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NAPSW FORUM

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# Screening and Comprehensive Support Services for Perinatal Mood Disorders

## A MODEL PROGRAM FOR WOMEN IN SOUTHERN NEW JERSEY

**Susan Ellis Murphy, MA, BSN, RNC-OB, LPC**

### Introduction

In October 2006 the New Jersey legislators enacted a law mandating screening of new mothers for postpartum depression symptoms prior to discharge from any hospital or birthing facility and during the postpartum period. This law also requires healthcare providers to educate pregnant women, fathers and other family members, as appropriate, about postpartum depression. The Edinburgh Postnatal Depression Scale (EPDS) is the acknowledged instrument for compliance with this mandate. In preparation for the passage of this law, New Jersey launched the "Recognizing Postpartum Depression: Speak Up When You're Down" campaign. It became the first state to commit resources and contract with providers to screen and treat uninsured and underinsured new mothers for postpartum depression.

The Southern New Jersey Perinatal Cooperative (SNJPC) began as a demonstration project in 1981 to assess a regionalized approach to perinatal health services. Although initially focused on an inter-hospital system for transporting women and newborns, access to care, prevention and primary care became the new concerns for the organization. SNJPC's accomplishments were so impressive to the Robert Wood Johnson Foundation that a 5-year grant was issued in 1987 to duplicate and expand the SNJPC model on a statewide level. During the next 5 years, the value was demonstrated for improving birth outcomes. The NJ Department of Health (DoH) decided to continue the system and codified the network through regulation. In 1993, SNJPC was approved as the Maternal Child Health Consortium to serve the seven-county, South Jersey region and licensed by the DoH.

After passage of the screening mandate, SNJPC submitted a proposal to the DoH outlining the creation of a comprehensive support service program to identify women at risk for a perinatal mood disorder. Funding was awarded and the Postpartum Wellness Initiative (PWI-SJ) was created to serve women throughout the southern region. This article will focus on the primary goal of the model program, which was to increase the identification of women at risk for a perinatal mood disorder. A web-based EPDS screening process was developed for use at ambulatory healthcare provider locations and via the confidential telephone "warmline." Other goals of the program included: creating group support at locations throughout the region for women at risk, educating medical and behavioral health providers and recruiting behavioral health providers for those women who are in managed care networks.

### How the program works

PWI-SJ uses a care management approach that is team-based and patient-centered. It was designed to assist the client in taking an active role in self-managing her perinatal mood disorder more effectively on a day-to-day basis. The strategy for implementing PWI-SJ's care management approach at the ambulatory healthcare provider location is as follows:

**Provide** the mechanism to assure compliance with mandatory screening laws in New Jersey via the web-based EPDS process;

**Address** the needs at the healthcare provider location (screening methods: iPad vs Paper);

**Maintain** confidentiality and limit access to the PWI HIPAA-secure database (log in accounts for each staff member); and

**Educate** the staff at the ambulatory location regarding account security, response protocol to the clinical team and use and administration of the EPDS.

The PWI-SJ team works to build collaborative relationships with the participating ambulatory healthcare provider locations to:

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The National Association of Perinatal Social Workers was incorporated in Oklahoma City in 1980 as a nonprofit educational, professional organization whose mission is to promote and support excellence in perinatal social work to maximize healthy outcomes for babies and their families.

***Every baby, every family...supported with competent and compassionate care.***

# *from the president*

This is my final address to NAPSW membership as president. I am completing my second term as president of NAPSW. Inspirational presidents like Debbie Segi-Kovach, Rasa Ragas, and Lisa Baker mentored and supported me before and after my appointment. I now have the honor of doing the same for our new incoming president Ali Tiedke. Serving as president of NAPSW has been an amazing experience. As with any leadership journey, it was filled with its share of challenges, failures, opportunities, and accomplishments. In all these experiences, I have grown a lot and learned more about my leadership style, endurance, resilience, resources and supports.

I am certain that I would not be where I am today in my career if it were not for NAPSW. Being president has opened opportunities that may have never materialized. Indeed, I will now start other leadership journeys as a result of the experiences I have had as president. I will continue as liaison and board of directors' member with our strategic partner, National Perinatal Association (NPA), I will start a new position as Mayor Muriel Bowser's appointee to the DC Maternal Fatality Review Committee, and continue with teaching and mentoring students at Howard University. One of my goals at Howard University is to increase student interest in health care and unapologetically promote maternal child health and NAPSW as the premier and ONLY social work organization dedicated to perinatal social workers. My teach–ing, research interest and publications all focus on maternal and child health because of the opportunities, colleagues and leadership I received at NAPSW.

I have learned a lot about NAPSW as president, including the ability to leverage the skills I have as a perinatal social worker. I now know how to lead an organization and address the needs of members through working more effectively with the board and committee chairs to update operating manuals, develop a strategic plan, complete actions plans and develop a scholarship program. I understand the importance of having membership set the tone and guide the direction of this organization and its strategic plan. Most importantly, I know how to lean on the experience and expertise of the board and other talented members. Sometimes that requires removing obstacles in order to let other leaders shine in their respective skills.

This final address is not about me, but if I can use my personal narrative and witness to the strength and power of NAPSW in developing its members than the presidency would serve me AND membership well. If you have not considered it, nominate someone or yourself to the board of directors. If you are on the board, run for an officer position. If you want to test the waters before taking the full plunge, consider being a state representative or liaison or committee chair for web, social networking, and/or advocacy. I want our members to grow professionally as much as I have grown. Before closing this letter, I would like to thank others in leadership who have helped me have a successful term as president: Hannah Raiden Wright, Evelyn Mascarenas, Tiffany Hanff, Linda DaBear, Joan Hebert, Shelly Bunker, Dasi Schulp, Kay Ammon, Barb Menard, Beth Paul, conference chairs (2015-2019), board of directors (2015-2019) and all those I may have missed. I am both happy and excited to now follow the leadership of Ali Tiedke, the new president of NAPSW.

Warmly,

**JaNeen Cross**
**President**

## Screening

*Continued from page 1*

**Maintain** administrative contact with the location to ensure screening compliance and database security;

**Encourage** the support staff on how to reach out to the PWI clinical team with questions or concerns;

**Engage** the healthcare provider in encouraging prenatal and serial screening; and

**Provide** consultation in medication management, education and referral resources.

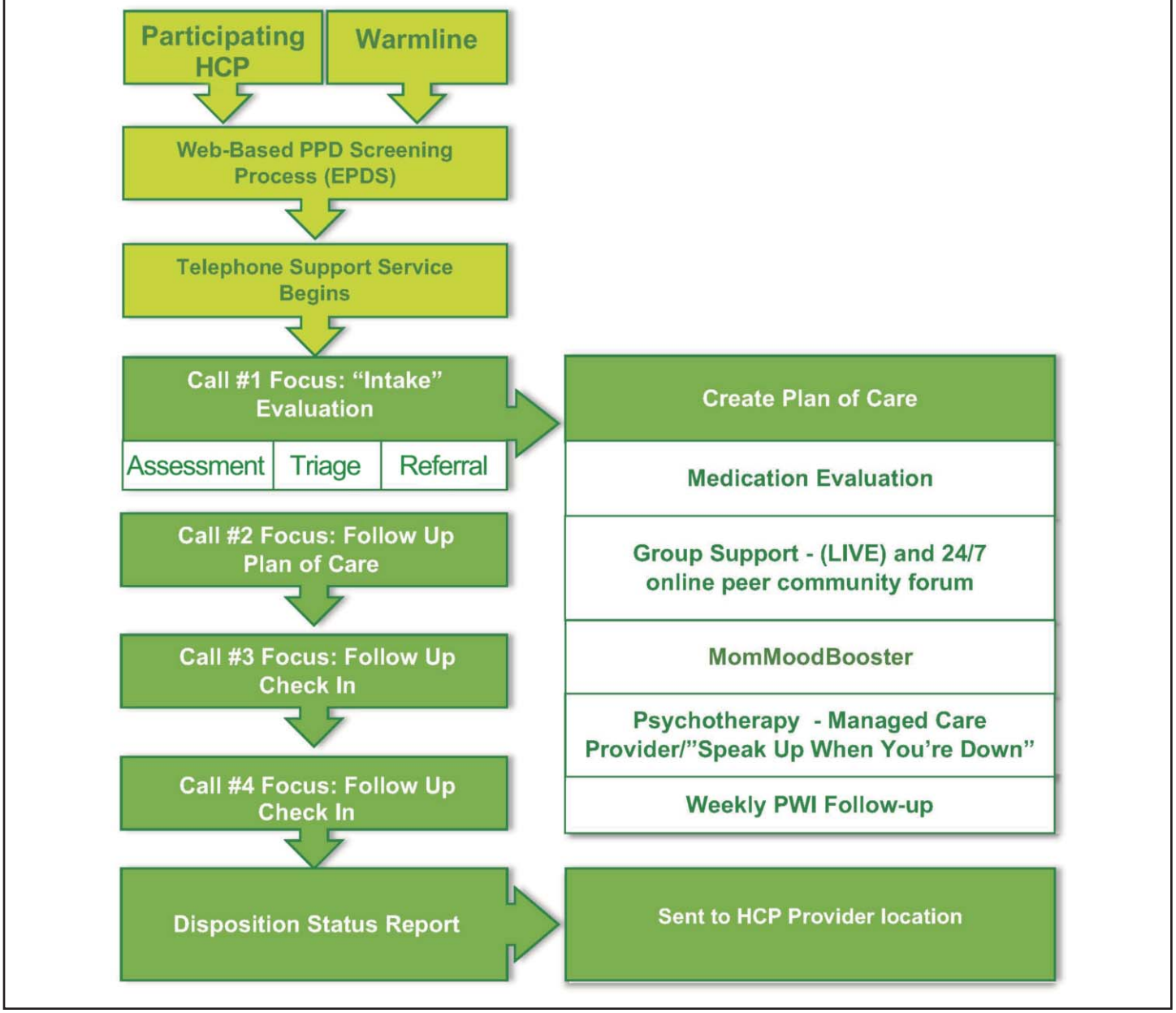
**Close the Loop!** The clinical team member sends the status disposition when the case is closed. This summary includes the plan of care, recommendations and weekly follow up data.

## It all starts with the EPDS!

The EPDS is a 10 question, self-administered tool that screens for self-reported symptoms in the last 7 days that may indicate that a new mother is at a risk for developing a perinatal mood disorder. Research has shown that the EPDS is a valid and reliable tool for screening both pregnant and postpartum women. It has been translated into many languages. The EPDS is the recommended screening in New Jersey.

*Continued next page*

## The Process: Assessment — Triage — Refer — Follow Up



The web-based EPDS process is used by healthcare providers in ambulatory settings and the PWI-SJ clinical team via the telephone "warmline." All screens are entered into PWI's secure database either via the client (iPad), a staff member at the HCP location (paper) or by a member of the PWI clinical team during a "warmline" call. High risk screens (EPDS score >11 and positive response to Question #10) are "tagged" on entry to the database or at the request of a licensed healthcare provider at the location. Healthcare provider participation includes OB and pediatric providers in prenatal care centers, private offices and federally-qualified health centers. The program is voluntary for the healthcare provider and offered free of charge to ensure compliance with mandatory screening. Currently, the web-based EPDS screening process serves sixty multi-practitioner locations. The no-cost PWI confidential telephone "warmline" is available to those women whose provider does not currently participate in the web-based EPDS screening process.

## The PWI clinician team member

The PWI clinical team member starts with removing barriers during the telephone assessment. During this initial call, she acknowledges that this is an absolutely overwhelming experience in this mom's life that is in direct opposition to what she had expected, establishes rapport; creates an environment of trust and validates the new mom's feelings and gives words to them. She assesses the caller's history, readiness to learn, as well as the motivation and activation level. The clinical team member works to create a voluntary plan of care that addresses self-management support and assesses readiness to change the current situation. There is discussion that takes place on expected/wanted outcomes, education on symptom management, medication compliance and when/how to get immediate help. By the end of the initial call, recommendations are made in reference to outpatient psychotherapy and/or MomMoodBooster (description below). Outreach and telephone follow up over the next few weeks includes monitoring and evaluation. Is she taking her medication as prescribed? Does she have an appointment with the therapist? Does she have a follow up appointment with her OB? Is she interested in enrolling in MomMoodBooster? Telephone support for her to self-manage her symptoms, goal setting, tracking her progress and encouragement for her to learn from this experience and apply this knowledge to other areas of her life.

## Program's early years: Lessons learned

**Step #1 – "Buy In" from obstetric and pediatric health providers is essential**

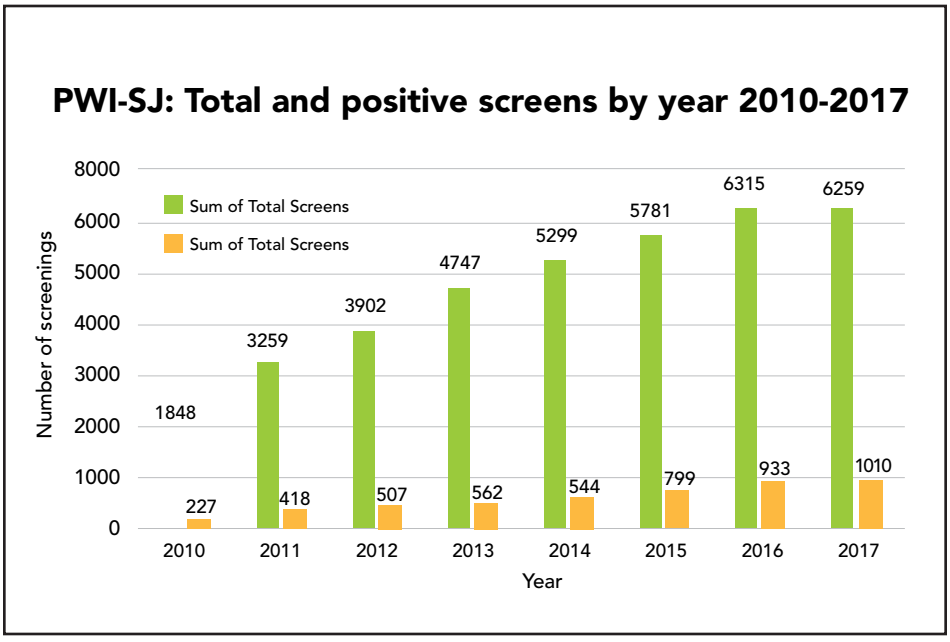
- Get your foot in the door
- Find a champion at the location whether it be a physician, midwife or nurse practitioner.
- Attend OB and pediatric departmental meetings. Pitch the program directly to them and show them how this program can benefit them and assure they are compliant with the mandatory screening laws.
- Encourage telephone consultation with the healthcare provider in the ambulatory setting. Provide education on management of psychotropic medications.
- Identify a "point person" at each location. It may be the nurse, medical assistant or office manager.
- Build a rapport with staff so they will answer your call or email. Get to know them.

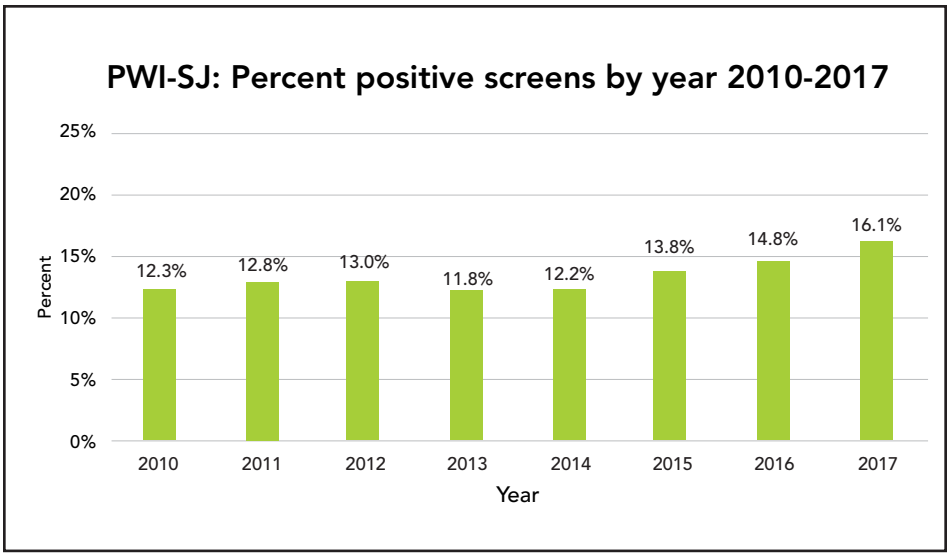
**Step #2 – Well-defined team role**

- The clinical team members are "care extenders." They provide timely feedback and easy access to address clinical concerns by staff in the ambulatory setting.
- The administrative team provides outreach to the ambulatory locations to ensure screening compliancy and maintain database security.

**Step #3 – Ongoing education for the healthcare provider and staff at the ambulatory locations**

- "Lunch and Learns" are an excellent way to provide program updates and share a location's screening data, reward compliance and address performance improvement issues.






## How are we doing?

One of the initial program goals was to offer a comprehensive screening program to help providers comply with NJ's mandatory screening law. In 2016, the Program Coordinator envisioned telling the story of the program's reach. All staff wanted to better understand how the program was being applied at healthcare provider locations. An evaluation survey was created that addressed training messages, use of the iPad/database, distribution of patient education materials and communication with the PWI staff. A staff member was identified at each participating location for the interview process.

Looking at the whole picture from screening to data entry to follow to the client disposition report, the goal was to elicit feedback about the clinical and administrative/technical support team members and program development. Concrete data on how the program was actually working were obtained. Positive feedback was given for program improvement. The survey provided a useful program synopsis for grant-writing purposes.

## What's new?

In August, 2017, Postpartum Wellness Initiative launched MomMoodBooster for women who reside in South Jersey. Mom Mood Booster is a 6-session cognitive behavioral therapy web-intervention for women with mild-moderate postpartum depression. This secure, confidential and evidenced-based internet intervention provides an important option for women. It is offered free of charge, regardless of insurance status following screening and assessment by the clinical team member. Each participant is assigned a personal coach, a member of the clinical team who provides non-therapeutic psycho-education during weekly follow up calls.

Although the program does not replace individual psychotherapy, the literature has shown that the program is particularly helpful for women who might otherwise not seek treatment due to barriers. Some barriers include stigma, cost, time management, childcare issues, lack of transportation and logistical difficulties in scheduling counseling visits.

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**Other websites:**

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4101986/
https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/caremanagement/index.html
http://www.chcs.org/media/Care_Management_Framework.pdf
https://www.ncbi.nlm.nih.gov/pubmed/23968267

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## Edinburgh Postnatal Depression Scale (EPDS)

If you are pregnant or just had a baby , we want to know how you are feeling. The EPDS is a tool that screens for symptoms of postpartum depression. It helps us know if you need extra support. Your information will be sent to the Postpartum Wellness Initiative (PWI). Depending upon your score, a clinician from PWI may call you.

**I have read the above and agree to complete the EPDS screening tool:** ☐ Agree ☐ Do not Agree

**Name:**_____ **DOB** _____

*Please circle the answer that best describes how you have felt **over the past 7 days**. Not how you feel today.*

1. I have been able to laugh and see the funny side of things.
   - **0** As much as I always could
   - **1** Not quite as much now
   - **2** Definitely less than I used to
   - **3** Hardly at all

2. I have looked forward with enjoyment to things.
   - **0** As much as I always could
   - **1** Not quite as much now
   - **2** Definitely less than I used to
   - **3** Hardly at all

3. I have blamed myself unnecessarily when things went wrong.
   - **3** Yes, most of the time
   - **2** Yes, some of the time
   - **1** Not very often
   - **0** No never

4. I have been anxious or worried for no good reason.
   - **0** No, not at all
   - **1** Hardly ever
   - **2** Yes, sometimes
   - **3** Yes, very often

5. I have felt scared or panicky for no good reason.
   - **3** Yes, quite a lot
   - **2** Yes, sometimes
   - **1** No, not much
   - **0** No, not at all

6. Things have been too much for me.
   - **3** Yes, most of the time I haven't been able to cope at all
   - **2** Yes, sometimes I haven't been coping as well as usual
   - **1** No, most of the time I have coped well
   - **0** No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping.
   - **3** Yes, most of the time
   - **2** Yes, sometimes
   - **1** Not very often
   - **0** No, not at all

8. I have felt sad or miserable.
   - **3** Yes, most of the time
   - **2** Yes, quite often
   - **1** Not very often
   - **0** No, not at all

9. I have been so unhappy that I have been crying.
   - **3** Yes, most of the time
   - **2** Yes, quite often
   - **1** Only occasionally
   - **0** No, never

10. The thought of harming myself has occurred to me.
    - **3** Yes, quite often
    - **2** Sometimes
    - **1** Hardly ever
    - **0** Never

**TOTAL SCORE** ☐

[1] Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 . *V: 04/28/2011*

# Listening to the Heart

## Music Therapy's Role in the Neonatal Intensive Care Unit

**by Brie Mattioli, MT-BC**

### Introduction

The first sound we hear in life is our mother's heartbeat in the womb. We are surrounded at that time in warmth and protection, optimized by the acoustics of hearing mother's heartbeat on repetition with the whooshing sounds of the intrauterine fluids and the calming vibrations of feeling the pulse of mother's breath. The rhythm of a mother's heartbeat is one of the most primitive coping mechanisms for pre-and post-birth infants. Rhythm itself is innate and has the power to evoke life and create harmony. Music therapy's role in perinatal work recognizes this intrinsic power of sound and uses a variety of skills and techniques to help infants organize and thrive in their new worlds outside of the womb.

Throughout this article, one will learn what music therapy is in a broad sense, as well as narrowed specifically to the techniques, efficacy and longitudinal gains observed when working within the perinatal population of a neonatal intensive care unit. I will provide NICU family testimonials and patient case studies along with details about how I practice therapeutic creativity as an expressive arts therapist.

### What Is Music Therapy?

As defined by the American Music Therapy Association (AMTA), "Music Therapy is the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program."

To become a Board Certified Music Therapist, one must attend an AMTA accredited university and achieve a bachelors and/or masters specifically in Music Therapy. Within these programs, the student will practice in a variety of practicum settings and then be required to complete a 1200-hour internship at an AMTA approved site.

Once these steps are completed, the stuent will be required to pass the board certification exam for music therapists (CBMT). A Board Certified Music Therapist will gain the title of "MT-BC" and can work with a wide spectrum of patient populations, including pediatrics, geriatrics, special education, hospice, psychiatry, rehabilitation, and trauma and this spectrum of patients a music therapist can benefit is continually expanding.

Currently, the highest demand for music therapists is within geriatrics and hospice due to more established funding for end-of-life care.

### History of Music Therapy

Music in general is a universal language and has been regarded as a powerful medium for healing since the evolution of all sound, serving as an integral element of communication development. Music used as therapy on a clinical level gained acceptance by physicians after the two world wars, "when community musicians of all types, both amateur and professional, went to veterans' hospitals around the country to play for the thousands of veterans suffering both physical and emotional trauma from the wars. The patients' notable physical and emotional responses to music led the doctors and nurses to request the hiring of musicians by the hospitals." Scientists are still trying to figure out what's going on in our brains when we listen to music and how it produces such potent effects on the psyche. The field of music therapy was officially founded in 1950 by the National Association for Music Therapy (NAMT). The American Association for Music Therapy (AAMT) was founded 20 years later. In 1998, the NAMT and the AAMT merged, creating the American Music Therapy Association (AMTA). Currently, AMTA has more than 5000 members in the U.S

### Qualities of a Music Therapist

A music therapist is a trained musician, a clinician and a therapeutic provider. Most music therapists are primarily vocalists, but they are required to play many different instruments and be familiar with current music recording technology to best serve a variety of patient needs. Music therapists use therapeutic intuition to establish goals and select interventions within their ever-expanding toolbox of techniques.

### ISO-Principle

Each music therapist may rely on an eclectic range of psychological philosophies dependent on their therapeutic preference, but are grounded by a common rule, known as the "ISO-Principle." The ISO-Principle is "A technique by which music is matched with the mood state of a client, then gradually altered to affect the desired mood state. This technique can also be used to affect physiological responses such as heart rate and blood pressure" (Davis, Gfeller, & Thaut, 2008). In essence, the ISO-Principle describes meeting the patient/client where they are at. In the clinical setting, patients of all ages are regarded as the conductors of each session: Interventions and goals will be adapted based on the patient's mental, physiological and emotional state at that time as well as their desired goals. When working in the NICU, a music therapist will take cues from the baby's affect, movements, vocalizations, physiological state (HR, RR, SpO2) and details of their environment (voices in the room, sounds of machines beeping,

## NEONATAL MUSIC THERAPY

*When working in the NICU, a music therapist will take cues from the baby's affect, movements, vocalizations, physiological state (HR, RR, SpO2) and details of their environment (voices in the room, sounds of machines beeping, etc.) in order to meet the babies where they are at in that present moment and work to transition them to a more positive state.*

etc.) in order to meet the babies where they are at in that present moment and work to transition them to a more positive state.

### Overall Music Therapy Techniques and Clinical Goals

Differing by population and patient needs, a key technique utilized by a NICU music therapist is the ISO-Principle (explained below). Other techniques commonly used within music therapy sessions are: rhythmic entrainment, environmental music, songs of kin, vocal toning, positive touch, infant-directed singing, contingent singing, instrumental play, music and movement, heartbeat recordings, songwriting and recording with the caregiver, lyrical substitution and analysis, drum circles, song circles, active instrumental play, music listening, clinical instrumental lessons, patient preferred music, and guided imagery.

The quality of the music created is often not the focus, but rather the gains achieved based on the clinical assessment of patient's projected goals. Common clinical goals are:

- relaxation
- neurodevelopmental simulation
- fine and gross motor movement
- opportunity for patient's control over environment
- normalization of environment
- positive memory/legacy-making
- pain management
- positive distraction
- self-soothing
- self-regulation
- providing various coping techniques
- family support
- caregiver-infant bonding
- self-expression
- opportunity for patient to lead (patient empowerment)

### Music Therapy in the Neonatal Intensive Care Unit

Music therapy in an NICU setting is unique and has gained more notice and accolades in recent years due to the amount of research presented which indicates the multitude of perinatal benefits for both baby and caregiver. In studies of music therapy incorporated in the NICU environment, researchers have shown that infants receive many benefits:

- earlier discharge
- more rapid weight gain
- less risk for developmental delay from prolonged hospitalizations
- stronger opportunities for caregiver-infant bonding
- decreased agitation
- increased self-soothing and self-regulation
- better visual tracking
- improved sustained attention length
- faster language development
- more consistent demonstration of positive social smiles and brightened affect
- more successful breast feeding and skin-to-skin experiences with mother
- faster recovery from pain (i.e. heel pricks, vaccinations, etc.)

According to one of the most resourceful NICU music therapy texts, *Music Therapy in the Neonatal Intensive Care Unit:* "Research has demonstrated that presentation of music in the NICU helps increase oxygenation in infants with respiratory dysfunction (Collins & Kuck, 1991), and promotes healthy respiration and heart rates. Music has also been shown to provide analgesia for infants with chronic pain (Standley, 1998). Moreover, music has been shown to reduce stress for infants in the NICU (Shwartz, Ritchie et al., 1998). In addition, it has facilitated self-regulatory processes, such as nutritive and nonnutritive sucking responses (Standley, 1998); increased feeding efficacy (Caine, 1991); and has reduced infants' physical agitation, thereby assisting in the preservation of precious calories" (Caine 1991; Collins & Kuck, 1991). Researchers found that "[w]hen lullaby music was played in the NICU there were fewer episodes of oxygen desaturation." Current research is extremely compelling and has created a strong platform for music therapists to present in clinical settings to gain trust with physicians, nurses and the entire interdisciplinary team, inclusive of patients, families, social workers, child life specialists, spiritual care, NICU developmental team and more.

One of the most compelling aspects of research reflects on the decibel levels of sound recommended in the NICU setting. The standardized maximum level of noise recommended for the NICU setting by the American Academy of Pediatrics is 45 dB., However, when implemented by a trained music therapist, "[m]usic intervention using sound levels between 65 to 80 dB rendered results of soothing behavioral changes, higher oxygen saturations, and more rapid weight gain" in the NICU setting (Cassidy & Ditty, 1998). This is because music is "different than noise, it is organized sound" (Standley, 2010). Furthermore, infants in the NICU setting may be at risk for delays due to sensory deprivation. Incubator noise and ambient sounds mask the sound of human voices and may contribute to the premature infant's sensory deprivation.

**Music Therapy in NICU**

- more rapid weight gain/earlier discharge
- faster language development/less risk for developmental delay from prolonged hospitalizations
- more successful breast feeding
- opportunities for caregiver-infant bonding
- increased self-soothing
- better visual tracking/longer sustained attention
- positive social smiles/brightened affect
- faster recovery from pain

Creating an environment filled with positive, peaceful sound controlled by a music therapist improves these infants' opportunities for positive neurodevelopment sensory stimulation and serves as a bridge the outside world, helping them better tolerate everyday noise after discharged to home.

Remembering the power of the heartbeat once again, music therapists are able to incorporate a variety of techniques that significantly affect infants in the NICU on a physiological level. The "rhythmic entrainment" technique utilizes the ISO-Principle to match patients' physiological statistics (heart rate, respiratory rate, oxygen saturations) and manipulate these to a more positive baseline. Rhythmic entrainment is a pillar technique, akin to the ISO-Principle, that aims to encourage patients' relaxation, self-regulation, and self-soothing within the intensive care unit settings, especially within the neonatal population. Research has illustrated consistently that with the use of music therapy, patients can receive significant benefits with their heart rate and respiratory rate decreasing, while their SpO2 increases. A music therapist carefully guides the tempo based on a patient's physiological rates displayed on their monitor.

If there is ever a question of music therapy's validity in the NICU setting, the infant's monitor should be regarded, because there is high efficacy in the infant's gradual decrease of elevated heart rate and respiratory rate, with a simultaneous increase in the infant's oxygen saturation (if clinically needed) as the music progresses. This effect is produced by the music therapist matching the rhythm of the infant's elevated heart rate and then gradually slowing the tempo to synchronize the music therapist with the infant and guide the infant to a more positive physiological baseline.

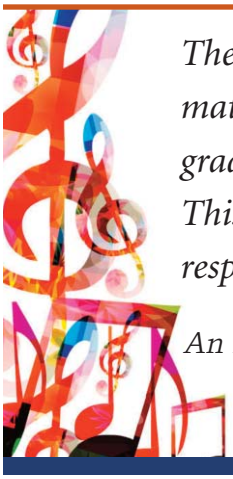
Rhythmic entrainment is also used significantly to encourage infants during nutritive activities. By entraining to the baby's sucking rate and rhythm on the pacifier, bottle, and/or mother's breast, the music therapist is able to regulate the baby's pace, strengthening its consistency and encouraging a baby to suck more rhythmically. Similar to running while listening to music, a baby will feed better when a rhythm for their sucking rate is being supported. According to one of NICU music therapy research pioneers, Joanne Loewy's, DA, LCAT, MT-BC, practice of "Rhythm, Breath, Lullaby" (RBL) a small wooden box, known as a "gato box" is helpful to mimic the sucking rate of baby. Additionally, guitar, voice, and an ocean drum are successful tools to incorporate. Jane Standley, PhD, MT-BC, another pioneer of NICU music therapy research, has contributed quantitative evidence that music "can be used to reinforce sucking rate and endurance" (Standley, 2000). Standley and other researchers have found daily weight significantly improved (in some cases doubled) when premature babies in the NICU were exposed to music therapy (Standley, 1998), resulting in "3 to 5 days earlier discharge" (Caine, 1991).

Music therapists may choose to use their voice to match the infant's vocalization (e.g. crying out-loud). They may use a technique known as "contingent singing" to mirror their vocalizations and relax them to a degree where baby feels heard and safe, resulting in a form of conversation between infant and music therapist. One of the leaders in NICU music therapy research, Helen Shoemark, PhD, RMT, is the founder of this technique and provides significant evidence supporting the power of

*[F]or virtually all of us, music has great power, whether or not we seek it out or think of ourselves as particularly "musical." This propensity to music — this "musicophilia" — shows itself in infancy, is manifest and central to every culture, and probably goes back to the very beginning of our species. … Much of what is heard during one's early years may be "engraved" on the brain for the rest of one's life. … [Music] may be especially powerful and have great therapeutic potential for patients with a variety of neurological conditions.*

Preface to *Musicophilia*

Author Oliver Sacks, CBE FRCP (1933-2015) was professor of neurology and psychiatry at Columbia University Medical Center and professor of neurology at the NYU School of Medicine.



*The ISO-Principle is a "technique by which music is matched with the mood state of a client, then gradually altered to affect the desired mood state. This technique can also be used to affect physiological responses such as heart rate and blood pressure."*

*An Introduction to Music Therapy: Theory and Practice*
Davis, Gfeller & Thaut, 2008

the human voice alone. Along with contingent singing, techniques such as "tonal vocal holding" (humming melody) and "vocal toning" (vocalizing tones) are significant techniques used to empower infants by mirroring their vocalizations, making them feel heard and safe. These vocalization techniques are often improvised and repetitive to appeal to the infant, allowing them to feel as though they are effectively communicating with the music therapist. Since babies are unable to describe verbally what may be distressing them, these techniques can be extremely powerful in promoting an infant's abilities to self-soothe, relax, distract from pain, self-regulate, and eventually serve as a positive step towards language development. Additionally, these techniques can be taught by the music therapist to the caregivers, creating stronger efficacy with the use of familial voices as well as serving as a strong tool for caregivers to use for continuity of care.

"Environmental music" is another pillar technique used within most music therapy sessions in all settings. Due to the importance of how sensitive infants are in particular to their immediate surrounding environment, music therapists utilize a combination of all of the techniques to transform the infant's environment from positive to nurturing. Rhythmic entrainment is used to adapt to the tempo of both physiological rates of the baby displayed on their monitor as well as the potential rhythmic tapping of mother's hand on the baby's back, rocking of baby's swing, beeping of baby's machine, etc. The ISO-Principle is used to regard baby's facial affect (expressions) and movements. Songs of kin, family preferred music, tonal vocal holding, and vocal toning are used to alter the negative sounds of the environment to a more positive baseline, essentially transforming a NICU room into as close as possible to a comfortable nursery setting for baby and family. Combined with reflective listening, words of encouragement, and guided imagery/ relaxation/ deep breathing techniques with baby's caregivers, this transformation of baby's environment can carry substantial benefits to the entire patient-family centered care experience. Positive change enacted by all of these tools require a wide range of observation by the music therapist to sensory details, as well as an authentic therapeutic presence to make the baby and caregivers feel comfortable, and courage to improvise an adapt every moment being sensitive to the entire room's needs. One researcher reports, "When lullaby music was played in the NICU there were fewer episodes of oxygen desaturation" (Caine, 1991). This is how powerful the potential of music is in this setting.

Sensitivity to the details is truly a key to success in creating positive change in the mist of the perceived "chaos" of an NICU setting. Music therapists have even gone to the lengths of discovering what infants prefer musically. For example, term infants may prefer higher pitched singing and consonance over dissonance. Infants also prefer repetition of simple melodies with small intervals (distance between two pitches) when they are first born, and grow to prefer more complex melodies with larger intervals once their tolerance of neurodevelopment stimulation expands. Many studies have been conducted with the favorite lullaby song, "Twinkle Twinkle, Little Star" to which infants have shown a significant preference because of its repetitive and simplistic interval melody. Applying this principle of understanding infants' musical preferences to caregivers' favorite songs ("songs of kin") creates opportunity for the music therapist to expand song choices being offered during sessions from purely infant developmental songs to songs of kin with a lullaby feel. For example, if a family's song of kin is "Proud Mary" the music therapist can adapt the song to have more of a lullaby feel, and, thus be better suited for the infant at that time. Additionally, "lyric substitution" can be used, and the music therapist can work with the caregivers to reword the song to be individualized for their child, serving as a special memory, and meaningful staple to their child's musical repertoire.

## Songwriting and Recording with the Caregiver

Taking it a step further, songwriting with the caregiver can provide exponential benefits in terms of caregiver-infant bonding, family support, adjustment difficulties, coping with long hospitalizations, positive memory/legacy making and continuity of care to home. Different techniques can be used, but my preference is to begin with an interview style format with the infant's caregiver. Questions such as, "What dreams do you have for your baby? For your family? For yourself?" are asked to the caregiver present and a sheet can be sent home with the same questions if a family member at home would like to contribute to the songwriting process. Musical preferences are also asked along with if they would like to participate musically during the writing and recording of the song.

In one case, the infant's mother was a singer and she was brave enough not only to write but record the song that she'd written with me

during her baby's hospitalization. "Benny's Song" lyrics follow on next page (with the consent of the mother).

This mother remarked how she felt the entire experience to be highly therapeutic for her and how she sincerely valued having this special memory she created for her son, displacing some of the painful memories experienced during his extended stay in the NICU. If the caregiver chooses not to participate musically, they can still be instrumental in the lyric writing process. In either case, the caregiver is sent home with a recording of their CD completed with the music therapist singing and playing accompaniment for their special song.

"Proud Shiloh" (lyrics printed below with consent) illustrates how I worked with an NICU mother, using lyric substitution to rewrite their song of kin, "Proud Mary" to "Proud Shiloh."

This mother shared this testimonial with me, stating, "Music is the one thing that I can always do for our boy no matter the circumstances. It's how I can connect with him even when I can't hold him. Thank you for giving me that gift and for being such a huge part in my son's life and bringing such amazing music into it. Thank you for sharing your beautiful talent with us, we see your heart in what you do and we are so thankful you share that with us."

In addition to songwriting with the caregivers, I have recorded my process of creating, "Individualized Lullaby CD's" (Brie Mattioli, 2016) which are singing lullaby versions of patient preferred and parent-requested songs. These CD's have been integral in providing continuity of care to home, as well as within the use of NICU developmental therapy treatments (physical therapy [PT], occupational therapy [OT], speech therapy [ST]) in the absence of the music therapist's presence for that session. Live music is always preferable considering the many benefits gained from a trained music therapist being present to adapt to the patient and environment during the session, but with consistency of the same voice and generalized NICU music therapy techniques, the CD's have proven to be a significant tool.

## Music Therapy's Role in Palliative Care, End of Life and Bereavement

Music therapy has also found a significant role within the more recent movement of improving palliative care for patients. Music therapists have begun utilizing new technologies to record patients' heartbeats before they pass, serving as legacy/memory making for the patient and a keepsake for the patient's family. As part of this process, a referral is made, often by a social worker or case manager who knows the family, and the music therapist has a conversation with the family asking if they would like for their child's heartbeats to be recorded. Families rarely decline this offer for keepsakes and are given the choice to add a special song to their child's heartbeat CD if they wish. The music therapist then creates the infant's personalized heartbeat CD by editing two to four beats of their heartbeat and create a looping of it to have both solo on one track of the CD and incorporated with a song (sounding as the drumbeat of the song) if the family chooses a special song. These "Heartbeat Song CD's" are then given to the infant's family. This service currently exists in many hospitals, especially pediatric hospitals, and it is a way many creative arts therapists can help patients and families cope with a palliative or end-of-life prognosis. Furthermore, this reflects once again on the importance of the heartbeat. Everyone's heartbeat is unique and symbolic of that person's rhythm of life.

## The Importance of Working Within an Interdisciplinary Team

From my perspective and many other like-minded expressive arts therapists, it is highly important to integrate and work well within an interdisciplinary team. Music therapy in the past had received some negative connotation, regarded as a "holistic healing modality." Although it is indeed holistic, healing and a modality, the proven clinical benefits have demonstrated clinical efficacy enabling music therapy to take its place on the same tier with other therapeutic disciplines, such as occupational, physical, and speech therapy. The new wave of music therapists in clinical settings advocate strongly to be accepted as colleagues with therapists in other disciplines. Patients in turn receive stronger benefits and therapists are able to achieve more goals by working as a team. I am a strong proponent of collaboration with the NICU developmental team — OT, PT, ST, Child Life specialists, lactation consultants, spiritual care and others. By working together, families feel more supported and patients have opportunity to reach their goals more efficiently, while obtaining the benefits from these goals on a longitudinal scale.

## As a Social Worker, when is it appropriate to refer?

Technically, almost every patient in a pediatric setting can be regarded as an appropriate candidate for music therapy services, especially within the NICU population. Due to the heightened demand of music therapy in this setting and typically not enough funding for a music therapist to be on every unit, music therapists have to prioritize their census based on the acuity of patient needs. Oftentimes, patients who are most critically unstable and in need of pain management would be given the highest priority. Specifically, in NICU settings, babies who have a complex diagnosis, are subjected to multiple surgeries, or likely to have a prolonged hospitalization would be considered high priority. Based on an NICU social worker's knowledge, a baby on a hospital hold, withdrawing from maternal substance abuse, with complicated family dynamics or lack of family support, anticipated to stay for a prolonged hospitalization, in need of caregiver support for coping with hospitalization, and maternal/paternal anxiety/ depression would be considered the highest priority. In my experience, the social workers have been instrumental in referring patients to me for music therapy. Additionally, when a patient is deemed palliative or end-of-life, a social worker can be one of the best resources for notifying Child Life and a music therapist to create keepsakes/legacy making for the patient and family. By receiving

## Benny's Song

*Love, mom*

Benjamin, Benjamin, my little Benjamin
How much I love you
We were so scared for you
But you showed us the truth
You are a fighter

You are my baby boy
And I'll always be here for you
Reach for the brightest star
You can do anything you want to

You are my baby boy
And I'll always be here for you
Reach for the brightest star
You can do anything you want to

Benjamin, Benjamin, my little Benjamin
How much I love you
You make my skies so blue
I'll always love you
My little Benjamin

You are so strong
Just like your Daddy
You make us so proud

Benjamin, Benjamin, my little Benjamin
How much I love you
We were so scared for you
But you showed us the truth
You are a fighter

## Proud Shiloh

*Love, Mommy and Daddy*

Left a good womb in my mommy one month early
Working with no fluid every night and day
Mommy and daddy lost lots of minutes of sleep
In the hospital for 8.5 weeks

Mama Roo keep on rollin'
While dialysis keep on flowin'
And we're dwellin' and we're dwellin'
On dialysis

Listen to my warrior story

Cleaned a lot of toxins with my PD Dialysis machine Dixy

Spent a lot of time gettin' snuggled by my kidney team
But I never missed a feeding time
No matter how much or how little I was fortified, I never seemed satisfied

So Mama Roo keep on rollin'
While dialysis keep on flowin'
And we're dwellin' and we're dwellin'
On dialysis (x2)

Listen to my warrior story

Proud Shiloh (x3)

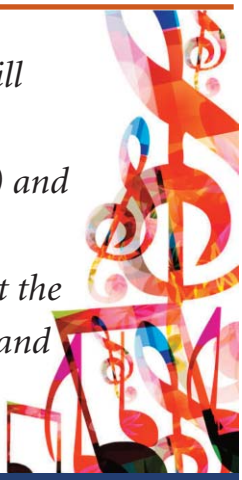
this reason for referral, a music therapist can speak with the family and offer heartbeat recordings, heartbeat song CD's, and live music during withdrawal if the family desires.

## Conclusion

As illustrated throughout this article, music therapy holds an incredibly unique and significant role in perinatal work. In this setting, music therapists serve as the vessels for creating positive sound, relief from pain, and happy memories for the NICU infants and families. This is despite how medically critical the environment may be. Both the infants and caregivers are treated as the patients in a family-centered dynamic and caregivers are taught how not only to communicate more successfully with their baby, but also are given moments of joy and comfort by nurturing the beauty of their innate connection. Babies who are not fortunate to have a supportive family system with which to enter this world are supported by the NICU interdisciplinary team and, therefore, leave our NICU with less developmental delays, more acclimation to positive touch, and the promise of a better future despite their difficult beginnings.

When speaking of music therapy in a clinical setting, many intuitively regard the benefits and remark, "Well, of course, music is medicine." The more powerful effects come from the understanding that music combined with medicine is a force to be reckoned with. By tapping into the intrinsic power of the heartbeat, using rhythm and observation as a guide to transform these infants' everyday symptoms into symphonies of positive sound, there are huge gains to be achieved. To people without this knowledge, music therapy in the NICU may be perceived as simply serenading a baby. As more research and recognition continues to blossom in this field, I hope the powerful effects of music therapy in this setting will be more accurately understood, renowned and appreciated, thus creating more funding so one day every patient and family in a NICU setting will have the opportunity to receive this uniquely transformative therapy.

*When working in the NICU, a music therapist will take cues from the baby's affect, movements, vocalizations, physiological state (HR, RR, SpO2) and details of their environment (voices in the room, sounds of machines beeping, etc.) in order to meet the babies where they are at in that present moment and work to transition them to a more positive state.*



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# NEW MEMBER SPOTLIGHT

## NAPSW is happy to welcome three new members: Rebekah Hazlet, Maria Reale and Benjamin Russell

### Rebekah Hazlet, PhD, LMSW

Rebekah is new to the field of perinatal social work and she was thrilled to discover the NAPSW while considering next steps in her personal and professional growth. Rebekah received her MSW from the University of Central Florida (UCF) in 2002. She also holds a PhD in Public Affairs and Social Work from UCF.

Rebekah has over 10 years of teaching and administrative experience in the university setting and is currently an Assistant Professor of Social Work at Middle Georgia State University. Prior to discovering a passion for teaching social work, Rebekah was an LCSW in Illinois. Her clinical experience included medical social work, hospice and home healthcare services. Now an LMSW in Georgia, Rebekah is seeking opportunities to complete her remaining clinical supervision hours—preferably in the area of perinatal social work—to reestablish her LCSW and "break into" perinatal social work.

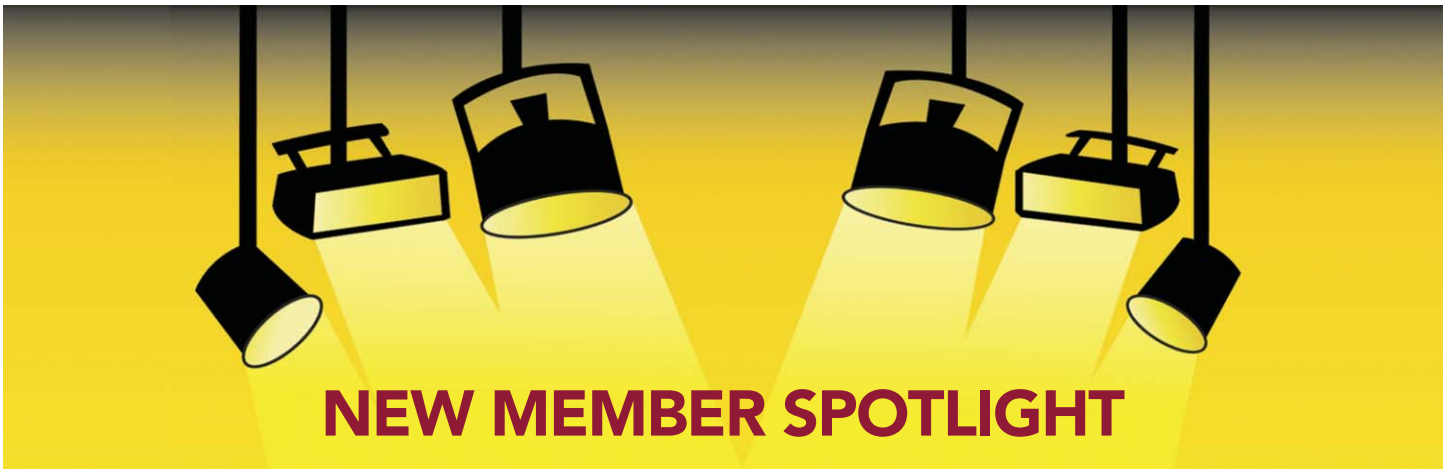
Over the past three years she has developed an interest in supporting the needs of families with newborns and small children; particularly in the areas of breastfeeding and access disparities. Building on her academic roles, she has worked with the Healthy Start program of Pembroke, North Carolina, the Public Health Department of Robeson County, NC and Macon AIM in Georgia regarding initiatives related to infant mortality, breastfeeding, and early literacy. She is also completing steps for La Leche League Leadership in order to provide support in her community to breastfeeding families. She looks forward to the opportunities for growth in knowledge and networking that await her as a member of NAPSW.

On a more personal note, Rebekah and her husband, Eric, have two children ages three and seven, who keep their lives full of love and activity. As recent transplants to Georgia, Rebekah and her family enjoy spending time exploring all that urban and rural Georgia have to offer, including Atlanta, local small towns and festivals. In her limited alone time, she enjoys gardening, learning about and sampling wine and doing her best to stick to yoga and exercise.

### Benjamin Russell, MSW, LSW

I received my BSW in social work in 2016 from Ohio State University (OSU). The following year I earned an MSW through an accelerated OSU program. I completed my internship in the NICU at Nationwide Children's Hospital (NCH) in Columbus, Ohio. Currently an LSW, I am employed at NCH and working towards my LISW.

At NCH I am one of eight neonatal social workers. Five of us manage the 130-bed inpatient unit; three social workers manage the outpatient clinics, which include an early developmental follow-up clinic, the bronchopulmonary dysplasia (BPD) clinic and neonatal abstinence syndrome (NAS) clinic. My primary work assignment is on our newer neonatal floor that has 16 private rooms, primarily designed to house our NAS infants. Each room is equipped with a bed, TV and full bathroom to help promote parents staying at the bedside.



# NEW MEMBER SPOTLIGHT

One day each week I work in our outpatient eye clinic doing care coordination for our retinopathy of prematurity population. I participate in our safe-sleep committee and monthly NAS committee, comprised of a large multi-disciplinary team focusing on interventions and practice guidelines to best support families and patients during their infant's hospitalization. Two of our main goals are to decrease length of stay and decrease the need for pharmacological treatment when possible. We are always working to increase non-pharmacological interventions for these infants, as appropriate.

My wife Shelby and I were married in 2016. We live with our two cats and newly adopted dog, Max. Social work is actually a second career for me. I graduated from culinary school in 2008 and spent the next 7 years working as a line cook and chef in fine dining restaurants. Cooking remains one of my passions in life, along with my obsession for our hometown Columbus Blue Jackets NHL team.

**Maria Reale, MSW**

Maria's career has always been in hospital social work and primarily hospital pediatrics. After receiving her MSW at Cleveland State University in 2002, she joined the University of Michigan Health System-Michigan Medicine, spending the first 3 years in an outpatient pediatric traumatic brain injury day treatment program. This multidisciplinary program provided therapeutic services to anyone under the age of 18 who had sustained a brain injury. These services included social work counseling for parents and guardians.

In 2004 Maria transitioned to inpatient social work as a member of the ICU team at C.S. Mott Children's Hospital, Ann Arbor. She was assigned to the pediatric cardiothoracic ICU and worked in this role from 2004 to 2009. She provided social work support to the staff and patients' families who came from all over Michigan and the U.S. for heart surgery and cross-coverage for her colleagues in the pediatric ICU as well as the neonatal ICU.

From 2009 to 2015, Maria took time out from social work for her two daughters (now nine and a half and six). Upon her return to the University of Michigan Health System-Michigan Medicine, she covered the Children's Emergency Department as a contingent social worker. Her duties included weekend coverage for the entire C.S. Mott Children's Hospital. In 2016 became a part-time social worker in the trauma-burn ICU at University Hospital, Ann Arbor, where she provided social work support to patients who had sustained a traumatic injury and/or burn and their families as well as the staff.

Last year Maria accepted a full-time position in the neonatal intensive care unit at C.S. Mott Children's Hospital, Ann Arbor. Maria is one of the NICU's two full-time social workers, providing social work support to the infant's families (who travel from all over the state for this complex care) and NICU staff. Maria participates in the Ronald McDonald House (RMH) Family Centered Care committee that meets quarterly. This group works diligently to address the needs of the families that utilize the RMH facilities to provide them with comfort during the most stressful periods of their lives that requires them to be away from their homes.

At the NAPSW conference in Savannah, Maria presented with her NICU-Social Work partner. Maria is thrilled to be a member of such a supportive and resourceful group of social workers!

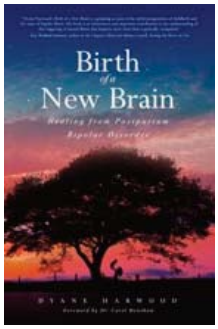
# Book Review

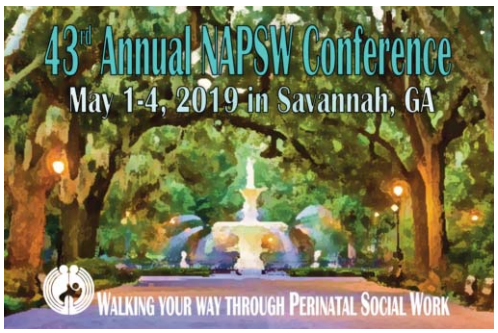
## Birth of a New Brain by Dyane Harwood

**Reviewed by Sandy Dykstra, APSW**
**Children's Hospital of Wisconsin**
**Milwaukee, WI**

This book is a compelling read, hard to put down after getting to know the author. Dyane Harwood writes in a style that makes you feel like you are reading a letter from a friend. She shares her journey of a life with Bipolar Disorder. She reflects on her childhood and how that is connected to her emerging, then all-consuming, diagnosis of Bipolar Disorder. The author ("a thoughtful, introspective writer her whole life") is able to take us on her journey of self-discovery. The birth of her baby leads to her own birth of a brain learning, to live and thrive with Bipolar Disorder—"a birth of a new brain."

The author shares the highs and lows of her journey with honesty and openness. Her courageous writing, although therapeutic for her, is to be commended. The author tries many modes of treatment and shares her experiences, both positive and negative. While her Bipolar Disorder seemed to emerge more definitively after pregnancy and childbirth, she sensitively reflects on her family history as well. In addition to her story wonderfully told, the author includes an excellent appendix full of informative basics about Bipolar Disorder, an exercise module, guidance for creating a peer support group, and an excellent list of recommended reading. While the book specifically addresses the author's experience with Bipolar Disorder, it can serve as a helpful primer on considering the feelings of our families experiencing any mental health complications during and after a pregnancy. The range of emotions that the author shares with us reminds us of the range of normal emotions we can expect when life is complicated by mental health challenges. While the author did not have an NICU experience, we as NICU practitioners struggle to understand what our families are going through, and this is a very honest picture of what someone with Bipolar Disorder may be experiencing. It gives some concrete information that can help us help others in navigating the additional stressor of the NICU experience.




## Savannah NAPSW Conference, May 2019

Many NAPSW members gathered in Savannah last May. We listened and learned. We discussed personal challenges and professional concerns. We connected with old friends and entered into new friendships. We had fun. And we came away with new insights and renewed energy for our work. Stay tuned for conference highlights and photos in the summer issue of FORUM.


## NAPSW 2020 CONFERENCE

# Chicago

APRIL 29–MAY 2

## Theme: Securing the Good in the Second City: Perinatal Social Work for All

**Dates:** Wednesday, April 29 to Saturday, May 2
**Place:** St. Jane Hotel, 230 N Michigan Ave, Chicago

- Located downtown, just south of the Chicago River
- Room blocks, Monday 4/27 to Sunday 5/3
- Rooms w/ King-size bed, $199/night; two Queen-size beds, $209/night

**Transportation**
**Airports:**

- Midway:
  - ~$30 cab/Uber ride to hotel
  - Public transport: Easy access to take Orange and Red Line to hotel
- O'Hare
  - ~$40 cab/Uber ride to hotel
  - Public transport: Easy access to take Blue and Red Line to hotel

**Parking:**
Most affordable to use an app like "Spot Hero." Daily rates for ~$15 and extended stay rates for ~$125 (4 nights).

**Night Out:**
Chicago Architecture Foundation Center River Cruise

**Committee Involvement:**
If you are interested in being a part of the planning committee, please contact:
Kim Stobbe: kstobbe@NCH.ORG
Kelli Weber: weberkelliann@gmail.com

# NAPSW: From the Beginning

**From the Board of Directors Manual**

Although the National Association of Perinatal Social Workers was incorporated in May 1980 at the Fourth National Conference on Perinatal Social Work in Washington, D.C., its early beginnings go back several years to 1974.

It was then, in 1974, that a Tri-Regional Workshop on Maternal and Child Health Services was held in the southern part of the country. The program included a workshop on perinatal social work, attracting social workers who were working in Newborn Intensive Care Units (NICU's). Those who attended found that they were all in similar situations—-struggling for an identity within their units, functioning without guidelines or formal job descriptions, had little or no support from the unit medical staff, and were generally unclear as to what services they could offer to patients, families and staff.

That next year, the Newborn ICU Social Work Staff at the University of Tennessee, City of Memphis Hospital sponsored a second meeting to bring together perinatal social workers. Although only three of the ten invited attended, and the six Memphis staff outnumbered them by two to one, they found that this type of meeting to share ideas and experiences was invaluable.

Horizons broadened in 1976 when the Eight Memphis Conference on the Mother, Fetus and Newborn sponsored a day-long session on perinatal social work. Formally known as the First Memphis Conference on Perinatal Social Work, the meeting attracted 85 social workers from 27 states. Again, participants were relieved to meet others who were doing the same things and struggling with the same problems.

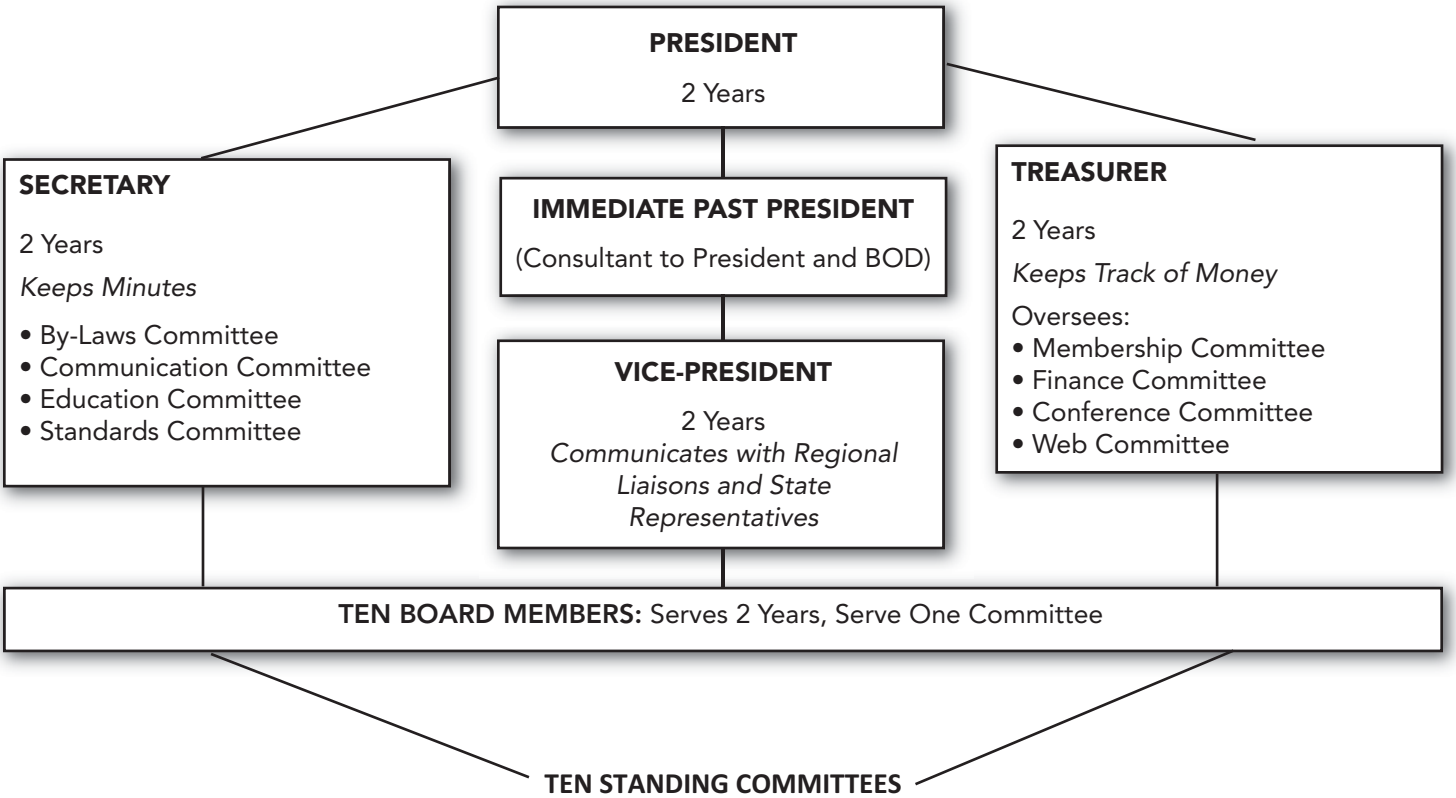
At the closing session, it was decided that the conference concept should continue as an annual event and be located in a different city each year. Eighteen months later, the Second Conference on Perinatal Social Work was held in Denver, Colorado. Since that time, annual meetings have been held each May.

For the two years from the close of the Denver Conference in 1978 through the 1979 conference held in San Diego, California to the spring of 1980, a fifteen member volunteer group worked on the task of forming a national organization. Although the annual conferences were perceived as vital in bringing perinatal social workers together, it was also seen as important to dialogue throughout the remainder of the year. An organization was needed to provide the formal mechanism for ongoing communication and sharing.

Thus, in 1980, the National Association of Perinatal Social Workers was officially born. Its purpose, as stated in the By-Laws, is "to promote, expand and enhance the interests and role of social work in perinatal health care."

*Perinatal social workers intervene to:*

- *Work with women and families to assess their strengths and challenges as they approach child-bearing;*
- *Ameliorate the effects of psychosocial and medical challenges by working directly with the woman and family, while also assisting them to access long term supportive services where needed;*
- *Assist in creating healthy and nurturing parent-child relationships;*
- *Advocate for the woman and her family within the health care setting and in the community.*




1. Communications Committee/Forum: Chair is appointed; Editor is a paid position
2. Education Committee: Chair is appointed – Other Eligible Members
3. Executive Committee: President, VP, Immediate Past President, Secretary, Treasurer
4. International Committee: Chair is appointed
5. Long Range Planning: Immediate Past President is Chair, Other committee members are President, Treasurer, 1 Canadian Board Member, 1 Board Member, 1 Member at Large
6. Membership Committee: Chair is appointed by Executive Committee — Others are Eligible Members
7. Nominating Committee: Chair is appointed by Executive Committee — 2 Members Elect
8. Program Committee: Chairs are those Hosting Conference (Present, Treasurer, Past Program Chair, and other Members)
9. Standards Committee: Chair is appointed — Others are Members
10. Web Committee: Chair is appointed, Web Master is paid professional

## OTHER COMMITTEES

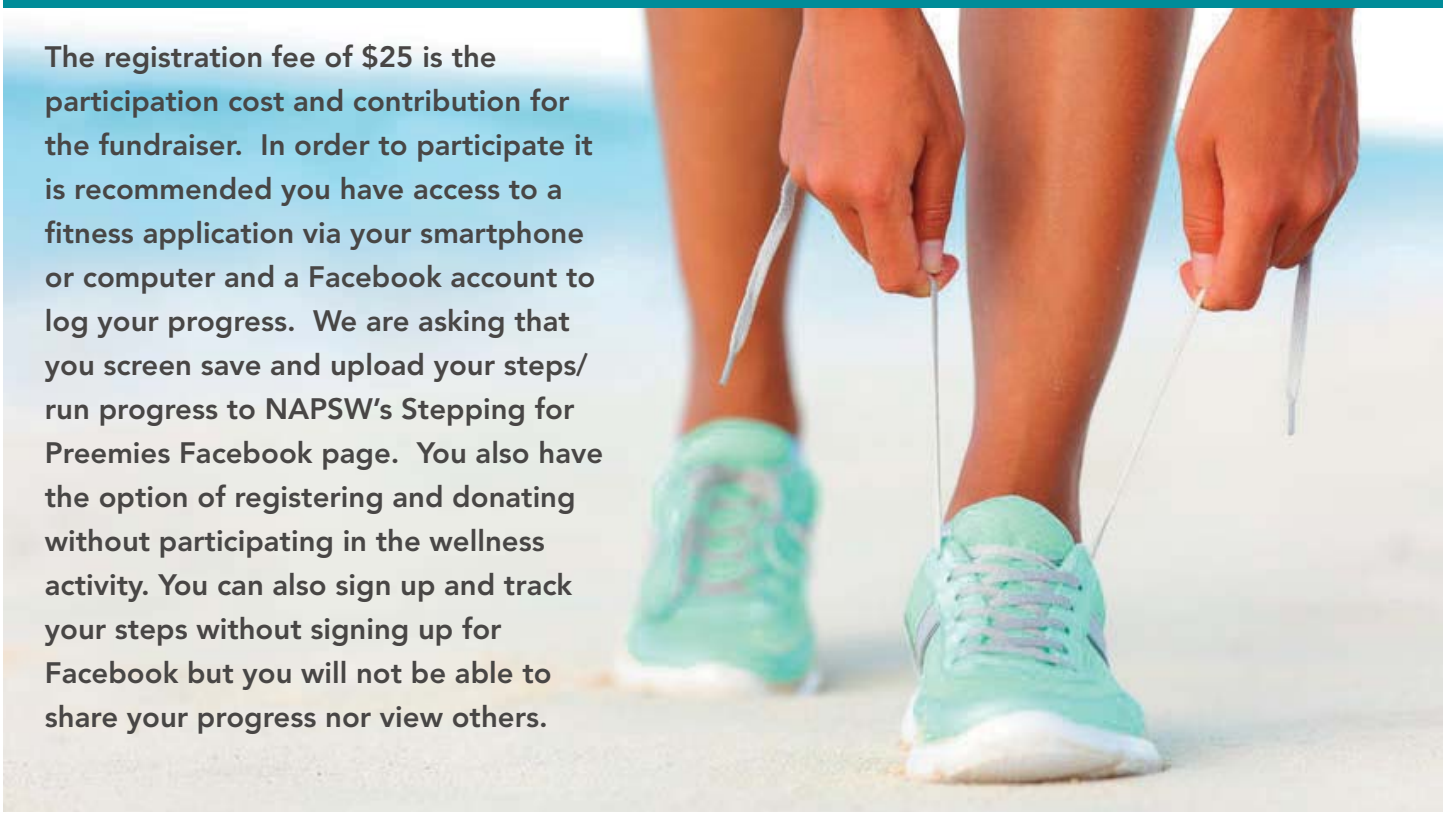
1. Awards: Immediate Past President is Chair — Coordinates Award for Excellence — Consultant and Board
2. By-Laws: Chair Volunteers, Other Eligible Members and Members at Large
3. Finance: Chair is Treasurer, Previous Treasurer on Committee
4. National Perinatal Association: Chair Volunteers, Coordinates on-going contact between NPA and NAPSW
5. Social Action: Chair Volunteers, Other Members
6. Social Networking: Chair is appointed — Others are Members

National Association of Perinatal Social Workers

# STEPPING FOR PREEMIES

## A Healthy Way to Raise Funds For Hospital Family Support Programs and NAPSW Scholarships

**This fundraising campaign is meant to be a wellness activity that raises funds for both for NAPSW conference scholarships and Family Support Programs for local NICUs! How do we do this? Use your tracking device (Fitbit, Smart Phone app, Up Band, etc) to monitor and keep track of your steps.**



**The registration fee of $25 is the participation cost and contribution for the fundraiser. In order to participate it is recommended you have access to a fitness application via your smartphone or computer and a Facebook account to log your progress. We are asking that you screen save and upload your steps/ run progress to NAPSW's Stepping for Preemies Facebook page. You also have the option of registering and donating without participating in the wellness activity. You can also sign up and track your steps without signing up for Facebook but you will not be able to share your progress nor view others.**

**How To Participate:** Register using the link below. You will then be invited to access the private NAPSW Stepping For Preemies Facebook page where you can upload photos, share your progress and throw some shade at your competition! May enroll in groups of up to four and even give yourself a team name.

**When:** Register anytime. The campaign starts July 1, 2019 and ends August, 31, 2019.

**Cost:** $25 per individual

**What Do I Get Out of It?:** The opportunity to improve your fitness in a fun way, while raising money for hospital family support programs and NAPSW scholarships.

**Can I Still Do It If I Don't Want to Join Facebook:** Yes. Registering does not require signing up for Facebook or participating in the private NAPSW Stepping for Preemies Facebook page.

**Do I Have to be a Member of NAPSW?:** No. Anyone and everyone is welcome to participate.

The National Association of Perinatal Social Workers

# Call for Papers

## 44th Annual NAPSW Conference
## April 29 - May 2, 2020

## *"Securing the Good in the Second City: Perinatal Social Work for All"*


NAPSW is seeking workshop presentations for the 2020 Conference. Specific areas of interest are: perinatal and social work ethics, enhancing social work clinical skills, difficult conversations with perinatal families, surrogacy, adoption, antenatal support, fetal diagnosis and support, NAS, end-of-life and bereavement, staff support, professional boundaries, cultural competency, mental health, self-care, perinatal social work reasearch, and NICU.

Please submit a one page, double-spaced description/abstract of the material to be presented, with three (3) learning objectives. Include a cover sheet that contains the title, author's name(s), professional credentials, phone number, and email address.

Call for Papers due November 30, 2019.

Send abstracts to Rasa M. Ragas at
rragas@lumc.edu or rragas@ameritech.net.

www.napsw.org