of experienced or adequately trained supervisors to provide I-ECMH reflective supervision. Discrepancies occurred between those who identified themselves to be providers of Reflective Supervision in I-ECMH and their experience in doing so. For example, some descriptions of what they were offering or already providing to supervisees was actually quite different from the definition as described above.

Clinician new to Australia

"If you work in mental health in NZ and Britain then you must have clinical supervision...organisations provide it, pay for it..no one shudders..people here have unusual attitudes.... Snooker vision"

There is unanimous support for the development of a reflective practice supervision framework in the I-ECMH workforce. Practitioners and services expressed a desire for a platform to begin implementation of reflective practice supervision into the workforce. Innovative solutions to the barriers that many practitioners are faced with in accessing and receiving reflective supervision included: the development of group supervision or peer supervision groups within and across services; and accessing experienced supervisors in reflective practice nationally and internationally by using skype or teleconferencing.

Practice Example:

Two child services collaborate to develop a joint IMH assessment and intervention model. This model includes a regular group supervision session which involves practitioners from different disciplines across the two services.

"Refection after our clinical sessions is a time for revision of the session and how we felt".

(clinician experience of group reflective supervision)

The family partnership model is an example of how a whole service approach can encompass some of the principles of reflective practice in I-ECMH field into service delivery across all levels and disciplines. "The Family Partnership Model is based upon an explicit model of the helping process that demonstrates how specific helper qualities and skills, when used in partnership, enable parents and families to overcome their difficulties, build strengths and resilience and fulfil their goals more effectively" (http://www.cpcs.org.uk).

AAIMH WA identify reflective practice and reflective supervision as a priority area of training need and provided two workshops on Reflective Practice in August 2013, which were received very positively by participants with 85% of respondents rating the experience as higher than 8/10.

Participants who were interviewed for The Project questioned how the IMH reflective practice model of supervision will fit with their organisation's current model of supervision and training. For example, CPFS queried how reflective practice would fit with their model of 'appreciative inquiry' and a manager of an early learning program wondered how an IMH reflective practice supervision model would fit with the early years learning framework 'reflection' principle.

"Initially it (reflective practice) has been a stressful practice for educators, however, they are now seeing how good it is and we are interested in knowing how we can further develop this skill area in our staff". (Early Childhood Learning Centre Manager)

One non-government organisation is in the process of developing a supervision framework for the multidisciplinary practice staff. The organisation has identified a need for a model of reflective supervision that will fit within their service. This organisation aims to support the capacity of practice staff to reflect on their own emotional responses and reactions when working with infants, young children and their families and in turn create an awareness of the parallel process and how this can inform the way staff intervene with young children and their families.

Case illustration (continued)

Sharing observations of families using a reflective practice model the clinicians discuss an observation from the waiting room where this mother had chosen to prop her baby up with a bottle to feed in her buggy and continue to text on her mobile phone. They wonder what this feeding experience is like for the infant? He doesn't protest, he seems to accept that feeding involves little or no contact with his mother. This exploration brings clinicians to think about how the feeding observation can lead to understanding of what is happening in this relationship. This mother never wanted children and was 'convinced' by her partner to have a child, was mum struggling to accept this infant as her child? Did she resent having a child and why did she never want children? The occupational therapist remarks "I *thought this mum's actions were developing independence from a young age, something I have always encouraged in my work with families, however now I am beginning to think that independence too early may indicate more complex emotional struggles.*

I don't think I really grasped what a disconnected infant-parent relationship actually looked like". After further reflection the occupational therapist says "I find thinking about this emotional stuff difficult and it brings me back to my own childhood and what I experienced growing up. I didn't think about how my own experiences would influence how I work with families but now I am beginning to realize it does…

- Reflective practice deepened learning experiences for all parties, including parents, and was a building block for sustainable I-ECMH practice
- Co-location of clinical psychologist with I-ECMH expertise with other allied health professionals enabled ease of reflective consultation between professionals and between clients and professionals.
- Brief reflective consultations with clinical psychologist with I-ECMH expertise by Allied Health Professional changed course of therapy without adding to waitlist.

Conclusions

The extensive literature review identifies reflective supervision as a core competency required for all professionals working in I-ECMH across all settings. Reflective supervision is consistently recognised as a core component of any training program in I-ECMH and an on-going requirement for maintenance of I-ECMH practice. In National postgraduate programs, Reflective Supervision is a core component. It is practiced on-site and via Skype for interstate students.

In Western Australia:

a) There are a few examples of innovative ways the reflective supervision model is used in practice within and across services however, overall there is limited knowledge, understanding and use of an I-ECMH reflective supervision model in the workforce.
b) There is eagerness and motivation from majority of interviewees' including management to learn more about the supervision model and its application to building I-ECMH workforce capacity. Reported barriers to implementing reflective supervision include limited funding allocation, competing demands of the service, no dedicated time within working hours, lack of support from management and limited supervisors with experience and skills in reflective supervision
c) There is unanimous support for the development of a reflective supervision framework and curiosity as to what it would look like in practice.
d) The MI-AIMH Framework articulates IMH competencies specific to reflective practice across four levels. As a requirement of Endorsement (level two to four) professionals must engage in a minimum number of hours of reflective supervision in conjunction with training and practice in the field.

Recommendations for building I-ECMH workforce capacity through reflective practice

1. Reflective practice and relationship based principles to be embedded in a training infrastructure of I-ECMH programs delivered in Western Australia. Reflective supervision has been identified by stakeholders as a significant gap in professional development and there is unanimous support by stakeholders for reflective practice to be provided in current workplace and/or external I-ECMH training programs
2. Building workforce capacity in I-ECMH to include the following concepts: Reflective practice, reflective process and reflective supervision/consultation
3. Reflective practice skills in I-ECMH to be developed across the workforce to include practitioners in mental health and non-mental health settings who are involved in promotion, prevention, intervention and treatment in I-ECMH.
4. Engage with The MI-AIMH Framework to provide a structure to ensure that activities, trainings, workforce development are of high quality and reflect international best practice guidelines in the field. The MI-AIMH Framework has identified reflective practice supervision and Consultation as a core area of expertise (MI-AIMH, 2002a). The MI-AIMH Framework the attributes and associated behavioural descriptors for the different levels of IMH expertise and as a component

of level two, three and four specifies hours of reflective supervision required to demonstrate competency.

5. A 3-to-5 year time frame be allocated for implementation of reflective practice principles. Sufficient time is required for the workforce to understand the need for reflective practice, what is been implemented, practice and master skills and embed these into daily practice. Organisations need time to understand, facilitate and support reflective supervision as part of organisational practice. To ensure the sustainability of building reflective practice capacity in the WA workforce a 'significant time commitment (3-5 years) is required to institute and sustain substantive change' (Fullan, 1993; 1999 cited in (Knapp-Philo, Hindman, Stice, & Turbiville, 2006, p.47).
6. The workforce in varying capacities in line with their work place can provide emotional support to all the families they come into contact with, work more closely with each family to support social and emotional development of their child and provide screenings and when required specialised assessments and interventions to address social, emotional and behavioural concerns. Inherent in these goals is a shift towards relationship based reflective practice in working with infants, toddlers and their families (Gilkerson & Ritzler, 2005, p.428).

ADDITIONAL FINDINGS AND SUMMARY

There is recognition that in Western Australia the field of infant and early childhood mental health is a diverse one that is growing rapidly in an uncoordinated fashion. Additional findings to those presented under The Project parameters include:

1. there is insufficient detailed knowledge of the client and workforce population parameters;
2. frequently multiple systems may be involved with families with infants and young children
3. the I-ECMH field has its own tensions and frictions and these devolve in part from lack of a coordinated system across all sectors of the workforce that hold in mind the needs of infants and young children;
4. there are significant gaps in knowledge and awareness in I-ECMH at all levels (prevention, promotion, intervention, education, policy making and research); and
5. there is an awareness that even professionals totally committed to the promotion of infant-early childhood mental health sometimes find it difficult to keep the infant in mind against the needs of parents and the demands of systems in which they work and they require Work begin immediately to build the competency based training framework.

In summary, The Project identified a widespread desire to build capacity across all sectors which work with infants, young children and their families. Recent impetus was given to this movement by the MHC/AAIMHI WA scholarship program that provided a foundation for widespread workforce development and sowed the seeds of culture change through the model of delivery.

Another driver for change is a sense of urgency. There are now have five decades of accumulated evidence as to what infants and young children require to develop to their potential and to show that

when this occurs the whole society benefits. There is a sense of urgency to meet the growing demand of infants and young children in distress

There is unanimous support from all participants in this project for a coordinated and inclusive approach to building workforce capacity through a competency based model. There is a sense of relief and excitement at the possibility of integrating the widely disparate and ad hoc nature of the field as it currently exists.

There is optimism that Western Australia might lead the way towards the development of a national plan.

"It is surprising how long it takes and how much persuasion is needed to create an interdisciplinary work force development system for IMH [infant mental health]. We started with folks in the IMH field who were hands-on but learned that we needed policymakers at the table, too. It was only with the leadership and support of policymakers that we could bring about real systems change in building capacity within the IMH service community. The relationship between clinical folks and policymakers is essential."

Deborah Weatherston, Ph.D., Executive Director, Mi-AIMH.

DELIVERY MODEL FOR I-ECMH TRAINING AND SUPERVISION

This section of the report begins with an introductory statement of the influences that are underpinning culture change in the field of I-ECMH. The section continues with brief outlines of the method of investigation, findings about the delivery of training and conclusions. The focus of the section is on the recommendations for a delivery model of training in I-ECMH. The recommendations include detail of the structure of the model, a framework for training activities, partnering to develop and deliver the training model as well as a reflective practice framework. Finally, an implementation schedule and costing and possible funding sources are presented.

Culture change

There is pressure on governments and on non-government organisations to make policy decisions that are informed by science. Accountability for expenditure in times of global economic uncertainty as well as consumer expectations mean that effective solutions are required and that these must be underpinned by a sound theoretical base that has been embraced by the clinical field. Large scale change requires a shift in philosophy at all levels.

In the field of I-ECMH the culture change is in the air. There is recognition around the globe that the I-ECMH workforce must be trained at depth in new knowledge and skills and that new practice must encompass ongoing reflective supervision (Zero to Three, 2013a).

The evidence base underpinning the drive for change in the Field of I-ECMH includes:

- Five decades of science to support the importance of relationship based practice. Bowlby first alerted the clinical world to the importance for later development of the infant's relationship with its attachment figure (Bowlby, 1969, 1973, 1980). Ainsworth's rigorous empirical definition of Bowlby's concepts made accurate research in this field possible and burgeoning information on all aspects of the attachment relationship became available from international research groups (Ainsworth, 1964, 1991).
- In the past two decades, revolutionary discoveries in neuropsychology have confirmed the importance of healthy parent child relationships for infant and child development. It has been shown that experience changes the expression of infant genes and plays a part in adapting the baby to the world in which he/she is expected to develop in (Meaney, 2010). Where a child experiences a mildly disturbed parent child relational environment we know that an insecure attachment relationship is a possible outcome and where this disturbance includes maternal withdrawal and dissociation and other perturbations then a disorganised attachment is more likely. Where other risk factors exist then an insecure attachment has capacity to put the child at risk of poor developmental outcomes.
- Dramatic evidence that a disorganised attachment in infancy conveys risk of psychopathology in early adulthood (Lyons-Ruth, 2011; Sroufe, Egeland, Carlson, & Colllins, 2005). We know that trained practitioners can identify relationships that are struggling and placing children at social

and emotional risk in infancy. We know too that these trajectories may be altered and improved by sustained and sensitive interventions.

This knowledge was not available to previous generations of parents and policy makers and must now be recognised as an important change agent.

Furthermore, over recent years there has been growing momentum for the use of competency frameworks in I-ECMH. This is due to:

- the broad based interdisciplinary nature of the field;
- a need to establish quality services in I-ECMH and to maintain these
- a need to identify specific characteristics that accurately describe competence in working within I-ECMH and that may be used to inform training and workforce development.
- the need for evidence that provides a 'level of assurance to families, agencies, and the public at large that the person who is providing services to infants, young children, and their families meet standards of knowledge and skill that have been approved by a professional organisation devoted to promoting IMH'(Weatherston et al., 2006, p. 5)

There are now a number of competency frameworks pertaining to the I-ECMH field, all of which have been developed in the USA (Korfmacher & Hilado, 2008). The MI-AIMH Framework is recognised as the most widely recognised set of competencies and provides a comprehensive system of endorsement, which details how a practitioner can demonstrate meeting the range of competencies in IMH practice across four levels.

In preparation of culture change for both consumers and the I-ECMH workforce it is essential to have a quality assurance mechanism to ensure practitioners across the promotion, prevention and intervention spectrum are providing high quality services that are relationship based and in line with the principles of I-ECMH. The MI-AIMH Framework provides this quality assurance mechanism through Endorsement.

Method of Investigation

The Project engaged in extensive consultation with international policy makers and practitioners who have demonstrated capacity to develop an I-ECMH workforce in their respective countries as well as with those in Australian states who are in various stages of developing workforce capacity.

The Project team reviewed the interview material gathered from stakeholders in Western, Australia and additional discussions were held with trainers in key organisations and with university teaching and learning development staff.

Literature searches were conducted using key words that included workforce development, Infant mental health, early childhood mental health and workforce culture change.

Findings on delivery of training

In keeping with sound business principles sustainable delivery of a training structure recommends the funding body to be independent of an agency or agencies that coordinates and delivers training.

In line with the international policy recommendations for early childhood development policy and service delivery, "mechanisms to promote coordination across sectors and institutions are essential. This type of intersectoral coordination is also important to facilitate longitudinal tracking and long-term service provision and follow-up for children" (The World Bank, 2013, p. 26). In Western Australia, multi-sectoral collaboration already exist for service delivery via tender approaches.

Successful international models of competency based training in I-ECMH are typically structured to have a central coordinating body in a collaborative partnership. It is recommended that such an organisation has the following characteristics:

- the improved emotional and social wellbeing of infants' and young children as its core business;
- no conflict of interest;
- a philosophy of developing a shared understanding and collaborative engagement with all service providers in a model that is inclusive of wellness, prevention, intervention and reflection;
- clear representation across all allied health service professions, medical professions, education professions, policy and administration and all levels of service involved in infant mental health;
- demonstrated capacity to deliver training in collaboration with government bodies to the WA infant and early childhood workforce;
- demonstrated capacity to collaborate with other professional organisations to provide knowledge and skills in training events such as national conferences that focus on the emotional wellbeing of infants and young children;
- established affiliations in the National and International arenas of IMH giving it access to innovative forums and initiatives;
- Affiliation with WAIMH (World Association for Infant Mental Health). A requirement to purchase The MI-AIMH Framework, is that one of the partners to the contract must be an affiliate of WAIMH. The experience of The USA states has been that this requirement is significant and important since the WAIMH affiliate is typically constant in its focus on I-ECMH workforce development whereas this focus ebbs and flows according to competing demands in government departments and NGO's.

AAIMHI WA is an example of a body that is capable of fulfilling this role.

Conclusions

The key conclusions drawn from the findings are as follows:

a) There is a wealth of data to drive change in I-ECMH policy and practice.

b) Change is in the direction of workforce development. There is recognition that the I-ECMH workforce must be trained in new knowledge and skills and that new practice must encompass ongoing reflective supervision to maintain new found competency.

c) Current models of best practice include a competency based training framework, for which the gold standard is the MI-AMHI Framework.

d) Models of training delivery typically structure a funding body to be independent of an agency or agencies that coordinates and delivers training.

e) Models of delivery in I-ECMH training typically include collaboration with an organisation that has I-ECMH principles as core business. In Western Australia AAIMHI WA as an independent body could fulfil this role.

- AAIMHI WA is currently a volunteer organisation and will require support to develop the infrastructure necessary to step up to this role.
- There is a precedent for this with successful collaboration between the MHC and AAIMHI WA. The MHC funds administrative support to AAIMHI WA for implementation of a scholarship program in I-ECMH.

Recommendations for a Delivery Model for I-ECMH Competency Based Training

Structure of Delivery Model

a) MHC and AAIMHI WA partner to manage funding of The MI-AIMH Framework.

b) A Training and Supervision Committee be established that comprises representation from AAIMHI WA as well as funded specialist I-ECMH positions including: Endorsement Coordinator (EC), Service Development Leader (SDL) and a part-time administration assistant. See Figure 2.

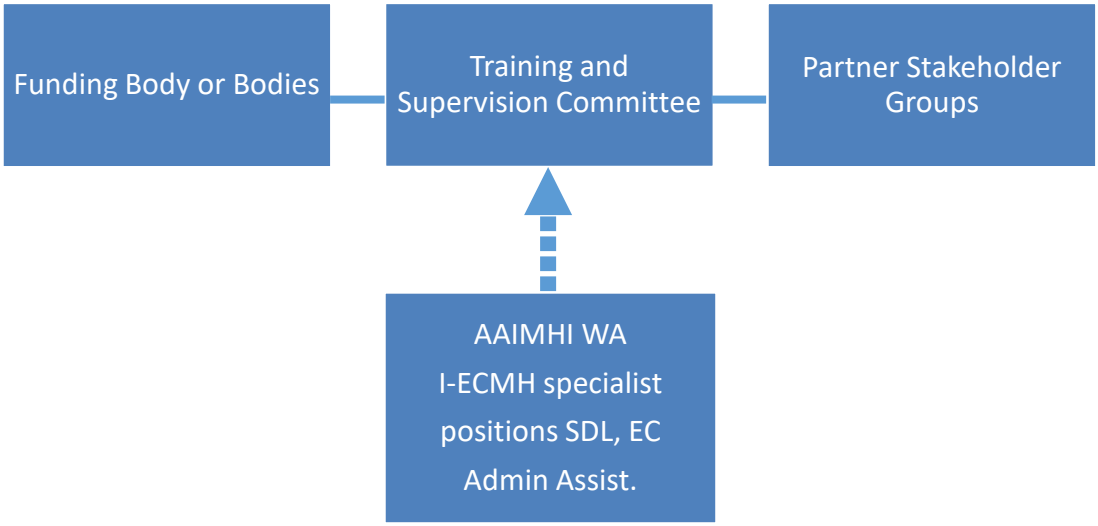
c) The Training and Supervision Committee collaborates with partner stakeholder groups that represent the universal, targeted and selected levels of service delivery. See Figure 2. The Training and Supervision Committee and partners develop, coordinate and deliver pre-service and in service training and professional development that is in keeping with identified I-ECMH competencies. Key partner stakeholder groups include:

a. WA Association for Mental Health (WAAMH);
b. WA Council of Social Service Inc, (WACOSS);
c. The Department for Communities;
d. The WA Department of Education (DoE);
e. The WA Department of Health (DoH);
f. Department for Child Protection and Family Support (CPFS);
g. The Disability Services Commission.

d) The Training and Supervision Committee establish creative partnerships with universities and education providers of certificate level courses (e.g TAFE, Marr Mooditj). The Training and Supervision Committee collaborate with representation from relevant Stakeholder groups to develop and deliver the relevant level of training.

e) The Project team proposes that the training framework be phased in over a five year period so as to provide the opportunity to build workforce capacity, align with The MI-AIMH Framework and establish a sustainable model.

Figure 2. Proposed I-ECMH competency based training organisational structure for WA.



Training Activities Framework

The educational and training activities and programs for the I-ECMH workforce are suggested below. These activities are aligned with The MI-AIMH Framework (Weatherston et al., 2009) and complement the principles of the platform approach designed to 'help communities undertake work to help support children's development' and emotional well-being (WACOSS, 2013) p 36. Appendix B provides a summary of training priorities for the workforce and uses Level 3 of The MI-AIMH Framework as a detailed example.

Table 4 is a proposed training framework of activities specifically designed for the Western Australia I-ECMH workforce. The training activities framework builds on existing activities by incorporating the training currently available in Western Australia and also including new modules to meet identified gaps in I-ECMH training. The training activities are suggested across three levels in line with The MI-AIMH Framework and include proposed new AAIMHI Coordinated Knowledge modules at levels 1 and 2 as well as newly designed training modules at Level 3. Key competency areas pertaining to The MI-AIMH Framework (knowledge and reflective practice) are identified and include ways of sustaining I-ECMH skills (participation in Reflective Practice groups or Reflective Practice Supervision Groups). Training Requirement and Reflective Consultation boxes specify the number of hours required at each level of The MI-AIMH Framework to meet endorsement requirements.

Table 4. Suggested sustainable Training Framework of activities including those already available and development of new modules.

Level 1 Training	Level 2 Training	Level 3 & 4 Training
On-Line Training National: Beyond Blue Matrix International: Seeing is Believing (Minnesota) Zero To Three Podcasts Education Scotland	**On-Line Training** National: Beyond Blue Matrix International: Seeing is Believing (Minnesota) Zero To Three Podcasts Education Scotland	**On-Line Training** National: Beyond Blue Matrix International: Seeing is Believing (Minnesota) Zero To Three Webinars & Podcasts Education Scotland
National Conferences AAIMHI (and where I-ECMH present in others e.g ECA, QE11, Marcé)	**National Conferences** AAIMHI (and where I-ECMH present in others e.g ECA, QE11, Marcé)	**National and International** Conferences (where I-ECMH featured) e.g WAIMH, AAIMHI, (some of ECA, QE11, Marcé, RANZCP, IACAPAP)
Recurrent Local Training Family Partnerships Training Cos (1 & 2 Day) Working with Aboriginal people in the perinatal period EPDS & Baby Wheel Ngala: Trends and issues with babies; Parenting across cultures	**Recurrent Local Training** Family Partnerships Training Cos (4 &10 Day) Working with Aboriginal people in the perinatal period EPDS & Baby Wheel Ngala: Trends and issues with babies; Parenting across cultures	**Recurrent Local Training** Family Partnerships Training Cos (4 Day & 10 day) Working with Aboriginal people in the perinatal period EPDS & Baby Wheel
AAIMHI WA Co-ordinated Knowledge Modules *Introduction to I-ECMH Attachment Theory for non-clinical settings EDPS & MI-AIMH Baby Wheel Applying Reflective Practice Early Identification and Assessment tools ie. NBAS & NBO Home visiting models of care AAIMHI Seminar Series	**AAIMHI WA Co-ordinated Knowledge Modules** *Introduction to I-ECMH Attachment Theory for non-clinical/clinical settings EDPS & MI-AIMH Baby Wheel Applying Reflective Practice Early Identification and Assessment tools ie. NBAS & NBO Home visiting models of care AAIMHI Seminar Series	***Training Modules to be designed that are locally designed and managed and/or internet accessible.** University Badged Professional Development Modules that build towards graduate and postgraduate qualifications in I-ECMH Specialist therapeutic approaches including parent-infant psychotherapy. Home visiting models of care AAIMHI WA Seminar Series DC 0-3R and ability to adopt a crosswalk that matches codes from RDC-PA, DSM-V & ICD-10

AAIMHI Coordinated Reflective Practice Via community groups and/or consultation	**AAIMHI Coordinated Reflective Practice** Via community groups and/or consultation Within or across agency coordination.	**Reflective Supervision Groups** AAIMHI WA coordinated, CAHS, CPFS co-ordinated; Within or across agency coordination. Individual Reflective Supervision
	Post Graduate Certificates IMH UNSWIOP Uni Melbourne **Local university badged PD**	**Post Graduate Certificates IMH** UNSWIOP Uni Melbourne **Local university badged PD**
		Specialized Placements Internships
Training Requirement 30 hours	**Training Requirement** 30 hours	**Training Requirement** 30 hours
Reflective Consultation Provided by Level 2, 3, 4	**Reflective Consultation** 24 hours within 1-2 years Provided by Level 3, 4	**Reflective Consultation** 50 hours within 1-2 years Provided by Level 3, 4

*Modules will address:
The emotional development of infants and young children.
Emotional contribution of parents and other caregivers
Dynamics of relationships
Influence of culture on caretaking practices and expectations
Contribution of trauma, substance abuse, and domestic violence to the infant-caregiver relationship
Use of screening, assessment, intervention and research tools
Reflective Practice.

The principles needed to sustain the suggested training framework include:

- Close association with supportive universities.
- Recognition of the interdisciplinary nature of the I-ECMH workforce.
- Flexible modes of delivery that include video and teleconferencing.
- Ongoing requirements for reflective supervision that are to be built incrementally over a five-year period.
- Implementation process ensures that workforce development is conducted in stages gradually building a sustainable training program.
- Evaluation to ensure continuous quality improvement.

The expected outcomes from this suggested comprehensive sustainable integrated training framework include:

- Development of a more collaborative and cohesive learning community where information and ideas are freely shared, avoiding duplication of effort and fostering peer support
- Positive outcomes for child, family, practitioners and services
- Building a framework that supports sustainability and expansion
- Solid training structure embedded across levels of service and across professions in metropolitan and rural regions
- Highly qualified and skilled workforce in I-ECMH across promotion, prevention, intervention and treatment services
- High quality services across promotion, prevention, intervention and treatment services
- Increased awareness and infusion of I-ECMH principles throughout community including the emotional needs of infants, young children and their families.

Training around competencies has been unifying, we went from concern over who would house IMH to how can we meet the need of the IMH workforce and we now have a group who wants to collaborate and work across systems and are moving forward in the same direction'

Suggested training activities for each level of competency that builds upon those already in Table 4.

The boxed and highlighted areas require development and will align with The MI-AIMH Competency Guidelines. These areas have been identified as essential content areas in I-ECMH training in the UK and USA and have been identified as gaps in Australia and WA (see literature review).

Partnering model to deliver training

The Training and Supervision Committee referred to in this section comprises specialist I-ECMH representatives from AAIMHI WA, Service Development Leader, Endorsement officer and representatives from relevant stakeholder groups. Sustainability of learning from participation in modules presented in Table 4 is delivered through reflective practice.

Partnering for training at Level 1

At Level 1 the Community Services Health and Education Industries Training Council (CSHEITC) and representative staff from Certificate 3 courses who understand the requirements of the Australian Qualifications Framework (2013) will be essential partners with the Training and Supervision Committee and stakeholder groups who provide services at the universal level.
Design and development of I-ECMH modules at Level 1 will require:

- Experts in I-ECMH that have levels 2-4 MI-AIMH accreditation or working towards this e.g Service Development Leader (SDL), Endorsement Officer (EO)
- AAIMHI WA representative
- CSHEITC (Community Services Health and Education Industries Training Council) representatives

- Representatives from Certificate 3 courses in Early Child Education and Care, Community Services, Enrolled Nursing, Aboriginal Health workers.
- Representatives from partner stakeholder groups who deliver services at the universal level

This partnership model will provide stakeholders and experts the opportunity to have input into course content and other training designed for use across child oriented agencies and will facilitate coordinated delivery of training to the broad I-ECMH workforce.

Partnering for training at Levels 2-4

At Levels 2-4 of The MI-AIMH Framework, universities and those who provide targeted and intensive specialist services are recommended partners with the Training and Supervision Committee, to maintain the focus of I-ECMH across all professional disciplines, agencies and sectoral silos.
It is recommended that a coordinated approach to cross-agency workforce training that is infant focussed and relational in nature be considered for in-service training and professional development. Development and delivery of two modules per year over four years for levels 3 and 4 that are partnered with universities is recommended. An example of one such unit is outlined below.

The proposed CAMHS Training Framework (Caunt, 2013) includes an IMH component. Collaboration around this has possibilities for delivery to the wider workforce beyond CAMHS. Partnering ideas for development and delivery of I-ECMH training modules include but are not limited to the following:

- The wider workforce accesses the proposed CAMHS component module, through communication and coordination of the wider workforce through the competency based training structure suggested in this report. Creative partnering possibilities for funding to be considered e.g secondments, user pays, scholarships, cross agency sharing and trade in I-ECMH modules.
- Development of additional modules by CAMHS in collaboration with experts in I-ECMH, AAIMHI WA and other stakeholders
- Specialist modules be developed and delivered by agencies that have a different focus such as CDS and CPFS and these modules are then also made accessible to the broader workforce
- Interagency placements for I-ECMH modules. Staff from agencies such as CPFS, CAMHS, CDS who complete modules in specialised interventions consolidate their learning through seconded placements.
- Funding support from government for a university to support development and delivery of a series of I-ECMH modules in order that they become part of a university accredited course.
- Modules be developed to include flexible learning packages that have capacity for rural outreach.
- Design of an Introductory module to I-ECMH of 12 weeks of 2 hours duration (university terms) may include:
    - One module comprised of input from multiple agencies for two sessions each.
    - Several complete modules developed to provide more intensive knowledge and skills and incorporate a reflective practice component. Suggestions include:
        - Introduction to I-ECMH for professionals working with infants in high risk families (provided by CPFS)

  - Introduction to I-ECMH for professionals working with hospitalised infants (provided by PMH)
  - Introduction to I-ECMH for professionals working with infants in families where there is a mental illness (provided by CAMHS)
  - Introduction to I-ECMH for professionals working with infants and young children with developmental delay (provided by CDS)
  - Introduction to I-ECMH for professionals working with infants and young children with disabilities (provided by DSC or Centre for Cerebral Palsy)
  - Introduction to I-ECMH for professionals in community settings and policymakers (provided by AAIMHI WA).
- Cross disciplinary and cross agency reflective supervision groups will require development to sustain the practice of skills and knowledge learned in the training.

Inclusion of I-ECMH principles into existing undergraduate degree courses will be a challenge for university course coordinators who are typically bound by professional accreditation requirements as well as the Australian Qualifications Framework. The Training and Supervision Committee must take a lead in engaging university personnel with the field.

Reflective Practice Framework

The Training and Supervision Committee and partner stakeholder groups as suggested above will be required to establish and model reflective practice principles to the workforce.

The Training and supervision Committee to introduce a Reflective Practice Framework to the WA workforce and to oversee the implementation of an I-ECMH reflective practice supervision and consultation model into the WA workforce including early childhood services.

Implementation to be phased in over a 3-to-5 year period.

Professional development strategies that promote reflective practice should also be supported. These include reflective supervision, observation, the sharing of ideas and strategies with peers, planning ways to use the new strategies, and on site follow up (Knapp-Philo & Stice, 2004; cited in (Knapp-Philo et al., 2006, p.47)

The Training and Supervision Committee and partners to embrace The MI-AIMH consultation that accompanies purchase of The MI-AIMH Framework. In the event WA adopts The MI-AIMH Framework an I-ECMH consultant, who has expertise in reflective practice will work with the committee. This will be provided by MI-AIMH Consultants who offer a monthly consultation as part of the license package. WA will also then be part of the League of States established by those states who have adopted The MI-AIMH Framework and that 'serves as a forum to regularly examine and discuss issues related to the use of the guidelines' (Weatherston et al., 2010, p.24) It is highly recommended that The WA Training and Supervision Committee embrace this consultancy.

One of the roles of the Training and Supervision Committee will be to develop a data base of available supervisors who can provide I-ECMH relationship based reflective supervision. This data base will be held by AAIMHI-WA and regularly updated. Over the three to five year 'phase in' period this data base will grow to include I-ECMH Supervisors who have achieved endorsement at the

necessary levels to provide supervision. This will ensure that high quality reflective supervision will be available to practitioners and organisations seeking a supervisor for individual or group reflective supervision.

An intensive training program will be developed for a core group of leaders and experienced clinicians in reflective practice (MI-AIMH levels 3 and 4) including non-mental health and mental health clinicians.

A training program specifically targeting administrators will be developed as they will play a key role in decisions to implement reflective supervision initiative and provide training for staff. They will play a role in engineering cross departmental changes and resource allocation or reallocation (Alper, 1995).

Training resources in reflective practice will be developed that can be offered as building blocks for implementing reflective practice. These resources will be aligned with specific competencies in reflective practice across the four levels of The MI-AIMH Framework and to include the range of professionals working with infants, young children and their families (early childhood education to management and policy).

A short course (e.g. 10 weekly sessions) for practitioners currently working in the I-ECMH field will be established. As part of the course reflective supervision, observation and reflective activities will be included as core components of training to reflect the relationship based principles of I-ECMH. The training program will be modelled on the interdisciplinary training models offered by MI-AIMH, University of Melbourne and NSW Institute of Psychiatry Postgraduate training in I-ECMH to include theory and research, I-ECMH practice and supervised clinical practice (Warren & Mares, 2009; Weatherston, 2005). The training program will be aligned with The MI-AIMH Framework and offer a pathway towards endorsement at level two, three and four.

An interdisciplinary I-ECMH training program will be offered locally and established as a permanent course. This will be the initial building block for establishing a post graduate course in I-ECMH.

The Training and Supervision Committee will facilitate a small number of reflective supervision groups (piloted in lead stakeholder groups) led by an I-ECMH reflective practice supervisor. These groups will be interdisciplinary and where possible members will come from across services and include mental health and non-mental health practitioners. A pilot group will be trialled by AAIMHI-WA.

A sub-committee, in collaboration with university and key stakeholder groups will develop a formative evaluation plan to measure the effectiveness of reflective supervision groups in supporting professional development of practitioners and improving outcomes for families within services that practitioners work in. Examples of models of evaluation include:

- the Social Emotional Pilot (Gilkerson & Ritzler, 2005);
- a study by University of California compared the effect of reflective supervision and traditional supervision in childcare settings (Amini Virmani & Ontai, 2010);

- the Tomlin (2009) study that investigated methods of exploring practitioners self-reporting of the importance of reflective practice in their work with young children and their families.

It will be important to develop a mutual understanding of why reflective practice is a core competency required for all professionals working in the I-ECMH across all settings. Explicitly connecting the value of reflective practice to ongoing organisational visions is essential to ensure innovation in this field is sustained. For example, the Early Years Learning Framework includes reflection as a key area and reflective practice in IMH (detailed in MI-AIMH Competency Guidelines) offers a framework for enhancing these skills in the early childhood field using a relationship based model. Collaborations with education are the building blocks for thinking about an Early Childhood Mental Health Consultation Model (ECMHCM) and a way of improving quality of early childhood education in WA.

Implementation Schedule

Consensus from all those consulted in The Project suggests establishing a solid infrastructure and sustainable partnerships as a springboard for next steps. Training programs that are built around competency frameworks ensure high quality up skilling of practitioners in an organised and coherent manner. Once widespread understanding and support for the competency framework is established and training underway then the workforce will be better placed to implement an endorsement process. Table 5 contains a suggested schedule for implementation.

Table 5: Implementation Schedule

Project Phase 1	Key Milestones	Project Phase 2	Key Milestones	Project Phase 3	Key Milestones	Project Phase4	Key Milestones
Establish partnership structure for training and competency	MHC/ AAIMHI WA drawn up and signed MOU MOU with Partner stakeholder groups completed MOU with MI-AIMH completed	MI-AIMH 3 day support and consultation process begins and includes representation from major stakeholder groups across continuum	Personnel agree to commit to the process of: a) development as I-ECMH mentors b) Practice in reflective supervision and piloting supervision groups	Facilitate explanatory workshops Raising awareness of the importance of early development to set stage for more formal learning. Engagement with the workforce in understanding competency guidelines	Presentations at meetings targeting early childhood providers to promote simple messages about importance of early emotional development for prevention of more serious challenges. Workshops held for all levels of service delivery to explain competencies	Incorporate RP into management and operational structure using AAIMHI WA Competency Guidelines	Wide use of competencies and reflective practice model in organisations
AAIMHI WA review structure		AAIMHI re-structure	For example: Executive Director & Advisory Board appointed				
Purchase & Delivery of MI-AIMH Competencies and Endorsement License	Competencies & endorsement branded AAIMHI WA		Core group learn AAIMHI WA model and identify nature of personnel to be invited to advisory group. Shared experience and understanding of model	Establish working group to align competencies and levels from AAIMHI WA with current competency frameworks for early childhood workforce. Engage with endorsement process	Gaps in training needs identified for all levels of service provision Set up endorsement data base, training and test system	Develop additional PD modules Continue with endorsement process	Deliver core training modules Continue with endorsement data base, training and test system

Employ Project Officers and Administration Officer	Project Officers employed and engaged with stakeholder groups and initial stages of implementation. Identify initial group to participate in MI-AIMH training process. Establish reflective supervision group process and personnel	Establish Training and Supervision Committee I.e. Identify Service Development Leader and admin assistant Endorsement Officer	Appoint: SDL Admin assistant Endorsement Officer	Identify and develop initial core training modules for each level of competency and identified areas of high need across levels. Begin endorsement process	Initial modules written and delivered. Diary of training events identified Deliver AAIMHI WA seminar series Identify and Publicise – e-learning modules	Update modules	Delivery of updated modules
		Develop a model for research for I-ECMH that includes Population parameters; the process of reflective supervision and evaluation of training	Scholarships for research created advertised	Pilot Reflective supervision groups in lead agencies & organisations	A number of reflective supervision groups are set up across mental health & non-mental health agencies	Implement evaluation	

Costing

a) Purchase of The MI-AIMH Framework will incur the following costs:

   a. License purchase fee is for three years and renewable annually after initial three-year period. Purchase fee is US$ 40,000 (increase to $45, 000 in 2014).

   b. Training and technical assistance is US$ 6,000 for 2 trainers for 2 days plus travel expenses.

   c. There is a minimal fee of US$ 1, 000 for annual renewal after the initial three-year period. See Budget Supplement A (Licence purchase fee to increase to $1, 200 as of January 1, 2014).

b) Recurrent costs to roll out a sustainable training framework including design and delivery of professional development modules and support to the workforce to attend training are of the order of $400 000 per annum. See Budget Supplement B

c) Singular costs that will progress the development and implementation of a sustainable and integrated competency based training framework and build upon training that has already been funded by the MHC are included in Budget Supplement C.

d) Costs for the development and delivery of modules are suggested in Budget Supplement D. Due to the diversity of the workforce, assumed FTE costs are used to give costs to stakeholder groups to release employees for reflective practice over the 1-to-2 year period stipulated in The MI-AIMH Framework. Costs to an agency for development and delivery of provision of training modules are also modelled for the various levels of The MI-AIMH Framework using notional salary scales.

Funding Sources

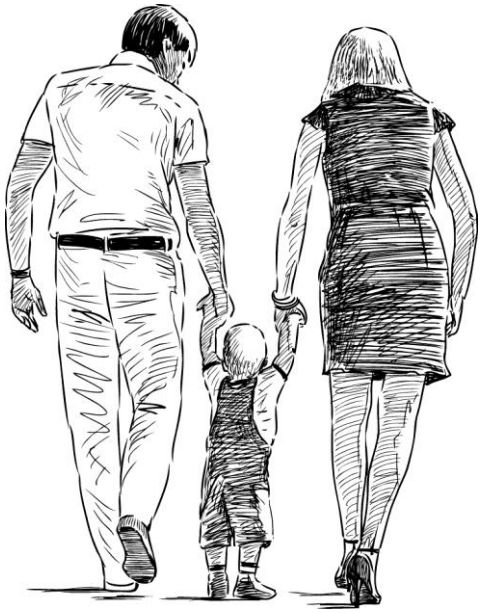
Possible funding arrangements identified by The Project team include but are not limited to:

1. The MHC be the sole provider of funding.
2. The MHC in collaboration with the private sector jointly source funding.
3. AAIMHI WA and a philanthropist together finance and build a high quality training infrastructure to support and sustain the field in the same way as the Irving Harris Foundation has done from Chicago throughout The USA since 1996 (Zero To Three, November, 2012). See Philanthropy Australia at http://www.philanthropy.org.au/links/fund.html.
4. MHC WA/Private Sector/Government Departments/University / TAFE collaborate financially to support the I-ECMH competencies, training and supervision infrastructure.
5. MHC WA, and The National Mental Health Commission source joint funding for a National I-ECMH competencies and training project.
6. An Endowed Early Childhood Development Fund that includes both public and private funding where those who give private funds receive tax concessions and governments have a repository to put unused funds from non-viable projects (Calman & Tarr-Whelan, 2005).

CLOSING STATEMENT

The intended outcome of this project is to provide better outcomes for infants and young children and their families' through:

1. A shared understanding of the breadth and depth of I-ECMH.
2. Up skilling of the current workforce at all levels of engagement.
3. Providing appropriate support and intervention as required for all families with infants and young children to enable an optimal future.
4. Developing and maintaining inter-sectoral collaborations.
5. Advocacy for the field of I-ECMH, especially the social and emotional needs of infants, young children and their families.



The Project anticipates that uptake of the recommendations will deliver financial savings through smarter allocation of funds in a cohesive and coordinated manner. Flow-on benefits for the Western Australian workforce are likely to include improved professional identity, increased job satisfaction, improvement in skills, promotion of ongoing learning, and the promotion of a culture of constructive collaboration, intervention and practice.

Further, we envisage financial and social savings to the community due to a reduction in the numbers of children requiring intensive level services; a reduction in stress leave taken by parents where there is an infant or young child in emotional difficulty; increased school success; a reduction in stress leave by teachers; a decrease in crime in society; less demand on intensive mental health resources; less burden on child protection services and many additional intangible benefits.

Finally, The Project team would like to thank the advisors and staff at the Western Australian MHC and at AAIMHI WA who had the courage to initiate this project and to incorporate I-ECMH into priority areas of the MHC for the future of infants and young children and their families in Western Australia.

LITERATURE REVIEW

Background

Economic reasons for the importance of attending to mental health in infancy and the early years.

"85 percent of who you are—your intellect, your personality, your social skills—is developed by age 5. Let's invest where it makes the most difference." Massachusetts Early Education for All
(Calman & Tarr-Whelan, 2005)

Advances in the I-ECMH field have been strengthened by the research of Nobel prize winning economist, James Heckman, who has brought together research from neurobiological, behavioural and economic fields of study to demonstrate the critical importance of what occurs in the early years in building foundations for development throughout the lifespan (Heckman & Masterov, 2007). He and his colleagues argue that:

1. The platform for later skill development begins in infancy. Contemporary society requires a workforce that is able to perform adult duties which include intellectual flexibility, well developed problem solving skills, emotional resilience and capacity to work well with others and ability to manage a 'continuously changing and highly competitive economic environment' (Knudsen, Heckman, Cameron, & Shonkoff, 2006, p.101061) and that lifecycle skill formation begins in infancy (Heckman & Masterov, 2007).
2. Early intervention lowers the cost of later intervention. This economic argument highlights the potential impact of intervening at the earliest possible point in development and the long, lasting effects interventions in infancy and early childhood will have on society as a whole. For example, intervening with a vulnerable parent-infant relationship at risk in infancy or a child at risk of school failure may save dollars later in special services.
3. Steps to reduce inequality may be taken in infancy: 'the most cost effective strategy for strengthening the future The USA workforce is to invest greater human and financial resources in social and cognitive environments of children who are disadvantaged, beginning as early as possible' (Knudsen et al., 2006, p.10161).

There are many ways to estimate costs of overlooking the mental health of children , for example, a proportional analysis of the cost of conduct disorder to English society was provided by Knapp (1999). These authors identified that whilst the health care system might be encumbered with 16% of costs, factors such as the lost employment opportunities of parents (26%), the need for special education (31%), social care (7%) household repairs (5%) and benefits paid (15%) – also contribute to costs.

An Australian paper, using epidemiological data identified relational and environmental exposures that contribute to the high level of burden of mental health disorders including amongst others non-secure

attachment relationships, poor quality parental skills, poor quality care and family stress (Zubrick et al., 2000). Zubrick and colleagues argued for increased integration between the science and practice of prevention and promotion and that of treatment. They also argued that the economic, social and personal costs for individuals, communities and on a global level are typically underestimated. Costs mentioned in this paper included: costs of inpatient care, costs of outpatient mental health treatment; length of treatment; costs associated with downward developmental trends and chain of intergenerational transmission; persistence of disorder; costs of specialised care in justice, education, child protection, community health and mental health settings. Zubrick and colleagues called for leadership and political resolve to monitor the costs and consequences of mental disorders in young people.

Economic reasons for the importance of attending to I-ECMH workforce development

It is well documented in the economic discipline that up-skilling and training the workforce leads to increased productivity, a motivated workforce, and increased staff retention and stability amongst others. Training can not only give rise to increased productivity, but also adapt the skills of the workforce to satisfy labour market demands. Huang et al (2004: 168) argued that in the area of children's mental health, "advances in new service delivery models have outpaced preparation of the human service delivery workforce." They continue stating that "there are significant gaps between educational preparation and actual service provision, as well as a lag time between development of evidenced-supported interventions and their implementation in the field." (Huang et al., 2004: 168).

Parent–infant work is typically relational in nature whether it occurs in community based supportive settings, primary health care settings or intensive specialist services. The success of the work depends on the quality of the relationship that forms between practitioner and the client in much the same way as that of the parent and infant. Practitioners are required to hold and contain complex emotions that arise for all parties. Practitioners need to have confidence in their skills as well as in their self-awareness in order to do the work in I-ECMH effectively. When workers feel under pressure, under skilled and/or undervalued then not only does the service to the families suffer but job satisfaction declines and professional identify suffers. There becomes less energy to embrace change, collaboration and remain open to new learning.

Importance of Training in Infant-Early Childhood Mental Health

> *The scientific treasure of which we speak is largely stored in our libraries, but the babies themselves have not been its full beneficiaries, between the library and the baby in need there is a great gulf: We are missing the scientist-intermediary who can bridge this gulf. We need psychiatrists, paediatricians, nurses, psychologists, and social workers who can identify the psychologically imperilled infant, and bring the resources of psychiatry and the community to the baby and his parent in programs of clinical intervention. We need infant mental health specialists in each of these disciplines, and we need a very large measure of training in normal and deviant infant development to enable the mental health professions to engage in a vast collaborative work on behalf of infants (Fraiberg, 1994, p.4)*

The following points are made in further detail in this section:

1. The acquisition of new knowledge and skills by the workforce is essential to provide services to the required standards that are fit for purpose and effective. Consumers and policy makers expect I-ECMH interventions to be underpinned by sound theory and supporting research.
2. The evidence base underpinning the relationship based principles of I-ECMH has leaped ahead in the past five decades so that we know:
    a. How environmental and relational experiences adapt the baby to the world in which he/she is expected to develop in.
    b. The importance of early assessment and interventions for infants, young children and their families. For example, disorganised attachment pattern in infancy, and persistent childhood aggression are risk factors for mental health problems over the lifespan and trained clinicians can recognise these. Parental capacity to mentalize is a protective factor for their children and can be improved by trained clinicians.
3. We have sophisticated classificatory systems and assessment tools that trained I-ECMH workers might use to identify and intervene with at risk parent-infant relationships.
4. Education and training must keep up with policy and practice change in order to prepare the workforce to provide quality service and care. For example, traditional training in discipline specific silos does not adequately prepare the workers for the shift to working in collaborative partnerships with families and other professionals.

The demand for principles of best practice

The demand for evidence to inform new interventions that has historically come from scientific fields, particularly that of medicine, has now trickled into many spheres of modern life. Professional organisations of many disciplines including psychology, education, psychiatry, occupational therapy, speech therapy, physiotherapy, psychiatry, nursing, community mental health, health promotion and social work now expect interventions to be informed and/or supported by principles of 'best practice' that often include a scientific theoretical basis and to be reported in peer reviewed and academic

journals (Kauffman Foundation, 2004). Consumer expectations are that interventions will be underpinned by sound science and that they will have been tried and tested by replicable methods. Health providers will typically only support interventions that are informed by a sound body of evidence. The same principles now exist in the business world where 'results- focussed policy' and 'managing for outcomes' guides decision making.

There is pressure on governments and on non-government organisations to make policy decisions that are informed by science. Accountability for expenditure in times of unstable global economy means that new policies must be underpinned by a sound theoretical base that has been embraced by the clinical field and that has made progress towards an evidence base, before being embraced on a large scale.

The "naughty" preschool child will continue to be viewed as 'naughty' by the untrained worker rather than as a child struggling with overwhelming feelings with rudimentary skills for self-regulation. Opportunity to change the trajectory for this child and this family will possibly be lost without up skilling workers and families.

Project interviewee- policy maker and administrator.

As with parenting practices that are handed down from generation to generation and that are largely based on unconscious intuition, unless one is explicitly thoughtful, practitioners who do not have access to current training in best practice will rely on idiosyncratic practice that has worked for them in the past. The acquisition of new knowledge and skills by the workforce is essential to provide services to the required standards that are fit for purpose and effective. Such change requires a change in philosophy at all levels of the workforce to one that encompasses solid training and ongoing reflective practice to consolidate new learning and practices.

Growth in evidence that underpins relationship based principles of I-ECMH

In the field of infant and early childhood mental health, there has been a burgeoning of evidence to support relationship based practice over the past five decades. Attachment theory built upon the close observation of infants separated from their mothers as well as supporting evidence and theory from related disciplines by Bowlby and his colleagues in the 1960's and 70's to advance knowledge of the impact of healthy parent-child relationships for the developing child (Bowlby, 1969, 1973, 1980). Ainsworth operationalised this work through a rigorous scientific approach that tested and supported the theory and that has continued to be supported over time and across cultures (Ainsworth & Wittig, 1969; Ainsworth, 1964; Ainsworth, Blehar, Waters, & Wall, 1978). Concurrent with the pioneering work of Ainsworth and Bowlby brain researchers were discovering neuro-plasticity properties that radically changed the ways we think about how our brain anatomy develops and that support the importance of healthy parent child relationships for infant and child development. Research by Michael Meaney (2010), for example, exists to show that maternal quality of nurture in the first few weeks of life impacts gene expression and has a pervasive effect on the how the child is likely to develop. It seems that experience is changing the expression of infant genes and plays a part in adapting the baby to the world in which he/she is expected to develop in (Meaney, 2010). How important it is then to make this world the best possible.

The past two decades have seen a concurrent rise in evidence to support the importance of early assessment and interventions for infants, young children and their families. We now know that a disorganised attachment in infancy is found in normative samples and is more prevalent in high risk samples (O'Connor et al., 2011) and that it is a risk factor for healthy social emotional development. A disorganized attachment in infancy is likely to remain evident in disturbed parent child relationships and in child behaviour at age 3 years; poor teacher child relationships and externalizing behaviours by preschool years and disturbed peer relationships through the school years. The disturbed infant-parent relationship also conveys risk of psychopathology in early adulthood. In school age children, disorganized attachment has been found to be associated with higher child reports of depressive symptoms and shyness, and with parent-reports of social anxiety, inattention, and thought problems, and that disorganized children were more likely to have symptoms that meet clinical criteria(Lyons-Ruth, 2011; Lyons-Ruth, 2008; O'Connor et al., 2011).

We know that while many toddlers exhibit aggression and defiance most of them have found ways to regulate this by the time they enter preschool, however, we know also that there are a percentage of toddlers who do not show this decline in aggressive behaviour as they mature and in fact demonstrate a rising levels of high aggression that can extend into pre-adolescence and adolescence (Côté, Vaillancourt, Barker, Nagin, & Tremblay, 2007). This group of children tends to encounter poor social adjustment and academic progress, rejection by peers, and delinquent and impulsive behaviour that is likely to manifest in antisocial behaviour and psychopathology in adulthood(Côté et al., 2007). Many of the factors associated with childhood aggression are family and parent-child relationship factors that are identifiable by trained professionals and may be ameliorated by intervention in infancy, and early childhood. Aggressive behaviours in school-aged children are significantly more difficult to treat (Priddis, Landy, Moroney, & Kane, 2013) and as previously noted, more costly to society.

We also know that children who have parents who can mentalize have better outcomes in many developmental arenas than children whose parents have limited capacity to mentalize. It has also been found that the capacity to mentalize for your child can be a protective factor even where there is insecure attachment. We know, too, that these trajectories may be altered and improved by early identification and assessment followed by sustained and sensitive interventions.

Development and use of assessment tools

We have clinically and psychometrically well-established assessment tools to identify infants at risk. The Strange Situation procedure remains a gold standard for assessing infant patterns of attachment (Ainsworth, Blehar, Waters, & Wall, 1978) including infants who behave in a disorganised manner in the presence of their caregiver (Solomon & George, 2008). The Strange Situation procedure is also used for assessing atypical maternal behaviours that are often associated with disorganised attachment (Bronfman, Madigan, & Lyons-Ruth, 2009). As children mature and have more resources such as language available to manage their relationships, a similar procedure may be used to identify subtypes of controlling behaviour identified as disorganised in the preschool child (Cassidy & Marvin, 1992). These procedures and others like these typically require extensive training in order to use them confidently. The intensive training undertaken by practitioners to master these assessments typically also results in the development of sophisticated awareness and ability to identify relationships at risk.

That clinical disorders in infants and young children exist is evident by the intensive efforts to classify the range mental health issues in this population. A diagnostic classificatory system that focussed on the first 4 years of life was first published in 1994 after seven years of investigation by an interdisciplinary professional leadership committee. An extensive clinical examination and research process over two years saw a revision published in 2005 (Zero to Three, 2005). In 2001 The US Academy of Child and Adolescent Psychiatry also saw fit to identify and classify disorders in the preschool period and supported a downward extension of the DSMIV-TR (Task Force on Research Diagnostic Criteria: Infancy and Preschool 2003).These systems are multiaxial and include behaviour disorders such as sleep and eating behaviour disorders as well as two types of depressive disorder, anxiety disorder and posttraumatic stress disorder as well as developmental disorders. Behavioural disorders as identified in the RDC-PA are also under consideration for inclusion in the next revision of the DC0-3 system for the under three's. Assessment typically takes place over an extended number of sessions (3 x 45 minutes minimum) and includes direct observation of the child as well as of the parent child relationship and parental interviews by trained practitioners.

Longitudinal studies provide evidence that trained practitioners can identify children in vulnerable relationships and those children at social and emotional risk in infancy and early childhood. For example, in a Western Australian study, the strange situation procedure was used to follow preschool age children from the regular community through to preadolescence. In this non clinical sample children who were identified by trained clinicians to have more extreme patterns of insecure attachment as five-year-olds, self-reported themselves to have symptoms of depression that remained unseen by their parents seven years later (Priddis & Howieson, 2012).

In an international study Lyons-Ruth (2011) identified clinical risk in infancy that was associated with more disturbing psychopathology including borderline traits and suicidality in young adults aged 20 years. What is striking about this study was that **trained clinicians identified infants in their first year of life who were most at risk of increased impulsive self-damaging behaviour at age 20 years.** Specifically, her research found a 6-9 fold increase in relative risk compared to those who were not referred from low income, high risk groups in the regular community. Further investigation found that this pernicious early environment was a separate risk factor even to later abuse both of which contribute independently to borderline features and suicidality in adulthood. Important to the issue of training is that the factors clinicians were identifying in the caregivers were not always obvious. Most people can identify negative, intrusive parental behaviours and angry, punitive parenting styles, however, this research identified that caregiver behaviours that predicted later borderline features and suicidality included disoriented, confused, fearful, or withdrawn behaviours in the relationship with the infant and/or contradictory signalling or frequent redirection of the infant to toys and away from the caregiver.

Given the enormous cost to society of managing the pervasive symptoms associated with borderline personality such as substance abuse, reckless driving, promiscuity, binge eating, drinking, suicidality, (50% higher in this population) tense and unstable relationships, and affective instability, let alone the effects on family and friends, how satisfactory it would be to eliminate such issues by improving the parent-child relationship in infancy.

Education and training must keep up with policy and practice change

New knowledge, skills and values must be incorporated into workforce training (Huang et al., 2004). Traditional training in discipline specific silos does not adequately prepare the workforce for the shift in practice of working in collaborative partnerships with families and other professionals and for interagency collaboration. Traditional impairment and symptom-reduction approaches to problems in infants and young children does not fit with the increased evidence base that identifies building resilience and developing healthy parent-infant relationships as key to improving the social and emotional wellbeing of infants, young children and their families. Increasing cultural diversity in the population requires attention in education and training on cultural competence. Changing roles and responsibilities create anxiety if up skilling does not occur with these. For example, frontline providers in child protection services are increasingly expected to deal with more complex situations; general practitioners are faced with more diverse and complex parental issues; school personnel are becoming involved earlier and earlier in the lives of children and their families and child health nurses find themselves faced with more complex parent-infant situations.

To summarise, there has been a rapid expansion of knowledge in the I-ECMH field, changing population needs, changes in models of service delivery and changing awareness of the potential of assessment and interventions in parent-infant relationships to change developmental trajectories over the lifespan. It is essential that education and training for the E-IECMH workforce keep pace with this to provide knowledge and skills and values that are fit for purpose. One step towards this is to invest in the development of competency based training curriculum (Huang et al.).

COMPETENCY BASED FRAMEWORKS IN I-ECMH

'For many years, the IMH field has recognised the need for training within a multidisciplinary perspective to enable service provision across the promotion, prevention, treatment spectrum. Numerous references have described major areas of training needs and the importance of considering the integration of IMH principles and practices across many professions and providers'

(Fraiberg, 1994; Shahmoon-Shanok, 2005; Shirilla & Weatherston, 2000); Wieder & Greenspan, 1997; cited in (Quay et al., 2009, p.182)

The field of infant mental health includes a variety of practitioners from varied disciplines working across a broad continuum of services focusing on promotion, prevention, intervention and treatment. The diversity of the workforce in early childhood mental health has posed challenges in defining competencies and standards of practice. However, within the diversity there is overwhelming support for an 'infant mental health orientation to treatment and care' (Korfmacher & Hilado, 2008). Despite different professional orientations and levels of service provision there is a shared understanding of the importance of relationships in the development of a child's social and emotional wellbeing and the need to adopt an IMH model for assessment and intervention when emotional, behavioural and social disturbances have been identified.

Early childhood services addressing mental health in infants, toddlers and young children have unique characteristics when compared to other mental health services for older children and adults (Korfmacher & Hilado). Often services for this cohort are operating from a prevention model and are not specifically dealing with identified mental health disorders in young children. Furthermore, services are provided in natural environments for young children such as childcare or home whereby services are offered indirectly to the parent. This complicates intervention as alternative models of intervention are required and it also has implications for funding (Korfmacher & Hilado). The unique features of early childhood services warrant the need for competencies that address promotion and prevention as well as the early intervention and treatment components of I-ECMH.

Over the past ten years there has been increased interest in developing a set of competencies that can identify the skills and knowledge required to work across the varied settings of I-ECMH. It has also been acknowledged that the establishment of a set of competencies, which includes different levels of expertise and multiple disciplines, will inform the training and guide professional development in the field.

Defining Competency

There has been a shift towards emphasis on the attainment of competencies in I-ECMH in keeping with an increasing demand for services and practitioners to meet the social, emotional and behavioural needs of young children and their families. This paradigm shift focuses on outcomes rather than learning objectives which are a feature of traditional models of education. In broad terms, competency can be understood as 'demonstrating capability or meeting a level of qualification for work in one's

field' (Weatherston et al., 2009). When understanding competency in the I-ECMH field important factors include:

- One's ability to analyse or think carefully
- To make observations and assessments that lead to good decisions and best practice
- To be self-reflective [Rodolfa et al, 2005 cited in (Weatherston et al., 2009, p.650)]

Behavioural descriptors that describe what the competencies look like in practice are important inclusions in any set of I-ECMH competency frameworks. Specifically, behavioural markers that indicate the effective performance of the acquired knowledge and skill. In addition, Weatherston and colleagues (2009) identify the importance of competencies been measurable and the need to have consensus from professionals in the field that the competencies reflect I-ECMH in practice (Stratford, 1994).

There are competency frameworks/systems developed within the field of I-ECMH. For the purposes of this report a competency system or framework is defined as 'a detailing of areas of knowledge and practice required of a specialist' (Korfmacher & Hilado, 2008).

I-ECMH COMPETENCY STANDARDS AROUND THE WORLD

USA

Over the past decade there has been growing momentum across The USA to develop and define descriptors that link with competence in the broad based interdisciplinary field of IMH (Johnston et al., 2013). Korfmacher & Hilado reviewed six of the IMH competency systems which were developed in the following states, Michigan, California, Vermont, Florida, Indiana and Connecticut. Since this review, Indiana and Connecticut along with 14 other states in The USA, have adopted The MI-AIMH Framework. The MI-AIMH set of Competency Guidelines defines 'the knowledge, skills, and experience that IMH providers should possess' (Johnston et al., 2013, p.53) across four levels of expertise.

Table 6. An overview of the competency frameworks (adapted from Korfmacher & Hilado, 2008)

State	Age Focus	Competency Level	Purpose
Michigan (MI-AIMH) Competency Guidelines and Endorsement	Birth to 3years, principles can be extended to incorporate up to 5 years old	1. Infant/Family Associate 2. Infant Family Specialist 3. Infant Mental Health Specialist 4. Infant Mental Health Mentor	Build workforce capacity and develop training programs to reflect competencies. Endorsement framework to recognise specific abilities and skills in IMH. Available in 17 states and interest internationally in Ireland and Japan
California	Birth to 5 years	I. Transdisciplinary Infant-Family 2. Early Childhood Mental Health Practitioner 3. Infant-Family and Early Childhood Mental Health Specialist	Offers an endorsement process, discrete number of training hours to be met in each competency area
Vermont	Birth to 8 years	1. Foundation 2. Intermediate 3. Advanced 4. Experienced	Competencies to guide what is required for service delivery with this population. Credentialing developed for Level 2 only
Florida (one large children's services agency in Florida has purchased a License to use the MI-AIMH Competency Guidelines only)	Birth to 5 years	1. Front line providers 2. Developmental professional 3. IMH Specialist	Competencies can be used as a professional development tool in self-evaluation of knowledge in the field of ECMH

Between the distinct and separate I-ECMH competency systems (Michigan, California, Vermont and Florida) there are a number of commonalities. These include focus on the core principles of I-ECMH (such as relationship based, holistic view of the child to include family systems, understanding of social-emotional development, risk and resiliencies and self-reflection), acknowledgement that I-ECMH is a field of diversity comprised of professionals working in a range of services directly or indirectly concerned with I-ECMH and the importance of including knowledge areas that are related to what constitutes healthy social and emotional functioning in early childhood (Johnston et al., 2013; Korfmacher & Hilado, 2008).

All competency frameworks identify the need for all professionals working in the field of I-ECMH to have a set of core skills when working with children under five years. Standards all outline that practitioners 'should be well versed in early development, understand the factors that contribute to risk and

resiliency; and be able to skilfully observe, assess and intervene within the bounds of practitioner's own discipline.' (Johnson et al., 2013, p. 54). All competency systems address up to the preschool years (5 years, with Vermont extending to 8 years) with the majority of competencies within these systems focussed on knowledge and skills in the age range of 0 to 3 years. There is acknowledgement that there are some different competencies required for different age groups (such as peer relations in 3-5 years), however, there is consensus that the IMH framework can be readily applied to extend to 5 years given the focus is on the philosophy of care rather than specific skill set (Korfmacher & Hilado, 2008). This report will follow with a summary of competency frameworks available in The USA and a detailed description of The MI-AIMH Framework which is internationally recognised as the most comprehensive framework available in the I-ECMH field.

California

The California competency system was specifically designed to guide the development of a training protocol which included academic course work, workshops, internships, clinical work with supervision across undergraduate and post graduate levels of education. It commenced as a two level system (Mental Health Professionals and Core Providers) covering eight areas of competency. The main difference between the two levels was that the mental health professional is required to complete significantly more hours of course work (180 hour versus 90 hours) and supervised clinical experience (500 hours versus 60 hours) than core providers. The rationale for this distinction between the two levels was that the more intensive training will allow 'mental health workers to be able to move from an understanding of core concepts to more in depth clinical applications and interventions approach for young children and their families within the context of their agency and practice area' (California AIMH, 2003, p 13).

Since this model was peer reviewed in 2008 (Korfmacher & Hilado) there have been some changes to the system and it was revised in 2011. There are now 3 levels (I:Transdisciplinary Infant-Family; II: Early Childhood Mental Health Practitioner and III: Infant-Family and Early Childhood Mental Health Specialist) and clinicians can work towards endorsement at those 3 levels which specify in detail a number of hours required in acquisition of knowledge, skills and engagement in reflective facilitation. Practitioners are required to complete a portfolio documenting training, clinical experience and reflective supervision.

The California Competency Guidelines and Endorsement process is comprehensive and offers a detailed account of competency areas and behavioural descriptors associated with areas of knowledge. Since 2008, the revised set of Competency Guidelines and Endorsement process has not been peer reviewed. There are some limitations to this model when compared to other competency models in I-ECMH. First, it only offers endorsement and competency guidelines for those professionals who have attained a bachelor's degree in a related field, limiting practitioners who work in professions such as childcare. Second, the requirements for attaining knowledge in the different domains of competency are specific to a discrete amount of hours (i.e., Infant, toddler and preschool development requires 24 hours). Consequently, there is no flexibility in acquiring the knowledge base outside of these specific hours outlined and this may reflect a specific training program that is offered in California.

Vermont

Vermont has developed a set of competencies for early childhood mental health (Early Childhood Family Mental Health Competencies) spanning from 0-8 years and their planning group included representation from special education, mental health and early intervention. It took four years to develop and the impetus for having a set of competencies was to use it as a 'protocol that could be used to guide development of a system of service delivery around social and emotional well-being in young children and families' (Korfmacher & Hilado, 2008, p.9). Similar to The MI-AIMH Framework, Vermont's system has four levels of competency with level four reflecting a stronger focus on clinical expertise rather than policy and leadership roles of level four in The MI-AIMH Competency Guidelines.

In 2011 the Early Childhood Family Mental Health Credential was formed. This Credential is based on the Early Childhood Family Mental Health Competencies – Intermediate Level (Level 2) and is for professionals currently working with young children (birth to 8 years) and their families in the classroom or other group setting, as a home visitor, or as a consultant. Candidates may come from different disciplines- education, health, related therapies, child care, social services, or mental health.

To begin the credential process a practitioner must meet the following requirements:

1. be working with children and families for at least 3 years;
2. have completed education (minimum 21 college credits in related fields),
3. have 3 years or more of work experience with young children and their families, and
4. have completed training in the last five years in the Early Childhood Mental Health core knowledge areas

The Vermont Early Childhood Mental Health Competency and Credentialing model is relatively new (2011) and only offers credentialing for level two practitioners. In addition, it does not include reflection as a core area of competency or any requirement to engage in reflective practice supervision. Reflective supervision and reflective practice have long been identified as an essential component of working in the early childhood mental health field (Gilkerson & Ritzler, 2005).

Florida

Florida State University developed a provisional tri-level model of service provision in early childhood mental health (front line providers, developmental professionals and IMH Specialist) [FSU Center for Prevention and Early Intervention Policy, 2001; cited in (Korfmacher & Hilado, 2008)]. The work group identified a set of 143 infant mental health competencies spanning across seven domains (normal development, abnormal development, emotional behavioural disorders, assessment, intervention, community resources and referral services and organisational skills and communication skills) and had 23 identified experts in the IMH field rate how essential each of these were to establish an empirical basis for the final set of competencies (Quay et al., 2009).

Findings from this study have guided the development of an IMH training program at Florida State University and the list of competencies can be used as a professional development tool in self-evaluation of knowledge in the field of I-ECMH (Korfmacher & Hilado, 2008; Quay et al., 2009). A limitation of this framework is that the identified competencies are concerned with acquiring knowledge

and skills without the inclusion of behavioural descriptors of how these competencies are demonstrated in practice. It is also of note that one large children's services agency in Florida has purchased a license to use The MI-AIMH Framework.

The Michigan Association for Infant Mental Health (MI-AIMH) Framework

History

The MI-AIMH Framework has been the most widely documented and reviewed set of IMH competencies and framework for credentialing professionals working in the IMH field (Michigan Association of Infant Mental Health, 2002a, 2002b). The Framework is recognised as the most comprehensive system available and is grounded in Michigan's long history of providing a range of infant mental health service provisions to infants, toddlers and their families and offering support to practitioners working in the field. After taking six years to develop, The MI-AIMH Framework is now used in 17 states across The USA. These states have purchased the licence to use The MI-AIMH Framework to 'support the expansion of relationship based services to infants and families and to promote knowledgeable, skilful, and reflective infant mental health practice' (Meyers, 2007; Weatherston et al., 2009, p.649; Weatherston et al., 2006).

The National Disability Act of 1986 identified the need for a set of core competencies for professionals working in the early childhood field and Michigan Department of Education became the lead agency for Part C in 1996. They identified five areas of competency for practitioners working with children zero to three years and their families, across a range of services and disciplines (theoretical foundations, legal and ethical foundations, interpersonal and team skills, direct service skills, and advocacy skills). MI-AIMH added another three areas of competency that were deemed an essential part of IMH practice and these included systems expertise, thinking, and reflection. Following the identification of competency areas an interdisciplinary working group (early childhood education, psychology, social work, nursing, occupational therapy, speech and language therapy, physiotherapy and other disciplines) expanded the areas after gathering detailed information on work practices across disciplines and levels of service. The process took two years and included facilitation of a number of focus groups, reviewing work journals (clinicians in the field were asked to write detailed work journals) and employing a professional skilled in developing workforce credentialing. Completion of this resulted in a detailed set of competencies including behavioural descriptors demonstrating these competencies across a four level system (Weatherston et al., 2009). The four level system includes:

- **Level I: Infant Family Associate**

  Practitioners who provide universal services fall within this category and include early learning childhood educators (certificates 3 or 4), home visitors, family day care providers, play group facilitators, teacher assistants and parenting educators.

- **Level II: Infant Family Specialist**

  Practitioners need to have a minimum of a Bachelor's degree and provide universal, promotion, prevention and intervention services and include Social Worker, Physiotherapist, Speech and Language Therapist, Nurses, General Practitioners and Occupational Therapists.

- **Level III: Infant Mental Health Specialist**

  Practitioners are required to have a minimum of a Master's Degree or Equivalent and include mental health clinicians, clinical nurse practitioners, early intervention specialists, clinical and counselling psychologists and psychiatrists.

- **Level IV: Infant Mental Health Mentor (Clinical, Policy, or Research/Faculty)**

  Practitioners are required to have a minimum of a Master's Degree and include clinical supervisors, researchers, academic faculty members and policy specialists.

The four levels include the same set of competency areas with 'increased complex behavioural and/or skills at each of the four levels' (Weatherston et al., 2009, p.652). Accompanying each level of competency is an 'impact map' which describes infant mental health service goals, objectives, responsibilities and competencies' (p. 652). The MI-AIMH Endorsement Framework was developed in conjunction with the Competency Guidelines. There was identified need for a credentialing system to ensure 'a level of assurance to families, agencies, and the public at large that the person who is providing services to infants, very young children, and their families meet standards of knowledge and skill that have been approved by a professional organisation devoted to promoting infant mental health' (Weatherston et al., 2006, p.5). Furthermore, development of an endorsement system was also in a response to the growing need to develop a pathway for building workforce capacity in the field of IMH. There was a sense of urgency around 'how to build a knowledgeable, skilful workforce' that can promote and intervene appropriately to the emotional and social needs of infants, young children and their families (Weatherston et al., 2009, p.654).

The MI-AIMH Endorsement Framework includes four levels, each requiring acquisition of knowledge and skills pertaining to the IMH field, clinical experience in the field, in-service training experiences and reflective supervision or consultation experiences. Practitioners applying for endorsement are required to provide a signed IMH code of ethics, provide reference ratings (linked to competencies and practice guidelines) from teachers, employers, supervisors who have provided reflective supervision or consultation; and at Levels 3 and 4, successfully complete a 3 hour written exam (Weatherston et al., 2006, p.6).

Earning The MI-AIMH Endorsement has provided a professional development plan for those working in the I-ECMH field. Below are some examples of professionals' experiences in earning The MI-AIMH Endorsement and the impact on their practice.

I have the Level I MI-AIMH Endorsement®. As a nursing diploma graduate (1967), I was experience rich and credential poor. I have found that the endorsement has given me greater credibility with my employer and professional colleagues. Further, the credentialing process encouraged me to continue my education to fill the gaps in my practicing knowledge. In 2003, I earned my Associate's Degree and in 2006 I earned my BA. I am in the process of applying for MI-AIMH endorsement at Level II with plans to earn my Master's degree and continue to move up the endorsement ladder.

Sandy Bump Lownds, IMH-E® (I) Infant Family Associate *moved to Level II in 2007*

The MI-AIMH Endorsement® has opened a whole new world for me regarding infants and toddlers. The process itself, especially the reflective supervision, has strengthened my personal and professional development. This reflective supervision has given me a stronger base from which to work, allowing me to integrate my expanding knowledge of best practice and research into my growing ability to really see, hear, feel and be with the families I serve as an early intervention teacher.

Marian Ohriel, IMH-E® (II) Infant Family Specialist *moved to Level III in 2007*

To be endorsed by MI-AIMH is, for me, a commitment to an organisation that has nurtured me in my own professional infancy and has had immense influence in the way I am able to be with and connect with the families and professionals with whom I work. MI-AIMH's commitment to infants, toddlers, families and to those who work with them is remarkable and it is a privilege to be endorsed and recognized by such an organisation.

Carla Barron, IMH-E® (III) Infant Mental Health Specialist *moved to Level IV in 2008*

Endorsement as an Infant Mental Health Mentor, Level IV says to others that knowledgeable support for infant-family work they do can be readily offered by me. I have also had a prosecuting attorney use the endorsement credential to support my testimony as an expert witness.

Sheryl Goldberg, IMH-E® (IV) Infant Mental Health Mentor

The MI-AIMH Framework offers a framework for building workforce capacity in early childhood mental health in a way that incorporates the promotion of optimal social and emotional well-being and nurturing early relationships, in addition to intervening where there are disturbances. Their comprehensive system has incorporated these principles of IMH and addresses the following issues in the I-ECMH field:

Provides a way of responding to the urgent need to build a knowledgeable, skilful and reflective workforce that is grounded in theory and best practice guidelines;

A framework for working towards developing local systematic training in I-ECMH and identifying how current trainings align with a set of competencies in I-ECMH for a more collaborative and integrative approach;

Model for workforce development to promote I-ECMH which can be delivered across services and disciplines at universal, promotion, prevention and intervention levels;

Building foundation for the establishment of recognised qualifications for I-ECMH practitioners;

Offers a developmental pathway for professionals across disciplines to integrate knowledge, skills and practice within a reflective practice model to ensure a quality service is been delivered to young children and their families;

Opens the door for those working at a policy and tertiary education level to obtain knowledge, skills and expertise in IMH within a reflective practice framework.

Outcomes following implementation of The MI-AIMH Framework

1. Individuals, government services and community agencies have identified areas of expertise, competency details and practice guidelines to influence the development of services that promote social and emotional well-being; relationship based practice, and I-ECMH in Michigan.
2. Creation of positions for 'Early Childhood Mental Health Practitioners' which specify a preference for professionals whose expertise have been endorsed by MI-AIMH.
3. Development of reflective supervision and consultation groups from front line staff and services to support reflective practice in mental health and non-mental health settings. Ten set up over a two year period.
4. Workshops, trainings and conferences sponsored by MI-AIMH and other infant-toddler associations have been organised with a specific relationship to the knowledge and skills identified in The MI-AIMH Competency Guidelines to support practitioners in up skilling and meeting requirements for endorsement.
5. Endorsement competencies have shaped the revision of course content in a Graduate Certificate Program in IMH and formed the basis for development of a new course titled 'Introduction to Infant Mental Health'.
6. University of Michigan has developed specialised training programs and individual courses that introduce graduate students in psychology, early childhood, nursing, family studies and social work to the field of IMH, expanding and preparing the workforce to promote and/or provide infant and early childhood mental health services.
7. Child Mental Health (CMH) agencies must support staff in participating in IMH training and make provisions for reflective practice supervision as required for endorsement.
8. Staff receive a US$ 3,000 bonus when they earn endorsement as an incentive.
9. Over 530 practitioners in Michigan are endorsed as of December 2012 and 283 are working towards endorsement.
10. Across the state of Michigan, universities are cross-walking the competencies with existing curricula in order to streamline application for endorsement after graduation (Weatherston et al., 2009; Zero to Three, 2013a).

The MI-AIMH Framework beyond Michigan

MI-AIMH has copyrighted the The MI-AIMH Framework. To date, 17 states have purchased the license to use either the MI-AIMH Competency Guidelines® or Endorsement Framework ® or both (Alaska, Arizona, Colorado, Connecticut, Idaho, Indiana, Kansas, Minnesota, New Jersey, New Mexico, New Jersey, Oklahoma, Texas, West Virginia, Wisconsin, Virginia). Two additional states are in the process of licensing (Washington and Rhode Island). Together, these states are known as the League of States. MI-AIMH nurtures the League of States by:

- providing mentorship and technical assistance for the first years;

- coordinating monthly conference calls for the states to discuss challenges and opportunities, such as creating practitioner interest in the endorsement system;
- sharing content for competency-based trainings;
- discussing cross-systems policy changes; and
- building capacity to provide reflective supervision and consultation.

Further, leaders from each state within the League of States plan an annual retreat to share information, develop strategies for reflective practice, review policies and procedures, explore strategies for growth, and strengthen collegial relationships – all for the purpose of building a knowledgeable and skilled infant mental health workforce (Zero to Three, 2013a, p 8).

The MI-AIMH Framework has been adapted in various states, each of whom have very differing local contexts and varying levels of IMH training and service provision. New Mexico has used the competencies to begin to develop training and alignment of competencies with existing certificate strands in early childhood education, early intervention, behavioural health and managed care. In Texas, it was identified that the workforce was not adequately meeting the needs of children aged 0-6 years presenting with social and emotional difficulties. A workgroup was formed (which represented a range of services and disciplines) and it was agreed that 'identifying core competencies for early childhood mental health, developing a framework for professional training, and creating a system for endorsement or credentialing in the infant-family field might lead toward a solution for the state' (Weatherston et al., 2006, p.12).

Texas initially began developing their own competencies, however, after two years of work and still a substantial amount of work required to develop and implement their own competencies they decided to adopt The MI-AIMH Framework in Texas. To ensure that The MI-AIMH Framework met the needs of the Texan context there was close collaboration between the two states to develop a framework that covered the 0-6 year age range and tailor The MI-AIMH Framework to meet the needs of Texan practitioners (Weatherston et al., 2006).

The number of states adopting The MI-AIMH Framework is steadily increasing and each have demonstrated how The MI-AIMH Framework can be adapted and tailored to meet the needs of each state. Here are some examples of how different states have adopted The MI-AIMH Framework (information sourced from 2012 League Competency and Endorsement Activity Summary on MI-AIMH Website):

Wisconsin has established a post graduate Infant, Early Childhood and Family Mental Health Certificate Program at the University of Wisconsin (2010), which is aligned with The MI-AIMH Competency Guidelines

In New Mexico, The MI-AIMH Competency Guidelines have been integrated into Associate and Bachelor level course in Early Childhood Education

The MI-AIMH Competency Guidelines were taken into consideration in the development of Early Educator Standards and competency plan in Colorado. The plan was cross-walked to existing systems to show alignment between the two sets.

In Arizona, The MI-AIMH Framework is included in a review and adoption of workforce competencies for early childhood system providers, specifically child care and home visiting

There has been an increase in training on reflective practice and the use of reflective supervision/consultation groups in Kansas.

Virginia held an Early Childhood Mental Health Summit in 2012 involving legislators, from early childhood and mental health which resulted in recommendations for Virginia.

International Collaborations with MI-AIMH

Ireland

There has been growing interest outside of The USA in The MI-AIMH Framework. Ireland is investigating funding opportunities which will enable them to adopt The MI-AIMH Framework. The Irish Association for Infant Mental Health (IAIMH) has developed a long-standing relationship with MI-AIMH, which has supported and guided building I-ECMH workforce capacity within the Irish Health Services. This relationship has resulted in the development of a number of building workforce capacity initiatives in I-ECMH including: various interdisciplinary training programs; ongoing reflective practice consultation groups to ensure sustainability of skills and knowledge gained in training opportunities and integration into clinical practice across all levels of service delivery.

IAIMH is working towards the development of a partnership with Irish Health Services and non-government agencies in order to recognise the need for competency guidelines and an endorsement framework. IAIMH considers this to be a critical objective in order to ensure early infant and toddler mental health and wellbeing is both promoted and supported, that quality services are provided to families with young children and that practitioners are also supported in having the highest standards of workforce capacity and competencies when working with early years services. Furthermore, IAIMH also seeks to provide a framework for the development of a formalised training program in I-ECMH. This has been identified as a significant need within early years education, as dedicated university based training I-ECMH courses are not yet available in Ireland (Maguire & Matacz, 2012).

Japan

Japan is currently researching The MI-AIMH Framework to determine whether they can be translated to be culturally appropriate for the Japanese workforce.

Europe

There are no comprehensive competency frameworks specific to I-ECMH within the United Kingdom or Europe. The Tavistock Clinic based in London have identified some core competencies required when working with infants, toddlers and their families aimed at practitioners working in health, social services

and early years education (presentation by Dr Louise Emanuel: Consultant Child Psychotherapist). In comparison to the other competency frameworks this set is smaller and does not include behavioural descriptors of the key skill and knowledge areas identified. The competencies appear to be specifically linked to the trainings offered by the Tavistock Clinic. The Tavistock Clinic offer a range of trainings which target practitioners working with families who require universal, targeted and specialist I-ECMH services.

The United Kingdom has developed a competence framework for Child and Adolescent Mental Health Services. This is a competency framework specific to practitioners working within Child and Adolescent Mental Health Services and covers six domains and targets clinicians working within tier two (specialised workers offering assessment and treatment services within primary care), three (specialist multidisciplinary teams dealing with problems that are deemed too complicated for tier two) and four (specialised day and inpatient units where patients with more severe mental health problems can be treated and assessed) services.

This framework draws on some of the same principles of I-ECMH practice such as, focusing attention on 'managing the emotional content of a session' (Generic Therapeutic Competency) and having knowledge of development in children and young people and of family development and transitions (core competency). However, there are also distinct differences with minimal emphasis on understanding the relationship as the clinical focus and no competency on reflective practice (although training is identified as an important component of ensuring clinical outcomes). These differences are also reflected in the map of CAMHS Competence specific interventions for infants and toddlers, which identify 'behavioural interventions for sleeping problems and feeding problems' and parent training and social skills training (Incredible Years Dinosaur school) for social and behavioural difficulties.

New Zealand

Real Skills Plus CAMHS : A Competency Framework for the Infant, Child and Youth Mental Health and Alcohol and other Drug Workforce-The Werry Centre New Zealand (2011)

'Real Skills Plus CAMHS is a competency framework describing the knowledge and skills that a practitioner needs to work with infants, children and young people who have moderate to severe mental health and/or alcohol or other drug (AoD) difficulties, their whänau and their community' (Werry Centre for Child and Adolescent Mental Health Website). This competency framework is a progressive two level system labelled at 'practitioner-core' and 'practitioner-specialist'. There are six domains that underpin this competency framework and they are:

1. Focusing on the infant, child, youth
2. Working from a developmental perspective
3. Focusing on whänau
4. Focusing on community systems
5. Focusing on rights (legislation)
6. Focusing on advocacy.

These six areas of skill are organised within a framework which follows a family's journey through contact with a mental health service and they are Engagement, Assessment, Intervention, Outcome/Evaluation. Within the framework there is a dedicated skill set (core and specialist) for practitioners working with infants and their families (infant defined as 0-4 years). Examples of skills required in each level are presented in Table 7 (excerpts taken from Real Skills Plus CAHMS Competency Framework, 2011):

Table 7. Real Skills Plus CAMHS infant component (0-4 years) of Competency Framework

Framework level	Core	Specialised
Engagement The practitioner will actively involve and support the infant, child, young person, and their whānau, working in partnership in all aspects of their contact with the service as appropriate	Demonstrate an understanding of the key principle that optimal growth and development occurs within nurturing relationships and therefore engagement must occur with the infant in the context of their parents/caregivers (Karoly, Kilburn & Cannon, 2005; Zeanah, 2000	Be a resource to the health practitioner team on appropriate engagement techniques with infants in the context of the infant-parents/caregiver relationship (consider teaching, mentoring, supervision)
Assessment The practitioner will be able complete a multi-dimensional assessment of the infant, child, young person and their whānau. This will be inclusive of: physical, social, emotional, psychological, cultural and spiritual aspects from a developmental perspective, the formulation to be developed in partnership with the child, young person, whānau and the care-team to determine whether mental health services are required or not.	Assess the strengths and difficulties in the infant-parent/caregiver relationship. Communicate these to parents/caregivers and the health-practitioner team	Complete an assessment of the infant's emotional well-being which would include an interpretation of the infant's communication with their parent/caregiver, and an assessment of the infant-parent/caregiver communication during play. With the parent/caregiver and the care team, develop a care plan articulating the infant's needs using specific knowledge of the effects of attachment on human development
Intervention The practitioner will be able to provide a range of best practice/evidence – informed and culturally appropriate interventions. These are described in comprehensive care-plans for infants, children and young people with mental heatlh/AoD concerns and their whānau.	Demonstrate knowledge of the evidenced-based interventions appropriate for intervening with infants and their parents/caregivers and be able to apply some of the techniques of these interventions under the supervision of a specialist-level practitioner	Deliver at least one evidence-based behavioural, cultural, psychotherapeutic or systemic intervention **Examples include but are not limited to:** Guided Interaction (McDonough, 2004) Child-Parent Psychotherapy (Leiberman, 2005) Watch, Wait and Wonder (Cohen & Muir, 1999) Steps Towards Effective Enjoyable Parenting: STEEPtm (Egeland & Erickson, 2004)

		DIR (Greenspan & Weider, 2006) Family/ Whänau therapy (for an overview see Carr, 2004; Gurman & Kniskern, 1991) Be a resource and a role-model for the team regarding the provision of intersectorally-based interventions (See the Community section of this document). Provide appropriate interventions in partnership with parents/caregivers with mental health, AoD difficulties, or be a consultant to adult mental health services.
Outcome/Evaluation (across all groups) The practitioner will be able to work in partnership with the infant, child and young person, their family/whänau and their community to measure the effectiveness of their contact with the mental health service and to participate in research that is aimed at enhancing service provision.	Demonstrate an understanding of outcome measures and the ability to collect outcome data.	Demonstrate an ability to interpret outcome data. Ability to use data in service-delivery planning.

The Real Skills Plus CAMHS Competency Framework offers a set of competencies in IMH specifically designed for clinicians working within a CAMHS setting. The competencies reflect principles and practices of IMH and recognises the need to have a core set of skills when working with young children and their families such as relationship based assessment and intervention, understanding that development occurs within a caregiving relationship, ability to use the DC: 0-3R, understanding of attachment principles and using therapeutic relationship as the basis of intervention. This framework also highlights the importance of working in partnership and collaboration with other sectors such as education, maternal services and social services (Child Protection).

Implementation of the Real Skills Plus CAMHS Model

The Werry Centre has developed an implementation model to facilitate the putting into practice of the Real Skills Plus CAMHS Competency Framework. This is based on the 'driver' model which 'ensures that there is an identified person(s) who has the time available and the required knowledge and skills to 'drive' the implementation process within the service' (Real Skills Plus CAMHS Training Compendium p.25). Tools and supporting resources to assist the implementation process have been developed and an evaluation process is scheduled at various points of The Project.

The Real Skills Plus CAMHS Competency Framework does not address the needs of the I-ECMH workforce in as much detail as The MI-AIMH Competency Guidelines due to its wider scope to including

children and young people (0-19 years) and its focus on practitioners working in CAMHS. The MI-AIMH Competency Guidelines compliment the Real Skills Plus CAMHS model by providing a more detailed set a competencies and behavioural descriptors that can enhance the current set of competencies for Infants (0-4 years) at core and specialised levels. The MI-AIMH Competency Guidelines also compliment the Real Skills Plus CAMHS framework by offering competencies for practitioners working outside the CAMHS setting, which is likely to foster collaboration and working in partnership with other sectors who work with young children and their families. The importance of building relationships with a broad range of agencies is a feature throughout the Real Skills Plus CAMHS Framework and The MI-AIMH Competency Guidelines.

National Context-Australia

There are a number of important practice standards in Australia that must be considered when investigating use of a competency framework for the Australian I-ECMH workforce. The next section of the report will review (1) The National Practice Standards for the Mental Health Workforce, (2) NSW CAMHS Competency Framework and (3) Early Years Learning Framework to demonstrate how The MI-AIMH Competency Guidelines aligned with each of these frameworks.

National Practice Standards for the Mental Health Workforce (2002)

The National Practice Standards for the Mental Health Workforce (Practice Standards, 2002) were developed in response to international and national trends in mental health workforce development indicating the need for practice standards and training modules aimed at increasing knowledge, skills and attitudes of the Australian workforce. The Practice Standards include 12 standards to be used across the lifespan spanning from infancy to old age. The document was developed in consultation with professional bodies, State and Territory Governments, education and training groups, and consumers and carers for the following disciplines, (1) Mental health nursing, (2) Occupational therapy, (3) Psychiatry, (4) Psychology and (5) Social work. The skills required for working with children and families are present in the Practice Standards and it is acknowledged 'that children of parents with a mental health problem and/or mental disorder have specific needs, which vary depending upon their age and circumstances (Australian Government, 2002, p.10).

Standard Five focusses on promotion and prevention strategies for the mental health workforce. This standard emphasises the importance of early detection and a population based approach to mental health which will 'have an impact over time on the prevalence and incidence of mental health problems and mental disorders' across the lifespan (p. 19). In relation to children, Standard Five identifies the ability to 'recognise that children are a particularly vulnerable group and a prime focus for prevention' as a required skill (p. 19). In reference to children, Standard Five also identifies the preschool setting as one of the key areas to target when considering strategies to improve mental health knowledge and awareness across the population.

Alignment of the National Practice Standards for the Mental Health Workforce (2002) and The MI-AIMH Competency Guidelines (2002)

The National Standards and The MI-AIMH Competency Guidelines align with each other across many of the standards and both have a similar overarching framework which includes:

- A focus on the interdisciplinary nature of working in mental health;
- Importance of cultural considerations;
- Using standards/competencies to complement existing standards of practice and competencies that exist for professions working in mental health; and
- Standards/competencies across promotion, prevention and intervention services

The MI-AIMH Competency Guidelines compliment the National Practice Standards by addressing the specific skills, knowledge and attitudes required for early childhood mental health (0-5 years) whilst keeping in line with the National Practice Standards as an overarching set of skills required for the entire mental health workforce. The MI-AIMH Competency Guidelines include a wider range of professionals which reflects the interdisciplinary nature of the I-ECMH field. One of the strengths of The MI-AIMH Competency Guidelines is that it focusses on skills required in working specifically with infants and toddlers, an age group which is included within the broad age range of 'children' in the National Practice Standards. It also has the potential to provide a framework and set of competencies when mental health professionals recognise limitations in their knowledge and expertise and require further specialised skills pertaining to infants and young children.

NSW Child and Adolescent Mental Health Services (CAMHS) Competency Framework

The NSW CAMHS Competency Framework addresses areas of practice to include CAMHS inpatient, community, consultation-liaison and mental health promotion roles and addresses both core and advanced competencies. The competencies are defined under three headings (1) Universal competencies, (2) Clinical competencies and (3) Population approach competencies, which represent the range of professionals working across promotion, prevention and tertiary services. This set of competencies is aligned with international CAMHS Competency frameworks, in particular the Real Skills Plus CAMHS New Zealand Framework (2011) and the UK Competence framework for Child and Adolescent Mental Health Services (Roth, Calder, & Pilling, 2011). The CAMHS Competency Framework is also in line with the Australian National Practice Standards and both specifically address the following professions, Psychiatry, Nursing, Social work, Psychology and Occupational therapy. The NSW Competency Framework recognises that other professionals also play a role in service delivery in child and adolescent mental health services and report that this competency framework could also contribute to elements of their core practice.

The NSW Framework offers a two-level system of competency. A core competency level for 'New to CAMHS' practitioners in the first two years of clinical practice in CAMHS and Advanced competencies for experienced clinicians who are developing specialised skills in a particular area or advanced skills across general practice domains.

The NSW Competency Framework identifies an Infant and Early Childhood (0–4 years) cohort, similar to the Real Skills Plus CAMHS New Zealand Model. Within the principles of the framework which adopts a bio-psychosocial model of conceptualising mental health in children and adolescence, there is a section dedicated to understanding the developmental context of the infant period (defined 0-4 years inclusive). Table 8 contains examples of the key areas in the NSW Framework 'Developmental Context' section pertaining to the Infant (0-4 years inclusive).

Table 8 . Developmental Context and associated Developmental Markers for Infants (0-4 years inclusive)

Key Relationship Domains Development in this age group occurs primarily in the context of the adult/child dyad so the client in relation to 'self 'and 'others' is combined in this section	**Developmental Markers**
1. & 2. The client in relation to *self* and *others* (primarily primary caregivers)	• Regulation – feeding, sleep/wake cycles, crying/dyadic settling strategies (somatic and/or emotional regulation) • Relationship patterns – primary caregiver/child relationship – response to care giving, separation and strangers, social seeking or avoidance, development of trust • Behaviour • Sensory Adaptation responses • Developing Autonomy in self care • Communication • Play
3. The client in relation to *the world*	• Develops sensory preferences (e.g., food, textures, sounds) • Play – development of play preferences (e.g., favourite toys and books) and development of symbolic play in making sense of the world • Emerging decision making about self care and play choices

The Framework offers a comprehensive set of competencies, implementation plan and accompanying tools to guide workforce development across CAMHS services in NSW. It has identified the target group as 'Psychiatry, Nursing, Social Work, Psychology and Occupational Therapy' and outlines a number of ways in which the model can be utilised including 'assist in personal reflection, develop standards of practice, develop training and resources and develop team practices and services' (NSW Health, 2011, p.41). The Framework provides a range of tools (Competency Review Tools) that can be used to measure whether competence in a particular area is been achieved. These tools are to be used in conjunction with structures such as reflective practice, clinical supervision, professional development

and performance appraisals. The various structures offer a way in which the competency framework can be embedded in everyday practice for clinicians, managers and supervisors.

Alignment of NSW CAMHS Competency Framework (2011) and The MI-AIMH Competency Guidelines (2002)

The NSW CAMHS Competency Framework covers a broad age range (0-17 years) and whilst there is a specific section for infants under Developmental Context there is no dedicated skill set identified for infants and young children in the 12 competency areas. The MI-AIMH Framework is aligned with the NSW CAMHS Competency Framework. Both models complement each other and specifically address areas of competence that are relevant across both I-ECMH and child and adolescent mental health (examples include Communication, Cultural Issues, Partnership and Collaboration, Direct Service Skills to include Assessment and Intervention). The I-ECMH field has a more discrete age range (0-5 years) and subsequently The MI-AIMH Competency Guidelines is able to provide a detailed competency framework and associated behavioural descriptors for this age group. It is also able to offer a significant contribution to enhancing the NSW framework when considering the specific skill set required to work with infant, young children and their families. The MI-AIMH Competency Guidelines provide clinicians and services with clear training guidelines in I-ECMH that are specific to a CAMHS setting. Furthermore, it offers an endorsement system in which training, clinical experience and knowledge in I-ECMH can be formerly recognised.

The NSW Framework offers a specific set of descriptors for cultural competence with Aboriginal families that The MI-AIMH Competency Guidelines does not provide. Although The MI-AIMH Competency Guidelines provide competencies pertaining to cultural competence they are broad and not specific to the Australian context. In considering adopting The MI-AIMH Framework to the Australian context it may be important to develop a more specific set of behavioural indicators and to draw on the set of 8 domains under Competency 4 'Working with Aboriginal children, adolescents, families and communities' in the NSW CAMHS Competency Framework.

In considering how the two frameworks align, Reflective Practice is an example of an area of competence that is identified in both frameworks. In the NSW CAMHS Framework in Competency 6: Continuous Quality Improvement under Professional Practice and Development 'uses reflective practice' is identified as a competency area (6.3.3). The MI-AIMH Competency Guidelines (level three) also have an area of competency labelled 'Reflection' and outline specific skill areas (contemplation, self-awareness, curiosity, professional/personal development, emotional response and parallel process) and associated behavioural descriptors (7 descriptors) to demonstrate what the skill looks like in practice at this level of expertise. An example of one of the descriptors is:

'regularly examines own thoughts, feelings, strengths, and growth areas; discusses issues, concerns, actions to take with supervisor, consultants or peers' (Weatherston et al., 2009, p.656).

The detailed reflective practice skill areas and associated behavioural descriptors in The MI-AIMH Competency Guidelines provide CAMHS services and practitioners a more detailed competency framework on reflective practice that is in line with the NSW CAMHS Competency Framework.

Early Years Learning Framework and Classroom First Strategy

Australia's first national Early Years Learning Framework for early childhood educators was launched in 2009 (Australian Government, 2009). The framework was developed to 'extend and enrich children's learning from birth to five years and through the transition to school. The Council of Australian Governments (COAG) developed this Framework to assist educators to provide young children with opportunities to maximise their potential and develop a foundation for future success in learning. In this way, the Early Years Learning Framework (the EYLF) will contribute to realising the COAG vision that: "All children have the best start in life to create a better future for themselves and for the nation." (Early Years Learning Framework; Australian Government Department of Education, Employment and Workplace, 2009, p. 5).

There are five main principles in the EYLF. In the EYLF principle of 'secure respectful and reciprocal relationships' it is recognised that developing a secure attachment relationship enables young children to regulate their feelings, feel safe in the world and explore their environment with confidence. The EYLF identifies that the early educator has a significant role to play in providing a child with emotional support and nurturing relationships, which in turn contribute to building capacity to interact with their peers and relate to others. 'Ongoing learning and reflective practice' is another one of the five main principles of the EYLF and is used as a way of building professionals' skills in the field of early childhood education and creating learning communities.

Principles in the EYLF are supported by 'Classroom First Strategy', an initiative of the Director General, Sharyn O'Neill Department of Education, Western Australia (2011). One of the two focus areas in the Kindergarten year has been identified as 'personal and social competence'. This area of competency outlines specific capacities in a child that are linked to their ability to succeed in the school setting and includes ability to 'join in and participate in groups, deal with frustration and stand up for themselves'(Department of Education, 2011, p.6). These are important social and emotional developmental milestones and the I-ECMH field provides extensive literature and knowledge demonstrating how factors such as early attachment relationships contribute to personal and social competence at this stage of development.

Alignment of the Early Years Learning Framework with The MI-AIMH Framework

The MI-AIMH Competency Guidelines align with the EYLF. Both frameworks provide behavioural descriptors which articulate the skills and knowledge required by staff in an educational setting to respond to social and emotional needs of infants, young children. The MI-AIMH Competency Guidelines describe in more detail what some of the identified principles in the EYLF (pertaining to social and emotional development) look like in practice. The MI-AIMH Competency Guidelines can also inform training and program development in I-ECMH for Early Educators, whilst in keeping with the main principles in the EYLF.

Ongoing learning and reflective practice is a key principle in the EYLF. The MI-AIMH Competency Guidelines are strongly aligned with this principle and again offer a detailed framework as to what is required to engage in reflective practice at this level and what specific skills are required (i.e. Contemplation, curiosity, self-awareness, professional/personal development, emotional response and parallel process, (Weatherston et al., 2009). The five learning outcomes in the EYLF are also closely aligned with the outcomes outlined in the 'Impact Maps' in The MI-AIMH Competency Guidelines. The EYLF outlines that relationships are the foundations for the construction of identity and The MI-AIMH Competency Guidelines offers a relationship based framework to understanding the emotional needs of young children.

Summary

There are a number of international competency frameworks relevant to I-ECMH, which have been reviewed in the current report. Careful and detailed analysis of these reveals that The MI-AIMH Framework is the gold standard and most comprehensive and detailed IMH competency framework available. Although some of the other frameworks bear a number of similarities they lack the behavioural descriptors and/or an endorsement or credentialing process. These two qualities of The MI-AIMH Framework ensures a more objective, standardised system of determining whether a practitioner has demonstrated the skills required rather than allowing a more subjective assessment by their supervisor or senior. The MI-AIMH Framework has been successfully adopted in 17 states in The USA and are currently under investigation for use in two countries outside The USA, all of which suggests this is the most appropriate model with capacity to be adopted for use within a West Australian context.

TRAINING MODELS FOR THE I-ECMH WORKFORCE

A literature search of international training programs and models of delivery in Infant Mental Health identified a series of initiatives in the USA, Canada, UK and Europe. The majority of these were influenced by or in joint collaboration with the respective Associations of Infant Mental Health and many have university affiliations.

WAIMH

The approach to training that is encouraged by the World Association for Infant Mental Health (WAIMH) is one of a clearinghouse of relevant ideas, questions, innovations and issues in the field of I-ECMH. WAIMH maintains an active website linking affiliate associations in Africa, Asia, Australia and Oceania, Europe, the Middle East, Canada, The USA, and South The USA. The organisation has a face book page for affiliate committees that allows for cross country fertilization and exchange of ideas. WAIMH hosts an international biennial congress that attracts around 1000 participants where exchange of ideas, methods and debates on current issues are encouraged. The "Rights of the infant", Reflective Supervision and competency based models for training are currently topical on the international scene.

WAIMH publishes a peer reviewed bimonthly journal "Infant Mental Health Journal " that has a respected citation factor and provides access to the latest peer-reviewed research articles, literature reviews, program descriptions/evaluations, clinical studies, and book reviews that focus on infant social-emotional development, neurobiological correlates of emotional development, caregiver-infant interactions, contextual and cultural influences on infant and family development, and all conditions that place infants and/or their families at risk for less than optimal development. The journal is dedicated to interdisciplinary approaches, including diverse theoretical views, to the optimal development of infants and their families. Special emphasis is given to high risk infants and very young children and their families.

TRAINING EXAMPLES FROM AROUND THE WORLD

United Kingdom

England

In the United Kingdom, AIMH UK acts as a disseminator of information across all levels of service and levels of competency in much the same was as AAIMHI WA and AAIMHI do. AIMH UK is a source of expertise and provides advice to governments and organisations on I-ECMH issues. Its members have made training videos and vignettes for dissemination. Delivery of training primarily remains with the respective recognized agencies who buy in to training or through individuals who access training independently.

In 2006 the National CAMHS Support Service (NCSS) in the UK recognized the need for a sustainable and accessible approach to training in Mental Health across the lifespan and commissioned and funded "Everybody's Business". This is an online learning forum that contains modules on Perinatal and Infant Mental Health as well as Health Promotion and Understanding Mental Health and was updated in 2009. The training package was the result of collaboration with several I-ECMH practitioners (e.g. Robin Balbernie Psychotherapist and committee member UK AAIMHI, Tessa Baradon; Jane Sedgewick mental health nurse) with expertise in cross sector working and service development. The materials were then developed by a private company and converted to multimedia by another private company (National CAMHS Support Service, 2009).

One example of Training across the Perinatal and Infant Mental Health (PIMH) workforce in the UK is that of the 'Windscreen Training Model' of the NHS North West (2011). The NHS training needs analysis for PIMH, identified that the largest demand for training was in parent-infant relationship assessment skills, followed by those in perinatal mental health assessment. Risk assessment, psychotherapeutic skills and overall awareness of PIMH issues were also identified. Those who were accessing training did so in an ad hoc fashion through special interest groups, national accredited courses and individuals. The training model that the NHS service developed emphasises joint cross professional training and cross-sector training with a focus on training for emerging and developing practices in order that new skills are recognised and accredited and to support cross-sector mobility. The comprehensive training

package is presented within a mental health framework across universal, targeted and indicated trainings. Examples from the windscreen model are given in Table 9 .

More specific training in the UK for Level 3 and 4 (M-AIMH) occurs through a specialist training centre known as the International Training School for Infancy and school years (ITSIEY). This Training Framework was established in 2012 and comprises collaborations with three established leaders in the field of I-ECMH: Anna Freud Centre (UK), Yale University Child Study Center (USA) and Tavistock and Portman NHS Foundation Trust (UK)(ITSIEY, 2013). The ITSIEY courses are typically offered in modules so that health service workers can build upon their learning to gain a postgraduate certificate. Modules are offered at introduction level with specialist level modules due to be available in 2014. See Table 9.

Each centre advertises and runs the ITSIEY modules as well as their own badged modules. For example, Tavistock in collaboration with University of East London University offers a module on Early Years development: I-ECMH that aims to enhance the capacity of the workforce to observe closely and work therapeutically with infants and young children and their families and the Anna Freud Centre continues to offer other courses in specific assessment such as the Parent-Infant Relational Assessment Tool (PIRAT) and in CBT and in Mentalizing.

Scotland

In Scotland, the Scottish finance committee recognized that preventative spending on intervention and health promotion in early childhood years is more effective use of public spending. This committee recommended that both the Scottish government and the Scottish parliament take the lead in delivering a radical step change in the existing approach to interventions in infancy, toddler hood and the early child years. One such outcome is The Pre-Birth to Three National Guidance and Multimedia Resource that was created by an “Early Years Team” in collaboration with the Scottish Government and I-ECMH practitioners, universities, colleges and MHS Health Scotland. The Rights of the Child, Relationships, Responsive Care and Respect are the four key principles which form the basis of this guidance and the guidance program encompasses Pre-Birth and highlights the importance of children’s development from the very earliest years as well as the importance of supporting and working with prospective parents. It is a 5-hour DVD supported by case studies of ‘practitioners at work’ with links to websites and policy and research evidence. It is not all mental health focused (teaching and learning oriented parts) and includes information for parents and carers(Galloway, 2012).

At Level 3 and 4 (The MI-AIMH Framework), Scotland have collaborated with New Orleans and with Arietta Slade in Minding the Baby in pilot studies and Heads up Scotland have made recommendations for training. See Table 9.

Table 9. Summary Table of UK Training models

Location	Program	Training /PD Model
London	AAIMH UK	Clearing house of appropriate I-ECMH training and disseminates knowledge
	International Training School for Infancy and school years (ITSIEY) Comprises collaborations with Anna Freud Center, Yale University Child Study Center with Tavistock and Portman NHS Foundation Trust	Have recently developed a competence based framework to sit alongside training. Currently seeking accreditation with relevant organisations. Pathway1 Continuing Professional Development including Medical education. Modules range from 1-4 days and user pays. Pathway 2. Foundation in Infancy and early years mental health Pathway 3: Specialist level in development.
	Tavistock/ University East London	2 year Master of Arts that includes 2 year weekly infant observation and a dissertation. Postgrad cert after year 1.
	Everybody's Business (NCSS)	On-line learning modules (4 sessions each I-ECMH includes one session each on "becoming a parent; When things go wrong;Ways to promote positive mental health ; attachment –the language of relationships)
NHS North West	PIMH: Improving outcomes and ensuring quality: A guide for commissioners and providers of perinatal and infant mental health services.	Windscreen training model and framework to build capability and capacity in the workforce. Four levels of service delivery are identified with associated levels of learning. Level 1 has National e- modules that include baby massage and assessment with Brazelton's NBAS Level 2& 3 includes IAPT/CBT training for adults and children, Reflective video feedback & relational observation. Level 4 includes training in specialist therapeutic approaches including DBT, parent-infant psychotherapy, mentalizing,
Scotland	Pilot New Orleans Intervention Model and Minding the Baby	Over last 5 years recognizing importance of early years – Recommends common core training for all staff Recommends I-ECMH to be made part of core curriculum for all courses for public health nurses, u/grad doctors

		Recommends post qualification training in identification of “at risk’ families to be made to midwives, public health nurses, child mental health and childcare and education professionals. Recommends joint training for frontline staff delivering perinatal services CAMHS staff to deliver support to universal service personnel to have completed module in I-ECMH Recommends Standards and core competencies to be developed See nspcc.org.uk
Scotland	Scottish Social Services Website: Education Scotland Early years Website	http://www.educationscotland.gov.uk/video/p/genericcontent_tcm4639148.asp?strReferringChannel=earlyyears&strReferringPageID=tcm:4-633855-64 Includes filmed conversations with experts e.g. Colwyn Trevarthen, Robin Balbernie National Guidance and multimedia resource launched December 2010 called “Pre-Birth to three: Positive outcomes for Scotland’s Children and families)
	NSPCC (The National Society for the Prevention of Cruelty to Children). A UK charity . Breakdown or Breakthrough	http://www.nspcc.org.uk/Inform/trainingandconsultancy/learningresources/breakdown-or-breakthrough_wda87681.html
		http://www.nspcc.org.uk/Inform/trainingandconsultancy/educare/educarechildprotectionawareness_wda47926.html

Europe

In Europe, The WHO Regional Office for Europe published a 10 year action plan for mental health reform in 2005(World Health Organisation, 2005). This group included representation from WAIMH (Tuula Tamminen, President) and while not directly focused on infant or child mental health issues it has needs that are in line with those in WA. These are too:

- Identify new staff roles and responsibilities across the specialist and generic workforce employed in the health sector and other relevant areas, such as the education and justice sectors;
- identify strategies to encourage the recruitment of new mental health workers and enhance the retention of existing workers, and ensures an equitable distribution of mental health workers;
- plan and fund, in partnership with colleges and universities, programs addressing the training needs of existing and newly recruited staff, with plans considering the issue of lack of expertise in new technologies of present trainers and including a "train the trainers" program;
- include mental health in the curricula of all health professionals and design continuing professional education and training programs for the workforce;
- include service user and family input into human resource planning, education and training (pages 108-09)

Examples are given throughout the document, one of possible interest for adaptation to the WA IMH context is that of an Icelandic project known as (Geðrækt (which means mental health promotion). This involved a multi-sectorial partnership between three sectors of society: "state, private and civil." This was a health promotion innovation based on a need to keep The Project independent and to attract funding from the private sector. Private companies gave 75% of the total funding with the remaining 25% coming from government ministries. The approach used was a merging of the top down and bottom-up approaches, with the policy aims of the top-down approach and the action – oriented bottom up perspective (page 121). The Project reports that a survey two years later indicated that 50% of the nation knew of The Project.

The Child and Adolescent Mental Health in Europe plan (Braddick et al., 2009) identifies training for child and adolescent mental health per se to be poor in the curricula for most professionals. It is viewed as variable for child psychiatry, where in some countries it has only recently been developed as a specialty and in others such as Germany (especially Baden – Wuttemburg) and Finland comprehensive training in child and adolescent psychiatry and in child and adolescent psychotherapy for allied health professionals exists.

This report recommends that systematic data collection for every level occur from consumer surveys through to community providers as well as through levels in the health system in order to better understand the needs for service and training required. The report provides data that highlights the plights of groups of vulnerable children who require extra attention by services including those living

in poverty, those who are homeless, children in care, asylum seeker children, traveller children, abandoned children due to parental migration for employment, minority /ethnic groups, adopted children, disabled children, children with parents with mental illness and/or substance abuse, abused children. No specific mention is made of infants in these situations but they must be presumed to exist. For infants and young children in these groups' services and concomitant workforce development is a priority. Multisectoral examples include: The Efficient Child and Family Program organized by STAKES. This is a nationwide development and training program for professionals who work with children and families at high risk, which aims to develop working processes for use by social and health care professionals, different co-operating partners and organisations (Braddick et al., 2009, pge 14).

A specific focus on Infant Mental health is evident in Germany in 2005 where a collaborative project with the German Association for Infant Mental Health, the University of Heidelberg and the Federal Centre for Health Education jointly collaborated in a project to assess all institutions and registered GP's in terms of their consultation and treatment with parents and infants or toddlers. Norway also does a yearly audit of all specialist mental health services and identified a need to up skill GP's and increase their competence in recognizing mental health issues in children.

In Sweden, a national strategy of prevention has been implemented. Recognizing that intervention starts antenatal and from birth at universal access points such as the midwife and child health nurses, this country has established a strategy that sees 99% of pregnant women access maternity health care services and they typically have 11 individual contacts, mostly with midwives. After the birth 99% of all families make use of health care services and typically access 20 individual contacts with nurses. In addition, in Sweden 98% of maternity healthcare clinics offer group parenting education to first time parents and in Stockholm, 61% of parents access at least 5 sessions.

Midwives in Sweden spend around 10% of their time on parent education and have access to regular professional training, often facilitated by a psychologist. Evidence this system is benefitting the well-being of infants may be seen in the breastfeeding figures where 98% of Swedish mothers begin to breastfeed and 72% still do so at 6 months compared to (79% and 22% in the UK respectively – Australian data is unavailable to this project). Perhaps this health start is reflected in the small number of births to teen mothers in in Sweden (1.6% versus 7.1 % in the UK)(Hosking, 2011).

Ireland

Ireland has an I-ECMH strategy that aims to support every child (with extra support for vulnerable populations) in order to build protective and resilience factors within population to create gradual reduction in number of children and families in crisis (Hosking, 2011)

Ireland now has an Irish Association for Infant Mental Health (I-AIMH); established in 2009, it is an Affiliate of the WAIMH. I-AIMH has a growing membership, currently comprising of 48 health care professionals. As the field develops it has become clear that there is a dearth of skills and capacities to deliver an IMH service across all disciplines and levels of service. To fully address these gaps, a range of generic and specific interdisciplinary training models was required for the purpose of opening referral pathways for service provision.

Correspondence with an international supervisor, along with international experts and colleagues in the field of IMH coupled with a review of the extensive evidenced based literature, enabled leaders of the North Cork IMH Project to devise the guiding principles required to develop and deliver an interdisciplinary Infant Mental Health Training Model.

Delivery of the North Cork Infant Mental Health Training Model took place in 3 stages:

- Introductory training program which consisted of a Pre Training Introductory Lectures
- A 3 day Master Class facilitated by an international Infant Mental Health Consultant, in collaboration with the two local accredited Infant Mental Health Specialists.
- Post training evaluation questionaires were used to assess the effectiveness of the Master Class Education program and significant shifts were reported by all disciplines.
- Development of an IMH Network Group was established to provide group members with continued reflective practice, learning and education skill development in Infant Mental Health along with further opportunities to develop their core competencies in this field. The Network Group included educational meetings which involved a theoretical component, clinical case discussions and reflective practice.

This model was designed so that it would ultimately provide a structure for professionals progressing towards achieving endorsement in line with The MI-AIMH Endorsement Framework. Advances in I-ECMH are now evident within the health service delivery within Ireland and it is gradually developing across multiple tiers of service delivery, including college and university based health service training programs and in voluntary and community based services. There is also growing awareness emerging in government health departments. The North Cork Infant Mental Health Training Model is replicated across a number of counties in the Republic of Ireland and is considered the examplar model for building workfroce capacity in IMH.

Training is an identified strand to build capacity of statutory/community services to understand and respond to infant mental health need, through training in competencies and endorsement. Training builds capacity of services to respond to infant social and emotional need and enables:

- capacity building for staff, families, programs, systems
- identifies, treats and reduces mental health problems, birth – 3 years
- direct observation of children and care-giving environment
- design of interventions to change behaviour

Canada

An overview of Infant Mental health in Canada (St-Andre & Wittenberg, 2010) highlights that differing definitions of early childhood, regional politics, and fragmented services impede the development of coordinated quality services for infants, foetuses and young children. Many initiatives in Canada for this population occur through the Hospital for Sick children in Toronto and through the Hincks-Dellcrest Institute in collaboration with WAIMH affiliates.

The IMHP (Infant Mental Health Promotion) was initiated in 1988 by the Department of Psychiatry of The Hospital for Sick Children. Since then the organisation has grown considerably and maintains strong representation from community-based agencies across Canada. Infant Mental Health Promotion (IMP) provides a collaborative, informed and passionate voice for infants, families and caregivers through a quarterly newsletter, DVD on understanding self-regulation and attachment; a website and calendar of training events all aimed at front line workers. Through collaboration with York University a program of study has been developed.

The hospital runs a group intervention for mothers/ father and young babies that aims to "*foster adaptive attachment relationships…(and) integrates multiple theoretical approaches to help parents recognize the significance of infant observation, the development of infant's mind and the influence of the parent's state of mind and behaviours on the baby's sense of security* " (pge2). A second intervention integrates the efforts of child protection and the legal system with infant mental health and social service systems for vulnerable infants and young children.

The Hincks-Dellcrest Institute was established in 1986 to improve the training of professionals involved in the mental health care of children, it exists alongside a clinic service. It offers a clinical infant mental health program that provides workshops, consultation and supervision services and certificate courses and provides training for professionals working with infants, young children and their families. Browsing this calendar in July 2013 showed a course on "Introduction to infant-parent psychotherapy: The Clinical Assessment, Formulation, and Treatment of the Under Fives and Their Families" a 30-week user pays course with 3 hour seminars held weekly.

Training for professionals and front line practitioners in infant mental health principles in Canada is in the main ad hoc, depending on staff expertise and hospital conditions, philosophy and politics. A coordinated approach to training is called for. This is developing in Quebec through partnerships with universities, professional organisations and field organisations that organize workshops, course and educational programs and congresses. There is a dedicated Infant Psychiatry clinic at British Columbia's children's hospital that is involved in training of infant mental health fellows from a number of disciplines (child psychiatry, infant development, anthropology, and psychology/criminology). In collaboration with a government ministry and the Western Canadian affiliate of WAIMH a web based course was designed for newly hired

mental health professionals. Community agencies and the hospital hold monthly Infant mental health rounds to come together to share knowledge about research and interventions.

The USA

There is a wealth of literature on the growth of I-ECMH training in the USA that is beyond the scope of this paper to review.

A summary of training programs identified in 2007 included 25 programs in 13 states. By 2009 this number had grown to over 30 programs in 15 states and today 18 States have competencies and training programs in existence. All states have had the support of either a philanthropic organisation, a supportive university or a committed Non-government organisation as well as collaboration with government for training (Bartlett et al., 2007). Collaborations and multi-collaborations are the norm and frequently these are headed by academic institutions or between an academic institution and another entity such as a mental health clinic, hospital childcare program, IMH association or government agency.

A thorough and informative paper that is essential reading for anyone involved in planning a training curriculum for the I-ECMH workforce is that titled “Lessons for Massachusetts from the National Landscape by “Bartlett, Waddoups, Zimmerman.

This paper identifies that issues for the development of training programs include balancing breadth and depth as well as a prevention, promotion and intervention. The authors surveyed training programs in 14 states and identified the following recurrent content areas:

- Emotional development of young children;
- Emotional contribution of parents and other caregivers;
- Dynamics of relationships
- Influence of culture on caretaking practices and expectations
- Contribution of trauma, substance abuse, and domestic violence to the infant-caregiver relationship
- Use of screening, assessment, intervention and research tools. (page 10).

Four essential skills also emerge: observation, interpretation, self-reflection and establishing and maintaining empathic relationships (page 12).

Typical settings for I-ECMH training in the USA include: Infant Mental Health Association sites; agency sites with AIMH workers delivering training; agency based consultation.

The recommendations pertinent to training made in the Bartlett et al report (p.4) are summarized verbatim below

- Promote a culturally competent IMH training model that supports and enhances the dynamics of relationships.
- Require foundation IMH training for all professionals interacting with babies, toddlers, preschoolers, their families, and other significant caregivers.

- Provide appropriate professional and/or academic recognition for IMH training.
- Deliver in-service training that brings together staff from every level of an agency or program e.g., director, supervisor, frontline.
- Encourage academic institutions to set up degree programs in broadly defined IMH.
- Include training in each state initiative focused on children ages birth to five.
- Integrate an evaluation component into all IMH training.

The USA example 1

Minnesota (Graham et al., 2012)

Minnesota draws upon four decades of focus on I-ECMH. It was the site of the first university based longitudinal research to study risk and adaptation from birth to adulthood (Sroufe et al., 2005) that has greatly influenced awareness of the importance of the early years throughout the world. Based on the findings of this study Project STEEP was developed in the mid-80's and influenced home visiting programs throughout the world for high risk infants and families. The Irving Harris Foundation has supported Project STEEP and from this research base disseminated the findings and educated practitioners and informed policy development for early childhood throughout the state. With this momentum cam recognition for the need to more sustained training for frontline workers as well as to up skill mental health professionals to work with infants', young children and their parents. The University of Minnesota in collaboration with the Foundation. Local foundations and the early childhood community developed the Infant and Early Childhood Certificate program at the University of Minnesota in 2007. In addition, the university and other local partners lent resources to the Children's Mental Health Division to develop the clinical capacity to provide interventions to children under five years old and their families. In 2005 this collaboration saw over 1000 clinicians trained in the use of DC0-3R (Zero to Three 2005). This training was supported by monthly consultations groups using teleconferencing. The Minnesota model is characterised by relationships and partnerships between agencies that are based on solid research linked with training and dissemination of skills and knowledge.

The University of Minnesota's Center for Early Education and Development runs a series of online courses one of which addresses *Michigan Association for Infant Mental Health, (MI-AIMH) Competency Guidelines and Endorsement for culturally sensitive, relationship-focused practice promoting infant mental health®.* At a cost of US$ $290 a participant can enrol on line for a course comprised of eight modules that cover introduction to IMH, IMH as an integrative multidisciplinary field of research and practice, Becoming an IMH specialist, observing infants, collaboration in IMH, group care of infants and toddlers and relationship and reflection on IMH work. The course takes 42 clock hours and is accredited for 24 hours training with a number of Us associations.

The USA Example 2: Training in a related approach

DIR Institute Certificate Program (DIRC) initiated by Serena Wieder and Stanley Greenspan to support the DIR model of Infant Mental Health (Wieder, 2005).

DIR is a comprehensive developmental framework called the Developmental, Individual-Difference, Relationship–Based (DIR™) model to guide interventions with infants and young children who have mental health challenges.

DIR takes a relationship based approach to working with infants, young children and their families. It integrates perspectives from all disciplines to understand the functional aspects of the individual child; it builds upon strengths in the child and the important relationships the child has; it understands that parent child interactions have bi-directional influences.

DIRC originated out of implementation a six-year longitudinal (NIMH) research based protocol for the DIR intervention. Research staff found they required intensive reflective supervision to be essential to sustain the staff and the program.

DIRC has as its target audience professionals from a diverse range of disciplines and with a range of clinical experiences in working with infants, young children and their families.

DIRC trainers are mostly I-ECMH practitioners with broad clinical, research and administrative experiences.

DIRC trainers respect and recognize the various cultures that exist that within the range of disciplines represented by I-ECMH professionals and aims to broaden understanding across professional borders.

DIRC began with case conferences at interdisciplinary meetings and annual conferences. In 1999 they invited interested senior clinicians to be trained and these people later became trainers.

The issues they faced are the same we face today: Who to train; How to offer training when they were not a clinical service or an educational service and had only done seminars and conferences until that point; What sorts of numbers would they attract, locally, nationally and internationally; How to offer mentorship; How to determine levels of competence; how to use technology without lessening quality of clinical training? How to cater for distance and for those who had limited time due to work, how to make it self-paced? And leave room for expansion

Phase 1- Top down in that invited most experienced clinicians to become certified and who were likely to become trainers.

- Large scale introductory programs open to professionals and parents, using lecture, video material, opportunity for questions, Readings, handouts, reference lists and training materials that could be studied independently.
- Formed study groups, often organized by senior clinicians. Parent to parent groups to support and learn from one another (in case developmental disability?)
- Mentorship and consultation offered

Phase 2

- Launched a summer institute for clinicians and educators who had participated in phase 1.
- Case based discussion groups and mini courses
- Special short courses for particular I-ECMH interested groups e.g. administrators, educators, parents, and practitioners- held these regionally.

Phases 3 &4

- Developed pre-service education programs for academic institutions at undergraduate and postgraduate levels
- Integrating DIR into existing degree programs

Phase 5

- Offer a distance learning program, at introductory and advanced learning levels.

The USA Example 3 – Zero To Three

Zero To Three is an The USA "non-profit organisation that provides parents, professionals and policy makers the knowledge and know how to nurture early development" (Zero To Three, 2013b) that was founded in 1977 by experts in the field of I-ECMH. Today it employs over 100 people with a Board of Directors comprising distinguished expert practitioners and policy makers in the field of I-ECMH. This organisation hosts a National Training Institute each year for experienced professionals in the field of I-ECMH that typically attracts 1700 delegates. The Training arm of Zero To Three offers many free of charge on-line training modules, webinars for professionals working with maltreated infants, toddlers and their families in a range of settings. It offers an extensive variety of training for supervisors, trainers and for mental health clinicians.

NATIONAL TRAINING IN I-ECMH

Currently no national training model for I-ECMH exists in Australia. AAIMHI national is the only body to coordinate training specifically for this purpose.

Australian Association for Infant Mental Health Incorporated (AAIMHI)

AAIMHI recently appointed a National Training Coordinator to manage the possibilities for national training. Currently AAIMHI operates a website that informs practitioners of training that is occurring across Australia and through the communications network state organisations inform each other of training that is planned in each state. AAIMHI was established in 1988 as an inclusive and broad based organisation to improve the profile of infancy and to provide a forum

for multidisciplinary interactions and collaboration that improve the mental health in all infants and their families (Warren, 2007). There are now AAIMHI branches /affiliates in all states with the exception of Tasmania (which is exploring the possibility) and in the ACT.

From its inception, AAIMHI has hosted a national conference each year with a focus the mental health of infants and young children from a relationship based perspective and which in recent years typically attracts upwards of 400 participants. AAIMHI has partnered with related organisations to joint badge national conferences the most recent being Marcé (2010), RANZCP (2011), and the research based organisation of ARACY (October 2013). The experience of AAIMHI has been that each of these organisations brings an additional element to thinking about the emotional well-being of infants and young children, however, for the partner organisations I-ECMH is but one of the issues to be supported when it is brought by AAIMHI into the foreground rather than core business.

In 2010, AAIMHI joined the National Children's Mental Health Coalition along with the Royal Australian and New Zealand College of Psychiatrists, the Australian Psychological Society, NIFTeY (National Investment for the Early Years), the Australian Infant, Child, Adolescent and Family Mental Health Association, the Australian Association for Infant Mental Health and the Australian Child and Adolescent Trauma, Loss and Grief Network with the explicit purpose to advocate and lobby the Federal Government to increase spending for mental health for children from early life.

Around the Nation

NSW and Victoria have equally long and relatively rich histories of formal training in perinatal and infant mental health. They are the only states in Australia and New Zealand to offer nationally accredited tertiary training for professionals from a range of disciplines in the specific field of perinatal and infant mental health. Training in these states will be discussed alongside that in Queensland and South Australia since these are closest to or ahead of WA in terms of numbers of professionals in the I-ECMH field and associated resources.

NSW

The NSW Institute of Psychiatry (NSWIOP) was the initiator of the first AAIMHI, beginning with 16 foundation members from adult and child psychiatry, psychotherapy, occupational therapy speech pathology, social work and child psychology and who actively sought to include representatives from child protection social work, nursing, paediatrics and physiotherapy to make it a truly multidisciplinary committee.

Training began with workshops, seminars, and a newsletter that continues to be published quarterly through the national AAIMHI organisation today.

The NSW IOP offers a postgraduate degree program in perinatal and infant mental health that today is offered at both undergraduate and post graduate levels. These are summarised in

Table 10. Brief details of programs that include any infant focused or parent –infant relationship based content are included.

Table 10. NSW Postgraduate Degree Programs

NSWIOP Grad certificate In Mental Health (Perinatal and Infant) Nationally accredited	Undergraduate Multidisciplinary	1-2 years part or half time. Essential requirements: to be practicing in the field Available to interstate students by a combination of distance and face to face
NSWIOP Graduate Diploma in Mental Health (Perinatal and Infant) Nationally accredited	Post graduate Multidisciplinary	2 years part-time Available to interstate students by a combination of distance and face to face
NSWIOP Master of Mental Health (Perinatal and Infant) Nationally accredited	Post graduate Multidisciplinary	2 years part time includes a work placement and an intensive face to face week each semester. Available to interstate students by a combination of distance and face to face
NSWIOP Infant Observation Units	Postgraduate Multidisciplinary	U/grad required+ current work in field IMH Two units of study are offered
Perinatal mental health Advanced training SJOG	Multidisciplinary	2 days and 4 days
Karitane	Multidisciplinary	1 day

In NSW outside of the tertiary settings there appears to be no coordinated cross disciplinary training strategy for practitioners who work with infants' young children and their families. In much the same way as in Western Australia there are isolated pockets of focused work specifically on the emotional health and wellbeing of infants and young children.

Karitane is a community agency, which is part of a consortium that includes Ngala in WA; Queen Elizabeth 11 Family Centre, Tweddle Child and Family Services and O'Connell family Services in Victoria; Tresillian in NSW; Child and parenting Service in Tasmania and QE11 in the ACT the Royal NZ Plunket Society in New Zealand. Karitane takes referrals from GP's, paediatricians, and child and family health nurses. This agency runs a toddler clinic for families with toddler's aged 15 months to 4 years that is underpinned by a relationship based play-therapy model developed in the USA, known as Parent-Child Interaction Therapy. A one day interactive workshop is run

for health professionals about the program importance of the early years is offered by this agency. Karitane is also involved in collaboration with the tertiary sector (University of Western Sydney) in provide training to nurses in much the same way that Ngala is in WA, with its collaborations with ECU and Curtin universities. The University of Technology, Sydney, and The NSW College of nursing Graduate certificates in Child and family nursing are offered to registered midwives and nurses.

Within the NSW Health Department Perinatal and Infant Mental Health expertise are included together in the "Families NSW Supporting Families Early Package" (NSW Government, 2009). "Safe Start" guidelines recognise the importance of intervention in the perinatal, and infancy periods. In an initiative with the NSW Health Department, Community Partnerships Branch and Mental Health and Drug and Alcohol Office an integrated model of care for women, their infants and families in the perinatal period is outlined. The model recognizes the importance of maternal mental health for the newborn baby and infant, however, in attending to this the focus for intervention is almost exclusively on the parent. When discussing infant crying it does so in terms of the impact on the family and recommends a multidisciplinary approach to the problem including referral to management of the family in residential settings such as Tresillian, Karitane or a paediatric unit. The model recommends front line assessments that include a psychosocial series of questions and provides guidance on the process including use of the EDPS as a screen: no mention is made of parent-child relationship assessments or infant mental health assessments.

With respect to training, The Safe Start package recommends multidisciplinary case discussion and review or referral pathways to become a source of knowledge and expertise for others in the service. The only training recommendations in the three-document package are for psychiatrists and registrars and include regular supervision, the development of clinical practice guidelines, and packages to support rural perinatal and infant mental health service provision.

Victoria

Victoria have a number of distinctive training events in I-ECMH. The Queen Elizabeth centre is one service in Victoria that provide support for children aged 0-5, and hosts an annual conference that frequently includes I-ECMH as a focus. The state has a very active branch of AAIMHI that have regular weekend training days and seminars and which also holds an annual competition for writing that elucidates the subjective world of the infant and commemorates the work of an Australian pioneer in Infant Mental Health, Ann Morgan (AAIMHI). This tradition is also evident in the first dedicated Postgraduate Degree program in Mental Health Science (Infant and Parent Mental Health). The course overview reads as so: *This course is aimed at health care professionals working in the infant mental health field, who wish to develop their understanding and clinical skills in working with infants and parents or who are interested in participating in service development, delivery and evaluation. The course has been developed out of clinical teaching work of the Infant Mental Health Group at the Royal Children's Hospital and draws on the disciplines of psychiatry, developmental psychology and psychoanalysis for*

its theoretical basis. The course focuses primarily on the baby and the infant/parent relationship and provides training in skilled assessment and intervention with families which can greatly assist the capacity of parents to facilitate their child's development. Infant and Parent Mental Health therefore is able to play a major role in the prevention of serious psychiatric disability (The University of Melbourne, 2009)

Table 11. Victoria Postgraduate Degree Programs

University Melbourne Graduate Diploma Health Sciences (Infant and Parent Mental Health)	Postgraduate Multidisciplinary Available to interstate students by a combination of distance and face to face	1 year fulltime Essential requirements: a degree in medicine or allied health profession 2 years clinical experience in the I-ECMH field. Currently working in the IMH field
University Melbourne Master of Health Sciences (Infant and Parent Mental Health)	Postgraduate Multidisciplinary Available to interstate students by a combination of distance and face to face	2 years full-time

Queensland

The Queensland Centre for Perinatal and Infant Mental Health (QCPIMH) is funded by the QLD Government and can be described as a hub of expertise with responsibilities in perinatal and IMH across four key areas: (1) Service Development and Implementation, (2) Workforce Development, (3) Mental Health Promotion and Prevention, and (4) Research and Evaluation. Staff at the Centre emphasised mental health promotion and prevention as an important area of workforce development in IMH (personal communication with the team). “A Perinatal and Infant Mental Health Working Group comprising specialist mental health clinicians from across Queensland undertook a consultative planning process to provide advice regarding perinatal and infant mental health service models with goodness of fit for the Queensland context” (Queensland Centre for Perinatal and Infant Mental Health). The foundation work done by this group lead to the establishment of the Queensland Centre for Perinatal and Infant Mental Health.

The QCPIMH service model and practice framework includes Education, Training, Supervision and Staff Support components. The team are aware of the development of competency frameworks in IMH and expressed interest in knowing more about The MI-AIMH Framework. They identified the broad scope of The MI-AIMH Framework to include promotion, prevention and intervention services as strength of the model (personal communication with the team).

Refer to http://www.health.qld.gov.au/qcpimh/docs/qcpimh-poster1.pdf for more details of the QCPIMH.

Table 12. Queensland I-ECMH training

Perinatal and Infant Mental Health Universal Psychosocial Screening module	Universal level service providers Training booklet and PowerPoint and self-directed e-learning	4 learning units includes one on I-ECMH and another on screening tools.

South Australia

Adelaide has one of the strongest AAIMHI associations in the country in terms of active training provisions in the field of I-ECMH, providing regular seminars and frequently hosting overseas IMH clinicians to train in specific assessments and interventions and to run workshops. However, across South Australia there is no other coordinated approach and each organisation provides their own training. The South Australian Health Department through the Women and Children's Hospital differentiates between IMH and Perinatal Mental Health and offers a Certificate in Infant Mental Health as well as an innovative program for perinatal mental health that includes some material specific to I-ECMH in South Australia. See Table 13 below.

Table 13. South Australia Health Department Training

SA Health Department Certificate in Infant Mental Health	Face to face and video link up with groups of 7 for supervision. For a variety of Mental Health and community health workers including those in NGO's, CAMHS, Child protection etc.	10 week Certificate in Infant Mental Health- focuses on infant development and attachment includes a 10 week x 1 hour infant observation.
SA Health Department Connecting Mum's Babies, Family and Culture	Aboriginal Health care workers, GP's, Mental Health Workers& Community and maternal Child Health workers, NGO's, Child Protection etc.	One day workshop on the Assessment and treatment of perinatal and infant mental health for moderately and severely mentally ill Aboriginal People
SA Health Department Perinatal Mental Health workshop	For Health care staff who work with perinatal women and their families Face to face	One day workshop includes knowledge of attachment styles and impact of perinatal depression on the mother-infant relationship
SA Health Department Certificate in Perinatal Mental Health	Face to face and video link up with groups of 7 for supervision.	10 week Certificate in Perinatal Mental Health-

SA Health Department Introduction to perinatal mental health	For health care staff	includes a 10 week x 1 hour infant observation. On-line 1-2 hour modules

Western Australia

In Western Australia, there is no specific training in I-ECMH that is provided on an ongoing basis other than the seminar series run by AAIMHI WA. The Beyond Blue Training Matrix only includes perinatal training (The EDPS and perinatal anxiety). Stakeholder groups run pre-service and in – service trainings that sometimes include a module related to I-ECMH. For example, Family Partnerships training is part of the workforce development programmes across some services. See Table 2 and Table 3 for more details of recurrent and periodic training in Western Australia. AAIMHI WA has the largest state membership in Australia. AAIMHI WA trainings consistently focus on current IMH issues and practice so that over the past decade focus has included:

1. Seminar series for up skilling targeted and specialist levels of clinical intervention and practice
2. Professional development days
3. The promotion and prevention aspects of infant mental health
4. Advisory roles
5. National and international collaborations

Web based-communications (see www.aaimhi.org)

6. Flexible learning medium including video links to rural WA
7. Training collaboration with the MHC to administer scholarship scheme for up skilling the workforce in IMH. For the first time the association employed an administrative assistant to manage this.
8. Collaborative research with the MHC contracting out this competency and training project

Related National Organisations

ARACY

The Australian Research Alliance for Children and Youth (ARACY) was established in 2001 with a focus on collaboration between researchers and practitioners in the early childhood, the middle years and young people. Amongst its activities is a social marketing strategy to increase "positive parenting practices" pitched at parents of infants and young children known as the "Engaging Families in the Early Childhood Story". ARACY relies on funding and support from

federal and state governments, philanthropic organisations and the corporate sector to develop projects and disseminate research findings but does not have a training focus (ARACY).

MARCÉ

The MARCÉ Society is an international society with a branch in Australia that has its focus on maternal mental illness in the perinatal period. It is multidisciplinary and "provides a forum for exchange of information and ideas between professionals concerned with the welfare of women and their families around the time of child birth" (http://www.Marcésociety.com.au/) This society is broadening its interest base in Australia to include the maternal-infant attachment theory, the psycho-biology of pregnancy, antenatal and postnatal education, psycho-social aspects of obstetrics, perinatal bereavement and all aspects of mental health of women and their families during pregnancy and the postnatal period. The society organises a biennial conference and ad hoc meetings to stimulate collaborative research (Marcé Society). The focus of Marcé is predominantly on the mental health of the mother and a growing awareness of the importance of holding the infant in mind.

Beyond Blue

Beyond Blue: This national organisation was established in 2000 as an initiative to promote community awareness of depression. Its success resulted in an extension of funding to 2015 an expansion of staff from 9 to 60 and an expansion of its focus to include anxiety. Infants and young children receive attention from this organisation by virtue of being a family member, rather than in the foreground (Australian Government, 2013a).

The organisation recently documented an extensive table of identified perinatal mental health training programs for the wide range of health professionals in the ante and perinatal mental health workforce. http://www.beyondblue.org.au/docs/default-source/8.-perinatal-documents/bw0116-perinatal-mental-health-training-programs-for-health-professionals.pdf?sfvrsn=2.

In addition to the tertiary level training at UNSWIOP and University Melbourne, Beyond Blue identified around 50 training events. Brief details of those relevant to infant or early childhood mental health have been included in the state by state discussions above.

Relevant national training identified by Beyond Blue includes:

Table 14 National universal level training Relevant to I-ECMH identified by Beyond Blue

Start Strong Rural Health Education Foundation	Indigenous child and maternal health focused health workers	26 minute DVD

Australian Childhood Foundation (ACF)

The ACF has a focus on trauma and its impact, some of which is specific to working with infants. It is a national organisation that includes a training arm providing current, practical training

opportunities to welfare, health and education organisations across Australia(The Australian Childhood Foundation, 2009). They have been providing a training arm for the past seven years. 'The training and education programs are delivered through a national training calendar of workshops and seminars – generally between 60 and 70 per year in every state and territory of Australia – as well as international guest speaker tours' (http://www.childhood.org.au/our-work/educating-for-change). This organisation offers a range of training opportunities including conferences, seminars, accredited training programs and web based learning resources and customised professional development programs (http://www.childhood.org.au/training/customised-training/customised-training).

Triple P- Positive Parenting Program (Sanders, 2012)

In Australia, the establishment of Triple P as a training ground for providers of its manualised parenting programs is worthy of consideration as one model that has successfully developed training across disciplines and levels of service.

Triple P has five levels of service provision of increasing intensity from broad media based information through parenting advice, parent skills training to behavioural family interventions. Training courses are available for four of these and are conducted by accredited Triple P trainers who have Masters or doctorate level qualifications, undergo a two-week training program, and complete a skills-based accreditation process.

Triple P has a coordinator in major government organisations in WA; DoE, DSC, CPFS to ensure the customized delivery of its services. Program drift is minimized through the use of standardized materials and ongoing trainer accreditation. An on-line practitioner network enables Triple P staff members to troubleshoot issues and to maintain currency.

Summary

There are a number of international training frameworks that focus on I-ECMH and that have been reviewed in the current report. One constant factor in the coordination of training services around the globe is the presence of one Association that has the focus of I-ECMH as its priority. Organisations that have this role include The World Association for Infant Mental Health and Affiliates and The Zero to Three organisation. Both organisations provide a clearinghouse of information as well as development and co-coordination of training. Common features of the international programs that deliver training in I-ECMH and that were explored in this review include:

1. A focus on developing coherent training that emphasise joint cross professional training and cross-sector training.
2. Collaborations with universities, colleges, government, I-ECMH practitioners, organisations and community based services to provide I-ECMH training in the curriculum of allied health professionals and educators; to provide continuing professional development and post graduate training.

3. Recognition of the importance of specific training for in I-ECMH principles across all levels of the workforce. For example, regular professional training of midwives in Sweden is linked to increased well-being in infants.
4. Training for professionals and front line practitioners in I-ECMH principles is in the main ad hoc with institutions in the UK, USA and Canada continually making calls for coordinated training.
5. The most coordinated systems of training exist in the USA where competency based trainings supported by philanthropy, universities or committed NGO's and government exist.

Within Australia there is no National training model in I-ECMH. States that are most advanced in developing I-ECMH training models are those that have university accredited postgraduate education programs. There is a recognition within Australia that a set of I-ECMH competencies to assist the direction of training programs is required.

REFLECTIVE SUPERVISION IN I-ECMH

There is wide agreement that reflective practice is the hallmark of competence within the infant mental health arena (Scott-Heller, Steier, Phillips, & Eckley, 2013, p.24).

Young children experience their world as an environment of relationships, and these relationships affect virtually all aspects of their development intellectual, emotional, physical, and behavioural (Shonkoff as cited in NSW Health (2011, p.90).

Reflection is a crucial component of competency for all professionals working with young children and their families (Weatherston, Weigand, & Weigand, 2010, p.23)

As director, I know how valuable (Relationships for Growth) is for children, parents and staff….Children's challenging behaviours improve…teachers experience less stress in the classroom, so staff moral improves. The ripple effect results in less staff turnover, which equals more experienced staff' (Head Start director) (Finello, 2005, p.460).

This section of the report will provide definitions of reflective practice and reflective supervision and a review of these concepts in I-ECMH literature. It will follow with examples of how reflective practice is used in models of training and building workforce capacity in I-ECMH. Special attention will be given to understanding how The MI-AIMH Framework builds competencies in reflective practice across all levels of the workforce. An example of how reflective practice and reflective supervision is implemented in non-mental health settings such as early childcare using an Infant Early Childhood Mental Health Consultation Model (I-ECMHM) will be discussed.

Reflective supervision and reflective practice have been considered to be an integral part of the I-ECMH field since the 1980's, although how this translates into practice remains a work in progress. There have been rapid advancements in understanding reflective practice and reflective supervision and its applications to working with infants, young children and their families.

Reflective practice is defined as 'able to examine one's thoughts and feelings related to professional and personal responses within the infant and family field' (*The Michigan Association for Infant Mental Health, (MI-AIMH) Competency Guidelines and Endorsement for culturally sensitive, relationship-focused practice promoting infant mental health®*, (2002a; 2002b, p.30). Reflective practice is the development of reflective skills which enables practitioners to work with families in a relationship based framework developing capacities to observe, listen carefully and understand the infant/young child's presentation within the caregiving context.

Reflective supervision is a 'learning experience in which a professional/service provider meets regularly with an experienced infant mental health professional to explore personal thoughts and feelings in relationship to work in the infant and family field' (The *Michigan Association for Infant Mental Health, (MI-AIMH) Competency Guidelines and Endorsement for culturally sensitive, relationship-focused practice promoting infant mental health®*, 2002, p. 30). Reflective supervision is a way in which professionals can learn 'ways of thinking about responses to families….learning how to formulate informed questions that might lead to greater understanding instead of quick problem resolution' (Heffron, 2005). The understanding is that reflective supervision will support and promote the development of reflective skills in professionals and translate principles of reflective practice into action.

In the late 1980's Zero to Three established a working group, titled 'Training Approaches for Skills and Knowledge (TASK)' to investigate the skills required for practitioners working in the field. This team identified four necessary components in training of which reflective supervision/practice was identified across two of the core elements (Fenichel, 1992). The core components of training are:

- A robust knowledge base
- Opportunities for direct observation and interaction with a variety of children less than three years and their families
- Collegial support, within and across disciplines, throughout a practitioner's professional life; and
- Individualised supervision to allow reflection on all aspects of work with young children and families.

A Multidisciplinary Task Force was developed that included mental health and non-mental health leaders (Fenichel, 1992). The aim was 'to explore individual supervision more deeply as a potentially untapped resource for infant-family practitioners seeking to enhance their knowledge, skills and practice' (Eggbeer, Mann, & Seibel, 2007, p.6). The Task Force noted similarities with clinical supervision, (which has historically been part of mental health practitioners work practice), however, also highlighted the distinctive nature of reflective practice, whereby reflective supervision could be provided by a supervisor who was from a different discipline other than the supervisee (Eggbeer et al., 2007). Other differences have also been identified when reflective supervision is compared to other models of supervision. For example, In I-ECMH reflective supervision the supervisor is viewed as the more experienced person in the relationship, whereas in psychodynamic models the supervisor is considered the expert, the one holding a status of more authority and power (for detailed account of difference in current supervision models refer to (Schafer, 2007)

Reflective supervision is now recognised as an essential component of practicing I-ECMH and a crucial element of any training programs in I-ECMH. It is understood to be a process in which the supervisee is given a reflective space to wonder about the family he/she is working with and to understand his/her own reactions (thoughts, ideas, sensations and emotions) that are evoked in working with family relationship. These complex experiences are occurring within a supervisory relationship that is characterised by trust, openness, security and respect. The

supervisee is held by the supervisor, whose primary task is to support the supervisee in gaining a deeper understanding of her case and remaining open to what the family brings to her.

Below are some definitions of reflective supervision that are widely used in the I-ECMH field:

'The essential feature of this supervisory relationship are reflection, collaboration, and regularity of occurrence' (Eggbeer et al., 2007, p. 5).

'Although reflective supervision may incorporate administrative and clinical tasks, and include attention to collaboration within learning relationships, its primary focus is the shared exploration or the emotional content of infant and family work as expressed in relationships between parents and infants, parents and practitioners, and supervisors and practitioners' (Weatherston & Barron, 2009, p.63).

Reflective supervision provides 'a practice arena that can shape and strengthen the interveners knowledge of self in regards to relationships, empathy for others, and skills in perspective taking' (Heffron, 2005, p. 118).

['Reflective Supervision is a] shared process in which [the supervisor] provides a safe and compassionate kind of mirroring…[three core reflective tasks include] relating and re-experiencing emotionally significant events …;examining and evaluating the meaning of the feelings, thoughts, intentions, actions evoked during those events; and considering how [to] use this understanding for professional [and personal] growth' (Weigand et al., 2007, p 18).

'The process of a relationship based supervision becomes a mutual exploration by supervisor and supervisee of their feelings fantasies and perceptions of the child, client mother and one another-with the expectation that this very exploration will become a change agent within the treatment process' (Schafer, 2007, p. 13).

Reflective supervision is a way of supporting practitioners in the therapeutic work they do with infants, young children and their families and ensuring a quality service is being provided. Furthermore, it is an essential component to any training or educational program in IMH. Reflective supervision consolidates skills acquired in training and ensures integration of skills into everyday practice. It is a relationship based model of supervision, drawing on concepts such as cybernetics, feedback loops and systems theory and the central premise that development occurs within a relationship context (Schafer, 2007). It provides the practitioner with 'the continual conceptualisation of what one is observing, doing and feeling' (Gilkerson & Ritzler, 2005, p.434).

Parallel Process

An important feature of reflective supervision is paying close attention to the parallel process that occurs between supervisor and supervisee, supervisee and family, and child and family.

Exploring these relationships and understanding how they impact on each other is an important facet of the model (Schafer, 2007; Weatherston et al., 2010). The supervisory relationship provides an opportunity to have a shared reflective space, where the intersubjective experience between the supervisee and supervisor is a place where new insights and deeper understanding of how the infant, young child and their caregivers/family develop. This is done by together exploring the parallel processes, emotions, how the child is perceived, what is understood about the mother and how they relate to each other and it is in this exploration that change is likely to occur in the intervention process (Schafer, 2007).

Qualities of a good reflective supervisory relationship

Qualities that enable the development of a strong, stable and trusting reflective supervisory relationship include:

- Safety
- Consistency
- Dependability
- Respect
- Confidentiality
- Honesty (Weatherston & Barron, 2009)

Leaders in the field have also highlighted the need for supervisors to have the ability to 'hold' the supervisee by being able to listen attentively without judgement, wait patiently and support the supervisee in discovering solutions, new ideas and novel ways of thinking about the family on his own, without interruption from the supervisor or consultant (Weatherston et al., 2010).

Case example

A practitioner who tends to move too quickly to provide toys for a family because of her own discomfort with the infant's lack of play materials might be asked questions designed to increase herself awareness and her notion of the impact of her actions on the family. These might include remarks such as, 'what is it like for you to see Cari with so few toys?' Do you think the family is as worried about this as you are?' 'Have you had a chance to think about what it will mean for the family to bring toys to them so suddenly? I wonder how we could help dad understand that the kids need some things to play with?...'the supervisor helps the intervenor identify her own needs and feelings about the situation, consider the perspective of the family, think about intervention strategies that would fit the situation, and plan approaches and language that address these concerns (Heffron, 2005, p.116-117)

Reflective Supervision Models in Practice

There are a variety of ways that reflective supervision is used to enhance reflective capacities in professionals. Implementation of reflective supervision depends on staff needs, availability of resources, access to supervisors, pre-established ways of providing staff support and supervision

(Heffron, 2005). It can be offered individually or in small group settings, typically face to face, however, with advancements in technology it can be offered via distance modes of communication such as telephone and Skype. Implementation of reflective supervision requires 'organisational understanding, sanction, and fiscal support so that supervision activities are defined as a valued part of the scope of the work and not as an add-on to an already taxing work schedule' (Heffron, 2005, p.129).

The need for distance technology in IMH training has been recognised and methods include telephone, videoconferencing (Wajda-Johnson, Smyke, Nagle, & Larrieu, 2005) in more recent times Skype. The implications of adopting new ways of accessing reflective supervision through the use of technology are largely unknown and these new ways of delivery pose challenges in relation to maintaining core principles of reflective supervision. Research is needed to explore important questions about how distance impacts on understanding 'the other's experience' in a supervisory relationship. Furthermore, in what way are the qualities of reflective supervision such as holding, empathic listening, confidentiality and safety ensured in a supervisory relationship that is characterised by physical distance and sometimes an absence of any visual interface between supervisor and supervisee?

There is a dearth of research evaluating the effectiveness of reflective supervision in I-ECMH. There is a need to investigate factors such as staff turnover, retention of families receiving therapeutic interventions and consumer evaluations to determine whether qualities of reflective supervision contribute to effective interventions with families. It is anticipated that the creation of a competency system such as The MI-AIMH Framework will assist practitioners and supervisors offering reflective supervision in their skill development (Heffron, 2005). A review of models that have integrated reflective supervision and reflective practice activities into training and workforce development follows.

MI-AIMH Framework

The MI-AIMH Framework includes reflective supervision as a core competency in the field of I-ECMH across the four levels of endorsement. It now has a multistate collaboration which is looking at ways in which these skills can be developed across the workforce to include practitioners in mental health and non-mental health settings who are involved in promotion, prevention, intervention and treatment in I-ECMH. The MI-AIMH Framework identified Reflective Practice Supervision and Consultation as a core area of expertise(Michigan Association for Infant Mental Health, 2002a; 2002). The specific attributes include Contemplation, Self-Awareness, Curiosity, Professional Personal Development, Parallel Process and Emotional Response. They have outlined specific behavioural descriptors of competency in Reflective Practice and these include:

- Regularly examines own thoughts, feelings, strengths and growth areas
- Seeks or consults regularly with supervisor, consultant, and peers to understand own capacities and needs, as well as the capacities and needs of families.

- Seeks a high degree of agreement between self-perception and the way others perceive him/her.
- Remains open and curious.
- Identified and participates in learning activities related to the promotion of infant mental health.
- Keeps up to date on current and future trends in child development and relationship based practice.
- Uses reflective practice throughout work with infants/young children and families to understand own emotional response to infant/family work and to recognise areas for professional and/or personal development (Michigan Association for Infant Mental Health, 2002a, p.18).

MI-AIMH League of States have developed Best Practice Guidelines for Reflective Supervision (Weatherston et al., 2010, p.25) which provides a guide for reflective supervision requirements for all levels of endorsement. At levels two, three and four of The MI-AIMH Endorsement Framework it is a requirement to engage in a minimum number of hours of reflective supervision over a two year period. Table 15 is a summary of reflective supervision requirements of The MI-AIMH Endorsement Framework (2002b).

Table 15 Reflective supervision requirements of The MI-AIMH Endorsement Framework (2002b).

	Level 2: Infant Family Associate	Level 3: Infant Mental Health Specialist	Level 4: Infant Mental Health Mentor
Reflective Supervision and/or Consultation	Minimum 24 clock hours over a two year period	Minimum 50 clock hours within a two year period	Minimum 50 clock hours within a two year period

The MI-AIMH Endorsement Framework is in line with the current trends in the I-ECMH field and recognises that reflective practice is essential in relationship based work with infants, young children and their families by including a requirement of reflective supervision hours. The League of States is currently exploring ways of determining how good reflective practice affects outcomes with families. They recognise the complexities of this and note that 'learning how to recognize and evaluate change over time whilst accepting heterogeneity in reflective capacity and the sloppiness of the process remains an important consideration' (Weatherston et al., 2010, p.28).

The League of States has developed what they call a 'community of reflective practice' that is a group of varied professionals with expertise and experience in I-ECMH from different settings, meeting together regularly and supported by MI-AIMH to explore the meaning of reflective practice in the infant-family field and ways in which reflective supervision can be improved and

developed (Weatherston et al., 2010). This group has developed shared understanding of how to develop training that is reflective. States addressed the issue by developing reflective supervision experiences in a group setting which enabled clinicians to experience a reflective supervision relationship based model that was not always available previously. The frequency and nature of the reflective practice groups have varied depending on the capacity within the state. Examples include:

- commencing reflective practice groups for front line practitioners who come together once a month to share experiences of their work with young children and families for a minimum of one year;
- developing supervisor groups for reflective practice, 'offering opportunities for live or fishbowl supervisions followed by thoughtful discussions with all of the supervisors about their roles, responsibilities, and experiences supervising others in reflective work.

The model of live supervision was provided by AAIMHI WA in a one day workshop with Beulah Warren in August 2013. This experience was received positively by those who attended and there was a strong desire for more training experiences looking at reflective supervision. It is important to note that Beulah Warren has a long-standing relationship with MI-AIMH and uses their reflective supervision model as her model of I-ECMH practice in NSW.

Ireland's Interdisciplinary IMH Network Groups Model

Ireland has developed a model of reflective supervision and training based on The MI-AIMH Framework. In 2006, development of an IMH Network Group was established to provide front line practitioners with continued learning and skill development in Infant Mental Health along with further opportunities to develop their reflective practice skills within a group setting. The Network Group provided educational meetings involving a theoretical component and clinical case discussions using a reflective practice relationship based framework. This model was designed so that it would ultimately provide a structure for professionals progressing towards achieving endorsement in line with The MI-AIMH Endorsement Framework. Since the establishment of the first group there are now six across the Republic of Ireland. The first group continues to meet on a monthly basis and is facilitated by the group members and no longer requires an infant mental health specialist to facilitate the group. This model, along with models which have developed in the League of States, demonstrates the capacity for sustainability in the IMH workforce and how a reflective practice framework supports this and nurtures the continual growth of those working in the field.

NSW: Incorporating reflective practice in I-ECMH postgraduate training programs

'the relationship model has been a source of strength and support throughout the course…Thank you for the journey. You have given me roots and wings' (Smart, personal communication, November 2007; cited in (Warren & Mares, 2009, p 632)

In the postgraduate training programs in IMH offered by the New South Wales (NSW) Institute of Psychiatry in Sydney, reflective supervision and reflective practice are central components. The

course aims to promote 'in trainees the development of their observation skills (of self and other), their capacities to engage emotionally without shutting down, their ability to reflect critically on the assumptions underlying their responses to families and infants, to incorporate new knowledge into practice, and to use reflection to work thoughtfully, sensitively, and respectfully in the service of infants and their families' (Warren & Mares, 2009, p.622). The program was developed using key principles from MI-AIMH which focussed on addressing four central questions, one being, 'what about the practitioner?' (Weatherston, 2005, p.4-5)

The NSW IOP course uses a relational framework with trainees to foster growth and development of their skills in IMH. Reflection is incorporated throughout the training and includes infant observations in the first year (36 home visits over the infant's first year of life), where students are supervised weekly over a period of one year in a small group setting. This is followed by reflective supervision in the second year of study in which a small group of trainees meet weekly over a period of one year and discuss their own case material. Theoretical units taught during the training programs include a reflective component to ensure that learning is applied to the trainees clinical practice.

Student feedback has identified the reflective practice components of the course valuable and highly relevant to their practice:

'Overall, I have felt that reflection and the development of my abilities in this area, has been one of the most important aspects of the course for me'. (Neonatal nurse, working as a discharge liaison nurse with graduates of the NICU of a large hospital, personal communication, Siu, October, 2007 (Warren & Mares, 2009, p.631)

South Australia: Reflective Supervision with an Early Intervention Team

In South Australia, O'Rourke described her experience of offering reflective supervision to an Early Intervention Team in which members are from varied disciplines (O'Rourke, 2011). This is one of the few international published articles in I-ECMH that offer an Australian perspective on implementation of reflective supervision in a community setting. The paper highlights the challenges practitioners confront when working with highly vulnerable and distressed families and emphasises the emotional impact of the clinical work as 'feeling states often trigger early, preconscious memories in the worker' (O'Rourke, 2011, p.166). There are a number of factors that contribute to the success of reflective supervision which largely depend on the capacity to establish and build a trusting, authentic relationship between supervisor and supervisee/supervisees. In a group setting reflective supervision can offer:

- Powerful relational experience
- Anxieties and feelings of inadequacy are normalised and universalised
- Exposure to a wide range of personal responses
- Creating a culture of curiosity and valuing 'not knowing'
- Present moment experiences of intersubjectivity (O'Rourke, 2011, p.171)

The South Australian perspective parallels what is reported in the international literature, emphasising the need for a relational framework in organisations that provide I-ECMH services

and support at all levels of the system (including practitioners and management) for implementation of reflective supervision. 'When workplaces provide and value reflective, relationship based supervision, then meaningful authentic relationships can be realised throughout the system. Relational work is required at every level of the system' (O'Rourke, 2011, p.172).

Reflective Practice in non-mental health settings

Early Childhood Mental Health Consultation using an I-ECMH model

The role of reflective supervision and I-ECMH in early childhood education settings such as childcare has recently gained attention in the literature and the Early Childhood Mental Health Consultation (ECMH) model has provided a framework for how reflective supervision and practice can be embedded into non-mental health organisations. Duran and colleagues (2009) identified that for the most effective ECMHC programs, reflective supervision was used to support workers. In this work, reflective supervision is understood to be a supervisory model that 'helps build consultant competencies in a nurturing and supportive way and supports a parallel process that will enhance a consultant's ability to meet the needs of those they are serving' (p.52). The goal of the ECMH Consultant is to foster an increased awareness and understanding of the child's experience in the childcare setting by offering a reflective space for the childcare workers through reflective supervision. Through the experience of the supervisory relationship and/or consultation in a relationship based reflective framework the childcare worker or teacher in class room setting has the opportunity to:

- Learn new social and emotional skills that will benefit her developing a more meaningful relationship with children, co-workers and families
- Become increasingly reflective, rather than reactive, to the challenges of their profession (Scott-Heller et al., 2013, p.22)
- Be part of a culture for high quality service provision and professional growth

There is a growing evidence base of the effectiveness of ECMHC. To date many studies have shown that ECMHC is related to more positive outcomes for very young children with problematic behaviour (Johnston et al., 2013). A recent study investigating the impact of reflective supervision on childcare providers found that those who received a model of training that included reflective supervision had increased ability to be insightful with children in their care, when compared with those who participated in the tradition training model (Amini Virmani & Ontai, 2010). The reflective supervision framework enabled childcare providers to think more deeply about the children they cared for and move beyond focusing on a child's behavioural presentation. 'There is a need to look beyond caregiver educational histories and move toward on-going professional training interventions that will support not only attainment but ongoing maintenance of sensitive caregiving practices' (Amini Virmani & Ontai, 2010, 2010., p.30).

Summary

The workplace systems within which ECMH practitioners are working often do not have structures in place such as reflective supervision to provide support for the workers who experience strong and powerful emotions when working with distressed infants, toddlers and their families(O'Rourke, 2011). Consequently, this impacts on staff turnover, retention, results in increased pressure on staff and creates a system which does not encompass a relational approach to working with infants, young children and their families. Reflective supervision in training and in the work place is a process in which practitioners are held whilst experiencing and processing the complexities of their cases. This can be provided in individual reflective supervision or in small group sessions with an infant mental health supervisor. The outcomes of including and placing value on reflective supervision in training and workforce development in I-ECMH include:

1. 'Reflective practice is well accepted in the infant family field, and the link between skilled use of reflective supervision and program quality is often described' (Heffron, 2005, p.136). Reflective practice and reflective supervision have been identified as a core area of competency in the I-ECMH field and providing opportunities for a shared reflective process will have a direct impact on the capacity of practitioners to offer effective relationship based interventions with families.
2. Infusing all levels with the same principles of relationship based practice can result in new and enhanced awareness of the importance of relationships across daily interactions and activities of the organisation resulting in a higher quality service provision. It is therefore important to include reflective practice/supervision/consultation at all levels to include managers, practitioners, support staff. Family Partnerships program is a good example of this.
3. Reflective supervision and Reflective consultation model offer mental health and non-mental health agencies a model of building relationships and sustaining relationship based practice principles. It is a way of developing systems working together to change how communities are able to support very young children and their families.

APPENDIX A
LIST OF PARTICIPATING STAKEHOLDER GROUPS

Australian Association for Infant Mental Health Inc (AAIMHI)

AAIMHI WA

Anglicare WA

Best Beginnings, (CPFS)

Child and Adolescent Health Service, workforce development.

Child and Adolescent Mental Health Services (CAHMS)

Child Development Centres

Child Psychiatry Training

Connecticut Association for Infant Mental Health

Commissioner for Children and Young People

Community Services Health and Education Training Council

Communicare

Curtin University

Department of Communities

Department of Child Protection and Family Services (CPFS)

Department of Education

Edith Cowan University

Early Childhood Australia

Family Court

Family Pathways

General Practitioners (WA and Victorian)

King Edward Memorial Hospital

Marr Mooditj

Melbourne University

Mercy Care

Mental Health Commission Infant Mental Health Planning Group

Michigan Association for Infant Mental Health

Mother and Baby Unit (MBU:/KEMH)

New Mexico Association for Infant Mental Health

Ngala

Nursing Workforce Development

New South Wales Institute of Psychiatry (NSWIOP)

Office of Early Development and Learning (OEDCDL)

Office of the Minister for Communities

Parent Child Centres

Playgroup WA

Private Practitioners: Psychiatry, Paediatrics, Psychology, Physiotherapy, Occupational Therapy, Nursing, Strategic Planning, Economics, Speech Pathology

Princess Margaret Hospital

Raphael Centre, SJOG

Relationships Australia

RUAH Community Services

Social Outreach and Advocacy, St John of God Health Care

South Australian Health Department

Triple P

United Kingdom CAMHS

University Western Australia

Queensland Centre for Perinatal & IMH Child & Youth Mental Health Service

WA Association for Mental Health Inc (WAAMH)

WA Council for Social Service (WACOSS)

WA Perinatal Mental Health Unit (WAPMHU)

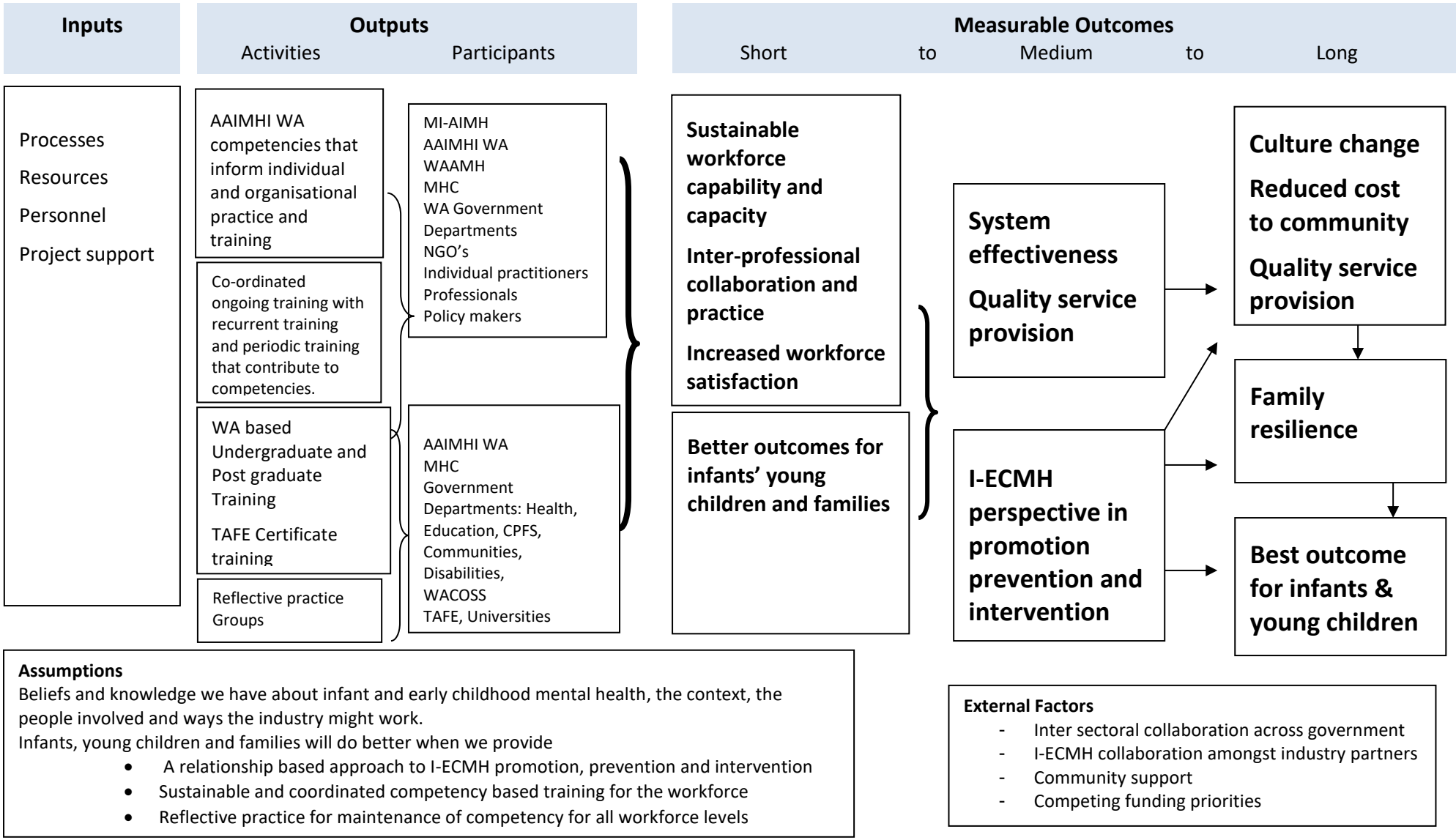
APPENDIX B

TRAINING PRIORITIES DETAILING 3 DOMAINS OF LEVEL 3 OF THE MI-AIMH FRAMEWORK

Level	Example of practitioners	(1) Theoretical Foundations	(2) Direct Service Skills	(3) Reflective Practice	Client Group Impacted Upon
Level 1: Training for the workforce to meet UNIVERSAL needs of basically promotion of social and emotional wellbeing or infant mental health and early detection of risks and vulnerabilities	Health Workers, Early learning centre staff, Mother craft nurse, Enrolled nurses, Parenting coordinators, Volunteers, Practice development officers	As per The MI-AIMH Competency Guidelines	As per The MI-AIMH Competency Guidelines	As per The MI-AIMH Competency Guidelines	All caregivers and **infants and young children** with no identified needs
Level 2: Training for the workforce in prevention of risks of social and emotional disturbance/ disorders of infancy and early parenthood	Psychotherapist, Physiotherapist in child services, Paediatricians, Child Protection case worker, Midwife, Registered Nurse, Occupational Therapist, Speech and Language Therapist, Psychologist, Lawyer, General Practitioner, Teachers	As per The MI-AIMH Competency Guidelines	As per The MI-AIMH Competency Guidelines	As per The MI-AIMH Competency Guidelines	Caregivers and **infants and young children** presenting with vulnerabilities and risk factors, additional needs identified and requiring preventative intervention
Level 3: Training for the workforce focus of mainly intervention to reduce identified risks of social and emotional	Clinical/Counselling psychologist, Psychiatrists, Social Clinicians, paediatricians with Infant Mental Health Masters Degree,	*Pregnancy and Early Parenthood. Infant Young child development and behaviour. Infant young child family centered practice.	*Observation & Listening Screening and Assessment Responding with Empathy	*Contemplation Curiosity Self-Awareness Professional and Personal Development	Caregivers and **infants and young children** with identified needs requiring specialised

disturbance/diagnosed disorders of infancy and early parenthood		Relationship based practice. Family relationships and dynamics. Attachment, separation, trauma and loss. Cultural competence. Therapeutic practice. Disorders of infancy in early childhood. Theories of change. Mental and behavioral disorders in adults.	Treatment Planning Developmental Guidance Supportive Counselling Parent-infant toddler psychotherapy Advocacy Life skills and Safety	Emotional Response Parallel Process	IMH assessment and intervention
– (Clinical) mainly treatment of identified relational disturbances/diagnosed disorders of infancy and identified mental health and behavioural disorders in adults	**Level 4** Clinicians, Policy Makers, Administrators and Researchers and Academics	As per The MI-AIMH Competency Guidelines	As per The MI-AIMH Competency Guidelines	As per The MI-AIMH Competency Guidelines	

APPENDIX C PROJECT FLOWCHART



APPENDIX D INDEX OF ACRONYMS

AAIMHI	Australian Association for Infant Mental Health
AIMH UK	Association for Infant Mental Health United Kingdom
AAIMHI WA	Australian Association for Infant Mental Health West Australian Branch Incorporated.
ACF	Australian Childhood Foundation
AEDI	Australian Early Developmental Index
AHPA	Allied Health Professions Australia
ARACY	Australian Research Alliance for Children and Youth
CAHS	Child and Adolescent Health Services
CAMHS	Child and Adolescent Mental Health Services
CCYP	Commission for Children and Young people
CDS	Child Development Services
COAG	Council of Australian Governments
COS	Circle of Security
COPMI	Children of Parents with Mental Illness
CSHEITC	Community Services Health and Education Industries Training Council
DC: 0-3R	Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood Revised
DIRC	DIR Institute Certificate Program
DIR	Developmental, Individual-Difference, Relationship–Based
DoE	Department of Education
DoH	Department of Health
DPFS	Department for Child Protection and Family Support
EC	Endorsement Coordinator
ECMHC	Early Childhood Mental Health Consultation
EPDS	Edinburgh Post Natal Depression Scale
EYLF	Early Years Learning Framework
I-AIMH	Irish Association for Infant Mental Health
I-ECBH	Infant Early Childhood Behavioural Health
I-ECMH	Infant-Early Childhood Mental Health
IMH	Infant Mental Health
IMHPG	Infant Mental Health Planning Group
ITSIEY	International Training School for Infancy and Early Years
MBU	Mother and Baby Unit
MHC	The WA Mental Health Commission
MI-AIMH	Michigan Association for Infant Mental Health
NBAS	Neonatal Behavioural Assessment Scale
NBO	Newborn Behavioral Observations system
NCSS-UK	National CAMHS Support Service UK
NECD	National Early Childhood Development Strategy
NGO	Non-Government Organisation
NIFTeY	National Investment for the Early Years
NMAIMH	New Mexico Association for Infant Mental Health
NPDI	National Perinatal Depression Initiative

NSPCC	The National Society for the Prevention of Cruelty to Children
NSW Framework	NSW CAMHS Competency Framework
NSWIOP	New South Wales Institute of Psychiatry
PIMH	Perinatal and Infant Mental Health
PIRAT	Parent-Infant Relational Assessment Tool
Practice Standards	The National Practice Standards for the Mental Health Workforce
PUP	Parents under Pressure
QCPIMH	Queensland Centre for Perinatal and Infant Mental Health
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RDC-PA	Research Diagnostic Criteria-Preschool Age
Real Skills Plus CAMHS	A Competency Framework for the Infant, Child and Youth Mental Health and Alcohol and other Drug Workforce-The Werry Centre New Zealand
SDLs	Service Development Leaders
SJOG	Saint John of God
TASK	Training Approaches for Skills and Knowledge
WAAMH	WA Association for Mental Health
WACOSS	Western Australian Council of Social Service Inc
WAPMHU	Western Australia Perinatal Mental Health Unit
WAIMH	World Association for Infant Mental Health
WHO	World Health Organisation

APPENDIX E GLOSSARY

Australian Association for Infant Mental Health West Australian Branch Incorporated (AAIMHI WA)	Affiliated with The World Association for Infant Mental Health (WAIMH), it is a West Australian organisation of professionals from many fields who work with infants and their families. WAIMH affiliates all aim to improve professional and community recognition that *infancy is a critical time for psycho-social development.*
Child and Adolescent Community Health Service (CACHS)	Western Australian Government Service within the Department of Health. Provides a comprehensive range of health promotion and early identification and intervention community based services to children and families, focussing on growth and development in the early years, promoting wellbeing during childhood and adolescence. Includes Child Development Services (CDS).
Child and Adolescent Health Service (CAHS)	Western Australian Government Service within the Department of Health. Provides paediatric care to young West Australians and includes CAMHS and CACHS
Child and Adolescent Mental Health Service (CAMHS)	Western Australian Government Service within the Department of Health. Provides mental health services to infants, children, adolescents and youth.
Child Development Services (CDS)	Western Australian Government Service within the Department of Health. Formerly State Child Development Centre it provides a multidisciplinary team for the initial assessment and management of children with a range of suspected or actual developmental problems.
Child Protection and Family Support Services (CPFS)	Western Australian Government Department that provides a range of child safety and family support services to individuals, children and their families throughout the state.
Developmental, Individual-Difference, Relationship-Based model (DIR)	Comprehensive developmental framework to guide interventions with infants and young children who have mental health challenges
Early Years Learning Framework (EYLF)	Australia's first national Early Years Learning Framework for early childhood educators, developed to extend and enrich children's learning from birth to five years and through the transition to school.
Endorsement Coordinator (EC)	A specialist I-ECMH position responsible for educating the workforce about Endorsement, processing Endorsement applications and responding to queries about Endorsement
Infant-Early Childhood Mental Health (I-ECMH)	'Developing capacity of child from birth to 5 years to form close and secure adult and peer relationships; experience, manage, and express a full range of emotions; and explore the environment and learn-all in the context of family, community and culture.'
Infant-Early Childhood Mental Health Consultation Model (I-ECMHC)	Primarily provided in early childhood settings it is a model of developing increased awareness and understanding of a child's experience in the childcare setting by offering a reflective space for workers through reflective supervision.
Infant Mental Health (IMH)	Interdisciplinary field of research and clinical practice. It is concerned with the healthy social and emotional development of a child from birth to three years. A central focus of IMH is devoted to promotion, prevention and treatment of mental health problems of very young children in the context of their families.
Michigan Association for Infant Mental Health (MI-AIMH)	An American organisation affiliated with the World Association for Infant Mental Health, comprised of individuals who are devoted to

	strengthening relationships between infants, parents and other caregivers.
MI-AIMH Competency Guidelines	30 page booklet describing specific areas of expertise, responsibilities and behaviours that are required to earn the MI-AIMH Endorsement.
MI-AIMH Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health	A competency based system for workforce development in I-ECMH. Recognition and documentation of competency within I-ECMH field.
National Practice Standards for Mental Health Workforce	A set of 12 practice standards to develop knowledge, skills and attitudes of the Australian workforce. To be used across the lifespan spanning from infancy to old age for five professional groups: Mental Health Nursing, Occupational Therapy, Psychiatry, Psychology and Social Work.
New South Wales Child and Adolescent Mental Health Services Competency Framework	Articulates the sub speciality work of CAMHS and describes particular competencies for working with infants, children, adolescents, their families and carers.
Real Skills Plus CAMHS: A Competency Framework for the Infant, Child and Youth Mental Health and Alcohol and other Drug Workforce	A competency framework describing knowledge and skills that practitioners need to work with infant, children and young people (0-19 years) who have moderate to severe mental health and/or alcohol difficulties, their whanau and their community.
Reflective Practice	The practice of examining one's thoughts and feelings related to professional and personal responses within the I-ECMH field (MI-AIMH definition).
Reflective Supervision	Considered important professional competence in the I-ECMH field. 'A practice arena that can shape and strengthen the interveners knowledge of self in regards to relationships, empathy for others, and skills in perspective taking' (Heffron, 2005).
Service Development Leader (SDL)	A specialist I-ECMH position responsible for overseeing the implementation of competency based training framework and building relationships with I-ECMH services and supporting community partnerships and networks to improve workforce capacity in I-ECMH.
Training and Supervision Committee	This committee comprises of a SDL, EC, and administration assistant and includes representation from AAIMHI WA. It is responsible for collaborating with stakeholder groups and establishing creative partnerships with training bodies to develop and deliver I-ECMH training.
World Association for Infant Mental Health (WAIMH)	A not-for-profit organisation for scientific and educational professionals. The central aim is to promote the mental wellbeing and healthy development of infants throughout the world, taking into account cultural, regional, and environmental variations, and to generate and disseminate scientific knowledge.
Zero To Three	An American non-profit organisation that provides parents, professionals and policy makers the knowledge and know how to nurture early development

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