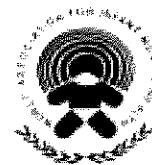


The Signal



Vol. 13, No. 2

Newsletter of the World Association for Infant Mental Health

April - June 2005

DEVELOPMENTAL CARE AND NIDCAP

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Our increased capacity to keep smaller and smaller babies alive introduces new dilemmas. How do we deliver highly technical intensive care with the minimum of suffering to baby and family? How do we improve the potential of these vulnerable survivors in the light of increasing evidence of long term developmental consequences, particularly, but not solely, for the most extremely premature infants? These consequences are costly in personal terms, in lost potential, and the need for support services. The number of NICU graduates with severe disability is significant but

small; a much larger proportion will have mild to moderate problems across the whole spectrum of function – motor co-ordination, sensory deficits, cognitive problems, emotional, behavioural, and social difficulties.

While neonatologists continue to search for chemical and technical solutions to the iatrogenic risks of neonatal intensive care, the notion of potent strategies derived from psychological, social and neuro-developmental sciences is becoming more and more plausible.

"Developmental Care" overlaps with other conceptual frameworks that seek to improve the conditions of neonatal care by making it more humane and family centered but, in addition, developmental care expects to improve development outcomes. This is a difficult area to research (to assess risks as well as benefits) in the same way as other medical interventions where large randomized control trials are the gold standard, but there are promising results from an increasing number of RCTs investigating a model (Newborn Individualised Developmental Care and Assessment Programme - NIDCAP) that is based on the interpretation of naturalistic observation of babies (Als, Gilkerson, et al., 2003; Kleberg, Westrup, et al., 2002; Tyebkhan, Peters, et al., 2004). While NIDCAP is still controversial, it has been

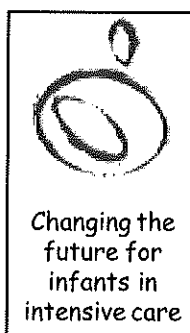
embraced by leading neonatologists in other countries and European training centres have been established in Sweden, France, and the Netherlands.

NIDCAP, developed Dr. Heidelise Als and colleagues, has a strong and eclectic conceptual and theoretical framework. It is an intervention program that can be applied by all disciplines, utilizes the best available scientific evidence, and incorporates other approaches such as kangaroo care, breast feeding, and stress/pain management. The training is rigorous and standards are monitored by an international non-profit organization. Although it has not yet been possible to test long-term effects short-term benefits have shown shorter hospital stays, reduction of chronic lung disease, more normal brain development, better short-term developmental outcomes, and more confident

parents (Als, Gilkerson, et al., 2003; Kleberg, Westrup, et al., 2002; Tyebkhan, Peters, et al., 2004; Als, Duffy, et al., 2004).

Contents:

- 5 School Readiness -Statewide Initiative
- 11 Dev of the Ohio Association Web site
- 17 Affiliate News
- 18 Special Notice -IMHJ
- 19 Call for Nominations
- 22 By the Red Cedar
- 23 WAIMH Awards



Even the sceptics who are doubtful about the validity of these results will agree that this sort of care is kinder to babies and that we do not need scientific evidence to aim for that. However, in practice, it is perhaps the transition to a more humane standard of care that is one of the main barriers to change. When staff start to observe babies carefully some begin to reflect on their own practice and may feel, with considerable pain, that they have not been caring well for them. Some may deal with this in a defensive, dismissive, or destructive way; others may feel depressed and guilty. As staff become more sensitized to the baby they, and the parents they are working with, may become more aware of the shortcomings of other staff, leading to divisions in the team. For these reasons, developmental care at the NIDCAP level can only thrive in a unit where it is strongly backed by management and where staff is given adequate education and ongoing support.

The expectation that developmental care can improve developmental potential comes from looking at the contrast between optimal environments for brain development and the experiences of premature and sick newborn infants in hospital (Perlman, 2001). The last three months of pregnancy is a period of dramatic and significant brain development. Neuroimaging techniques have shown that the brains of preterm babies look different compared to full-term babies, both in volume and structure. This may be due to a number of pre and perinatal factors such as poor nutrition and growth; physiological immaturity and the impact of intensive care itself; infection; disrupted biorhythms; the effect of repeated exposure to stress and pain; and inappropriate sensory experience. Developmental care works to counteract some of these disadvantages through measures that increase physiological stability,

conserve energy, minimize pain, promote uninterrupted sleep-wake patterns, support feeding success (in particular breast feeding) and provide sensory experience that fits the developmental stage of the infant.

At the most critical stage when babies need life support this primarily means supporting efforts to achieve physiological stability, creating a better climate for brain growth and maturation by helping to stabilize blood circulation and the flow of nutrients and oxygen to the brain. Developmental care supplements medical care by reducing environmental stressors (light, noise), positioning the baby comfortably in an ergonomically efficient way, and adjusting the timing and organization of essential tasks to minimize disturbance (Warren, 2002).

All babies in intensive care undergo many potentially painful procedures and although some neonatologists still believe that the nervous systems of very preterm babies are too immature to register pain, it is increasingly acknowledged that the stress response, whether associated with pain or not, can have a damaging effect (Anand & Scalzo, 2000). Recently doubt has been expressed about the usefulness of sedatives such as morphine in preterm pain management and neonatologists have begun to see developmental care as the first line of defense against pain and distress (Anand, Hall, et al., 2004; Franck & Lawhon, 2000). Helping parents to understand the best way to meet their baby's individual preferences for comfort is part of this process.

Developmental care also helps the baby to conserve energy for growth by adapting tasks to help the baby to regulate his own responses to events. A more stable, comfortable baby also digests food more efficiently, an added bonus. Sleep is also important for brain development and the same

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The Signal is a quarterly publication of the World Association for Infant Mental Health. Address correspondence to Paul Barrows.

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strategies that help to reduce stress and increase stability can also enhance sleep. Skilled observation of baby behavior helps caregivers to recognize behavioral states so that they can adjust care-giving plans to protect the baby's sleep patterns as much as possible

Another important aspect of developmental care is babies' relationships with the people who will be their primary ongoing developmental influence - their families. The positive benefits of close contact with parents are emphasized, at first perhaps through the comfort of still hands during a difficult time, then through lovingly carried out care, holding the baby close with skin-to-skin contact, and pleasurable feeding experiences. Parents learn to understand and interpret their preterm baby's way of communicating, beginning the essential processes of attachment and attunement that will stand them in good stead for a healthy emotional future, and enabling parents to be active partners with hospital staff in planning and giving their baby's daily care.

These are some of the more general advantages to developmental care as applied at various levels in units that express an interest in this way of working. The advantage to the NIDCAP approach is the emphasis on how things are done rather than what is done. A specific focus of the NIDCAP is the relationship between sensory experience and the creating and pruning of neural connections. There is a wealth of information from animal studies about the impact of early experience on fetal/newborn brain development and later behavior. Obviously, this does not translate directly to human development, but nevertheless the principle of critical periods of development when the genome is activated by experience is well established.

It is fairly obvious that the conditions expected for normal fetal development are very different to those that face the preterm infant in the NICU, where possibly the only remotely familiar sensory input the infant experiences is the sound of the mother's voice. However, the preterm infant is not the same as a fetus and we cannot assume that the answer is simply to try to create womb-like conditions. The developing human infant normally seeks out appropriate stimuli for his or her developmental stage and withdraws or becomes disorganized in the face of overwhelming or inappropriate experience. When this principle is applied to the preterm infant, we look for behavioral cues that indicate the baby's readiness for an experience, and the ability to regulate his own coping strategies. The caregiver's task is then to act as a facilitator or co-regulator (Als, 1999).

The NIDCAP views the infant as an active agent, constantly responding and adapting to the environment through the organization of physiological, motor, state and attention functions. The baby's ability to self regulate is demonstrated by avoidance and approach behaviors in each of these subsystems, and it is through naturalistic observation of these behaviors that the caregiver understands the baby's current competence and vulnerability and can imagine the baby's next steps towards physiological stability, motor organization, modulation of states of arousal and use of alert states to pay attention and interact with caregivers. When this interpretation of the baby's behavior is done, recommendations can be made for helping the baby to achieve these next steps.

NIDCAP observations are made before, during, and after an episode of care and are recorded at two-minute intervals on a detailed chart that acts as an aide memoir for subsequently writing a narrative that describes the environment, and the baby's behavior

in response to events. The baby's nurse, doctor, and family are consulted and encouraged to contribute. At the end of the process there is an individualized care plan that can be clearly related to the observed behavioral cues of the baby, a plan that is baby led rather than task directed and which gives caregivers positive reinforcement about their own role in supporting the baby.

The NIDCAP report is written in everyday language to make it accessible and is firmly focused on the positive aspects of the baby's behavior and the care given. The plan is temporary and does not lay down laws about how to treat the baby, but demonstrating the links between behavior and experience raises caregivers' sensitivity to the baby's individuality and helps them to be creative in adapting their way of interacting to bring out the best in the baby. The term caregiver is used here to include hospital staff and the parents. Helping parents to learn how to tune into their baby is an investment, not only for the present but also for the baby's future.

Typical recommendations in a care plan might include management of noise and lighting to protect the baby from noxious stimuli; bedding to support comfortable posture and positions that allow self-comforting strategies such as grasping and getting a hand to the mouth; guidelines for approaching and comforting the baby during procedures; opportunities to suck and breast feed, and for parents to give loving touch, including "kangaroo care". The recommendations for a 24-week-gestation infant being ventilated will be quite different to those made for a 34-week-gestation baby in the special care nursery preparing to go home, because the abilities and sensitivity of the babies will be manifestly different. In the first case, physiological stability is likely to be the baby's only goal, while in the

second, we might expect the baby to be aiming for robust physiology, smoothly organized movements, and defined sleep/wake states. Likewise, the recommendations will differ as the baby can be increasingly challenged to manage more with his own efforts.

Developmental care is often perceived in rather general terms, or as a collection of isolated interventions that can be adopted without much in the way of education or training, but this is unlikely to be very effective. In contrast, the NIDCAP is a highly skilled, detailed process. Trainees have to complete thirty, or more, observations and it usually takes at least two years to reach reliability. It is not realistic to expect large numbers of people in any nursery to be fully trained, but a small number that includes someone with a leadership role can make a big difference. There are a few people with NIDCAP training in the UK, but only a handful that actually practices. Access will improve with the introduction of training in the UK this year.

One of the factors that may have held back the adoption of NIDCAP has been the need for more research (Sizun, Westrup, et al., 2004) to supplement the encouraging results from the first wave of small RCTs. The European Science Foundation funded a three-year program with the purpose of stimulating research in Europe as a result of which a multicenter randomized control trial is being considered. However, planning is complicated by the enormous methodological problems of trying to evaluate complex, individualized interventions across a range of centers with very different styles and standards of care. The qualitative research methods that would be more appropriate tend not to find favor among the clinicians without whose support no progress will be made. Once practiced, developmental care is usually perceived to be good for babies and both nurses and parents

are reluctant to see this standard of care denied to babies in control groups. Most of the centers that have enough trained staff to carry out a research program are already convinced of the benefits and have little appetite for more research. Perhaps the onus is on the sceptics to show that traditional styles of neonatal care that disregard the individualised approach of NIDCAP are safer and better for the baby.

References

Als, H. (1999). Reading the premature infant. In E. Goldson (Ed.). *Nurturing the premature infant: Developmental interventions in the neonatal intensive care nursery*. New York: Oxford University Press.

Als, H., Duffy, F.H., McAnulty, G., Rivkin, M.J., Vajapayam, S., Mulkern, R.V., Warfield, S.K., Huppi, P.S., Butler, S.C., Conneman, N., Fischer, C., & Eichenwald, E.C., (2004). Early experience alters brain function and structure. *Pediatrics*, 113(4), 846-857.

Als, H., Gilkerson, L., Duffy, F., McAnulty, G.B., Buehler, D., Vandenberg, K., Sweet, N., Sell, E., Parad, R., Ringer, S., Butler, S., Blickman, J., Jones, K. (2003). A three-center, randomized, controlled trial of individualized developmental care for very low birth weight preterm infants: Medical, neurodevelopmental, parenting, and caregiving effects. *Journal of Developmental & Behavioral Pediatrics*, 24(6), 399-408.

Anand, K.J., Hall, R.W., Desai, N., Shepherd, B., Bergqvist, L.L., Young, T.E., Boyle, E.M., Carbajal, R., Bhutani, V.K., Moore, M.B., Kronsberg, S.S., Barton, B.A., NEOPAIN trial group. (2004). Effects of morphine analgesia in ventilated preterm neonates: Primary outcomes from the NEOPAIN randomised trial. *Lancet*, 364(9433), 498.

Anand, K.J., Scalzo, F.M. (2000). Can adverse neonatal experiences alter brain development and subsequent behaviour? *Biology of the Neonate*, 77(2), 69-82.
 Franck, L.S., & Lawhon, G. (2000). Environmental and behavioural strategies to prevent and manage neonatal pain. In

Anand, K.J.S., Stevens, B.J., McGrath, P.J. (Eds.). *Pain research and clinical management*. (2nd Revised and Enlarged Edition) (Vol. 10, pp. 203-216). Elsevier: New York.

Kleberg, A., Westrup, B., Stjernqvist, K., Lagercrantz, H. (2002). Indications of improved cognitive development at one year of age among infants born very prematurely who received care based on the newborn individualised developmental care and assessment program (NIDCAP). *Early Human Development*, 68(2), 83-91.

Perlman, J.M. (2001) Neurobehavioral deficits in premature graduates of intensive care – a potential medical and neonatal environmental risk factors. *Pediatrics*, 108(6), 1339-1348.

Sizun, J., Westrup, B., & ESF Network Co-ordinating Committee (2004). Early developmental care for preterm neonates: A call for more research. *Archives of Disease in Childhood Fetal Neonatal Edition*, 89, F384-F389.

Tyebkhan, J.M., Peters, K.L., Cote, J.J., et al. (2004). The impact of developmental care in the NICU: The Edmonton randomized controlled trial of NIDCAP. *Pediatric Research*, 55 (4), 2862, Part 2 Suppl. S Apr.

Warren, I., (2002). Facilitating infant adaptation; the nursery environment. *Seminars in Neonatology* 7(6), 459-468.

Further Reading:

Cohen, M. (2003). *Sent Before My Time*. London: Karnac Books (The Tavistock Clinic Series).

Kenner, C., McGrath, J.M. (Eds.), (2004). *Developmental Care of Newborns and Infants: A Guide for Health Professionals*. (National Association of Neonatal Nurses) Mosby.

Singer, L.T., & Zeskind, P.S. (2001). *Biobehavioral assessment of the infant*. New York: Guilford Press.

Warren, I., (Ed.), (2001). *Guidelines for infant development in the neonatal nursery*. Winnicott Foundation: St. Mary's Hospital. (3rd Edition).

Information about NIDCAP is available at www.nidcap.org

SCHOOL READINESS THROUGH PARENT INVOLVEMENT AND EDUCATION: A STATEWIDE INITIATIVE

By:

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During the late 1990s, a variety of conditions converged in Michigan that allowed for the emergence of the All Students Achieve Program—Parent Involvement and Education (ASAP-PIE) Grant program. The Michigan economy was strong, resulting in a surplus in state revenues and especially in the state school aid fund. The ASAP-PIE enabling legislation made an annual allocation of 45 million dollars available for three years from the state school aid fund. The source of this funding constitutionally required the money to flow to local and intermediate school districts (ISDs) and a competitive grant process was designed to award the funds. ISDs were created by the Michigan Department of Education (MDE) to provide school districts with programs and services too expensive or too extensive to be offered individually. Grantees were mandated to make services available to all parents of children birth to five years of age.

What Made the ASAP-PIE Program Unique?

The ultimate goal of the program was to improve school readiness among children birth to five years old primarily by changing or enhancing

the environment provided by parents. This approach was based on the early childhood field's increasing understanding of how early relationships with parents and other caregivers can have an impact on children's development, and of how early intervention can influence those relationships (Shonkoff & Phillips, 2000). ASAP-PIE was modeled after the Parents as Teachers Program (PAT; Parents as Teachers National Center), a widely used model of universal services for parents of young children. With this goal in mind, all of the grantees shared common, legislatively defined outcomes aimed to improve school readiness for children birth to age five, foster the maintenance of stable families, and reduce the need for special education services by:

- Encouraging positive parenting skills
- Enhancing parent-child interactions
- Providing learning opportunities that promote development
- Promoting access to needed community services through a home-school-community partnership

In collaboration with the grantees, we defined school readiness as a multifaceted construct comprised of the development of age-appropriate (a) language and cognitive skills (b) emotion regulation abilities and (c) capacity to form and maintain relationships (Emig, Moore & Scarupa, 2001; Shonkoff & Phillips, 2000).

To promote these outcomes, services required by the ASAP-PIE legislation included:

1. Home visits conducted by home visitors trained in child development to

help parents understand each stage of their children's development, encourage learning opportunities, and promote strong parent-child relationships

2. Group meetings of participating families

3. Periodic screenings for children's development, health, vision and hearing

4. A community resource network that provided referrals to state, local, and private agencies to assist parents in preparing their children for academic success and to foster stable families

5. Connections to quality preschools

This initiative acknowledged the premise that comprehensive, community-based systems of services provide better outcomes for children and families, especially when children are considered to be at increased risk because of poverty or other life circumstances. In her review of successful programs for high-risk children and families, Schorr (1989) identifies a "broad spectrum of services" (p.256) that provide concrete help as well as social and emotional support as one essential component for success. Likewise, studies of the implementation of Early Head Start programs for at-risk families indicate that programs have developed community partnerships to meet families' needs and that these partnerships have evolved over time to meet emerging needs (Kisker, Pausell, Love, & Raikes, 2002).

In addition to these required services, some grantees also provided additional services as part of their recruitment of families with young children into the program and/or comprehensive approach to service delivery. The most common targeted recruitment strategy employed by ASAP-PIE grantees was systematic outreach to families with newborns, including the provision of information and home visiting services. Other special populations targeted included parenting teens, fathers, and ethnic families. Some grantees recognized the necessity to respond differentially to those children at greatest risk by providing specialized services. Fourteen ASAP-PIE programs had infant mental health specialists available in their community provider network; five specifically built in additional resources to expand the services to their families and children.

A Theory of Change: Comprehensive Services to School Readiness

The evaluation team developed a theory of change in order to inform the evaluation process (Figure 1). This theory of change suggests that school readiness, the desired legislative educational outcome, could be influenced by three factors that contribute to family stability: (a) the parents' teaching skill (b) their interactions with their children, and (c) the extent to which the family's basic needs are met.

Services provided through the initiative, in turn, were expected to affect the factors that contribute to

family stability. For example, home visiting is a service provided by parent educators to parents and children together in their home. For the ASAP-PIE program, parent educators generally focused on modeling and teaching strategies that improve parent-child interactions and parental teaching skills. Consistent with other home visiting programs, parent educators often found it necessary to connect families to services designed to help meet basic needs as well (Fitzgerald, Mann, Cabrera, & Wong, 2003; Tableman, 1999-2000a & b).

Taken together, the combination of mandated ASAP-PIE services, plus the additional requirements for universal service to families delivered via a community partnership, laid the groundwork for grantees' development of a comprehensive system of care and education. Local history, resources, and opportunities also influenced the services provided.

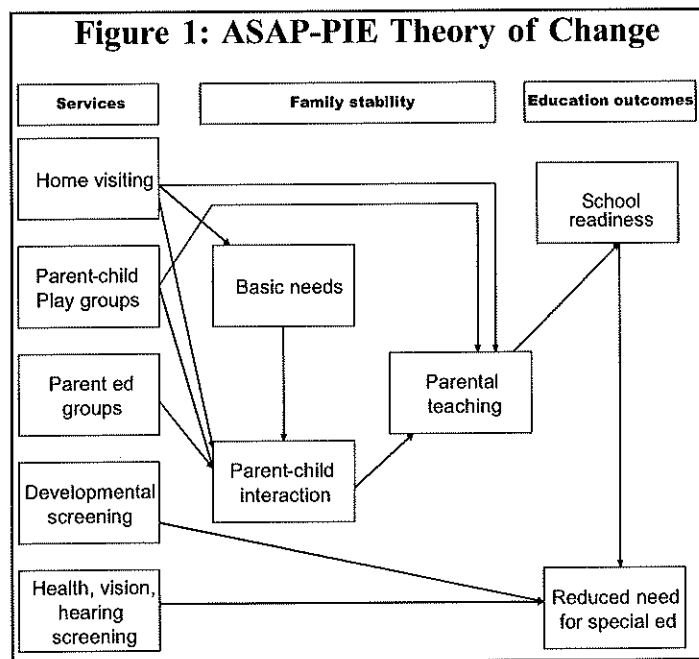
How Did Children Benefit from ASAP-PIE?

Trends suggested that some of the

service components and combinations were effective in improving developmental outcomes for children:

- Children who had developmental delays when first screened and received home visiting were more likely to show improvement in their development when compared with children who did not receive this service
- Children with delays specifically in personal-social or problem-solving skills appeared to benefit from parent-child play groups
- Children who had developmental delays and received home visiting combined with play groups were three times more likely to show no developmental delay at a second assessment
- Children with developmental delays in communication or problem solving were more likely to improve if they received hearing screening.

Although one goal was to assess the degree to which particular curricula were successful, because 21 of the 23 grantees used the Parents as Teachers curriculum and most also used one or more other curricula as well, this was not possible. It was also difficult for the evaluation team to determine grantees' differential success with specific subpopulations because the collection of demographic data was both inconsistent across grantees and also within a single grantee's service programs. Anecdotal reports from grantees suggested that this was due in part to some grantees' reluctance to request personal family information, especially for the less intensive services



and/or those programs where a relationship had not been developed between the service provider and the family. In addition, grantees that formed partnerships with other community agencies to deliver required services did not have accompanying agreements to receive data on those families. As a result, an ironic consequence is that the better integrated the community system of care, the less likely data were available on families and children served via that system. This suggests that developing evaluation capacity should be a core goal of service providers, both individually and collaboratively, especially given the increasing role of accountability in funding decisions.

managed the services, but the local school districts delivered the services (the Local School District Model). Education system-based grantees were more likely to:

- Co-locate (i.e., different agencies provide services in the same location) or co-administer all services for children ages 0-5 operated by the ISD
- Incorporate 0-5 services as part of the district's school improvement plan
- Emphasize connecting parents to elementary schools
- Promote planning for school transition.

The other 12 grantees viewed their task as expanding and enhancing

• Consider services provided by the ISD as only one component in an overall system of services for children ages 0-5

• Include agencies that were providing services but were not receiving ASAP-PIE subcontracted funds as partners in the system

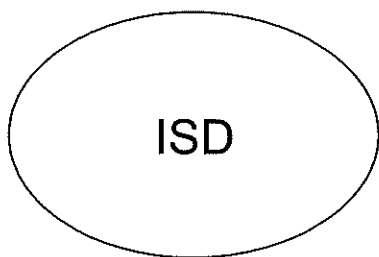
• Co-locate ISD staff and staff of partner agencies.

Using the lens of service model, what did "universal services" mean?

When penetration rates were examined across the four models, the rates were similar (28-38%); however, grantees

using different models placed a different emphasis on the age groups served. If children were served proportionally by age groups (i.e., 20% of the children served were from birth to age 1, 40% from ages 1 to 3 and 40% from ages 3 to 5 years), the grantee would have provided universal services across age groups. Among the four, the Local School District

Model A - ISD ISD provides services



Model B - LEA LEAs provide services

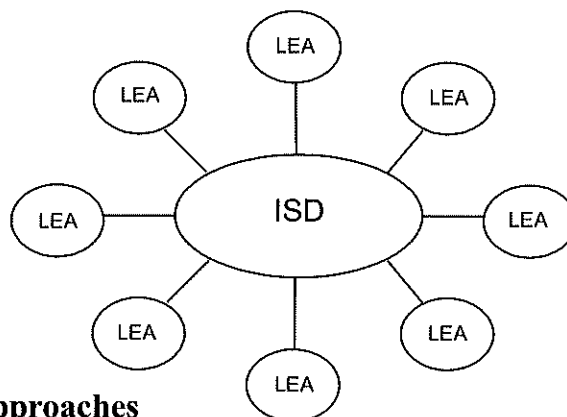


Figure 2: Education-based Approaches

How Did Grantees Approach Service Delivery?

The ASAP-PIE grantees used two basic approaches to organize and deliver services. Fifteen grantees saw their task as implementing the specified services within the education system (Figure 2). Four of these education-based grantees saw the intermediate school district as the primary organizer, manager and service provider (the ISD model). For the other seven education-based grantees, the ISD organized and

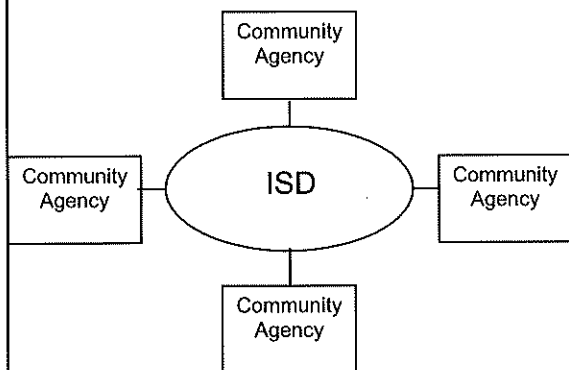
community services (Figure 3). For five of these community-based grantees, the ISD contracted with existing community agencies to provide services by expanding existing services or funding new services (the ISD-Community Model). Seven grantees downplayed the role of the ISD and emphasized the role of community agencies, working toward the development of an inter-agency community system (the Community Model). Grantees using a community-based approach were more likely to:

Model services to children were the closest to the 20%-40%-40% proportional pattern. The ISD-Community Model grantees, in contrast, served children in all three ages groups similarly. Both the Community and the ISD Models focused their services on younger children; twice as many as expected (approximately 40%) of the children receiving services in both models were aged 1 year or younger (Figure 4).

Figure 3: Community-based Approaches

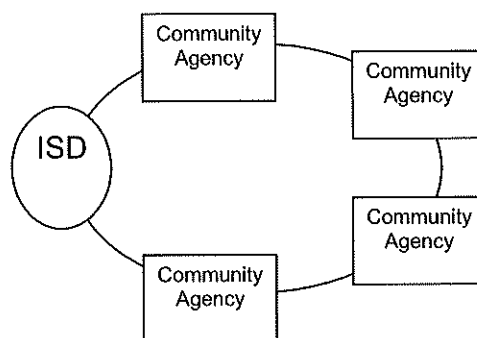
Model C – ISD-Community

Expanding existing agency services



Model D - Community

Developing a collaborative community structure



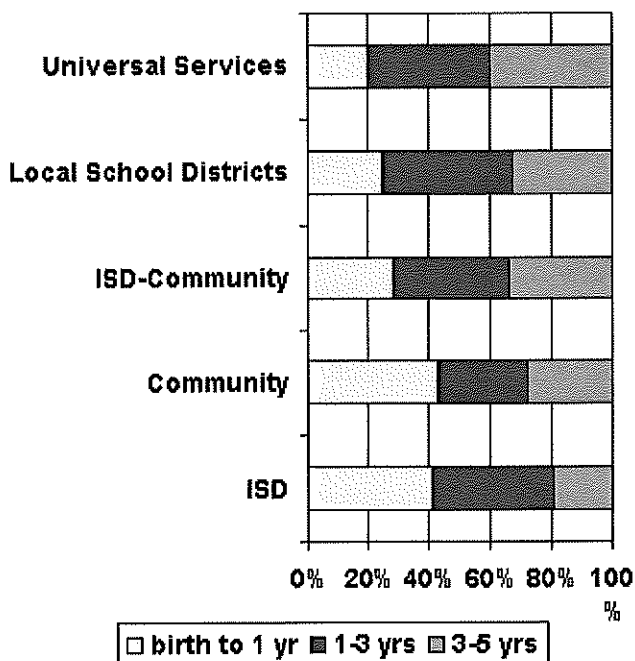
Using the lens of service model, what service components were emphasized?

Differences in services delivered emerged based on the service delivery model used. Grantees using Community Models were less likely than the other three to do home visiting. This may be due to their smaller per-child grants and the relatively higher cost of home visiting services or it may be that community partners delivered these services as part of the community system of care. (Recall that we do not know if fewer families actually received home visits, since no grantee reported data on services delivered by their community partners.) The grantees using ISD Models were less likely to provide group experiences for parents and their children. This may have been a function of their prior experience coordinating early intervention services for infants and toddlers with disabilities, through which ISD staff provided parent education via home visits

rather than in group settings. Those employing Local School District Models were more likely to provide parent education and parent-child play groups. Again, parent educators' comfort with this way of working with parents and children in groups may

have influenced this ASAP-PIE programming choice. The differences among the models are summarized in Table 1, with odds ratio values ranging from 1.5 to 5. An odds ratio of 1.50 (i.e., something is 1.5 times more likely to occur in one condition than in another condition) is considered small, 3.5 is moderate and 9.0 is large (Hopkins, 2002).

Figure 4: Comparisons of Children Served by Age and Delivery Model



Using the lens of service model, what benefits did children receive? There were striking differences in the benefits received by families and children based on the service delivery model used. Children enrolled in services delivered using a Community Model were twice as likely to improve on at least one subscale of the Ages and Stages Questionnaire (ASQ) as children enrolled in other models. Further, children enrolled in a community model were more likely to improve in communication and problem-solving (ASQ

subscales) than children enrolled in other models.

It would be tempting to assume that some of the benefits accrued from differences in funding levels (i.e., more funds) or service components (i.e., more home visits) previously mentioned. However, compared to grantees using the other three models, those adopting a Community Model spent the least amount of funds per child and were least likely to do home visits (probably a reflection of their smaller amount of available funds and use of unfunded community partners to deliver services).

Discussion

Our data suggest that community-based models of service delivery may provide better outcomes for children with a lower investment of dollars. Recognizing the limitations in our data and the fact that local community contexts vary widely, we recommended that the Michigan Department of Education promote a philosophy of the ISD as partner in the system of care and education for families and children ages 0-5 in their future programming. In addition, we made a suggestion that those communities without a history of, or positive experiences with, collaboration have the option of receiving planning grants prior to service delivery grants.

How Do We Explain the Differences Achieved by Service Delivery Approach?

If community-based approaches are to be promoted, then it is important to understand how community approaches can be fostered, especially in different community contexts. An interesting question for us was how these intermediate school districts, presumably with pre-existing structures and supports for families and children in place in their communities, came to have such different models for organizing their

services. That led us to hypothesize that the four models represent phases or stages along a continuum or developmental pathway. We considered three possible alternatives:

- **History/collaboration.**

A developmental pathway characterized by the amount of cross-organization collaboration required. There was some data available on the history of collaboration among partners; no obvious patterns for the differences among models were found.

- **Old/new relationships.**

A developmental pathway characterized by the challenge of moving partners from "doing business as usual" to synthesizing new relationships. We had no data that could be used to test this model.

- **Managing the territory.**

A developmental pathway based on the size of the service delivery area. Our data did provide some support for this model.

In the smallest communities (6,000 or fewer children ages 0-5 years), the ISD and ISD-Community Models were generally interchangeable. Grantees with medium-sized populations (more than 6,000 and fewer than 17,000 children) predominantly used the Community Model. When grantees had the most children to serve (21,000-62,000 children), the Local School District Model was most frequently used. There were several exceptions: two Community Models and a Local School District Model were used in the smallest communities; an ISD Model in the medium-sized communities; and an ISD-Community Model in the largest communities.

However, the overall pattern seems to suggest that there may be an optimal size for partnering models. Perhaps in the smallest communities, where there are few partners and the ISD may already provide most of the needed

services, there is little difference between doing it themselves and contracting with other agencies. Further, relationships may be well enough developed in small communities that contracts between the ISD and the community partners are sufficient to create necessary coordination. Among these grantees in medium-sized communities, the Community Model was the clear preference for serving families and young children. In communities this size, there may be enough differentiated services for agency representatives to understand the benefits of working together, but not so many partners that the process becomes cumbersome. Grantees in the largest communities adopted a Local School District Model. Perhaps this choice reflects their attempt to apportion services for their many families in manageable chunks of territory, and for this grant-making program, the obvious territory was the local school district.

What Recommendations Emerged?

What lessons have MDE and MSU learned from this venture? The evaluation team made a number of recommendations for improving outcomes-related data in future projects, such as the identification of common definitions (e.g., services, levels of service, dosage, enrollment categories, etc.). Strategies for improving measurement learned here (e.g., common instruments and tools) have already been incorporated into a subsequent contract between MDE and MSU for out-of-school time programming. However, neither of these recommendations will necessarily increase and/or improve ISDs' participation as community partners in the services they provide to families and young children. Four recommendations may have that effect.

- Improve the collaborative relations among the state level agencies whose local affiliates are expected to partner at the community level.
- Set aside funds for planning grants to support the development of local inter-agency collaborative arrangements prior to the development of intervention services.
- Provide consultation, training and technical assistance on collaborative approaches to grantees.
- Systematically collect data on the mechanisms for implementing collaborative structures, not solely on family and child outcomes associated with these structures.

What is the ASAP-PIE Legacy?

The ASAP-PIE grant program linked directly to two MDE reform initiatives, ensuring early childhood literacy and integrating communities and schools. The State Board of Education recognized the role of parents and the importance of children's early years in fostering each child's readiness for learning and success in a later formalized school environment. The ASAP-PIE program served as a major initiative to educate parents of very young children more fully regarding the development of their children, thus enhancing their children's school readiness.

This effort provided a vehicle to move toward a seamless system of early education and care for families with young children. Early childhood programs offered by the Department, such as Early On, as well as other community agencies were linked to ASAP-PIE. Families of three-and-four-year olds were linked to quality preschool community settings such as MDE's Michigan School Readiness Program, Head Start, and accredited full day and half day child care centers. Individual children also received Early On services, preprimary special education services, infant mental health services and/or

assistance in transitioning to quality preschools and kindergarten. Families were linked to mental health services, local elementary schools, family counseling, Even Start family literacy programs, Zero to Three Secondary Prevention programs (to prevent child abuse and neglect) and other programs in the area of housing, health, etc. depending on their needs.

In the foreseeable future, the state of Michigan is unlikely to have the funds to embark on a direct, large-scale application of the lessons learned from ASAP-PIE. However, the ASAP-PIE experiences have influenced a subsequent MDE and MSU team evaluation contract on out-of-school time programs, and significant shifts have occurred in cross-department and inter-agency thinking. MDE is applying its experience to other early childhood interdepartmental actions. At the local level, the modest amount of available ISD resources are being regarded as part of the community's total set of assets and a new Early Childhood Investment Corporation has been formed to coordinate early childhood development activities across state departments and privately funded initiatives. As Michigan moves to a system of early education and care across all services, the lessons of ASAP-PIE can provide valuable information in that system's redesign.

Acknowledgements

We acknowledge the project participation of our former Project Principal Investigator Marguerite Barratt, Ph.D., Director of the MSU Institute for Children, Youth, & Families (currently on leave with the National Science Foundation, Division of Behavioral and Cognitive Sciences), the staff of the 23 grantees, and the graduate student members of our evaluation team for their assistance in carrying out this project.

References

- Caughy, M.O. (1996). Health and environmental effects on academic readiness of school-age children. *Developmental Psychology*, 32, 515-522.
- Emig, C., Moore, A. & Scarupa, H.J. (2001). School readiness: Helping communities get children ready for school and schools ready for children. *Child Trends Research Brief*, October 2001, second printing.
- Fitzgerald, H.E., Mann, T., Cabrera, N. & Wong, M.M. (2003). Diversity in caregiving contexts. In R.M. Learner, M.A. Easterbrooks & J. Mistry (Eds.), *Handbook of psychology: Vol. 6. Developmental psychology* (pp.135-170). New York: Wiley.
- Hopkins, W. G. (2002). A scale of magnitudes for effect statistics. In: *A new view of statistics*. Internet Society for Sport Science.
- Kisker, E.E., Paulsell, D., Love, J.M., & Raikes, H. (2002, December). Pathways to Quality and Full Implementation in Early Head Start Programs. Princeton, NJ: Mathematica Policy Research. Parents as Teachers National Center, 10176 Corporate Square Drive, Suite 230, St. Louis, MO 63132.
- Schorr, L. (1989). *Within Our Reach: Breaking the Cycle of Disadvantage*. New York: Doubleday.
- Shonkoff, J.P. & Phillips, D.A. (Eds.). (2000). *From neurons to neighborhoods: The science of early childhood development*, pp. 340-341. Washington, D.C.: National Academy Press.
- Tableman, B. (Ed.). (1999-2000a). *Effective home visiting for very young children - 1 (Outcomes)*, Best Practice Brief #17, E. Lansing, MI: Michigan State University, University Outreach and Engagement.
- Footnotes***
- ¹This contract was supported by state school aid grant funds; the All Students Achieve Program-Parent Involvement and Education was legislatively created by Section 32b (6) of Public Act 121 of 2001. Correspondence concerning this chapter should be addressed to Celeste Sturdevant Reed, University Outreach and Engagement, Michigan State University, Kellogg Center, Garden Level, East Lansing, MI 48824-1022, 517-432-8439, csreed@msu.edu



DEVELOPMENT OF THE OHIO ASSOCIATION FOR INFANT MENTAL HEALTH'S (OAIMH) WEB SITE

By

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In this article we discuss the use of an Infant Mental Health (IMH) web site www.oaimh.org to provide current information regarding relationship-based, culturally sensitive, best practice in IMH and to promote the formation of reflective peer supervision groups. We share the many lessons we've learned along the way as we trace the process of Web site construction from start to finish. Content within each of the major sections of the Web site is highlighted—about OAIMH, newsletters, finding a provider, professions in IMH, information & resources, and collaborative peer [supervision] groups. Future opportunities are explored such as adding training and job announcements, research funding sources, expansion of caregiver-focused information, and development of an interactive message board for those participating in Collaborative Peer Supervision Groups. Our intent is to provide sufficient background material so that others with similar interests can either modify an existing site or create and maintain a new IMH Web site for their WAIMH affiliate. An unabridged version of this paper containing more detailed information is available from the first author.

WEB SITE PRECURSORS

With the launch of www.oaimh.org in 2003, The Ohio Association for Infant Mental Health (OAIMH) capitalized

on seven years of collaborative work among state government workers and IMH clinicians (Thomasgard & Merrilees, 2004). Much of what was included in our Web site was derived from the first two editions of the Ohio Infant/Family Mental Health Provider & Resource Directory [Directory (Thomasgard, 1997; 2001)]. The first edition contained a listing of 150 IMH providers and the holdings of the state IMH Lending Library. A two-step process was used to screen and identify IMH providers, as outlined in Thomasgard (1998). The display format included the clinician name, professional title, office, e-mail address, area(s) of expertise and required provision of at least one of the following—IMH services, training, or mentoring.

Eligibility criteria for the second edition were strengthened to include endorsement of "What is an Infant Mental Health Specialist?" (Weatherston, 2000) and specialized training relevant to IMH; workshop attendance was not sufficient. College education history, year of graduation, undergraduate/graduate degree(s), and relevant professional licensure information were required. Provider entries were organized alphabetically by county, then by clinician last name; a map of the state showing counties and regions was included. The Resource section of the 2001 Directory was expanded to include Web sites for state, national, and international organizations with an IMH component; a glossary of terms; training/licensure requirements for clinicians (e.g., counselor, psychologist, and child psychiatrist) and basic information regarding starting a peer supervision group (Thomasgard, Warfield, & Williams,

2004). While the printed editions of the Directory were a giant step forward, they did not take full advantage of links to e-mail addresses or Web sites. The utility of our written directories was further compromised by an inability to make corrections or additions in a timely fashion. With 200 IMH providers, it soon became apparent that we also needed a searchable database.

Shortly after the 2nd edition of the Directory was published, the first author and a computer analyst/programmer began work on designing a customized electronic database utilizing a software package known as Microsoft Access (1997). Demographic data and, when applicable, training and practice information were included for the 500 clinicians initially contacted in the process of creating the provider portion of the Directory. This database served as a starting point for expansion of OAIMH's membership, the creation of regional Collaborative Peer Supervision Groups, and formation of local chapters of OAIMH. Our next step was to carefully review the components of other WAIMH affiliate Web sites and one award winning site devoted to infants and toddlers.

EXISTING WEB SITES

We carefully examined the ten existing WAIMH Affiliate Web sites, six of which were in the United States. Table 1 presents a summary of our findings.

In addition to the shared features of existing Web sites as outlined in Table 1, a number of unique Web applications were identified. Illinois'

Table 1: Infant Mental Health Web Sites										
	WAIMH	Australia	German Speaking	Nordic Speaking	United Kingdom	Colorado	Illinois	Kansas	Louisiana	Maine Michigan
What is IMH?					X		X			X
Map		X	X							
About Us	X	X	X	X	X	X	X	X	X	X
IMH Principles								X		X
What's New?						X		X		X
Committees		X	X					X		X
Officers	X	X	X	X	X	X	X	X	X	X
Contact Us	X	X	X	X	X	X	X	X	X	X
Newsletter *		X*		X	X*			X		X
Conferences	X	X	X	X	X	X	X	X	X	X
Position Papers		X	X		X		X	X		X
Membership Application	X	X	X	X	X	X	X	X	X	X
Links	X	X	X	X	X	X	X	X	X	X
Publications	X	X	X	X				X		X
Inquiry Form	X				X					
Careers	X									X
Discussion Group				X			X	X		
Lending Library	X									X
Documents in Multiple Languages				X				X		
Job Postings							X			X
*Indicated password Protected										

U.S. Web site contained IMH best practice summaries and conference reports. Kansas, U.S. www.kaimh.org provided slides for presentations as well as a speaker's bureau. Michigan, U.S. www.miamh.org provided detailed information regarding their endorsement process for varying levels of culturally sensitive, relationship-based practice promoting IMH. The German Speaking Association for IMH www.gaimh.de/ provided advice centers in multiple countries, information on research (e.g. scientific software, current projects, workshops) and work wanted.

We also reviewed www.zerotothree.org, the Web site for ZERO TO THREE—"a ... [U.S.] nonprofit [organization] whose mission is to promote the healthy social, emotional, and intellectual development of ... infants and toddlers..." This site offered comprehensive materials for parents and professionals such as answers to questions about child development and the relation between early childhood activities and later school success. It contained a useful 'Frequently Asked Questions' section and downloadable 'Healthy Minds' handouts that outlined developmentally appropriate activities for caregivers to engage in with infants and young children. Professionals could find information about training and consultation for their work with infants as well as learn about public policy initiatives sponsored by Zero to Three. The annual Zero to Three Conference, its professional journal, Zero to Three, the contents of its bookstore and links to other sources of information about infancy and early childhood were featured. Having reviewed these existing sites, we were now in a position to find an organization to construct and host our Web site.

WORKING WITH A WEB SITE DEVELOPER

At our first meeting with Third Element Interactive (3E)—the Web site vendor for the Children's Hospital, we briefly outlined our affiliate's history/mission and the desired content for our Web site. This important step helped ensure that the look (i.e. colors, tones, balance between pictures and text) and feel (i.e. static versus dynamic components) of the entire site was consistent with the mission of our organization—the power of relationships to encourage and sustain relationships throughout the lifespan. We envisioned yearly updates of relatively static information such as the glossary and board membership, with quarterly updates of more semi-dynamic information, such as announcements or newsletters.

Before 3E could begin the visual design of the Web site, clarification of our target audience was required. The most frequent visitors were expected to be community and hospital-based health and mental health clinicians, OAIMH members and caregivers of infants and young children, birth to age 6 years. We decided against having our Web site folded into that of the Children's Hospital for two reasons: 1) to avoid the perception that such services were only available through one institution and 2) to minimize liability issues. OAIMH had not required IMH providers to forward copies of their licensure and credentialing certificates, nor had we verified this information with the appropriate state agency. We dealt with this issue by including a disclaimer within the find a provider section.

Initial funding to develop the flowchart depiction for how the Web site would be organized and the "landing"/home page, was provided by Children's Hospital Behavioral Health. Considerable hours were also donated by the staff at 3E. Having a

single point of communication between OAIMH and 3E helped streamline the flow of information and ensured that any new or revised material for the Web site had been carefully reviewed and approved. The "experience" of visiting the site was enhanced by the careful linkage of three visual elements—color, photographic image, and our logo. These elements were used to create a three section frame into which unique information for each page of the site was placed. The three frames were: left—for site navigation (e.g., about oaimh); middle—for unique section content and subheadings (e.g. our purpose, membership, and contact us) and right—for a graphic header (e.g., a photo image and quote above this (e.g. a young girl, "Children are apt to live up to what you believe of them" Lady Bird Johnson) with the OAIMH logo below). Once agreement was reached on the general look and feel of the site, a number of more specific issues were addressed. These included where to place certain passages of text, which forms would be 'read only,' and what photographic image was to be used for each major section of the site. We chose royalty-free, color stock photos to minimize costs to a one time fee. These were available at <https://creative.gettyimages.com>. While off to a good start, the next phase of the project proved to be very challenging.

FINDING FUNDS TO COMPLETE THE PROJECT

To complete the Web site, we requested that 3E draw up a proposal that could be shared with potential funding sources. Deliverables for this portion of the project included coding for the content of the site's main sections (i.e. find a provider, professions in IMH, information resources, and joining OAIMH). To simplify navigation, we requested that the find a provider directory be searchable by: 1) name 2) city—via a drop down menu with scroll bar selection 3) zip code 4) county—via a

drop down menu with scroll bar selection and 5) region—via a rollover and click-sensitive map. With a completion plan and budget in hand, we contacted several local foundations. Unfortunately, the mission statements for the foundations we chose did not overlap sufficiently with that of OAIMH. In general, they tended to favor local, rather than regional projects. Our search for funding did however provide us with much useful information regarding the continuum of mental health services across our state.

The Ohio Chapter of the National Association for the Mentally Ill and its parent organization (www.nami.org), taught us about the effectiveness of a grass roots advocacy model built upon there being “one voice” for mental health. Three aspects of this newly formed relationship with NAMI Ohio were particularly salient. First, NAMI Ohio had established linkages with nearly every state government agency and department that directly or indirectly impacted the mental health of all Ohioans. Second, NAMI Ohio was primarily focused on maintaining existing funding for treatment programs serving late teens and adults. Little attention had been paid to the prevention of later mental health difficulties by helping to ensure that infants and young children get off to a good start in life. Third, NAMI Ohio was utilizing their web site, www.namiohio.org, in the same ways we had envisioned using ours: to make information available at the grass roots level regarding advocacy, research and treatment.

Having failed to secure financial support to complete our Web site, we made one last appeal to the Children’s Hospital Behavioral Health Program. Fortunately, funding for the entire project was approved, since its overall purpose was consistent with both the goals of the institution and was in line

with the first author’s clinical and research interests. With funding secured, we expanded the joining OAIMH section to include detailed information on forming a local chapter, our by-laws, membership form and start-up materials to form regional multidisciplinary Collaborative Peer Supervision (CPS) Groups (Thomasgard, Warfield, & Williams, 2004). The latter would ultimately become its own section in 2005, with funding from the U.S. Maternal and Child Health Bureau (Thomasgard, Warfield, Kessler, 2005).

In late September 2002 we registered our Domain Name or URL, defined as the World Wide Web address of a site on the Internet. We did this by going to www.directnic.org, where we made two straightforward choices: www.oaimh.org and www.oaimh.com in exchange for payment of a nominal yearly fee. The rationale for choosing both URLs was to ensure that another organization with the same initials would not be confused with ours. In November 2002, our executive board was able to view our Web site. Feedback was requested regarding the overall feel and look of the site (e.g. size of the text, colors, and photographs) with less emphasis on the actual content for each major page, since this would have been too costly to change. In early 2003, all database tables, documentation for variable names and possible range of values were transferred to 3E. From this point forward, work proceeded rapidly.

DEVELOPING AN ADMINISTRATIVE WEB SITE

A primary goal was to minimize the number of individuals and steps needed to enter and transfer data to the Web server—the computer where all of the code for the Web site resides. An elegant way to accomplish this was for 3E to develop an administrative Web site whose functionality included the ability to

add, edit or deactivate (this feature also allows one to ‘reactivate,’ saving time in the long run) an IMH provider or OAIMH member profile. An administrative assistant could also record the payment of dues and generate customized mailing lists. Access to this site was restricted to a limited number of individuals via a login and password. While an initial option was to maintain the database on a server at the Children’s Hospital, this proved to be too costly. In the long run, this decision was fortuitous since it allowed OAIMH to more fully benefit from 3E’s Web site development and maintenance expertise.

THE FINAL WEEKS

Completion of this phase in Web site development was not without its rough spots. One unanticipated and quite lengthy task was to proof all of the text and functionality of email links and URLs on the Web site prior to “going live.” Since our initial membership form for OAIMH was created prior to the existence of our Web site, we had not asked for permission to list individual contact information on a public site. We solved this dilemma in two ways. First, we included a line on all subsequent membership forms stating: “Note well: unless you indicate otherwise, this information will appear on our web site.” Second, we published a special issue of our newsletter—BabyTalk (Volume 3, March 2003) that contained brief summaries of each major section of the Web site and requested that members please let us know by a given date if we had permission to list all or none of their contact information. This meant that not all OAIMH members would appear on the Web site. However, their data could still be viewed on the administrative Web site. Several other decisions regarding the best way to display information in each section and the specifics of our final contract with 3E are outlined in the more detailed version of our paper. In

March 2003, the Web and administrative sites were connected to the World Wide Web. Our point of communication shifted from the artistic director of 3E back to the account executive for all subsequent site updates.

SUBSEQUENT DECISIONS

As OAIMH began to grow at both the affiliate and chapter level, we faced decisions that directly impacted the Web site. One example involved having to reconcile WAIMH's mission with the changing landscape of infant and young child mental health. Specifically, several local chapters wondered if there were any stipulations regarding their names: in particular, could a chapter be named the "Eastern Ohio Association for Infant and Early Childhood Mental Health"? We wrote to Hiram Fitzgerald, Executive Director of WAIMH, who responded in an e-mail on 4/29/03:

The only stipulation is that the Affiliates (chapters) bylaws be consistent with the WAIMH bylaws. From time to time the Board actually discusses the limitations of the "infant mental health" part of WAIMH's name, but so far there has never been a critical mass sufficient to provoke bylaw change discussion. We do after all cover a broader developmental period than just "infancy" and we have lots of members (like me) who do not actually do infant mental health practice, but primarily are involved in prevention research or direct research....

This same reasoning impacted the wording on our landing page: "OAIMH promotes and supports healthy development and nurturing relationships for all infants and young children in Ohio. OAIMH provides a forum for interdisciplinary collaboration by advocating for the application of infant mental health

principles in services for infants, young children, and caregivers..."

Once our Web site had been live for one year, we considered registration with several search engines, such as Google, Netscape, and Yahoo, so that individuals with an interest in IMH would be led to www.oaimh.org. When we checked the rankings of our site at these search engines, we were pleasantly surprised to learn that without formally registering our Web site, our name appeared in the top 2-3 choices. This meant that our site was well coded since the search engine 'spiders' visiting it had found sufficient information on our landing page to make us visible. We realized that this ranking could easily change over time with the pace of access and utilization of the World Wide Web ever accelerating. For this reason, it's becoming more important than ever to consider cultural and language aspects of Web sites.

'CULTURAL' ASPECTS OF WEB SITES

Throughout the entire process of Web site development, we remained cognizant of the potential to form new links across disciplines, geographic regions (e.g. there are similarities that go beyond the boundaries of a particular country and extend over an entire region, as represented by the Nordic and German Speaking Associations for IMH), political beliefs and cultural backgrounds. As pointed out at the last WAIMH World Congress in Melbourne, Australia our organization has virtually no representation in South America, Africa, China or the former Soviet Union. The same could be said for access to the World Wide Web, although this is rapidly changing. In contrast, "... it is now possible for more people than ever to collaborate and compete in real time with more other people on more different kinds of work from more different corners of the planet and on a more equal footing than at any previous time in the

history of the world—using computers, e-mail, networks, teleconferencing, and dynamic new software" (Friedman, 2005, p.8).

As the world continues to 'flatten' (Friedman, 2005) due to extremely rapid changes in technology, the relative importance of a visual versus an auditory culture may become very salient.

Like traveling in a foreign country where architecture, spatial orientation, language, and gestures all contribute to creating a new and sometimes disorienting environment, the Web is populated with content, language, design, and interface that can welcome or confuse users depending on their cultural familiarity with those elements.... [The process of localization can include] . . . modifying address and phone number formats to follow national standards; and accommodating cultural preferences for color, style, and imagery (Nelson, 2000, p. 73).

Where dramatic differences in written language exist such as between Arabic and English, the previously mentioned 'three column format' is very useful (e.g., www.arabia.com). The main content appears in the middle—in either English or Arabic, with navigation on the right for Arabic—to accommodate the right to left orientation of Arabic script, or on the left for English, depending on the language the user has chosen on the home page (Nelson, 2000, p. 80). In the context of our own Web site, we did our best to select pictures for the major sections of the site that were diverse with respect to gender and ethnic/racial groups, however, some have pointed out our quotes were not taken from equally diverse sources. Due to the ever-increasing interconnectedness of the world through technology, we turn next to several potential future updates to our site.

FUTURE APPLICATIONS

Several new sections for our Web site have been proposed such as: 'Hot topics,' 'New on this Site,' 'Training and job opportunities' and 'Parenting tips/News'—to help caregivers become better advocates for their infant and young children's social-emotional development. Future functionality may include: 1) the ability to register and pay on-line for OAIMH conferences 2) developing a system to allow members to update their membership data via the Web site 3) automatic generation of membership renewal notifications and 4) creating the ability for new or established members to pay dues with a credit card via the site.

Up to the minute communication between OAIMH members and IMH providers could also be facilitated via 3E's Atomic Mail system that targets e-mail based on personal interests (e.g. area of expertise). There will continue to be opportunities to update the information resources section with new: 1) links to helpful Web sites 2) terms to add to the glossary based on the latest government programs serving the birth-to-six population and 3) contributions to our IMH Lending Library. As OAIMH's membership continues to grow, it will become increasingly important to facilitate the flow of information at the local chapter level. For example, links to Ohio's local mental health boards could be provided to facilitate more direct communication among those who determine how funds are spent (i.e. the county commissioners), IMH providers, and the actual consumers of these programs—infants, young children and their families. A rollover and click-sensitive map of the counties covered by a given OAIMH chapter will also be added to provide an up-to-date listing of OAIMH chapter members and to promote growth and communication at the local level.

CONCLUSIONS

The multidisciplinary nature of IMH is an inherent challenge for the field. An IMH Web site represents one means to draw together the many diverse strands that collectively contribute to our expertise with infants, young children and their caregivers. Our *professions in IMH* section is a step toward a better understanding of the training requirements for clinicians from a variety of different disciplines as well as the types of service each can offer infants, young children and families. Our new section on *Collaborative Peer [Supervision] Groups* provides a centralized resource for those seeking to form, maintain, and evaluate such case-based, continuing education programs that promote ongoing professional development. It behooves IMH clinicians to seriously consider the use of a Web site to promote state of the art care for infants, toddlers, and their families while also furthering professional development through trainings, newsletters, and other shared resources.

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Acknowledgements

Supported, in part, by Maternal and Child Health Bureau (MCHB) Interdisciplinary Leadership Training Program Grant MCJ-T73MC00049A0, MCHB SPRANS Grant MCJ-T21MC00125, and Children's Research Institute, Children's Hospital, Columbus, OH. The authors wish to thank the many dedicated individuals who've made this Web site possible, Third Element Interactive and Children's Hospital.

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References

- Friedman, T. (2005). *The world is flat: A brief history of the twenty-first century*. New York, Farrar, Straus and Giroux.
- Microsoft. (1997). *Microsoft Access (SR-2)*. Redmond, WA: Microsoft Corporation.
- Nelson, K. (Ed.). (2000). *Websights: The future of business and design on the internet*. New York, RC Publications.
- Thomasgard, M. (1997; 2001). *Ohio infant/family mental health provider resource directory*. Columbus, OH: Ohio Department of Health.
- Thomasgard, M. (1998). Linking infant/family mental health services: The Ohio experience. *Infants & Young Children*, 10, 80-87.
- Thomasgard, M., & Merrilees, K. (2004). *Linking infant/family mental health services: Revisiting Ohio's experience*. *Infants & Young Children*, 17, 184-195.
- Thomasgard, M., Warfield, J., & Williams, R. (2004). Improving communication between health and infant mental health professionals utilizing ongoing collaborative peer supervision groups. *Infant Mental Health Journal*, 25, 194-218.
- Thomasgard, M., Warfield, J., & Kessler, D. (2005). *The collaborative peer supervision group project: A continuing education model to promote professional competence*. Zero to Three, In Press.
- Weatherston D.J. (2000, October/November). Qualities of the infant mental health specialist. *Zero to Three*, 21, 3-10.



WAIMH *Affiliate News*

Ohio Association for Infant Mental Health

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Our Association traces its origins to a 1993 challenge by Ohio's governor to the Departments of Health and Mental Health to more effectively promote infant and early child/family development. A group of 17 stakeholders representing different systems (e.g., community-based mental health, early intervention, state government) and disciplines (e.g., education, nursing, pediatrics, psychology, and social work) from across the state first met in 1994. Our goals were to promote early child social-emotional development by embracing strengths rather than pathology and by emphasizing the caregiver-infant relationship, rather than focusing exclusively on the infant or the caregiver. Our working model of collaboration was one in which the expertise of clinical practitioners would be fused with those in state government to strengthen existing state programs, improve service delivery at the local level and forge an Ohio Infant/Family Mental Health Plan for the future. The challenge was how to balance the idealism of a combined health and mental health prevention effort against the political realities that money equals power and funding priorities could change overnight.

Trainings in early social-emotional development were a major component of our initial efforts as a group. These were provided to both established and new clinicians well before much of the US media attention on the importance of early brain development in shaping the lives of infants and very young children. This topic became even more compelling in the context of welfare reform in the US. New mothers were required to (re)join the work force at a time when their children were still very young, with a resultant increase in the use of less than optimal childcare services.

From 1994 to 2000, our group produced two Infant/Family Mental Health Provider and Resource Directories, established an IMH lending library, provided numerous multidisciplinary trainings on the importance of early social-emotional development, and piloted a case-based, continuing education program, known as Collaborative Peer Supervision Groups, to promote ongoing professional development. In 2000, we held a one-day retreat that led to the development of an Ohio IMH Plan that enumerated both short and long-term goals. A series of desired outcomes were also generated (e.g., reduction of the number of young children in foster care, reimbursement by Medicaid for IMH services, and seamless connections between organizations).

In 2000, a competitive environment arose within Ohio's state government

that forced the members of our group to choose between the mental health and health systems. To preserve our commitment to relationship-based health and mental health care, we became an independent organization, the Ohio Association for Infant Mental Health. We held our first statewide meeting in May 2001 and haven't looked back since! The events of 9/11 rapidly transformed the life of our first President, John Kinsel, who provided child care services at Pier 94 in New York. John provided us with a glimpse of how infants handled the disaster (e.g., protest, withdrawal, vigilance) as well as a rich data set derived from the personal experiences of over 60 disaster child care professionals, with whom he worked. John created Baby Talk - our quarterly newsletter - whose contents have expanded to include research abstracts from local, national and international meetings; case studies; book reviews; job offerings, and helpful Web links.

Our Association has held a number of Fall Conferences beginning in 2001 when Hiram Fitzgerald, Ph.D. (Executive Director of WAIMH), presented his research findings on infants and fathers from the American Early Head Start Studies. In 2002 and 2003, Charles Zeanah, MD shared his clinical and research expertise on the topics of Attachment and Relationship-based Interventions for infants, young children and families affected by violence, separation and stress. In November 2005, we will

have two keynote speakers. Georgia DeGangi, PhD will discuss the assessment and treatment of pediatric disorders of regulation in affect and behavior, while Susan McDonough, PhD, MSW will discuss her Interaction Guidance therapeutic treatment model.

Our Association's Web site www.oaimh.org began in 2003. It features two directories, one for Association members, while the other contains Infant Mental Health Clinician practice profiles (e.g., training, experience and areas of expertise). Additional Web site sections include past issues of Baby Talk, information/resources—a glossary of common terms and the contents of our IMH lending library, as well as an entirely new section on Collaborative Peer Groups. The latter was funded, in part, by a grant from the US Maternal and Child Health Bureau as a special project of regional and national significance. We are particularly excited about this project since it provides materials to form, sustain, and evaluate what is known to be a critical component of infant mental health practice—access to regular, collaborative, and reflective supervision and mentoring.

Our Association has approximately 150 members with four local chapters and two more about to emerge in the near future. We still have a long way to go with respect to increasing the diversity of our membership. This is true for systems (e.g., foster care, adoption, judicial, business leaders), disciplines (occupational, physical, speech therapy, nursing, pediatrics), and with respect to socioeconomic, cultural, and ethnic diversity. Association members are just beginning to more effectively utilize the media to advocate for infants, toddlers and their families. Our newly elected President, Kate Merrilees, cc44@ucmail.uc.edu, is committed to enhancing the role of local chapters in our Association, expanding access to

intensive IMH training sessions and retreats for clinicians across our state.

Perhaps the greatest ongoing task for our Association is to infuse infant mental health principles into every facet of state programs that affect infants, young children, and their families. One successful effort involves Association input to the Ohio Department of Mental Health's Early Childhood Mental Health Initiative that provides consultation and training to child-care providers and programs. Our Southwest Chapter has pursued a theme of working with local individuals from the Juvenile Court program (i.e., "Going to Court: A Guide for Therapists"). The Greater Dayton Chapter has co-sponsored trainings related to regulatory disorders and the floor-time model first conceptualized by Stanley Greenspan, MD.

As an independent Association we may be in a better position to understand and advocate for the full range of state and local opportunities to promote IMH in Ohio without being wedded to a particular government program. There needs to be better integration between local and state governmental systems and service agencies for there to be effective implementation of programs designed to promote literacy, emotional, cognitive, and physical development. One potential mechanism to move this wish forward is to have some of the local Family and Children First Council meetings be devoted to case-based interdisciplinary discussions. This would echo the relationship-based model first begun at the previously mentioned Stakeholder meetings. Such an effort would add a "real world dimension" to the process of constructing local programs and could lead to more effective implementation of services at the local level for infants, young children and their families. By consistently modeling a relationship-based approach, Association members can continue to

promote a strength-based model of care that emphasizes ongoing social-emotional growth across the entire lifespan. Our Association will, through its Web Site, continue to promote its educational, research, advocacy, and service efforts across the entire state. Our Association remains committed to sending its President to the WAIMH World Congress. Perhaps you'll see Kate there in 2006!

SPECIAL NOTICE INFANT MENTAL HEALTH JOURNAL

Because of the damage caused by hurricane Katrina, it was necessary to shift the operations of the Infant Mental Health Journal to the WAIMH Central Offices in Michigan. The operations of the Journal will continue to take place in Michigan until Joy Osofsky, editor of the IMHJ, is able to return to Louisiana State University Medical Center and reopen her offices. Please address all correspondence about the journal, including manuscripts for submission, to:

Dolores Fitzgerald
Infant Mental Health Journal
University Outreach and Engagement
Kellogg Center, Garden Level
Michigan State University
East Lansing, MI 48824-1022
dkf@msu.edu, Tel: 517-432-3793
Fax: 517-432-3694

or, contact me directly at
fitzger9@msu.edu

The Michigan Association for Infant Mental Health Publication Committee and the WAIMH Central Office staff appreciates your patience and understanding as we deal with this temporary re-location of IMHJ operations.

Hiram E. Fitzgerald
WAIMH, Executive Director



ROME, JUNE 24-25, 2005

A very hot Rome welcomed many colleagues from across Europe to this meeting, hosted by Massimo Ammaniti and jointly organized by him together with Bernard Golse and Sam Tyano.

Two packed days involved detailed expositions and discussions about the development of the PRINCE database in Israel and the PILE research program into early language development lead by Bernard Golse.

The format allowed for these exciting projects to be covered in refreshing depth and the end of the meeting gave time to think about the nature of the association between the various European affiliates and the degree to which there is a common European identity (despite the recent French rejection of the European constitution!). This led to plans for possible presentations and seminars at the forthcoming World Congress in Paris and the decision to try to organize a follow-up European Affiliates meeting at that time.

On the Friday evening we were treated to a delightful reception courtesy of the town council on a fabulous terrace location overlooking the Coliseum. Thanks from all the participants to the organizers.

Paul Barrows

**CALL FOR NOMINATIONS
AFFILIATE REPRESENTATIVES TO
THE WAIMH BOARD OF
DIRECTORS**

It is time to nominate candidates for the position of Affiliate Representative to the WAIMH Board of Directors. According to the WAIMH Bylaws,

Article 14

The President, with the advice of the Executive Committee, may appoint an individual to function as the Affiliate Representative for the 2000-2002 time period. Thereafter, the Affiliate Representative will be elected by the Affiliate Associations. The Affiliate Representative shall serve as a key liaison between Affiliate Associations and the WAIMH Board of Directors. At minimum, the Affiliate Representative shall organize meetings of Affiliate representatives at the biennial meeting of the ASSOCIATION.

The Affiliate Representative has several responsibilities as defined by procedures that have developed over time and as approved by the Board of Directors. These include, but are not limited to:

- 1) Facilitating development of new Affiliate organizations worldwide, including evaluation of Affiliate applications and recommendations to the Board of Directors for action.
- 2) Organizing meetings of Affiliate Presidents at the Biennial Meetings of the World Association for Infant Mental Health (in collaboration with the WAIMH Program Committee).
- 3) Facilitating electronic communication networks consisting of Affiliate Presidents and inter-Affiliate programs and initiatives (in collaboration with the WAIMH Central Office).

Of course, the Affiliate Representative is also a full member of the Board of Directors and shares collective

responsibility for all Board actions and deliberation. This position on the Board of Directors was approved by the membership in 2000. As noted in the bylaw above, the Presidents of the Affiliate associations elect the Affiliate Representative. In the interest of fairness, the policy is that there is only one vote per country (countries with multiple Affiliates will have to arrive at one vote for a candidate). We are handling this by procedural rule during this election, with the hope that we will not have to move to a process requiring revisions to the bylaws. So PLEASE NOTE, Affiliates do not nominate individuals, but Affiliate Presidents elect the individual from the set of nominees that are identified.

Prior Affiliate Representative to WAIMH Board of Directors

2000-2002 Brigid Jordan, Australia (appointed)
2002-2006 Brigid Jordan, Australia (elected)
2006-2010

Nomination Process

(NOMINATIONS AND ELECTION ARE THE RESPONSIBILITY OF THE AFFILIATE ASSOCIATIONS)

1. All WAIMH Affiliate associations are eligible to nominate an individual for the position of Affiliate Representative. Countries with multiple Affiliate associations can nominate one individual for each affiliate (but when the election is held, there will only be one vote for each country, regardless of the number of Affiliates in that country).
2. Individuals nominated **must** be a member of WAIMH.
3. Nomination materials are to be sent electronically to the following email address: **dkf@msu.edu**.

If it is not possible to submit nomination materials electronically, then mail a hard copy to

**World Association for Infant Mental Health
c/o Hiram E. Fitzgerald, Executive Director
Kellogg Center, Garden Level
Michigan State University
East Lansing, MI 48824-1022 USA**

4. Nominations must include:
 - a. Completed nomination form (enclosed)
 - b. Three (3) letters of support (one of which can be that of the nominator)
 - c. Written evidence that the individual will serve the four-year term, if elected.
 - d. A letter from the nominee indicating that he or she would like to be the Affiliate Representative to the WAIMH Board of Directors.
5. Nominations are then compiled and sent to the Chair of the Nominations Committee for verification and approval.
6. The Ballots will then be distributed to the Affiliate Presidents for the election.

Timeline:

Nominations Deadline to WAIMH:	November 15, 2005
Nomination list sent to Nomination Committee:	December 15, 2005
Ballot Prepared:	February 2006
Ballots Distributed to Affiliate Presidents:	March 1, 2006
Deadline to receive Completed Ballots:	March 30, 2006 (election completed)
Election results announced:	April 2006

REMEMBER:

1. Every Affiliate can nominate a candidate.
2. Election will be restricted to one vote per country.

Nomination Form

AFFILIATE REPRESENTATIVE TO WAIMH BOARD OF DIRECTORS

Nominee:

Name: _____ Degree: _____

Profession: _____

Mailing Address: _____

Phone Number: _____ Email: _____

Web page? Yes ☐ No ☐ If yes, web page address: _____

Member of WAIMH? Yes ☐ Member of Affiliate? Yes ☐

Name of Affiliate _____

Source of the Nomination:

Name of Affiliate Association making the nomination: _____

Affiliate President: _____

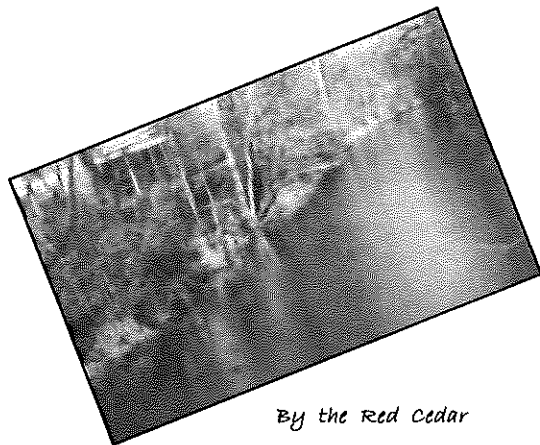
Member of WAIMH? Yes ☐ No ☐

Affiliate Address: _____

Email: _____

Has the nominee agreed to serve, if elected? Yes ☐ No ☐

(If the answer to this question is not yes, the candidate will not be eligible for the election)



By the Red Cedar

The WAIMH World Congress rapidly approaches. July 9-12 (July 8 for those attending the Precongress meetings) we will gather in Paris to once again examine the world of infant mental health from clinical, research, and public policy perspectives. The program committee anticipates an exciting congress and is introducing two innovations to the program: (1) Master Lectures: there will be 12 master lectures (4 each morning) representing a significant enhancement of the continuing education portion of the congress, and (2) we introduce Clinical Interfaces, presentation of a clinical case, with discussion from several different perspectives. Add in the Clinical Teach-

ins, Plenary Sessions, Workshops, Poster Sessions, and the WAIMH World Congress surely will provide an exciting opportunity to hear about cutting edge clinical and scientific work being done with infants, toddlers and their families in home and community based settings. We are also especially interested in featuring infancy work from around the world, capturing the diversity of human culture, while simultaneously searching for the commonalities across cultures. This issue of *The Signal* contains important information about nominations. First, we must elect a new member of the Board of Directors, the Affiliate Representative. Enclosed are detailed procedures related to this process. Note that because many countries have multiple Affiliates, to assure fairness, only one vote for Affiliate Representative will be allowed per country. The Board of Directors has established this policy as a procedural rule, but it may be necessary to formalize it with a change in the by-laws. This year will be the test case. I encourage Affiliate Presidents in countries with multiple Affiliates to form a consortium so that when it is time to cast a vote, there is within-country consensus. Because the

nomination process is wide open, all members of WAIMH have an opportunity to submit a nomination.

The process of transitioning the central office of WAIMH from the United States to Finland has begun. At the Board of Directors meeting in Paris this past July, President Tamminen recommended that Dr. Palvi Kaukonen be appointed Associate Executive Director, and the nomination received unanimous approval by the Board of Directors. In addition, Dr. Kaija Puura has been assigned special responsibilities related to World Congress activities and will assist the Executive Director through the 2006 and 2008 World Congresses, and thereafter will represent WAIMH for World Congress management. Other plans are underway to assure a smooth transition of WAIMH's operations to Finland immediately at the conclusion of the 2008 World Congress.

I look forward, as usual, to seeing everyone in Paris in 2006.

Hiram (Hi) Fitzgerald

THE WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

AIMS and ORGANIZATIONAL GOALS

The World Association for Infant Mental Health (WAIMH) is a not-for-profit organization for scientific and educational professionals. WAIMH's central aim is to promote the mental wellbeing and healthy development of infants throughout the world, taking into account cultural, regional, and environmental variations, and to generate and disseminate scientific knowledge.

More specifically, WAIMH seeks to facilitate:

- Increased knowledge about mental development and disorder in children from conception to three years of age;
- The dissemination of scientific knowledge about services for care, intervention and prevention of mental disorder, and impairment in infancy;
- The dissemination of evidence-based knowledge about ways to support the developmental transition to parenthood, as well as the healthy aspects of parenting and caregiving environments;
- The international cooperation of professionals concerned with promoting the optimal development of infants, as well as the prevention and treatment of mental disorders in the early years;
- Aspects of research, education, and interventions in the above areas.

General Organization, Content Areas, and Activities

WAIMH is a membership association. Individuals from all parts of the world who are willing to promote the achievement of WAIMH's goals, as noted above, are invited to become members of the association. Content areas that guide members in accomplishing WAIMH's goals include the following: a) development of infants and families; b) psychopathology of infancy and toddlerhood; c) interventions, both preventive and therapeutic; d) parent and caregiver education; e) professional education and knowledge exchange; f) cultural influences; g) biological influences; and h) social and public policy.

WAIMH pursues its goals by:

Organizing international congresses and regional meetings; Publishing *The Signal*, a quarterly newsletter for members; Sponsoring the *Infant Mental Health Journal*; Supporting existing and new regional and/or national affiliates; Maintaining an information repository Web site; and Collaborating with other organizations; Establishing task forces, study groups, and committees; Carrying out special projects.



Nominations are invited for each of the following Award Categories

WAIMH AWARDS

WAIMH Award

Given in recognition of significant contributions to the World Association for Infant Mental Health, either directly or through one of the WAIMH Affiliate Associations.

Past recipients of the WAIMH Award are: Serge Lebovici; Justin Call; Eleanor Galenson; Robert Emde; Hiram Fitzgerald; Sonya Bemporad (1996); Joy Osofsky (2000); Dilys Daws (2002).

Sonya Bemporad Award

Given in recognition of significant contributions to the advancement of social and public policies that contribute to the mental health and overall benefit of infants, toddlers, and their families. Nominees typically are not involved in service delivery or scientific or clinical studies of infants. Legislators, officials, advocates, media representatives, foundation directors, and concerned citizens may qualify for the award.

Past recipients of the Sonya Bemporad Award are: Paul Steinhauer (2000); Salvador Celia (2002); Betty Tableman (2002).

Serge Lebovici Award

Given in recognition of significant contributions to the international development of infant mental health. Nominees typically are individuals who have been actively involved in collaborative efforts that have cross-national implications for infant mental health. Past recipients of the Serge Lebovici Award are: Myriam David (2002).

Réne Spitz Award

Given in recognition of significant lifetime contributions to clinical and/or experimental research on topics related to infant mental health. Nominees typically are individuals who have made substantive scientific contributions to the interdisciplinary field of infant mental health. Past recipients of the Réne Spitz Award are: T. Berry Brazelton (2002).

Required nomination support materials:

1. A 250-500 word statement indicating why the nominee should receive the award.
2. A copy of the nominee's resume, vita, or biographical sketch. If you are nominating a group, provide a complete description of the group and its members as well as a brief history of its relevant activities.
3. Three supportive letters from individuals who endorse your nomination.

4. Submit all nomination materials in one packet and mail it to the WAIMH Central Office with postdate no later than **December 15, 2005**.

New Investigator Award

The purpose of the WAIMH New Investigator Award is to recognize and encourage promising new investigators in infant mental health. The applicant must be a member of WAIMH or must be sponsored by a member of WAIMH.

The applicant must have earned a university degree no more than eight years prior to the application deadline. The individual selected as new investigator receives a cash award, a plaque, and acceptance of his/her paper for publication in the *Infant Mental Health Journal* (this involves exposure to the peer review process as a way of assisting the investigator's professional development). In addition, the new investigator must be prepared to present his or her work at the following world congress. Past recipients of the New Investigator Award are: Ann McDonald Culp (1996); Laurie A. Van Egeren (2000); Kaija Puura (2002).

Required nomination support materials:

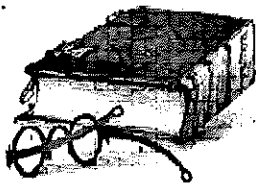
1. A cover letter on institutional letterhead indicating that you want to be considered for the New Investigator Award competition.
2. One copy of the applicant's curriculum vitae or resume.
3. One copy of the SHORT ABSTRACT submitted to the program committee of the congress.
4. Four copies of an original unpublished version of the paper described in the abstract.
5. A sponsor's letter IF you are not a member of WAIMH. The sponsoring letter must be written by a member of WAIMH.

The deadline is **December 15, 2005**. Send the entire application packet to the WAIMH Office.

Direct any questions to: Hiram Fitzgerald, WAIMH Executive Director (fitzger9@msu.edu)

Send applications/nominations to:

WAIMH
Kellogg Center, Garden Level #24,
Michigan State University
East Lansing, MI 48823, USA



LITERATURE MONITOR

These listings are for
information.
Inclusion does not imply
endorsement or
recommendation.

Articles

Tanaka, S. (2005) Parental leave and child health across OECD countries. *The Economic Journal* 115 (February): F7-F28

This study found that the extension of weeks of job-protected paid leave has significant effects on decreasing infant mortality rates. The largest effect was found on post-neonatal mortality rates....The results indicate a significant relationship between paid leave and low birth weight...

Dennis, C-L (2005) Systematic review for prevention of postnatal depression: Psychosocial and psychological interventions. *British Medical Journal* 2005; 331;15 <http://bmj.com/cgi/content/full/331/7507/15>

Ward, A. (2005) 'Mothers' thinking and babies' survival.' *Psychoanalytic Psychotherapy*, 19 (2): 135-159. This paper offers a spectrum of cases, in which the mother's ability to think about painful issues shaded from sensitive to near psychotic, and in which the outcome for the infant varied accordingly...

Books

The Practice of Psychoanalytic Parent-Infant Psychotherapy: Claiming the Baby

by Tessa Baradon and the Parent Infant Project Team at The Anna Freud Centre. London: Routledge

This comprehensive handbook addresses the provision of therapeutic help for babies and their parents when their attachment relationship is derailed and a risk is posed to the baby's development.

Drawing on clinical and research data from the biological and psychological sciences, this book presents a treatment approach that is comprehensive, flexible and sophisticated, while also being clear and easy to understand. The first section, *The Theory of Parent Infant Psychotherapy*, offers the reader a theoretical framework. The second section, *The Therapeutic Process*, invites the reader into the consulting room to participate in a detailed examination of the relational process in the clinical encounter. The third section, *Clinical Papers*, provides case material to illustrate the unfolding of the therapeutic process.

Written by a team of experienced clinicians, writers, teachers and researchers in the field of infant development and psychopathology, *The Practice of Psychoanalytic Parent-Infant*

Psychotherapy, is unique in its systematic approach to describing the theoretical rationale and clinical process of therapy. It will be of great interest to all professionals working with children and their families, including child psychiatrists, psychoanalysts, psychotherapists, and clinical and developmental psychologists.

Psychological Processes of Childbearing, Joan Raphael-Leff (2005) Fourth Edition, Anna Freud Centre, London (distributed by Karnac Books).

This accessible resource book highlights dramatic changes that have occurred in human reproduction over the last decades. It focuses on the emotional aspects of pregnancy and early parenting and ways in which psychosocial beliefs, fantasies and practices inform discrepancies between expectations and realities. It draws on empirical research from a wide range of disciplines including psychoanalytic, neuroscientific, neonatal, sociological, obstetric and anthropological, emphasizing interweaving internal and external facets of the transition to parenthood.

**WORLDASSOCIATION
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