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Perspectives in Infant Mental Health

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From the Editor-in-Chief

by Jane Barlow (United Kingdom)

In our first of three **Clinical Papers**, Victoria Yarzebski, Rebecca MacDonald, and Kathryn Couger describe a longitudinal case study documenting the emergence of prodromal signs of ASD and the implementation of a novel intervention beginning when the infant is 8 weeks of age. This fascinating case study details ASD symptom progression and presents a framework for a scaffolded preemptive intervention including developmentally-informed behavioral interventions aimed at optimizing outcomes for this group of infants.

Our next two Clinical Papers for this issue continue the focus of the last issue on decolonisation, by describing the development and implementation of two innovative methods of working to support IECMHC programmes within ethnically diverse and underserved communities. Amittia Parker, Natalia Castellanos González, Stephanie Mitchell, Karyn Hartz, and Deborah Perry describe their team's efforts to develop and implement a decolonized, racial equity-centered approach to evaluating an established IECMHC program within a metropolitan region of the U.S., primarily serving Black and Latine populations in historically underserved communities. Similarly, Erin Snowden, Aza Nedhari, Deborah F. Perry, and Rabiyah Amina discuss the culturally congruent Mamatoto Village's Mothers Rising Home Visiting (MRHV) program which they describe as 'exemplifying what is possible when reproductive justice, cultural humility, and community leadership are central to care. They describe how 'through rigorous workforce development, culturally reflective services, social connection, and an intergenerational approach' MRHV can be used to advance health equity and foster community resilience.

Our **Professional Development** paper, also continues the theme of our last issue on decolonisation, in which Marva Lewis and Megan Smith present a process model of reflective practice based on what they describe as the 'foundational principles of the sociocultural and psychological impact of the shared trauma responses of slavery and colonization that manifest as hidden Adverse Childhood Experience (ACEs)' They provide a checklist tool to guide the decolonization of reflective practice in a relationship-based space for both supervisor and practitioner. The paper concludes with a call to action for training local groups of IECMH professionals 'to collectively examine and

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develop tools based on local cultural beliefs, values, and norms within the communities they serve'.

Our first **Community Voices** paper by Niels Rygaard highlights reflections on the intercultural cooperation involved in the delivery of a Global Infant Mental Health Program (Fairstart) including educating 950 staff for NGO and government partners in 38 countries. The paper describes an innovative model in which students train groups of parents, foster parents, and teachers with sessions in attachment-based care and learning, that has reached over 100,000 infants and children.

Roop Zainab Rana then describes Pakistan's first international conference on infant and early childhood mental health in the Spring of this year. Entitled "The Baby Matters Conference", this landmark event featured 15 distinguished speakers from Australia, Canada, the Philippines, South Africa, and the United States as well as multidisciplinary experts from across Pakistan, gathering over 1,000 participants both in-person and online.

In our **Opinion Piece** for this issue Kevin Nugent, Susan Nicolson, Campbell Paul, and Lise Johnson propose that the human rights guarantees for newborns and their families enshrined in The United Nations Convention on the Rights of the Child, can be put into practice as part of high-quality healthcare through the use of the Newborn Behavioral Observations (NBO) system. The NBO emphasises the infant's personhood and relational agency from the moment of birth, serves as human rights advocacy, in terms of affirming the newborn's rights to dignity and respect and to be an active participant in their family, community and culture.

Finally, our **Book Review** by Arietta Slade describes the many joys of Claudia Gold's newly published book: *Getting to Know You: Lessons in Early Relational Health from Infants and Caregivers*.

Please note that our Special Issue for August 2026 focuses on innovative work with Fathers. Please let us know if you have a piece that might fit into one of categories: Research; Clinical; Professional Development; Ethics; Community Voices; Opinion Pieces or letters (see Guidelines for Authors - Perspectives).

In the meantime, very best wishes for a Happy Holiday at the end of what has been a very difficult year for many people across the globe.

Call for Papers: Perspectives in IMH Special Issue August 2026: Integrating Fathers into IMH Care: A Paradigm Change on the Horizon

The importance of early relationships is central to the field of infant and early childhood mental health (IECMH), yet the role of fathers has too often been overlooked or relegated to the margins. This special issue seeks to reframe and elevate fatherhood by centering father's voices, experiences, and contributions as integral partners in shaping early relational health and child development.

We invite submissions that expand the lens of IECMH to include fathers as essential in nurturing attachment, resilience, and healing. We seek work that illuminates the unique ways fathers strengthen the parent–child relationship and how fatherhood itself can be a powerful pathway for healing, both for the child and for fathers who carry their own histories of adversity.

Topics of interest include but are not limited to:

- **Cultural Perspectives**: Fatherhood across diverse cultures and communities
- **Adversity and Healing**: Fathers with histories of ACEs and trauma, and the pathways to resilience that emerge through parenting
- **Navigating Systems**: Fathers' experiences with racism, immigration, and poverty, and their impact on family wellbeing
- **Redefining Masculinity**: Shifting narratives to include nurturing, caregiving, and relational leadership
- **Strengthening Relationships**: Fathers' roles in deepening the parent–child bond, co-parenting, and intergenerational healing
- **Fathers as Partners in Healing**: The power of a father's presence in child resilience and family restoration
- **Innovative Practice & Policy**: Models, interventions, and policies that effectively engage fathers in IECMH

By bringing these perspectives together, this special issue aims to challenge assumptions, amplify underrepresented voices, and provide a framework for practice, research, and policy that recognizes fathers as integral to early relational health and to the wellbeing of young children and families.

Submission Deadline

1 May 2026

Submission Categories

a. Research Papers (max 3000 words, including references)

b. Clinical Papers (max 3000 words, including references)

c. Professional Development (max 3000 words, including references)

d. Ethics (max 3000 words, including references)

e. Community Voices (max 800 words, including references)

f. Letters (max 800 words, including references)

g. Opinion pieces/Policy/Advocacy (max 1000 words, including references)

h. Book Review (max 800 words, including references)

Submission Guidelines

APA 7th Edition.

12-point font.

1.5 or double-spaced.

All in-text citations, references, tables, and figures to be in APA 7th Edition format.

Papers with tables and figures: Please submit the paper as a Word-format document with separate files attached for each table and/or figure.

We welcome photos of babies and families. All photos need to be sent in a separate file with a resolution of at least 72 pixels/inch. All photos need to include:

- A permission statement from the author/s for WAIMH to publish the photo in Perspectives and on all WAIMH printed and online platforms.
- A photo credit (if known).

All research papers must contain the Ethics Approval Reference Number and Ethics Approval Body Name.

Contact

To inquire about Perspectives in Infant Mental Health or to submit articles, please contact:

Jane Barlow (DPhil, FFPH Hon) (Editor-in-Chief)

Email: perspectives@waimh.org

From the Desk of the President of WAIMH

by Astrid Berg (South Africa)

Dear Colleagues,

In September of this year, I had the opportunity to attend The Perinatal & Infant Mental Health Conference 2025, co-hosted by the Australasian Marce Society for Perinatal Mental Health and the Australian Association for Infant Mental Health. The event was held in Melbourne, a welcoming and well-maintained city, where I was able to reconnect with colleagues, including several whom I had previously trained.

I was especially impressed by the conference program's emphasis on collaborative initiatives with Aboriginal Communities. The theme "Honouring First Nations children and families' voices" was woven throughout the sessions, demonstrating a strong commitment to learning from each other. This focus also aligned closely with the latest Perspectives Special Issue on Decolonizing Infant Mental Health Research, Practice and Intervention.

What resonates with me is how much we learn from one another. Every human group, community, and family has its own meaningful traditions for caring for infants—practices that have supported them for generations. While approaches from industrialized societies are often seen as the standard, they are not always the most effective, despite common assumptions.

I look forward to attending our *Harmony in Diversity: Nurturing the Youngest Minds Around the World* Conference in Toronto this October. This event offers North American and international colleagues a chance to connect. The Sponsor-a-Delegate Programme helps delegates from LMIC countries participate, so please consider supporting it if possible.

At the Congress we are also planning a series of Symposia under the heading of Infants in Global Crises. Members of this group have been actively exploring ways in which caregivers of infants and young children could be reached and supported. You will find details about this on the WAIMH website [Join us in supporting workshops and humanitarian efforts in the Middle East - Perspectives]

Working with infants, children, and caregivers often involves challenging clinical situations and ethical dilemmas due to the focus on relationships. WAIMH is partnering with the IECMH Ethics Working Group who are developing a survey, which will be available on the WAIMH website. Completing this survey will help guide the creation of a code of ethics, providing valuable support for complex clinical work.

Although global turmoil persists, WAIMH has concentrated its efforts where they matter most, and I am grateful for this collective dedication. The organisation's focus on supporting infants, children, and caregivers during challenging circumstances highlights the importance of prioritising those most in need. WAIMH's ongoing commitment to collaborative initiatives, ethical practice, and humanitarian outreach demonstrates our shared resolve to make a meaningful difference in communities where we can. I am deeply grateful to all my colleagues who are making this possible.

Astrid Berg, November 2025

Photo: Astrid Berg

WAIMH Executive Director Corner

by Kaija Puura (Finland)

Dear colleagues and friends,

Here in the Northern Hemisphere we are experiencing perhaps the darkest months of the year. November is *marraskuu* in Finnish, with the word literally meaning death or dying and comes from us seeing plants die from cold. December days will also get shorter and shorter until the winter solstice makes the turn once again. Even though November and December here may sound horrible, they are months filled with work and activities and often the time just flies away.

At the end of November I was invited to write a report for the Committee for the Future of the Finnish Parliament on parental mobile device use and its effects on child development. I also attended the report publication event as one of the panelists together with the other researchers writing for the same report, "Children in the Digital World." Listening to my fellow writers Minna Ruckenstein and Suvi Uski in the panel discussion, I came to think about the film *Ron's Gone Wrong* (2021). It is a 3D animated feature where a tech giant called *Bubble* creates a line of AI-powered robots called B-Bots, marketed as "your best friend out of the box." These bots are marketed to parents with a statement that they help kids connect socially and give them a constant companion. But the catch is that the B-Bot is not just a friend but an algorithm that knows what the child wishes for even before they know themselves. And this is now not just a plot of a film but our everyday life, as algorithms and AI are everywhere in social media.

Suvi Uski's report describes the current reality of Finnish youth: they spend up to 1,800 hours a year in social media – in practice another full day after school and hobbies. And when algorithms reward provocative content, even younger children learn that the more outrageous the content, the more likes you'll get. Social media is not anymore a place where you share ordinary things like a picture of your birthday, but a global arena where emotions are sold and bought. Minna Ruckenstein explained the nature of algorithms; they are greedy. The algorithms want only one thing: our time. Also, the platforms where they appear are no longer regulated by any ethical standards. The more time our children spend in social media, the more data the tech companies get and the more commercial time they can sell. And when children are on TikTok, Instagram or YouTube, they don't see the same content as "all the pals" but the content the algorithms think will keep them hooked. It can be a dance video, but it can also be images of how thin one ought to look or some influencer's thoughts on how to be successful. No wonder we parents are sometimes confused about what our children are thinking and saying: where did that come from?

We parents ought to be wiser when it comes to digital devices and content, but the reality is that many of us scroll our own feed while children are trying to get our attention. Technoference – a fancy word for a smartphone or pad interrupting interaction with others – is a true phenomenon. And when parents are looking at the phone or screen, they are not paying attention to children's needs and cues. For the youngest children this is particularly critical, as the early years are important for brain development. Parent-child interaction with gaze contact, shared joy and talking and playing together are needed also for building children's self-confidence and sense of safety. Several studies from many countries show how repeated or long-lasting technoference increases the risk for children's poorer speech and emotional development and may hamper even attachment relationships.

Due to the constantly fast technological development, we face new challenges that were not there twenty years ago. The report of the Committee for the Future of the Finnish Parliament is one attempt to recognize and tackle those, with suggestions for recommendations for parents and even more importantly for the government. In addition to the new challenges, families in many countries are still facing poverty, natural disasters and armed conflicts. How to battle these huge challenges without becoming hopeless? One thing is for sure: we need each other's support in our daily work for young children and their families as well as new ideas on how to support them. We also need each other to think about how we can get governments and policymakers to listen to us and make changes for the better.

Photo: Kaija Puura

Spreading knowledge and ideas on how we can make a difference is one of WAIMH's main goals. The submission of abstracts for our 19th World Congress in Toronto in October 2026 has just ended, and within the submissions there is both clinical and research knowledge on what works in promoting infant and early childhood mental health. In addition to the program, the Toronto Congress provides unique opportunities for networking with people from many countries and many occupations. October 2026 is less than a year from now, and I hope that many of you will find a way to come to the Toronto Congress and experience the warm hospitality of our Canadian hosts.

With my warmest regards to you all,

Kaija

Prodromal Identification and Intervention in Autism Spectrum Disorder: Case Report

by Rebecca P. F. MacDonald, PhD[1,2]; Kathryn Couger, MA, MS[1,2]; and Victoria Yarzebski, MSEd, MS[1,2] (United States)

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Data Availability Statement

Deidentified data supporting the findings of this study are available from the corresponding author upon reasonable request.

Funding Information

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Conflict of Interest Statement

The authors declare no conflicts of interest.

Ethics Approval and Consent to Participate

This study was approved by the Institutional Review Board (IRB) at Western New England University. Written informed consent and release documents were obtained from the child's legal guardians. Child assent was continuously monitored throughout the study.

Abstract

Both neurobiological and behavioral indicators of autism spectrum disorder (ASD) have been described in the first year of life; however, many children experience significant delays in accessing services. Identifying the earliest signs of ASD provides the opportunity to preemptively intervene and improve outcomes. This longitudinal case study documents the emergence of prodromal signs of ASD and the implementation of a novel preemptive intervention model beginning at 8 weeks old. The participant was enrolled through a specialized research and educational facility in the United States. Prodromal ASD behaviors at 8 weeks included eye gaze avoidance, reduced orienting to sound, and diminished social smiling. Intervention followed a scaffolded model of parent coaching and naturalistic, developmentally-informed behavioral therapy. At 12 months, the participant met ASD diagnostic criteria and began receiving intensive one-to-one therapy. Observational and standardized assessment data showed skill gains throughout the course of intervention, with the most substantial progress during intensive therapy. By age 2, the participant no longer met ASD diagnostic criteria, and developmental gains were maintained at 5 years. This case study details ASD symptom progression, presents a framework for a scaffolded preemptive intervention, and provides additional support for intensive, developmentally-informed behavioral interventions in achieving optimal outcomes.

Keywords: Autism Spectrum Disorder, early identification, parent coaching, early intervention, high-risk infants

Introduction

Autism spectrum disorder (ASD) is a neurodevelopmental condition characterized by impairments in social communication and restricted, repetitive behavior (American Psychiatric Association [APA], 2013). Neurobiological and behavioral indicators of ASD have been documented in the first year (Courchesne et al., 2019). Despite early signs, diagnosis remains unreliable until complex social behaviors emerge (Pierce et al., 2019). Early identification improves access to services and quality of life, yet most children are not diagnosed before age 4 (Maenner et al., 2021). Identifying early markers allows for intervention before ASD fully manifests, but consensus on their timing and presentation varies, and few studies have explored infant intervention models (Ozonoff et al., 2018; Rogers et al., 2014).

While the predictive validity of ASD indicators before 12 months is unclear, research supports the emergence of prodromal behaviors in the first year (Ozonoff et al., 2018; Zwaigenbaum et al., 2021). Studies report differences in social and nonsocial attention as early as 1 week (Di Giorgio et al., 2016), reduced eye contact by 2 months (Bradshaw et al., 2020; Gangi et al., 2021; Jones & Klin, 2013), and diminished responsiveness to social cues by 6 months (Chawarska et al., 2013). Broader attention differences and

atypical crying patterns have also been noted (Elsabbagh et al., 2013; Sheinkopf et al., 2012). Research further indicates reduced sensitivity to social stimuli between 6 and 12 months (Macari et al., 2021) and inconsistent response to joint attention by 9 months (Stallworthy et al., 2022). Motor delays, including poor coordination, head lag, and postural instability, have been observed from 3 months (Libertus et al., 2014), with repetitive behaviors documented by 8 months (Scully et al., 2023).

Early identification enables timely interventions and improved outcomes. Applied Behavior Analysis (ABA) is a widely accepted, evidence-based ASD intervention (Vismara & Rogers, 2010). Earlier diagnosis has led to developmentally-informed models like Naturalistic Developmental Behavioral Interventions (NDBIs) which integrate behavioral strategies into daily routines with caregiver involvement (Schreibman et al., 2015). Early Intensive Behavioral Intervention (EIBI) is another well-supported approach, emphasizing systematic instruction and one-on-one support, yielding lasting gains in language, cognition, and social skills (MacDonald et al., 2014).

Despite evidence of early ASD signs, few interventions target infants under 12 months. Rogers et al. (2014) adapted the Early Start Denver Model (ESDM) for infants 9–15 months, showing reduced ASD onset by 36 months. Colombi et al. (2023) extended these findings to a 6-month-old, who later developed typically.

ASD behaviors are detectable before 12 months, but preemptive interventions before 6 months remain unexplored. This case study documents ASD symptom emergence in a high-risk infant from 2 months and extends EIBI and NDBI research by presenting a novel early intervention.

Methods

Mark was an 8-week-old male infant enrolled in the ongoing Infant Sibling Study at the New England Center for Children (NECC). His family was White and English was the only language spoken by his family. He had two older brothers with ASD, but no other relevant family history. Mark was born full-term after an uncomplicated pregnancy and delivery. His Apgar score was normal, and he was deemed healthy at birth. After developmental concerns emerged at 8 weeks, Mark was referred for medical follow-up. At 3 months, he underwent audiological testing and an early intervention evaluation. Hearing was normal, but he qualified for early intervention due to cognitive and motor delays.

At 4 months, Mark's pediatrician noted an increase in head circumference from the 75th to the 100th percentile. An ultrasound showed no neurological abnormalities. Before 12 months, Mark had recurring ear infections and received tympanostomy tubes. Follow-up audiological testing was normal. At 12 months, Mark attended a neurodevelopmental evaluation at a specialized autism clinic. A licensed psychologist outside NECC determined he met diagnostic criteria for ASD.

Ethics Approval and Consent to Participate

This study was approved by the Institutional Review Board (IRB) at Western New England University. Written informed consent and release documents were obtained from the child's legal guardians. Child assent was continuously monitored throughout the study.

Intervention

The intervention was delivered using a scaffolded model that included parent coaching alone, parent coaching with 15 hours of one-to-one therapy per week, and parent coaching with 30 hours of one-to-one therapy per week (see Table 1).

Parent Coaching

Parent coaching sessions were held at home for one hour weekly. Sessions were primarily with Mark's mother, though other family members, including siblings, participated. Coaching involved collaborative engagement, individualized goals, and structured family activities to support skill development. Each session began with a check-in to provide support, answer questions, and identify needs. Throughout sessions, the therapist provided psychoeducation, including strategies to foster skills through imitation and praise, maximizing enjoyment in social exchanges, and sustaining positive joint interactions. The therapist demonstrated activities, modeled approaches, and observed the parent practice each skill with Mark before providing feedback. Sessions concluded with discussing how to incorporate practice into daily routines (e.g., diaper changing, bathtime). The approach encouraged family involvement and was adapted to individual needs.

One-to-One Therapy

One-to-one therapy integrated principles from established NDBI and EIBI models. Interventions were embedded within daily routines, used natural consequences, and incorporated Mark's interests to promote motivation and engagement. Learning opportunities were created by following Mark's lead and structuring the environment to support skill development through strategies such as playful obstruction, controlled toy access, and adult-led social activities

Table 1. Overview of Intervention Components.

Intervention	First year of intervention		Second year of intervention	
	2 to 4 months	5 to 11 months	12 to 14 months	15 to 22 months
Parent Coaching	1 hr/week	1 hr/week	1 hr/week	1 hr/week
1:1 EIBI/NDBI				
Home		15 hrs/week	12-15 hrs/week	10-12 hrs/week
Daycare			15 hrs/week	18 hrs/week
BCBA/BCBA-D Direct Supervision		1-2 hrs/week	2-4 hrs/week	2-4 hrs/week
OT/SLP Consultation			2 hrs/month	2 hrs/month

Note: EIBI = Early Intensive Behavioral Intervention; NDBI= Naturalistic Developmental Behavioral Intervention; BCBA= Board-Certified Behavior Analyst (master's level); BCBA-D= Doctoral-Level Board-Certified Behavior Analyst; OT= Occupational Therapist; SLP= Speech and Language Pathologist.

(e.g., blowing bubbles, pushing a swing). Skills were broken into smaller steps, and acquisition was supported through modeling, maximizing opportunities for success, and repeated practice. A primary goal was to foster independence in natural settings. Therapist support was systematically faded, and skills demonstrated in one-to-one therapy were incorporated into parent coaching sessions to support generalization across contexts with family members.

Staffing

Parent-coaching sessions and standardized assessment batteries were conducted by a licensed clinical psychologist and doctoral-level Board Certified Behavior Analyst (BCBA). One-to-one interventions were delivered by trained therapists enrolled in an ABA master's program. In-person one-to-one therapy supervision occurred weekly by either the overseeing psychologist or a master's-level BCBA. Weekly team meetings were held to monitor Mark's response to intervention and adjust therapy goals as needed. Beginning at 12 months old, a doctoral-level speech-language pathologist and a master's-level occupational therapist provided monthly consultation through Mark's home-based EIBI program.

Curriculum

A developmental scope and sequence was established for each skill domain (e.g., cognitive, social-emotional, fine motor, gross motor, communication) to guide therapy goals and intervention planning. Skills were selected and arranged using research on patterns of social and regulatory behavior in infancy, criterion-referenced milestone norms, and existing curriculum systems for at-risk infants and young children (Johnson-Martin et al., 2004; Nugent et al., 2007, Sheldrick et al., 2019; Squires et al., 2009). As the intervention progressed, published interventions for toddlers with ASD (e.g., ESDM, EIBI) informed social skill goals. Intervention targets were introduced systematically and selected based on Mark's developmental level and chronological age. A hierarchical model of skill development was used, with an emphasis on developing foundational skills before introducing more advanced abilities. Curriculum guides were developed for each skill and specified how to create learning opportunities, facilitate responding, and provide natural consequences to establish each skill. Figure 1 depicts the progression of curriculum targets throughout the intervention.

First Year of Life

2 through 4 months

Clinicians first noted developmental concern during Mark's initial evaluative session at 8 weeks old. He displayed a flat affect, gaze avoidance, reduced visual tracking, and diminished orientation to sound (e.g., his mother's voice). Parent coaching was initiated, and target skills included social smiling, sustained eye contact, tracking a face, and reciprocal vocalizations. Activities were arranged to encourage social interactions and active responding through body positioning rather than physical prompting. For example, gaze avoidance was addressed by holding Mark in a cradled position and positioning the adult's face 12 inches from midline while talking softly. Affective behavior (e.g., social smiling) was addressed similarly and began by touching Mark gently and tickling him while singing, making silly sounds, and smiling. By 3 months old, additional activities were introduced including tracking noisy objects and shifting attention between objects and people. At 4 months, parent coaching curriculum included rolling over, reaching for toys, and shifting social attention.

5 through 11 months

At 5 months of age, Mark began receiving 15 hours per week of one-to-one therapy. Targets included tracking silent objects, responding to his name with eye contact, and displaying anticipatory excitement during games. By 6 months old, Mark independently localized a rattle at midline and shifted attention between familiar adults. At 7 months, Mark began gaze shifting between objects and people and started reaching for toys. Social smiling and tracking a silent object were mastered by 8 months old.

By 9 months, Mark began visually tracking objects/people and started rolling. At that time, intervention focused on increasing vocalizations and using an isolated finger point. At 10 months, Mark began displaying emerging repetitive behavior mannerisms. He began repeatedly patting toys with an open palm or finger and a reduction in developmentally-appropriate object exploration was observed. As these behaviors inhibited Mark's ability to develop other foundational skills, more appropriate toy play became a target of intervention. The therapist neutrally redirected repetitive engagement by introducing close-ended construction activities and modeling appropriate engagement. By 11 months, Mark had made gains in gross motor progression (e.g., crawling); however, repetitive behavior and delays in communicative and social development remained.

Second Year of Life

12 through 14 months

At 12 months old, Mark received a formal ASD diagnosis and was enrolled in a home-based EIBI program for 25 to 30 hours per week. Target skills remained developmentally-informed and therapy sessions accommodated Mark's nap schedule and daily routines. Skills introduced during the first year of intervention were targeted in sessions until independence was achieved. An overarching goal was to develop skills to ensure success in an integrated setting without one-to-one support. Mark began attending a community daycare two days per week with a therapist. Mark was placed in a classroom with eight typically-developing, age-matched peers. Skills that were not observed in daycare were taught during home-based sessions or through least-intrusive supports provided by the therapist in the classroom. Between 13 and 14 months of age, curriculum targets included sustained eye contact during games (e.g., turn-taking with a ball), responding to and initiating joint attention, receptive language (e.g., following instructions, indicating body parts), expressive language, and parallel and constructive play.

15 through 22 months

Between the ages of 15 and 22 months, one-to-one therapy, parent-coaching, and routine developmental evaluations continued. Daycare hours increased to two and a half days per week. At 15 months, Mark began engaging in sustained eye contact during games and started to independently imitate one-step actions with objects. At 18 months, targets included imitating motor actions, matching and sorting objects within a classroom cleanup routine, naming objects, and following two-step instructions. Between 19 and 21 months, significant skill gains were observed across communicative and social domains. Mark began

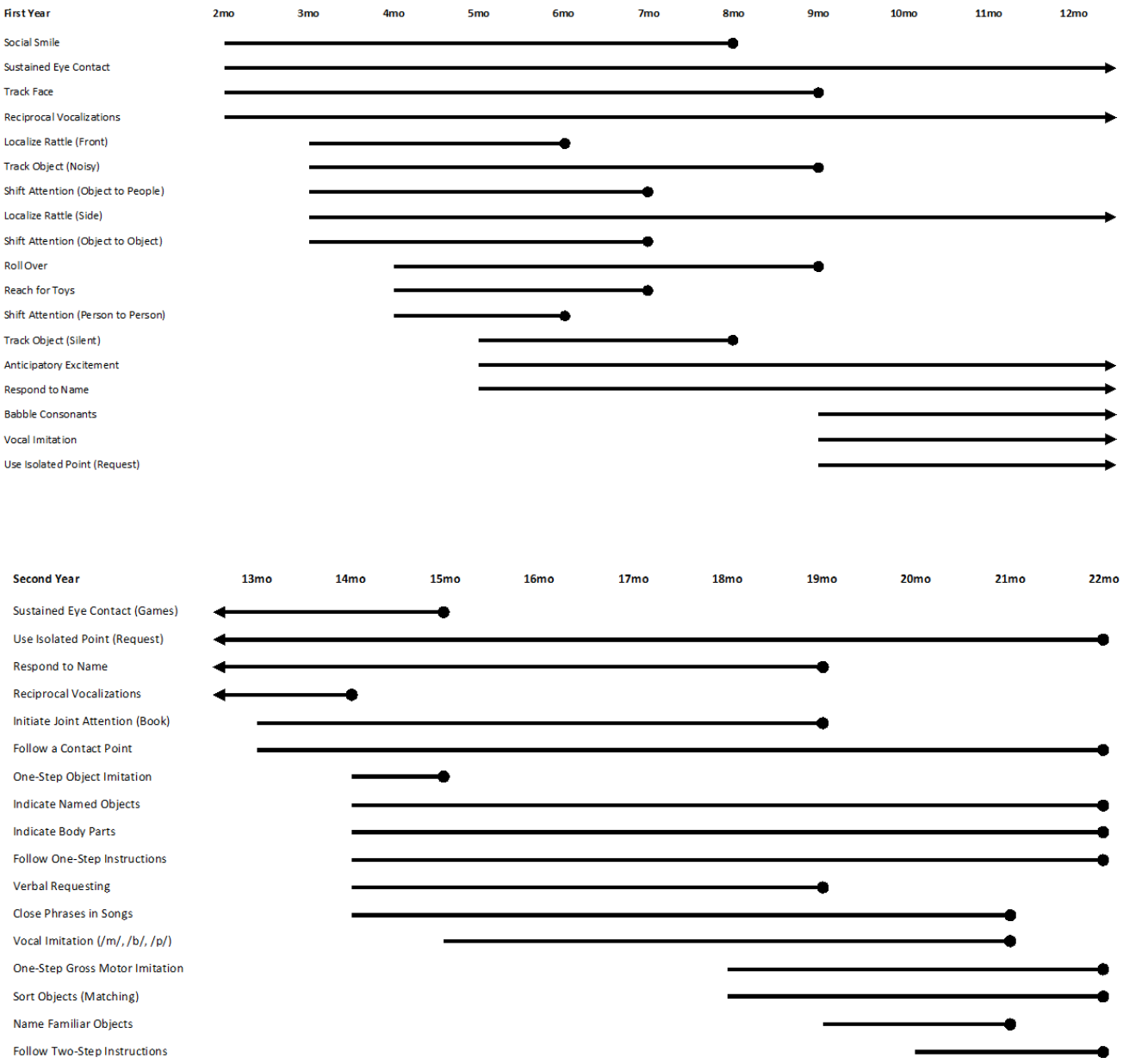

Figure 1. Skills Targeted During the First and Second Years of Life.

Note. This figure demonstrates the progression of curriculum targets across the first and second years of life. Mark's age in months is reflected in the top panel of the diagrams. Each horizontal line indicates a target skill in intervention and begins at the age in which the skill was introduced. Arrows reflect skills that were targeted across both the first and second years of life. Solid circles indicate mastery of a target skill. Skills are listed in the order in which they were taught.

independently responding to his name, spontaneously initiating joint attention, naming objects, making requests, and completing simple phrases when singing songs. By 22 months, Mark used an isolated point to request, responded to bids for joint attention, indicated objects and body parts, followed multi-step directions, imitated actions, and sorted toys. Therapist support was gradually faded across settings and services were discontinued.

Outcome Measures

Mark's developmental progress was assessed weekly through his performance on systematic, criterion-referenced assessment instruments and structured observations based on age-normed items from milestone questionnaires (Harden & Peisner-Feinberg, 2001; Squires et al., 2009). Beginning at 6 months, comprehensive neurodevelopmental batteries were completed every 3 months to assess social, cognitive, adaptive, communication, and motor progression using standardized assessments.

Mullen Scales of Early Learning (MSEL; Mullen, 1995)

The MSEL is a standardized assessment designed for use with children from birth to 68 months of age. Performance is measured across five domains, including Visual Reception, Fine Motor, Receptive Language, Expressive Language, and Gross Motor. The MSEL has strong internal consistency and test-retest reliability (Mullen, 1995). The

MSEL was administered at 6, 12, 15, 18, 22, 34, and 38 months of age.

Autism Observation Scale for Infants (AOSI; Bryson et al., 2008)

The AOSI is a semi-structured measure designed to detect and monitor for early signs of autism in infant siblings ages 6 to 18 months of age. It consists of six behavioral presses during which social communicative behaviors (e.g., eye contact, orientation to name, social smiling) and non-social communication behaviors (e.g., disengagement of attention, repetitive behaviors) are assessed. The AOSI has strong interrater reliability and fair test-retest stability (Bryson et al., 2008). The AOSI was administered at 6, 12, 15, and 18 months of age.

Autism Diagnostic Observation Schedule, Second Edition (ADOS- 2; Lord et al., 2012)

The ADOS-2 is a standardized measure designed to elicit social and communicative behaviors and assess for symptoms associated with an autism spectrum disorder. Administration occurs through a series of structured and unstructured activities that allow for a direct observation of behavior. The presented activities and scoring algorithm are dependent on the individual's chronological age and language abilities. Performance on the ADOS-2 is depicted as range of concern for an autism spectrum disorder or a diagnostic classification (Lord et al., 2012). The ADOS-2 was administered at 12, 15, 18, 22, and 38 months of age.

Vineland Adaptive Behavior Scales, Third Edition (VABS-3; Sparrow et al., 2016)

The VABS-3 is a semi-structured parent interview designed for use with individuals from birth to 90 years. Performance is measured across Communication, Daily Living, Socialization, and Motor adaptive skill domains that comprise an Adaptive Behavior Composite. The VABS-3 has strong internal consistency and test-retest reliability (Sparrow et al., 2016). Mark's mother was interviewed using the VABS-3 when he was 12, 49, and 62 months of age.

Results

Mark initially showed delays at 2 months old, and progress was recorded through weekly milestone tracking from 2 to 24 months (see Figure 2). More formal progress tracking was completed through standardized assessments beginning at 6 months of age (see Table 2).

Standardized Assessment Results

At 6 months, Mark's performance on the MSEL fell 1- to 4-months below age-level across domains. Scores in gross motor, visual reception, fine motor, and expressive language domains were substantially delayed. On the AOSI, Mark received a total score of 32 with 16 markers including reduced visual tracking, lack of orientation to name, inhibited social response, and reduced reciprocal babbling. At 12 months, Mark received a comprehensive battery of assessments including the MSEL, AOSI, ADOS-2, and VABS-3. The VABS-3 and the ADOS-2 were administered by a licensed psychologist unaffiliated with the present study. On the MSEL,

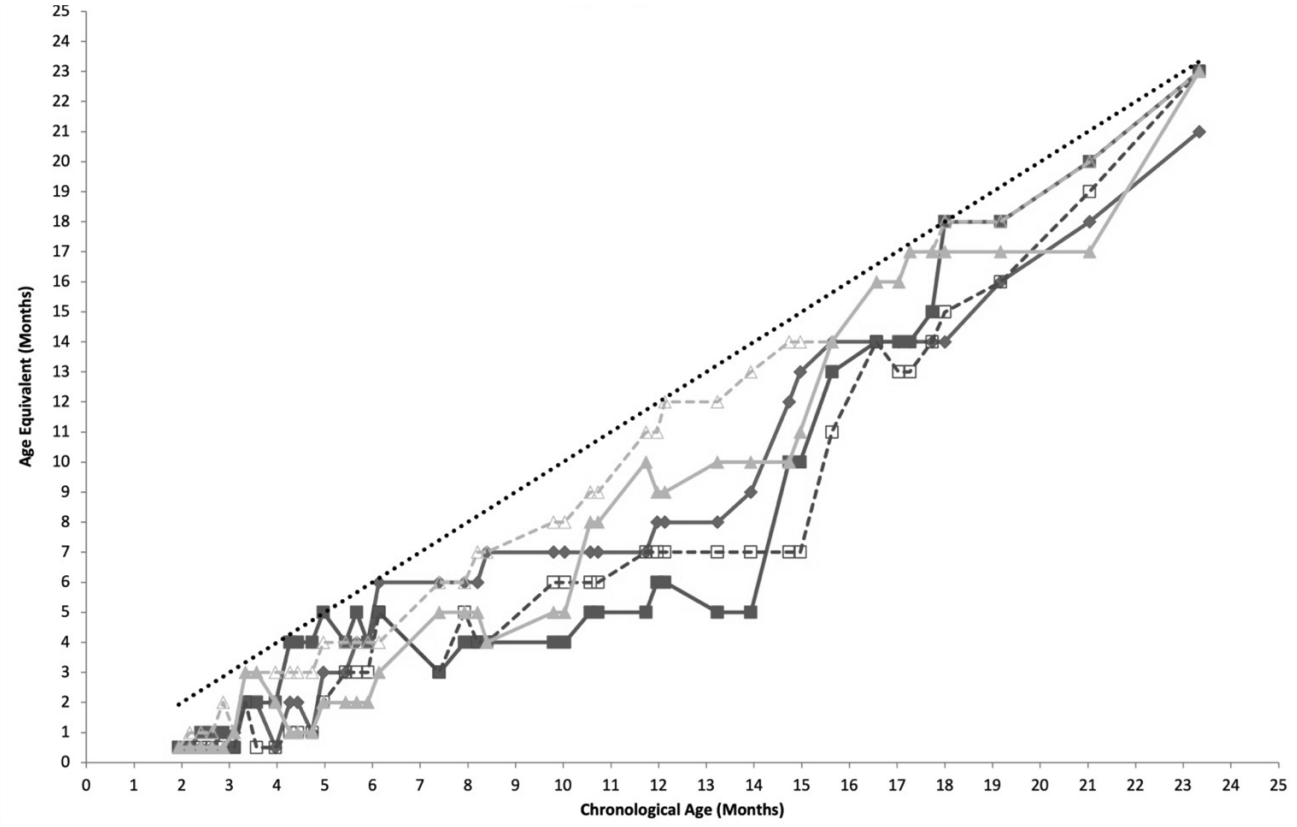

Figure 2. Weekly Milestone Tracking Performance.

Note. Mark's performance on weekly milestone assessments from 2 months to 24 months. EL= Expressive Language; RL= Receptive Language; AE= Age Equivalent. The dotted line represents age-level performance.

average performance was observed in gross motor, visual reception, and fine motor domains with below age-level performance in areas of receptive and expressive language. Responses on the VABS-3 also supported concern in communication domains. Scores on the AOSI fell above the cutoff for ASD-risk with a total score of 16 and performance on the ADOS-2 reflected moderate-to-severe concern for ASD.

At 15 months, Mark's performance on the MSEL fell below average in areas of visual reception, receptive language, and expressive language. Scores on the AOSI were above the threshold for ASD while performance on the ADOS-2 continued to reflect moderate-to-severe concern for ASD. At 18 months old, scores on the MSEL improved across gross motor, visual reception, receptive language, and expressive language while a reduction was observed in fine motor skills. Performance on the AOSI fell below the ASD cutoff and scores on the ADOS-2 reflected little-to-no concern for ASD. At 22 months, stable performance was observed in gross motor and visual reception domains on the MSEL while improvement occurred across fine motor, receptive language, and expressive language domains. Observation during the ADOS-2 continued to reflect little-to-no concern for ASD and one-to-one services were discontinued.

Table 2. Standardized Assessment Results.

Assessment	Age (Months)								
	6	12	15	18	22	34	38	49	62
MSEL									
Gross Motor									
AE	4	13	14	18	22	33	38		
SS	75	97	87	102	103				
%	4	42	18	54	58				
Visual Receptive									
AE	2	12	13	19	24	33	31		
SS	55	94	79	105	109	93	81		
%	1	34	8	62	73	31	10		
Fine Motor									
AE	5	14	18	16	19	31	34		
SS	64	108	111	78	93	88	88		
%	1	69	76	7	31	21	21		
Receptive Language									
AE	5	8	14	19	27	33	38		
SS	91	78	84	102	118	94	99		
%	27	7	14	54	88	34	46		
Expressive Language									
AE	4	8	12	18	27	35	31		
SS	79	75	76	102	120	99	82		
%	8	4	5	54	90	46	12		
VABS-3									
Communication									
SS		90						108	102
%		25						70	55
Daily Living Skills									
SS		95						95	95
%		37						37	37
Socialization									
SS		95						116	118
%		37						86	88
Motor Skills									
SS		102						100	85
%		55						50	16
Adaptive Behavior Composite									
SS		90						107	105
%		25						68	63
AOSI									
Total Score	32	16	5	3					
Number of Markers	16	12	3	3					
ADOS-2									
Level of Concern		Moderate-to-severe concern	Moderate-to-severe concern	Little-to-no concern	Little-to-no concern		Minimal-to-no evidence		

Note. Performance on standardized measures across time. Scores on the MSEL and VABS-3 are reflected as Standard Scores for interpretability. Empty cells indicate that standardized measures were not completed at that time. AE= Age Equivalent (Months); SS= Standard Score; MSEL= Mullen Scales of Early Learning; VABS-3= Vineland Adaptive Behavior Scales, Third Edition; AOSI= Autism Observation Scale for Infants; ADOS-2= Autism Diagnostic Observation Schedule, Second Edition.

Follow-up

At 23 months old, Mark was enrolled in an integrated preschool setting without support or ancillary services. Prior to his third birthday, Mark obtained an evaluation by his public school district to determine eligibility for an Individualized Education Program. Mark did not qualify for special education services due to age-level or above performance on school-based testing.

At 34 months, Mark received initial developmental follow-up through the Infant Sibling Study. Scores on standardized measures continued to fall in the average range. Subsequent follow-up completed at 38 months revealed stability in receptive language, fine motor, and gross motor abilities. Reduced performance was observed in expressive language and visual reception domains. Performance on the ADOS-2 did not reach the cutoff for ASD and no social concerns were observed or identified during the evaluation. Additional follow-up sessions were completed when Mark was 49 and 62 months old. Results of the VABS-3 reflected average performance across communication, daily living, socialization, and motor domains. Mark is presently enrolled in a fully integrated public-school classroom and there are no reported developmental concerns.

Discussion

This case study extends the literature on early ASD signs and describes a novel intervention model for an infant showing behavioral indicators. Concerns were identified at 2 months and paralleled existing research on early ASD markers (Di Giorgio et al., 2016; Gangi et al., 2021; Jones & Klin, 2013). Intervention began at 8 weeks using a scaffolded parent coaching model and developmentally informed instruction. Targets were based on developmental literature and age norms. Response to intervention was monitored through behavioral data, milestone evaluations, and standardized assessments. After an ASD diagnosis at 12 months, additional services were provided. By age 2, Mark no longer met ASD diagnostic criteria, with maintained social skill gains.

This study documented prodromal ASD behaviors emerging at 8 weeks in a high-risk infant. Infants are born with regulatory skills, responsivity to stimuli, and motor control (Nugent, 2007), which set the foundation for social development. Research has shown atypical attention patterns (Di Giorgio et al., 2016; Elsabbagh et al., 2013), reduced eye gaze (Gangi et al., 2021; Jones & Klin, 2013), atypical vocalizations (Paul et al., 2011; Sheinkopf et al., 2012), and motor delays (Libertus et al., 2014). Delays in these areas, along with reduced

affective responding, were observed in this study.

Prodromal ASD behaviors before 6 months have not been distinguished from other developmental conditions. Infant sibling research suggests ASD-specific symptoms emerge between 6 and 12 months (Ozonoff et al., 2018; Zwaigenbaum et al., 2021). However, given the accumulative nature of ASD symptoms, behaviors in early infancy likely indicate later manifestation. Between 6 and 12 months, Mark showed attentional weaknesses (e.g., inhibited disengagement, differences in social/nonsocial attention), no response to name, reduced joint attention, and emerging repetitive behaviors.

Early identification allows for timely intervention. Few interventions target the first year, and this study used a scaffolded approach to ensure developmental appropriateness. Targets addressed early skill deficits before advancing. Naturalistic behavioral principles were applied and adjusted based on developmental level. Initially, body positioning and shaping promoted responding, later progressing to modeling and proximity fading. Sessions occurred at home, embedded in daily routines (e.g., diaper changing, bath time), later expanding to daycare to encourage peer interactions.

Skill gains directly corresponded to intervention intensity. Parent coaching alone was insufficient; intensive instruction was required. Moderate gains were seen with 15 weekly intervention hours, but ASD-specific deficits remained. At 12 months, Mark received a formal ASD diagnosis, making him eligible for 30 weekly one-to-one hours, ancillary services, and increased supervision. When intervention met EIBI-supported levels (at least 28 hours/week; MacDonald et al., 2014), significant developmental progress occurred. By 22 months, Mark no longer met ASD diagnostic criteria and functioned independently in an integrated setting.

While parent coaching alone did not result in significant skill gains, this element of treatment was integral in both providing the family with support and strengthening the relationship between Mark and his mother. The present intervention incorporated parent coaching and feedback throughout the interventions to support family-based goals. This element further provided the opportunity for Mark to practice skills targeted in sessions across the day and with a number of family members. His siblings were involved, when possible, to increase opportunities for family-based care and support.

This case study documents early ASD signs and an intervention model for a high-risk infant but is limited by its single-case design. Without experimental control, external validity is reduced, and rigorous trials are needed to confirm efficacy. However, this study aligns with existing research on early ASD markers and adapts EIBI and NDBI for infants. Results suggest that identifying early developmental deviations may enhance understanding of ASD emergence, leading to earlier identification and preemptive intervention.

Currently, an ASD diagnosis is required to access services, though reliable diagnosis before 12 months is not feasible (Pierce et al., 2019). While preemptive intervention models show promise, widespread implementation is limited within existing systems. This study supports universal screening, continued research on ASD predictive markers, and randomized controlled trials on preemptive interventions (Colombi et al., 2023; Rogers et al., 2014).

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The Journey Towards an Equity-Centered Infant and Early Childhood Mental Health Consultation Program Evaluation

by Amittia Parker[1], Natalia Castellanos González[1], Stephanie Mitchell[1], Karyn A. Hartz[2], and Deborah F. Perry[1] (United States)

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Introduction

Infant and Early Childhood Mental Health Consultation (IECMHC) is a capacity-building, prevention-based, multi-level service where mental health professionals collaborate with child-serving staff and families to promote healthy social-emotional development among young children (Tidus et al., 2022). The evidence base for IECMHC has grown substantially over the past several decades, with numerous studies demonstrating its effectiveness in improving child outcomes, enhancing teacher practices, and reducing early childhood expulsions (Center of Excellence, 2021; Tidus et al., 2022). Despite these positive findings, significant racial disparities persist in early childhood settings (Iruka, Curenton, & Durden, 2017). Young Black boys and children with disabilities continue to experience disproportionately high rates of expulsion and suspension (U.S. Department of Education, 2024).

Recently, the Center of Excellence for IECMHC, funded by the U.S. Substance Abuse and Mental Health Services Administration, disseminated a theory of change that articulates how IECMHC works to impact directors, teachers, children, and families (See Figure 1, below; Center of Excellence, 2021). A recent literature synthesis on IECMHC highlights the strengths and gaps within the extant literature on IECMHC and directions for future research, including examining different experiences and impacts, strengthening study design and measures, and "expanding the methods used to acknowledge non-Western ways of knowing and to honor community voice and personal narrative as valid sources of data." (Tidus et al, 2022, p.18). These recommendations, along with best practice guidance, are helpful, yet there is a need for practical guidance on how to operationalize them in evaluations of IECMHC.

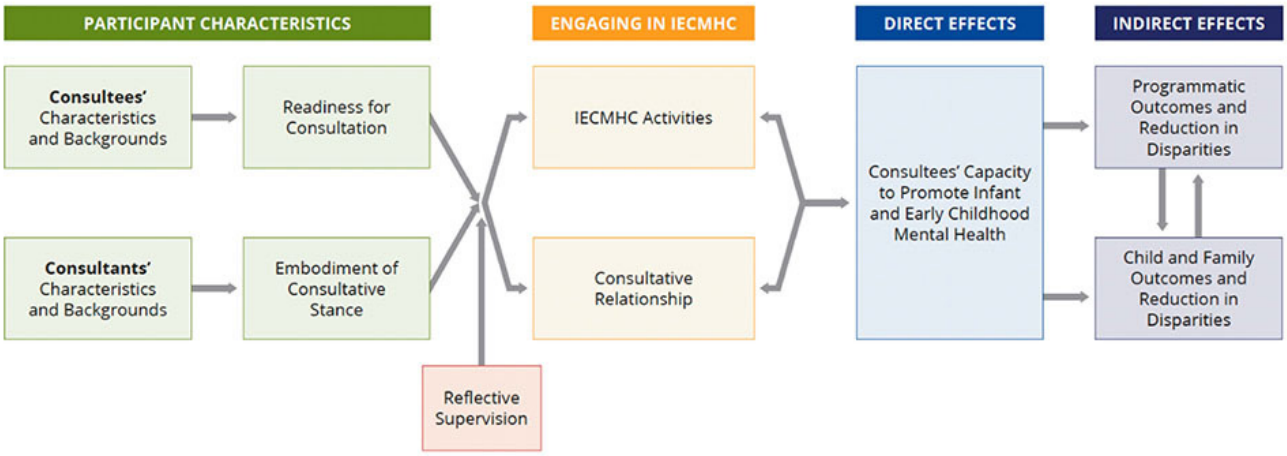

Figure 1. Center of Excellence for IECMHC Theory of Change. Taken from Center of Excellence for Infant & Early Childhood Mental Health Consultation. How mental health consultation works: A theory of change for research and evaluation. https://www.iecmhc.org/resources/how-mental-health-consultation-works-a-theory-of-change-for-research-and-evaluation/

Traditional IECMHC evaluation approaches have often overlooked examining how consultation services are experienced across different racial and ethnic groups and have typically neglected to consider how the racial and cultural identities of consultants might influence their work with diverse populations. To decolonize IECMH and consultation, it is necessary to create spaces to identify how racism has and is operating in both practice and research, and also address it, while also promoting collaborative relationships and collective healing through research to improve practice, professional development, and research. To facilitate this process, it is important to acknowledge the paradigms guiding who we are, how we are, and what we do as researchers and evaluation partners in this work. Datta (2018) highlights that being oriented and trained within western or eurocentric paradigms leads to more positivist worldviews and subsequent practices such as seeking a single truth rather acknowledging the existence of multiple truths, privileging objective scientific discovery over subjective and experiential knowledge, and promoting objectivity and detachment rather than partnership and collaboration. Our capacity to decolonize IECMH and consultation is built on the extent to which we can acknowledge and take intentional action to unlearn, learn, and adopt more African-centered, indigenous, and other nondominant paradigms. Doing so will facilitate a more transformative and empowering experience for the researchers and participants (Datta, 2018). This paper describes our team's efforts to develop and implement a decolonized, racial equity-centered approach to evaluating an established IECMHC program within a northeastern metropolitan community.

Program Context and Evaluation Framework

The IECMHC program that participated in this project provides embedded consultation services to child development centers (CDCs) in a metropolitan region of the U.S., primarily serving Black and Latine populations in historically underserved communities. The program has been in existence for over a decade and has recently undergone significant expansion, tripling its consultant workforce and the number of CDCs it serves.

Our evaluation framework was co-created through a partnership between a university-based team of academic researchers, several with clinical experience, and the local government agency that operated the IECMHC program. Our team's lived experiences, training, and anchoring in the Center of Excellence for IECMHC Theory of Change (ToC; Center of Excellence, 2021) provided a foundation on which to intentionally center equity in our evaluation. We deliberately expanded the ToC framework to incorporate explicit considerations of racial equity—a response to the IECMHC field's recent revision of professional competencies to elevate equity concerns in service delivery and evaluation (Schoch et al., 2024). We also used the Equitable Evaluation Framework, which offers guidance in how to center equity in evaluation by exploring, questioning, learning, and unlearning in ways that help inform actions and decisions (Equitable Evaluation Institute, 2025). This framework assisted our team in operationalizing equity and applying the ToC in our evaluation.

Community-Engaged Evaluation Methods

Centering racial equity in our evaluation approach began with the composition of our team. The five-member evaluation team included researchers with diverse racial and ethnic backgrounds: three members identify as white, one as Black/African American, and one as Hispanic/Latina. With varied backgrounds, education in public health, psychology, and social work, as well as professional development and work experiences, this diversity brought varied perspectives to our evaluation design, interpretation of findings, and dissemination. See the team's **positionality statements** in Figure 2. Despite this diversity in backgrounds and lived experience, each of the team had formal training in positivistic research paradigms which informed our approach. And the funder and local decision makers sought empirical data to answer the question: was fidelity maintained when the expansion was implemented?

Community Engaged Approach

We employed community-engaged methods to align our evaluation priorities with the concerns and interests of those most affected by the program. There were multiple time points at which our team encountered equity-focused decision-making. These are depicted in Figure 3. Prior to finalizing our evaluation protocol, we conducted "community listening sessions" with consultants and supervisors to understand which program components warranted the closest examination through a racial equity lens, and what they desired to learn through the evaluation. These sessions revealed concerns about the consistent implementation of the model across diverse populations and curiosities about cultural responsiveness in service delivery and evaluation. We listened and heard the unique experiences of staff given various racial and cultural backgrounds, educational experiences, time working in the program, and communication style differences. Therefore, we decided that it would be helpful to offer the opportunity to share experiences with us through surveys, interviews, and focus groups. Given the sensitivity in talking about race and racialized experiences, we solicited the participants' preferences for racial affinity in interviews and focus groups.

Researcher Reflexivity

Research reflexivity was essential in our team's approach and a way to reflect before, during, and after engaging with our community partners. Some of the questions offered for individual reflection after interviews or focus groups and team debriefing process included:

- What is staying with you? What did you learn? Did anything surprise you?
- What evoked emotion within you during the experience? What happened and what emotions were present?
- Given your social location or experiences, how did the question on racialized experiences go?
- Is there anything else that you think would be helpful to consider as we continue?

A couple of the themes that emerged from our reflections and debriefing included increasing awareness of how social location and racialized issues emerged–and maybe more importantly–failed to emerge in the context of the IECMHC program and the evaluation, and how the individual

Amittia Parker

Who I am is as important as how I am in my work in the field of IECMH. My positionality as a Black, woman of faith, wife, mama, mimi (step mom), tia (aunt), friend... and social worker, researcher, trainer, endorsed infant and early childhood mental health (IECMH) consultant, and scholar activist informs who I am and how I do my work. The responsibilities and roles that I play and have played including past experience as a mental health consultant, as well as the struggles, particularly negative racialized experiences and subsequent decolonizing work, led to my interest and desire to embody equity centric evaluation in ways that promotes reflection, dialogue, and healing, for consultants, children, families, staff, programs, communities, and for ourselves, is essential for ethical and meaningful research.

Natalia Castellanos González

My positionality as a Latina woman with a master's degree in public health, researcher, and consultant contributes to my approach to this work. My cultural background and gender identity inform my understanding of health disparities and social determinants that disproportionately affect marginalized communities. My training in public health and professional experiences in research and consulting shape how I frame research questions, interpret data, and develop recommendations. I bring both academic knowledge and cultural insights to my analysis of health challenges, particularly those affecting underserved populations. These intersecting identities have sensitized me to structural inequities while also affording me certain educational privileges.

Stephanie Mitchell

I have dedicated my research to understanding and supporting the experiences of low-income, minority parents of young children. My positionality as a White woman with a PhD in developmental psychology, mother and wife affects my approach to this work. I am married to a Black man, and together we are raising three bi-racial children. This family context continually informs my awareness of the complexities surrounding race, privilege, and identity in both personal and professional spheres. I recognize that my position as a White researcher working with minority communities brings both opportunities for advocacy and the responsibility to reflect on my own biases and assumptions. I strive to approach my work with humility and reflexivity, acknowledging that my interpretations are influenced by my background and that ongoing dialogue with the communities I serve is essential for ethical and meaningful research.

Deborah F. Perry

My positionality as a white public health researcher who grew up with a Hispanic immigrant grandfather with limited formal education has rooted my commitment to use my privilege to close the research to practice gap on behalf of communities whose voices have been ignored and silenced. My intersecting identities as a daughter, sister, mother, wife and mentor motivate me to create opportunities for the next generation of scholars (particularly women of color) to take a seat at the tables where I am invited. My work has focused on perinatal and infant mental health as a unique developmental window to deliver culturally congruent interventions to bolster resilience and promote life course wellbeing

Karyn A. Hartz

My positionality as a white, English-speaking woman, mother, wife, psychologist, researcher, infant and early childhood mental health consultant and therapist contributes to my approach to this work. My identities and experience as a mental health consultant and therapist, as a parent of children attending early childhood education centers, and as a family member of many educators and early childhood providers, inform my interest in and understanding of evaluation of IECMHC programs. Through my experience I have also witnessed disparities that persist across levels in early childhood. Multiple identities I hold have afforded me privilege. Striving to expand my knowledge, skills, and practice in equity-centered, de-colonizing practices motivates my engagement in evaluation and programmatic approaches to center equity.

Figure 2. Team Positionality Statements.

Note. This visual depicts our team's positionality statements, which highlight our team's racial and cultural identities, backgrounds, and lived experiences, and how they intersect with our evaluation and research work in infant mental health.

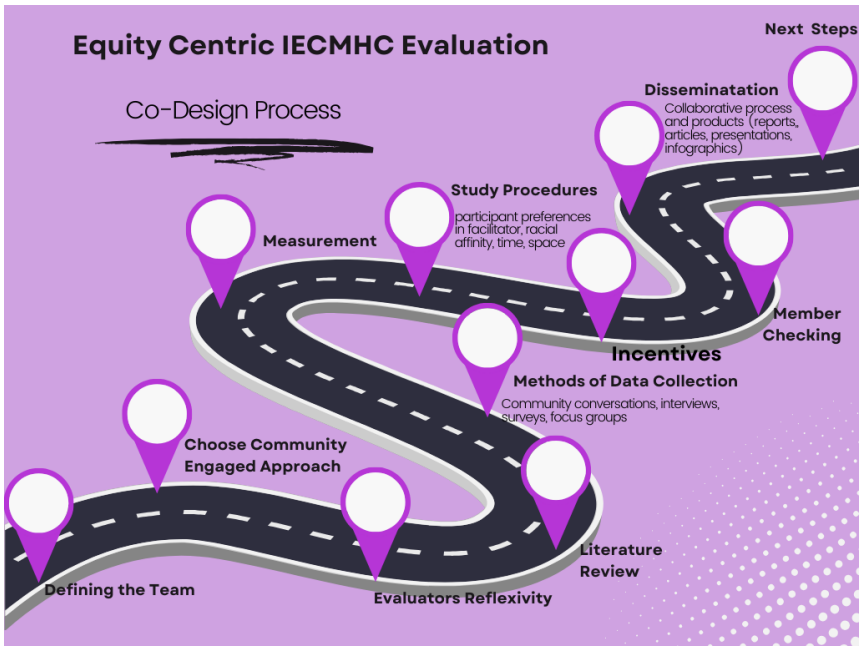

Figure 3. Applying the Equity Evaluation Framework.

Note. This visual demonstrates some of the steps in our equity-centered decision-making process to ensure that equity remains a priority in our evaluation.

team members could reflect on their own positionality in relation to the conversations that were had with consultants and supervisors. We had to navigate our emotions and determine how to respond to sensitive matters or the unexpected shared with the evaluation team. A reflection shared by AP:

> "I remember feeling really happy, like really happy when I heard that consultants that were Black were working with predominantly Black programs and most had Black supervisors. I know it sounds biased, but as a Black woman and past consultant who never had a Black supervisor–and wanted one, this really stayed with me. No code switching with families, directors, or in supervision–that sounds amazing, way less exhausting. Another strong emotion that stayed with me was about how a racial incident shared with me was handled. Racial issues happen every day but I felt this in my body, it did not sit well with me. As I struggled to manage my emotions, I also felt I had to be really careful about what I said given the situation, yet also show up authentically and respond sensitively. That was hard."

Another team member [SM] wrote these reflections:

> "I was really struck by her comment that teachers feel bias from kids, because in my head they're less-biased. But I know that was too quick an assumption for me to make – my own kids started verbalizing racial generalizations around age 4."

Throughout the evaluation process, we maintained a reflective and collaborative approach within our team and with the mental health consultation program partners. We prioritized sharing preliminary findings and soliciting feedback on data interpretation. This approach builds on and embodies Shivers and colleagues' (2022) work and can be described as "de-colonizing" evaluation practices by shifting power dynamics and privileging the interpretations of those closest to the work.

Measurement and Data Collection Approaches

Our evaluation employed a mixed methods measurement approach that captured multiple dimensions of IECMHC implementation through a racial equity lens (Table 1).

By examining consultants' racialized experiences, ensuring linguistic accessibility, and gathering data from multiple perspectives, we strove to identify strengths and disparities in program understanding, engagement, and satisfaction across different racial, ethnic, and linguistic groups.

Consultant Well-being and Experiences: We conducted individual interviews and focus groups with consultants. The interview and focus group guides included questions about their thoughts about the program, their hopes in the evaluation, and their experiences as consultants, and in particular training and reflective supervision experiences, racialized experiences, management of stress, and supports for their mental health, and wellness. Given the nature of the dialogue, we asked the consultants about their preferences to be interviewed by different members of our racially and linguistically diverse team. This allowed our team to facilitate racial matching in the interviewing process, if desired and acceptable. We used rapid qualitative analytic methods to analyze the interview data, which proved helpful in quickly translating the findings for member checking to ensure adequate representation and use of the findings to inform continuous quality improvement within the IECMHC program.

We measured consultants' professional quality of life using the Professional Quality of Life. Professional Quality of Life (ProQOL) (Hudnall Stamm, 2009), which assesses compassion satisfaction, burnout, and secondary traumatic stress. We recognized that consultants' ability to effectively serve diverse communities might be influenced by their own well-being and support systems, so we also measured perceived social support using an adapted version of the Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet et al., 1988). Our adapted version focused on the perception of support across contexts, specifically support from someone close to them (romantic partner), family or friends, work, and community.

Table 1. Key Measures Used in the IECMHC Evaluation. (*Continued on next page*)

Measure	Description	Examples of Questions
Professional Quality of Life (ProQOL)	Adapted selected items from 30-item self-report measure of compassion satisfaction and fatigue (burnout and secondary traumatic stress) in helping professions using a five-point Likert scale	1. I get satisfaction from being able to provide (mental health consultation) MHC to people. 2. I feel connected to others. 3. I feel invigorated after working with those I provide MHC to. 4. I am not as productive at work because I am losing sleep over traumatic experiences of a person I provided MHC to. 5. I feel trapped by my job as a MH consultant. 6. I like my work as a MH consultant. 7. I have beliefs that sustain me. 8. I am pleased with how I am able to keep up with MHC techniques and protocols. 9. I am the person I always wanted to be. 10. My work makes me feel satisfied. 11. I feel worn out because of my work as a MH consultant. 12. I have happy thoughts and feelings about those I provide MHC to and how I could help them. 13. I feel overwhelmed because my case MHC load seems endless. 14. I believe I can make a difference through my work. 15. I am proud of what I can do in MHC. I feel "bogged down" by the system. 16. I have thoughts that I am a "success" as a MHC I am a very caring person. 17. I am happy that I chose to do this work.
Multidimensional Scale of Perceived Social Support (MSPSS)	10-item measure assessing self-reported social support across contexts (family/friends, workplace, community)	1. I can count on the IECMHC program to help me when things go wrong (e.g. an issues with a director, teacher, or family). 2. There is someone within the IECMHC program that cares about my feelings and experiences. 3. There is someone in the IECMHC program that I can talk to if I have a question or concern. 4. I get the emotional help and support I need from a program or service in the community. 5. There is a program or service in the community that is a real source of comfort to me. 6. I can talk about my problems with a person within a program or service in the community. 7. I get the emotional help and support I need from my family and/or friends. 8. I can talk about my problems with my family and/or friends about the problems or challenges I face in my work. 9. I have a special person who is a real source of comfort to me. 10. There is a special person in my life who cares about my feelings.
Racialized Experiences in the Workplace	12 items exploring experiences with racialized interactions in the workplace, adapted from Shivers et al. (2022) and Hardy (2017)	1. Do racialized experiences come up in your work? 2. With whom are you most likely to encounter racialized issues? 3. What racial topics/situations cause you the most discomfort in your day-to-day work? 4. What is your CURRENT reflective supervisor's ethnic and/or racial identity? It is okay to guess if you are not sure. 5. Have you ever had a reflective supervisor that shares the same race/cultural-ethnic heritage as you? 6. Do you locate yourself in your practice of reflective supervision? Please rate how much you agree with the following statements about racialized experiences in reflective supervision: 7. I am open to talking about my social identities/cultural background in reflective supervision I am comfortable bringing concerns about culture and race into reflective supervision 8. My supervisor applies a equity lens in reflective supervision 9. In reflective supervision, we discuss our power and privilege due to our various identities/social 10. In reflective supervision, we engage in racial conversations without defensiveness, suspicion, fear, and negative accusations 11. I feel stressed by talking about racial issues (like racial bias or white privilege) at work 12. Is there anything else you'd like to share with us about your racialized experiences at work?
Training Experiences	Measured the consultants' perception of impact of training received on building capacity related to equity	1. Use of racial equity critical eye or lens 2. Awareness of implicit biases 3. Mindfulness of racialized instances that cause dysregulation or discomfort 4. Confidence to discuss racial equity-related topics or instances with colleagues or staff in programs 5. Comfort level in discussing racial equity related topics with a supervisor or staff in programs 6. Readiness to discuss racial equity-related topics or instances with others

Embodiment of the Consultative Stance	10 items assessing consultants' embodiment of core principles of the consultative stance (Johnston & Brinamen, 2006)	1. Convey the value of co-constructing meaning and developing hypotheses about a child/family/situation with your consultee(s). 2. Avoid the position of the sole expert. 3. Adopt an approach that embraces wondering instead of knowing. 4. Seek to understand another's subjective experiences. 5. Consider all levels of influence on a child/family/situation (e.g. systems, programs, interpersonal relationships). 6. Listen and give voice to all--especially the child. 7. Aim interventions at improving relationships, not individual people. 8. Acknowledge the power of the parallel process in your work. 9. Be patient, instead of seeking quick solutions. 10. Convey hope in the face of daily crises and persistent challenges.
Early Childhood Consultative Alliance Questionnaire (ECCAQ)	7-item measure assessing the quality of the consultative relationship (Mathis et al., 2019)	1. The educator is easy to talk to. 2. The educator avoids meeting with me. 3. I put extra effort into my relationship with this educator. 4. The educator talks with me about the emotions s/he experiences when working with children. 5. The educator is not interested in trying new ideas in the classroom. 6. The educator uses me as a source of support. 7. The educator values our time together.

Of particular importance to our racial equity focus, we included measures of racialized experiences in the workplace, adapted from prior work by Shivers et al. (2022). These items examined encounters with racial issues, comfort discussing race and culture in reflective supervision, and experiences of racial microaggressions. Additionally, items were developed to identify consultants' self and community care practices.

Consultative Approach and Relationships: We developed a novel measure to assess consultants' embodiment of the consultative stance based on Johnston and Brinamen's (2006) framework. This measure captured consultants' approach to their work through 10 items corresponding to core tenets such as "avoid the position of sole expert" and "seek to understand another's subjective experiences." The consultants' understanding and intentions on mitigating the power imbalances and capacity for empathy are important areas of development in decolonizing infant mental health work (Mullan, 2023). Both consultants and supervisors completed this measure, allowing for multi-perspective assessment. The quality of consultative relationships was measured using a selected (or a subset of) items from the Early Childhood Consultative Alliance Questionnaire (ECCAQ) (Mathis et al., 2019), with consultants rating their relationships with selected teachers and teachers rating their relationships with consultants. An innovation in this approach was asking the consultants to rate teachers that they were working with and felt they had both a positive and negative consultee relationships with.

Reflective Supervision: Recognizing the importance of reflective supervision in supporting consultants' work, we assessed both consultants' experiences of supervision (using the Reflective Supervision Rating Scale RSRS; Gallen et al., 2016) and supervisors' confidence in providing effective reflective supervision (using the Reflective Supervision Self-Efficacy Scale for Supervisees RSSESS; Shea et al., 2020). These measures allowed us to examine the extent to which reflective supervision supported consultants in general, and specifically in creating a safe enough space to increase reflective capacity and action for equity.

Various Community Partner Perspectives: We gathered data from multiple community partner groups (CDC directors, teachers, and families) to examine how IECMHC was experienced across different groups. The Family Experiences Survey, developed specifically for this evaluation, included questions about program understanding, comfort discussing mental health, and service satisfaction. Importantly, this survey was available in both English and Spanish to ensure linguistic accessibility. Teacher and Director Surveys assessed perceptions of service helpfulness, knowledge gains, and practice changes resulting from consultation. Incentives were offered to community partners to compensate them for their time and contributions. Creating space to be informed and guided by families and early childhood program staff enhances the program's services and evaluation in a number of ways, including helping to shift and share power.

Implementation Fidelity: We developed a comprehensive set of fidelity metrics based on the Center of Excellence for IECMHC's essential elements framework (Schoch et al., 2024) and the Healthy Futures program model. These metrics were calculated using administrative data from their data management system and covered three levels of consultation: programmatic (CDC-level), classroom, and child-specific. This approach allowed us to pinpoint places where the quality of the implementation fidelity was not high enough to address disparities as intended, which identified critical areas for program quality improvement.

Analysis

The analysis and write-up of the findings presented another step in our evaluative process, and like other steps, it too presented both opportunities and challenges as we tried to center equity in our evaluation. Despite our best efforts to balance the use of qualitative methods with validated tools, we found ourselves limited in what we could say about any of the important constructs we sought to elevate. The small sample size for this evaluation (n=17 consultants; n=65 teachers; n=20 directors of CCDs; and n=73 families served) reduced our ability to say anything conclusive about the quantitative data from the surveys. The intimate nature of the

programmatic team made it difficult for us to protect the anonymity and confidentiality of the respondents in the qualitative analysis. In the end, the underlying tension that emerged from our own internal struggles against our positivist training left some on the team feeling frustrated by the "findings" as we summarized them for the program partners. Some on our team, in particular our white researchers, had worked hard to use all the "best" tools and measures to try to quantify what we believed to be important empirical components of the program's implementation; concurrently, "our Black researcher [AP] was leaning in to the relational, qualitative work that shed insight into the consultants' experience implementing this complex intervention in a dynamic and racially charged context. In the end, as a team, we questioned the extent to which this approach allowed us to do either one as well as we would have liked.

Dissemination

What we did do well was to stay true to our collaborative, reflective, and intentional evaluation framework from the start to the end of this project. We prioritized dissemination activities and deliverables that were most helpful to the IECMHC program; therefore, we shared findings back through a newsletter, a presentation that was delivered to staff live and recorded via Zoom, and a written report. Of no surprise, at the culmination of this work, it was clear that our relationships and this work had just begun, as in the conversations with the program leadership and consultants the sense of safety that grew overtime, and at the end, there was more comfort in dialogue and explicit sharing with our team, and in particular AP about racialized experiences and goals to advance equity. This was a really meaningful outcome. We also shared this work in a national conference alongside other IECMH researchers and invited the IECMHC program to provide feedback on our presentation, and participate in the session, if desired. While the project ended, at the close of the funded work, our evaluation team and the IECMHC program remains in community, and intends to continue the mutually beneficial relationship in the continued dissemination of this work, and also in partnership in the advancing equity and IECMHC through policy, practice, and research.

Conclusions

Our evaluation of the IECMHC program demonstrates both the importance and feasibility of centering racial equity and using decolonizing practices within IECMHC program evaluation. Through this work, we captured a snapshot of the experiences of consultants and their supervisors, as well as the teachers, directors, and families served. The co-constructed mixed-methods design with prolonged, collaborative, and deeply reflective engagement created space for the exploration of IECMHC within the context of racialized experiences, equity, as well as the promotion of wellness and healing among consultants and those they serve.

Decolonizing IECMH starts with us (Mullan, 2023). Research is a powerful force—guiding thought, feelings, and actions (or inaction) in our field. This work represents a paradigm shift; we are not separate, we are creating spaces through research that can be decolonizing by asking about history, experiences of racism, and healing. We have the opportunity to shift the narrative about research and researchers. The act of engaging in research and dissemination such as this, using decolonized practices, challenges our training as researchers, and can be a form of resistance and even liberating for both researchers and participants (Datta, 2018). When we include those with lived experiences meaningfully, allow them to lead the work, and provide training and reflective spaces for professional development and healing in the context of our research and evaluation work: This type of research is resistance.

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Author Note

This research was approved by the Georgetown Institutional Review Board: Study 00006711. The authors have no conflicts of interest to report.

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Mothers Rising: Radical Collective Care through Culturally Congruent Perinatal Home Visiting in DC

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Credit: D2D Focus (2025)

Declarations

Funding Statement

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Conflicts of Interest

Aza Nedhari serves as the Executive Director of Mamatoto Village and is the organization's co-founder. Erin Snowden is the Director of Data and Social Impact and Rabiyah Amina was the Research Specialist at Mamatoto Village. Deborah Perry was paid as an independent consultant to Mamatoto Village to complete the development of this manuscript after a sub-award to Georgetown University concluded.

Ethics Approval

Ethical approval for this study was obtained by the Georgetown University Institutional Review Board (STUDY00002183).

Consent to Participate

Clients in the qualitative study cited in this paper provided informed consent in accordance with the IRB protocol listed above.

Availability of data and material

Data from this study are not available to the public given the small sample size would compromise the confidentiality and anonymity of the clients.

Authors' Contributions

The authors confirm their contribution to the paper as follows: program conception and design: A. Nedhari; data collection: E. Snowden, R. Amina; draft manuscript preparation: E. Snowden, A. Nedhari, D. F. Perry, R. Amina. All authors reviewed the results and approved the final version of the manuscript.

Authors' Permission Statement

The authors E. Snowden, A. Nedhari, D. F. Perry, and R. Amina grant WAIMH permission to publish the included photographs in Perspectives and on all WAIMH printed and online platforms.

Photography Credit

Photograph credit for all included photographic images belong to D2D Focus (2025).

Background

Across the United States, Black women are impacted by a persistent maternal health crisis, experiencing a maternal mortality rate 2.6 times higher than that of White women (Hoyert, 2023). Despite being the capital of one of the wealthiest nations in the world, Washington, DC, is emblematic of this national emergency. In 2018, the DC City Council responded to this public health emergency by establishing the Maternal Mortality Review Committee (MMRC), a group tasked with identifying the root causes of maternal mortality and advancing promising solutions. By 2020, Aza Nedhari, Executive Director of Mamatoto Village (MV), one of DC's most respected community-based perinatal support organizations, was appointed co-chair of the committee. Under her leadership, the MMRC's 2021 report revealed that between 2014 and 2018, the city's pregnancy-related mortality rate was 44.0 deaths per 100,000 live births, as compared to 28.4 deaths per 100,000 for the United States during that same period (Office of the Medical Examiner, 2021).

Although Black women constitute approximately 50% of all births in DC, they account for 90% of all pregnancy-related deaths and 93% of pregnancy-associated, non-related deaths. In contrast, White women account for none. Although shocking, these disparities are not a new phenomenon, but rather a reflection of deeply rooted structural inequities shaped by centuries of systemic racism, medical abuse, and systemic destabilization and vilification of community-based solutions such as Grand Midwives who long acted as a protective factor against obstetric harm (Menzel, 2021). In the face of these injustices, Black women are reclaiming their position in birth work. As an act of service and protest, Black women are creating the solutions they need to thrive by prioritizing culture and communal care, demanding reproductive justice, and determining exactly how that vision is achieved.

Inspired by their own life experiences, Mamatoto Village co-founders Aza Nedhari and Cassietta Pringle entered the field of birth work by completing a national doula training that they believed fell short in delivering the core competencies, skills, and community relevance necessary for providing meaningful and effective care. They believed Black women deserve dignity, respect, and care reflecting their experiences. Together, they committed to providing services built on cultural congruence, a practice beyond shared racial identity and surface-level awareness. Cultural congruence is a reciprocal process between the client and provider that fosters trust and improves outcomes through a deep commitment to delivering care that is respectful of and responsive to the cultural values, beliefs, and practices of clients and their families. With this understanding, they created Mamatoto Village, a community-led perinatal health organization in Washington, DC, dedicated to equipping Black families with the support, education, and resources needed to experience healthy pregnancies, self-determined parenting, and holistic well-being.

Mamatoto is the Swahili word for mother-baby, reflecting the unique connection in the mother-child dyad. Additionally, the term "Village" emphasizes the importance of a supportive community. This understanding guided the founders' vision for the organization: "Healthy Mamas, Healthy Babies, Healthy Communities." This vision is operationalized through an array of innovative programs, training, and services that acknowledge the historical and systemic challenges that have led to persistent perinatal health disparities, while also celebrating the resilience of the families seeking care at MV. Services are offered in a physical space located within the DC neighborhood where most of the program's clients reside. It is more than a provider's office, but a warm and welcoming second home filled with vibrant colors, textures, art, and photographs that celebrate the beauty and diversity of Black culture. This space is unapologetically Black, designed to feel familiar and affirming to the clients, staff, and the community it serves.

Credit: D2D Focus (2025)

Credit: D2D Focus (2025)

Program Description

An Evidence-Informed Solution: Mothers Rising Home Visiting

One of the primary vehicles MV uses to deliver quality services to clients is through Mothers Rising Home Visiting (MRHV), a strengths-based perinatal home visiting program that builds social capital for Black women in DC. The program has three main goals: 1) improve perinatal outcomes, 2) prevent and reduce maternal mortality and severe morbidity, and 3) increase family stability. MRHV recognizes that individuals are the sole experts on their lives. Therefore, the care journey begins with a comprehensive biopsychosocial intake assessment that considers not just pregnancy but the complete social and cultural context in which the participant lives. Using the results of the assessment, the MRHV team partners with the participant to co-create an individualized care plan outlining the provision of nonjudgmental, culturally congruent care to reduce the impact of socio-economic burdens, provide care coordination, counseling, and health education, and help build a support system resulting in more positive perinatal and infant health outcomes.

An innovative aspect of MRHV is that it is simultaneously supported by a robust workforce development program. In addition to providing home visiting services to at least 300 clients per year, MV has trained over 200 perinatal health workers (PHW). PHWs are primarily Black women from the MRHV service area – including former

program clients – who complete one of MV's workforce training pathways, particularly the Perinatal Community Health Worker (PCHW), a term and training model coined and developed by Mamatoto Village in 2015. The PCHW training is a 225-hour immersive experience grounded in a human rights, reproductive, and birth justice framework. The curriculum provides foundational knowledge of public and community health, documentation and charting, the history of obstetrics and midwifery in the US, as well as an analysis of systemic and structural racism, and its impact on perinatal health and parenting experiences of Black people. Additionally, it entails an understanding of preconception health, the physiologic changes during the perinatal period, nutrition, the stages of the birthing process, including labor support techniques; newborn care; pregnancy and postpartum complications, loss; perinatal mental health; intimate partner violence and substance use disorder; care coordination and resource navigation; lactation; and reproductive health. Bridging evidence that supports both doula and community health worker (CHW) models, this training program goes beyond these traditional pathways and is a 1) pathway for Black women into sustainable careers that drive community transformation and diversify the perinatal workforce to reflect those most impacted by maternal health disparities and 2) direct pathway for a highly skilled and community-cultivated workforce necessary to sustain the MRHV program.

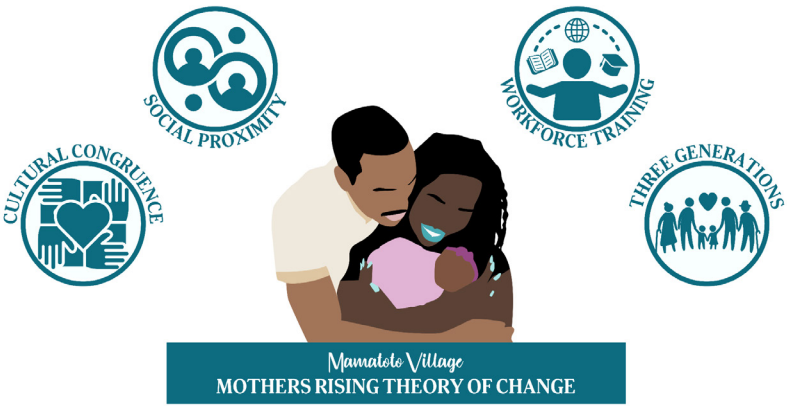

Figure 1. Mothers Rising Theory of Change.

Mothers Rising Theory of Change

The theory of change for MRHV operationalizes the founders' commitment to implementing a place-based approach that mobilizes a perinatal workforce deeply rooted in and dedicated to advancing the health and well-being of the community. This theory of change reflects the tenets of culture, social connection, and community care. It highlights four key components: rigorous training, cultural reflection, social proximity, and a three-generational approach (Figure 1).

Training. As described above, women from the communities that the MRHV program serves are recruited to join a rigorous training cohort. With didactic education, MV's workforce training is focused on the specialty of perinatal health infused in a CHW model grounded in human rights, reproductive, and birth justice.

Credit: D2D Focus (2025)

Cultural reflection. The program approaches perinatal care through cultural congruence and humility. PHWs are highly trained professionals with direct ties to the community. They are dedicated to delivering respectful care that celebrates the participant's culture. The Black experience is not a monolith; therefore, it is impossible to assume that the staff will reflect every aspect of the culture represented among clients. However, barriers to engagement are often overcome through a shared identification with Black culture. From interpersonal communication to educational materials, MRHV staff, administration, and clients are reflected throughout every aspect of the MRHV program, creating an environment of familiarity, safety, and trust.

Social proximity. The MV staff is comprised of people who mirror the experiences, family dynamics, and neighborhoods of those they serve. They strive to make the transition into parenthood self-determined and rooted in nurture, nonjudgmental support, advocacy, and evidence-based information, realizing their work impacts and uplifts the entire community. PCHWs are committed to meeting the needs of their clients where they are and providing services in various settings, including the home, providers' offices, and the general community.

Three-generations approach. The mother-baby dyad does not exist in a silo. The recognition of the intergenerational transmission of health, health literacy, well-being, wealth, and social status is reflected in the three-generation approach, which is an upstream solution requiring holistic interventions to optimize parent and child bonding. It emphasizes the need to respectfully engage, educate, and

empower the woman and the familial support system to move the entire family toward self-determination, wellness, and joy.

Essential Program Components

MRHV uses evidence-based and evidence-informed elements to form a core model with a cultural overlay that is adaptable and scalable for other communities, contexts, and populations. Over the span of an average 30-week enrollment, PHWs work in teams to provide clients with wrap-around care, including education and support related to pregnancy and postpartum, social needs, and overall wellness, including fitness, nutrition, stress management, mental health, and lactation. The building blocks for this approach are (1) an evidence-informed biopsychosocial intake assessment; (2) an interdisciplinary team-based model; (3) individualized care plans; (4) supported behavior change fueled by autonomy, health literacy, and family stability; and (5) improved perinatal and social outcomes (Figure 2).

Evidence-based Assessment

Upon referral to the MRHV program, clients complete a proprietary intake assessment. During this visit, clients self-report demographic information and detail their mental, physical, environmental, and social health. They also share their health status from preconception to the current pregnancy, as well as any past medical history. Following this assessment, clients are tiered using a perinatal risk stratification tool that combines health and social factors. This tool was adapted from the validated American Academy of Family Physicians' Risk-Stratified Care Management and Coordination Tool (American Academy of Family Physicians, 2021).

Interdisciplinary Team-based Model

Care teams are comprised of a variety of Perinatal Health Workers (PHWs) who have expertise in one or several of the following areas: care coordination, perinatal education, nutrition and fitness, perinatal mental health and stress management, labor support, postpartum and newborn care, and lactation. Having a multidisciplinary team ensures clients receive specialized care tailored to their needs, while also ensuring each team member can perform duties within their area of expertise, while minimizing burnout.

Individualized Service Plans

MRHV combines a standardized service schedule with customizable offerings to give each enrollee an individualized experience. Key services–such as antepartum and postpartum visits, breastfeeding anticipatory guidance, childbirth and parenting education, postpartum planning, and postpartum respite care–are offered to each participant on a standardized timeline (Figure 3). The cadence of visits is designed to align with the participant's level of acuity and milestones in the perinatal period, where critical decision-making, education, and advocacy needs are elevated. Clients are also offered fundamental resources such as hygiene products, wellness supplies, baby care items, clothing, food, and safe sleep items.

Supported Behavior Change

During group sessions, clients are provided a safe space to build meaningful connections and a supportive community with other clients. These sessions facilitate social connection by uniting individuals around a shared goal of having a healthy pregnancy and positive parenting experience, creating an environment of mutual support and accountability. The sense of community helps normalize positive behavior changes, making healthy practices feel both achievable and socially reinforced. Sessions include perinatal fitness, childbirth education, newborn care, sudden infant death syndrome prevention, breastfeeding, perinatal mental health, and parenting skills. These classes and support groups focus on helping expecting parents maintain a healthy pregnancy and successful transition into parenthood by reducing pregnancy-related morbidities such as diabetes, hypertension, and preeclampsia, and educating them about childbirth, breastfeeding, and newborn care. Aside from coaching, classes, and support groups, MRHV offers access to necessary maternity and postpartum mother and child supplies, such as breastfeeding tools, clothes, and newborn essentials.

Improved Perinatal and Social Outcomes

The program collects, analyzes, and reports on program outcomes and impact using key perinatal indicators, including mode of delivery, gestational age, birthweight, breastfeeding

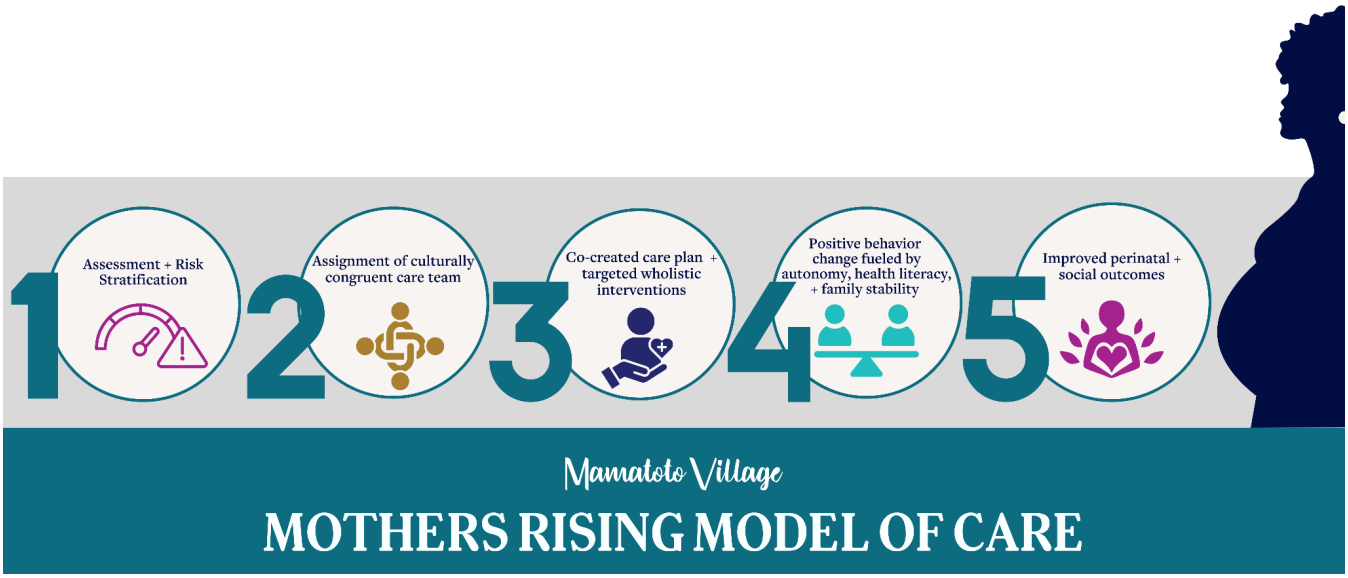

Figure 2. Mothers Rising Model of Care.

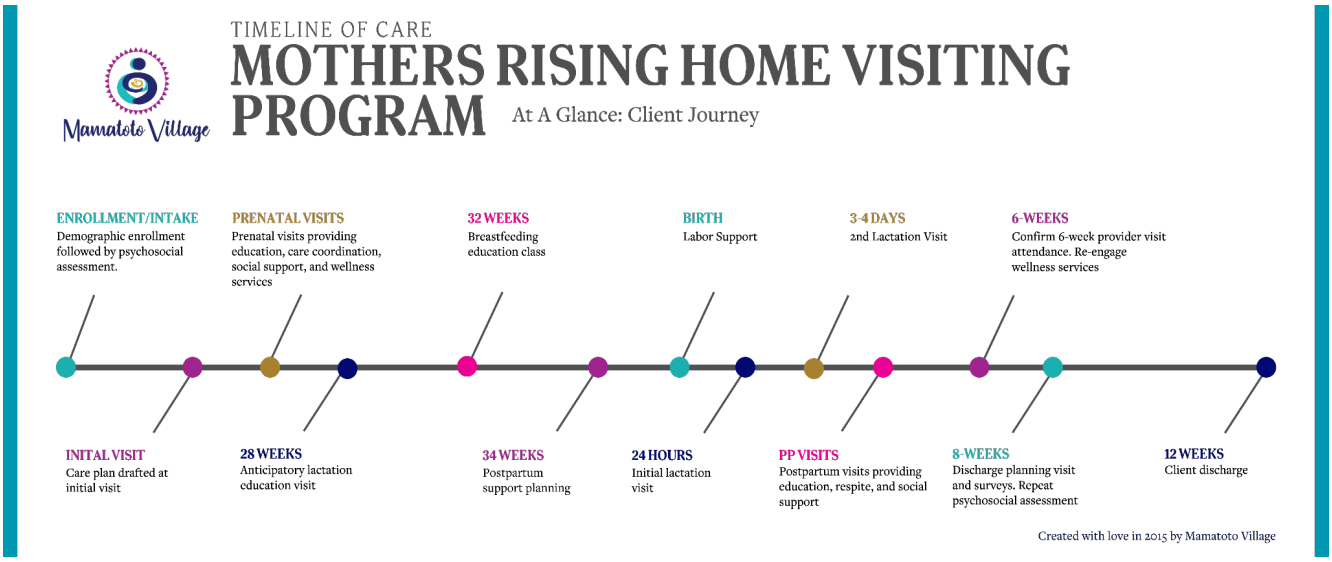

Figure 3. Mothers Rising Home Visiting Timeline of Care.

initiation, and neonatal intensive care unit (NICU) admission status. Clients also self-report on employment, housing, food security, safety, and perceived stress indicators. Improvement of the participant's socio-emotional stability is assessed by comparing data about these indicators collected at the start and end of program enrollment.

Building Evidence

Since its founding, MV has been identified as a viable community-led solution to the Black maternal health crisis (Barthel et al., 2022; Goode, 2014; National Partnership for Women and Families, 2019). Recognized as an award-winning and cutting-edge practice by the Association of Maternal and Child Health Programs (AMCHP), MRHV has advanced health equity and improved maternal outcomes for historically marginalized perinatal populations over the past ten years. The program has provided service to over 2,000 Black women and supported more than 1,000 births while maintaining a 0% maternal mortality rate. In 2021, MV partnered with Georgetown University's Center of Child and Human Development to conduct a mixed-methods evaluation of MRHV. Data from a sample of 102 participants were compared with a group of similar birthing people drawn from a Medicaid managed care organization serving Washington, DC. Small but statistically significant differences in gestational age favoring the MRHV participants were found (Snowden et al., 2024). Additional quantitative data demonstrating clinically significant differences in a broader range of perinatal outcomes are presented in Table 1.

Table 1. Quantitative Data Comparing Outcomes for Mothers Rising Home Visiting Participants and Non-participants in the United States and Washington DC.

Variable	United States National Average for Non-Hispanic Black Women	Washington DC Average for Non-Hispanic Black Women	Mothers Rising Sample (*n* = 102)
Preterm Delivery Rates	14.36% (2020)[a]	22.7% (2019-2020)[d]	10.1%
Low Birthweight Rates	14.15% (2019)[a]	13.2% (2017-2019)[e]	13.6%
Cesarean rate	36.3% (2020)[b]	36% (2019)[f]	30.3%
Breastfeeding initiation rate	74.5% (2020-1)[c]	72% (WIC; 2019)[c]	93.9%

[a]Brown et al. (2023)
[b]National Vital Statistics (2021)
[c]District of Columbia Lactation Commission (2021)
[d]National Partnership for Women and Families (2023)
[e]DC Department of Health (2022)
[f]March of Dimes (2023)

In addition to analyzing quantitative data, the evaluation team also interviewed 10 MRHV participants who had had a prior pregnancy without the support of the MRHV program, essentially serving as their own comparison group. The full results of these analyses will be published separately, but they provide additional support for the program's theory of change. One example from the qualitative findings highlights participant motivations for seeking care from a community-led and rooted perinatal home visitation program. Participant motivations were coded into three categories: 1) avoidant: seeking to avoid recurrent negative experiences, 2) seeking: seeking to

replicate the positive care experiences or relationships they previously experienced, and 3) sustaining: having a desire to deepen already established experiences in culturally reflective care (Figure 4). Regardless of their motivation for entry, the experience and support provided by the MRHV team were transformative. One participant stated, "Everybody was Black women, it's Black women everywhere. [My PCHW], like she's from DC, she lives in DC, so she understands the culture here and how we are here and things that may rub me the wrong way or may not… So, I really like that she understood me and who I was, and she had no problem coming to my house despite what goes on out there."

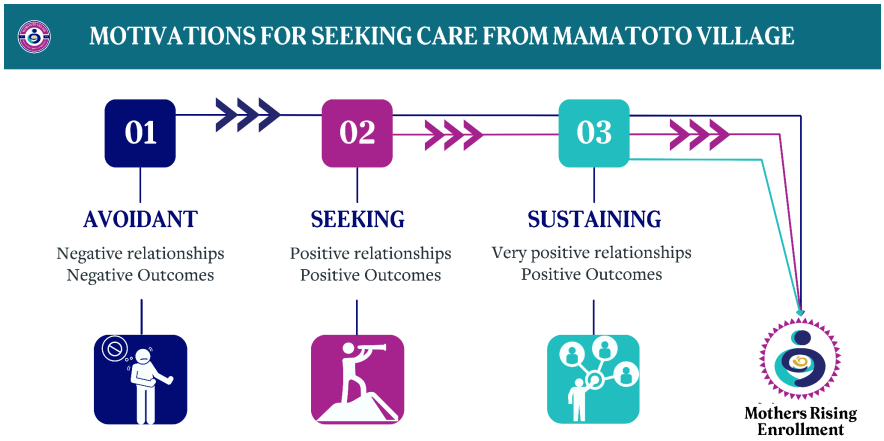

Figure 4. Motivations for Seeking Care.

Conclusion

Addressing the Black maternal health crisis requires more than clinical interventions; it demands culturally congruent, community-rooted models of care that are affirming, build trust, and acknowledge the lived realities of those most impacted. Mamatoto Village's Mothers Rising Home Visiting (MRHV) program exemplifies what is possible when reproductive justice, cultural humility, and community leadership are central to care. Through rigorous workforce development, culturally reflective services, social connection, and an intergenerational approach, MRHV advances health equity and fosters community resilience. The program's success, demonstrated by its positive perinatal outcomes, proves the value of investing in community-led solutions. Moreover, MRHV builds social capital by creating supportive networks that normalize positive behavior change and empower families to thrive. Mothers Rising Home Visiting offers a pathway, not only for the families of Washington, DC, but for communities across the country seeking to dismantle inequities and reimagine perinatal care through the lens of justice, joy, and self-determination.

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The Process of Decolonizing the Shared Space in Reflective Practitioner/Supervisor Relationships

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Abstract

In the field of infant and early childhood mental health (IECMH), there is a need for decolonized theories, research, community interventions, and clinical practice that are viewed through the lens of colonization and racism. This decolonization of reflective practice is a process that emphasizes the critical role of dynamic self-awareness for IECMH professionals serving targeted colonized and racially traumatized groups. This paper presents a process model of reflective practice based on foundational principles of the sociocultural and psychological impact of the shared trauma responses of slavery and colonization that manifest as hidden Adverse Childhood Experience (ACEs). The toxic behavioral outcomes of voicelessness, feelings of invisibility, unrecognized privileges and power, emotionless responses in relationships of the oppressed and oppressor, and reactive agency (VIPERs) are discussed within the framework. We offer a checklist as a tool to guide the decolonization of reflective practice in a relationship-based space for supervisor and practitioner. The paper concludes with a call to action for training local groups of IECMH professionals to collectively examine and develop tools based on local cultural beliefs, values, and norms within the communities they serve.

Keywords: Reflective Supervision, Infant Mental Health, Early Relational Health, Historical Trauma, Reflective Practice, Colonization, Anti-Racist, Power, Privilege, ACE Adverse Childhood Experience, Community Interventions, Culture, Race, Ethnicity, Internalized Oppression.

The Process of Decolonizing the Shared Space in Reflective Practitioner/ Supervisor Relationships

Throughout history human development centered on the need for protective interpersonal relationships. Relationships among humans first ensured the simple survival of the group. The introduction of the concept of mental health introduced the dynamic quality of relationships that lead to human thriving. From the secure-base of attachment relationships to the confidential and trusted space of therapy in clinical practice, the quality of the relationship is the key outcome. When humans experience the threat of oppression in modern times the quality of relationships may be impacted, and revert to the early survival mode.

In the field of infant and early childhood mental health (IECMH), there is a need for theories, research, community interventions, and clinical practice that are viewed through the lens of colonization and racism. We need to confront the prevailing paradigm of human development based on Western, industrialized, educated, rich, democratic (WEIRD) societies (Henrich et al., 2010). This theoretical framework leads to a paradigm of relationships that center the individual socialized into standards and cultural prescriptions for behaviors grounded in Eurocentric values and perspectives. The act of decolonizing reflective practice within a framework of relationships presents a new direction for workforce initiatives to achieve goals of effective, supportive services to families from groups targeted for discrimination, racial trauma, and structural inequality. Reflective Supervision/Consultation (RSC) raises awareness of the implications of shared racialized trauma and the need for protection through anti-racist organizational strategies (Hardy & Bobes, 2017; Noroña et al., 2021; Shivers et al., 2022; Wilson & Barron, 2022).

Trauma reverberates throughout a social system and across generations (Lewis, 1996; Moore, et al., 2023; Perry, et al, 2021; van der Kolk, 2014). Decolonizing reflective practice requires a flexible process model that utilises an ecological systems theoretical framework which includes the individual, contextual, and sociocultural factors influencing the early relational health of infants and young children, family health, and community well-being (Lewis et al., 2021; Shivers et al., 2022). In a decolonizing process model of reflective practice, the first step is understanding that the trauma of oppression, colonization, and racism is a shared experience. Maria Sotero's (2006) public health model of historical trauma provides a sound theoretical framework for this beginning point, noting that what is often missing in descriptions of historical trauma events, such as genocide, slavery, and wars, is the

psychological reality that all members of the society are impacted. The legacies of these shared trauma responses are factors that shape the quality of relationships of members of the group targeted for the violence of oppression and members of the group carrying out the violence to oppress. Trauma responses amongst the targeted group, such as active or passive resistance, protective parenting responses from parents (Lewis, 2019), and, in extreme cases, internalized colonization (Fanon, 1968; Worrell et al., 2024), are the result of survival by any means necessary. In this psychological state, the targeted group may come to believe the toxic stereotypes about themselves and their group members. For members of the dominant oppressor group, their trauma response reflects experiences in a system designed to subjugate one population and assign dominance and power to another. These unearned privileges are translated into all the areas of the social determinants of health, most notably education, employment, and the criminal justice system.

The process of reflection on shared trauma begins with understanding the sociocultural meaning of "self and targeted others" identifying the "privileged self" and "subjugated self" (Hardy & Bobes, 2016; Lewis et al., 2023). Most importantly, the quality of dynamics in interpersonal relationships—specifically emotional tone, communication styles, and the dynamics of power—between members of the oppressed social class and the dominant oppressor group is central to the decolonization process.

We argue that decolonized reflective practice centers on the underrecognized childhood experience of race-based trauma of families and professionals that impact the quality of interpersonal relationships—that the context of race, power, and privilege is a 'nappy-haired ghost in the nursery' that must be acknowledged (Fraiberg, 1975; Lewis, et al., 2023). Whereas being 'nappy-haired' refers to African-Americans that have kinky, tightly coiled, and textured hair which leads to childhood experiences of racial acceptance or rejection (CERAR) (Lewis, 2021; Lewis et. al., 2021). We propose that the lived experiences of the historical traumas of colonization and slavery are the hidden Adverse Childhood Experiences (ACEs) that may emerge as trauma triggers in modern experiences of both sides of the relationship in reflective practice. These unrecognized implicit biases, discrimination, policies, and practices are based on stereotypes that support a social hierarchy for a racially and culturally specific "standard normal person" (Ossorio, 1995). Recognizing them endorses the process of decolonizing reflective practice through a developmental lens of shared traumas.

Table 1. Fanon's (1968) Core Principles of Internalized Colonization.

Psychological Oppression	Colonization doesn't just affect the physical realm; it profoundly impacts the psyche of the colonized. This includes feelings of inferiority, self-doubt, and a distorted sense of self.
Cultural Domination	Colonial powers impose their native languages, culture, values, and worldviews on the colonized, leading to a devaluation of indigenous cultures and traditions.
Internalized Racism and Self-Hatred	Targeted colonized and oppressed people often internalize the racist stereotypes and prejudices perpetuated by the colonizer, leading to self-hatred and a rejection of their own identity.
The Role of Education	Colonial education is often used as a tool to brainwash the colonized with the colonizer's ideology, further reinforcing feelings of inferiority and dependency.

The Process Model of Decolonized Reflective Practice

True liberation necessitates both political independence and a comprehensive psychological and cultural decolonization process (Moore et al., 2023; Wilkenson, 2020). Table 1 presents the psychological outcomes to colonized groups in the bottom rungs of social hierarchies. Decolonized reflection is an honest appraisal of individual responses to the psychologically toxic social context of systemic racism, structural inequality, and oppression. The racialized trauma responses may include, voicelessness, invisibility, unrecognized privileges and power, emotionlessness, and reactive agency - VIPER - experienced by both members of the targeted oppressed groups and members and descendants of the groups that oppressed them. Intentional strategies are necessary to recognize and disrupt the traumatic and poisonous outcomes of VIPERs in a decolonized reflective practice relationship.

Voicelessness as a shared trauma response refers to the systematic silencing and suppression of a group's narratives, experiences, and perspectives (Duran & Duran, 2000). For oppressed, marginalized cultural, racial, or religious groups, this coping behavior often manifests as an internalized inability or unwillingness to speak out against injustice, share their suffering, or advocate for their rights due to generations of being ignored, dismissed, or punished. This act of self-silencing is a survival mechanism aimed at preventing further harm or re-traumatization. Still, it can lead to a profound sense of powerlessness and a culture of silence where individuals may avoid discussing traumatic pasts or present-day grievances, even within their own families and communities.

To be *invisibilized* means that the existence, contributions, suffering, and cultural practices of a group are systematically erased from the historical record (Fanon, 2008; Wilkenson, 2020). As an invisibilized group, subsequent generations are also ignored, denied, or rendered invisible within the dominant societal narrative. In response to colonization and oppression, marginalized groups may cope by adopting behaviors that further their invisibility, such as withdrawing from mainstream society, minimizing their cultural markers, or suppressing their unique identities to avoid discrimination or persecution. These coping mechanisms can protect individuals from direct harm or scrutiny, but also perpetuate their marginalization by denying them recognition, resources, and a place in collective memory (Fan & Ma, 2014).

In response to the *unrecognized privileges and power* in societies of structural inequality, the dominant

group often responds with a range of behaviors that serve to maintain the status quo (Wilkenson, 2020). These responses frequently stem from a lack of awareness, an inability to critically examine their position, or as a defense mechanism against perceived threats to their advantages. Typical responses include dismissing the existence of systemic inequalities or attributing disparities to individual failings rather than structural issues, minimizing the impact of historical trauma or ongoing discrimination on marginalized groups, defensiveness and feelings of being personally blamed or attacked, and anger or resentment when privileges are pointed out. The oppressor may also engage in color-blindness or claiming not to "see" race or other social categories, which, while seemingly benevolent, effectively ignores the realities of systemic discrimination and the unique experiences of marginalized groups (McIntosh, 1988). The prism of unacknowledged privilege often results in a lack of accountability for the historical and ongoing perpetuation of inequalities and a resistance to policies or actions that aim to address these imbalances. Ultimately, the unrecognized nature of privilege enables the dominant group to maintain its elevated position without acknowledging the historical and ongoing mechanisms that sustain it, thereby perpetuating structural inequality (Lewis et al., 2023).

Table 2. VIPER: A Tool for Decolonizing Relationships for Authentic Reflective Practice.

Response to Trauma	Internal Experience	External Experience	Decolonized Reflections for Authenticity
Voicelessness	Feelings of guilt or shame.	Not seeing oneself reflected, heard, or understood in groups or society.	• Whose voice is heard? • Is there anything not being said in this relationship? • What are the risks and benefits of raising my voice?
Invisibilization	Feeling tokenized or unseen.	Experiences of stereotyping and discrimination.	• How have I been, or how have my identity groups been invisible for generations? • What are the risks and benefits of being seen?
Unrecognized Privileges & Power	Denying benefits received from privileged identities, minimizing impact of position of power.	Aligning with subjugated identity over privileged identity, acting out of fear of losing it all to "others".	• How have I allowed my privilege to separate me from my humanity? • What would it be like to truly see how my privilege shows up in this relationship?
Emotionless	Conflict avoidant, internalizing stereotypes, abandoning self-care.	Denial of others' emotions/experience, a pervasive culture of inauthenticity (e.g., "nice" versus "kind").	• What do you notice when you rest your attention on what's going on in your body in this present moment?
Reactive-agency	Cultivate an understanding of the multigenerational context of trauma and resilience (Lewis et al. 2023).	Engaging in community-based care, participating in cultural rituals, connecting with community elders.	• Where might my unique gifts be most needed in my community? • What information do I need to have a consistent narrative about where I come from and how that shows up in my reflective relationships?

Emotionless behavior, in the context of historical trauma, describes a coping mechanism where individuals or groups appear to suppress, numb, or detach from their emotions. This is not a genuine absence of emotion, but rather a protective strategy to manage overwhelming pain, grief, or anger stemming from past and ongoing oppression, avoid re-experiencing intense emotional distress, or present an impenetrable façade to the dominant group (Stuckey, 1987). The classic poem of Paul Laurence Dunbar (1997) "We Wear the Mask," describes the necessity for marginalized people, specifically African Americans, to "mask," hiding their true emotions behind a façade of smiles and pleasantries as a "debt [paid] to human guile" that allows individuals to survive.

Reactive-agency refers to how oppressed and marginalized groups assert their will and agency in response to the historical traumas and ongoing injustices they face. Unlike proactive agency which involves initiating change from a position of power, (Bandura, 1997), reactive agency often responds to existing oppressive structures or events. This reactive response to chronic experiences of racial trauma can manifest as acts of resistance, protest, cultural preservation, community organizing, or the development of unique coping strategies that challenge dominant narratives and reclaim identity. For example, the creation of distinct cultural practices, languages, or spiritual beliefs can be an act of reactive agency, preserving a sense of self and community in the face of attempts to erase them (Moore et al., 2023; Stuckey, 1987). It signifies a refusal to be wholly defined or defeated by trauma, even if the actions are primarily in response to external pressures rather than initiated from a position of complete autonomy (Fine & Weis, 1998).

Guidelines for the process of development of a decolonized IECMH training

IECMH professionals working on behalf of targeted colonized and racially traumatized groups may benefit from receiving professional development from IECMH professionals that engage in decolonized reflective practice.

This can be one anti-racist tool to eradicate the VIPERs in the interpersonal relationships between IECMH professionals and the infants, children, and families they serve.

The authors engaged in this process from 2019 to 2022 in a northeast American city with significant racial disparities in child health and wellbeing, educational outcomes, economic wellbeing, and housing (ACT Rochester, 2020). This imperfect initial attempt can serve as a guideline for what is possible when it comes to available tools to decolonize IECMH training and ensure better outcomes for diverse families and communities (Lewis et al., 2023). We recommend embarking on the following steps in conjunction with the Alliance for the Advancement of Infant Mental Health's *Training Guide & Self Assessment*.

1. Gather a diverse training staff with unique perspectives and ways of knowing. Ideal candidates may not be content experts at first glance, but consider the wealth of experience that parents of children with disabilities, the neighborhood elder, a community organizer, a retired educator, or clergy member might offer. It's easier to teach someone how to deliver a training than it is to teach human connection, resilience, and relationship-based values. If a scan of your community fails to produce what you're looking for, turn to your stakeholders. Ask early care and education directors, pre-k teachers, families receiving community-based services, or home visiting staff who they would recommend to help other professionals best learn about decolonized early relational health.
2. Recognize any limitations of knowledge on the subject regardless of your experience, education, and expertise. When you know—and acknowledge—what you don't know, you can call in other perspectives to fill those gaps and provide feedback (e.g., parent leaders, former clients, etc.).
3. Model parallel process by cultivating a relationship with a reflective consultant steeped in decolonizing reflective practice. A consultant can provide direct and indirect training development support throughout the process as well as a holding container for the trainers to grow and thrive. When IECMH trainers receive decolonized reflective practice support, they are more resourced and empowered to provide it to others.
4. When engaging in the parallel process of receiving decolonized reflective practice support, ensure staff from targeted colonized and racially traumatized groups receive support from someone who shares that identity. If this is not available or not an option, provide existing reflective supervisors with robust training, education, and relationship-based support specific to racialized reflective practice. Operate under the assumption that they have the capacity to cause harm and supervisees may be afraid to fully express themselves. Familiarize yourself with the *Digging Deeper Report: Decolonizing our Understanding and Practice of Reflective Supervision through a Racial Equity Lens* (Shiver et al., 2022).
5. Resist the urge of White Supremacy Culture to get this done quickly. Once the team is gathered and receiving decolonized support, you may need to meet regularly over many months to develop a consensus on gaps in knowledge, build relationships, and collect multiple perspectives. The authentic implementation of decolonization in reflective practitioner/supervisor relationships is a journey (Lewis et al., 2023).
6. Set initial parameters on what must be covered during training and then unleash your trusted team on curriculum development. Example of parameters include:

   a. Identifying ways to uplift diverse voices, particularly of Black, Indigenous, and People of Color (BIPOC) IECMH experts

   b. Providing multiple ways of learning/engaging in the content (e.g., internal reflection, external expression, opportunities for individual and group creativity, hands-on practice, etc.).

   c. Resist primarily didactic ways of educating and instead be curious about how to engage adult learners in unique ways. Can you be more playful, prioritize discussion over lecture, or forego a PowerPoint altogether?

   d. Including diverse images, voices, and examples of parenting people in training content to ensure diverse participants can see themselves reflected.
7. Remain curious and test out materials with training cohorts to adapt them based on feedback and new information. Explore the following questions with your team to reflect back on the process and consider your next steps:

   a. What was most supportive in decolonizing our IECMH training?

   b. What might you need more of to sustain this work?

   c. Which relationships forged during the training will stick with you?

   d. Share something you learned that you want to integrate into the next offering.

   e. Explore themes from the VIPER model (e.g., How did we address voicelessness or emotionlessness in our training cohort? How did we keep privilege and power in mind?)
8. Provide payment for services for any person assisting with the development, delivery, or consultation of this training for decolonized reflective supervision or practice.

Conclusion

The process of building authentic relationships between people from the oppressed and oppressor groups offers a clear ray of hope and healing. To support decolonized reflective practice, there is a critical need for tools and relationship-based strategies that elevate traditional cultural practices, leading to collective survival and thriving.

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Intercultural cooperation in search of the best elements of infant care: Experiences from a Global Infant Mental Health Program

by Niels Peter Rygaard, CEO at Fairstart Foundation (Denmark)

Intro

In the post-colonial era, many Indigenous communities, ethnic groups, and nations return to their roots by rekindling and preserving their traditional family and childcare practices. Escalating migration has intensified conflicts over cultural identity, adding to challenges in intercultural cooperation, and created a dilemma: how can extensive childcare research from formerly colonizing nations be integrated with the rich traditions of indigenous infant care—on equal terms?

This column highlights reflections from Fairstart´s program, educating 950 staff for NGO and government partners in 38 countries. Students train groups of parents, foster parents, and teachers with sessions in attachment-based care and learning, covering 100,000 infants and children. By invitation from editor Hiram Fitzgerald, the design is described in Handbook of Infant Mental Health (Rygaard, 2024).

Working with partners spanning from Asia to Chile and the Global South profoundly challenged the author´s Western foundation in child psychology – to the point of asking himself whether the term "formerly colonized" should be replaced by "still colonized"? One eye opener indicating continued oppression and exploitation was the United Nation's count of 153 million orphans worldwide, raising a number of questions: How can equal cooperation happen on de facto unequal terms, and how can low-cost interventions be upscaled by using semi-virtual solutions?

Background: who cares for the caregivers of infants and children?

During a 2006 world tour of lectures and dialogues with local caregivers of orphans, the author observed a stark gap between Western academic knowledge and the local knowledge of frontline caregivers. Most caregivers were formally untrained and underpaid women, caring for traumatized children. For example, interviewing a 65-year-old rural foster mother in Rwanda, hosting three foster children, three babies from her sister who died of AIDS, and three from her brother, killed in the Rwandan genocide. When asked what kept her going, she indicated that she lives by the Kafala tradition where any relative takes the responsibility to care for children of troubled relatives. Or, interviewing an Inuit teacher in Greenland who had been sterilized at age 12 in a Danish state program to prevent overpopulation, then sent to a Danish foster family to help "civilize" Inuit children. Or, two women in a Mexican orphanage caring round the clock for 29 babies, abandoned in the wake of desperate migration. These observations - and the gap between research and practice – led the author to co-found the Danish Fairstart Foundation.

Think global, act and design with the local partner

To accommodate to various cultural contexts, Fairstart adapts programs according to ten principles for intercultural projects (Bruns and Walker 2008): Planning must be grounded in local partner and caregiver's perspective, and be strength based. Participants must share responsibility for developing, implementing, monitoring, and evaluating programs. They must have respect for and build on the values, culture, and identity of the child. Fairstart added: Local researchers and governments must participate in program design and implementation.

Why does indigenous care organization enhance secure attachment?

Secure infant attachment requires time and support for parents and caregivers. And above all, the avoidance of traumatic parent/infant separations. And an analysis of indigenous strengths in care cultures: in collectivist cultures, any extended family member can replace another, children are raised in groups, mothers breastfeed their neighbor's child, and community networks are strong. Colonization and mass migration to cities often disrupt traditional care and networks (in 2050, 80 % of the world population will live in a major city). Urban individualization causes increased parental burnout (Roskam et al., 2021), frequent divorces, weakened community bonds, and daily separations of infants from an early age, leading to the overwhelming of mental health services. In this merger on unequal terms, valuable indigenous care practices are lost. As Fairstart is

based on mutual learning, it works to map and reinstate them. In trainings, caregivers learn to replace the dark sides of traditional care (such as physical discipline, the mutilation of young girls, and gender inequality) with jointly developed relational care skills.

Towards global ethics in decolonization

At the European Congress of Psychology 2025, a panel on global ethics addressed the need for cooperation on equal terms: Saths Cooper who shared a prison cell with Nelson Mandela, later president of the International Union of Psychological Science, spoke about economic colonization. Professor Ava Thompson, University of Bahamas, spoke about teaching her students professional integrity in an exploited society, and the author spoke about the global rights of families and children. This and other initiatives may contribute to a set of global ethics in the process of decolonization.

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The Baby Matters Conference: Pakistan's First International Infant Mental Health Conference using The Honeybee Model

by Dr Roop Zainab Rana, Chief Organiser, Baby Matters Conference 2025 (Pakistan)

The Spring of 2025, brought with it Pakistan's first international conference on infant and early childhood mental health, held at the Health Services Academy (HSA) Islamabad, from 11th to 13th April. Aptly named "The Baby Matters Conference", this landmark event featured 15 distinguished speakers from Australia, Canada, the Philippines, South Africa, and the United States as well as multidisciplinary experts from across Pakistan, gathering over 1,000 participants both in-person and online.

Origins and Vision

The Baby Matters Conference vision was conceived through collaboration between the Fellows of the prestigious Zero to Three Fellowship (2022–2024) and realised through by support from the Health Services Academy (HSA) Vice Chancellor Dr Shehzad Ali Khan of the Health Services Academy University, whose forward-thinking vision and unwavering support made this event possible. National and International academic and social organisations such as The Healing Triad, Pakistan Institute of Living and Learning (PILL), Pahchaan, Omer e Rawan Foundation collaborated and organised workshops in five major cities, putting the "Honey Bee Model" into practice. Major educational and medical institutions across the country hosted workshops to train a variety of audiences, notably parents, educationists, health professionals, psychologists and policy makers. What began as a vision for change blossomed into a groundbreaking national movement to place infant mental health at the centre of national attention.

Photo: Dr Roop Zainab Rana. Credit: Health Services Academy, Pakistan

The Honey Bee Model: Diversity, Inclusion, Equity based Innovative and Inclusive Model of Public Health Care

The authors *Honey Bee Model*, was employed by the Baby Matters Conference as an innovative and inclusive approach inspired by the natural behavior of honey bees (Rana, 2020). Just as bees gather nectar from different flowers, transforming it into honey that nourishes the entire hive, this model emphasizes collecting knowledge and expertise from multiple global and local sources. The Model attempts to bridge the gap between research, health services, and health policy, by connecting the community, the researchers, health service providers, and the health policy makers. The Conference invited experts, researchers, academicians, policy makers, and community leaders, from across Pakistan and around the world. Delegates met at the "Hive", the Department of Public Mental Health, at HSA, Islamabad. The purpose of the meeting on Day One was to share ideas around challenges in the field of infant mental health, existing models of child care, and take stock of existing realities. The 'honeybees' then travelled across Pakistan, to collect 'nectar'. Academic activities, training workshops, interactions with parents, teachers, students, and health professionals were organised in the country through sessions in Lahore, Karachi, Rawalpindi, and Peshawar, as well as Islamabad. National and international experts and participants travelled between cities, cross-pollinating their knowledge and skills, to return to the 'hive' at HSA Islamabad. The Baby Matters Conference, therefore, became the first such activity to demonstrate the use of the Honeybee Model.

Workshops and Sessions

The Baby Matters Conference was conducted over the course of three

Photo: Baby Matters Conference. (L-R, Back-Front) Dr Nicki Dawson, Dr Chandra Ghosh Ippen, Prof Mowadat Rana, Prof Charles Zeanah, Dr Yolanda Fountain Hardy, Dr Roop Zainab Rana, Dr Jessica Gordon, Dr Marva Lewis, Dr Saadia Aseem, Dr Mary Dozier, Dr Joanna Herrara, Ms Ghalia Batool, and Ms Dani Stamm Thomas. Credit: Health Services Academy, Pakistan

days. Day One of the Conference was designed to showcase local expertise to international guests. Pakistani professionals from a wide range of government and non-government sectors, including public health, paediatrics, obstetrics, mental health, and policy makers, as well as academics shared the state of early childhood mental health practices in the country. This day served not only as an orientation for visiting experts, but also as a celebration of indigenous innovation, resourcefulness, and resilience in caregiving and clinical approaches. The core conference events at HSA began with a Pre-Inaugural Session featuring plenary speeches from Dr Rochelle Matacz, Dr Alexandra Harrison, and Dr Mary Dozier. This was followed by an Inaugural Ceremony, the chief guest of which was Dr Nelson Azeem, Member of National Assembly and Parliamentary Secretary National Health Services, Regulation and Coordination. Keynote speeches on the importance of early childhood mental health on lifelong wellness were given by Prof Charles Zeanah, international expert on Infant Mental Health, and Prof Mowadat Rana, Professor of Psychiatry and Behavioural Sciences. Sessions on integrating infant mental health into maternal and child health systems featured rich dialogue among speakers from diverse professional backgrounds including health policy, paediatrics, community health, and mental health. The evening session was chaired by Prof Abid Malik, head of the department of Public Mental Health in Pakistan, Prof Farid Minhas, world renowned expert on Psychiatry, and Child Trauma Research expert Dr Chandra Ghosh Ippen. Experts from across Pakistan talked about their work in integrating infant mental health into maternal and child health systems, perinatal mental health training, and capacity building for community health workers, and the development of childhood mental health services in Pakistan. The session featured rich dialogue among speakers from diverse professional backgrounds including policy, paediatrics, community health, and mental health.

Day two was dedicated to a bilateral flow (cross pollinations) of knowledge, infant mental health related skills, and the development of research ideas through interactions with health professionals and community. The international speakers, all of whom are globally recognized leaders in their fields, facilitated skill-based workshops across multiple cities. Each workshop was led by a trio of facilitators: an international expert, a Pakistani expert, and one or more co-facilitators. This collaborative model ensured contextually relevant teaching and grounded discussion. The sessions were structured in two parts: the first part involved the teaching of a particular skill or exploration of a theme in infant mental health and early childhood development. The second part invited reflection and co-creation with members of the community (ranging from parents, newlywed couples, students, teachers, and community leaders from various social classes to policymakers) to brainstorm potential research questions rooted in their lived realities. All activities planned on day two aimed to generate service delivery models in the field of infant and early childhood mental health care, based on indigenous needs, and data. The idea was simple, that research *about a people must come from the people*.

Workshops were tailored for a varied audience. One of the defining features of the Baby Matters Conference was its commitment to inclusivity and placing parents at the centre of conversations about early childhood mental health. Parents, policy makers, educationists, health professionals, community health workers, and psychologists all convened in the same learning spaces. This broke with the conventional format of scientific conferences, which often remain closed to laypersons. By bridging this divide, Baby Matters created a living laboratory for shared learning and co-creation of knowledge. In each one of five major cities, two types of workshops were held: one regarding normal development and promotion of mental health and one on identifying and managing infant mental health in medical settings.

At Iqra University, Karachi, a workshop on Wellness Through Play, was facilitated by Dr Yolanda Fountain Hardy, to teach parents the importance of play in child development and how to indulge in play with children who now increasingly spend more time indoors with very few peers, due to growing urbanization and the increasing numbers of families

Photo: (Top Row, R-L) Prof Nadeem Bajwa, Prof MH Rana, Vice Chancellor Health Services Academy (HSA) Prof Shahzad Ahmed, Prof Abid Malik, HoD Public Mental Health, HSA, Dr M Zeshan, Mr Nadeem Kiyani HSA, Dr Yolanda Fountain Hardy, and Dr Saadia Aseem. (Lower Row, L-R) Dr Roop Zainab Rana, Ms Sania Awan, Dr Sabahat, Dr Marva Lewis, Dr Gordon, Ms Ghalia, Dr Mary Dozier, Dr Joanna Herrara, Dr Nicki Dawson, Dr Alexandra Harrison, and Dr Chandra Ghosh Ippen. Credit: Health Services Academy, Pakistan

living in nuclear settings. Another prestigious venue in Karachi, Ziauddin University Hospital, hosted a workshop for health professionals, focusing on early childhood mental health: early detection and intervention, led by Dr Jessica Gordon. These sessions provided practical insights into evidence-based interventions and therapeutic play.

Lahore hosted two insightful sessions: Punjab University offered a comprehensive exploration of brain development from prenatal to five years, led by Dani Stamm Thomas, that was widely attended by parents, health professionals and educationists. Concurrently, the session at Mayo Hospital organised by Prof Nazish Imran, featured Dr Nicki Dawson, presenting Ububele's Baby Mat Intervention, emphasizing responsive mental health practices. The evening session involved a planning session on how to indigenise and implement the Baby Mat Service in Pakistan at Pahchaan, a not-for-profit child rights and protection organization working to enhance and better the future of refugee families and those living in severely impoverished conditions.

Peshawar's Khyber Medical College's Department of Psychiatry organized a full-day workshop on nurturing early childhood mental health, with expert guidance from Dr Joanna Herrera and Dr Angel Belle Dy. The event was centred around integrating principles of infant mental health into paediatric practice, as paediatricians in Pakistan are the main touchpoint for parenting and child health advice for families. Paediatricians across the city rallied under Dr Arshia Munir, of the Pakistan Paediatric Association to attend this impactful session.

Islamabad hosted two impactful workshops at different venues. Dr Marva Lewis's Touch Talk and Listen programme was presented at Islamabad Model College for Girls. A large audience of parents and educationists explored culturally informed caregiving rituals, highlighting practical strategies to foster joyful and connected parent-child relationships. The other critical session, conducted by Dr Chandra Ghosh Ippen, addressed the profound impact of early childhood trauma and effective intervention strategies at the National Disaster Management Authority. The aim was to educate disaster management policy makers on integration of principles of infant mental health into national disaster policy.

In Rawalpindi, the Institute of Psychiatry at Benazir Bhutto Hospital facilitated a workshop on grief-sensitive healthcare, expertly led by Dr Celeste Poe and Prof Asad Nizami, emphasizing compassionate clinical care approaches for families experiencing grief in the perinatal period. Healthcare professionals were then engaged in a skill building exercise in provision of grief sensitive healthcare, facilitated by Dr Sawera Mansoor. The evening session organised by Prof Azhar engaged participants on brainstorming research proposals on how to improve grief sensitive healthcare provision.

Another important activity was the inauguration of Pakistan's first Wellness Centre for Mother and Child health in Rawalpindi. The Centre was inaugurated by Prof Charles Zeanah and a celebrity from the field of Obstetrics and Gynaecology, Prof Rashid Latif. This event brought together paediatricians, OBGYN's and mental health professionals who agreed to come together to work on this initiative

Day 3 was structured as a day of synthesis and reflection. Pakistani and international experts reconvened to discuss the workshops, evaluate the quality and diversity of audience participation, and present the research proposals generated in the previous day's sessions. This collective dialogue allowed for meaningful exchange, feedback, and refinement of ideas.

The day concluded with a formal closing ceremony and press conference during which the outcomes of the conference—including proposed research, institutional partnerships, policy directions, and the establishment of an Infant Mental Health Repository—were officially announced.

Objectives and Outcomes

Central to the conference was the launch of the Baby Matters Campaign, aimed at raising awareness, fostering interdisciplinary collaboration, equipping caregivers and professionals, advocating policy change, and encouraging research. Notable outcomes included the formation of an Infant Mental Health Repository, presentation of 10 research proposals, introduction of five therapeutic methods, and establishment of a secretariat for the future Pakistan Affiliate of WAIMH. A significant highlight was the launch of a fully funded diploma in Public Mental Health for researchers engaged in infant mental health projects, and initiation of two PhD projects in the field of infant and early childhood mental health, HSAU.

Another major outcome was the drafting of a significant policy paper by Dr Roop Zainab Rana. This crucial session was chaired by Prof Abid Malik and Prof Mowadat H Rana, engaging discussions with prominent national experts including Dr Saadia Aseem, Dr Siham Sikander, Ayesha Mian, Brigadier Sikandar, and international authorities such as Profs Charlie Zeanah, Alexandra Harrison, Mary Dozier and Muhammad Zeshan. The Policy document had inputs from partner organisations such as HSA, Pakistan Institute of Living and Learning, and The Healing Triad.

A National Movement: Looking Forward

The Baby Matters Conference signified more than an event—it marked the birth of a transformative movement. Extensive media coverage underscored the national recognition of early mental health care. Future plans involve integrating infant mental health into national systems, solidifying a sustainable, evidence-driven framework.

In conclusion, Baby Matters set a robust foundation for continued advocacy and action, a commitment that every infant in Pakistan—and around the world—will receive the foundational support necessary for lifelong wellness and success. The next Baby Matters Conference will be held in two year's time to discuss the progress of the projects initiated and continue to map the way forward.

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The Promotion of Human Rights and the Newborn Behavior Observations (NBO) system

By J. Kevin Nugent (United States), Susan Nicolson (Australia), Campbell Paul (Australia), and Lise C. Johnson (United States)

Introduction

The United Nations Convention on the Rights of the Child, the most widely ratified human rights treaty, states that every newborn baby has the right to equality, freedom from discrimination, and equitable care (United Nations, 1989). We propose that human rights guarantees for newborns and their families can be put into practice as part of high-quality healthcare through the use of the Newborn Behavioral Observations (NBO) system (Nugent, Keefer, Minear, Johnson & Blanchard, 2007). The NBO is an evidence-based clinical tool that supports perinatal mental health, early parenting, and infant development by helping parents see and respond to their infant's communication, capacities and vulnerabilities. In underscoring the infant's personhood and relational agency from the moment of birth, the NBO is also an act of human rights advocacy, affirming the newborn's rights to dignity and respect and to be an active participant in their family, community and culture.

The United Nations Convention of the Rights of the Child

The UN Convention on the Rights of the Child (UNCRC) recognizes the fundamental human dignity and rights of all children and the urgency of ensuring their well-being and development (United Nations, 1989). The UNCRC emphasizes the provision of supports and guarantees to families from birth onwards.

The World Association for Infant Mental Health (WAIMH) fully endorses the UNCRC, and the subsequent General Comment Number 7 (United Nations, 2005), to strengthen understanding and implementation of children's rights in early childhood. The *WAIMH Position Paper on the Rights of Infants* contends that there are unique considerations regarding the needs of infants from birth through the first three years of life, underscored by the impact of early relational experience on the development of the human brain and mind and on life-long health outcomes (Shonkoff, Boyce, & McEwen, 2009; WAIMH Position Paper on the Rights of Infants, 2016). The Diversity-Informed Tenets for Work with Infants, Children and Families further call upon clinicians to champion children's rights globally, to acknowledge privilege and combat discrimination, to recognize and respect nondominant bodies of knowledge, honor diverse family structures, allocate resources to systems change, open pathways for the marginalized, and advance equitable policies for families (Thomas, Noroña & St. John, 2019).

Translation of these rights into practice is a prerequisite for high-quality newborn healthcare around the world - in health facilities and at home. Access to high-quality universal health care is the right of every newborn, and although suboptimal care still impedes desired health outcomes in many parts of the world, as neonatal mortality decreases, global agendas are expanding their focus from survival to care that optimizes neurodevelopmental outcomes (Kuruvilla et al., 2016; Wojcieszek et al. 2023).

High Quality Care and the Promotion of Human Rights in the Newborn Period

Newborn behavior and development and human rights are usually discussed as separate fields, but we are proposing that human rights should be at the core of clinical work with newborns and their families. High quality newborn care involves more than addressing biological needs, it requires attunement and responsiveness to the infant's emotional and relational signals to support their wellbeing and development, even in lifesaving intensive care settings. This demands respect for the infant as protagonist in their life, with the right to be listened and responded to, not just assessed, treated and talked about.

Within the first 1000 days of life, the first 100 days of life may be the touchpoint *par excellence* in promoting the infant's health and human rights. This period consists of a series of survival and adaptive challenges for the infant and the emerging parent–child relationship, the resolution of which constitutes the foundation of the child's developmental outcome (Als,1982; Brazelton, 2009; Bruschweiler-Stern, 2009; Porges, 2015; Trevarthen, 2003). During this particularly significant period there is unparalleled/major brain growth, maturation and transformation in many neural functions, supporting the infant's behavioural adaptation to their

environment and early relationship formation with their caregivers. All this offers great opportunity for interventions to impact the life trajectory (Barlow et al. 2011; Feldman, Bamberger, and Kanat-Maymon, 2013; Mayes, Rutherford, Suchman and Close, 2012; Reddy & Trevarthen, 2004; Sadler et al. 2002; Tottenham, 2020; Tronick, 2007).

The use of the NBO in affirming the baby's human rights

The newborn period provides the parents, the family and the community with a unique opportunity to see, hold, touch, and engage with their baby. At this pivotal time, the NBO - a clinical tool, designed for use in the first three months of life - allows practitioners to learn with parents about their child's communication strategies and overall development and allows the baby the space to show through their behavior who they are, and what relational support and connection they seek, need, and value.

The NBO system consists of 18 neurobehavioral observations, addressing sleep protection, crying and consoling, motor tone and reflexes, response to the visual and auditory stimuli, and stress tolerance. During a session, the newborn may demonstrate a wide range of visual, auditory, and perceptual abilities that enable them to explore the world around them and connect with their caregivers, engaging in face-to-face, eye-to-eye mutual exchange (Brazelton, 2009; Trevarthen 2003). Self-regulatory challenges and strategies are observed and supported throughout.

With the NBO, newborn health care and human rights advocacy are integrated: the baby's voice is respected and amplified through observation. The practitioner respectfully joins the parent and together they meet with baby and explore the infant's capacities and vulnerabilities; the baby's agency and right to participate are affirmed; and parents are supported to see and accept their newborn's experiences and caregiving needs in real-time, in other words, to see the baby as a person and to see themselves in relationship with this person. Parents begin to learn from the baby how they can support their wellbeing and their overall development and advocate for their rights. Moreover, the flexibility of the NBO allows for its use in multiple settings - hospital, outpatient office or clinic, or home, with nuclear family, extended family, kin and important community members' participation. By design, the NBO welcomes all, serving as a vehicle for the newborn to "speak" to and connect with their community.

While the NBO reveals and respects the unique personhood of the baby, it also asserts that the consequent responsive caregiving that will best support the child's entry into their society, be it collectivist or individualist, belongs in the hands of the parents and caregiving circle. Affirming the importance of traditions and cultural values for the protection and harmonious development of the child, the NBO is explicitly designed to be useful across different cultural contexts and acknowledges the centrality of kinship, connection, and social responsibilities for wellbeing in Indigenous communities (Spicer, Korfmacher, Sarche, 2024). These are important facets of how the NBO embodies human rights advocacy.

In sum, the NBO can be used within newborn health care to formally recognize and confirm the child's personhood, celebrate their entry into the community and their right to live an individual life in society, to be brought up in the spirit of peace, dignity, tolerance, freedom, equality and solidarity, as articulated by the United Nations Convention. In practising the NBO, multi-disciplinary professionals model an attitude of respect, attention and advocacy for even the youngest and most vulnerable humans. This helps to shift societal norms, ensure infant rights are recognised early, and empower families and communities to protect and nurture those rights.

Research with the NBO

A series of randomized studies have demonstrated the effectiveness of the NBO in influencing the parent-infant relationship (Tazza, Ioverno & Pallini, 2023; Yago, Takahashi, Tsukamoto, Saito and Saito, 2023). Involvement in the NBO results in enhanced mother–infant engagement (McManus and Nugent, 2011, 2012; Nugent, Dym-Bartlett, Vonende and Valim, 2017), higher sensitivity and non-intrusiveness and reduction of anxiety symptoms in distressed mothers (Nicolson, Carron and Paul, 2022), fewer maternal depressive symptoms (McManus, Blanchard, Murphy & Nugent, 2020; Nugent, Dym-Bartlett and Valim, 2014), greater gains in cognitive and adaptive function at 6-months (McManus et al. 2020), parent's greater understanding of their infant's communication cues and their ability to establish a relationship with the infant (Høifødt et al. 2020; Kristensen, Juul and Kronborg, 2020), and higher maternal confidence and increased knowledge about their infant (Valla, Slinning, Wentzel-Larsen, Røsand & Arnardóttir, 2025).

It must be acknowledged that, while the NBO is widely used around the world and has been found to positively influence the parent-infant relationship in a range of cultural settings, most NBO research hitherto has been conducted in higher socio-economic countries, with under-representation of minority ethnicities and cultures among the study participants. Further, research to date has focused on the parent-infant relationship in a nuclear one-parent or two-parent context - occasionally including siblings or grandparents. The impact and value of conducting an NBO in Majority World study populations and of involving the child's extended family, kinship group and community need to be better understood.

Conclusions

The field of infant mental health has increasingly turned its attention to questions of justice (Keren, Abdallah & Tyano, 2019; Spicer, Korfmacher, Sarche, 2024; WAIMH Position Paper on the Rights of Infants, 2016; Zeanah, Steier, Lim, Korfmacher & Zeanah, 2023). However, if we define our commitment to human rights and justice too abstractly, we will fail to specify how to meet that commitment. The NBO answers this call with its focus on engaging in real time in a relationship with the newborn as a competent and communicative person. We believe that how newborns are treated affects not just their lives but also the lives of their parents and family, the entire community, and indeed the health and well-being of the whole culture.

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Book Review: Getting to Know You: Lessons in Early Relational Health from Infants and Caregivers

Reviewed by Arietta Slade, Ph.D. (United States)

Professor Adjunct of Child Psychiatry, Yale Child Study Center

Book reviewed: *Getting to Know You: Lessons in Early Relational Health from Infants and Caregivers*

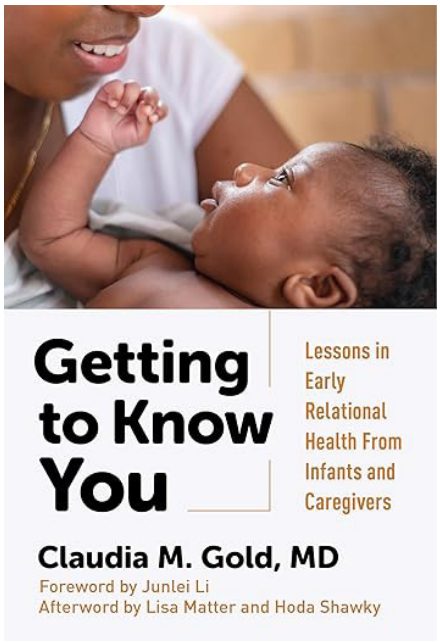
Author: Claudia M. Gold, M.D.

Getting to Know You: Lessons in Early Relational Health from Infants and Caregivers, by Claudia Gold, is just a terrific book. I have worked in the field of infant mental health for many decades, as a clinician, teacher, supervisor, and researcher, and I am familiar with much of the work Dr. Gold synthesizes and integrates. Despite this, I learned from every page. I learned from her remarkably cogent and synthetic descriptions of contemporary developmental theory and science; I learned from her rich depictions of the ways the child, the caregiver, the relationship, and the broader environment contribute to relational health, but mostly I learned from the way she describes her work with families. In one rich clinical vignette after another, the essentials of the work emerge: listening, tolerating uncertainty, and being open to stories. We are in the room with her, absorbing her rich guidance as we struggle to make sense and find meaning.

Like Winnicott and Brazelton before her, Dr. Gold is a pediatrician who began her career in general practice. Time and again she came up against the limitations of "system" and "symptom" checks, longing instead to connect with her patients and their families, and to understand the deeper meanings behind their challenges. The burgeoning literature on infant mental health, relational health, mentalization, and neuroscience transformed her practice, and inspired her writing. Indeed, this is the fifth in a series of books that Dr. Gold (Gold, 2011, 2016, 2017; Tronick & Gold, 2020) has written about mental health practice and developmental science over the last fifteen years. In each, she skillfully translates theory, research, and science into language and ways of thinking that orient the reader to both the "why" and "how" of clinical practice. In *Getting to Know You* each chapter closes with a summary of its key developmental lessons, along with questions for discussion.

Dr. Gold starts this book with a simple premise, that the practitioner's capacity to hold a stance of humbly "not knowing" – often in the face of great pressure to do otherwise - is the key to therapeutic change. It is the clinician's "superpower". Observing, watching, waiting, and listening are her anchors, even when parents and other professionals demand answers and fixes. Again and again, she helps us see just how this works, using clinical vignettes that bring alive the power of listening, of resisting the urge to do and just be with parents who are at their wits' end, with children who are often dysregulated and deeply distressed. The vivid clinical examples, which include a description of her own process (acknowledging her feelings, her anxieties, her decisions about what to say), are so familiar and so illustrative of the complexities and the miracles of the work. Tolerating the uncertainty of not-knowing, caregivers and their children are slowly helped to make meaning of the messy pain that brought them into the therapeutic space in the first place.

Dr. Gold also makes clear the value of *stories*; stories that busy practitioners (of all stripes) are often too busy or too distracted to elicit. It is these stories that bring coherence to all manner of disorganization and dysfunction. As we listen and we hear stories, shame gives way to compassion, anger to openness and connection. Infant mental health practitioners have understood the value of stories since Selma Fraiberg first introduced us to "ghosts in the nursery" (Fraiberg et al., 1975). But it is Gold's integration of the power of stories with the power of listening, humility, and simply not-knowing, that is so powerful. She describes with great poignancy time and again just struggling to sit, to observe, to *not* know, to *not* give advice, but to let the stories emerge in the holding environment she creates. I resonated so deeply with her struggle; creating the space for stories can seem like the hardest job in the world. But the rewards for doing so are great. Dr. Gold also weaves her own personal story of trauma, loss, and remarkable resilience into the book in a way that I found very moving. In this, and in so many other ways, her humanity leaps off the page.



Book Cover: Getting to Know You: Lessons in Early Relational Health From Infants and Caregivers (2025). Author: Claudia M. Gold. Publisher: Teachers College Press.

This is a book I would want to read if I were beginning again. This is a book I hope beginners, mid-career and even advanced practitioners will read, too. It is brilliant - clear, synthetic, wise, and smart. It is also profoundly grounding, pointing us again and again to what is most important in the clinical exchange. In this, Dr. Gold brings to life not only the complexity of the work, but its simplicity and eloquence too.

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PERSPECTIVES IN INFANT MENTAL HEALTH

Perspectives in Infant Mental Health (formerly, The Signal) is a Professional Publication of the World Association for Infant Mental Health (WAIMH).

It provides a platform for WAIMH members, WAIMH Affiliate members, and allied infant mental health colleagues to share scientific articles, clinical case studies, articles describing innovative thinking, intervention approaches, research studies, and book reviews, to name a few. It also serves as a nexus for the establishment of a communication network, and informs members of upcoming events and conferences.

It is a free open access publication at www.waimh.org

During the past 50 years, infant mental health has emerged as a significant approach for the promotion, prevention, and treatment of social, emotional, relational, and physical wellbeing in infants and young children, in relationship with their parents and caregivers, in their families and communities.

Within this same time frame, the infant mental health movement has expanded to a global network of professionals from many disciplines. This infant mental health global network community of research, practice, and policy advocates, all share a common goal of enhancing the facilitating conditions that promote intergenerational wellbeing; including intergenerational mental health and wellbeing relationships, between infants and young children, parents, and other caregivers, in their communities.

The global reach of infant mental health demands attention to the cultural context in which a young child and family lives, as well as critical attention to issues that affect child development, child health, child mental health, parental mental health and early relationship development.

Invitation to contribute

We invite all members of WAIMH and WAIMH Affiliate members to contribute to Perspectives in Infant Mental Health.

WAIMH is a member-based organization, and as such, we invite each of you to think creatively and consider submitting an article that provides a "window on the world" of babies and their families. We are especially interested in papers that incorporate diverse perspectives and center the cultural contexts and experiences of babies and families across the globe. We encourage submissions that reflect on how cultural, social, and economic factors shape early childhood development and highlight the unique strengths, challenges, and traditions that influence family systems and infant mental health.

In the spirit of sharing new perspectives, we welcome your manuscripts. Manuscripts are accepted throughout the year. Articles are reviewed by the Editors, all of whom are committed to identifying authors from around the world and assisting them to best prepare their papers for publication.

Full issue publication dates

April issue:

Papers received by January 1
will be considered for inclusion in this issue.

August issue:

Papers received by May 1
will be considered for inclusion in this issue.

December issue:

Papers received by September 1
will be considered for inclusion in this issue.

Perspectives in Infant Mental Health Submission Guidelines

APA 7th Edition.

12-point font.

1.5 or double spaced.

All in-text citations, references, tables, and figures to be in APA 7th edition format.

Papers with tables and figures: Please submit the paper as a word-format document with separate files attached for each table and/or figure.

We welcome photos of babies and families. All photos need to be sent in a separate file with a resolution of at least 72 pixels/inch.

All photos need to include a permission statement from the author for WAIMH to publish the photo in Perspectives and also on WAIMH online social media platforms.

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WHAT IS WAIMH?

The World Association for Infant Mental Health (WAIMH) is a non-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.

Why become a WAIMH member?

- To promote principles of infant and child health, development and mental health.
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- To have access to resources that promote infant mental health.
- To learn from world experts about the health, mental health and optimal development of infants, toddlers and their families across cultures and around the world.
- To expand your professional, social network.
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Affiliate Council Representative: Azhar Abu Ali

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- Make it possible to build capacity for promoting the well-being of infants and their families.

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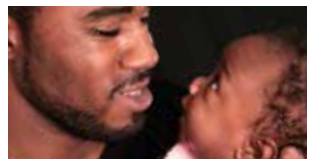

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