A Model for the Introduction of Infant Mental Health Services to Community Mental Health Agencies

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Abstract. This paper describes a unique model of clinical training undertaken jointly by the Child Development Project at the University of Michigan, 12 community mental health agencies, and the Michigan Department of Mental Health. The objective was to train clinicians as infant mental health specialists as a way of introducing infant mental health services to the community mental health network. This paper describes the program and illustrates the pathway from trainee to specialist and consultant. The impact of the program is briefly evaluated.

The concept of infant mental health as a clinical treatment modality is relatively new. Few mental health agencies offer clinical services to infants under 3 years of age. This is so despite the fact that recent scientific, epidemiologic, and clinical evidence have underscored the importance of the infant years, especially the early affective experience between parent and child, for later affective and cognitive development.

The Child Development Project (CDP) at the University of Michigan has been engaged for some time in a clinical research program in the field of infant mental health, offering diagnostic and treatment services to children under 3 and their families (Frai-

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berg et al., 1975; Shapiro et al., 1976; Adelson and Fraiberg, 1977). Through its work CDP has become acutely aware of the urgent need for expanding infant mental health services. In 1973 these concerns were brought to the attention of the Michigan Department of Mental Health (MDMH) which had a general interest in the development of new preventive programs. The desirability of providing infant mental health services was agreed upon. The problem then became to translate this desire into an effective clinical program within the rather stringent resource constraints mandated by the State.

The evident widespread and immediate need for these services suggested locating them within Michigan's existing network of community mental health programs. A corps of infant mental health specialists, recruited from existing clinical staffs, was needed to design and service programs. Further, the diagnostic and therapeutic skills implicit in infant mental health programming indicated the need to involve a wide range of professionals such as pediatricians, psychiatrists, psychologists, social workers, and nurses. Clinical training was seen to be central for the eventual development of new programs. However, agency administrators, whose support was essential for future development of infant mental health services, would also have to be involved. In all, a two-year program was thus developed to train infant mental health specialists from 12 agencies, with the ultimate goal of establishing new services.

The Training Program

The first aspect of the training model was the cooperative agreements established between MDMH, the 12 community agencies, and the CDP. The State gave the CDP a grant which enabled them to undertake the training program. Each year 6 agencies participated in the full program. Each agency was asked to assume the costs of transportation, release time, and additional clerical help needed for the trainees. In addition, they promised a program for the development of infant mental health services as a condition to their participation.

The 12 agencies that participated were widely scattered within a 300-mile radius of Ann Arbor. They were located in rural, sparsely settled areas with minimal services, and in urban areas densely populated and served by a full range of medical and social institutions. Some were children's agencies and others were general agencies. The seminar members were equally diverse, ranging in age

from the late 20s to the late 50s. A few were long-term clinicians and supervisors, the others were at the staff level with varying amounts of experience. Their backgrounds were in nursing, social work, psychology, and counseling.

In designing the program we took into consideration the diversity of these agencies, the varied background of the trainees, the idiosyncratic community needs, and the overall goal of the program; i.e., the establishment of a range of infant mental health services. The development of "the trainee's" expertise would be at the center of the program, but ties to the agencies and community of origin would be supported. Because home-based support would be critical in the development of future programs, it was decided that the trainees would remain in their agencies but come to the CDP for a year of biweekly seminars and individual case supervision. Further, workshops were planned to which the trainees would invite agency and community colleagues.

In developing the training goals and designing the training program, the CDP attempted to address the following issues: (1) Could the CDP effectively train a widely diverse group of professionals to become sufficiently expert in new assessment skills so that they could create and organize the resources for adequate infant assessment? (2) Could sufficient clinical training be offered to enable the trainees to provide guidance and supportive therapy to referred families where this approach was sufficient? (3) Would the trainees, at least in some cases, be able to attempt long-term intensive infant-parent psychotherapy with a gravely at-risk infant, or would they be encouraged to develop other approaches for the delivery of services to the infant at risk? (4) Would the training program begin a new process that would establish infant mental health as an important area for community programming?

It was decided that the basis for the new skills would be an intensive education in infant and early childhood development which would focus on the increasing body of knowledge regarding normal and deviant development, heavily emphasizing the importance of bonding and human attachment. Most of this would be made available through seminars. An important part of the clinical learning would occur through the carrying of cases referred to the participants by their own agencies and supervised biweekly at CDP. In this way, contact with original communities and their resources would be strengthened, and individual training needs could also be responded to.

The workshops were used to introduce broad issues in infant

mental health to agency staff and community colleagues and to build a background of support and understanding for the trainees.

Trainee Experiences

A useful way to illustrate the nature and effectiveness of the training model is to consider in some detail the way two trainees used their experiences to expand their clinical work and then to move from direct casework in their own agencies to the role of agency and community infant mental health consultant. These examples were chosen because the work of these trainees is representative of the path that most of the trainees followed in moving to the role of infant mental health specialist.

The first example is that of a clinician at North Central Michigan Mental Health Center, a 4-county rural agency. As a result of his training at CDP, the trainee slowly began to develop a caseload: a baby beaten by his 16-year-old mother, an infant who had been vomiting since birth, a baby with leukemia, etc. He soon recognized that one mental health staff person on his own could not make much of an impact on the high-risk infant-family problems in his area. He realized, too, that there were some very competent and dedicated people in his community already dealing with infants. However, some of the systems developed to serve babies did not always improve the baby's chances for sound emotional growth. He thus decided to organize a multidiscipline team to discuss infant mental health needs. Accordingly, he visited 18 people in public health, social services, the probate courts, the cooperative extension service, and the hospital. They agreed to participate in a working group. The Infant Development Team began by reviewing what the trainee had learned about the identification of high-risk babies and modes of intervention, and how this might be used by these agencies. After working through the need for administrative sanction, the group coalesced into 12 to 15 members meeting regularly for half a day a month for mutual learning and program discussion. That monthly meeting was augmented by a case-coordinating committee which met weekly to review cases.

The trainee also provided consultation to public health nurses, the probate court, and others who were carrying the bulk of the infant caseload. It soon became apparent that this trainee's consultation was very helpful to these community practitioners as they tried to engage mothers who had previously been considered "hard to reach." With new understanding regarding bonding and human

attachment, and the meaning of separation and loss for the mothers and fathers as well as the babies, a more constructive therapeutic context was developed. The practitioners' abilities to engage families as well as the parents' responsiveness to the guidance and care being offered were enhanced.

Another trainee, a skilled nurse, used her training to become head of children's services at Marquette Community Mental Health Center. Infants in families she had been seeing now became more differentiated and visible to her. In this context, she became concerned about Karen, a 5-month-old twin baby girl. Her healthy twin, Sandra, was developing normally in all areas. This was not the case for Karen, who spent most of her days lying neglected in bed. The reciprocity that existed between mother and Sandra did not occur between mother and Karen, and the expected responsiveness of smile, recognition, and gaze were absent between them. Further, the Bayley criteria showed that she was behind both cognitively and motorically. It became clear that the mother avoided this baby.

The trainee undertook the case for assessment under supervision at CDP. The assessment raised the following questions: What was the basis for Karen's poor development and what accounted for the neglect of this baby by her mother? The carefully supervised assessment revealed that there were complex diagnostic issues. Although both babies were premature, only Karen experienced poor health, which led to prolonged and repeated hospitalizations. There was now evidence of a severe impairment in the bonding process between Karen and her mother. Further, a psychiatric assessment revealed that the mother was clinically severely depressed.

The assessment was not an easy one. Nor was the outcome a comfortable reunion of infant and mother. As a result of the crisis situation and the unavailability of intensive therapeutic care for the mother, the baby was temporarily placed in a foster home. The trainee and her colleagues now realized that there had been critical points along the way where appropriate intervention could have promoted bonding between Karen and her mother. Karen's mother had needed early guidance about the developmental problems of premature babies. She had distanced herself from her baby whom, she feared, she might lose. She needed supportive therapy to respond to her own feelings of anticipated loss, and the difficulty in ministering to a baby at home who seemed indifferent and unresponsive after repeated separations.

In this case, the trainee, in the process of reaching a resolution,

shared her new knowledge about infants and mothers with the nurses and physicians in the hospital and the public health program. This led to the development of a multidiscipline, ongoing case review and discussion group. The work of this group led to the modification of practices in the newborn nursery of the pediatric unit, making possible preventive intervention in future cases. As a result of this case, the trainee also became involved in consultation to protective services and child welfare workers. In her community there are now strong linkages between the public health program, the hospital, the child welfare agency, and the community mental health clinic. These linkages are also developing in the other communities where services are being offered by other trainees.

Impact of the Training Program

In evaluating the program, we would like to assess the trainees as infant mental health specialists and the extent of program development at agency and state levels. The competency of the trainees as clinicians was assessed by supervisors and the director of the program at CDP, and was based on case presentations and video case material. Close collaboration between MDMH and CDP also enabled an assessment to be made of the effectiveness of the trainee within his agency and community. Periodic sessions including agencies, the MDMH, and CDP allowed for a review of the training itself and developing agency programs.

All the trainees became sufficiently expert in assessment skills so that they could adequately undertake or organize infant assessments, and all were capable of providing supportive therapy and guidance. Only the most experienced clinicians could and did undertake infant-parent psychotherapy with gravely at-risk infants. The training program could only supplement the depth of clinical skills which the clinicians brought with them. However, as in the two examples, the clinicians are using their new assessment skills to obtain the best care possible given their communities' and agencies' capacities and the families' needs. There still is extensive need for trained clinicians capable of treating the most seriously at-risk cases.

There have been significant changes in the roles of the 12 trainees. Ten are functioning as infant mental health specialists within their original agencies. One is developing a program in Pennsylvania, and one is working in a pediatrician's office.

In the 10 Michigan agencies, services are now extended to in-

fants whose problems previously would have been overlooked or misdiagnosed. Six of these agencies have established infant mental health as a new priority and have reallocated staff to this now separate, identifiable service.

Recently the Michigan Department of Mental Health allocated project grants to 6 mental health agencies to implement infant programming. These programs will be developed in terms of the following issues: risk identification in hospitals, benefit of public health-mental health collaboration, intervention as part of the health service delivery, and preventive intervention for teen-age mothers. The funding of these programs illustrates the fact that infant mental health has become a new priority.

As was shown in the case examples, the introduction of infant mental health services highlighted the need for cooperation between mental health and other agencies serving children. Most of the trainees have become consultants to these agencies and have offered case consultations, seminars, and workshops. Thus a working relationship between mental health, public health, and child welfare agencies has begun to develop. This has been a long-desired but difficult-to-reach objective.

In response to increasing interest and community needs, the trainees have organized as a group, and recently formed the Michigan Association of Infant Mental Health. Now that the CDP's role has ended, this group meets four times a year to continue their own training and to consider policy issues. Recently a two-day conference organized by this group at the University of Michigan attracted 800 participants.

Summary

This model of efficiently introducing a new field of service into the community mental health system has proved to be effective. The flexibility of design was responsive to individual needs of the trainees and those of the agencies. The close collaboration between agency, MDMH, and CDP enhanced the entire program. The training of specialists in two small groups was helpful in that the trainees offered each other colleagial support, enabling each to carry the burden of new knowledge and responsibilities. The most successful trainees were those who developed relationships of trust and professional acceptance within both their agencies and communities. As a result of the program there are significant changes in agency and community practice, and new priorities in state pro-

gramming. The initial step has been taken toward a comprehensive infant mental health program.

References

ADELSON, E. & FRAIBERG, S. (1977), An abandoned mother. *Bull. Menninger Clin.*, 41:162–180.

FRAIBERG, S., ADELSON, E., & SHAPIRO, V. (1975), Ghosts in the nursery. *This Journal*, 14:387–421.

SHAPIRO, V., FRAIBERG, S., & ADELSON, E. (1976), Infant-parent psychotherapy on behalf of a child in a critical nutritional state. *The Psychoanalytic Study of the Child*, 31:461–491.