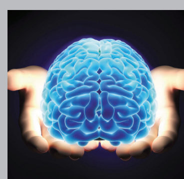
infant**mental**health

Learning Network
North Cork

Infant Mental Health Network Groups

Evaluation of an interdisciplinary model for integrating Infant Mental Health principles into everyday clinical practice and service in the community



RESEARCH STEERING GROUP:	AGENCY:
Dr. Jennifer Hayes Catherine Maguire	HSE Cork North Child and Family Psychology Service
Mairead Carolan	Senior Clinical Psychologist with Adult Mental Health Services
Ronnie Dorney Hilary Fitzgerald Brendan Scahill Stephen Kelly	HSE Cork North Community Work Department and Tusla Child and Family Agency Community Work Departments

Acknowledgements

The Infant Mental Health Research steering group would like to acknowledge that Infant Mental Health practice in North Cork was led in 2000 by the pioneering work of Catherine Maguire and Rochelle Matacz, Senior Clinical Psychologists and Infant Mental Health Specialists, HSE Cork North Child and Family Psychology Services with support from Yvonne Finn Orde, General Manager HSE and Brid O'Sullivan, HSE Principal Community Work Department.

The research steering group also extends its thanks to Dr. Deborah Weatherston, Executive Director, Michigan Association for Infant Mental Health for her editorial work in the research and the consultation supervision and mentoring of IMH North Cork since its inception. Others we wish to Thank are research assistants, Emma Hennessy,Geraldine Hannon and Hannah O Connor who assisted us at various stages of this Project' The IMH Network members of Mallow and Fermoy must be commended for their participation and ongoing commitment to the well being of babies, toddlers and their families in North Cork. Finally, this research was funded by the HSE Cork North Community Work Department.

Infant Mental Health Network Groups

Evaluation of an interdisciplinary model for integrating Infant Mental Health principles into everyday clinical practice and service in the community

Executive Summary

Infant Mental Health (IMH) is an interdisciplinary field and embraces the importance of promoting positive mental health development within a relational framework with the child's caregiver(s). IMH practice is best understood along a continuum which includes promotion, prevention, intervention and treatment integrated across services and disciplines. IMH principles incorporate developmental, clinical and preventative perspectives that inform the practice of service providers of different disciplines whose original training may have emphasised a different knowledge base and different skills. Some lack knowledge about infant development and behaviour in the early years, but have a strong clinical understanding. Others are well prepared to meet the developmental needs of very young children but may be new to infant mental health principles and practices. For most, working within a relational framework is new and requires specialised education and training relevant to each individual discipline but, more importantly, also on how best to integrate IMH principles across disciplines and services. The work in this document discusses the implementation of this training and an analysis of its benefits in the HSE North Cork Child & Family Psychology Service (NC-CFPS) and Community Work Department (CWD).

Since the development of the NC-CFPS in 2000, the service has recorded increasing numbers of infants and toddlers presenting with difficulties including attachment and separation anxiety, behaviour and emotional regulation difficulties, and parent-child interaction or relationship problems. A gap in service delivery was identified, along with the absence of a model for appropriate service delivery, for infants, toddlers and their families. With guidance from the leadership at the Michigan Association for Infant Mental Health (MI-AIMH), clinical psychologists from the NC-CFPS developed and integrated a framework model for early assessment and intervention services into existing service delivery. This framework model also incorporated IMH principles into service provision for infants and toddlers under 3 years of age and their parents in the North Cork catchment area. It soon became clear that there were many more infants and families in need of service than the North Cork CFPS could respond to within existing resources.

Across services in North Cork, there was a recognised need to build a workforce with the knowledge and skills to respond to infants, toddlers and families. Based on best practice guidelines, professional consultation and empirical evidence, the clinical psychologists from the NC-CFPS organised cross-systems IMH training for early years professionals from multiple disciplines representing primary, secondary and tertiary services across the service sector. In 2009, NC-CFPS team members met with the HSE Cork North CWD (CWD) to explore how Infant Mental Health training networks could be further developed throughout the North Cork community.

NC-CFPS sought to integrate this knowledge into all systems and organisations that offer early childhood services within a community setting, particularly to those who are vulnerable or marginalised. One of the key functions of the CWDs within the HSE structure is to support the building of strong, resilient communities where good health and wellbeing for all is central. (Community Development Strategy, 2012). Through this commitment to a multidisciplinary working model the CWD seeks to narrow the gap in health inequalities and improve the health and wellbeing of the population within a community. This means working to address the determinants of ill health and reducing risk factors, including those associated with poverty and social exclusion, and this can only be achieved in partnership with the community. (Community Development Strategy, 2012). Community Development begins from the principle that within any community there is a wealth of knowledge and experience which, if used in creative ways, can be channelled into collective action to achieve the communities' desired goals. (Alinsky, 1967). Consequently, a partnership between the two departments was an ideal vehicle to advance this vision to promote mental health for all across the life span.

The central impetus for the CWD involvement in the Infant Mental Health partnership was the community-oriented health approach of the Department in involving people who experience poverty and social exclusion in contributing to anti-poverty and health-promotion policies and practice. Combat Poverty (2000) has defined community development as "a process whereby those who are marginalised and excluded are enabled to gain in self- confidence, to join with others and to participate in actions to change their situation and tackle the problems that face their community." (*Combat Poverty Agency, 2000*)

Another strong impetus for the CWD involvement in the Infant Mental Health partnership was a recognition of the emotional and social health gains that could be achieved within a community through the application of IMH principles. A further aim of the CWD involvement in the partnership with the NC-CFPS team was to enhance Infant Mental Health knowledge and skills at the front line delivery level working with children in the 0-3 age category within the North Cork community. The CWD is often the first point of contact for the many diverse voluntary and community organisations and the staff team aimed to develop spaces within and between voluntary groups where the tenets of Infant Mental Health could be discussed, delivered and implemented.

A sample of types of community groups identified for participation within the Infant Mental Health networks by the Community Work team included:

- Parent and Toddler groups
- Community Childcare Projects
- Family Resource Centres
- Development work with ethnic minority groupings
- Domestic Violence family support projects.

As a result of this collaboration, an IMH training model was rolled out across the North Cork Community and Infant Mental Health Network Groups (IMH NGs) were established as a mechanism to disseminate and consolidate this knowledge within the community. The IMH NGs were conceived as a network of professionals involved in providing services and support to caregivers, families and children age 0-3. They are multidisciplinary, educational, and supportive, and primarily use a model of reflective practice. The IMH NGs allow their members to share experiences, transfer knowledge and to develop a cross-disciplinary perspective on IMH theory and practice and their integration into service delivery across the community. The North Cork IMH NGs are believed to be the first of their kind internationally and it is was therefore important to assess their impact and effectiveness as a model which could be extended, first on a national basis and then internationally.

The present report presents the results of a study which examined what members of three IMH NGs reported were the benefits and the challenges of participating in a continuous learning group. It was hypothesised that participants who took part in an IMH NG would successfully integrate new IMH knowledge and skills into their everyday practice with infants, toddlers and families and share their learning with colleagues in the North Cork community. In the study, data was first collected from a two-hour Focus Group in which 10 IMH NG members answered semi-structured and open-ended questions about their experiences in an IMH NG. The evaluators then developed and administered a demographic questionnaire as well as an IMH NG questionnaire with 158 items specific to the benefits and challenges of participation in the group experience. Thirty-one (31) IMH NG participants completed both the demographic and IMH NG questionnaires.

The overall results were very positive and confirmed the initial hypothesis. Overall, the IMH NGs were viewed as effective with the great majority of members expressing satisfaction with their participation and their resulting changes in practice

Analysis of the written transcript of the 2-hour Focus Group resulted in the identification of six major themes of importance:

- Knowledge,
- Skill;
- Service Policy and Delivery;
- Outcomes for Clients and Staff;
- Factors that Strengthen IMH-NGs
- Factors that Challenge Effectiveness.

Overall, the participants identified significant improvements across the first four themes as a result of participation in an IMH NG. Areas were also identified from the final two themes which could contribute to even further increasing the effectiveness of the IMH NGs.

- In “Knowledge”, improvements were recognised across seven subthemes: ‘Improved Understanding of Reflective Practice’, ‘Attachment’, ‘Symptomatology’, Child Development (social, emotional and cognitive)’, ‘IMH Terminology / Language’ and ‘Parent/Child Relationships.’

- In “Skill” IMH NG respondents reported that they have “significantly improved clinical skills in (our) work” and the majority of participants were in agreement that attendance in the IMH NG resulted in improved clinical skills in the areas of assessment, delivering psycho-education, intervention skills or work practices, case consultation, using reflective practice with families and report writing. In the area of assessment, participants reported significantly improved observation and listening skills.

- In “Service Policy and Delivery”, results highlighted that IMH NG members had changed the way they worked in terms of service policies used or model delivery as a result of their participation in an NG. For example, it was noted that members now engaged in additional home visits to families in comparison to their previous work. In addition, members found themselves considering more carefully the emotional needs of infants and young children and creating new ways of working as a result.

- In “Outcomes for Clients and Staff”, subthemes that emerged were ‘Parents, Infants and Toddlers,’ this theme indicated an improved understanding of the importance of the parent child relationship in promoting infant and toddler social and emotional health. On the theme of ‘Adults and Teenagers,’ this reflected an increased understanding of the impact of early childhood stage of development on development across the life span. Community Members not directly involved in an IMH NG’ and ‘Personal Gains for IMH NG Members’ with strongly positive benefits and gains in each subtheme.

- In ‘Factors that Strengthen IMH-NGs’, the five sub-themes were ‘Effective Teaching / Learning Strategies’, ‘Multidisciplinary Input’, ‘Reviews of Group Progress’, ‘Support from Higher Management’, and ‘Group Ethos of Respect and Participation’. These are factors which we recommend should underpin all IMH NGs.

- In ‘Factors that Challenge Effectiveness’, the present study also identified the challenges associated with participation in an IMH NG including resources, difficulty disseminating knowledge and sustainability and with implementing an integrated IMH programme across disciplines and services.

The results of the study provide valuable insights into the benefits as well as the challenges of participating in a continuous learning group. These results may be used to improve the organization and coordination of IMH Network Groups in the future. They will help to ensure that they are successful in their aim of educating interdisciplinary groups of professionals, voluntary groups and, in turn, the public, regarding Infant Mental Health principles and practices and integrating them into service across the community - making infant and toddler mental health everybody's business.

Section 1 Literature Review

> *"During the first 18 months of life a child constructs a lasting internal vision of what human relationships are, how they work, what to expect from them, and what to offer in return. What gets set in early life is one's deepest beliefs about human relationships. These determine how a person goes about learning, profiting from experience, using help, and parenting one's own children."*
>
> W. Schafer, 1991

Introduction

Most simply stated Infant Mental Health refers to the optimal development of infants and very young children within the context of secure and stable relationships with caregiving persons, most often their biological parents, but also adoptive or foster parents or grandparents who have primary caregiving roles. How an infant or toddler is taken care of, as well as the stressful experiences affecting an infant's or parent's life, "sets either a strong or fragile stage for what follows" (Shonkoff & Phillips, 2000, p. 5). When infants experience neglectful or abusive care at the hands of their parents, development may be seriously compromised and treatment services may be necessary (Davies, 2011). However, John Bowlby reminds us of the hopefulness for change when he said,

> "The course of subsequent development is not fixed, and changes in the way a child is treated can shift his pathway in either a more favourable or less favourable one….It is this persisting potential for change that gives opportunity for effective therapy. "(Bowlby, 1988, p 139)"

It is in this spirit that Infant Mental Health becomes profoundly important.

Research has consistently demonstrated the impact of early childhood experiences on mental health across all of the lifespan: early experiences matter. Consequently, what happens during the infant stage of development lays the foundation for psychological social and emotional functioning (Mares, Newman & Warren, 2011), health and wellbeing across the life span. This period provides a window of unparalleled opportunity to take a life span approach to ensuring that the mental health and wellbeing needs of infants, toddlers within the context of their caregiving relationship are provided with the best possible opportunity to prosper.

Investing in early intervention initiatives that promote infant and toddler social and emotional health also makes economic sense and will offer significant returns to the Irish economy through reductions in spending on mental health in later years. Rates of return to investment in human

capital is highest in the Preschool period with the most effective period for intervention being in the pre -birth to preschool period. (Carniero & Heckman,2003)

It is in this spirit that Infant Mental Health becomes profoundly important to the service community in North Cork.

What is Infant Mental Health?

The National Center for Infants, Toddlers and Families in Washington, D. C. has defined Infant Mental Health as:

> The developing capacity from birth to 3 to experience, regulate, and express emotions; to form close relationships; and to explore the environment and learn, all in the context of family, community, and cultural expectations for young children (ZERO TO THREE, 2001).

Infant Mental Health represents a shift in focus from attention to the mental health of adults or children to the social and emotional wellbeing of infants, toddlers and their families or those who share responsibility for their care and nurturing. “Infant” refers to children under three years of age. “Mental” includes social, emotional and cognitive wellbeing. “Health” implies wellness (Fraiberg, 1980).

As a field of practice, Infant Mental Health embraces new understandings about early development and assures that every infant and every parent will benefit from scientific studies related to the importance of early experiences and mental health outcomes across the life span (Felitti,et.al,1998). Research regarding early brain development provides further confirmation of the importance of this relatively new field, as does the literature regarding early care and education, early identification of risk or disorder in infancy and early childhood, the consequences of abuse and neglect in infancy, and intervention or treatment options to reduce the risk of significant emotional impairment (Perry, 2009). Of necessity, Infant Mental Health is an interdisciplinary field and embraces the importance of promoting positive development within a relational context, understanding how to best support it across service systems and disciplines.

Infant Mental Health principles incorporate developmental and clinical perspectives that inform the practice of service providers whose original training may have emphasised a different knowledge base and different skills, e.g. those who work in community child care, early intervention, public health, mental health, paediatric units, hospital nurseries or family resource centres, to name a few. Some lack knowledge about infant development and behavior in the early years, but have a strong clinical understanding; others are well prepared to meet the developmental needs of very young children, but may be new to mental health principles and practices. For most, working within a relational framework is new and requires specialised training and supervised experiences (Weatherston, Tableman & Foulds, 2014)

A core belief is that all infants and young children benefit from a sustained primary relationship that is nurturing, supportive, and protective. Basic Infant Mental Health principles that flow from this core belief are:

- Optimal growth and development occur within nurturing relationships;
- The birth of an infant offers a family the hopefulness of new relationships and possibilities for parental growth and change;
- A secure and stable attachment relationship between parent and infant or toddler is optimal for healthy development across the life span;
- Early development occurs sequentially from one stage to the next; behavioral markers lay the foundation for social and emotional competence; unsuccessful accomplishment of one stage may predict unsuccessful accomplishment of the next steps;
- Early developing attachment relationships may be disturbed or interrupted by parental histories of unresolved trauma or loss;
- The supportive presence of a practitioner informed by Infant Mental Health principles offers guidance and support to reduce the risk of developmental or relationship failure and offers hope for positive, nurturing parental response;
- Personal beliefs and values affect infant mental health practice; opportunities for self-reflection through training and supervision support practitioners' to appropriately respond to families' service needs.

Infant mental health principles should guide the practice of all those who serve families with infants or toddlers and seek to nurture healthy relationships and positive social-emotional development (Hinshaw-Fuselier, Zeanah, &Larrieu, 2009; Stinson, Tableman, & Weatherston, 2000 ; Weatherston, Tableman & Foulds, 2014).

As an interdisciplinary practice, Infant Mental Health is characterized by the following skills and strategies:

- Work with the infant or toddler and parent together, in an office, community setting or the family's own home;
- Offer your relationship to the family as the instrument for change;
- Observe the infant or toddler and parent together, offering opportunities for the parent to reflect on the infant's development, behavior and social or emotional needs;
- Create opportunities for warm and playful interaction between parent and infant to encourage the development of a secure and stable relationship;
- Invite the parent to talk about the infant or current parenting experiences and listen to the parent;

- Allow parent to talk about difficulties, past or present, that affect the parent's care of the infant; listen carefully and respond to the emotions expressed;
- Remain curious and open to what the infant and parent show and tell you;
- Use reflective supervision or consultation to support you in offering best practice service to the family (Weatherston, 2010).

Such practice requires a safe and trusting helping relationship in which parents and professionals are able to think carefully, in the presence of the infant or toddler. Given the complexity of service needs, Infant Mental Health practice is best understood along a continuum including promotion, prevention, intervention and treatment. Very briefly, the components of the continuum are described below (Weatherston, 2012):

- Promotion: Support parents who anticipate the birth of a baby or are caring for very young children with practical information and opportunities to meet other families through breastfeeding education groups, community parent-child play groups, nurturing programs, family resource centres, and the like;
- Prevention: Screen or assess where there are concerns about the pregnancy or during the first years of life and offer concrete resource assistance, developmental guidance and emotional support where there is an identified developmental, relational or caregiving risk;
- Intervention: Assess carefully the infant or toddler and parent, if indicated, with the follow up offer of developmental, educational, relational, and/or psychotherapeutic services as determined by early identification of risk or disturbance or disorder. The intervention approach is strengths-based but addresses the vulnerabilities within a trusting relationship, inviting thoughtful guidance to the parent and opportunities to reflect about the infant or toddler and caregiving demands. Past and present stressors, losses or traumas may be shared within a safe and emotionally containing therapeutic relationship;
- Treatment: If the disorder(s) is clearly identified in infancy or toddlerhood or if the parent is not able to attend to the needs of the infant or toddler because of a mental health diagnosis or recent trauma or loss, a more intensive treatment may be required. The young child or parent may require hospitalisation or a psychiatric evaluation. The infant mental health practitioner may continue to work with the family, working closely with other professionals, maintaining a focus on the relationship, offering emotional support, developmental guidance, and infant-parent psychotherapy, as needed, to treat the immediate and complex mental health needs of the child and family.

Reflective Supervision

What supports this service continuum? Believed by many to be the cornerstone for promotion, prevention, intervention, and treatment services, reflective supervision invites the management and co-regulation of personal responses in the face of complex professional challenges when working with infants, toddlers and families (Eggbeer, Mann, & Seibel, 2007; O'Rourke, 2011; Eggbeer, Shahmoon-Shanok, & Clark, 2010). The depth and intensity of such supervision, as well as an individual's capacity to be reflective, will vary. Most optimally, the supervisor sets the tone, explains the expectations, and creates a safe place for conversation. She or he invites the supervisee(s) to explore what was seen or heard or experienced with an infant and family. The supervisee(s) may share the details of the work in individual supervision or in a group format, describing the infant or toddler, discussing the nature of the interactions as observed, and offering what she or he felt or experienced while with the family, adding worries or concerns. As trust in one another grows, supervisor and supervisee(s) become engaged in the emotional journey of infant mental health, learning to be more fully present and available to families, reflective, and self-aware (Schafer, 2007). In sum, reflective supervision is an essential component of all services to infants, toddlers and families and must be considered as integral to workforce development (Weatherston, Weigand & Weigand, 2010).

Section 2 Infant Mental Health Model of Training and Service Development

Introduction

The extensive literature which encompasses theories of attachment and evidence-based research have consistently cited improved outcomes for child development when early intervention services are directed towards infant-parent relationships (Weatherston, Kaplan-Estrin & Goldberg 2009a; Cohen et al., 1999, 2013; Cicchetti, Rogosch &Toth, 2006; Hoffmann, Marvin, Cooper & Powell, 2006; Zeanah, Stafford & Zeanah, 2005; Lyons-Ruth, Connell, Grunebaum, & Botein, S., 1990) and incorporate a relational focus.

IMH training has long been recognised as a necessary component of developing skills and expertise in remediating mental health problems during infancy and toddlerhood. Over the last thirty years, there has been considerable growth and development in international IMH training programmes. Distance Learning Programmes have been established and offer professionals who cannot access on site training a pathway for training, consultation and supervision.
International IMH experts designed these programs with a central aim to 'integrate theory and research about early relationship growth and health with supervised practical experiences' and to recognise the importance of early relationships in social and emotional development (Weatherston, 2005, p. 326).

Currently, focus is now centred on development of the specific competencies required to provide services for infants, toddlers and their families. In addition, service providers, institutions and employers have also been noted to seek credentials that appropriately acknowledge IMH skill, education and experience and training (Weatherston et al. 2009a). Since 1996, the Michigan Association for IMH (MI-AIMH) has worked extensively to address this challenge and develop a comprehensive set of competency guidelines for IMH practitioners together with an accessible, effective procedure for their professional endorsement (Weatherston et al 2009b; Weatherston, Moss & Harris, 2006).

This pioneering work culminated in 2002 with the publication of the MI-AIMH Competency Guidelines® and the MI-AIMH Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health® (Michigan Association for Infant Mental Health, 2002). Today, both sets of competency and endorsement guidelines are used by many international IMH affiliates, centres, and organisations to support the development of relationship based services for infants, toddlers and their families. They are also used to promote and support the skill, knowledge and reflective practice that are at the core of infant mental service provision (Weatherston et al 2006; Meyers 2007).

However, in Ireland, many clinicians have struggled with the gaps that exist in bridging the evidence base and incorporating the relevant findings into services that will ultimately benefit

infants, toddlers and families. Furthermore, early service providers who want to build their skills and improve their competencies in infant and toddler mental health are often stretched in their capacity to do so or to even know where to begin. Furthermore, there is a shortfall of designated training programs available to meet the needs of those professionals working with infants, toddlers and their caregivers within the Irish health services (Maguire & Matacz , 2006; Matacz and Maguire, 2007). Similar to other international settings, many undergraduate and postgraduate programs do not include principles and practice of IMH assessment and intervention as part of their curriculum, (Wajda –Johnston, Smyke A.T., Nagle & Larrieu 2005, Weatherston 2005).

Children's services that promote IMH principles are important investments for creating the groundwork for healthy brain development and positive life outcomes. Current Irish legislation and strategy documents (Vision for Change, 2006; The Agenda for Children's Services, 2007) underpinning service delivery all advocate for an early intervention and prevention approach. Within current health service provision, children presenting with social and emotional difficulties aged 3 years and older have, too often, experienced clinical symptoms that developed at an earlier age but went undetected. Consequently, later intervention, though still effective, as repair is always possible, are more costly to the health budgets and human resources.

Increased focus is therefore required on the effectiveness of prevention, early intervention efforts and the prompt, timely detection of infants and toddlers displaying initial clinical symptoms of social and emotional distress. Unfortunately, the early childhood psychological services have remained underdeveloped, reflecting shortcomings in current policy and professionals who are well trained to respond to the social and emotional needs children under 3 and their families (Maguire, 2011, 2012).

It was from this perspective in 2004 that North Cork Child and Family Psychology Service sought to address deficits in the professional competencies and resources required to deliver services to infants and toddlers presenting with social and emotional health problems.

The North Cork Perspective – Background

Since its inception in 2000, the North Cork Child, Adolescent and Family Psychology Service has observed increased referrals of toddlers presenting with social, emotional and behavioural difficulties, which included attachment and separation anxiety, sleeping and feeding difficulties, emotional regulation difficulties, and parent-child interaction problems (Matacz & Maguire, 2008; Maguire & Matacz, 2012). A significant gap in service delivery to this population group was identified along with the absence of a framework to develop service provision for the 0-3 year age group. To address this, during 2003, clinical psychologists sought an understanding of the skill base and clinical expertise required to address the mental health needs of infants, toddlers and their caregivers.

A literature search was conducted, findings revealed an absence within Ireland of available literature, journals and textbooks pertaining to IMH. There was also a dearth of clinical expertise and no opportunity in Ireland to access further training in IMH at a postgraduate level. The Clinical Psychologists were therefore determined to bridge the gap in the skill base and service development framework for the 0-3 year period in a service that also has a legislative responsibility for a 0-18 population. The Clinical Psychologists brought these gaps in service delivery to the attention of local management, who supported their initiatives.

In response to the absence of training, expertise and knowledge, links were established with international organizations and professionals that guide professional development in IMH. Subsequently, an international supervisory relationship with an IMH Consultant from the Michigan Association for Infant Mental Health (MI-AIMH) was established. Through this supervisory relationship, the clinical psychologists within North Cork Child and Family Psychology were introduced to the MI-AIMH Framework for Endorsement. This provided a pathway for a professional qualification in IMH which could be achieved by distance learning. The MI-AIMH Endorsement® is competency-based and affords 'individuals in the infant and family field, a professional development plan that focuses on knowledge, best practice skills and supervised work experience that lead to increased confidence and credibility within the infant and family field' (Michigan Association for Infant Mental Health, 2002). The core competencies and framework for professional development in the Endorsement® offered a feasible and cost-effective means of developing the specialised skills required to provide a service provision for infants and toddlers presenting with mental health concerns and their families.

Over the next three years, the clinical psychologists worked towards attaining 'Level 3 IMH Specialist' and were awarded this qualification in June 2006. Level 3 requires candidates to meet clearly-defined areas of expertise, responsibilities and behaviours that demonstrate competencies at this level. Reflective supervision is a core component of Level 3. Furthermore, the supervisory relationship was essential in providing support, guidance and structure in working towards endorsement. This relationship was particularly important given the challenges of completing a professional training program through distance learning.

Reflective Supervision was bi-monthly and was conducted via telephone consultation for the duration of ninety minutes. Telephone supervision has been recognised as a method of distance supervision and it is recommended that supervisor and supervisee strive to meet in person on a quarterly basis (Wadja-Johnson et al., 2005). Phone consultation was easily accessible to both supervisor and supervisees and the supervisory relationship was consolidated over time through a series of face-to-face meetings. This supervisory relationship has continued and remains a core component of the clinical practice and the development of formalised training.

Development of an IMH Interdisciplinary Training Model within North Cork

Following successful completion of the MI-AIMH Endorsement, and in partnership with the MI-AIMH, the clinical psychologists in North Cork commenced the development of a national framework for the delivery of IMH training. The first stage was piloted within the local catchment area and was established in a way that would facilitate its replication in other catchment areas. The development of this training model was timely as it addressed the training and development needs of professionals working within child and family services. It was also developed at a time where major transformations within healthcare services were taking place.

'Health Strategy Quality and Fairness: A Health System for You' was launched in 2001 and was considered a defining document on health policy in Ireland. Outlined in the Health Strategy was the recognition 'that there was a need to update mental health policy and a commitment was made to prepare a national policy framework for the further modernisation of mental health services' (Vision for Change, 2006, p. 7). Coinciding with this document was the launch of the Primary Care Strategy (2001). 'Primary Care is an approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services' (Primary Care, 2001, p. 15).

The model of Primary Care includes an interdisciplinary, team-based approach where, prior to this, service provision was provided by unidisciplinary teams, particularly within the community services. Encompassing the objectives of "Health Strategy and Primary Care", 'A Vision for Change' (2006) recommended that 'Appropriately trained staff should be available to the primary care level to provide programmes, to prevent mental health problems and promote wellbeing' (Vision for Change, 2006, Recommendation 7.4, p.64). An interdisciplinary model of training has long been recognised as an effective way of intervening with mental health problems in infancy and toddlerhood (Weatherston, 2005). In order to effectively intervene with 'the whole baby', practitioners require a skill base to enable them to work collaboratively towards a complete understanding of the needs of a child and its family (Shahmoon-Shanok et al., 2005, p. 453).

The North Cork model of IMH training was established to address the above recommendations and to complement the interdisciplinary team based approach to service provision. Careful consideration was given to the development of a training model which would meet the professional competencies of the workforce involved who were responsible for service delivery in the zero to three year age populations. Consultation with Dr. Deborah Weatherston, international IMH supervisor and mentor, along with other international experts and colleagues in the field of IMH, coupled with a review of the extensive evidenced based literature, enabled

the clinical psychologists to devise the guiding principles required to develop and deliver an interdisciplinary IMH Training Model. The training model was thus developed in line with Selma Fraiberg's principles of IMH theory, practice and reflective supervision (Fraiberg, 1980).

The key aims and objectives of the IMH Training Model are outlined in Table 2.1:

Table 2.1 The key aims and objectives of the IMH Training Model

1. Increase knowledge and understanding of what contributes to optimal social and emotional development in infancy and toddlerhood and the role of the caregiving relationship.

2. Decrease prevalence and long-term consequences of mental health problems across the lifespan by intervening at the earliest possible point.

3. Develop a framework for transforming IMH knowledge and expertise into effective and innovative actions to improve outcomes for children and their families.

4. Build workforce capacity by developing core competencies among all professionals who work with infants, toddlers and their families.

5. Bridge the knowledge and service gaps by integrating the significant body of theory and research on IMH into a multidisciplinary and interdisciplinary model of clinical and evidence-based practice which would be integrated into primary, secondary and tertiary services.

6. Establish a world-class service provision for children under five years presenting with social, behavioural & emotional difficulties across primary, secondary and tertiary settings in line with best practice and which can be defined, measured and evaluated. (Matacz & Maguire 2008); Maguire & Matacz, (2006).

Health Services National Partnership Forum (HSNPF) Grant Funding

A Health Services National Partnership Forum (HSNPF) Grant application was made by the North Cork Child and Family Psychology Service in 2006. Its approval facilitated an interdisciplinary training event and provided local project funding to develop and integrate IMH principles and practice into the broader North Cork community services. Guided by the MI-AIMH Competency Guidelines® a three-day Master Class was developed and delivered in 2006 by Deborah Weatherston, PhD, Executive Director, MI-AIMH, in conjunction with the two local clinical psychologists who had received endorsement as IMH Specialists.

The Learning Objectives for the Master Class were as follows:

- Gain an understanding of the principles of IMH and their application in clinical practice;
- Understand and become familiar with the theoretical frameworks and evidenced based practice underpinning IMH;
- Develop skills in screening, assessing and intervening with infants, toddlers and their families presenting with mental health problems;
- Integrate skills acquired into clinical practice within the workplace.

Representatives of the disciplines involved in the provision of service delivery to infants, toddlers and their families across primary secondary and tertiary services were invited to participate. The group included 16 professionals from the following disciplines and services: Adult Mental Health, Child and Adolescent Mental Health, Area Medical Officers, Social Workers, Childcare Leaders, Paediatric Physiotherapists, Paediatric Occupational Therapists, Public Health Nurses, Community Workers, Speech and Language Therapists, and Clinical Psychologists within Community Care Services.

The core components of the 3-day Master Class were:

- Review of theoretical underpinnings on IMH;
- Understanding resiliency and risks in pregnancy, infancy and toddlerhood;
- Interaction and relationship - putting parent and baby together;
- The tasks of observation, assessment and relationship building;
- Therapeutic relationship & reflective based practice;
- Attachment, separation, loss & strategies for intervention;
- Developing therapeutic relationships, building alliances;
- Assessment & intervention strategies;
- Communication: Role of Listening: a powerful strategy for assessment and intervention;
- Case studies involving Irish families;
- Reflective practice supervision.

Delivery of the North Cork IMH Training Model took place in 3 stages:

Phase 1: Introduction to IMH

A one-day introductory lecture, facilitated by IMH specialists, provided an introduction to IMH, principles of IMH and infant and toddler social-emotional development. Learning resources included video-based work, group activities and reflective exercises.

Phase 2: IMH Master Class

A three-day Master Class facilitated by an international IMH Consultant and local IMH Specialists. Learning resources included video-based work, case studies, reflective practice exercises and small group work. Post-training evaluation questionnaires were used to assess the

effectiveness of the Master Class Education programme and significant shifts were reported by all disciplines.

Phase 3: Creating Sustainability – Development of IMH Network Groups

Supported by Dr. Deborah Weatherston, International Master Class Facilitator and Supervisor, the concept of the IMH Network (IMH-NG) Group was developed as a medium to facilitate sustainability. An IMH-NG was established after the three-day Master Class in November 2006 and initially comprised the 10 clinicians who completed the Master Class.

IMH Network Group (IMH-NG) Structure:

- Monthly 1.5 hour meetings on the 3rd Thursday of each month, 9.30-11.00, with the exception of July and December to minimize disruption because of holiday periods. Groups are held in Mallow Primary Health Centre;
- Facilitated by the two local IMH Specialists under the supervision of their International IMH Consultant Supervisor;
- Provision of a shared language and understanding by which to understand infant toddlers and their relationship with their caregivers;
- Consolidating learning and strengthening of professional skill development and core knowledge and practice in IMH by participating "in environments of continuous learning" (Emde 2009);
- Provision of Reflective Practice space with a relational focus for group process;
- Provision of a theoretical component: evidence-based literature is provided and, where appropriate, supplemented with video/audio presentation. Case material follows which facilitates discussion, reflection, capacity for critical thinking, opportunity to generate hypotheses, case planning and intervention plans; "learn to use yourself as a tool" (Emde 2009).

Using the IMH competencies as standards, this training model created a paradigm shift in how practitioners understood the baby and the importance of early relationships. Transfer of core competencies into clinical practice fuelled interest across disciplines to create sustainability; all were committed to the integration of these clinical skills by developing IMH Networks. (Matacz & Maguire 2008; Maguire, 2014). In a recent in-service evaluation of one North Cork IMH network group, Walsh (2013) reported that the group provided a forum for reflection, skills development and self-exploration. Participants who were more reflective found the group less challenging and were more open to change. Thus, reflective capacity may have implications for group participation and preparation for future changes in the group. Overall, these studies aid understanding of the role of interdisciplinary groups in facilitating reflection and learning.

Interdisciplinary training was a new phenomenon for North Cork clinicians and a shift away from uni-disciplinary domain specific models. Holding of interdisciplinary IMH Network Groups at 9.30-11.00am within the clinician's working day was also a new experience for all clinicians involved and was supported by local Line Managers. It provided pathways for sustainability to

ensure that what was taught would be embedded into clinical practice rather than remain abstract in theory or training manuals (Maguire, 2014).

The overall concept was that, by using evidence-based literature, case studies, reflective practice, and guided by the MI-AIMH Competency Guidelines®, early years practitioners would successfully infuse IMH learning and self-reflective activities into clinical practice across primary, secondary and tertiary services and develop further opportunities to expand their core competencies in this field. The IMH Network Group is modelled after the MI-AIMH framework for professional development in IMH. Similar continuing education models have been in existence internationally in the development of Collaborative Peer Supervision Groups (CPSG). (Thomasgard, Warfield & Williams, 2004).

Limited literature exists on relationship-based qualities of groups used to enhance professional development and to improve communication between health and IMH clinicians. However, evaluation of these groups has acknowledged their role in improving the clinician's ability to assess, treat, or appropriately refer infants and young toddlers with developmental variations, problems and disorders of mental health (Thomasgard, Warfield & Williams, 2004; Thomasgard & Warfield 2005). The monthly IMH-NG meetings, started in 2006, continue today. Examples of topics covered in the IMH-NGs are given in Table 2.2.

Table 2.2 Example topics covered in the IMH-NGs since 2006

- Psychological tasks of pregnancy, antenatal period;
- Social and emotional development;
- Attachment theory and its application in clinical practice;
- Development and consolidation of emotional regulation/self regulation in the preschool years;
- Role and developments of reflective practice skills;
- Reflective functioning;
- Infant-parent relationships; assessment and intervention;
- Therapeutic relationship and reflective practice;
- Observation skills;
- Case presentation skills;
- Trauma in infancy and toddlerhood;
- Impact of abuse and neglect.

Developing a Systematic Approach to Workforce Development: Creating Partnerships

Following the establishment and success of the first IMH-NG, North Cork Child and Family Psychology Service understood that a systematic approach to workforce development in IMH could not be limited to a single discipline or agency. Implementing the IMH training model across North Cork Region required the building of partnerships between psychological services and those responsible for the provision and empowerment of community-based health, particularly in pre-school education, and within the childcare systems at statutory and voluntary service levels.

In 2009, team members of the HSE Child and Family Psychology Service met with the HSE Cork North Community Work Department (CWD) to explore how IMH training networks could be further developed throughout the North Cork community. Following agreement with local management, a partnership was formed to advance a systematic approach to workforce development within this setting which included early years service providers in local community-based family resource centres, crèches, childcare services, and playschool and pre-school group programmes, including psychotherapists from the local domestic violence service centres.

The rationale for CWD involvement in the IMH partnership was based on the following:

1. Significant emotional and social health gains could be achieved within a community setting by facilitating the integration of IMH principles into the service provision of the relevant early service providers.
2. Promotion and dissemination of information about social and emotional wellbeing in the early years and the importance of nurturing relationships to foster health and growth (Matacz and Maguire, 2007).
3. Enhancement of IMH knowledge and skills of the workforce providing an early service provision to the 0-3 age category.

REPLICATION

The ultimate aim of this collaboration was to allow the replication of the initial IMH-NG model across both statutory and non-statutory primary, secondary and tertiary services in North Cork. The CWD were ideally placed within the community and possessed the skills necessary to facilitate this replication.

The Principles and Practice of Replication

The concept of replication, (Krieg & Lewis, 2005) has been used as a “Model” approach to the healthy development of young children. The basic principles underpinning Replication are:

- The adaptation of a successful model program or practice to new locations or new populations;

- The organisation that has developed the model (the 'lead agency') documents the effectiveness of the program through formal evaluation and identifies which elements of the model are essential, flexible or optional;
- Ongoing training is key: the lead agency must train and retain people at the site when the model changes or staff turnover;
- In addition to staying true to the core of the model program, the replication site must secure funding past the start up period and ensure buy-in for the replication from the organisation and the community.
  (Krieg & Lewis, 2005),

The process of "Replication" in models of early years childcare programs is well documented in the literature (Krieg & Lewis, 2005) where it is described as "an art grounded in science and practical experience (McGongiel, 2005). Replication programmes that are successful demonstrate "win-win opportunity" whereby positive results are achieved within the existing organization by not having to re-invent the wheel. In this process, a positive result provides a gradual effect on all of an agency's locations. (Krieg & Lewis, 2005).

At a community level, integrating this existing and effective model of North Cork interdisciplinary IMH training created the rationale for replication (Matacz and Maguire, 2007). Replication of the North Cork IMH-NG was enhanced and guided by The MI-AIMH Competency Guidelines®. The Interdisciplinary IMH Training Model already in place provided the framework for further advancement of workforce capacity and expansion of knowledge, skills and reflective practice capacity within the community and voluntary sector. This collaboration with the CWD resulted in a systematic replication, two further, three-phase, cross-systems training and infant mental network groups were established within the North Cork region.
The interdisciplinary training model used to establish these new groups comprised of:

Phase 1: Introduction to IMH

A *one-day introductory lecture* facilitated by IMH specialists provided an introduction to IMH, principles of IMH, and infant and toddler social-emotional development. Learning resources included video-based work, group activities and reflective exercises.

Phase 2: IMH Master Classes

Three day master classes facilitated by local psychologists with acquired competencies in IMH and in conjunction with locally-based IMH specialists provided a review of IMH, the role of attachment in social-emotional development, principles of IMH assessment, and intervention models. Learning resources included video-based work, case studies, reflective exercises and small group work.

Phase 3: IMH Network Groups

Monthly 90 minute meetings facilitated jointly by IMH specialists and Community Workers provided participants with continued learning and competency development in IMH. Meetings included a theoretical component, clinical case discussions and reflective practice.

Consolidation of Master Class Training: Creating Sustainability

The interdisciplinary training model described above, provided group members with continued learning and education skill development in IMH, along with further opportunities to develop their core competencies in this field, thereby creating sustainability. This model was designed so that it would ultimately provide a structure for professionals to meet criteria toward earning endorsement at the point when the MI-AIMH Endorsement® would become available in Ireland.

Three IMH-NG's now exist across North Cork and have the following roles and functions:

- To consolidate learning objectives, to further the development of interdisciplinary core competencies in IMH and to achieve sustainability of these objectives, an IMH Network Group is developed, where possible after a Master Class training;

- IMH Network Groups meet monthly and use an approach which integrates evidence base practice literature and research into case material. This material is then presented in turn by clinicians from their respective clinical backgrounds. This enables a fluency in the language of early social and emotional development by which to understand and relate to the baby, the parent-child relationship and the breadth and depth of the complexity of early social and emotional development;

- This relationship based capacity development has facilitated considerable shifts in service provision within the North Cork health services health services and created a fresh perspective which now places the relationship, the baby and the parent/caregiver relationship at the heart of service provision for the early years, irrespective of the discipline and service provider. (Maguire, 2012)

- Added to this perspective has been the opportunity to build additional professional competencies in what Emde (Emde, 2009) describes "learning to use yourself as a tool" and to establishing"environments of continuous learning and improvements". Emde's description of such capacity building describes our IMH Networks and their ever-evolving importance in the day-to-day practice of clinicians dealing with a multitude of complexities where, for some disciplines, reflective supervision is not an option and where only a case management model is available,.

However, the impact of the IMH-NGs on developing professional competencies and clinical practice had yet to be formally evaluated by research.

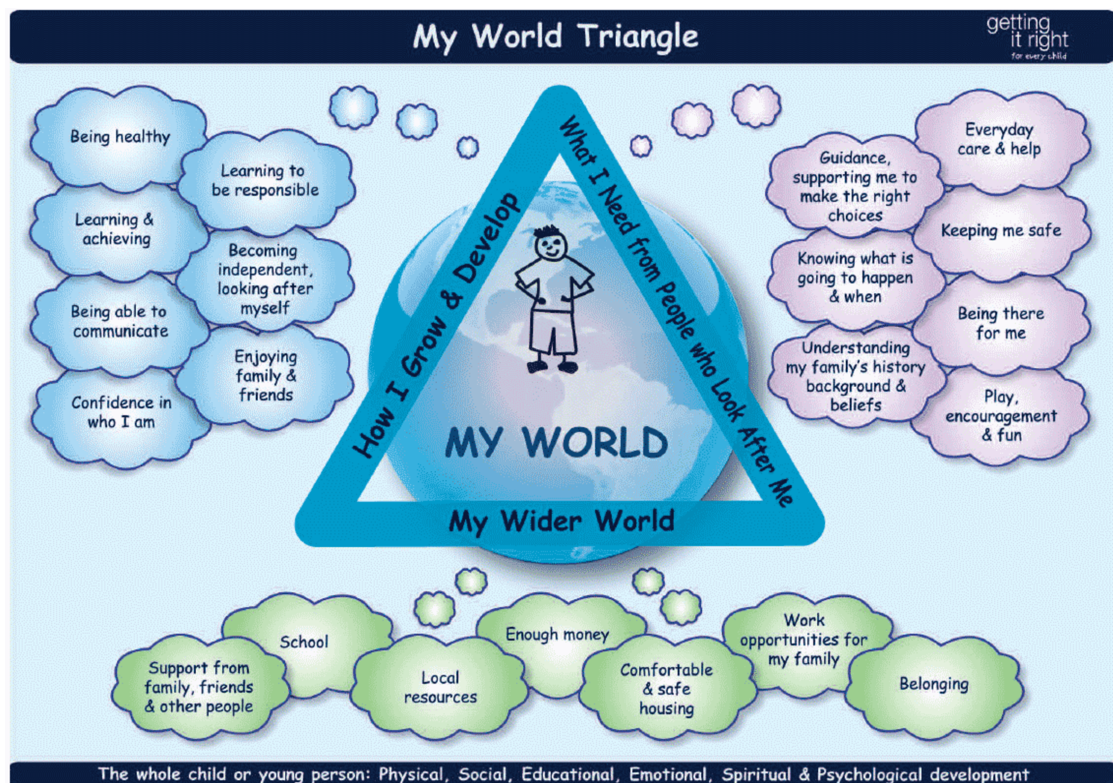
Section 3: Creating Community Partnerships: the role of the HSE Community Work Department in the Infant Mental Health partnership.

In Ireland, the role of communities in tackling poverty and social exclusion has been a major component of social policy development with several national programmes funded to address social inclusion such as the Community Development Programme; the Local Development Social Inclusion Programme and the Family and Community Services Resource Centres Programmes, amongst others. (Combat Poverty, 2006). Community development has been defined as a process whereby those who are marginalised and excluded are enabled to gain in self-confidence, to join with others and to participate in actions to change their situation and tackle the problems that face their community. (Combat Poverty Agency, 2000) The Northern Ireland Health and Social Care Board (2012) endorses this definition but goes further with an emphasis on prevention and early intervention: "Community development brings forward an agenda which tackles the root causes of inequalities and supports and promotes prevention and early intervention. This can only be achieved in a full partnership which includes service users, carers, families, local communities, communities of interest, the community and voluntary sector as well as a range of statutory health and social care organisations. (Health and Social Care Board, 2012).

Therefore, one of the key functions of the HSE CWD is to narrow the gap in health inequalities and support the improvement of the health and wellbeing of the population within a community. This means working to address the determinants of ill-health and reducing risk factors, including those associated with poverty and social exclusion, in partnership with the community and with statutory and voluntary agencies to affect change.

Adhering to the Community Work Department ethos, the baby/child and family are considered within the context of the community in which they live and learn. There is now considerable evidence that supports the argument that the communities where children grow up can have a significant impact on the well-being of both children and families. Communities can be supportive and protective or can add pressures and increase children's and families' vulnerabilities. (Scottish Government, 2008). The community development lens identifies that the level of support available from their wider family, social networks and within their neighbourhood can have a positive or negative impact for a baby/child. The wider world also includes the extent to which children and families feel included within their communities. In addition, the All Ireland Traveller Health Study found that social exclusion of children and entire communities can emanate from factors including racial and cultural discrimination. (All Ireland Traveller Health Study, 2010).

The Scottish 'My World Triangle', below, outlines a typical community-oriented model of support for babies, children and families in which a child's well-being should be considered using the eight indicators: safe, healthy, achieving, nurtured, active, respected, responsible and included. (Scottish Government, 2008). The My World Triangle outlines the need for a common, co-ordinated approach across agencies, aiming for an improved focus on needs-based and outcome-led early interventions. The model also supports the argument for effective collaboration among agencies leading to integrated approaches to the way the needs of children and families are met. (Scottish Government, 2008).



Reasons for the partnership model that emerged between the HSE North Cork Child & Family Psychology Service (NC-CFPS) and the HSE Community Work Department (NC-CWD)

As outlined previously, in 2009 NC-CFPS team members met with the CWD to explore how Infant Mental Health training networks could be further developed throughout the North Cork community. There is strong evidence-based research identifying that interdisciplinary partnerships create a shared commitment to improving service provision. In addition, working together across disciplines allows the various disciplines to gain familiarity with other approaches that can result in a change of attitude and practice (Jackson et al., 1999). Of equal importance, partnerships help to build an environment that is cooperative and collaborative,

encouraging professionals to learn beside one another (Emde, 2009). Emde further argues that the creation of community partnerships strengthens community investments in social and emotional health in the early years. (Emde, 2009).

Therefore, by working collaboratively, the HSE CWD and HSE NC-CFPS aimed to:

- Enhance Infant Mental Health knowledge and skills at the front line delivery level working with children in the 0-3 age category within the North Cork community;
- Engage a range of statutory, community and voluntary agency staff in the development of local learning groups, called IMH Network Groups (IMH NGs);
- Enable, through the IMH-NGs, opportunities for further professional development and interdisciplinary IMH training;
- Create, through the IMH-NGs, awareness and knowledge for front line staff of the social and emotional community health gains possible through the application of Infant Mental Health principles;
- Develop, through the IMH-NGs, spaces within and between voluntary projects in North Cork where the tenets of Infant Mental Health could be discussed, delivered and implemented;
- To promote the dissemination of information about social and emotional wellbeing in the early years and the importance of nurturing relationships to foster health and growth across the community

A sample of types of community groups identified by the Community Work team for participation within the Infant Mental Health networks included:

- Parent and Toddler groups;
- Community Childcare Projects ;
- Family Resource Centres;
- Development work with ethnic minority groupings such as the Traveller community ;
- Domestic Violence family support projects.

The role of the HSE Community Work Department in the development of Infant Mental health Networks in North Cork.

The CWD recruited the participant cohort of the two IMH NGs in Fermoy and Mallow in 2009 and 2011 and organized IMH master classes within the North Cork community facilitated by the NC-CFPS. To date, members of these IMH-NGs have included staff from community childcare projects, HSE child and adolescent mental health; public health nurses; social workers; speech and language therapists; community workers and clinical psychologists. The cost of participating in the IMH networks was acknowledged by the CWD and supported through the sourcing of quality childcare funding which allowed such projects, for example community childcare projects, to pay for relief staff during the IMH network meetings. This funding support has been ongoing for any member of the IMH NGs participating from the community and voluntary sectors.

Following discussion with the NC CFPS the CWD invited participation in the IMH NGs based on the following criteria:

- Participants would be drawn from frontline staff working with children aged 0-3 years and their families/caregivers in family support settings;

- A collaborative model of training would be supported with staffing from both statutory and voluntary agencies participating;

- Motivation, commitment and capacity to attend all training components needed to be considered when deciding to participate; IMH NGs set an 80% attendance rate as practicable;

- A timeline of five years was outlined in the invitation to participate which clearly outlined the envisaged partnership between the community sector, the HSE and other interested agencies working with babies and their families.

From a Community Development perspective, the IMH-NGs offer a number of unique elements:

- The teaching in IMH-NGs is community based;
- IMH-NGs involve key front line service providers and community personnel in family support settings;
- IMH-NGs are process driven;
- IMH-NGs enable discussion and analysis of current case studies;

- A unique reflective learning environment for members is supported in the IMH-NGs;
- IMH-NGs offer scope for complementary and parallel supports to children and parents.

Within the IMH learning networks in Fermoy and Mallow, front line staff engage in a unique learning environment where network members recapture their experience, think about it, and evaluate it. It is this process that is critical in learning and in the acquisition of a more enhanced skill set. Providing a supportive setting to discuss, in confidence, case scenarios helps participants to address and resolve issues such as these and ultimately ensures that both the HSE and local voluntary groups retain good staff and develop quality services. Anecdotally, this has strengthened relationships between statutory and voluntary personnel within the IMH learning networks thus supporting new referral pathways for community providers and creating space within the HSE Primary Care teams for community provider input.

Section 4 The Present Study

The present study explored what members of three Infant Mental Health Training and Network Groups (IMH NGs) felt were the benefits and the challenges of participating in a continuous learning group. It was hypothesized that participants who took part in an IMH NG would successfully integrate new knowledge and skills promoting infant mental health into their everyday practice with infants, toddlers and families and share their learning with colleagues in the North Cork community. Data was first collected from a two-hour Focus Group in which 10 IMH NG members answered semi-structured and open-ended questions about their experiences in a NG. The evaluators then developed and administered a demographic questionnaire as well as an IMH NG questionnaire with 158 items specific to the benefits and challenges of participation in the group experience. Thirty-one (31) IMH NG participants completed both the demographic and IMH NG questionnaires. The results from this study are summarised below. Discussion and recommendations follow.

METHOD

Data Collection

Focus group. Two researchers conducted a two-hour Focus Group with seven active IMH NG members and 3 group coordinators. To seek the views of participants regarding the benefits and challenges of participation in an IMH NG, the researchers prepared semi-structured questions in advance of the group and a few open-ended questions. The Focus Group was audio-recorded and subsequently transcribed to obtain a written transcript for data analysis and to use in developing the IMH Network Group Questionnaire for all group participants.

Demographic questionnaire. A 17-item questionnaire was administered to gather descriptive information about the 31 participants. The items included age, gender, discipline, level of qualification, work experience with the 0-3 age group and other age groups, number of children of his/her own, and frequency of participation in the group.

IMH Network Group questionnaire. This 158 item questionnaire was developed from analysis of the written transcripts of the Focus Group discussion in order to gather responses from all of the participants and validate the benefits and challenges of participation in the IMH Network Groups.

Data Analysis

Focus group. The analysis consisted of breaking the written transcript down into small sections; each line was numbered and coded. Codes were then redefined and main themes identified as they emerged from each section of data. To ensure that the codes captured the essence of the data, participants' own words were used as codes wherever possible. Codes were then grouped into mutually exclusive and meaningful categories. Where possible, categories were further merged to develop subcategories that accounted for more of the data. All subcategories and categories were grouped into one of two super-ordinate categories, namely Positive and

Negative Factors. Possible future recommendations for the running of the groups were also noted. The final coding frame was organised into a flowchart diagram that visually outlines the factors that IMH Network Group members are finding positive and negative regarding their participation in the groups.

Participants

The 31 participants represented a wide variety of disciplines and service agencies from the North Cork community with profiles as follows extracted from the Demographic and IMH Network Group Questionnaires (data is presented in Appendix A):

- Occupations, experience and professional context
    - Working in an early years setting as childcare or preschool workers: 15 (48.4%)
    - Health professionals including clinical psychologists, nurses and social workers: 9 (29%)
    - Community workers: 3 (9.7%)
    - Administration: 3 (9.7%)
    - Care assistant: 1 (3.2%)
    - The majority of participants work with the 0-3 age group (74.2%) as well as other age groups (83.9%) from children and young people aged 4-18 years to adults (18+ years).
    - The range of years of experience working with the 0-3 was normally distributed among participants with 45.2% having 6-18 years of experience.
    - Participants had an average of 12.3 colleagues (range 1-30) with daily hours of contact with their colleagues ranging from 1-8 hours. Participants' colleagues also worked for the same service (93.5%) and had experience of working with the 0-3 age group (90.3%).
- Demographics
    - The majority of participants were female (93.5%) between the ages of 30-45 years (54.9%) with children of their own (74.2%).
- Qualifications
    - Certificate or diploma:14 (45.2%),
    - Bachelor's degree:4 (12.9%)
    - Master's degree: 9 (29.0%)
- IMH participation
    - Participants reported which IMH NG they belonged to, the year they joined the group and their average attendance. Almost two thirds of participants were members of the Fermoy group. The majority of participants (71%) joined their group between 2010-2011 and 77.4% attend meetings on a monthly basis. Almost one third attend meetings on a quarterly, tri-monthly or bi-monthly basis.

SECTION 5 Results

5.1 Introduction

This section presents the outcomes of the IMH Focus Group and the results of the IMH Network Group Questionnaire. A thematic analysis of the written transcript of the Focus Group identified four major themes and associated sub-themes which are discussed in detail and correlated with the results of the Questionnaire. Overall, the results demonstrate that the IMH Networks produced positive outcomes for participants across all themes and subthemes with participants reporting the acquisition and integration of IMH knowledge and skills into their everyday practice with infants, toddlers and families. The sharing of their learning with colleagues in the North Cork community was a very positive aspect of the IMH NG participation which has also contributed to the development of an interdisciplinary, integrated IMH service in the sector.

5.2 Focus Group Thematic Analysis

Analysis of the written transcript of the 2-hour Focus Group resulted in the identification of five major themes, knowledge, skill, service policy and delivery, outcomes for clients and staff, and factors that challenge effectiveness. These could be further elaborated into sub-themes as shown in Table 5.1.

Table 5.1 Themes and subthemes emerging from the IMH Focus Group

Theme	*Sub-themes*
Increased Clinical Knowledge (5.3)	o Reflective Practice o Attachment o Risks and Protective Factors o Child Development o Infant Mental Health Terminology o Parent / Child Relationships
Enhanced Clinical Skill (5.4)	o Assessment o Psycho-education o Intervention / Work Practices o Case consultation o Using Reflective Practice in Clinical Work with Families o Report writing
Changes in Service Policy and Delivery (5.5)	o -
Outcomes for Clients and Staff (5.6)	o Parents and Infants / Toddlers (5.6.1) o Teenagers and Adults (5.6.2) o Professionals not directly involved in

	Network Groups (5.6.3) o Personal Gains for Network Group Members (5.6.4)
Factors that Strengthen IMH Network Groups	o Effective teaching / learning strategies o Multidisciplinary input o Reviews of group progress o Support from higher management o Group ethos of respect and participation
Factors that Challenge Effectiveness (5.7)	o Difficulty Disseminating Knowledge o Resource Constraints o Challenges to Self-Sufficiency o Pitching Material at Optimal Level o Difficulty Measuring Outcomes

For clarity, the results include summary information from both the 2-hour Focus Group written transcripts and the IMH Network Group questionnaire. The Focus Group results for each theme are discussed first, followed by summary results from the IMH Network Group questionnaire, providing a rich basis for considering the strengths and challenges of providing a continuous learning opportunity to promote IMH principles and practices in North Cork.

5.3Results from Focus Group: Increased Clinical Knowledge

An important function of the IMH NGs is to enhance clinical knowledge both through formal training and also by sharing of knowledge and experience between participants. The Focus Group analysis revealed six subthemes, Table 5.1, which are discussed in detail below.

Improved understanding of reflective practice

Focus group members reported an increased understanding of reflective practice and how to engage in it. They referred to "taking a step back" and pausing to think about what was happening before intervening. Participants spoke about learning how to "resist the urge to fix and solve something" immediately and acknowledging that they did not have immediate answers. The participants also stated that, when reflecting, they found themselves asking key questions to assist with reflective practice such as, "What is it like for the baby?". They also reported developing skills to think critically about what clients had said and done and vice versa. They referred to striving to "understand the impact that, as a worker, you have on the child and to understand the impact that the child is having on you as well". Group members also felt that the group provided a reflective space in which to think and have feelings about their work.

Attachment

Focus Group participants found that their knowledge increased in the area of attachment theory.

Risks and protective factors

It was reported by Focus Group members that they were better able to identify early signs of risk and risk conditions, understanding that warning signs may point to "a need for further intervention". Participants also referred to having a better understanding of the impact of environmental stress on children, particularly infants and toddlers. One said, "I learnt about environmental stress…I am more aware of the impact of it". Participants reported an increased understanding of presenting needs of mothers and children. Improved understanding of the concept that a child's "behaviour has meaning" and increased proficiency in recognising the meaning of different behaviours displayed by children also emerged from the data. In addition to knowledge of risk and risk conditions, members noted an increase in being aware of the "good things" or protective factors.

Child development (social, emotional and cognitive)

An increase in knowledge about social, emotional and cognitive development was identified as a fourth sub-theme. In the words of one Focus Group participant, "[I] learnt a lot about the development of children in that age group". Group members felt they had gained a better understanding of early brain development and deeper insight into the social and emotional aspects of child development. They also better understood how social and emotional development influences very young children's behaviours.

IMH terminology/language

Focus group members reported gaining "new language" that "influenced their practices and thoughts", helping them to understand and think about their work. They also reported using these new terms when talking and consulting with other professionals about cases which resulted in a "much deeper understanding" and gave them "greater confidence in being able to talk about [cases]".

Parent-Child Relationships

Knowledge about the parent-child relationship was the fifth subtheme to emerge. This included acquiring knowledge about the development of early parent-child relationships and the influence that these relationships have on the formation of relationships later in life. In the words of one participant, "[we learned about] what happens in relationships and how they impact on your whole life - from the day you are conceived until the day you go". There was also increased awareness that "the parent-child relationship begins even before the baby is born, during the prenatal period".

Increased understanding of intergenerational transmission of risk was also identified with one participant commenting that a "mother [who] has come from a difficult relationship

herself… could have… difficult relationships" later in life. Participants also referred to relationship difficulties during pregnancy and in the first weeks of a baby's life. Moreover, participants reported that maternal wellbeing is an important factor in the developing parent-child relationship. "If the mother is stressed, then what happens for the child?" A mother's "mental health difficulties may impact on her child. " Equally important for the infant and toddler is care that is "reliable, consistent and available".

Increased Clinical Knowledge - Results from the IMH Network Group Questionnaire

Findings from the IMH NG 158 item questionnaire demonstrate a high level of agreement among participants. Of the 31 respondents, 30 agreed or strongly agreed that attending the IMH NG "has significantly increased my clinical knowledge of the 0-3 age group". Further questions in relation to subthemes also demonstrate high levels of agreement e.g. 28/31 participants agreed that their understanding of and ability to engage in reflective practice were significantly improved.

5.4 Results from Focus Group: Enhanced Clinical Skill

The second sub-theme to emerge from the analysis was called 'Enhanced Clinical Skill'. This was made up of six subthemes, Table 5.1:

Assessment skills

The analysis indicated overall improvement in assessment skills through participation in an IMH NG. In the words of one participant, "We can now better assess those referred". Observational and listening skills emerged as significant factors in the development of assessment skills, leading to improvement in the quality of the assessments NG members carried out.

Psycho-education skills

An enhanced ability to provide psycho-education to parents was a significant outcome. Participants spoke of "imparting our knowledge to them [children and families]". This led to better understanding of the difficulties clients experienced as well as improved capacity to address those difficulties. One participant stated, for example, "'The knowledge we are gaining we can discuss with the mother and that helps her sometimes, for example, in a case where she can't understand why her child might be acting out, or why even the older children are acting the way they are". Psycho-education was also used to support parents in understanding their needs: "It is great to be able to give an adult you know some sense of what their earlier experiences were and how they have shaped how they are now…how they have influenced things that have happened to them…and to validate some of their experiences for them".

Intervention skills and practices

Enhanced intervention skills was the third subtheme to emerge and included making more home visits, recognising that change is possible and using this as a philosophy behind interventions, using IMH principles and practices when delivering interventions and recognizing when to make a referral for additional specialisation.

Participants believed their intervention skills improved as a result of participation in an IMH NG. They reported working more directly with parents and children together. This also influenced colleagues who did not attend an IMH NG as Focus Group participants reported observing other members of their teams reacting in more effective ways when meeting children's needs, as well as providing better support for parents when a child was upset and seeing them work with the child and giving the child space when upset. Results also indicated changes in practice associated with making referrals for appropriate services in that participants were now better able to recognise risks and help families seek further intervention if necessary. This, in turn, facilitated referral for early intervention. In the words of one participant, "I know about where to refer so that early intervention is possible". Another said that she now had "…the awareness, understanding and possibility for change" and was able "to seek support from the relevant services".

Case consultation

As a result of participating in an IMH NG, participants reported improved and more frequent engagement in case consultations with each other. For example, one participant reported being able to "…talk about [a case] articulately to other professionals". This facilitated the generation of treatment options through continuous case discussions. One participant, for example, stated that case consultation "…can change how we think about [a case]and [you can] come away with a different idea of what to do".

Using reflective practice in clinical work with families

One participant outlines this change in practice by stating that "before, it would have been the order to jump in and give solutions". Now, however, reflective practice encourages understanding the presenting difficulties and thinking creatively about possible interventions. Another participant refers to this as getting "a broader picture of what's going on". The results indicate that, in addition to the use of reflective practice during interaction with clients, it also resulted in reflecting about their interactions afterwards. One participant said, "I find that sometimes I might over-react and then, on reflection, [ask] how could I have approached this differently if I had taken the time to reflect?". Members felt that their reflective practice skills allowed them to work more accurately with children and families in that they were much clearer about what was happening with their clients and how to approach situations differently.

Report writing

This was the final subtheme to emerge and analysis pointed to an improvement in the overall quality of reports as a result of participation in the IMH NGs. For example, one Focus Group participant referred to "having more information about the parent-child relationships" and the benefit of including this in her reports.

Enhanced Clinical Skill - Results from the IMH Network Group Questionnaire

Overall, IMH NG respondents reported that they have "significantly improved clinical skills in (our) work" (83.7%, n=26/29). The majority of participants were in agreement that attendance

at the IMH NG resulted in improved clinical skills in the areas of assessment, delivering psycho-education, intervention skills or work practices, case consultation, using reflective practice with families and report writing. In the area of assessment, participants reported significantly improved observation and listening skills (90.3%, n=28/31 for both). However, when asked whether they have an improved ability to conduct assessments, agreement was 74.2% (n=23/29) with 19.4% (n=6/29) rating this statement as neutral. In the area of intervention skills and work practices, 83.9% (n= 26/29) reported an improved ability to work with parents and infants; 93.6% (n=29/30) reported that they were better able to recognise when an infant or toddler needs further intervention. The proportion reporting that they were better able to refer a baby or carer to the most appropriate professional was 71% (n=22/29) with 22.6% (n=7/29) rating this statement as neutral.

5.5 Results from the IMH Focus Group: Changes in Service Policy and Delivery

Results highlighted that, as a result of their participation in an NG, IMH NG members had changed the way they work in terms of service policies used or model delivery. For example, it was noted that members now engaged in additional home visits to families in comparison to their previous work. In addition, members found themselves considering more carefully the emotional needs of infants and young children and creating new ways of working as a result:

"I have gone out and instead of meeting Mom on her own, you know, I have gone looking at the relationship between Mom and Baby" [regarding a mother with post-natal depression].

"We were keen to have a focus on the emotional health of children and I think it's my involvement in the IMH group that has steered me towards looking at this issue".

Service Policy and Delivery - Results from the IMH Network Group Questionnaire

Just over half of those completing the questionnaire (51.6%) agreed that "there have been significant changes in service policy and in the model of service delivery where I work". 28/30 (90.3%) survey respondents agreed or strongly agreed that they "now spend more time contemplating the emotional needs of children and creating new ways of meeting these as a result".

5.6 Results from the Focus Group: Outcomes for Clients and Staff

This was the fourth and final main theme to emerge from the Focus Group analysis and had four subthemes, Table 5.1.

Parents, Infants and Toddlers

Results pointed to benefits stemming from increased clinician home visits and the provision of psycho-education to parents. Reported outcomes stemming from this included improvements in parent-child interactions, enhanced parental knowledge and understanding of their children's needs and on how best to meet these needs. Results also pointed to improved parental capacity

for reflection on their interactions with their infants and young children, their children's needs and on meeting those needs and improved parenting skills in general. Other positive outcomes for parents included parents seeking mental health services for themselves and benefiting from the clinician using an IMH model to support parents. These broad based improved outcomes are summarised by one participant who stated, "It doesn't just impact the 0-3 year olds - it's across the board, including parents as well". The overall outcome of these improvements was described by a participant as "opening doors for children, and for help, support and understanding for parents".

Teenagers and Adults

Although not a goal of the IMH NGs, there is evidence that teenagers and adults benefited from professionals who were members of IMH NGs. Professionals who work with adults and who are members of a learning group reported improved clinical understanding of how an adult's early years impact on their current difficulties. Similarly, those working with teenagers reported greater understanding of their current difficulties through knowledge of IMH principles and practice. Participation in an IMH NG helped when working with a "teenager and understanding what difficulties they have".

Professionals not directly involved in an IMH NG

Results from the analysis indicated positive outcomes as a result of sharing information and knowledge about IMH with team members and other colleagues in the community. One participant said she was " able to bring [IMH knowledge] to people who have not necessarily been involved in the groups". This affirmed the sharing of IMH principles and practices to colleagues not involved directly in the IMH NGs and being integrated into their work in the community in a positive way.

Personal gains for network members

Focus group participants reported a number of positive and personal gains from participation in the IMH NGs which led to a greater sense of personal confidence in themselves as people who work with infants, very young children and families. An increase in personal confidence was connected to feeling better-equipped to engage in reflective practice and feeling more confident in delivering information to others pertaining to their IMH work. In addition to an increase in professional confidence, participants reported that their involvement in an IMH NG resulted in gains in their own parenting skills. One participant stated, for example, "It [membership] has made a huge difference to me as a parent... the quality of my own parenting…".

Outcomes for Clients and Staff - Results from the IMH Network Group Questionnaire

Overall, 29/30 (93.5%) respondents agreed or strongly agreed that, as a result of their involvement in an IMH NG, clients and staff have benefitted directly; 26/29 (83.9%) agreed or

strongly agreed that "there have been improved outcomes for clients I work with". Over 80% of survey respondents agreed with the positive outcomes regarding improved parent-child interactions, knowledge and understanding, capacity for reflection and improved parenting skills. Participants also agreed (64.5%) that parents were more likely to access services for themselves. The survey respondents agreed (n=25/28, 80.7%) that they had a better understanding of the presenting problem of teenagers they work with as a result of knowledge gained in an IMH NG. In addition, participants have obtained better outcomes for adults/teenagers in their work (n=19/25, 61.3%).

For professionals not directly involved in the group, 67.7% agreed that they have filtered knowledge back to colleagues which has benefited the clients with whom they work, e.g. improved outcomes for clients (n=22/30, 71%). However, a number of participants provided neutral ratings of statements regarding professionals not involved in the group, e.g. nine participants (29%) rated themselves as neutral for the following statement "knowledge filtering back to my work colleagues… and this has benefitted the clients that they work with". All 31 participants reported a greater sense of personal confidence in their work with infants and families. For the majority, this personal confidence has also translated into greater confidence in engaging in reflective practice (n=28/31, 90.3%) and in delivering information to others about their work (n=28/30, 90.4%). Finally, 86% (n=19/22) also agree that they have become better parents as a result of their involvement in the group.

5.7 Results from the Focus Group: Factors that Strengthen IMH Network Groups

In addition to identifying the 'Positive Benefits' of IMH Network Groups, this study aimed to identify factors that strengthen the IMH NGs themselves. Based on the analysis of the Focus Group transcripts, five factors that strengthened groups were identified, Table 5.1:

Effective teaching / learning strategies

The way the groups were taught was found to be an important factor in the effectiveness of an IMH NG and played an important part in ensuring that the groups worked well. More specifically, the use of a diverse range of materials to facilitate group learning along with the active group participation was important to the strengths of this model. Participants referred to the use of video clips, along with hand-outs and articles for discussion, as an effective means of making the information accessible and easier to learn. They also stated that these methods resulted in them "building up the knowledge incrementally" over time. Furthermore, participants referred to the use of small group sessions as an important teaching strategy. One participant explained that "smaller group sessions bring out people who don't open up in larger groups", thus adding to the overall learning experience.

Multidisciplinary input

The inclusion of people from a variety of professions in the group was seen by Focus Group members to be an important aspect of the model used to deliver IMH NGs and one which results in improved teaching and learning. For example, one participant stated, "I think one of the strengths of the IMH groups is the multi-disciplinary aspect". This brought different points of view to enrich discussions and resulted in a sense that "group members are not just dependent on one discipline giving information". This learning was viewed as particularly important within the context of limited access to training opportunities in the current economic climate.

Reviews of group progress

Ongoing reviews of the progress being made by the group was seen to be another positive aspect of the IMH network groups which contributed to effective teaching and enhanced learning.

Support from higher management

This was regarded as crucial to the strength of the IMH NG. Support from management to encourage attendance emerged as a critical factor in ensuring that the groups were effective: "..we have to do CPD, professionally, and this is one thing we have fought for and thankfully our managers have agreed to it".

Group ethos of respect and participation

A group ethos of respect and participation emerged as an important theme. Recognising and appreciating that "everybody has something to bring to the group" and ensuring that "everybody has a voice'" were important factors that contributed to the overall success of the group. Focus Group participants pointed to the importance of seeing themselves and others as experts in their own right and the value of drawing on this to enhance group discussion and participation was also referenced. One participant stated, "You are an expert in your own field" and another, "We can all talk about our own experience, you know, we are all experts".

Factors that Strengthen IMH Network Groups - Results from the IMH Network Group Questionnaire

All respondents to the IMH NG Questionnaire agreed that how the groups are taught is an important factor and that the broad range of teaching materials and methods facilitates learning within the group. All respondents found the video clips and use of articles to be effective; the majority also found the handouts effective (87.1%, n=27/31). There was some divergence of opinion among respondents on the usefulness of small groups as 58.1% (n=18/31) were neutral or disagreed that "small group sessions helped me, and others, to open up to the group as a whole". However, the majority (74.2%, n=23/31) reported that "the use of smaller groups within the networks helped me to get my head around the information". Survey respondents were

almost unanimous in endorsing the usefulness of multidisciplinary input and supported the qualitative findings regarding the value of reviews of group progress and the importance of support from higher management. In addition, the role of group attendance as a valuable form of professional development was recognised by all respondents, agreeing about the importance of a group ethos of respect and recognising this respect as an important factor contributing to group success. However, a minority of participants disagreed that this ethos of respect was evident in the working of the group, e.g. 19.3% (n=6/31) rated themselves as neutral or disagreed with the statement that, "I feel I am regarded and respected as an expert in own right within the network groups". This is a significant minority and this issue requires further exploration to identify a solution.

5.8 Results from the Focus Group - Factors that Challenge Effectiveness

Analysis of the written transcript resulted in five sub-themes that challenge the effectiveness of the IMH NGs. These are: 'Difficulty Disseminating Knowledge', Resource Constraints', 'Challenges to Self-Sufficiency', 'Pitching Material at Optimal Level' and Difficulty Measuring Outcomes

Difficulty disseminating information

Participants reported challenges in disseminating the information they acquired to other colleagues who were not informed about infant mental health and to people in the community, including parents. One Focus Group participant stated, "The real challenge for us is to get it out so that parents have a knowledge about the importance of relationships".

In some cases, only one person from the workplace attended the IMH NG. On a practical level, one person said that it was "hard to bring everything back when you are the one person that attends". Another felt that sharing the knowledge would come across as she "knows it all". Other difficulties included a sense of confusion about what information was copyrighted and what was not. One participant stated, "..the copyright of some of the materials is a challenge...you know there is some confusion about that in terms of what you are allowed to bring back to your colleagues and share".

Resource constraints

This included the lack of people to provide psychological input, lack of input from Public Health and the lack of time. Participants acknowledged the important role that Psychology has in the provision of ongoing training and consultation to the IMH NGs but referenced the limited amount of time Psychology has to provide training.

Participants also referred to the decision made by management to withdraw public health nurses from the IMH NGs because their services were needed on the "frontline". As one person observed, "the biggest challenge is the absence of public health nurses in the NGs"

because of the nature of the work that they do and the fact that they meet parents and infants in the very early stages of their relationship. Public health nurses are in an ideal situation to recognise difficulties early on and ensure early intervention. One participant explained, "That's a huge loss because they are there two days after the birth".

Focus Group members pointed out that their frontline services are "completely over-stretched as it is" and that attendance in an IMH NG posed significant challenges in terms of time constraints. Creating the "space [for the groups] to happen in work time'" was difficult. Participants also pointed to the roll of higher management in supporting their attendance as critical in ensuring the continuation of the group.

Challenges to self-sufficiency

Focus group participants had reservations about running and sustaining a group on their own, "We are really over-reliant on the [Clinical Psychologists] to run [the groups] and do the teaching part of it". They also expressed concerns around lack of confidence, "…within our own network I don't know how confident people would feel delivering an input". This lack of confidence appears to be associated with a perceived lack of expertise to take on new roles. Participants referred to a sense that they were not well equipped to take on the teaching role that the groups require, stating that they were not 'specialists' in the field themselves.

Pitching material at an optimal level

This fourth challenge centred on ensuring that teaching material is relevant, pitched at a level appropriate to members and producing benefit for them. Newer members could feel like they were "trying to read a different language" that "…is difficult to grasp". In the words of one participant, "If it's [the material] pitched too high for where you're at, you're not going to feel motivated to keep going". However, there was also a consciousness of the risk of pitching the material at a level too low for the more experienced group members and causing experienced members to cease attending because they "are not benefiting from it". This is a challenge which needs to be addressed by striking an appropriate balance in the level of material.

Difficulty measuring outcomes

Participants reported finding the measurement of their case outcomes somewhat difficult as the changes they observed with clients were "very, very subtle" and that "it is very hard to pin down what is different".

Factors that Challenge Effectiveness - Results from the IMH Network Group Questionnaire

IMH NG respondents did recognise the challenge of disseminating knowledge beyond the NGs to colleagues, parents and the community in general. However, most disagreed that it was a

challenge to bring knowledge and skills back to the team (67.6%, n=21/31 rated as neutral/disagree) and did not identify negative perceptions (i.e. being seen as a 'know it all') as a barrier to sharing knowledge with colleagues (71%, n=22/31 strongly disagreed/disagreed). The questionnaire did identify a misunderstanding among group members that they could not share handouts outside the group because of copyright (71%, n=22/31). The responses identified, the absence of Public Health Nurses in the IMH NGs and constraints in terms of time to attend (67.8%, n=22/30). The majority did not find it difficult to advocate to line managers for time to attend the group and most were provided with time to attend by line managers (77.4%, n=24/31).

Respondents were in agreement regarding the challenge of developing a self-sufficient and self-perpetuating group (87.1%, n=27/31, strongly agreed/agreed). However, the results did not support the subtheme of over-reliance on Psychology for group facilitation: 67.8% (n=21/30) strongly disagreed, disagreed or were neutral on this item. When asked, just over a third (32.3%, n=10/31) of the group members reported that they would feel comfortable taking on a leadership or facilitator role in their IMH NG. The survey questions attempted to clarify the factors that may inhibit a member taking on a facilitator role including lack of confidence, lack of expertise and feeling under pressure. The results were mixed regarding a lack of confidence and feeling pressured at the idea of facilitating an IMH NG. Over half of respondents (54.8%, n=17/30) agreed that they lacked the confidence to take on the role but over a third disagreed that they lacked confidence for the role (35.5%, n=11/30). The respondents were also almost equally split about the idea of feeling pressured to facilitate the group. While just over 70% (n=22/31) agreed that they lacked the expertise to take on a facilitator role, less than half (45.2%, n=14/29) believed that being an IMH specialist as a requirement for taking on the facilitator role. Examining the data for these items more closely, the only respondents who were strongly positive in being comfortable at taking on a facilitator role and who also felt they had the expertise for this role were Community Workers (n=3/3) followed by Clinical Psychologists (n=2/3).

On the subtheme of pitching material at an optimal level within the IMH NGs, the respondents were almost unanimous in agreeing that the relevance of the material presented at groups is essential to maximise learning (93.5%, n=29/30). Respondents also agreed that it can be difficult for members to understand if material is at too high a level and that achieving the correct level is difficult in the context of rolling groups (87.1%, n=27/31). Most agreed that joining a group without previous IMH knowledge would be difficult (74.2%, n=23/31) and that completing a master class before joining a group is necessary (87.1%, n=23/31). Fewer respondents agreed that new members would feel out of their depth entering a group at its current stage (61.3%, n=19/30) or that they are likely to find material difficult to grasp (64.5%, n=20/31). In addition, 64.5% (n=20/30) agree that steps need to be taken to ensure that all groups are working at a similar level. The majority agreed that pitching material at too high (74.2%, n=23/31) or low a level (67%, n=21/31) may affect attendance.

5.8 Summary conclusions from results

Overall, the great majority of IMH NG members were strongly positive about participation in and their experience of being part of an NG, seeing the NGs as being effective in meeting their objectives. Specific areas of concern were identified that should be addressed to further improve member experiences and to enhance NG effectiveness. These are discussed further in the Discussion section of this document.

SECTION 6 Discussion

The present study set out to explore what members of three Infant Mental Health Network Groups (IMH-NGs) considered were the benefits and challenges of participating in a continuous group learning environment. The research specifically examined the initial hypothesis that participants who took part in the IMH NG's would successfully integrate their new Infant Mental Health knowledge and skills into their everyday work practice with infants, toddlers and their families. Furthermore, this research sought to establish whether participants had the opportunity to disseminate their new knowledge and understanding among professional colleagues within the North Cork clinical services and community settings.

The research, which combined qualitative and quantitative approaches, confirmed the initial hypothesis and also yielded information on the benefits of participation in IMH-NGs, the factors that strengthened IMH-NGs and the factors that challenged their effectiveness.

Specific benefits were increased clinical knowledge, enhanced clinical skills, changes in service policy and delivery, and enhanced outcomes for infants and their families.

Factors that were observed to strengthen infant mental health network groups included effective teaching/learning strategies, input from participants working in multidisciplinary teams, reviews of group progress, support from higher management and a group ethos firmly rooted in respect and participation.

Factors that challenged effectiveness of IMH NG's included resource constraints in releasing key frontline staff from their professional roles and responsibilities, challenges to self-sufficiency, pitching the infant mental health teaching material at the optimal level for members and ensuring that it produced benefits for members and their services. Participants reported finding it difficult to quantify the impact of the infant mental health model on their practice without the use of appropriate measures.

Findings in this research are consistent with literature sources (Weatherston, 2005,, Weatherston et al, 2006, Myers, 2007) regarding the role of interdisciplinary training in developing skills and capacity within the early years workforce in clinical and community settings .

The research confirmed that IMH NGs:

- Are effective in disseminating knowledge and training across the diversity of clinical and community services;

- Lead to the application of IMH principles "at the coalface", through the development of a shared language for understanding and intervening with infants and toddlers and their families across early years services;
- Make highly efficient use of the limited time availability of community and clinical professionals and the limited economic resources of the services;
- Lead to a sustainable and economic model of integrating IMH principles into the daily practice of clinical and community professional groups;
- Are successful in disseminating IMH knowledge to families and the wider community population.

Clinical implications

The results of the study provide valuable insights into the benefits as well as the challenges of participating in a continuous IMH learning group. These results may be used to improve the organisation and coordination of IMH-NGs in the future and to ensure that they are successful in their aim of educating interdisciplinary groups of professionals and, in turn, the public regarding IMH principles and practices and integrating them into service across the community.

IMH principles incorporate developmental and clinical perspectives that inform the practice of service providers whose original training may have emphasised a different knowledge base and different skills, e.g. those who work in community child care, early intervention, public health, mental health, paediatric units, maternity services, and family resource centers, to name a few. The IMH-NGs evaluated in this research sought to disseminate and integrate IMH practice across all statutory and voluntary bodies in North Cork Community Services.

In final summary, the groups were successful in demonstrating the effectiveness of the IMH-NG model and how it could be made even more effective as a model suitable for national roll-out.

SECTION 7 Recommendations from the Infant Mental Health Research

The highly positive familial, societal and economic impacts of Infant Mental Health (IMH) are recognised internationally, as described in the Introduction and Literature Review sections of the research report. Simply put, investment in early years mental health leads to both a healthier society and a sustained reduction in national mental health costs.

However, in the particular Irish context of a diversity of clinical and community services operating under strong economic and human resource constraints, it has not been obvious how to disseminate IMH knowledge and training among community and clinical professionals in an efficient and cost-effective way while accommodating these constraints. It was hypothesised that Infant Mental Health Network Groups (IMH-NGs) would not only meet this need but would also be effective in providing ongoing support to the professionals to introduce IMH principles to their daily practice, in providing mutual support in sustaining the use of IMH principles, and in disseminating IMH knowledge to other professional colleagues, to families and to the wider community.

The research has strongly confirmed that IMH-NGs:

- Are effective in disseminating knowledge and training across the diversity of community and clinical services;
- Make highly efficient use of the limited time availability of the community and clinical professionals and the limited economic resources of the services;
- Lead to a sustainable and economical model of integrating IMH principles into the daily practice of community and clinical professionals;
- Lead to effective application of IMH principles “at the coalface”;
- Are successful in disseminating IMH knowledge to families and the wider community.

The authors therefore make the following recommendations:

Expand the Infant Mental Health Network Group model nationally

This research has shown that IMH-NGs both work and are also very cost-effective. We recommend that this model should be expanded nationally so that all clinical and community-based practitioners working with infants, toddlers and their families are provided with access to interdisciplinary training to facilitate development of core competencies in IMH principles and practice.

The evidence base for the effectiveness of IMH is extensive but, in Ireland, there is an implementation gap between this evidence base and what is delivered in practice. To date, it has not been clear how best to bridge this gap. The IMH-NG research confirms a model of interdisciplinary training which is very effective at bridging this gap as reflected in the following research outcomes:

- Increased IMH clinical knowledge and enhanced clinical skills;
- Integration of IMH principles and practice into service policy and service delivery;
- Enhanced outcomes for babies, toddlers and their families;
- Improved understanding of early social and emotional development, as reported in increased parental capacity and ability to reflect on their interactions with their babies and toddlers.

The successful application of IMH principles and practice requires the development of referral pathways as reflected in a tiered approach to parent-infant services. This research shows that the IMH-NG model is very effective in establishing these pathways through making IMH competencies available across all tiers of service delivery. Practitioners and clinicians who have appropriate competencies can ensure timely access to services as they can deliver quality service interventions to infants, toddlers and their families who are presenting with social and emotional and parent-infant relationship issues. A relatively narrow window of opportunity exists during this period and early intervention is key.

We strongly recommend the development of a National Infant Mental Health/Early Years Policy to facilitate the range of services and the workforce capacity required to enhance mental health and wellbeing in the early years.

Create Sustainability

The research has demonstrated that the IMH-NG model is self-sustaining when supported by the Community Work Department once established. The highly successful interdisciplinary, interagency approach of the IMH Network Model:

- Sustains the development leadership in IMH across all disciplines and agencies responsible for early years provision;
- Facilitates training for IMH-NG members to enable further dissemination of IMH training within the community;
- Provides a balance between Promotion, Prevention and Intervention ensuring there is a place for IMH assessment and diagnostic intervention along with frontline services working in a generic prevention model in early years;
- Demonstrates to employers and managers that supporting staff participation in IMH-NGs delivers excellent value for their money;

To further increase sustainability in the immediate North Cork context, we recommend:

- The development, as a priority, of a North Cork Steering Group for IMH;
- The development of IMH hubs in community childcare settings in North Cork: aiming towards having IMH-trained staff in each childcare setting per geographical area.

These initiatives can form the basis of an expanded model for sustainability nationwide.

At a national Irish policy level, the development of a more accessible IMH certification/endorsement should be prioritised and explored within the Early Years National subcommittee, creating CPD and enhanced career development opportunities.

The focus so far in these recommendations has been on the training of existing professionals. However, sustainability can also be created by introducing IMH principles to those emerging professionals currently in education and training. National introduction of Infant Mental Health education modules in undergraduate community and clinical education programmes and practice training will be a very low-cost but very effective method of introducing IMH principles to everybody entering the community and health professions.

IMH modules should be considered and included as a key component for all practitioners/professionals working with infants and toddlers in all early year's childcare services at primary, secondary and tertiary service levels. This should also include inclusion of IMH interdisciplinary modules in undergraduate and relevant post-graduate programmes to ensure all clinicians and practitioners have the required core competencies to work with the early years.

Implement the recommendations from the Early Years strategy: match resources with policy in early years intervention:

The development and evaluation of the unique multidisciplinary IMH NG model in North Cork has been successful across all professions and services. These networks include practitioners from early years community childcare services; psychologists, speech and language therapists; occupational therapists; community workers; social workers; paediatric physiotherapists, community development workers from Family Resource Centres; Domestic Violence Projects; Social and Education Projects along with regional Disability services.

The authors urge that Infant Mental Health principles should be infused into a revised Primary Care Strategy as a universal model of promotion and prevention which emphasises the critical importance of the first three years in building and consolidating healthy social and emotional health and wellbeing across the lifespan.

Without this prevention-intervention approach, prevalence of mental health problems will increase in society along with a continuation of intergenerational transmission of risk for infants and toddlers and the escalating associated economic costs in addressing these issues.

Infant Mental Health principles and practice should be universally infused within the wider community and within a societal context; significant social, emotional and health gains will be achieved for the Irish population by raising awareness and providing the supports required to ensure that social and emotional health receives the same priority and attention as physical health in the 0-3 period.

Prioritising the application of the IMH model will lead, over time, to the development of communities and a society that are more resilient, have improved levels of social and emotional health and wellbeing, and improved self-regulation.

In Right From the Start, the Report of the Expert Advisory Group on the Early Years Strategy (Department of Children and Youth Affairs, 2014), it is strongly argued that the development and implementation of an Early Years Strategy could be the single most effective action on behalf of young children in Ireland.

The research reported here confirms the IMH NG model as a potential major contributor to the development and implementation of such as strategy.

References

Alinsky SD (1967). The poor and the powerful. International Journal of Psychiatry. 4(4): 304–309.

Bowlby, J. (1988). The origins of attachment theory, Lecture 2 In J. Bowlby (Ed.). A secure base, New York Books: Basic Books, pp 20-38.

Carniero, P. & Heckman, J. (2003). Human capital policy. In B. Friedman (Ed.) *Inequality in America: what role for human capital policies?* (pp 77-239). Cambridge: MIT Press.

Cicchetti, D., Rogosch, F., & Toth,S. (2006). Fostering secure attachment in infants in maltreating families through preventive interventions. *Development and Psychopathology,* 18, pp. 623-649.

Cohen, J., Oser, C., Quigley, K., Stark, D. (2013). Nurturing change: Strategies for improving infant and early childhood mental health. ZERO TO THREE Press, Washington, D.C.

Cohen, N. J., Muir,E., Parker, N., Brown, M., Lojkasek, M., Muir, R., & Barwick, M. (1999). Watch,wait and wonder: Testing the effectiveness of a new approach to mother-infant psychotherapy. Infant Mental Health Journal, 20 (4), 429-451.

Department of Health and Children, (2001). Primary Care: A New Direction, Quality and Fairness- A Health System for You. Dublin: Stationery Office.

Department of Health and Children (2006). *A Vision for Change: Report of the Expert Group on Mental Health Policy*. Dublin: The Stationary Office

Davies, 2011. The transactional model of development. In P. Mukherji & L. Dryden (Eds.) Foundations in Early Childhood, Sage Publishers, 2014, pp 91

Eggbeer, L. , Mann, T., & Seibel, N. (2007). Reflective supervision: Past, present, and future. ZERO TO THREE journal, 28(2), 5-9.

Eggbeer, L., Shahmoon-Shanok, R., & Clark, R. (2010). Reaching toward an evidence base for reflective supervision. ZERO TO THREE Journal, 31(2), 39-50.

Emde, R.(2009). Facilitating Reflective Supervision in an Early Child Development Centre. *Infant Mental Health Journal*, 30 (6). 664-672

Felitti V.J., Anda, R.F., Nordenberg, D. Williams, D.F et al. (1998): Relationship of childhood abuse & household dysfunction to many leading causes of death in adults:

The Adverse Childhood Experiences (ACE) study. American Journal of Preventive Medicine 14(4):245-258, May 1998.

Fraiberg, S. (1980). *Clinical studies in infant mental health*. New York: Basic Books.

Hinshaw-Fuselier, S., Zeanah, P.D., & Larrieu, J. (2009). Training in infant mental health. In C.H.Zeanah (Ed.). Handbook of Infant Mental Health, 3rd Edition, The Guilford Press: New York, 533-548.

Hoffmann, K., Marvin, R., Cooper, G. & Powell, B. (2006). Changing toddlers' and preschoolers' attachment classifications: The Circle of Security Intervention, *Journal of Consulting and Clinical Psychology.* 74(6), pp. 1017-1026.

http://www.nsvrc.org/publications/reports/effects-childhood-stress-health-across-lifespan

http://www.wested.org/cs/we/view/pj/207

http://www.zerotothree.org/imh

Jackson, S., Cleverly, S., Burnam, D., Edwards, R., Poland, B. & Robertson, A. (1999). *Towards indicators of Community Capacity: A study in four Toronto Communities*. Toronto: Centre for Health Promotion.

Krieg, I. & Lewis, J. (2005). Replication: A "model" approach to the healthy development of young children. Zero to Three 25(5), 4-8.

Lyons-Ruth, K., Connell, D., Grunebaum, H. & Botein, S. (1990). Infants at social risk: Maternal depression and family support services as mediators of infant development and security of attachment. *Child Development, 61,* 85-98.

McGongiel, M. (2005). Replication in Practice: Lessons from five lead agencies. Zero to Three 25(5), 9-16.

Maguire, C. (2014). The development and sustainability of an Irish interdisciplinary training model including reflections on the contributions of the MI-AIMH competencies. Paper presented at 14th World Congress of the World Association for Infant Mental Health, 16th June 2014, Edinburgh, Scotland.

Maguire, C. (2012). Advocating for a National Infant Mental Health Strategy for Ireland: Progress to date. *The Signal*, 20(2) April -June

Maguire, C. (2011). Advocating for a National Policy on Infant and Early Childhood Mental Health within the Irish Health Services: .*The Signal*, 19 (2) April -June

Maguire, C., & Matacz, R. (2012). Bridging the Gap in Service Development in North Cork and Primary and Continuing Care: The Development and Integration of an Infant Mental Health Model in to Existing Service Delivery, *Child Links Infant Mental Health: The Journal of Barnados' Training and Resources Service*, 2, 30-34

Maguire, C. & Matacz, R. (2006). Integrating Theory into Practice within the Irish Health Services. Symposium workshop presentation at 10th World Congress of the World Association for Infant Mental Health, 11th July 2006, Paris, France.

Mares, S., Newman, L. & Warren, B. (2011). *Clinical skills in infant mental health: The first three years*, 2nd Ed., ACER Press: Victoria, Australia.

Matacz, R. & Maguire, C. (2007) Building Infant Mental Health Capacity Within The Irish Health Services: Developing and Evaluating an Interdisciplinary Model of Training .
Paper Presented at "Baby In Mind" National Infant Mental Health conference November 2007

Matacz, R. & Maguire, C. (2008). Building Infant Mental Health Capacity within the Irish Health Services. Poster presentation at the 11th World Congress of the World Association for Infant Mental Health, 3rd July 2008, Yokohama, Japan

Michigan Association for Infant Mental Health Competency Guidelines (2002/rev.2011/rev. 2014)

Michigan Association for Infant Mental Health Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health (2002;rev. 2011/rev. 2014). MI-AIMH Endorsement® http://www.mi-aimh.org/endorsement

Meyers, J. (2007). Developing the work force for an infant and early childhood mental health system of care. In D. Perry, R. Kaufman & J Knitzer (Eds.) Social and Emotional Health in Early Childhood (pp. 97-120). Baltimore: Brookes

O'Rourke, P. (2011). The significance of reflective supervision for infant mental health work. *Infant Mental Health Journal*, 23(6), 593-605.

OMC. (2007). The Agenda for Children's Services: A policy handbook, *Office of the Minister for Children. Dublin: The Stationary Office*.

Perry, B. (2009) Examining child maltreatment through a neurodevelopmental lens: clinical applications of the neurosequential models of therapeutics. *Journal of Loss and Trauma*, 14: 240-255. Taylor & Francis Group LLC.

Schafer, W. (1991). Planning as an attachment experience. The Infant Crier. East Lansing: Michigan Association for Infant Mental Health.

Schafer, W. (2007). Models and domains of supervision and their relationship to professional development. ZERO TO THREE Journal, 28(2), 10-16.

Shahmoon-Shanok, R., Lapidus, C., Grant, M., Halpern, E., & Lamb-Parker, F. Apprenticeship, Transformational Enterprise, and the Ripple Effect. *Other books published by Jossey-Bass and the California School of Professional Psychology/Alliant International University: The California School of Professional Psychology Handbook of Multicultural Education, Research, Intervention, and Training, edited by Elizabeth Davis-Russell*, 453.

Shonkoff, J.P. and Phillips, D.A. (Eds.) 2000). *From Neurons to Neighborhoods: The Science of Early Childhood Development.* Committee on Integrating the Science of Early Childhood Development, National Research Council and Institute of Medicine. Washington, DC: National Academy Press.

Stinson, S., Tableman, B. & Weatherston, D. (2000). Guidelines for infant mental health practice. East Lansing: Michigan Association for Infant Mental Health.

Thomasgard, M., Warfield, J. & Williams, R. (2004). Improving communiction between health and infant mental health professionals utilizing ongoing collaborative peer supervision groups. *Infant Mental Health Journal* Vol 25(3), pp. 194-218.

Thomasgard, M. & Warfield, J. (2005).The collaborative peer supervision group project: A continuing education model to promote professional competence. *ZERO to THREE* Vol 25(5).

Walsh, C. (2013). *An Evaluation of an Infant Mental Health Reflective Practice Group.* Submitted in partial fulfilment of requirements for Ph.D. in Clinical Psychology. University of Limerick: HSE South

Wajda-Johnston, V., Smyke, A., Nagle, G., & Larrieu, J. (2005). Using technology as a training, supervision and consultation aid. In K.M.Finello (Ed.) *Handbook of Training and Practice in Infant and Preschool Mental Health,(357-374)* San Francisco: Jossey- Bass.

Weatherston, D. (2000).The Infant Mental Health Specialist, *Journal of Zero to Three*,21 (2), 3-10.

Weatherston, D. (2005). An Interdisciplinary Training Model: The Wayne State University Graduate Certificate Program in Infant Mental Health. In K.M.Finello (Ed.)

Handbook of Training and Practice in Infant and Preschool Mental pp 326-342) Health,(San Francisco: Jossey - Bass.

Weatherston, D. (2012). The gift of love: A birthright. *Child Links Infant Mental Health: The Journal of Barnados' Training and Resources Service*, 2, pp.2-7.

Weatherston, D., Kaplan- Estrin, M., & Goldberg, S. (2009a). Strengthening and recognizing knowledge, skills, and reflective practice: The Michigan Association for Infant Mental Health competency guidelines and endorsement process (pages 648–663) Infant Mental Health Journal, Volume 30,(6), pp 648-663

Weatherston, D. & Barron, C. (2009b). What does a reflective supervisory relationship look like? In S. Heller & L. Gilkerson (Eds.), A practical guide to reflective supervision. Washington, DC: ZERO TO THREE Press, 61-80.

Weatherston, D., Moss, B. & Harris, D., (2006). Building capacity in the infant and family field through competency-based endorsement: Three states' experiences. *ZERO TO THREE,* 22(1), 13-20.

Weatherston, D., Tableman, B., & Foulds, B. (2014). Early Attachments: IMH Home Visiting, Southgate: Michigan Association for Infant Mental Health.

Weatherston, D., Weigand, R.F., & Weigand, B. (2010). Reflective Supervision: Supporting reflection as a cornerstone for competency. ZERO TO THREE Journal, 28(2), 17-22.

Zeanah, P., Stafford, B. & Zeanah, C. (2005). Clinical interventions in infant mental health: A selective review. In *Building state early childhood comprehensive systems series* (Vol. 13), Los Angeles: National Center for Infant and Early Childhood Health Policy.

Zero to Three. (2001). *What is infant mental health?* Washington, DC: Zero to Three. Retrieved on June 16 2013 from: www.zerotothree.org

Appendix A

IMH network group questionnaire. Data from the quantitative questionnaires were analysed using SPSS 20.0.

Demographic questionnaire. Respondent characteristics were reported and organized into Table 1.

Respondent characteristic	n (%)
Age (yrs.)	
25-30	3 (9.7)
30-35	8 (25.8)
35-40	3 (9.7)
40-45	6 (19.4)
50-55	3 (9.7)
55-60	1 (3.2)
60-65	1 (3.2)
Gender	
Male	2 (6.5)
Female	29 (93.5)
Own children	
Yes	23 (74.2)
No	7 (22.6)
Missing	1 (3.2)
Qualification	
Leaving Certificate	1 (3.2)
Certificate/Diploma	14 (45.2)
Bachelor degree	4 (12.9)
Master's degree	9 (29.0)
Doctorate	1 (3.2)

Missing	2 (6.5)
Job title	
Childcare	10 (32.3)
Pre School	5 (16.1)
Clinical Psychologist	3 (9.7)
Community Worker	3 (9.7)
Social Worker	3 (9.7)
Nurse	2 (6.5)
Room Supervisor	1 (3.2)
Centre Manager	1 (3.2)
Project Co-Ordinator	1 (3.2)
Care Assistant	1 (3.2)
Missing	1 (3.2)
Work with 0-3 age group	
Yes	23 (74.2)
No	8 (25.8)
Experience with 0-3 age group	
0-3 years	1 (3.2)
4-6 years	4 (12.9)
6-12 years	6 (19.4)
13-18 years	8 (25.8)
18+ years	3 (9.7)
Missing	1 (3.2)
Work with other age groups	
Yes	26 (83.9)
No	3 (9.7)
	2 (6.5)

Missing	
Other age groups	
4-6 years	20/31 (64.5)
6-12 years	11/31 (35.5)
12-18 years	7/31 (22.6)
18+ years	8/31 (25.8)

Table 1

Respondents also reported which IMH NG they belonged to, the year they joined the group and their average attendance. All of these data are reported in Table 2.

IMH Network Group Membership	N (%)
IMH Network Group	
Mallow 1	5 (16.1)
Mallow 2	8 (25.8)
Fermoy	18 (58.1)
Year Joined	
2006	3 (9.7)
2010	12 (38.7)
2011	10 (32.3)
2012	2 (6.5)
2013	1 (3.2)
Missing	3 (9.7)
Average Attendance	
Monthly	24 (77.4)
Less than Monthly	6 (19.4)
Missing	1 (3.2)

Table 2

Finally, respondents provided information about the services they provided and contact with other colleagues in the service community.

Service Information	Mean (SD)	N (%)
Mean no. of colleagues	12.30 (7.65)	
Contact with colleagues (daily)		
1-2 hours		5 (16.1)
2-4 hours		8 (25.8)
4-6 hours		5 (16.1)
6-8 hours		9 (29.0)
Missing		4 (12.9)
Working in the same service		29 (93.5)
Colleagues experience with 0-3 age group		28 (90.3)

Table 3

infant**mental**health

Learning Network
North Cork

www.hse.ie/infantmentalhealth
www.tusla.ie

Feidhmeannacht na Seirbhíse Sláinte
Health Sevice Executive