SIMH-DC ~~2021~~ 2022!

WINTER LEARNING DAY

5. Pathways in IMH: pitfalls, obstacles and solutions

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What are we aiming for?

"create a multi-agency model of infant mental health provision to meet the needs of families experiencing significant adversity, including infant developmental difficulties, parental substance misuse, domestic abuse and trauma"

SG Programme for Govt 19/20

- Shared definition and understanding of what IMH is and why it's important
- Positive parent-infant relationships are nurtured and supported
- Prevention of relationship difficulties (and all that come with them downstream)
- Early intervention in Universal services, clear pathways to specialist help

Overarching Principles: reminder

- Motivated people! From across services and including families (steering group)
- Understanding of local need and national priorities
- An overarching vision (nationally and locally) and its aims (Theory of Change)
- A skilled workforce
- **Clear pathways & robust governance structure**
- Sufficient funding
- Sustainability
- An understanding of what's needed at Board level to move forward, and how to measure/ track that

a case example of why it's important to get your pathways and processes right.

Common Issues

- 'The P-I team became the de facto "graduation" service for PMH families as soon as the baby turned 1: we ended up with so few families without previous contact with PMH team'
- 'We did loads of work to skill MW/HV in signs of difficulty- too good a job because we were immediately complet ely bombarded way past our capacity'

Common Issues

- 'The <XX> service were so used to seeing these families, it ended up a bit of a scramble over referrals, and there was a feeling we were "taking" work from others'
- 'We got so many referrals that were really not for us, that we lost valuable clinical time clarifying, speaking to other agencies and referrers to explain why we weren't the right service. Often they'd referred to several other services at the same time and we didn't know'

Common Issues

- Gaps between services: need and offer
- Overlaps between services: need and offer
- Inter-service tension

- Difficult, delayed, repetitive, confusing re-traumatising processes for vulnerable people
- Assumed knowledge of differences in criteria/ focus
- "Contradictory" advice

So how to we overcome all this?

1. Key Components and tasks
2. Important Perspectives
3. Points in time

1. Components and Tasks

Good, clear, agreed **governance** structure

Comprehensive **mapping** of need

Clarity of aims, **interventions** and strategy *in context of other services*

Meaningful **inclusion** of experts by experience

Access to information for those who need it *Data and other services*

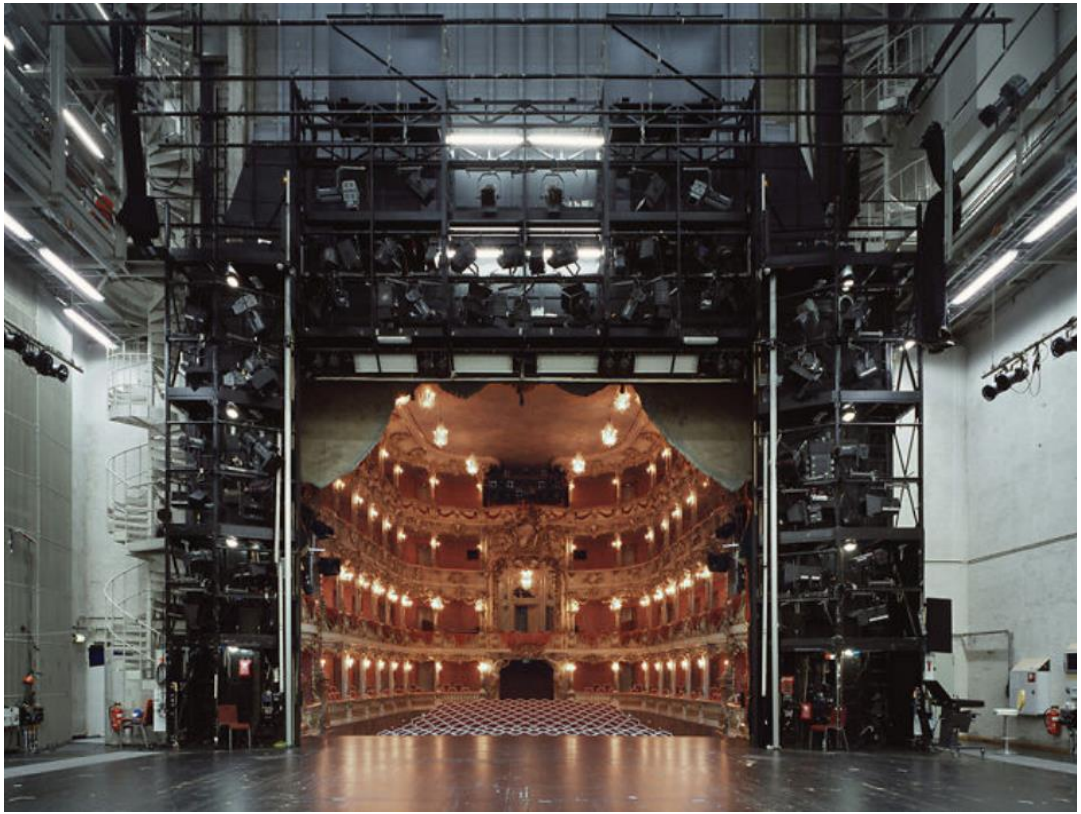
Collaboration beyond the clinical: data, outcome, language, theory lens, reporting, training

Clear, smooth transitions: stepping up/ down, joint work, transfer between services

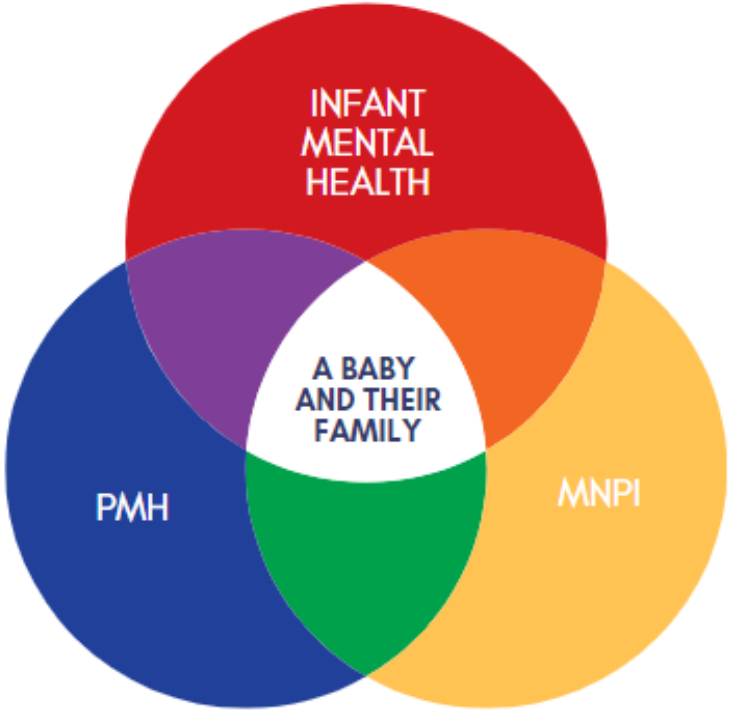
2. To foresee what will happen locally,

walk through your pathways from different perspectives

it pays to stop, and observe from different angles



Pathways within and between: partner services in Scotland



Pathways: partner and parallel services

3. Points in time (and development)

Keep a service-developmental view in mind, planning, testing, evaluating and iterating *from the start*

Time points for intentional pause/ review:

- **Design** of the pathway: *is it locally relevant, sufficient, practical*
- **Operational**: *Does it work? Does it work for service users? The service? Parallel and partner orgs/ services?*
- **Cyclically**: *stop, start, continue*
- **Regular and meaningful**

Some ideas and rules of thumb 1

- Governance should end up together high enough up
- Inter-team involvement in referral criteria: there is, of course, more than "enough" to go round: strike while the iron is cold, discuss and agree criteria so service users are not caught in cross-fire as much as possible
- Respecting (*really respecting!)* those who have been 'plugging the gap'
- Expert-by-experience involvement at all stages, especially and 'walk-throughs'
- Reciprocal, clear planning around consultation and joint-work; "Lead Service" model for join work
- Move towards shared definitions of risk and acuity: IMH is often further upstream manifestation of the same risks
- Collaborations around identifying and managing gaps *outside of core clinical time*
- Consideration of single point of access/ referral (risk if acuity in IMH not well-understood)
- Paperwork which makes sense outwith the service

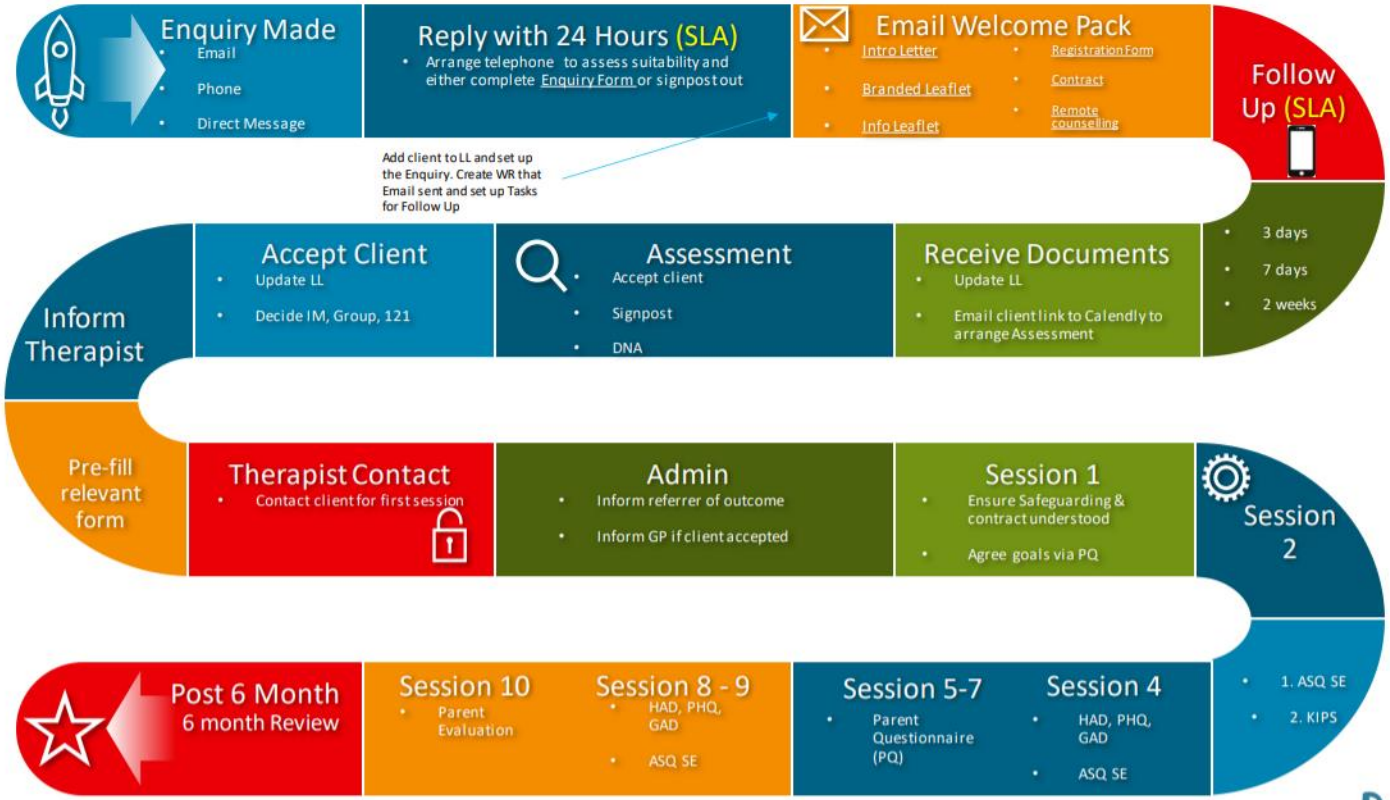
Tips and ideas 2

Senior clinicians creating (at least partly) shared:
- language
- outcome protocols
- training schedules
- overarching theoretical framework which can apply across services (e.g. CFT, MBT)
- reflective spaces

Senior Strategic leads taking responsibility for
- governance structures which work
- open addressing of gaps and overlaps, avoidance of defensive practice

Inclusion of consulted-to services in service design, refine and maintenance

Times protected for pausing, reflecting and seeing things from multiple viewpoints


Enquiry Made
Email
Phone
Direct Message
Reply with 24 Hours (SLA)
Arrange telephone to assess suitability and either complete Enquiry Form or signpost out
Email Welcome Pack
Intro Letter
Branded Leaflet
Info Leaflet
Registration Form
Contract
Remote counselling
Follow Up (SLA)
Add client to LL and set up the Enquiry. Create WR that Email sent and set up Tasks for Follow Up
3 days
7 days
2 weeks
Inform Therapist
Accept Client
Update LL
Decide IM, Group, 121
Assessment
Accept client
Signpost
DNA
Receive Documents
Update LL
Email client link to Calendly to arrange Assessment
Pre-fill relevant form
Therapist Contact
Contact client for first session
Admin
Inform referrer of outcome
Inform GP if client accepted
Session 1
Ensure Safeguarding & contract understood
Agree goals via PQ
Session 2
1. ASQ SE
2. KIPS
Post 6 Month
6 month Review
Session 10
Parent Evaluation
Session 8 - 9
HAD, PHQ, GAD
ASQ SE
Session 5-7
Parent Questionnaire (PQ)
Session 4
HAD, PHQ, GAD
ASQ SE

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