**INFANT MENTAL HEALTH SERVICE – DRAFT SERVICE MODEL - VERSION 4**

## 1.0 Purpose

The overall aim in commissioning the infant mental health service is to increase the universal, targeted and specialist support for 0-2 year olds and their parents and carers. A key route for delivering this will be by increasing existing staffing capability.

This service supports the Leeds Children and Young People's Plan key priorities of

- Helping children live in safe and supportive families
- Ensure that the most vulnerable are protected

And will support the citywide obsession to reduce the number of Looked After Children

## 2.0 Planned outcomes

- Increased numbers of parents who have been identified as vulnerable in the antenatal period feel that they are emotionally supported and develop confidence in their parenting abilities
- Increased numbers of parents/carers of pre-school children (0-2yrs in the first instance) are capable of providing a secure, containing and reciprocal environment
- More infants and children are able to remain at home with their parents in safe and nurturing circumstances
- Increased numbers of children entering school with secure attachment, and relationships which support healthy development and readiness to learn

## 3.0 Aim, Rationale and Evidence[1] Base

The aim of the Infant Mental Health Service is to promote awareness of the importance of infant mental health in Leeds, to advise and support with regard to the development of coherent strategies to meet the needs of infants and pre-school children and to directly support practitioners and parents to best meet the emotional needs of this population.

*'The essence of infant mental health lies within the parent-child relationship'*
[Solchany & Barnard, 2001)

Babies are born pre-programmed to seek out and adapt to the relationship that they have with their parents. The child's first relationship with the primary care giver, acts as a template for all subsequent relationships. The quality and content of this primary relationship has a physical effect on the

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[1] The evidence of a case to invest in the service and the model of delivery is summarised within *An Infant Mental Health Service: The importance of the early years and evidence-based practice (The Child Psychotherapy Trust, 2002)*

neurobiological structure of the child's brain that will be enduring. The brain is at its most adaptable, or plastic, for the first two years after birth. Secure attachment is a protective factor conferring confidence and adaptability, although not a total guarantee of future mental health, and without this resource neither child nor adult will be free to make the most of life's possibilities.

Children with problems related to insecure attachment begin to soak up statutory resources from early on when 'externalising' behaviour (aggression, non-compliance, negative and immature behaviours, etc) demands a response. The most sensible and economic time to put in therapeutic resources is into promoting and supporting the primary relationship.

Evidence supports the principle that proactive, strength based programmes beginning either pre-natally or at birth, have the greatest and most sustained effect.

It has been noted that there has been an inverse relationship between investment into resources for mental health interventions and age *(Getting It Right for Children and Young People, Kennedy Review 2010)*. Hence whilst infants and young children have the most potential to benefit from appropriate interventions, they receive the least resources. This anomaly has informed the conclusions of the Graham Allen's recent independent report which charges Government to establish an Early Intervention Foundation *(Early Intervention: The Next Steps 2011).*

The IMH service would play a central part in the local delivery of services that the Early Intervention Foundation is seeking to promote.

The IMH service can be seen as one key part of the specialist end of the continuum, which will support and promote good practice in universal and targeted service delivery through the provision of training and consultation (i.e., the Early Start Service) and undertake some direct (specialist) clinical delivery.

## 4.0 The service will provide:

The Infant Mental Health Service will ensure support is provided for all 0-2 year olds and their parent/ carers by both supporting universal and targeted services to develop their knowledge and skills (capability) in infant mental health and through holding a small specialist caseload (as per referral criteria and infant mental health pathway – see appendix 1).

The service will:

- Provide a training programme to community midwifes and the Early Start Service workforce on promoting infant mental health/ attachment, and on early identification of attachment problems and support
- Provide consultation/supervision to Early Start Teams and joint visits as appropriate

- Provide specialist clinical assessment and intervention; Psy

**5.0 Target Population:**
In the first instance the target population is 0-2 year old infants and their parents/carers

**6.0 Activity:**
For 2012/13 the team will consist of:
- Consultant Clinical Psychologist 0.4wte; Specialist Health Visitor 1wte, Infant Mental Health Practitioners 1.6wte, Child & Adolescent Psychotherapist 0.2wte.
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For 2012/13 the activity will be:

1. 30 training days will be delivered in the 6 months (20 working weeks).This equates to 1.5 training days per week. (3 days per week if training delivered by 2 trainers).

   (It is anticipated that 12-15 training days will be delivered in the year 2013-2014.)

2. Leeds IMH service will offer approximately (52) team consultations in 2012/13

3. Leeds IMH team will offer individual case consultation to approximately (104) phone consultations in 2012/13 and approximately (52) one to one case consultations in 2012/13

4. Leeds IMHT will offer approximately 20% of resources to direct work with families. This will amount to approximately (208) sessions in 2012/13 Interventions will range from brief (1-2 contacts) to long term (20 plus contacts, to be reviewed every 6 contacts)

5. “Sessions” will include patient contact and time spent writing up reports and other substantial pieces of case work

6.

The resource will be used flexibly in response to need; for example in the first year it is anticipated that more training will be delivered to Early Start teams; consultation will be available to teams once they have received the initial training programme.

Activity levels will be re-profiled with commissioners for 2013/14

## 7.0 Pathways:

The infant mental health service supports pathways from prevention, assessment, identification, intervention and on-going care/ discharge. The service offered at each stage will be tiered as

- Universal – training and consultancy to the Early Start service
- Targeted – joint working as appropriate with the Early Start service
- Specialist – direct clinical assessment and intervention

It may be that any individual may move from universal to specialist and back to universal. Initial contact with the team will be practitioner (Health Visitor) to practitioner, via a phone consultation and no direct work to families will take place unless a face-to-face professional consultation has taken place.

## 8.0 Eligibility criteria for targeted or specialist tiers:

Pregnant women and infants (24 months and under) where there are serious concerns about the attachment relationship between infant and primary carer.

In essence the attachment relationship is the 'client' for the IMH service and will be the main focus of the therapeutic intervention(s). When individual work is undertaken with one or both parents it will be in order to address barriers or impediments to the healthy emotional development of the infant and of the attachment relationship. Thus issues such as domestic abuse, past history of abuse and neglect, low mood etc may be appropriate to refer to the IMH service in some cases and not in others. In practice teenage parents and their infants are likely to be considered as suitable for referral to the service, but not inevitably.

### 8.1 Referral pathway:

Referrals are accepted from health visitors (Early Start Teams), midwives (including specialist midwives), family nurses from the FNP team, school nurses, and CAMHS practitioners.

All referrals are to be initiated by the referrer contacting the IMH service (the manager, specialist HV for IMH, or one of the IMH practitioners) for discussion (face to face or telephone) of potential referral and suitability of referral. The IMH service manager will have the final decision on acceptance or not of referrals. Where the referral is not deemed suitable support and advice will be provided to the referrer to assist in case-management.

If the referral is accepted as suitable, a formal referral will be made in writing on IMH referral form (paper or electronic version). Incomplete referrals will be returned to referrer for full completion.

## 9.0 IMH Intervention:

The team may contribute to assessments of infant-parent relationships alongside other professionals where appropriate.The team do not have the

resources to undertake numerous stand alone parenting capacity assessments within a child protection plan.

Key interventions are one or a combination of:

Universal

- Early attachment psycho/education training ('Understanding Your Baby,' etc) and consultation (see detail below)

Targeted/Specialist

- Specialist assessment and formulation
- Parent/carer video feedback
- Parent infant psychotherapy (e.g., Watch, Wait, Wonder)
- Psychometric assessment of parent or infant functioning/ development

**9.1 Consultation/ supervision**

Consultation and supervision will be provided to Early Start teams and other groups of prioritised practitioners e.g., the Family Nurse Partnership teams. Regular meetings (4-6 weekly) will take place for case discussion and topic based discussion as appropriate. Each IMH practitioner will be aligned to specific teams and will meet regularly with each team/group. Evaluation of effectiveness will be monitored through the use of CHI, in addition to tools to capture helpfulness and increased knowledge and confidence.

**9.2 Training Programme:**

The training programme delivered will consist of:

1. 'Supporting Parents to Understand their Baby: Applying Attachment Theory' (full day – accessed via the CAMHS Training Offer)
2. Introduction to Attachment Theory (half day– accessed via the CAMHS Training Offer)
3. 'Understanding Babies and Promotion Secure Attachment Relationships' (full day for Early Start Teams):
    - Early Brain development
    - Attachment Theory
    - Understanding Babies (Infant State/ Infant Behaviour/ Infant Cues)

**10 Potential Evaluation Tools/ Measures:**

Training

1. Training evaluation feedback form (CAMHS standard form)

Consultation

2. Feedback from practitioners on consultation using tailor made measure

Clinical Intervention

3. Feedback from practitioners using CHI (CORC measure)
4. Quality of Interaction using NCAST (with or without video record)
5. Goals based outcomes
6. Session by session monitoring

7. Infant measure (e.g., Ages and Stages questionnaire)
8. Parental measure (e.g., parenting stress or mood/ anxiety measure

## 11 Service current resource

For 2012/13 the team will consist of:

- § Consultant Clinical Psychologist 0.4wte; Specialist Health Visitor 1wte, Infant Mental Health Practitioners 1.6wte, Child & Adolescent Psychotherapist 0.2wte.

Grow service by 1wte HV (band 6) in 2013/14 and a further 1wte (band 6) in 2014/15 (part of planned investment into HV workforce)