Vol. 26 No. 4 | Fall 2018

Perspectives in Infant Mental Health

Professional Publication of the World Association for Infant Mental Health

Contents

How Refuge provides 'refuge' to Infants: Exploring how 'refuge' is provided to infants entering crisis accommodation with their mothers after fleeing family violence

This article by Wendy Bunston (PhD), Australia, is a summary of her doctoral research on infants' experiences of refuge while in Refuge crisis accommodation with their mothers. This PhD thesis can be fully accessed and downloaded by visiting: http://hdl.handle.net/1959.9/55917.

By Wendy Bunston, Australia

Infants under 12 months are more likely to be killed or harmed than any other age group in childhood (AIFS, 2010; AIHW, 2012a; Brandon et al., 2008; Frederico, Jackson, & Jones, 2006; Zeanah & Scheeringa, 1997). These risks are increased for the infant who lives with family violence. These infants are often present or nearby during incidences of familial violence within their home and make up the highest cohort of children to enter women's Refuges[1] (or alternatively, shelters/crisis accommodation) with their mothers after fleeing family violence (AIHW, 2012a, 2012b; Shinn, 2010). However, as a vulnerable population, infants experiences of violence and subsequent entry into women's refuges with their mothers to escape family violence is the least reported, thought or written about, and responded to of any age group in childhood (Bunston, 2017; Bunston, Franich-Ray, & Tatlow, 2017; Lieberman, Chu, Van Horn, & Harris, 2011).

1 Refuge with a capital 'R' refers to the physical place or accommodation provided and refuge with a lowercase 'r' refers to the emotional and social feeling of being.

The purpose of the research

The purpose of this PhD was to attempt to understand the experience of the infant in Refuge, and what was provided to them. There was no discernible research available regarding what occurred 'in-house' for infants who, with their mothers, become homeless as a result of family violence (David, Gelberg, & Suchman, 2012). High risk and transient populations such as these are often excluded from research as they are difficult to access, hard to engage and challenging to track (Booth, 1999; Thompson & Phillips, 2007). My interest was in what occurred in the Refuge setting to provide the infant with the experience of feeling that they had found refuge, and was that refuge experienced as a 'place', as a 'feeling of safety', or both? Six general questions were developed. These aimed to both guide this research overall and to set the parameters for collecting data regarding the infant, the mothers and the Refuge itself. Specifically:

- What is experienced as 'refuge' for the infant?
- How are the needs of the infant met within Refuge in order to make them feel safe?
- How are the infant/mother attended to in order to bring the infant into an emotionally regulated and healthy state?

WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

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Perspectives in Infant Mental Health is a quarterly publication of the World Association for Infant Mental Health. Address correspondence to Deborah Weatherston (dweatherston@mi-aimh.org). ISSN 2323-4822. All opinions expressed in Perspectives in Infant Mental Health are those of the authors, not necessarily those of WAIMH's. Permission to reprint materials from Perspectives in Infant Mental Health is granted, provided appropriate citation for source is noted. Suggested format: Perspectives in Infant Mental Health 2018, Vol 26, No. 4 WAIMH.

Perspectives Outreach
Calling all Infant Mental Health Professionals!

It is especially thought provoking to understand that every infant and family is affected by forces far beyond their reach - forces that may strengthen or hinder social, emotional, and relational health. A truly global organization, WAIMH invites professionals from around the world to contribute to its quarterly, open-source publication, WAIMH Perspectives, offering insights into the ways of seeing and being and working in diverse contexts, cultures and communities with infants, very young children, and their families.

We are calling for:

• commentary, field reports, case studies, conceptual or theory building papers,

• research articles, book reviews, news from WAIMH affiliates and (when proper permission can be obtained) adaptations of previously published articles

Our shared hope is that Perspectives will offer a space for interesting observations and articles around the world that promote reflection and interdisciplinary discussion. We publish Perspectives quarterly throughout the year. An open-source publication, members and others interested in infants and infant mental health have access to current and archived issues. The format for each article may be quite informal or formal, but within these guidelines:

Double spaced

12 point font

250 words per page

APA, 6th edition for style

Articles of varying length are welcome. However, length should not exceed 10 pages, word format

Send pictures and tables in separate files, with a resolution of 72 pixels/inch

Send your submission to: WAIMH Perspectives Editor, Maree Foley, maree.foley@xtra.co.nz

- How does entry into Refuge impact on the infant/mother relationship?
- How does the infant experience safety ('refuge') in a refuge environment?
- What knowledge do both staff and mothers have in relation to the needs of infants entering the Refuge?

The scope of the research

In 2014 I visited eight women's refuges in three countries; Australia, England and Scotland. I undertook collecting data from ten infants, interviewed ten mothers, and thirteen staff. I endeavoured to capture something of the subjective experience of the infant; first and foremost. This was done through using infant observation techniques I had been trained in as an infant mental health practitioner. The research methodology was purposefully 'infant led' (Bunston, 2008, 2016; Paul & Thomson-Salo, 1997), contextually sensitive and unobtrusive and drew from the concepts of intersubjectivity using a constructivist grounded theory research methodology (Charmaz, 2014).

Infant Observation as the starting point

It was necessary to first engage and build trust with each Refuge before I could gain entry. This led to staff recommending me to mothers, and mothers then meeting me for a preliminary outline of the research and to gain informed consent. Data collection began with undertaking an hour of observation with each infant (depending of accessibility I had one to three infant observations sessions with each of the ten infants involved in the study). I used traditional infant observation techniques (Bick, 1964; Datler, Datler, Hover-Reisner, & Trunkenpolz, 2014; Rustin, 1997), seeing this as the most discreet and ethical method to collect data directly from the infant in such a sensitive setting.

Immediately following each observation, I either spoke my process notes into an audio-recorder (which I then transcribed later) or wrote lengthy process notes. Once this data was collected I then proceeded with interviewing mothers, and later followed this with staff who were representatives of the three different countries in which I visited the Refuges. My two PhD supervisors and a critical friend (a teacher of infant observation methods) acted as the 'seminar group' within which the raw infant observation data was presented and nuances of the data could be explored (Bick, 1964; Caron, Sobreira Lopes, Steibel, & Schneider Donelli, 2012; Caron, Sobreira Lopes, & Schneider Donelli, 2013; Datler et al., 2014; Rustin, 2009; Waddell, 2013).

Infant led research

My research focused on the preverbal infant (12 months and under). Processes were in place to terminate sessions should the research process cause any distress to baby or mother, and post-observation and/or interview support for all participants was made available. The ethics of including infants in this research was weighted up against the importance of the research, the need to include the experience of the infant and that infants have a right to be included in research which directly concerns them (Pinheiro, 2006). I deliberately commenced with collecting data from the infant before any other and undertaking my analysis of the infant data before any other. This ensured that the experience of the infant served as the foundation upon which all other data was analysed to ensure the infant was front and centre in all aspects of the research process. This commitment worked to embed the infant's presence and experience into this methodological approach, intentionally honouring the potential to more actively include their voice in this research. This was to ensure, as much as was possible, that what might be the experience of the infant was included and to protected. To not do so risked "the elimination of an important category of knowledge, namely the knowledge of the child" (Schmidt Neven, 2007, p. 202).

Findings

Specific to the infant I found that whilst the majority of the infants sought out their mothers for refuge (as a place and to feel safe) they did not necessarily experience what they received as feeling like refuge. There were few other choices for the infant other than to turn to their mother; when the assurances they sought were left unsated some infants actively self-soothed, shut down or accommodated what was needed in order for them to gain proximity. As the observer I experienced varying levels of distress, anxiety and sadness as I watched a number of infants floundering and in only two instances experienced observing a sense of joyful exchange, reciprocity and playfulness between the infant and their mother.

Overall, I found that Refuges, like many other settings, are predominantly 'adult-centric'. Women's Refuges and shelters were originally created by members of the women's liberation movement in the 1970's to provide safe accommodation for women and their children experiencing violence in their home (Schechter, 1982). The belief then, and still today largely centres on supporting the mother which, by osmosis then supports the infant. However, these often highly traumatised mothers are not always available to tend to their infants. Not because they are bad, or do not care, but because they are themselves distressed and/or dysregulated and not able to quickly recover and/or know how to make themselves available to their rapidly developing infant.

The staff themselves did not feel adequately trained nor supported to confidently respond to the infants' needs and it appears that only when an infant is obviously unwell or distressed is direct assistance for the infant sourced, and then this is from outside, specialist help. In remote areas such support is not actually available. Workers do not generally directly engage with or consider the experience of the infant. This does not appear to result from a lack of compassion but acts as a means of self-protection. It is too painful for both staff and mothers alike to fully immerse themselves in a sympathetic response to the distress and trauma experienced by the infant. Therefore, the infant is lost from view in the Refuge setting, often not finding refuge, and on occasion, appearing to feel less than safe in this setting.

An important finding of the research was that all mothers involved in the study were motivated to leave the violent relationship because of their concern for their infants' welfare. This motivation to protect their infant was far greater than their desire to leave the relationship for the sake of their own safety. Their entry into refuge appeared to attend to the physical requisite for safe shelter, but less so to supporting their emotional need for reassurance about their role as parent and anxiety about their ability to manage their relationship with their infant. What Refuge might offer them other than accommodation was left unsaid but appeared as a yearning for guidance and support in their parenting role and for securing their infant's future.

Truly experiencing refuge after violence

The setting of Refuge has the potential to offer amazing opportunities to engage with and provide important therapeutic support to vulnerable infants and their mothers. Refuges are, however, poorly resourced and often isolated from other services which could and should provide relevant and critical early intervention programs. Staff within Refuges are highly committed but poorly paid. They deal with complex presentations and support highly

traumatised families. Other services, such as mental health – for adults, children and infants – need to work alongside Refuges, given the strong correlation between the impact of family violence and mental health difficulties (Helfrich, Fujiura, & Rutkowski-Kmitta, 2008; Kemp, Green, Hovanitz, & Rawlings, 1995; Tolman & Rosen, 2001; WHO, 2013). Mental health services would also have much to learn about the intricacies of addressing family violence and the complexities of attachments formed in such contexts by engaging with the infants, families and staff who make up Refuge.

Conclusion

It is no longer acceptable to say that family violence is not 'core' business for other service providers in mental health, community health and maternal child health, and multiple others. To bring the infant relationally alive, to fan the hope derived from this new relationship and to support the infant's wellbeing, physically and emotionally, a commitment is now required to support a setting which, for decades, has been protecting our most vulnerable. For as long as family violence remains endemic, the Refuge environment remains a necessity and intervention programs "must consider the dyad-context system to better address particular needs and to tailor intervention services" (Mingo & Easterbrooks, 2015, p. 480).

Refuge for the infant needs to be less about the building and equipment and more about people and relationships. This is as true for the mother as it is for the infant. Refuge workers need to be encouraged to act as a community of carers for the infant and their mother and be supported in doing so. This is through adequate funding and a community of service providers working to support them and recognising that refuge is as much a critical emotional space for the infant as a building which provides shelter. Infant mental health services, as with Child and Adolescent Mental Health Services (CAMHS), could begin now by offering regular reflective supervision sessions and consultations to local Refuges and crisis accommodation services. It is time to build active partnerships between infant mental health and family violence services if we are to bring about opportunities for repair which may truly have the power to interrupt intergenerational familial violence.

Summary of Key Findings

1. The infant is not understood to possess their own subjectivity and therefore is often lost from view within the Refuge setting.

2. The mother, not the Refuge, is expected to be the refuge for her infant.

3. Only when the infant is in obvious need do they receive specialist, 'outside' help.

4. It is too painful for the adults in Refuge to see or think about the subjectivity of the infant, or of the infant having their own traumatic memories.

5. The infant is the catalyst for mothers to seek Refuge and it is this relationship which provides the hope for the creation of a different future.

Acknowledgements

I am indebted to three wise women, my PhD supervisors Professor Margarita Frederico and Dr Mary Whiteside, La Trobe University (Bundoora, Australia), as well as my 'critical friend' Dr Julie Stone, Infant, Child and Family Psychiatrist (Melbourne, Australia) in undertaking and completing this research thesis.

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This PhD Thesis can be fully accessed and downloaded by visiting: http://hdl.handle.net/1959.9/55917. In late 2016 the author was a recipient of the 'Nancy Millis' award for excellence in research.

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View this text online.

From the Editors

By Deborah J. Weatherston, Editor, Michigan, USA, dweatherston@mi-aimh.org

Maree Foley, Associate Editor, Switzerland/ New Zealand, maree.foley@xtra.co.nz

This Fall (2019) edition of WAIMH Perspectives in Infant Mental Health assembles the articles and notices that have been posted via social media since the Spring Edition. This is the second full edition that has been published using this new format. To recap, following review and acceptance, each submission is now posted to social media by the WAIMH Central Office staff. The effect of this format is weekly and or bi-weekly posts that call attention and consideration what WAIMH members and allied infant mental health colleagues, around the world, are thinking, doing, and writing about.

In addition to the new publication format of Perspectives, this issue marks another milestone. I am stepping aside from the role of Editor which I have been honored to hold for WAIMH since 2012 and Maree Foley, Associate Editor, will become the new Editor in January 2019. I will remain available and engaged as an Assistant Editor. I would like to thank the WAIMH Board of Directors and the Executive Directors, past and present, for their support of this publication and of me and offer a very special thanks to Minna Sorsa (Finland) from the Tampere Office who has worked with me to produce each issue of Perspectives, year after year. I am enormously grateful for the work of the Associate Editors of Perspectives: Hi Fitzgerald (Michigan, US), Maree Foley (New Zealand/Switzerland, and Joshua Sparrow (Massachusetts, US). Hi has been steadfast in his commitment to review and edit contributions; Maree has a gift for revising and editing and is a superb author in her own right; Joshua has been instrumental in generating many new ideas and developing a new column, "World in WAIMH". Each has reached out to contributors with an eye on relevant clinical, social and advocacy issues for babies and families around the world. Each has offered strong support to me in my role as Editor. Finally, but perhaps most important of all, thank you to each person who contributed articles to Perspectives and to those who reviewed them. As a result of your generous clinical and scientific contributions, we have had a window into the unique world of infant mental health around the world. That is the purpose of WAIMH Perspectives. For each of you, I am deeply appreciative.

This Fall (2019) edition begins with a previously posted article: How Refuge provides 'refuge' to Infants: Exploring how 'refuge' is provided to infants entering crisis accommodation with their mothers after fleeing family violence, by Wendy Bunston, Australia. This article is a summary of Wendy's doctoral research on infants' experiences of refuge while in Refuge crisis accommodation with their mothers. Wendy generously provided the full link to her PhD thesis. It can be fully accessed and downloaded by visiting: http://hdl.handle.net/1959.9/55917.

The next previously-posted papers are from the Alliance for the Advancement in Mental Health: (Part I) The Alliance for the Advancement of Infant Mental Health: A Grass Roots Journey for Infant Mental Health (Margaret Holmberg & Ashley McCormick, USA); and (Part II) The Alliance for the Advancement of Infant Mental Health: A Grass Roots Journey for Infant Mental Health (Margaret Holmberg & Ashley McCormick, USA). These two papers outline a brief history of the Alliance and identify current initiatives within the Alliance. The authors summarize the results of a 2017 survey conducted by the Alliance with a view to furthering understandings of: what makes an infant mental health association strong. The results of this survey are aptly described by the authors as a consolidation of the "inspiring work of the Alliance association members". They summarize this impressive and far reaching national and international body of work in the field of infant mental health via a synopsis of a presentation: "What Makes an Infant Mental Health Association Strong?" by Ashley McCormick.

Next is a review of a recently published book: Psychodynamic Interventions in Pregnancy and Infancy: Clinical and Theoretical Perspectives by Bjorn Salomonsson. The review was conducted by Lucie Zwimpfer, New Zealand: "The perinatal period can be fraught with worry; the worries of babies, caregivers, and of the professionals that come into contact with them. In his latest book Psychiatrist and Psychoanalyst Bjorn Salomonsson shows us how 'baby worries' can be safely brought out into the open and treated in a truly integrated way … I will return to this book again and again and consider it to be essential reading for any parent

Deborah Weatherston.

infant therapist, especially those who are responsible for supervising primary health professionals, upon whom we are dependant for recognising the baby worries in the first place" (Zwimpfer, 2018).

This paper is followed by a new introduction to the WAIMH office staff: Minna Sorsa, Sari Miettinen and Reija Latva.

Next, WAIMH affiliate news is reported from the WAIMH affiliate Chair (Anna Huber, Australia) and the affiliate representative, Jane Barlow, UK. What follows is the ever-current and relevant re-posting of, A WAIMH position paper: The Rights of Infants (reposted from 2016).

Finally, this edition closes with the announcement of a search for a new editor of the Infant Mental Health Journal (IMHJ). The IMHJ is the official publication of WAIMH and is copyrighted by the Michigan Association for Infant Mental Health. The Call for Applications briefly describes what the requirements are for the position and the time frame for applications.

Maree and I thank each person for their interesting and thoughtful contributions. We welcome submissions from the field that challenge the way we think about infants, families, culture, and community, and offer fresh perspectives on policy, research, and practice. As always, we invite comments in response to what is published in WAIMH Perspectives in Infant Mental Health.

From the Central Office: Introducing the people working in the WAIMH Central Office

By Minna Sorsa, Sari Miettinen and Reija Latva, Finland

This year we were pleased to work with the Local Organizing Committee and Program Committee of the Rome World Congress. Another big project for the Central Office has been working on our new website. At the end of 2017 we started with the redesigning of the WAIMH Brand. With the extremely supportive and helpful specialists from Differo (in Tampere, Finland), content strategist Santeri Niemi has collaborated with us in creating a much more vivid graphic design. As we also changed our website software, we have been very busy. Luckily Administrative Assistant Sari Miettinen has started to work at the Office.

WAIMH is more visible in the social media. We invite you to like WAIMH on Facebook and follow us on Twitter @WAIMHorg. You are welcome to join the conversation online in social media using the following hashtags: @WAIMHorg #WAIMH #WorldInWaimh #IMH #WAIMH2020 (the Brisbane World Congress).

In the last Issue of Perspectives the new Executive Director Kaija Puura told you more about herself. Now we want to introduce the other people at the World Association for Infant Mental Health you can connect and work with. Minna Sorsa is working as Senior Administrator, Sari Miettinen as Administrative Assistant and Reija Latva as Associate Executive Director.

Minna Sorsa

I started to work with WAIMH in 2006, when we started the transfer of the WAIMH Central Office from East Lansing in Michigan to Tampere in Finland. It was good to get to know the wonderful people behind WAIMH –Hiram and Dee Fitzgerald and Tina Houghton working at Michigan State University. One memorable moment was the biking tour along Red Cedar (the river running through East Lansing), as well as attending a spectacular Spartans football game at their stadium. WAIMH creates unforgettable memories.

The Office was officially transferred from the USA (Michigan State University) to Finland (University of Tampere) after the 2008 Yokohama congress. In the beginning the President of WAIMH was Tuula Tamminen. The subsequent Presidents were Antoine Guedeney, Miri Keren and currently Kai von Klitzing. It has been a privilege to work with all WAIMH Board members and Affiliates during the past years. Many of the WAIMH members have become my good friends

As ten years has since passed, we are now at a new development phase, with technological changes swinging WAIMH into the swift social media times, and thus our website also has to fill the requirements of current times. We are about to open a new website with Yourmembership. We have modernized Perspectives in Infant Mental Health, with weekly releases. Our members have chosen to keep the "old format" of Perspectives (formerly the Signal). In the future you will be able to browse past issues more easily, and share them openly.

In the Central Office I work on general questions, social media, WAIMH World Congresses and different administrative tasks. I have worked with Perspectives in Infant Mental Health (formerly the Signal) since 2006, with Miri Keren as the Editor until 2012, when Deborah Weatherston commenced as Editor with 3-4/2012 issue. I am in deep gratitude for the outstanding collaboration.

As regards my background, I was trained as a Psychiatric Nurse, and have had many types of work experience, also as a reporter. I have been involved in local community volunteer work in my hometown, which has meant that I have worked together with people striving to preserve our historical and cultural heritage (which exists visibly as architecture and invisibly as traditions). My interest in volunteering arises from my belief in communities and active participation as the basis of societies. I strive to create communities where everybody can experience belonging, instead of exclusion. In my volunteer work I am interested particularly in the meaning of inclusion, a focus which may come from my interest in Mental Health Policies.

As my colleague Professor Kaija Puura wrote in her previous article, I think that an optimistic approach is needed in current times. As WAIMH has the intention of continuing with the important work for infants and families all around the world, we also need to be aware of the huge importance of our network. We need the support of others and we need to be supportive ourselves, for example by asking each other how we are doing, being helpful and supporting each other, and sharing the experienced burdens together. In WAIMH we meet at biannual congresses, and in between on the web and in social media.

During the past years I completed my PhD studies on mothers living in complicated life situations (dual diagnosis) as help-seekers. I am interested in qualitative methodology, and currently I am seeking research funding. This means that I will occasionally work part-time in WAIMH.

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Sari Miettinen

My first WAIMH congress was in beautiful Cape Town South Africa in 2012, where I gave my first oral presentation in English. I was thrilled with the WAIMH atmosphere and all the enthusiastic and inspiring WAIMH members and leaders. So I was really honored when I was offered the opportunity to work at the WAIMH Central Office. I started as a part-time Administrative Assistant in the WAIMH Central Office last fall, in October 2017.

I trained as a mental health nurse and pediatric nurse (RN) and now work as a Nurse Practitioner (NP). I have been working at the Department of Child Psychiatry in Tampere University Hospital nearly two decades and in the field of psychiatry and mental health overall for a quarter of a century.

Besides my work as a Nurse Practitioner, I have worked as a research nurse for two doctoral dissertations (doctor of medicine). My interest is in developing mental health services and over the years I have been involved in many research and development projects here in Finland. Besides our clinical work at Tampere University Hospital, I have been working with our former Executive Director Pälvi Kaukonen and new Executive Director Kaija Puura and with our Senior Administrator Minna Sorsa within these projects. The latest project has been working as a part-time project coordinator in 2017-2018, in the Finnish government's key project: a national program to address reform in child and family services. The program contains four themes: a family center model, development of services at specialized and the most demanding levels, a new operational culture to strengthen children's rights and access to basic information, and early childhood education, schools and other educational institutions to support the wellbeing of children and youth. I have been coordinating the development of services at specialized levels and the integration of services in the Pirkanmaa Hospital District.

Outside my work I am a mother of two young adults just starting their own lives, still living at home with me and my husband. We love to travel and our hobby is sailing. I also adore cats, and I breed gorgeous Siberian cats.

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Reija Latva

My first memory of WAIMH is the 6th WAIMH World Congress in Tampere. At that time, I was a medical student at Tampere University. In spring 1996, I had just started to do research with Professor Tuula Tamminen. She told me about the upcoming congress and there I was, one of the blue and white stripe shirted medical students helping the congress participants, and I could not imagine what a wonderful path I had just started.

In 2006, at the 10th WAIMH World Congress in Paris, I had my first WAIMH congress presentation in a poster workshop. The atmosphere of the congress enthralled me and since then I have participated in every WAIMH congress. When the WAIMH Central Office was transferred to Finland the President of WAIMH Tuula Tamminen and Executive Director Pälvi Kaukonen gave me the great opportunity to start little by little working in the Central Office. During these years, I have also had the privilege to get to know the next presidents of WAIMH Antoine Guedeney, Miri Keren and Kai von Klitzing, board members and members of program committees when they visited the Kauppi Campus in Tampere.

During recent years, WAIMH has started to use more and more opportunities provided by social media. Social media also gave me my first official task in the association in 2014 when I started to work as WAIMH Social Media Co-ordinator. In 2016, I started to work for the program committee of the Prague congress. Working on the program committee gave me a new and interesting perspective on WAIMH congresses.

In August this year I started working as an Associate Executive Director. In the Central Office, I will be organizing the next world congresses together with Kaija Puura, Minna Sorsa, Sari Miettinen, members of the Program Committee and the Local Organizing Committees of the congresses. We already started organizing the 18th World Congress in Brisbane 2020 this autumn. It is a great honor to serve the organization as an Associate Executive Director and I promise to do my best in this important task.

In addition, let me tell you something about myself. I am a child psychiatrist and I have worked at the Department of Child Psychiatry in Tampere University Hospital since 1999. Infant psychiatry has been my special interest for many years. I have done research in the field of infant psychiatry and done my PhD on premature infants. As a child psychiatrist I have had the opportunity to work in the Family and Infant Psychiatry Unit of Tampere University Hospital for the last ten years, first as infant psychiatrist and for the last five years as deputy chief of the unit. This autumn I received a new challenge in my clinical work starting as head of the Child Psychiatry Department of Tampere University Hospital.

I wish you all a Merry Christmas and a Happy New Year 2019!

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The Alliance for the Advancement of Infant Mental Health: A Grass Roots Journey for Infant Mental Health: An Introduction

By M. Foley, Switzerland/New Zealand

The following two articles, written by Margaret Holmberg and Ashley McCormick, provide an overview of the US based, international organization: The Alliance for the Advancement of Infant Mental Health (Alliance). All Alliance associations are encouraged to become a WAIMH affiliate: 26 of the 29 U.S. Alliance member associations are WAIMH Affiliates; 3 of the 29 member associations, are in the process of applying/becoming a WAIMH Affiliate; and 2 international U.S. Alliance.

The first article, Part I: The Alliance for the Advancement of Infant Mental Health: A Grass Roots Journey for Infant Mental Health, outlines a brief history of the Alliance and identifies current initiatives within the Alliance and introduces results of a 2017 survey conducted by the Alliance with a view to furthering understandings of: what makes an infant mental health association strong. All Alliance member associations were invited to participate. The results of this survey are aptly described by the authors as a consolidation of the "inspiring work of the Alliance association members". The first two key finding areas of identity and cross-system collaboration were summarized as part of this impressive and far reaching national and international body of work in the field of infant mental health via a synopsis of a presentation: "What Makes an Infant Mental Health Association Strong?" by Ashley McCormick.

To continue to address the question: What makes an infant mental health association strong?", the second article, Part II: The Alliance for the Advancement of Infant Mental Health: A Grass Roots Journey for Infant Mental Health, addresses the remaining five areas: competency-informed training; reflective supervision capacity; a sound organizational structure; policy; and higher education.

The Alliance for the Advancement of Infant Mental Health, Inc.® (Alliance) is an international organization that includes those states and countries whose infant mental health associations (IMHA) have licensed the use of the Competency Guidelines® and Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health® (Endorsement®), both developed by the Michigan Association for Infant Mental Health. Each IMHA that purchases a license becomes a member of the Alliance. To date, 29 US IMHA and 2 international IMHA participate. (www.allianceaimh.org)

Introducing the authors

Margaret Holmberg, PhD, IMH-E® began her work with infants and toddlers when she was assistant professor at the University of Kansas and ran one of the laboratory preschools. Margaret went on to receive her PhD from the University of North Carolina in Chapel Hill followed by a long and committed service the field of infant mental health. As a member and past president of the Connecticut Association for Infant Mental Health (CT-AIMH), she has had the privilege of representing Connecticut on the Alliance Planning Board and then in 2016 to serve as the first President of the Board of Directors for the Alliance for the Advancement of Infant Mental Health, USA).

Ashley McCormick (LMSW, IMH-E®, Endorsement & Communications Director, Infant Mental Health Specialist) is dedicated to promoting workforce development standards for all professionals who work with infants, young children and families through the promotion and use of the workforce development tools, the Competency Guidelines® and Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant and Early Childhood Mental Health®. Additionally, Ashley provides in-service training and reflective supervision/consultation to professionals in the infant and young child-family field. Ashley's previous professional experience includes working as an Infant Mental Health Home Visitor in Detroit-Wayne County. Ashley's training includes a Bachelor's degree in Psychology and Child Development from Central Michigan University and a Master's of Social Work from the University of Michigan.

The Alliance for the Advancement of Infant Mental Health: A Grass Roots Journey for Infant Mental Health (Part 1)

By Margaret Holmberg, United States

Ashley McCormick, United States

What a pleasure and honor it has been to be involved with promoting infant mental health competency through the Competency Guidelines® and Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant and Early Childhood Mental Health® (Endorsement®). Both the guidelines and Endorsement® system are particularly important as early relationships have become a prominent concern for an increasing number of child care providers, home visitors, clinicians, policy makers and faculty. These standards and Endorsement® now identify more than 2,200 endorsed professionals who are connected through The Alliance for the Advancement of Infant Mental Health, Inc.®, referred to as the Alliance in this article.

History: Setting out on the journey

The journey toward the formation of the Alliance is a result of many people putting their feet to the ground and their voices in the air for infants, toddlers and their families. What started in early 2000 through the efforts of the Michigan Association for Infant Mental Health (MI-AIMH) has grown into a strong, grass roots organization, with 29 infant mental health state associations, including affiliates in Western Australia and Ireland.

Deborah J. Weatherston, who retired as the Alliance Executive Director in July of 2018, has supported our paths in each of our states and regions. Debbie brought first one then two then many infant mental health state associations together in 2003 to discuss issues of competency and recognition through Endorsement® for the workforce for infants, toddlers and their families. She then steered us to a highway of formal operations as an Alliance in 2016. We are so grateful for Debbie's compassionate direction and leadership.

The Alliance: A current overview

Alliance member organisations: All Alliance associations are encouraged to become a WAIMH affiliate. 26 of the 29 U.S. Alliance member associations are WAIMH Affiliates; 3 of the 29 member associations are in the process of applying/becoming a WAIMH Affiliate. The 2 international U.S. Alliance member associations are WAIMH Affiliates.

Competency Guidelines and Endorsement: Today with Nichole Paradis in the role of Executive Director of the Alliance, the Board and Alliance member associations are rapidly moving forward by expanding the Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant and Early Childhood Mental Health® to include those working with young children 3-6 years and their families (Early Childhood Mental Health Endorsement®). The Alliance is making the Competency Guidelines® and Endorsement® available to our Spanish speaking workforce.

Global connections and partnerships: The Alliance is identifying important partners that have nation-wide connections. The Alliance currently has an agreement with Healthy Families America (HFA), a widely recognized national home visiting model practiced in many states with federal dollars, to provide reflective supervision/consultation training to HFA supervisors to better assure the integration of infant mental health principles into home visiting practices and to encourage Endorsement®. Achieve OnDemand Ounce of Prevention, Erikson Institute FAN Training, Fielding Graduate University, Wayne State University Infant Mental Health Dual Title Program in Infant Mental Health, Early Relational Health Screen and UCDE Napa Fellowship/Parent-Infant & Child Institute are other entities with widespread connections who are committed to promoting the Competency Guidelines® as best practice standards for the field.

Other initiatives that the Alliance is advancing include incorporating the Diversity-Informed Tenets (Irving Harris Foundation, USA) into our trainings and setting diversity and equity as priorities for the field. The Alliance has partnered with the national organization, ZERO TO THREE, to establish a directory of state contacts for families and young children who are separated at the US border. The Alliance has produced position papers on the consequences of parent and young child separation, as well as the use of the baby and mother relationship as a vehicle for repair for mothers addicted to Opioids.

Annual Leadership and reflective supervision/consultation summits: Of additional importance, members of the

Alliance have come together annually for the past 11 years to participate in a 2-day Leadership Summit and for the past three years for a 3-day Reflective Supervision/ Consultation Symposium with over 100 infant mental health professionals in attendance. These events allow Alliance members to raise issues that are forefront for babies and families in their states and countries, to discuss with other Alliance members resolutions to those issues, and to advocate for training, research, policies, and practices needed.

Each year, through the lens of the Competency Guidelines® and Endorsement®, members of the Alliance summarize their annual activities that promoted infant and early childhood mental health (IECMH) principles and practices throughout their states and countries.

What Makes an Infant Mental Health Association Strong?

What makes an Infant Mental Health Association Strong Alliance Survey 2017: Each year for the past 8-years, participating IMHA leaders have prepared annual activity summaries that offer specific examples of the use of the Competency Guidelines® and Endorsement® in promoting infant and early childhood mental health (IECMH) principles and practices in their states or countries. This year we suggested that Alliance leaders summarize their reports using the following topics: the relationship between infant mental health (IMH) and other 0-3 and family programs; sustainability; grant activity and fund development; in-service training and higher education; community collaboration; policy development and systems change and reflective supervision/ consultation (RSC). Twenty-five of the 31 Alliance member associations contributed to the activity summaries and we look forward to hearing from newly established members next year.

What follows is a synopsis, based on the data found within the 2017 activity summaries, which explores the question, "What makes an infant mental health association strong?" The answer to that question was linked to the following seven areas:

- identity
- cross-systems collaboration
- competency-informed training
- reflective supervision capacity
- a sound organizational structure
- policy
- higher education

The results of this survey consolidate the inspiring work of the Alliance association members.

What makes an infant mental health association strong?" In answer to this question, the first two of the seven key areas are addressed below; identity and cross- systems collaboration (the following fove areas are addressed in Part Two).

> Identity: the quality(ies) or belief(s) that distinguish an IMHA; strong mission and vision statements that define who they are and their scope of work within the IECMH field.

IMHA have similar but varied mission statements. They include things like: increase collaboration among parents, caregivers, agencies and systems that touch the lives of infants and young children; foster public policy at the local, state and national levels to support the healthy social and emotional development of infants, young children and their families; and, promote optimal IECMH by way of supporting the birth-to-six professionals who work with or on behalf of infants, young children and their families. Strong associations are able to use their mission to help guide and define who they are, who they serve, and how they serve those identified.

Here are examples of associations who have successfully defined the scope of their work and allocate their time and resources accordingly.

Identity and offerings: The New Jersey Association for Infant Mental Health (NJ-AIMH) defined its identity as:

A statewide organization for multidisciplinary professionals, who work to support the relational and emotional development of families from pregnancy through early childhood.

This statement exemplifies the association's commitment to "who we are" by focusing on enhancing the benefits of membership to their association. For example, the 2017 annual membership dues provided access to a bi-monthly newsletter, 6 low-fee training opportunities, 2 free trainings, invitations to state conferences where competencies were assigned to workshops and networking opportunities. NJ-AIMH members were also offered access to other IMH professionals across multi-disciplinary fields. By focusing on the "who we are," NJ-AIMH ultimately strengthened "what we do" by providing IECMH professionals with workforce development tools that would help them succeed.

Identity and the importance of connections with key individuals who can speak to and for the mission or vision: The Colorado Association for Infant Mental Health (Co-AIMH) emphasized the importance of connections with key individuals who can speak to and for the mission or vision that defines the association within other circles. These essential connections were shown throughout diverse Board leadership, advisory committees, committee chairs and liaisons. Jordana Ash, Past President for (CoAIMH), was appointed the first Director of Early Childhood Mental Health at the Colorado Department of Human Services (CDHS) Office of Early Childhood (OEC) in 2016. She serves as a liaison between CoAIMH and CDHS OEC, facilitating a close working relationship between the two and keeping both of their best interests in mind.

Identity and current websites: The Connecticut, Kansas, Iowa, Michigan, Oklahoma, Rhode Island and Tennessee associations all spoke to the priority of updating and keeping their association websites current and in line with their association "branding" to increase the likelihood of member use.

It is clear from the summaries that identifying who you are as an association and having a strong "voice at the table" to represent IECMH values and beliefs is essential to building a strong IMHA.

> Cross-Systems Collaboration: the ability to work together, across systems, on an activity or project of mutual interest on behalf of infants, young children and their families; to cooperate with others to produce something.

Twenty-one out of the 25 associations described working closely with other systems, services or agencies, for the well-being of infants, young children and their families, as people from diverse service settings and disciplines sought funding to secure or strengthen competency-based workforce development through Endorsement®.

A majority of the associations have formed cooperative relationships with other organizations for the purpose of calling attention to the field of IECMH by participating in meetings or advisory panels and co-sponsoring events. Examples include the following:

- An Oklahoma Association for Infant Mental Health (OK-AIMH) Board member attends regularly scheduled Department of Health meetings and co-led the administration of the Infant and Early Childhood State Strategic Plan.
- A representative from the Rhode Island Association for Infant Mental Health (RIAIMH) sits on the Office of the Child Advocate's advisory board, the RI Early Learning Council and the advisory board for RI's new Safe and Secure Baby Court.
- The Iowa Association for Infant and Early Childhood Mental Health (IAIECMH) collaborated with Prevent Child Abuse Iowa to sponsor an IMH track at their annual conference last spring.
- For the second year, the Association for Infant Mental Health in Tennessee (AIMHiTN) partnered with the Tennessee Department of Mental Health and Substance Abuse Services in planning Tennessee's IMH conference, "Building Blocks for Infant Mental Health."
- The Michigan Association for Infant Mental Health (MI-AIMH) has partnered with the Infant Mental Health Home Visiting (IMH-HV) evaluation team that is taking place through the Michigan Collaborative for Infant Mental Health Research, involving researchers, clinicians and community representatives to examine the effectiveness, efficacy and impact of the Michigan IMH-HV model. Participants include: University of Michigan, Michigan State University, Wayne State University, Eastern Michigan University, Central Michigan University, the Alliance and the Michigan Department of Health and Human Services.

Robust cross-sector collaborations strengthen associations and help to move IECMH practice, programs and initiatives forward. This takes time and commitment from IMHA members.

Concluding comments

What makes an infant mental health association strong?" In answer to this question, the first two of the seven key areas have been addressed above; identity and cross- systems collaboration. The remaining five areas: competency-informed training; reflective supervision capacity; a sound organizational structure; policy; and higher education, will be addressed in Part Two of this article which will be published online in Perspectives, the near future.

Through the lens and use of the Competency Guidelines® and Endorsement®, Alliance IMHA members promote IECMH principles and practices throughout their states and countries. They utilize successful and creative strategies, within and across systems, to build capacity for RSC; to offer competency-informed training; to link with higher education institutions; to advocate for infants, young children, families and the systems that serve them; and to define a clear purpose for both their organizations and their organizational structures. IMHA are invited to use this report to celebrate what has been accomplished and to glimpse at what is possible in the future.

The Alliance for the Advancement of Infant Mental Health: A Grass Roots Journey for Infant Mental Health (Part 2)

By Margaret Holmberg, United States

Ashley McCormick, United States

What Makes an Infant Mental Health Association Strong?

What makes an Infant Mental Health Association Strong Alliance Survey 2017: Each year for the past 8-years, participating IMHA leaders have prepared annual activity summaries that offer specific examples of the use of the Competency Guidelines® and Endorsement® in promoting infant and early childhood mental health (IECMH) principles and practices in their states or countries. This year we suggested that Alliance leaders summarize their reports using the following topics: the relationship between infant mental health (IMH) and other 0-3 and family programs; sustainability; grant activity and fund development; in-service training and higher education; community collaboration; policy development and systems change and reflective supervision/ consultation (RSC). Twenty-five of the 31 Alliance member associations contributed to the activity summaries and we look forward to hearing from newly established members next year.

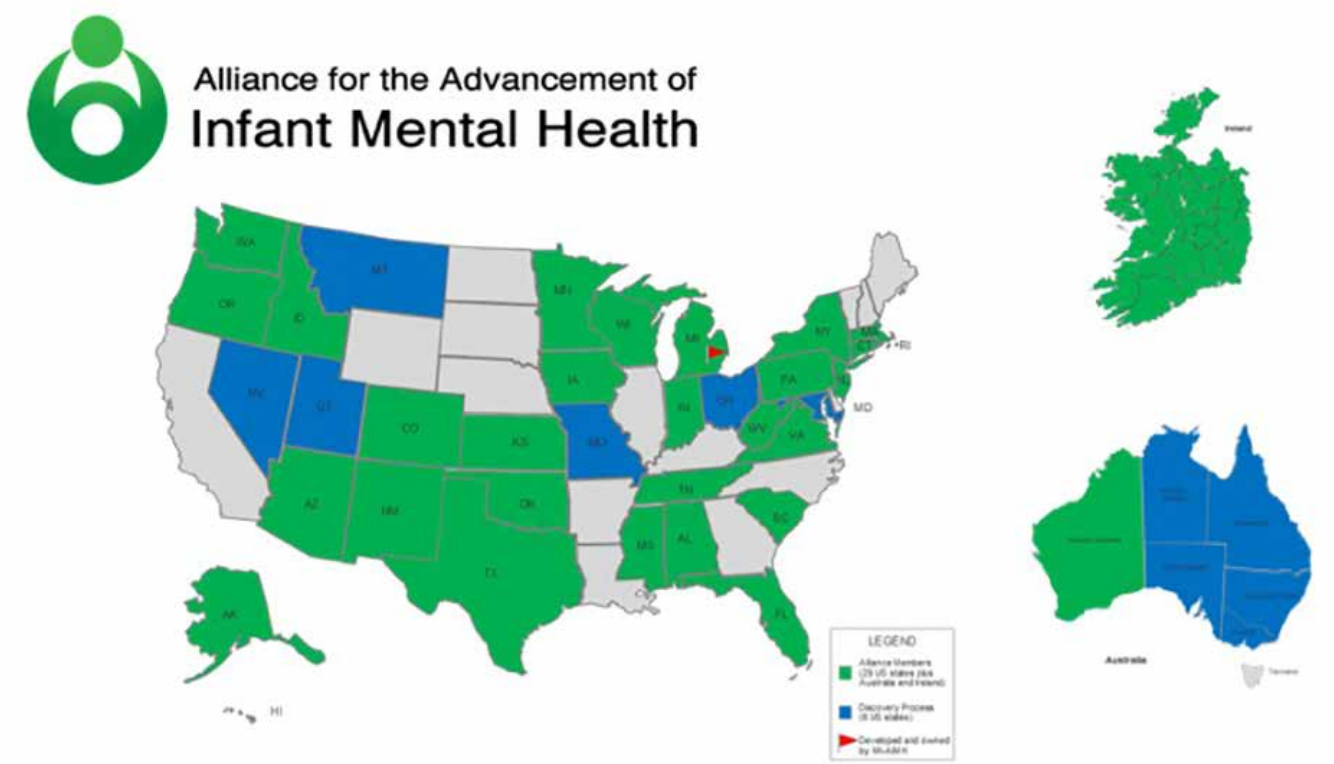
What follows is a synopsis, based on the data found within the 2017 activity summaries, which explores the question, "What makes an infant mental health association strong?" The answer to that question was linked to the following seven areas:

- identity
- cross-systems collaboration
- competency-informed training
- reflective supervision capacity
- a sound organizational structure
- policy
- higher education

The results of this survey consolidate the inspiring work of the Alliance association members.

> Competency-Informed Training: competency-informed or competency-based workshops, trainings and conferences that promote IECMH principles and practices; provided across disciplines to the infant, young child-family workforce.

Many IMHA sought and successfully secured collaborative funding to provide trainings that infused IECMH principles



and practices across a variety of service systems.

- Home visiting services grew in number and importance this past year, in large part due to federal funding to states through Maternal, Infant and Early Childhood Home Visiting (MIECHV). Recognizing the shared mission with IMH, IMHA in Alaska, Arizona, Florida, Idaho, Indiana, Kansas, Michigan, Oregon, Rhode Island and Wisconsin reported receiving funding to provide intensive competency-informed training and/or reflective supervision to programs like Parents as Teachers, Healthy Families America and Early Head Start/Head Start.
- Many IMHA received funding from Project LAUNCH. Although these funds were used in diverse ways, IMHA in Colorado, Florida, Pennsylvania, Washington and West Virginia used a portion of their funds to either provide competency-based IECMH trainings or send to their members to IECMH trainings.
- IMHA offered specialized programs in collaboration with Baby Casa training in Arizona, Baby Court in Michigan, Safe Babies Court Teams in Connecticut, Texas and Oklahoma and Safe and Secure Baby Court in Rhode Island. This meant that mental health and early childhood specialists provided training for staff working with or on behalf of infants, very young children and their families in judicial and child welfare settings, enhancing professionals' knowledge of early development and behavior, influencing decisions and reducing the risk of continuing trauma and profound loss in infancy and early parenthood. Of similar focus, the Australian Association for Infant Mental Health – Western Australia (AAIMHI WA) developed a 2-day pilot training on Perinatal and Infant Mental Health for all staff working in Child Protective Services. The training content is aligned with the Competency Guidelines® and was developed in conjunction with Edith Cowan University.

IMHA spent a great deal of effort in partnering with well recognized, birth to 3 and family organizations to establish crosswalks between training curricula and the Competency Guidelines® and to align and integrate their work. In instances where there are "gaps," associations have developed trainings to fill those gaps.

- The Wisconsin Association for Infant Mental Health (WI-AIMH) was successful in aligning IMH with other groups. The association chaired a workgroup to revise and update/ Infant-Toddler Pyramid Model training. The newly revised Infant-Toddler content integrates IMH concepts and competencies and includes materials and activities on reflective practices. Additionally, WI-AIMH offered Infant/Toddler training of trainers for Wisconsin technical assistance provides. The training is now offered by the approved trainers for Infant/Toddler Educators around the State. The training is Registry approved and meets YoungStar (QIRS) criteria.

Important collaborations exist between state departments of health, human services and behavioral health and many IMHA. As a result, funding has been available to support training initiatives that benefit large numbers of staff working with birth to six and family services to embrace social and emotional development and relationship initiatives.

- The NJ-AIMH received a grant from the Department of Human Services to initiate a comprehensive training series, "Keeping Babies and Children in Mind: Professional Formation Series in Infant and Early Childhood Mental Health." Funding allowed staff in counties who had not previously received training under funding from "Super Storm Sandy," to schedule the "Keeping Babies and Children in Mind" training for their infant, early childhood-family workforce.
- The WI-AIMH partnered with the state's Office of Children's Mental Health to apply for and secure a three-year technical assistance grant through SAMHSA's Center of Excellence on Infant/Early Childhood Mental Health Consultation.

- As part of a multi-year project, the Washington Association for Infant Mental Health (WA-AIMH) is working with the Washington Department of Health/Project LAUNCH to support cohorts of early learning providers in seeking Endorsement®. Professionals in the participating Project LAUNCH communities include both center-based and family home child care providers, and many of them serve military or Hispanic families. As part of this work, WA-AIMH is working to identify IECMH-relevant trainings that are offered to and/or required for early learning providers throughout the state and will be developing crosswalks that will map these trainings onto the Competency Guidelines®. The crosswalks will assist providers in identifying their level of preparation as an IMH professional and any gaps that may necessitate additional training.
- The Connecticut Association for Infant Mental Health (CT-AIMH) partnered with Department of Public Health and Office of Early Childhood, who provided funding for CT-AIMH to provide two-day early childhood obesity prevention training.

Associations were thoughtful about how to best reach their members through professional development offerings.

- RIAIMH offered a monthly conversation series (3 sessions per topic) in Spring (March-May) focused on early regulation challenges; and Fall (Sept-Nov) focused on attachment principles in practice. They recruited local experts in research and clinical practice to lead these conversations. They had consistent attendance of 50-80 participants per session.
- An increased number of IMHA, including those from Alaska, Iowa, Minnesota, New Jersey, Texas, Virginia and West Virginia sponsored or co-sponsored online competency-based training opportunities.
- IMHA from Arizona, Idaho, Indiana, Kansas, Michigan, New Jersey, Oregon, Tennessee, Texas and Wisconsin offered an annual or biennial IMH conference as both a way to generate funding and to provide competency-based material to the IECMH workforce.

All 25 of the associations demonstrated that providing ongoing professional development helps make an association strong as illustrated by their commitment to sponsoring or co-sponsoring of competency-informed workshops, trainings and/or conferences.

Reflective Supervision/ Consultation Capacity: commitment to building and sustaining reflective supervision/ consultation (RSC) capacity within the IECMH field.

As interest in RSC has increased across the country, MIECHV funded programs have turned to IMHA to enhance reflective practice skills. This has resulted in funding to support reflective supervision groups and reflective practice communities of learning across the country. Of additional importance, MIECHV has allocated funds to IMHA to assist in training home visiting supervisors over one and two years to engage effectively in reflective supervision with their staff. The shared commitment to building reflective capacity has strengthened understanding and forging relationships between IMHA and MIECHV funded program staff.

Many IMHA are working in creative ways to increase RSC capacity throughout their state or region.

- Co-AIMH convened RSC leaders from across Colorado in two, half-day meetings in 2017 in an effort to respond to the increasing need to build the capacity for RSC.
- MI-AIMH and the Minnesota Association for Children's Mental Health Infant and Early Childhood Division (MACMH-IEC) offered regular training opportunities on RSC to staff across disciplines and in various health, mental health and educational service settings.
- Associations in Alaska, Arizona, Indiana, Minnesota and Oregon reported on their use of virtual platforms to provide group RSC to those in geographically isolated or remote locations.
- NJ-AIMH provided a two-workshop series on RSC twice throughout the year. They offered a third, optional, workshop on group RSC. These five trainings qualified 32 IMH professionals to continue on in a two-hour monthly RSC series which will certify them to be "vetted" Reflective Supervisors in the state, as well as to gain hours toward the Endorsement® requirement.
- CT-AIMH offered eight RSC groups to child welfare, Part C, Early Head Start and community partners. Child welfare, Part C and the Connecticut Head Start State Collaboration Office funded the groups.

The impact of all of these efforts are wide-reaching in supporting multi-disciplinary professionals including early care and education, early intervention, mental health clinicians and child protective services. Many IMHA demonstrated effective and creative solutions to building capacity across service systems on behalf of the wellbeing of infants, very young children and families. Despite the creative solutions that some associations utilized, other associations expressed the need for support in regard to building capacity for reflective supervision.

Sound Organizational Structure: roles and functions of the staff, Board of Directors, committees and others that make up the association; evolve, when necessary, to meet the needs of association members.

IMHA committees are a tremendous asset to associations and often are the "engine" or "life blood," that bring policies to practice. Most committee members serve in a voluntary capacity and serve a purposeful role that is distinct and separate from that of the Board of Directors. Many associations spoke of various committees that exist, including, but not limited to, the following: Endorsement, Membership, Marketing, Fundraising, Education, Professional Development, Training/ Programming, Social Action, Messaging and Outreach.

Some of the ways that associations are ensuring a sound organizational structure are summarized here:

- The Florida Association for Infant Mental Health (FAIMH) just recently joined the Alliance. As their association members begin work related to the competencies and Endorsement®, they developed Outreach and Marketing Committees of the Board to begin developing an outreach plan and messaging that will be used with various stakeholders either directly or peripherally involved with Endorsement®.

- IMHA chapters or regional hubs were developed in many associations to support the ongoing work of the Board of Directors and associations staff. The Florida, Michigan, Pennsylvania, Virginia, and Wisconsin associations all have regional chapters/hubs in their states to create smaller networks, convene monthly or quarterly meetings of members and to move the work of IECMH forward.
- AIMHiTN Board of Directors used their "who we are" and "what we do" to guide a two-day strategic planning retreat to identify early goals with regard to sustainability. To build on the discussions from the planning retreat, AIMHiTN is creating and convening a sustainability committee. This standing Board committee will be charged with fully developing a strategic plan, inclusive of fundraising, marketing, and sustainability plans. The committee will include members of the Board, the executive director and targeted community partners.

All 25 IMHA have Boards of Directors and other integral partners who provide an essential organizing structure. However, some reported the need and desire for assistance in strengthening their Boards of Directors, bringing up new leaders and engaging in strategic planning. Consultation with experts regarding board functioning requires funding. This is an area of need expressed by multiple associations.

Policy and Practice: social policy, advocacy and/or systems change that advance IECMH understanding, principles and practices.

To strengthen their voice for infants and families, many IMHA have joined or continued policy and practice initiatives at the state and national levels. Eight associations reported specific ways that they are doing this. Some examples are:

- The Virginia Association for Infant Mental Health (VA-AIMH) and OK-AIMH both received grants from ZERO TO THREE for Training and Technical Assistance to begin to restructure the current Medicaid system. A VA-AIMH and OK-AIMH Board member sits on the lead team for the project. One important goal that was identified involves adoption of the DC: 0-5.
- The New Mexico Association for Infant Mental Health (NM-AIMH) Board supported the application of a member to be a partner in applying for the ZERO TO THREE IECMH Policy Convening for the 2018 year. If chosen, they would participate in national strategic planning network under the direction of ZERO TO THREE.
- New York State Association for Infant Mental Health (NYS-AIMH) was selected and participated in a ZERO TO THREE Learning Collaborative, "Enhancing Mental Health Capacity in Home Visiting: A Virtual Community of Practice for State Teams." Additionally, they participated in the development of The "First 1000 Days on Medicaid," a collaborative effort to bring together stakeholders to develop recommendations for a ten-point plan.
- The MI-AIMH Policy/Social Action Committee hosted an "Advocacy 101" training day in the fall. The committee met together in Lansing for a morning training on "Advocacy: Affecting Change," and then spent the afternoon meeting state representatives. Conversations were focused on the promotion of IECMH.
- The Infant/Toddler Mental Health Coalition of Arizona (ITMHCA) reported that Best Practices for Infants and Toddlers in the Courts are gradually being implemented statewide (i.e., placement decisions, parent-child coaching for visits, encouraging foster parents to fall in love with kids, timely access to needed services, child-parent psychotherapy, trauma therapy for parents).

IMHA leaders have a stake in the healthy social and emotional development of infants, young children and their families. As more IMH Board members and leaders join policy makers at the local, state and national levels, our public policies should reflect the values embedded in IECMH principles and practices.

Higher education: relationships with colleges and universities; commitment to expanding understanding and use of IECMH via faculty, certificate programs, degree programs in academic institutions.

IMHA who link with faculty in colleges and universities to build non-degree and degree programs in IECMH have grown in size, number and strength. Associations who collaboratively crosswalk non-degree/degree programs with the Competency Guidelines® benefit from similar growth. A few examples include the following:

- CT-AIMH completed a crosswalk with Central CT State University (CCSU) to promote the inclusion of IMH competencies in higher education (IMH bachelor's degree). CCSU received approval from the Board of Reagents for this new program and CT-AIMH will continue to support the addition of IMH content and courses into this program.
- Fielding Graduate University, PhD in Infant and Early Childhood Development (online/Santa Barbara, CA); this degree is designed for working professionals who wish to broaden their knowledge and understanding of infant and childhood development.
- University of Minnesota, Infant and Early Childhood Mental Health Certificate Program (St. Paul, MN); this online certificate program can be taken for academic credit or continuing education units.
- Portland State University, Graduate Certificate in Infant Toddler Mental Health (Portland, OR); this 20-credit, certificate is available online and is designed for professionals who are working with families who have children from the prenatal period to 36 months of age.
- University of Pittsburg, Infant Mental Health Certificate (Pittsburg, PA); this 18-credit, Post-Baccalaureate certificate is available within the Department of Applied Developmental Psychology.
- Wayne State University Merrill Palmer Skillman Institute, Dual Title in Infant Mental Health (Detroit, MI). Students earning an MSW or PhD in Social Work, a PhD in Psychology or a PhD or

DNP in Nursing can earn a Dual-Title in Infant Mental Health.

Many associations have developed resourceful strategies to form higher education connections.

- MACMH-IEC hosted a Faculty Symposium for educators from 2 and 4-year colleges. This opportunity provided the faculty with resources for embedding IMH practices into curriculum.
- The West Virginia Association for Infant/Toddler Mental Health (WV-AIMH) formed a Higher Education subcommittee to strengthen their relationships with colleges and universities throughout the state. This subcommittee is developing a survey to assess which IMH competencies are being integrated into current coursework across the state, as well as field experiences and child observation opportunities, qualifications of instructors, and what prerequisites are required. The hope is for this information to be used to develop a comprehensive plan to strengthen IMH-informed work across disciplines within higher education.
- The Oregon Infant Mental Health Association (ORIMHA) created a webinar on Endorsement® for Portland State University Graduate Students.
- NJ-AIMH developed an initiative to establish relationships with universities throughout New Jersey in order to promote awareness of IMH. This initiative includes presentations to faculty and graduate students and has a long-term goal of having graduate students join the NJ-AIMH Board. This will provide leadership and professional development to students, bring new energy and ideas to the Board, and establish relationships with universities offering graduate programs in IMH fields.

By infusing IECMH competencies into higher education, associations are prioritizing the future of the infant, young-child family workforce.

Concluding comments

Through the lens and use of the Competency Guidelines® and Endorsement®, Alliance IMHA members promote IECMH principles and practices throughout their states and countries. They utilize successful and creative strategies, within and across systems, to build capacity for RSC; to offer competency-informed training; to link with higher education institutions; to advocate for infants, young children, families and the systems that serve them; and to define a clear purpose for both their organizations and their organizational structures. IMHA are invited to use this report to celebrate what has been accomplished and to glimpse at what is possible in the future.

Margaret Holmberg (Connecticut AIMH, USA, President of the Alliance for the Advancement of Infant Mental Health, USA)

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Ashley McCormick (Endorsement & Communications Director, Infant Mental Health Specialist, Alliance for the Advancement of Infant Mental Health, USA)

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Book review

Psychodynamic Interventions in Pregnancy and Infancy: Clinical and Theoretical Perspectives

Originally published: 2018

Author: Björn Salomonsson

Reviewed by Dr Lucie Zwimpfer

Parent Infant Psychotherapist

Wellington, New Zealand

The perinatal period can be fraught with worry; the worries of babies, caregivers, and professionals who come into contact with them. In his latest book Psychiatrist and Psychoanalyst Björn Salomonsson shows us how 'baby worries' can be safely brought out into the open and treated in a truly integrated way.

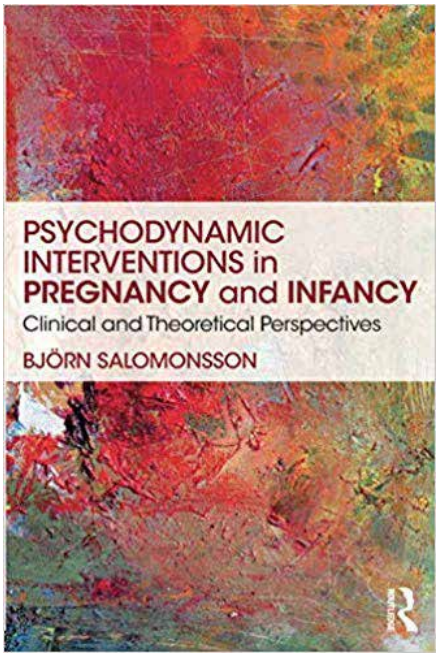
This book is in equal parts; both an explanation of technique and a sound theoretical perspective on work with infants and their parents. Salomonsson is firmly ensconced in a child health clinic, where he provides psychoanalytic consultations alongside nurse-provided general health support. He offers supervision and support to the nurses who are then more equipped and psychologically capable of recognising baby worries in the families they see. With an approach that is both educational and supportive, he offers the nurses words to try out with families - a flotation device of sorts to help them navigate the deeper waters of emotion. Salomonsson has gained the trust of the nurses he works with so that together they are able to offer the families of the child health centre an extraordinary service. Just as infant mental health is concerned with the physiological as well as the psychological, so too should interventions in the perinatal period be seamless across both realms.

Rich clinical case examples, theoretical concepts and research are used to highlight key phenomena in the perinatal period. Complex psychodynamic concepts are presented in an extremely digestible way. While he uses metaphor and imagery to come closer to and create a shared space with his clients, he also uses metaphor and imagery in his writing; the readers feel as though they are both literally and figuratively on the same page as him.

Of particular note is Salomonsson's description of the internal frame of his work. He considers it to be a mode of thinking in which he 'reads between the lines' or 'understands unconscious currents between conscious messages' (p.78). He describes beautifully how he holds both the roles of 'unmasking' and 'translating' alongside compassion and non-judgement in his technique. He has created a kind of psychological play-space that exists between supportive work and psychoanalysis. This feels so appropriate when the therapy takes place in a medical clinic and when working with parents who are simultaneously meeting the practical needs of a baby while also trying to reach and understand complex psychological dynamics. He takes a position in child health consultations which departs from the classical psychoanalytic one; he answers questions yet always analyses the impact of his words. He offers 'pop up comments' to facilitate an exploration below the surface, though cautions against going deeper if the patient is unwilling to participate.

Salomonsson provides a thorough review of clinical methods and research in psychodynamic therapy with infants and parents (PTIP), particularly noting whether differing methods address the baby in therapy or consider the baby to have an unconscious; he utilises both approaches in his own work. He ends the first half of the book with fascinating case examples of his work with couples and toddlers.

The second half of the book focuses on theoretical perspectives. He asks whether the baby's mind can be understood best through empirical observation or speculative theorising and concludes that analytic theorists and learnings from psychodynamic therapy with parents and infants have an important place alongside infant research and infant observation. Salomonsson reviews analytic models of infant anxiety and applies them to case studies before making a compelling argument for gaze avoidance as a defence against mental pain. He stresses the importance of conceptualising what happens inside both the mother and the baby - not to lose the insides of the baby to a focus on dyadic interaction. He argues that observation of dyadic interaction



does not 'give full credit to the baby's subjectivity' (p. 201) and describes his technique as both inter-subjective (based on communications between mother and baby) and 'intra-subjective' as he attempts to understand the psychological experiences of himself, mother and baby. It is also clear that Salomonsson encourages the nurses he supervises not to lose their insides in consultations with families.

In a fascinating discussion of the use of metaphor in parent infant therapy, Salomonsson shows us how useful metaphor can be in a context which is ripe for transmission of infantile material. He suggests it is a helpful technique for when the therapists own infantile helplessness is awakened, provided the therapist can keep a hold of his/her own 'narcissistic preoccupations'.

He ends with a vision for the future as he makes a strong argument for having a 'competent psychotherapist' available at child health centres. I will return to this book again and again and consider it to be essential reading for any parent infant therapist, especially those who are responsible for supervising primary health professionals, upon whom we are dependant for recognising the baby worries in the first place.

WAIMH Affiliates Corner

By

Anna Huber (Chair of the Affiliates Council) and Jane Barlow (Affiliate Council Representative)

Greetings to all WAIMH Affiliates. This brief update addresses: new WAIMH Affiliates, news from our activities in Rome, including the board's wish to address membership arrangements for Affiliate organisations and a reminder to keep the WAIMH office updated with any changes in your affiliate contact details.

New WAIMH Affiliates: Welcome

Over the last six months, the WAIMH Board has approved three new WAIMH Affiliate applications from South Carolina, California and Iowa. We welcome you all to the Affiliate Family and look forward to your ongoing involvement with us all.

News from Affiliate Activities at Rome World Congress May 2018

Pre congress Institute: This Affiliate event, organised in response to issues raised by members, was co-facilitated by Maree Foley and Anna Huber and involved a series of presentations by affiliate members who are experienced providers of Infant Mental Health training/programs from around the world. The training programmes described captured an array of contexts including online training, university-based training and community-based capacity building programmes. Participating presenters and panel members included: Clinical Associate Professor Julie Ribaudo (Michigan, US); Associate Professor Lynn Priddis (Australia); Emerita/Associate Professor Astrid Berg & Dr Anusha Lachman (South Africa); Dawn Cannon (UK); Ms Catherine Maguire (Ireland); Ms Catarina Furmark (Sweden-Nordic Association); Ms Nichole Paradis (Alliance for IMH); Dr Neil Boris (Florida, US), and Dr Daphna Dollberg, Dr Sigal Knei-Paz and Dr Adena Hoffnuung (Israel). The half day event was very well attended and lots of valuable ideas were exchanged. Further details of presenters can be found on the WAIMH website.

Affiliate Council leadership changes

Following the expiry of the four year terms of both Chair (Maree Foley) and Representative (Anna Huber), nominations were called for from Affiliate presidents or immediate past presidents for the two positions, and two nominations were received. A subsequent online voting process, administered by the WAIMH Office, ratified the election of Anna Huber (Australia) as Affiliate Council Chair and Jane Barlow (UK) as Affiliate Council Representative. A huge thank you goes to Maree Foley for all of her foundational work in supporting the establishment and development of the Affiliate Council since 2010, working initially with Martin St Andre till 2014 and from then with Anna. We (Anna and Jane) both look forward to building on Martin and Maree's work to support and represent Affiliates on the WAIMH board.

Issues for members:

Supporting Refugee Families with infants

Affiliate members participated in a roundtable to discuss the challenges and to share experiences of supporting infants and families who are refugees. This was a very engaging session starting with short presentations about the local issues from Elif Gocek (Turkey) and Meropi Michaleli (Greece). WAIMH president Kai Von Klitzing and other board members were present and agreed that this issue required WAIMH attention. A working group including affiliate members, was set up to plan how WAIMH might best respond, including how best to support local IMH associations dealing with these issues.

Affiliate and WAIMH Membership

Among members of Affiliate organisations, there is some confusion about WAIMH membership requirements. Some are not aware that under current arrangements, WAIMH membership and membership of a local WAIMH Affiliated IMH association are separately arranged. In addition, some IMH organisations who wish to become/are WAIMH Affiliates have difficulty achieving and/or maintaining the minimum of ten WAIMH members, or do not realise that this is an ongoing requirement to remain a WAIMH Affiliate organisation. To deal with this situation, the president has proposed changing the membership arrangements so that members of an Affiliate organisation become members of WAIMH at the same time. This would require a process of consultation with Affiliates and a vote to decide on the future membership arrangements.

All Affiliate organisations have been recently contacted by Anna and Jane to provide some preliminary information about their membership as a prelude to further discussion and consultation. We strongly urge Affiliate presidents to respond as soon as possible to the request for information so that you can fully participate in the consultation and decision making process as it proceed.

Guidelines for affiliates for WAIMH Congress bid and Congress organisation

In response to member feedback, the Affiliate Council has set up a working group to develop a set of guidelines for Affiliates wishing to bid for and (if successful bidders) subsequently co-organise a World Congress working with the Board, WAIMH Office and Congress Program Committee. The group, chaired by Anna Huber, will include Kaija Puura, WAIMH Executive Director, Giampaolo Nicolais (Italy), Libby Morton (Australia), Denise Guy (New Zealand) and Binu Singh (Belgium).

Keeping the WAIMH Office updated with any changes in affiliate contact details

The WAIMH office staff are working to update affiliate data into the WAIMH website. We understand that these details change over time as executive personnel change. We appreciate you updating the WAIMH office about these changes so we can always keep in touch with you with regards to affiliate council matters.

We wish you all the very best with your affiliate activities over the next months. We are always pleased to hear from you: your news, queries and challenges.

For any enquiries please contact:

The Affiliates Council Chair: Anna Huber (Australia) ahuber (at) familiesinmind.com.au

The Affiliates Council Representative: Jane Barlow (UK) jane.barlow (at) spi.ox.ac.uk

WAIMH Position Paper on the Rights of Infants

Edinburgh, 14-18 June, 2014 (amended March 2016)

Photo: Adobe Stock.

Preamble and Rationale

We, as professionals and members of the World Association for Infant Mental Health (WAIMH) who work with infants and parents within different cultures and societies, affirm that there is a need to recognize specific Rights of Infants, beyond those which have already been specified in the United Nations Convention on the Rights of the Child (UNCRC, adopted 1990). We fully support the United Nations Convention on the Rights of the child, and the subsequent document from the United Nations Committee on the Rights of the Child, General Comment Number 7, published in 2005, concerning the implementation of children's rights in early childhood. We affirm that the UNCRC in addressing the rights of children, does not sufficiently differentiate the needs of infants and toddlers from those of older children, in that infants and toddlers are totally dependent upon the availability of consistent and responsive care from specific adults for the adequate development of their basic human capacities. There are unique considerations regarding the needs of infants during the first three years of life which are highlighted by contemporary knowledge, underscoring the impact of early experience on the development of human infant brain and mind.

Drawing attention to the particular needs and rights of the child in the first years of life is needed for several reasons. An all-too-common view is that the baby is "too small to really understand or to remember" and thus the baby's perspective is often not appreciated by health professionals and even by parents. Infants have unique nonverbal ways of expressing themselves and their capacities to feel, to form close and secure relationships, and to explore the environment and learn – all of which require appropriate nurturing since they are fundamental for building a lifetime of mental and physical health. Moreover, infant needs and rights are often overlooked in the midst of conflicted priorities for rights of older children and parents (such as in custody disputes). Further, specifying the unique needs and rights of the child in the first years of life is needed in order to motivate infant oriented actions and policies at both community and societal levels. In spite of the existence of the CRC, many societies around the globe still pay insufficient attention to infants, especially in times of stress and trauma.

Additionally, consideration of infant needs and rights could guide policies of supports for mothers, fathers and caregivers, and in giving value to babies in contexts of risk and violence.

As indicated in the WAIMH by-laws, our aims include "…to promote education, research, and to promote the development of scientifically-based programs of care, intervention and prevention of mental impairment in infancy". Our forming a Declaration of Infants Rights represent a significant step WAIMH Board has actually decided upon, that is to be action-oriented and to take explicit ethical stance and advocacy positions.

This Declaration is divided into two parts: the Infant's basic rights, that should be endorsed everywhere, regardless of society and cultural norms, and the principles for health policy that are more sociocultural context- dependent.

I. Basic Principles of Infant Rights (Birth to three years of age)

1. The Infant by reason of his/her physical and mental immaturity and absolute dependence needs special safeguards and care, including appropriate legal protection.
2. Caregiving relationships that are sensitive and responsive to infant needs are critical to human development and thereby constitute a basic right of infancy. The Infant therefore has the right to have his/her most important primary caregiver relationships recognized and understood, with the continuity of attachment valued and protected--especially in circumstances of parental separation and loss. This implies giving attention to unique ways that infants express themselves and educating mothers, fathers, caregivers and professionals in their recognition of relationship-based attachment behaviors.
3. The Infant is to be considered as a vital member of his/her family, registered as a citizen, and having the right for identity from the moment of birth. Moreover, the infant's status of a person is to include equal value for life regardless of gender or any individual characteristics such as those of disability.
4. The Infant has the right to be given nurturance that includes love, physical and emotional safety, adequate nutrition and sleep, in order to promote normal development.
5. The Infant has the right to be protected from neglect, physical, sexual and emotional abuse, including infant trafficking.
6. The Infant has the right to have access to professional help whenever exposed directly or indirectly to traumatic events.
7. Infants with life-limiting conditions need access to palliative services, based on the same standards that stand in the society for older children.

II. Social and Health Policy Areas to be informed by these Principles:

1. Policies that support adequate parental leave so that parents can provide optimal care for their infants during the crucial early years of life.
2. Policies that minimize changes in caregiver during the early years of development.
3. Policies that promote the provision of informational support to parents regarding the developmental needs of their infants and young children.
4. Policies that recognize the importance of facilitating emotional support for mothers, fathers, and caregivers, as an important component of fostering the optimal development and well-being of the infant.
5. Policies that promote access to evaluation and treatment of risks to development by trained professionals who are culturally sensitive and knowledgeable about early development and emotional health.
6. Infants with life-limiting conditions need access to palliative services.
7. The provision of adequate circumstances, including time for mothers, fathers, caregivers to get to know their infants and become skilled in providing for their infant's care and comfort, throughout the support of their family and community. The right for parental leave, and its duration, should be valorized by the society, in a way that fits its contextual reality.
8. The provision of access to relevant early educational and psychological opportunities and programs that promote good-enough relationship experiences and thus, enhance cognitive and socio-emotional development.
9. Policies that ensure the provision of prompt access to effective mental health treatment for mothers, fathers, and caregivers that alleviates infants' suffering and insure optimal development for the child.
10. Policies that allocate resources for training and supervision for caregivers in babies' institutions, foster care professionals and foster parents, as well as resources for assessing and treating foster care infant's emotional and developmental status.

Appendix A.

WAIMH endorses the 10 principles of the UN Convention on the Rights of Children (as passed by the General Assembly of UN in 1989, and activated in Sept. 1990 with 54 Articles in total) that is:

1. The child shall enjoy all the rights set forth in this Declaration. Every child, without any exception whatsoever, shall be entitled to these rights, without distinction or discrimination on account of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, whether of himself or of his family.
2. The child shall enjoy special protection, and shall be given opportunities and facilities, by law and by other means, to enable him to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity. In the enactment of laws for this purpose, the best interests of the child shall be the paramount consideration.
3. The child shall be entitled from his birth to a name and a nationality.
4. The child shall enjoy the benefits of social security. He shall be entitled to grow and develop in health; to this end, special care and protection shall be provided both to him and to his mother, including adequate pre-natal and post-natal care. The child shall have the right to adequate nutrition, housing, recreation and medical services.
5. The child who is physically, mentally or socially handicapped shall be given the special treatment, education and care required by his particular condition.
6. The child, for the full and harmonious development of his personality, needs love and understanding. He shall, wherever possible, grow up in the care and under the responsibility of his parents, and, in any case, in an atmosphere of affection and of moral and material security; a child of tender years shall not, save in exceptional circumstances, be separated from his mother. Society and the public authorities shall have the duty to extend particular care to children without a family and to those without adequate means of support. Payment of State and other assistance towards the maintenance of children of large families is desirable.

7. The child is entitled to receive education, which shall be free and compulsory, at least in the elementary stages. He shall be given an education which will promote his general culture and enable him, on a basis of equal opportunity, to develop his abilities, his individual judgement, and his sense of moral and social responsibility, and to become a useful member of society. The best interests of the child shall be the guiding principle of those responsible for his education and guidance; that responsibility lies in the first place with his parents. The child shall have full opportunity for play and recreation, which should be directed to the same purposes as education; society and the public authorities shall endeavor to promote the enjoyment of this right.

8. The child shall in all circumstances be among the first to receive protection and relief.

9. The child shall be protected against all forms of neglect, cruelty and exploitation. He shall not be the subject of traffic, in any form. The child shall not be admitted to employment before an appropriate minimum age; he shall in no case be caused or permitted to engage in any occupation or employment which would prejudice his health or education, or interfere with his physical, mental or moral development.

10. The child shall be protected from practices which may foster racial, religious and any other form of discrimination. He shall be brought up in a spirit of understanding, tolerance, friendship among peoples, peace and universal brotherhood, and in full consciousness that his energy and talents should be devoted to the service of his fellow men.

Additionally, WAIMH endorses the points published in 2005 by the UN Committee on the Rights of the Child as "General Comment No. 7", that emphasizes the need to include all young children i.e. at birth throughout infancy, during the preschool years, as well as during the transition to school. Through this general comment, the Committee made clear that young children are holders of all rights enshrined in the Convention and that early childhood is a critical period for the realization of these rights, where parents and state parties play a major role. Assistance to parents is also mentioned as a right of the young child. A special section is dedicated to young children in need of special protection.

Appendix B.

As a background for the Declaration of Infant's Rights, WAIMH also endorses the United Nations Millennium Development Goals that include:

1. The eradication of extreme poverty and hunger.
2. The achievement of universal primary education.
3. Gender equality and women's empowerment.
4. The reduction of child mortality.
5. Improvement of maternal health.
6. Combating HIV/AIDS, malaria and other diseases.
7. Ensuring environmental sustainability.
8. Ensuring global partnerships for development.

Key documents underpinning the Declaration

Bartlett, S. (2005). "An Alternative Model for Responding to Children in Poverty: The Work of the Alliance in Mumbai and Other Cities." *Children, Youth and Environments,*15(2): 342-355.

Berard van Leer Foundation (2009). *Early Childhood Matters.*

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United Nations (2005). *The UN Committee on the Rights of the Child's: General Comment 7: Implementing Child Rights in Early Childhood.*

United Nations Human Rights Office of the High Commissioner Europe Regional Office (2011). *Rights of Vulnerable Children under the Age of 3, Ending Their Placement in Institutional Care.*

The Search for a new IMHJ Editor-in-Chief is underway

Edited By: Paul Spicer, PhD
Impact factor: 1.673
ISI Journal Citation Reports @ Ranking: 2017: 47/73 (Psychology, Developmental)
Online ISSN: 1097-0355

The Michigan Association for Infant Mental Health (MI-AIMH) and the World Association for Infant Mental Health (WAIMH) wish to express their deepest appreciation for Paul Spicer's work as Editor-in-Chief of the Infant Mental Health Journal (IMHJ). Paul has been an exceptional editor, broadening the reach of scientific contributions to the IMHJ and strengthening the depth of articles as they apply in meaningful ways to interdisciplinary practice. Paul will continue as the Editor-in-Chief through Volume 40, with the new editor joining him in July of 2019, and assuming responsibility for Volume 41 in October of 2019.

Sheryl Goldberg, Executive Director of MI-AIMH, owner of the IMHJ, has asked Nichole Paradis, a MI-AIMH member, WAIMH member, and Executive Director of the Alliance for the Advancement of Infant Mental Health®, to serve as Chairperson of the Search Committee. The Search Committee is composed of past editors of the IMHJ, representatives from MI-AIMH and representatives from WAIMH.

The position of Editor-in-Chief of the IMHJ requires:

1. A broad and strong interdisciplinary knowledge base from which to understand research, policy, clinical work, and practice in the field of infant mental health
2. Capacity to enter into and sustain working relationships with professionals including academics, researchers, clinicians, interventionists and others representing the infant mental health community across disciplines and around the world
3. Capacity to build and sustain an interdisciplinary editorial team with representation across the world
4. Understanding of editorial tasks including ability to make decisions about papers to be reviewed, knowledge with the editorial team of appropriate reviewers, organizational skills to handle submissions efficiently, confidence to expect reviewers to submit reviews in a timely manner, ability to make clear decisions about papers to accept, revise, or reject, ability to work with an interdisciplinary editorial board, and creativity to plan and solicit special issues to move the field of infant mental health forward in new directions
5. A 5-year commitment, beginning October 1 of 2019-September 30 of 2024.

Note: The Editor-in-Chief will receive a stipend for the editorial office.

The APPLICATION DEADLINE is December 15, 2018

THE DECISION WILL BE MADE BY April 1, 2019

The NEW EDITOR WILL BEGIN July 1, 2019 AND WORK COLLABORATIVELY WITH THE CURRENT EDITOR UNTIL OCTOBER 1, 2019

Please address any questions you have regarding the position or the application process to the Chair of the Search Committee, Nichole Paradis at:

nparadis@allianceaimh.org

If you are interested in applying for the position of Editor-in-Chief of the Infant Mental Health Journal, please submit the following information by e-mail to Nichole Paradis, Chair of the IMHJ Search Committee, nparadis@allianceaimh.org:

1. Letter expressing your interest in the position, relevant experiences, qualifications for the position, and vision for future for growth and development of the IMHJ
2. Your vita/resume, with contact information including mailing address, e-mail address(es), phone number, and fax
3. Contact information for 2 people familiar with your work