

positive beginnings

exploring UK provision for
the social and emotional
development of babies

Understanding
Childhood

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1 Executive summary

1.1 The importance of infant mental health

Research on brain development shows that the structure of the baby's brain is formed by experiences in the first few years of life.¹ It is in this sensitive period that children learn about emotions and social interactions in their family. Children who experience a poor relationship in their early years with the adults who care for them, have a greater likelihood of developing significant mental health problems,² conduct disorder and educational difficulties.³

Early preventative interventions have the potential to improve the parent-infant relationship. Infant mental health interventions focusing on the parent and infant can help form a secure attachment and act as a protective factor, minimising the risk of developing a mental health problem.⁴ However, the development of such schemes within child and adolescent mental health services (CAMHS) is fairly limited. Many CAMHS services are overstretched with long waiting lists. Given the pressure to meet existing demands, they are often not in a position to develop an infant mental health scheme.⁵

1.2 Aims and objectives of the study

The Child Psychotherapy Trust (CPT) Early Days Project has explored service provision in England and Wales focused on meeting the mental health needs of young children aged under three. Based on a small-scale largely qualitative design, the project has primarily gathered data from staff working in a sample of child and adolescent mental health services (CAMHS) about what services they offer to this client group. Alongside this, the study also attempted to pick up on any developments in this area offered by other providers such as voluntary sector agencies.

In addition, seven services were examined in depth, to consider how the provision has been developed, the successes and problems encountered, and to try and build up a picture of what components are required to enable a service to function effectively. Three of these services were CAMHS led; two operate under the auspices of Sure Start; one is run and managed by a health research unit, and the final scheme is organised and managed by a voluntary agency.

The overall aim of this modest project has been to provide some information and to stimulate interest

in the state of service development across the country. Key objectives included the following:

- ▶ To clarify the role and the attitudes of professionals with regard to the need for and development of infant mental health provision.
- ▶ To identify the factors which may assist in successful service development – or alternatively, the barriers which may impede this process.
- ▶ To highlight and share good practice in the field.

1.3 Research findings

Overall, the data gathered suggests that provision focused on meeting the needs of young children, including early intervention approaches, are becoming more common. Many services have developed solely within CAMHS, although other agencies are increasingly becoming involved, often under the auspices of Sure Start. However despite this increase, the scale of provision is limited, has often emerged in an ad hoc way and varies considerably in terms of quantity, quality and nature of service provided.

The research draws attention to the major pressures facing CAMHS and indicates that there is confusion about professional roles and responsibilities for this young client group. The challenges of inter-agency working have also been apparent. Very few CAMHS have been lucky enough to develop an infant service free from difficulties, notably accessing funding, and due to these difficulties, it appears that existing schemes are often the result of a few interested professionals who feel passionate about the area of provision. On a more positive note, as the case studies presented throughout this report illustrate, some innovative practice is emerging.

Key findings from the study include the following:

- ▶ Most of the provision identified is, in theory, offered on a universal basis to all families with young children. However in practice, many services are targeted on 'high risk' or vulnerable families, notably, young teenage mothers.
- ▶ Most schemes are focused on the under fives age group and data about services for the under threes is particularly sparse.
- ▶ Very few services offered input at the ante-natal stage.
- ▶ The nature of interventions/approaches offered varies widely and can include direct work with families/children; fast-tracking referrals; parenting groups, the training and support of primary care workers.

- ▶ Referrals for children at the upper end of the 0 to 5 age bracket predominate. This finding tends to suggest that an identified risk of using a wider age band is being borne out. That is, children at the upper end of the band will attract most attention and dominate referrals since any behaviour problems are likely to be both more developed and crucially, more visible/recognised due to their greater contact with outside agencies.
- ▶ Many barriers exist which are impeding service development. These include problems accessing funding; the overload on CAMHS and shortage of CAMHS staff generally, and the lack of staff with specific training/skills in working with young children under three.
- ▶ A lack of professional agreement over whether infant mental health services should fall within the remit of CAMHS is another significant barrier to effective and coherent service development – although the overwhelming majority of study respondents indicated that they felt there was a need for early intervention services for this client group.
- ▶ There appears to be a widespread lack of evaluative data about services in the UK, which can compound the problems of securing funds to develop service provision.

1.4 Recommendations

It is beyond the scope of this report to say where infant mental health services should be sited. Various options present themselves, including the development of dedicated services within CAMHS. Alternatively, services could be linked in some way to paediatrics or developed on a standalone, multi-agency basis including CAMHS, education, housing and voluntary sector agencies.

Whichever option is chosen, for the effective development of these services, a variety of things need to be in place – a clear and coherent policy framework and guidance; adequate numbers of properly trained staff and workforce planning; inter-agency liaison and collaborative working; systems for gathering data about outcomes and evaluating provision, and underpinning all of this, appropriate levels of funding.

Bearing these in mind, the following recommendations are made with regard to the development of infant mental health services in the UK:

A clear policy context

It is important that there is recognition within the National Service Framework for Children of the importance of addressing the emotional and relationship needs of parents and children under three, and ideally under two. This will provide an invaluable aid to the development of a comprehensive, consistent infant mental health strategy across CAMHS and other agencies and will go some way to clarifying professional roles and responsibilities.

Inter-departmental and inter-agency co-ordination and planning

There must be ongoing liaison and planning with staff implementing national policy initiatives such as Sure Start to ensure that the needs of this age group are given due attention.

The role of CAMHS

It is highly likely that CAMHS will continue to be a central player in infant mental health services given their responsibilities for supporting children, young people and their families. As such, it is crucial that ongoing attention is paid to tackling the numerous pressures and shortages affecting CAMHS nationally. In particular, Tier One services need continued support to ensure that they are able to develop to provide accessible, community-based services for families with babies and young children.

Workforce planning

The allocation and training of staff to work with this group requires attention, likewise the support and supervision needs of staff working with families who may often be highly vulnerable and/or hard-to-reach. The commissioning of and funding for services must also be properly examined.

Building up the knowledge base

More systematic national research, evaluation and sharing of good practice from UK-based services is needed, underpinned by secure funding, to build up the evidence base. The views of service users must also be addressed since data from this perspective is particularly sparse.

Education and health promotion

Across different professional groups, not only in health, there needs to be ongoing education and promotion of the importance of infant mental health.

2 Introduction

2.1 Overview

Over recent years, there has been increasing recognition that positive early childhood experiences are vital for healthy emotional development. Evidence on brain formation shows that during the first few years of life, the brain develops rapidly and is at its most malleable.⁶ Trauma or neglect experienced during this sensitive period, if left unaddressed, can lead to a range of problems in later life.⁷

Work conducted in the US and Europe demonstrates that well structured early intervention schemes focusing on the emotional relationship and attachments between caregiver and infant can, if administered with thought and consideration, have a beneficial impact on the lives of vulnerable families.⁸

Throughout the UK mental health provision for infants remains fairly limited, with confusion existing about whom should be professionally responsible for the delivery of an infant mental health service. Initiatives such as Sure Start are however making good progress. Similarly, the National Service Framework for Children provides a major opportunity for policy development in this area.

2.2 Purpose of the report

This report forms the second phase of The Child Psychotherapy Trust's (CPT) work on promoting infant mental health and emotional well being. It aims:

- ▶ To explain the value of an infant mental health service.
- ▶ To discuss the components required to enable a service to function successfully.
- ▶ To identify factors which may facilitate service development and/or barriers which may impede this process.
- ▶ To highlight and share good practice in UK-based services.

This report has been written to complement another new report published by the Child Psychotherapy Trust that examines the literature and international research on early intervention services, Reducing Risks: Relationship-based services for babies and parents.⁹

2.3 Background to the study

Inequalities in Child and Adolescent Mental Health Services (CAMHS) have been the subject of debate for sometime. In national reports produced by the Audit Commission and by the NHS Health Advisory Service, CAMHS were shown to be fragmented and insufficient.¹⁰ CAMHS are notoriously perceived as overloaded with long waiting lists that mean they are unable to respond promptly to referrals. Often, they also have to set strict guidelines in accepting cases. Within this, infant mental health services are often low on the list of priorities,^{11 12} and also, by their very nature of wishing to intervene early and proactively before a crisis presents, do not fit easily in the reactive crisis-driven mode of operation that many CAMHS have had to adopt.

Since the publication of these reports, Sure Start has become operational. Local programmes work with parents-to-be and children under four to promote the physical, intellectual and social development of babies and young children. Sure Start has been successful in developing greater awareness of the need for early intervention.¹³ The face of CAMHS and child health provision is also changing with the development of new child-centred initiatives, strategies and the allocation of significant amounts of money to improve CAMHS through the modernisation programme.

The Children's Taskforce is one such strategy created to drive forward all aspects related to child health. The Taskforce currently has eight project areas including:

- ▶ Overseeing the development of new standards through the **Children's National Service Framework**.
- ▶ **Cross government support for families and young people at risk** – work in this arena includes involvement in the delivery of services to children under four through the **Sure Start** project.
- ▶ Child and Adolescent Mental Services – Working with the CAMHS elements of the National Service Framework to reduce geographical inequalities.

A further joint development from the Department of Health and Department for Education and Skills Together from the Start is concerned with the delivery of services to children with disabilities in the age range birth to 2 and their families. Some of the key themes of this document, which was released for consultation in May 2002, were: active partnership with parents, and the prompt and co-ordinated assessment of needs.¹⁴

Inclusion of mental health promotion in some of these developments represents a major milestone. For the first time, the need for a cohesive mental health standard has been recognised. However, it has been contested that despite efforts to develop services for children in terms of education, not enough emphasis is placed on the **mental health** of infants. Young infants are not well served, instead falling through the gaps in the service provision with nobody claiming responsibility for care of their mental health.¹⁵

2.4 Study design

The study is a largely qualitative piece of research, based on the following:

- ▶ A review of relevant literature and research.
- ▶ A mapping of provision across the country based on postal questionnaires, telephone interviews and some site visits.
- ▶ In-depth examination of seven case studies of well-established services or approaches to working in this field.

Further details of the methodology, the response rates achieved and the issues considered in the interviews and questionnaires, are given in Appendix 1.

2.5 Structure of the report

The report is aimed at two key audiences – firstly, professionals who wish to develop a service for

families with children aged under three and secondly, policy-makers working in the field of mental health and in provision for children and families. There is a need to build up data about the range of provision currently on offer across the UK and to share information about good practice. It is hoped that the data gathered by the Child Psychotherapy Trust, whilst based on a small-scale, quite limited study, may make a contribution to both of these areas.

The report has been structured so that the research findings and the lessons learnt from both the mapping exercise and the case studies comprise the central piece of the report – Chapters 5 and 6.

Before that, Chapters 2, 3 and 4 provide the context for the study. This includes a brief review of the relevant literature on early intervention initiatives, research on early brain development and some discussion of the issues highlighted about research in the mental health field, notably about risk and protective factors. In the final chapter, the findings are considered overall in reaching some conclusions about the state of service development in this field.

In addition to the chapters, a number of case studies have been interspersed within the report. The selected services were chosen to be geographically representative and to present schemes that have as their focus the emotional relationship between the caregiver and infant.

3 A case for early intervention

3.1 What is early intervention?

Early intervention is not a straightforward issue and at the outset interested parties are faced with a range of questions. What is meant by early intervention and how early should they intervene? What type of early intervention is effective and who should provide it? What evidence is there about long-term effectiveness of early intervention? Will intervention have any economic benefits? Should interventions be targeted or universal?

In this chapter, some of the recent research findings concerning these different issues are outlined, to provide the background context to the research undertaken by the Child Psychotherapy Trust.

3.2 Research on brain development

Research suggests that the areas of the brain that mediate emotions and empathy are dependent upon relationship-based experiences.¹⁶ Therefore, the early relationship formed between the infant and the caregiver is crucial:

'Abuse and neglect in the first years of life have a particularly pervasive impact. Pre-natal development and the first two years are the time when the genetic, organic, and neurochemical foundations for impulse control are being created. It is also the time when capacities for rational thinking and sensitivity to other people are being rooted – or not – in the child's personality.'¹⁷

During this early stage of life, an infant must receive **good enough care** from their caregiver thus facilitating the development of a secure attachment. However, if the environment does not allow for good enough care, the result can lead to non-optimal brain development. A significant body of literature highlights that children who do not receive adequate care during this sensitive period of development often form insecure attachments that lead to difficulties in later life:

'These are the children who do not use education, who disrupt the classroom who demand attention as they become either bullies or victims and who sometimes harm themselves as much as others. During their teenage years they attract labels as an alternative to success – conduct disorder, disruptive pupil, delinquent or disturbed and mental health diagnoses get dropped around them out of desperation.'¹⁸

Up until the age of two the infant brain is at its most malleable and infants have the ability to adapt to

their social environment.¹⁹ Therefore, where there are difficulties for parents and infants to form secure attachments, early intervention can be most effective. A well designed sensitive early intervention scheme that focuses on enabling the parent and infant to form a good secure relationship can redress the balance and enable the brain to develop normally.

After the age of two the plasticity of the brain starts reducing and it becomes more and more difficult for interventions to be effective and to alter the brain's neural networks.²⁰

3.3 Information about risk and protective factors

There is a considerable range of research data concerning the range of factors that may place a young child at greater risk of developing mental health problems, or alternatively those factors that may be protective.²¹ This data provides further justification for interventions to be offered at an early stage in a child's life, for whilst some of the factors identified apply to older children and adolescents, many are obviously relevant to infants and in particular, touch upon the influence early parenting may have in either promoting or impeding children's mental health development.

In addition, this information provides a useful body of knowledge to draw upon in considering how early intervention services may be targeted and the range of issues and needs that services may have to address.

Risk factors may be found within the child, the family or within the child's local environment. They may include specific developmental delay; overt parental conflict or family breakdown and homelessness. (Please see Appendix 2 for a more comprehensive table of these various risk factors).

The prevalence of risk factors does not always mean the development of a mental disorder but the literature suggests that families presenting these have a significantly increased chance of incurring problems.²²

Protective factors are those likely to minimise a child's chance of encountering mental health problems. These factors might include some of the following:

- **Protective factors in the child:** temperament; positive self-image; secure attachment; cognitive skills.

- **Protective factors in the family:** affection and good parental relationships; supervision; adults building up and not putting down.
- **Protective factors in the community include:** good housing; high standard of living; access to wider social network.²³

3.4 International research

In the US, early interventions for vulnerable groups have been shown to work as a preventative measure with the potential of reducing difficulties such as insecure attachments, which can lead to conduct disorder and delinquency.²⁴

The accompanying report to this one, by Robin Balbernie, explores international early interventions and provides examples of schemes in the US and Europe.²⁵

Other international research by Egeland et al, in discussing the value of early intervention, analyses the repetitive nature of abuse to gain an understanding about why some abuse continues, whereas others are able to break the cycle of abuse. He suggests that:

'Early intervention can prevent damaging patterns emerging and build up a child's resilience to cope with the changes demanded by separations and new relationships and learning.'²⁶

3.5 Economic evaluation

'The purpose of economic evaluation is to inform decision about the best use of limited resources ... The most common definition ... is a systematic attempt to identify measure and compare costs and outcomes of alternative interventions.'²⁷

Interest in the costs of different service provisions has been a subject for discussion in recent years. Underpinning the need for cost data is the growing demand for evidence based practices. One such research project that focuses on counting the costs of early intervention is presented in the report Handbook of Early Childhood Intervention.²⁸ This work, which presents an economic analysis of early intervention programmes in the US, argues that there is an economic advantage to intervening early: 'Early intervention for disadvantaged children and their families can be a sound economic investment.'²⁹

Research conducted by Knapp et al demonstrates that the long-term cost of providing reactive services to children once they have a behavioural disorder as opposed to intervening early and preventing a disorder is significant.³⁰ Further studies conducted in America explore the cost of child abuse verses child abuse prevention. Results from this work again support the argument for preventative approaches to be implemented.³¹

Portsmouth – Premature Babies Service

Intervention model

The birth of a baby brings with it emotional anxiety for any new parent and when the baby is premature, these feelings are often heightened. The neonatal element of Portsmouth CAMHS targets this risk group **supporting parents with premature babies**.

The service, which is funded by CAMHS, was set-up just over one year ago and adopts a **parent-infant psychotherapeutic approach**. The provision is delivered by a child psychotherapist who provides one session per-week to the local hospital.

The model is based on the philosophy that secure attachments formed in early life are crucial for healthy development:

'In my work I have seen a lot of children who because they were not securely attached to their mother and father have had lots of problems so I believe in early intervention to ensure a better attachment.'

Mothers who are perceived as having poor quality attachments with their babies are referred to the service and receive a series of interventions. The approach is flexible and thus

the number of sessions given is dependent on need. In some cases, work may continue up to one year following the child's birth. Promotion of attachment and support is achieved partly through enabling the parent/s to respond to and recognise their baby's cues:

'It's about helping the mother to pick up cues from their premature babies because they do not communicate in the same way that other babies do and sometimes it is difficult for mothers to communicate with their premature babies.'

Training/professional involvement

The child psychotherapist providing the service works closely with the neonatal nurses, paediatricians and the CAMHS paediatric liaison team to ensure delivery of the provision.

Evaluative outcomes

The service is currently unevaluated although steps are being taken to design an evaluation process. Generally however, parents have found the service to be of value in a difficult time and have expressed gratitude that such a provision is available.

Tavistock Clinic Under Fives Counselling Service

The Under Fives model offers brief focused interventions to families with babies and pre-school age children. It provides a quick response to concerned parents and professionals. Families are contacted as soon as possible and seen within two to three weeks of referral. In the first instance, five meetings are offered, with the possibility of further sessions being available if required.

Common problems attended to are feeding and sleeping difficulties, tantrums, separation anxieties, toilet training or the effects of divorce, separation, post-natal depression and bereavement on the family. Help is also offered for a range of behavioural and developmental difficulties. Counselling is available for families with problems in pregnancy, and where there is perinatal bereavement.

Intervention model

In the counselling sessions, parents have an opportunity to discuss their concerns, to reflect on their interactions with their babies or young children, and to consider external and internal factors that may be contributing to their current difficulties. A particular focus of the work is the attempt to understand children's communications and non-verbal behaviour through their play and drawings and to help put their feelings into words, enabling them to feel understood. On the whole, parents and their children are seen together so that an understanding of the difficulties, and changes within family dynamics can be worked on together. On occasions parents will be seen on their own, if this is considered to be helpful.

The work of this service is influenced by a psychodynamic understanding of human relationships, training in infant observation, and findings from recent child development research.

The Under Fives Counselling Service is in the process of expanding to include parent-infant/toddler groups held at the Tavistock Clinic or in community settings, and to offer joint work with professionals from the community or voluntary agencies.

Training/professional involvement

The service is run by a multidisciplinary team of senior staff from the Child and Family Department. Child psychiatry, child psychotherapy and child psychology trainees are members of the team which also runs workshops for case discussion, where the primary focus is training. It also offers opportunities for dialogue with other professionals from the community or voluntary agencies involved in this area of work.

Referral process

Families may self refer (depending on geographical location) or request a referral from their G.P. or other professionals who may be involved.

Evaluation outcomes

The Under Fives Counselling Service is well-established and has carried out various audits in which parent satisfaction has been consistently high. There is on going evaluative monitoring of the service and in this process, the outcomes will be compared with similar work done in other clinics.

4 Infant mental health provision: key issues and dilemmas

This chapter provides an overview of some of the key issues and dilemmas relevant to the development of services for children under three and their families. Some of these were prominent in the review of the literature undertaken in the course of this study, or alternatively, were raised in the study interviews.

4.1 Defining infant mental health

One of the biggest problems in this area is that there is no widely agreed definition of infant mental health. For some, the term itself is difficult to grasp, whilst others accept the term infant mental health as recognising that infants as well as children and adults have mental health needs.

The lack of a definition poses considerable challenges for researchers in this area and also in the development and evaluation of provision. It is often hard to tell whether services are truly focused on the mental health needs of infants given there is wide variability in the way that services are delivered to this group. The lack of clarity also leaves many service providers unclear of their roles and responsibilities.³² Finally, when talking about infant mental health, the role of caregivers and the carer-child relationship are important variables that have to be considered.

The difficulties in recognising and accepting that infants have mental health needs, which arises through the lack of a definition and limited knowledge about infant development, mean that this area of provision often loses out in policy developments, service planning and guidance, and the allocation of financial resources. This again has allowed service development to be very variable in both quality and quantity.

4.2 Intervention model

The current literature on early intervention contains a number of key themes that are likely to be of importance in considering models of intervention. These include the following:

- ▶ Positive emotional and social development in early childhood is vital for healthy development.
- ▶ Recognition that early relationships influence the pathways of development.
- ▶ The importance of addressing parents' difficulties, since these may affect their ability to bond with their child.
- ▶ That needs may rest in the child, the parent/carer or in the dynamic between them.

- ▶ The importance of multi-professional interagency approaches given the range of needs which may need to be addressed.
- ▶ Recognition of the value of early intervention and preventative provision.

Given the above, intervention can take many forms. The current limitations of much of the research literature in this area, certainly UK-based research, means it is difficult to say which approach is most effective.³³ An intervention may be targeted to a specific risk group or universally available. It may adopt a relationship or Inter-actional Guidance based approach. What is clear through the research about early intervention is that working with infants requires very different skills to working with toddlers or older children.

4.3 Who should deliver infant health services?

Professionals have an important role to play in delivering early interventions and from the literature on providing mental health services, a recurrent theme is for the need for a diversity of therapeutic approaches and professional skills.^{34 35}

In addition, the information concerning risk and protective factors discussed in the previous chapter highlights: the need for multi-agency liaison; interventions that encompass a variety of disciplines; skills of engaging with families who may be marginalised and hard-to-reach and skills in engaging with both adults and children. This multiplicity of needs and the diversity of possible intervention approaches, poses a significant challenge in deciding who should actually provide these services.

The role of GPs and paediatricians has been identified as important in that such professionals have:

'unique opportunities to engage with parents in the early identification and management of problems'³⁶

Also the importance of staff working in Tier One CAMHS who:

'tend not to be perceived as stigmatising by parents ... Tier One services can succeed in maintaining contact and support over time – often a crucial factor in the effectiveness of any treatment ... Tier One professionals also frequently know a good deal about a child's family and wider situation, in that they are the local community-based, primary contact services'³⁷

Research has demonstrated that specially trained health visitors have been shown to provide a valuable intervention.³⁸ This would suggest that all health visitors should receive at least some infant mental health training as part of their standard qualification.

Child psychotherapists may also be important in these services. Work by Selma Fraiberg³⁹ suggests that psychotherapy may be a useful approach, in particular, in working with the caregiver and infant on relationship and attachment issues. Working in a psychodynamic way with parents enables them to become aware of the way in which they are unconsciously repeating their own childhood experiences in their parenting of their baby. If the parent has had an abusive or traumatic childhood, for example, where no intervention has been provided, this experience can be re-enacted with the parent's own child and so the cycle of trauma continues.⁴⁰

Finally, a theme evident in much of the literature concerning the effectiveness of mental health interventions for children is that of the importance of the networks between agencies and professionals:

'the network of relationships between services, between agencies, between tiers of provision – is now recognised to be almost as important in terms of service effectiveness and the experiences and outcomes for individual children and families as the content of treatment within a particular part of the network'⁴¹

4.4 Engaging hard-to-reach groups

Families most at need are often the most difficult to engage. Hard-to-reach groups may have had negative experiences of professionals or feel stigmatised by a targeted service. All parents try to do the best they can for their children, so it is understandable that sometimes the good intentions offered by a new service can be interpreted as simply interfering. There are no fix all solutions to this and all schemes must consider which approach is most appropriate to them.

Following the engagement of hard-to-reach families, further difficulties can present themselves. Engagement can result in uncovering a number of previously unknown disturbances. These disturbances can impact on the professionals working with this client group on two key levels and as such:

- ▶ There is the need for good interagency links to ensure that any uncovered problems can be adequately dealt with.
- ▶ All professionals working with these groups should receive good support and supervision to help them deal with their own issues and concerns when working with hard-to-reach groups.

Finally, and applicable to all families but perhaps in particular those who are hard-to-engage, various reports have highlighted the importance of considering the acceptability of services to families if they are to be effective:

'the essential ingredient of effectiveness ... Is not the range of service options, but the human qualities of the individuals who provide these options. If they are not respectful, empathic and genuine, then little they do will be of value to families'⁴²

4.5 Access/referral routes

One of the key factors affecting the nature of service provision is whether or not there is open access or some form of gatekeeping role. In recent years, many CAMHS have restricted access to their services and no longer take self-referrals.⁴³ This has been done in an attempt to manage the growing number of referrals and lengthening waiting lists that face many services. However this move has had serious implications in terms of being able to intervene early.

For services aiming to work with young infants, clearly a long wait will mean that the optimum time for intervention has passed – quite simply the infant is now a toddler! In the context of current service delivery, this illustrates the dilemma facing service providers – how to offer ready access when around them many services are restricting access. If there has to be a gatekeeper, then the question is how to develop this role to ensure that early intervention is still possible.

Put succinctly, the challenge of providing infant mental health services suggests a reversal of a number of trends that have emerged in CAMHS and other health and welfare providers over the last decade.

Finally, even if a referral has been successfully made, there remains the problem of staff shortages within CAMHS and in particular, the lack of professionals trained in working with young infants.

The Anna Freud Parent-Infant Project

Intervention model

The Parent Infant Project addresses the parent-infant relationship.

The Project aims to:

- ▶ Help families where there are problems with the attachment, through parent-infant psychotherapy.
- ▶ Train professionals working with infants to enhance their knowledge and efficacy of intervention.
- ▶ Research populations at risk and efficacy of intervention.

The Parent-Infant Project offers a range of services including: parent-infant psychotherapy to parents and babies, postnatal groups for mothers and babies, a training module in parent-infant mental health, tailor-made courses for individuals and professional groups/agencies, consultation and supervision, research into the efficacy of treatment and evaluation of the impact of training on the clinical practice.

Clinical services

The Parent-Infant Project offers clinical support to parents and infants experiencing difficulties with attachment, through psychotherapy and postnatal groups.

Parent-infant psychotherapy focuses on the evolving relationship between the parent/s and their baby. It takes into account the innate capacities of the baby's need. The Parent-Infant Project therapists are psychoanalytic clinicians who are also 'baby experts'. The baby will always participate in the therapy. Sessions may take place for the individual family or in a group. Digital video work is used as a feedback tool where appropriate.

Assessment service

The project also offers an assessment service to other agencies, based on its expertise in the field

of early attachment and infant development. Court assessments under the Children Act 1989 address the attachment relationship between parents and their infants in the context of severe professional concern around risk to the child's safety and/or development.

Training programmes in parent-infant mental health, for professionals working with families and babies

The Parent-Infant Project's training courses are designed to enhance understanding of infant mental health and give professionals the skills and confidence to identify problems and intervene successfully.

Research into infants populations at risk and efficacy of psychotherapeutic intervention

The Parent-Infant Project conducts research into at-risk infant populations and the efficacy of psychotherapeutic intervention. The project is developing a standardised tool to identify those babies whose development is at risk because of the nature of the bond with their carer(s). The assessment tool will enable primary care workers such as GPs, health visitors and social workers to identify reliably where the early relationship is in difficulties and the baby at risk.

A comprehensive outcome study of the Parent-Infant Project clinical services showed that, following therapy, 80% of the babies were no longer at it risk. It concluded:

'The standardised measures indicated that the best majority of children treated were now symptom free and that the programme has been successful in its declared aims in reducing the prevalence of mental health problems in the children of these high risk families where parents experienced significant problems in establishing a satisfactory parent-child relationship.'

Intervention model

The basic principle of the Sunderland Infant Programme is to increase the proportion of securely attached and socially competent infants. The service model is founded upon the theory that a secure attachment formed in infancy will act as a protective, resilience factor for later life. **A key theme of the project is to ascertain whether it is feasible, practicable and economical to routinely screen for parent-infant interactions and then to tailor intervention schemes accordingly.**

All families within the Sure Start area are given the opportunity to take part in the Infant Programme. Mothers interested in the study sign a consent form and arrangements are made for a health visitor to undertake a video-taped session with the parent and infant. **The mother is simply instructed to play and talk to her baby, the interaction is video recorded and as part of the evaluation, a baseline assessment of parental well-being is completed.**

The video-taped **parent-infant interaction is analysed using the CARE Index**, developed by Patricia M Crittenden of the Family Relations Institute in Miami. The method provides coding dimensions for the mother and baby interactions. Interventions are offered to families demonstrating difficulties in the interactions. When there are no problems in the interaction, feedback is given to the parent on the interaction but no additional intervention is provided.

Where interventions are given these essentially fall into four categories: developmental guidance, interaction guidance, parent-infant psychotherapy or couple/family therapy.

Developmental guidance aims to educate and advise the parent with regard to emotional development in infancy and is provided by the health visitor.

Interaction Guidance is guided by the CARE Index analysis. The aim of this is to accentuate the positives in the interaction and build on the available snippets of sensitive attuned interaction. The health visitor focuses on the interaction between the mother and the infant.

Parent-infant psychotherapy is employed for the more complex cases and is offered by a clinical psychologist. This intervention is usually offered where the parent's own psychological problems compromise their ability to attune to her baby.

Couple therapy/family therapy may be employed in situations of domestic conflict between the couple or in the extended family.

Training/professional involvement

Project workers are given additional training in video screening, infant mental health and early interventions to deliver the service. Health visitors are also given ongoing support and supervision.

Evaluative outcomes

The study is well evaluated comparing outcomes from an intervention and non-intervention group. A six-month follow-up specifically comparing the intervention and non-intervention group presents very positive findings. Families receiving an intervention demonstrated an increase in parent sensitivity as a result of the intervention. The incidence of post-natal depression was also reduced in the intervention group.

5 Infant mental health provision: research findings

For the purpose of this study infants are defined as those children in the 0 to 3 years age bracket. During the first few years of life the focus is on ensuring that babies can form secure attachment to their parents. As such, a key component of this study was to examine the level of service provisions focused specifically on promoting parent-infant attachment and those that focus on early relationships between the caregiver and baby/young child.

However whilst the study aimed to focus on provision for those under three, the information gathered indicates that a greater proportion of intervention models cover a broader age bracket including children up to five years. A general lack of data about provision for those under three subsequently became apparent.

5.1 What do professionals mean by infant mental health?

When asked to provide a definition of the term infant mental health, most respondents referred to parent-infant relationships in their response. For many, the mental health of infants was seen as intrinsically linked to the parent (caregiver). It was agreed that infants and parents are affected by the emotions of the other. For example, if the parent is distressed or frustrated so the infant will feel likewise and vice versa.

As the study respondents often stressed, it is therefore important that whenever and for whatever reason sensitive and responsive care is being hindered, early detection and early intervention is very important:

'Infant mental health is about positive secure attachments in young children and emotional well being ... You can't have one without the other.'
(Research participant)

Another commented that:

'Infant mental health is the capacity for emotional, physical and cognitive growth ... We all need to think about how to promote this.'
(Research participant)

5.2 Models of intervention

In gathering data about development of infant mental health schemes, the study sought to identify schemes where there is a psychotherapeutic input and to consider the following:

- ▶ The aims and objectives of the interventions.
- ▶ The target audience for an interventions.

- ▶ The range of interventions offered.
- ▶ The level of professional/organisational involvement.
- ▶ How interventions were funded.
- ▶ How schemes are evaluated.

Early intervention models can take many forms and CAMHS teams around England and Wales were invited to share initiatives in their own service, no matter how modest or extensive these might be. Comprehensive intervention models might be comprised of a large number of components adopting a complete strategy to infant mental health. These may provide fast track waiting lists for babies; training and support for Tier One professionals; parenting groups and parent-infant clinics or home visiting services. At the other end of the scale, some models simply contain one or two components such as Tier One support.

Aims and objectives of the intervention

A 38% (44 questionnaires) return rate was achieved. Over half of the CAMHS teams approached (64%) classified themselves as having some form of infant mental health scheme. The schemes provided ranged from training frontline professionals to offering parent/infant clinics.

Amongst the interviews there was a common perception that an infant mental health scheme should consider the parent and infant together, taking a holistic approach to service provision. In a small number of cases this model has been extended to include other siblings, adopting a family approach to intervention:

'We run a five session service for under fives. We aim to offer short-term help to parents and their under fives. Our aim is to establish the meaning behind the presenting behaviour and engage with the parents over our findings. We fully include the children in the work referring to their play-activity-language.' (Research participant)

With a strong psychotherapeutic input, the majority of schemes use observational techniques to understand the meaning and emotions behind presented behaviours. Where the child may be presenting a difficulty in feeding for example, the therapist may either observe or discuss what happens at meal times, exploring how this is experienced by the parent and by the infant. Through this technique the mother or caregiver is able to reflect and understand the interaction from their infant's perspective. Various respondents highlighted the value of this, for example:

'Psychodynamic schemes offer the mother the opportunity to reflect on their own experience.'
(Research participant)

Who are interventions aimed at?

Most of the study participants indicated that they did not target specific risk groups and that in theory services are universally available. In practice however, many services do operate some form of screening and try to target their resources on high-risk groups. Young mothers and parents with mental health problems were two of the groups mentioned in this capacity.

Data obtained suggests that few schemes offer intervention ante-natally, which is significant given that research indicates that interventions started before birth generally have more positive outcomes.⁴⁴

For the most part, schemes were focused on the under fives age group. This obviously presents the risk that the needs of children under the age of 3 may be overlooked as more referrals may be made from the upper end of the age bracket when problems can be more visible to outside agencies such as nurseries.

Type of intervention

Findings from the mapping exercise revealed that intervention models vary considerably from team to team. Some CAMHS teams offer help at a number of different levels; others may only be able to provide one or two.

Forms of interventions offered by CAMHS include:

- ▶ Training/supervision of primary care workers including health visitors and midwives.
- ▶ Home visiting, either on a joint basis with a CAMHS professional and health visitor, or one to one home visiting between CAMHS professional and the parent.
- ▶ Clinic based parent/infant provision.
- ▶ Parenting groups.
- ▶ Fast track referral service for infants.

Access and referral routes

The study findings indicated a prompt turn around time between referral and initial contact. This normally took between one and two weeks, although in a few cases, waiting times might extend to one or two months. 93% of referrals were reported to come via a professional route, usually from a health visitor. However, infant mental health schemes generally accept referrals from most primary care workers with over half (54%) also taking referrals from schoolteachers and school nurses. Opportunities for self-referral were more common under schemes supported by Sure Start.

A wide range of problems are referred through these routes including toileting, sleep problems, feeding difficulties to attachment and general

behavioural problems. Many of the study respondents perceived parent-infant psychotherapy as particularly valuable in dealing with complex issues of attachment and **96% reported working with attachment disorders**. Separation anxieties, behavioural problems and sleep problems are seen by a further 93% of CAMHS parent-infant schemes. Notably only 39% of clinics indicated work with children with learning difficulties. In terms of parental health, depression was dealt with in 89% of interventions.

Intervention techniques

Much of the provision identified is clinic-based and offers a limited number of appointments (five or six on average). A few participants were found to include the use of video in their intervention. For some, this has shown to be a very powerful tool that enables the parent to view and reflect upon interactions with their child.

Other techniques used include baby massage and play and language activities. Another commonly mentioned feature of intervention is parenting groups. In particular, the use of Mellow Parenting and Webster Stratton models are frequently employed.

Professional and organisational involvement

Positively, in regions where there was acceptance of the need for infant mental health services, intervention models are predominantly multi-disciplinary in their approach to set-up and delivery. In these areas it is recognised that infant mental health is the responsibility of everyone, not simply the immediate primary care workers.

The staffing of services identified in this study usually included the following key professionals: child psychotherapists (75%), child psychologists (61%) and psychiatrists (50%). Other professionals such as the social workers, health visitors and community psychiatric nurses were involved to a lesser extent. In many areas, child psychotherapists and child psychologists act as the key workers, with much less involvement from psychiatrists in actual day-to-day delivery of services.

In total, 64% of schemes were found to include an external agency in the delivery of an intervention model. The most commonly mentioned were mother and baby clinics and voluntary organisations.

Over half of CAMHS offering infant interventions also reported that they provide additional training and/or supervision to primary care workers. This is important given that a close working relationship with vulnerable families may bring to the forefront previously undiscovered difficulties.

Funding

39% of study participants mentioned funding as core stumbling block in developing new provision,

with some highlighting the challenge posed by resource constraints:

'Some have questioned whether early intervention is a good use of resources so I've had to heavily promote it as a preventative role.' (Research participant)

Existing CAMHS or local NHS Trusts provide the bulk of the funding for most schemes. Interestingly, whilst ten participants received at least part of their funding via Sure Start, very few interviewees had explored other avenues for funding. There may be many reasons for this, not least that finding appropriate funders and applying for funding can be a long and arduous process. Time for such applications may also be limited given the need to respond to the day-to-day demands of running the existing service.

Evaluation

There was a general lack of evaluation data from services in the study. Only 29% indicated that their service had completed an initial evaluation and often due to lack of resources, the amount that a team had been able to monitor was fairly limited. Many evaluations were simply comprised of measuring satisfaction with the scheme rather than outcome results.

Where a good evaluative scheme has been developed, initial outcomes for early intervention proves positive. User data taken from the Sunderland Infant Programme demonstrates the value parents place on early intervention support, for example:

'I used to struggle understanding my baby and felt I failed and felt quite down but now we get on very well and both feel fine.' (Case study participant)

The value of support to experienced parents was also highlighted by the following:

'I wish this had been around when I had my first baby. He has now found it difficult to settle in school but with the second one I've become so much more confident I don't expect he will have any problems.'

Several parents also specifically mentioned the value of interventions involving the use of video:

'I think that looking at the video and understanding what my child is trying to say has made a real difference.'

'Looking at the video is a very good way of learning about how your own child is.'

Key barriers to the development of infant mental health services

Data from the study respondents revealed an array of barriers facing the development of infant mental health services, some occurring when trying to set up new services and some emerging once services become operational.

Barriers identified in setting up services included the following:

- ▶ **Limited education and awareness** of what is infant mental health.
- ▶ **Problems with securing funding** with the majority of schemes being funded from within existing budgets (CAMHS or NHS Trust).
- ▶ **A shortage of staff**, notably within many CAMHS teams, which makes the introduction of new services difficult at best and impossible at worst.
- ▶ **Internal politics**, in particular, the need to constantly battle to get interventions focused on young children under three recognised amongst service commissioners and managers as a good use of scarce CAMHS resources.
- ▶ **Professional resistance** since in some areas of the country, senior clinicians were reported to be of the view that infant mental health services should not be within the remit of CAMHS.

Barriers at the operational stage included:

- ▶ **How to access and engage hard-to-reach groups** where the challenge still exists for many about how to engage these groups of families without them feeling stigmatised by the intervention.
- ▶ **Confusion over referral policies** with some schemes reporting difficulties receiving referrals due to lack of awareness of the service and confusion about when and what type of referrals should be made. Another problem is that of referrals being made too late, when difficulties are entrenched; this makes it difficult for a scheme designed to offer early intervention to work.

In the following chapter, a number of these issues are explored further in discussing how some of these barriers have been tackled by the case study services.

5.3 Conclusion

Overall, the data gathered from the mapping study suggests that early interventions focused on young children are increasing, notably within CAMHS, although also in other agencies involved in delivering Sure Start. However while many have introduced schemes, there is still a significant number who haven't tackled the subject of infant mental health or whose plans have been impeded by a lack of resources:

'There is some interest in developing an integrated under fives service in CAMHS here but resources are lacking' (Research participant)

Where infant mental health is on the agenda, there is also variation in the depth of service provision. At some clinics, rigorously controlled services have been set in place that consider the complete needs of the infant; in others, there may only be a limited infant service.

The models of intervention described and the target age for schemes varies from region to region and

are often dependent upon the interest of the scheme's lead clinician. Having said this, in the main CAMHS are working hard to meet all the needs of their client groups. For many, it is not the lack of enthusiasm or lack of recognition of infant mental health that prevents the development of a comprehensive service but instead competing priorities and commissioning politics:

'IMH is noticeably absent and not a priority on NHS Managers units.' (Research participant)

Summary of study findings

- ▶ Forty-four questionnaires were returned, a response rate of 38%.
- ▶ Twenty-eight (64%) of the sample had some form of an infant mental health service, some of them run under the auspices of Sure Start.
- ▶ The exact number of Sure Start schemes with an infant mental health component is unclear although data is currently being collected on this issue.
- ▶ Overall, there appears to be an increasing number of early intervention schemes BUT provision is fragmented, with little consistency in models used.
- ▶ Infant mental health is perceived as the relationship between the parent/infant. Therefore, with this theory in mind, for provisions to be successful they must take a holistic approach and consider the parent and infant together in applying an intervention.
- ▶ Searching for the meaning behind an infant's behaviour and engaging the parent was the focus of problem management for a number of the interventions.
- ▶ 75% of the interventions highlighted in the study were untargeted with no specific risk groups in mind. However an overarching theme of targeting generally vulnerable families was often used.
- ▶ Only seven of the intervention strategies had identified high-risk groups to be targeted for attention although here was a tendency to pay more attention to 'vulnerable' families. The most common criterion for 'high risk' was young adolescent parents.
- ▶ 43% of the study respondents have some sort of parenting group integrated into their intervention and a further 46% provide training and supervision as a component of their infant mental health scheme.
- ▶ A range of established tools were employed in the intervention schemes reported, including psycho-analytic parent-infant psychotherapy; baby massage; Webster Stratton and Mellow Parenting groups.
- ▶ The overwhelming majority of participants felt there was a need and value in early intervention but noted that there are a number of barriers to developing provisions.

Gloucestershire Sure Start – Parent/Infant Service

Intervention model

Part of the Sure Start programme in Gloucester, the service aims to offer extra help when the relationship between baby and parent is under stress. The core theme of the service is prevention, with a focus on identifying families before difficulties surface and to then help parents learn about themselves and their babies.

The scheme is facilitated by two clinicians, a child psychotherapist and a counsellor. The clinicians offer two days each per week specifically targeting vulnerable families with infants less than two years of age. The model uses a relationship-based intervention employing **counselling and psychotherapy skills to work with parents and infants together**. The team aim to provide an accessible, flexible, preventative and responsive service. The work is usually undertaken in the clients home:

'We offer infant-parent work where stress within a family make the baby vulnerable to later emotional or mental health difficulties. We have to be clear that our service is not for the adult who might have their own mental health problem that in itself needs more help, but is more focused on their relationship with the baby and how their own background might affect this.'

Training/professional involvement

Referral to the scheme is via a professional route. The main referrers are Sure Start workers, health visitors and family centre workers. The scheme utilises a screening tool, which defines a range of biological, parental, interactional and socio-demographic risk factors that can put a strain on the parent-infant relationship. However, the challenge that remains is ensuring referring professionals use the tool and consider the parent-infant service when they visit a family:

'Encouraging people to refer is difficult ... Getting them to realise that you don't have to refer once people have difficulties. They never use the screening criteria ... My concern is that we just get the dreadful cases where as if they had referred them six months earlier they would not have been dreadful and could have been helped quite quickly.'

Evaluative outcomes

Families who have been supported by the service have expressed positive outcomes as a result of interventions. The scheme has not been formally evaluated but it is anticipated that evaluation will be provided on a case by case basis.

Oxfordshire Home Visiting Service

Formed in January 2001 with funding from the Department of Health and the Nuffield Foundation, the Oxfordshire Home Visiting Service provides families identified as 'at risk' with intensive home visiting.

Intervention model

Participants in the study are recruited by midwives across Oxfordshire and Buckinghamshire. The midwife uses an in-house screening questionnaire to identify vulnerable mothers. A key purpose of the study is to evaluate the effectiveness of home visiting programmes. As a result, once recruited, participants are randomly allocated to either the control arm or the intervention arm. Families in both the control and intervention arms complete a series of baseline and follow-up assessments of their general well being. Following this, the **control group receive standard health visiting service** as provided by the NHS and the **intervention group receives intensive home visiting**.

In the intervention group, home visits are weekly, with the service commencing around six months ante-natally and continuing 12 months post-natally. The scheme aims to be **preventative** and **accessible** whilst supporting the parent-infant relationship and promoting well-being.

Training /professional involvement

Home visitors are trained health visitors who have received additional training in the home visiting model. The project workers are trained in parent counselling and in four methods of promoting/assessing mother-infant interaction and maternal empathy. These include firstly, infant massage, which has shown to be effective in reducing levels of distress behaviour and disturbed sleep patterns. Secondly, a modified version of the Brazelton Neonatal Assessment Scale is used to explore how the baby initiates relationships and responds to the attempt of others to communicate. A further method that is being used is the Dialogical Baby Dance; this encourages positive interaction with the parent and child through the use of a series of structured movements. Finally, singing and music is used to help parents empathise with their baby's mood.

The service is linked to 48 GP practices across Oxfordshire and Buckinghamshire and is available to families served by these practice areas. Professionals involved in the scheme are well supported through regular supervision sessions.

Evaluative outcomes

Initial outcomes from the home visiting model appear positive although it is too early to prove effectiveness through user data.

6 Lessons from the case studies: tackling the barriers

All new services face challenges both in their set-up and delivery of provision. The case study models identified in this report are performing well but as with all schemes, they have also faced some significant barriers. This chapter draws out some of the ways that the case studies presented have tried to deal with the challenges/difficulties of developing services. These have largely focused on:

- ▶ How to raise awareness of the need for infant mental health provision.
- ▶ How to apply for funding.
- ▶ Strategies to tackle professional resistance.
- ▶ Techniques for engaging hard-to-reach families.
- ▶ Developing and using service evaluation data.

6.1 Education and awareness

Education about early intervention and infant mental health is a theme that connects all barriers. Education can be **effective in reducing resistance and organisational politics as well as engaging professionals in service provision**.

The Infant Programme in Sunderland used evidence about the **economic benefits** and **preventative nature** of infant mental health to drive forward the project and reduce professional resistance. Likewise, the Oxfordshire Home Visiting Service provided evidence of the success of home visiting models from other countries to secure project funding:

'I spent some time providing a series of presentations to managers and senior officers and among the things to discuss I outlined Caldwell's research that for every dollar you spent on primary prevention you saved \$19 at the end of the line and they were very interested in that ... Because there wasn't any money around at that time I knew we would have to argue extensively for the service. As Sure Start emerged inviting bids in 1998-1999 I think we were the first in the queue!' (Case study participant)

Another noted that:

'I spent a lot of time looking at the literature and I was aware that home visiting programmes were something that had been quite extensively evaluated in the United States and that we had very little evidence of their effectiveness over here in the UK. It was clear that we needed to do more in this country to put home visiting programmes on the agenda.' (Case study participant)

6.2 Funding

Unfortunately there are no secret formulas that guarantee funding for a project. Those designing early intervention schemes must be prepared to argue their case, considering all questions that might arise as a result of the application. The process can also be very time-consuming, as illustrated by the following comments:

'Because, I was thinking about infant mental health for sometime arguing the case wasn't such an issue but arguing from scratch is hard work. The deadline is always yesterday. The trick is to know what you want and have arguments up your sleeve.' (Case study participant)

The table opposite highlights just some of the issues it is important to consider in applying for funding.

6.3 Internal politics and professional resistance

Professionals play an important role in early intervention, whether it is through support of a provision or through service referral. It is therefore crucial to engage appropriate professional groups from the initial set-up through to service delivery.

The idea of an infant mental health provision is still a relatively new concept and some professional groups remain to be convinced about the benefits of such a scheme. At the Anna Freud Centre and the Tavistock Under-Fives Service, the teams work in close contact with professionals, writing articles and conducting presentations to promote infant mental health and to break down the barriers of professional resistance, which emerges in many forms – for example:

'There is a measure of prejudice ... some individual GPs think that mothers and babies will get along no matter what and shouldn't be referred to a service because they feel it will emphasise the problem.' (Case study participant)

In addition, infant mental health training courses offered to professionals working with families and infants provides the basis for workers to understand more about the needs of infants and parent-infant relationship. (See Appendix 2 for information on infant mental health training courses).

Applying for funding – key issues to consider

Application components	Issues to consider
Project background	What are the core arguments for setting up this service? Do I have literature to support the arguments? Is there a need for the service? What other provisions already exist in the community? How will/could the service effect/link to existing provisions?
Project scope	What are the project objectives? What are the project targets? Who is the provision aimed at? Will it be targeted or universal? What is the expected waiting list time? Level of family involvement. Length of parent-infant intervention. What tools will be employed within the scheme? Will the service be clinic based or on an outreach basis? How long will the project run for?
Project monitor/evaluation	How will the project be monitored to ensure service quality? How will the scheme be evaluated? At what intervals will evaluations be made?
Professional/organisational involvement	Who will be involved in set-up/delivery of the scheme? Is extra training required for professionals involved? How will professionals be supported within the scheme including referral group? What if any, other organisations to be included?
Marketing	Marketing strategy – education and awareness creation. Will incentives be given to encourage hard-to-reach groups?

PIPPIN (Parents in partnership – parent infant network)

Pippin is a national charity concerned with the promotion of healthy parent and child development in the period around the birth. The key theme is to focus on early family and parent-infant communication and relationships. PIPPIN's work, both through research and training, supports expectant and new parents in their transition to parenthood.

PIPPIN offers a cascading model of training:

Professionals are trained in understanding the parent-infant relationship and how they can support the emotional transition period.



Through individual work and parenting classes the parent is empowered. The parent is able to better understand the needs of their child and the relationship dynamics with the child and within the couple relationship.



The infant is able to form a secure bond with the parent.

A range of short and longer training programmes is targeted towards health professionals and voluntary workers who support parents. The training aims to equip them with the ability to more effectively facilitate early parenting via routine care, home visits and parenting classes:

'It's about helping the parent to realise how their emotional state can affect what is happening with their bonding.'

PIPPIN's range of training programmes begins with a pre-requisite study day that forms the building blocks for all PIPPIN courses. This provides information about the PIPPIN approach and allows participants to reflect on their current practices. It also brings them up to date with developments in early parenting education and support and child development.

6.4 Engaging hard-to-reach groups

There are a number of techniques that can be employed to engage hard-to-reach groups. In the Oxfordshire Home Visiting Service, central to engagement is reducing the stigma of the scheme. Families are approached in the ante-natal stage to encourage the development of a trusting relationship with the professional group:

‘Literature has made it clear that interventions should start ante-natally primarily because the hard-to-reach families often haven’t had a very good relationship experience either with their own families or in particular with professionals and we thought that it was important that the home visitors established a good relationship with these families before the infant arrives and all the problems that go with childbirth and having a new baby. (Case study participant)

The terminology used to describe the service focus is also important. For example, vulnerable families may be apprehensive about schemes which claim they will reduce the number of children on the at risk register, or ones which use terms such as mental health, psychotherapist and psychologist because these may have negative connotations.

Instead it is vital to present an image of a supporting relationship-based service that recognises that the parent is doing the best for their child. Successful schemes focus on the positives in the parent-infant relationship and provide relevant information about the aims and objectives so that the service appears transparent and parents feel able to trust the professional group.

The following table summarises some of the strategies identified by respondents as helpful in engaging families.

6.5 Referral policies

Engaging professional groups to make referrals forms the next challenge, as illustrated by the following:

‘Encouraging people to refer is difficult, you need constantly to keep promoting the service.’ (Case study participant)

In many schemes, professionals may be unclear about the referral process and may not know who and when to refer. To tackle this confusion, staff from the case studies have developed their referral processes in a number of ways. These include the development of clear and well-structured referral processes to ensure that professionals understand the route they should take in referring a client.

All of the case study participants work hard to ensure that the professionals involved in the project understand the scope and aims of the scheme. They also recognise the need to provide regular support and supervision. In some services, such as the Infant Programme in Sunderland, the training and use of dedicated staff to deliver the intervention and make referrals has been introduced, which has helped to ensure that any referrals made to the service are appropriate.

To summarise, to tackle the issue of encouraging referrals, schemes have:

- ▶ Promoted the service via education about infant mental health.
- ▶ Supported the professional group through seminars and supervision.
- ▶ Provided a screening tool so that the referrer understands who and when to refer.
- ▶ Recruited and trained referring professionals specifically to work on the scheme.

Engaging hard-to-reach groups

Education	Provide clear, understandable aims and objectives. A transparent service where the approach and targets are clear may attract more people.
Promotion	Consider the target group and avoid stigmatising. Promotional material available at places other than health clinics, such as supermarkets or via free newspapers, may help reach the audience. Include success stories in promotional literature.
Language	Avoid the use of jargon or emotive terms such as mental health. A positive approach identifying how the scheme aims to support individuals may be more effective.
Accessibility	Accessing services can be an issue for some. Schemes may need to consider the possibility of home visits or providing a free bus service.
Incentive	Incentives such as vouchers, money or free meals have proved successful in some areas.
Building trust	Some schemes have demonstrated that early involvement in a parent-infant relationship can build greater trust between the professional and the parent.

6.6 Evaluation

A number of the case studies have evaluated their infant provision, exploring effectiveness as well as satisfaction and have used the information gathered to develop or refine their service. Typically, the services employ both qualitative and quantitative methodologies. In both the Sunderland Infant Programme and the Oxfordshire Home Visiting Service, it was recognised that to measure outcome effectiveness, a baseline assessment taken before therapy begins is valuable and both schemes have developed systems of information gathering for this purpose.

There are a number of standardised assessments on the market including the Parenting Stress Index, the General Health Questionnaire, the CARE index and the Child Behavior Checklist (CBCL). Usually these are offered before therapy and then at six monthly or annual follow-ups. The assessments are used to review changes or differences in behaviour, emotions and attitudes. Qualitative methods are often employed to support the information gathered from these quantitative approaches.

For the case studies, qualitative techniques were found to be useful in understanding how a parent or worker experiences a service and in understanding the strengths and weaknesses of a scheme.

6.7 Summary

The case studies in this report have each in turn found their own methods and techniques for dealing with the challenges they have faced. To summarise, some of the key strategies they have employed to develop their service and overcome barriers include:

- ▶ **Using research information** The teams completed research on the specialist field of infant mental health to ensure they fully understood the benefits and drawbacks of adopting an infant mental health strategy; they also ensured all team members were party to this information and thus the rationale of the services they were trying to provide. Through research, they could provide evidence of success from similar projects, as well as mapping out social and economic benefits. They also used research data to help them refine their strategies for engaging hard-to-reach families.
- ▶ **Awareness of other provisions** Linked to research, teams from the case studies described trying to work in ways that are supportive of other schemes in the area and as such, try not to duplicate other services. By establishing contact with other professionals working in their local areas, awareness about the provision for young children, could also be raised.
- ▶ **Well-structured services** The case studies strive to provide a well-structured service with clear service aims and objectives as well as a clear referral route. The use of dedicated staff, and training about appropriate referrals, were other techniques employed.
- ▶ **Systematic approaches to seeking funding** The need for a clearly thought through approach to seeking funding and for what purpose, was highlighted by several of the case study respondents, as key to their efforts in applications for funding.

7 Conclusions and recommendations

7.1 Overview

This study has revealed that services available to young children under three, whilst gradually increasing in availability, remain fragmented. Considerable variability, both across geographic regions and in the range and depth of services provided, is evident. Overall, there appears to be no consistent strategy for infant mental health services, with development appearing ad hoc and often reflecting the dedicated interest of a local clinician or group of professionals.

Within this picture, Sure Start is clearly making an impact in encouraging the development of new services. However a central player remains CAMHS and the research again highlights the considerable pressures and high demands facing services. It has indicated confusion over professional roles and responsibilities and the challenges of inter-agency working. At the commissioning level, it appears that infant mental health services are rarely on the agenda.

As such, the challenge to develop services for children under three, is considerable – and yet the growing research evidence into brain development, the importance of intervening early, and the economic benefits of so doing, presents comprehensive justification for just such development to be given priority. On a positive note, as the case studies illustrate, some services are already providing valuable examples of how this provision may be organised.

7.2 The challenge of developing infant mental health services

The challenges of planning and developing services for children under three present themselves on a variety of fronts. These range from a lack of a clear and widely agreed definition of what is infant mental health; a considerable diversity in treatment approaches and a lack of UK-based evaluative data concerning which approaches are effective and how they should be best employed. Differing views as to who should deliver these services and thus how they should be funded are evident. Finally, these services face the considerable difficulties in engaging and being acceptable to a client group many of whom may be hard-to-reach.

The research has picked up on these and many other themes and in so doing, has identified a range of barriers impeding service development. Of these,

probably the most significant are a widespread lack of awareness about the need for and value of such provision; problems securing funding for services and a shortage of staff, notably within CAMHS, experienced and available to work with this client group. The lack of UK-based evaluative data, compounds the difficulties of raising awareness and improving the knowledge base about infant mental health and the need for services.

Two other important issues also require attention that relate to the scope and focus of services. Firstly, a significant finding of the study is that very few services offer input at the ante-natal stage, when research has highlighted the benefits of interventions at this time. Secondly, many services currently use a wider age-band, namely 0-5 years, and this appears to be allowing referrals of children at the upper end of the age limit to dominate. There are also the questions of whether services should provide open access and how to develop services that are able to intervene early.

7.3 What are the necessary components of a mental health service for children under three?

The data gathered through the study has repeatedly highlighted the need for these services to be multi-professional in their approach – also that they need to be accessible, flexible and well linked into a network of other services, especially at the primary/local level. The value of intervening early has also been regularly noted.

Information from the study respondents highlights that the following 'core' factors are needed, irrespective of how a service is run and staffed, and the treatment model in use:

- ▶ Skills in working with children under three.
- ▶ Skills in working with families.
- ▶ A diversity of therapeutic skills.
- ▶ Skills in engaging vulnerable and hard-to-reach families.
- ▶ Inter-agency links.

Internally, such services need to provide education, training and supervision of staff, especially since working with hard-to-reach families may uncover other areas of difficulty and/or mental health disturbance.

Drawing from the information provided by the case studies, services also need: to have clear procedures for referrals and to ensure staff both inside and

outside the service are aware of these; to have a clear treatment rationale, which again is known to all involved parties; to develop a systematic approach to funding applications; to evaluate their provision and use the information gathered to raise awareness of the service and to refine provision offered.

It is important to note that even with these things in place, many services struggle. As such, commitment and support at the national level are crucial if the current patchy and inadequate state of service development is to be tackled.

7.4 Recommendations

It is beyond the scope of this report to say where infant mental health services should be sited. Various options present themselves, including the development of dedicated services within CAMHS. Alternatively, services could be linked in some way to paediatrics or developed on a standalone, multi-agency basis including CAMHS, education, housing and voluntary sector agencies.

Whichever option is chosen, for the effective development of these services, a variety of things need to be in place – a clear and coherent policy framework and guidance; adequate numbers of properly trained staff and workforce planning; inter-agency liaison and collaborative working; systems for gathering data about outcomes and evaluating provision, and underpinning all of this, appropriate levels of funding.

Bearing these in mind, the following recommendations are made with regard to the development of infant mental health services in the UK:

A clear policy context

It is important that there is recognition within the National Service Framework for Children of the importance of addressing the emotional and relationship needs of parents and children under three and ideally, under two. This will provide an invaluable aid to the development of a

comprehensive, consistent infant mental health strategy across CAMHS and other agencies and will go some way to clarifying professional roles and responsibilities.

Inter-departmental and inter-agency co-ordination and planning

There must be ongoing liaison and planning with staff implementing national policy initiatives such as Sure Start to ensure that the needs of this age group are given due attention.

The role of CAMHS

It is highly likely that CAMHS will continue to be a central player in infant mental health services given their responsibilities for supporting children, young people and their families. As such, it is crucial that ongoing attention is paid to tackling the numerous pressures and shortages affecting CAMHS nationally. In particular, Tier One services need continued support to ensure that they are able to develop to provide accessible, community-based services.

Workforce planning

The allocation and training of staff to work with this group requires attention, likewise the support and supervision needs of staff working with families who may often be highly vulnerable and/or hard-to-reach. The commissioning of and funding for services must also be properly examined.

Building up the knowledge base

More systematic UK-based national research, evaluation and sharing of good practice is needed, underpinned by secure funding, to build up the evidence base. The views of service users must also be addressed since data from this perspective is particularly sparse.

Education and health promotion

Across different professional groups, not only in health, there needs to be ongoing education and promotion of the importance of infant mental health.

Appendices

Appendix 1 Methodology

This 12-month study commenced in early 2002, with most of the data collection taking place throughout the Spring and Summer of that year. The study is small-scale and largely qualitative in nature, with much of the information being gathered through semi-structured postal questionnaires and telephone interviews. A review of relevant research and literature was undertaken to provide the backing for the primary data gathering.

For the mapping of service provision across England and Wales, a quantitative approach was used, with a total of 110 questionnaires being sent to a random selection of community-based CAMHS from around the country, based on the following geographic spread:

- ▶ 25 CAMHS located in Essex and the Home Counties.
- ▶ 25 CAMHS located in London and the East of the country.
- ▶ 20 CAMHS from the North of England.
- ▶ 20 CAMHS from the West of the country (including one from Wales).
- ▶ 20 CAMHS from the South of the country.

The questionnaires asked for information about the range of services offered to young children under three, about plans for new services and about staffing – that is, the disciplines and training of staff involved in planning, setting up and delivering services. Information about the funding of services, and any service evaluation data, was also sought. In total, 44 questionnaires were returned – with many however providing information about services targeted on the 0-5 age group and suggesting that **they had very little data specifically about services for children aged under three.**

Staff from 11 CAMHS also responded to calls for information placed in specialist mental health publications and were contacted by telephone. An interview was then undertaken with the key

professional responsible for the management of or delivery of infant mental health services – typically a child psychotherapist (eight interviewees); other respondents included one clinical psychologist; one specialist health visitor; one primary mental health worker and one support worker from an LEA Mother and Baby Clinic was contacted. The purpose of these interviews was to gather more in-depth information about the services offered.

Staff responsible for implementing Sure Start were also contacted, to discuss the range of services being developed for very young children through this national initiative.

The seven case studies were identified through the review of the literature and the mapping of services across the country. As much as possible, these were selected to pick up on geographic variations and different models of working. Attempts were made to ensure the inclusion of both CAMHS-based services and also those where Sure Start was involved. Unfortunately attempts to identify services focused on particular groups such as children with disabilities or from minority ethnic groups, were unsuccessful. For the case studies, information was gathered through a combination of telephone interviews and site visits.

Wherever possible, documentary information about service provision was sought to back the information gathered from the interviews. Attempts were also made to gain some information about the costs of services – unfortunately this proved very limited. Analysis took place on a continuous basis throughout the data gathering, with prominent themes being identified and clustered into a number of categories, which in turn were developed into the key topics discussed in this report.

For a copy of the questionnaires and discussion guides used in the study, visit the Child Psychotherapy Trust website www.childpsychotherapytrust.org.uk, or contact the Trust directly on 020 7284 1355.

Appendix 2 Risk factors

The extent and type of mental health problems vary in children according to certain predisposing characteristics such as brain damage and physical or

learning disability. Certain family situations and circumstances with which they grow up may also increase risk of children sustaining mental health problems. These 'risk factors' are given below.

Factors that increase the risk of mental health problems in young people

Child risk factors	Family risk factors	Environmental risk factors
Genetic influence	Overt parental conflict	Socio-economic disadvantage
Low IQ and learning disability	Family breakdown	Homelessness
Specific developmental delay	Inconsistent or unclear discipline	Disaster
Communication difficulty	Hostile and rejecting relationships	Discrimination
Difficult temperament	Failure to adapt to the child's changing	Other significant life events
Physical illness, especially if chronic and/or neurological	Abuse: physical, sexual and/or emotional	
Academic failure	Parental psychiatric illness	
Low self-esteem	Parental criminality, alcoholism, and personality disorder	
	Death and loss – including loss of friendship	

Source: The Audit Commission Children in Mind (1999) Appendix 2

Appendix 3 Resource section

Useful literature

For those trying to grapple with the various debates around infant mental health and early intervention the subject area can sometimes appear to be a minefield of confusing information.

The following section will identify key information for professionals wishing to find out more about infant mental health.

Defining the argument for infant mental health

The publications identified here provide information about the need for early intervention and infant mental health. These key documents will prove useful to professionals who are either interested in understanding more about infant mental health or who wish to develop their own service.

Balbernie R, Reducing risks: Relationship-based services for babies and parents (2003). The Child Psychotherapy Trust

This paper supports the Child Psychotherapy Trusts work in infant mental health. The work takes an in-depth look at the need for early intervention and cites successful schemes undertaken in the US and elsewhere.

Barnes J and Freude-Lagevardi A, From pregnancy to early childhood (2002). The Mental Health Foundation

The report provides a valuable insight into models of intervention that are designed to improve parenting, family functioning and young children's mental health.

Barrows P, 'Making the case for dedicated infant mental health services' (2000). *Psychoanalytic Psychotherapy* 14(2) pp.111–128

Hobson P, *The cradle of thought* (2002). Macmillan

Karr-Morse R and Wiley M, *Ghosts in the nursery: tracing the roots of violence* (1997). Atlantic Monthly Press

Martin Maldono-Duran J, *Infant and toddler mental health: models of clinical intervention with infants and their families* (2002). American Psychiatric Publishing Inc.

Zeanah C H, *Handbook of infant mental health* Second edition (2000). The Guildford Press

Shonkoff J P and Phillips D A, *From neurons to neighbourhoods: the science of early childhood development* (2000). National Academy Press

Stern D N, *The motherhood constellation* (1995). Basic Books

Eliot L, *Early intelligence: how the mind and brain develop in the first five years of life* (1999). Penguin Books

Scott S, Knapp M, Henderson J and Maughan B, 'Financial cost of social exclusion: follow-up study of antisocial children into adulthood' (2001). *British Medical Journal* (28 July)

Useful contacts/organisations

The Association for Infant Mental Health (UK) (AIMH)

www.aimh.org.uk

The Association aims to bring together professionals working to promote the mental health of infants, such as psychiatrists, psychotherapists, psychologists, social workers, nursery nurses, teachers, CPNs, health visitors, midwives, GPs, paediatricians and others. To find out more about the Association including how to become a member you can access their website or contact AIMH at the following address:

AIMH (UK)

Knowle Clinic
Broadfield Road
Bristol BS4 2UH
Tel/Fax: 01179 145526
E-mail: info@aimh.org.uk

World Association for Infant Mental Health (WAIMH)

www.msu.edu/user/waimh/main.htm

The World Association of Infant Mental Health is an international association that aims to promote infant mental research and education. A membership application form is available from the WAIMH website.

YoungMinds

www.youngminds.org.uk

YoungMinds is the national charity committed to improving the mental health of all children and young people. Services include the Parents' Information Service a free, confidential telephone helpline offering information and advice to any adult with concerns about the mental health of a child or young person. YoungMinds also offers training and consultancy, leaflets and booklets for young people and publishes YoungMinds Magazine every two months.

YoungMinds
102–108 Clerkenwell Road
London EC1M 5SA
Tel: 020 7336 8445

YoungMinds Parents' Information Service
0800 018 2138

Zero to Three

www.zerotothree.org

Zero to Three is a non-governmental non-profit organisation based in the US. Our mission is to promote the healthy development of infants and toddlers by supporting and strengthening families,

communities, and those who work on their behalf. We are dedicated to advancing current knowledge; promoting beneficial policies and practices; communicating research and best practices to a wide variety of audiences; and providing training, technical assistance and leadership development.

Zero to Three

National Center for Infants, Toddlers and Families
2000 M Street, NW, Suite 200
Washington DC 20036
(202) 638-1144

For further details about the case studies who took part in this research please contact The Child Psychotherapy Trust.

Infant mental health training courses

The courses outlined below are specific to developing an understanding of infant mental health. It should be noted that these do not constitute full psychotherapy training.

► Anna Freud Centre Parent-Infant Mental Health

www.annafreudcentre.org

Parent-Infant Mental Health

The course is directed at professionals working with infants and their families, who are looking to extend their knowledge in the field of infant mental health. The course aims to promote understanding of infant mental health issues, and to enhance professional skills in early intervention. The course is validated as a level 3, 2 credit free-standing module by South Bank University.

► Tavistock Postgraduate Diploma/MA in Infant Mental Health

www.tavi-port.org

Infant Mental Health (London and Bristol)

The course is aimed at professionals working with children and infants under five. The course will increase awareness of good mental health in infants, develop an understanding of psychological problems affecting this age group. The course is accredited by the Tavistock Clinic and University of East London.

► School of Infant Mental Health

www.infantmentalhealth.com

Diploma in Infant Mental Health

Intended for those who work with under-fives. Teaching methods include extensive use of video material, presentations, observations and internships in different settings, readings and small group discussion.

Infant Observation (two years)

The School of Infant Mental Health offers integrated educational and training programmes for professionals working with under-fives. Participants do weekly observations of a baby at home to learn

about normal development of emotions. Observations are discussed in class.

► University of Essex

www.essex.ac.uk

Childbearing and Perinatal Health

Essex University offer four courses that apply psychoanalytical thinking to the professional's role in working with families. The courses are designed for professionals working with women, babies couples and families. They explore the role of the professional in changing patterns of childbearing/rearing. They also focus on risk factors relating to areas of emotional vulnerability in clients.

Parenting training

► PIPPIN

www.pippin.org.uk

Mental Health (Stevenage)

PIPPIN courses are for individuals from all backgrounds (Sure Start, health, mental health, education, social services, childcare and the voluntary sector) who work with prospective and new parents and their infants. The training is to a professional level, and can lead to a range of recognised qualifications (at further and higher education levels).

Related IMH training

► The Solihull Approach

www.hcc.uce.ac.uk

Open Learning Resource Pack

The Solihull Approach is an open resource pack for health visitors and care professionals who work with families and children under five. The pack is available from the University of Central England (Birmingham). The pack aims to help practitioners become more reflective in their approach to working with families and children.

Training as a child psychotherapist

Professionals who wish to become a child psychotherapist and work within the NHS must be a member of the Association of Child Psychotherapist, who recognise seven training schools:

The Anna Freud Centre for the Psychoanalytic Study and Treatment of Children

21 Maresfield Gardens

London NW3 5SD

tel: 020 7794 2313

web: www.annafreud.org

Details from the course tutor

Birmingham Trust for Psychoanalytic Psychotherapy

Flat 1
Queens College
Somerset Road
Edgbaston
Birmingham B15 2QH
tel: 0121 455 9393
email: Btppoffice@aol.com

The British Association of Psychotherapists

37 Mapesbury Road
London NW2 4HJ
tel: 020 8452 9823
web: www.bap-psychotherapy.org
Details from the secretary

The Scottish Institute of Human Relations

13 Park Terrace
Glasgow G3 6BY
tel: 0141 332 0011
Details from the course organising tutor

The Society of Analytical Psychology

1 Daleham Gardens
London NW3 5BY
tel: 020 7435 7696
Details from the secretary

The Tavistock and Portman NHS Trust

120 Belsize Lane
London NW3 5BA
tel: 020 7435 7111
web: www.tavi-port.org
Details from the training administrator

**The Northern School of Child and Adolescent
Psychotherapy**

12 Victoria Terrace
Guiseley
Leeds LS20 9EX
tel: 07789 932 714
email: nwaggett@btopenworld.com
Details from project manager, Nick Waggett

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