**TEMPLATE shared by a parent-infant team**

**Infant Mental Health Service Specification**

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| **Service Specification No:** |  |
| **Service:** | Infant Mental Health Service  |
| **Commissioner Lead:** |  |
| **Provider Lead:** |  |
| **Period:** |  |
| **Date of Review:** |  |

1. **Population Needs**

The population of ……………is approximately ……with an annual birth rate of …….The area is covered by X number of CCGs and X number of Local Authorities including(CCG’s and local authorities). Overall the population in England is projected to grow by 5.9% between mid-2016 and mid 2026 with the local area showing variation to this with (data about local variation) as examples.

 The target population for the service is where the attachment of baby to parent is compromised .Nationally and locally under-fives represents a very small proportion of young people seen by children mental health services. The national referral rate is 2.5% as reported by the Child Outcome Research Consortium.

This is a highly specialist service and consequently is characterised by low volume but high levels of need. Prevalence is a complex picture given the range of factors that contribute to an attachment disorder or disorganised relationship between the baby and parent. Contributing factors include not only maternal mental health and domestic violence but also those associated with post traumatic distress syndrome which could relate to a traumatic birth experience or have been dormant and emerge with pregnancy and early parenthood i.e. history of neglect and/or sexual and violent abuse.

* 1. **National/local context and evidence base**

The quality of the first years of life has a direct correlation with long term outcomes in relation to health, education and wellbeing (Report of the Children and Young People’s health Outcomes Forum 2012).

The Guidance for Commissioners of CAMHs (2014) recommends a multiagency approach and services should cover pre- birth to 18 years and address all levels of severity. Services designed to meet the needs of pre- birth and the first few years of life need to be tailored to particular needs of this cohort and vary from systems traditionally associated with CAMHs i.e. access criteria and triage through a SPA. Identification and prevention of mental health needs in babies and infants are different to those symptoms seen in older age groups and require a specialist approach to triage, assessment and intervention.

In high-risk, low socio-economic status families, the rate of disorganised attachment in young children with depressed mothers has been estimated to be as high as 60%. (Lyons-Ruth, K., et al. (1990) *Infants at social risk: Maternal depression and family support services as mediators of infant development and security of attachment.* Infant Mental Health Journal. 17, 257-275.)

 The national NICE guidelines identify the need for specialist intervention for parent-infant interaction which is different to the intervention delivered to meet the mothers mental health needs (CG192/QS 115).

Preventionof long term mental health conditions is a key outcome of the service. Studies by Pawlby et al 2009 found that of all 16 year olds diagnosed with depression- all had mothers who were depressed mainly in the perinatal period. This indicated a direct correlation between maternal mental health and the outcomes for children and young people.

The importance of early intervention in a model which provides support and treatment to prevent or address recognised attachment disorders has a growing evidence base, research indicates that early trauma, stress and adversity may lead to neurological and psychological adaptations in the infant that alter the developing brain, hormonal and metabolic systems. The key in avoidable impact in babies is through ensuring a loving , organised and reliable caregiving relationship.

*If the early family emotional environment, especially over the first 1001 critical days, is hard-wiring the stress response system to be on high alert, too ready to respond to situations of everyday tension with the flight or fight or freeze/dissociate responses, then all areas of the child’s development are likely to be at serious risk of being compromised. At the same time early programming of the child’s emotional software, or internal working models, in a traumatic environment of toxic stress produces seriously disturbed attachments that will negatively impact the capacity to make and respond to significant relationships in the future. PIP UK*

A report by the London School of Economics and Centre for Mental Health found that that nearly three quarters of the costs associated with PNMH of £8.1m are due to the long term impact on children. However the 2017 Lancet series on PNMH emphasised that “**these adverse effects of perinatal disorders on children are not inevitable.”**

An ‘attachment disorder’ has a tight definition and probably will not apply in many cases where help is needed. Also, some take this to indicate that there is something ‘wrong’ with the child whereas this is relationship specific and not an individual characteristic at this early stage.

Changes associated with serious problems in the attachment relationship lead to problems with emotional regulation, empathy, mental health, learning, physical health and at the same time the future capacity to be an effective parent. A wide range of Adverse Childhood Experiences (ACE’S) studies clearly identify the impact and cyclic nature of stressful family presentations.

Professor Glovers recent research at Imperial College also demonstrates the physiological effects of PNMH and impact on the on babies in utero and postnatally with increased risks to behaviours, development, birthweight, anxiety and depression. Studies also show that sensitive and positive mothering can reverse this impact, therefore early recognition, good universal and specialist support is an effective investment, not only for short term effectiveness but longer term prevention.

1. **Outcomes**
	1. **NHS Outcomes Framework domains and Indicators**

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| **Domain 1** | **Preventing People from dying prematurely*** Recognising and reducing risk of harm to mothers and babies.
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| **Domain 2** | **Enhancing quality of life for people with long-term conditions*** Ensuring that the child’s primary caregiver feel supported and strengthen the attachment to their child.
* Enhancing quality of life for people with mental illness
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| **Domain 3** | **Helping people to recover from episodes of ill health or following injury*** Ensuring best health outcomes for children through secure attachment.
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| **Domain 4** | **Ensuring people have a positive experience of care*** Friends and Family Test
* Improving peoples experience of care.
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| **Domain 5**  | **Treating and caring for people in safe environment and protecting them from avoidable harm** * Reducing the incidence of avoidable harm
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* 1. **Locally defined outcomes**

The respective key performance indicators for these local outcomes will be embedded in schedule 6 of the Standard NHS contract with the provider.

The provider will be required to (details about data reporting requirements here). This is completed for each baby open to the service by the clinician.

A National Clinical Outcomes framework is currently being developed through the Royal College for Psychiatrists and will inform the requirements of the service in the future.

 The service will be expected to use a range of standardised outcome measures which assess the impact of the service examples include the (adapt to local requirements e.g. Levels of Adaptive Functioning scales from DC:0-5, ASQ: SE2 for infant social and emotional development and KIPs for quality of interaction between the parent and infant).

Alongside clinical outcomes and those associated with the current and future wellbeing of the infant there are expected system wide outcomes including:

* Children being removed from the child protection register within an earlier timeframe.
* Children not being placed on the child protection register due to early intervention.
* Prevention of the cyclic pattern of families presenting with high levels of need.
* Earlier discharge from specialist services including Mother and Baby Units.
* Increased wellbeing and reduction of stress for both the baby and parent.
* Achievement of appropriate School Readiness Score.
* To increase access to mental health services for infants.
* Increased knowledge and understanding of Infant mental health within wider services including Social Care, General Practice and Children’s services.

Evaluation of Service: (details about how the service might be evaluated if this is separate to data reporting)

1. **Scope**
	1. **Aims and objectives of service**

The prime task of the infant mental health service is to provide specialised strength based therapeutic services. These focus on the emotional and mental health needs of the baby and the relationship between baby and parents where this is at risk and/or demonstrating signs of a disorganised attachment. This will enhance the mental and physical wellbeing and future development of the child. The service will be designed to meet the mental health needs of babies pre-birth and the first few years of life through ensuring a secure baby attachment relationship leading to positive long term emotional, mental and physical outcomes.

As a specialist service with high level of expertise the service will provide training and advice for the wider system including social care, children services, midwifery and general practitioners enhancing the skills and knowledge throughout the children workforce. This will result in enhanced confidence in a range of practitioners in regards to recognition, assessment and intervention for those early relationships on the continuum of need.

Meeting the need for mothers and babies with attachment or bonding concerns can be considered as a continuum. The infant mental health service provides direct intervention for those at the severe/complex end of the spectrum and is focused for families experiencing high levels of stress, where the problem is already apparent. Where there is severe mental illness present requiring psychiatric intervention the service provision will include working alongside specialist perinatal mental health services.

The IMH service will have close relationships with universal support services and children’s services ie Children’s Centres, Sure Start. However it will not provide intervention for those whose needs should be met by other services such as Primary Care, Maternity Services , Health Visitors, Children Services or those families requiring additional clinical care within the Partnership Plus Framework Healthy Families. (Guidance to support the commissioning of the Healthy Child Programme 0-19: Health visiting and school nursing services PHE revised March 2018).

* 1. **Service description/care pathway**

The service will:

* Provide advice and consultation service for practitioners working with babies and their carers where they have identified concerns.
* Provide training opportunities for the wider children’s workforce including social care, health visiting, children’s centres, GP’s. These should be multiagency and offered in a variety of locations across the (area) footprint.
* Accept referrals where they clearly describe how the caregiving relationship is compromised. This maybe based on many discrete risks, which are accumulative, and not necessarily a single problem or symptom so the team can have a preventative approach.
* Referral triage will utilise a model of risk analysis. An example can be seen in the PIP UK model below:



* The process of triage may take some time allowing for appropriate information gathering and liaison.
* The team can have a skill mix but must include training in psychodynamic psychotherapy, family therapy or counselling that includes modalities in child development and attachment as well as psychodynamic thinking and practice.
* All staff should have completed infant observation course and AIMH Infant Mental health Competencies at level 3.
* Modalities of engagement and assessment should include a range of approaches to enable flexibility and the ability of the service to meet in relation to culture, needs and timescales.
* The service will provide direct assistance, advocacy, emotional support, developmental guidance, early relationship assessment, and parent infant relationship based therapies and practices such as Interaction Guidance.
* The service will follow the Michigan Competencies framework as part of the engagement phase. Treatment modalities should include infant -parent psychotherapy and at least 2 evidence based practice a list of these can be found in appendix 2.
* When contact with family ends the family should be signposted to appropriate sources of support.
* A letter should be sent to the GP and referrer and also to the family providing there is no clinical rationale why this may not be appropriate.
* A six month follow up by a clinician phone contact.

**3.3 Population covered**

The service is will deliver a service for families and main care givers registered with GPs in (area) The age range for the infant will be from the antenatal period to the second birthday.

**3.4 Any acceptance an exclusion criteria**

* Referrals where there are either ongoing or proposed child protection investigations or where the difficulty is something the parent is struggling with but their relationship with the baby is not unduly affected. Reasons for the referral being declined should be clearly explained to the referrer. Once the team is established it should be able to signpost to other services when appropriate.

**3.5 Interdependencies with other services**

The service will work in partnership with other providers and services to ensure safe, planned and joined up care in the (area) system. The developed pathways will ensure seamless and smooth transitions between services to avoid people slipping through the net. Information must be shared with people using services and all those professionals relevant to the care plan where consent has been agreed and risk considered in line with policy.

The key interdependencies are with:

* General Practice,
* Maternity Services
* Children’s social workers and social care teams.
* Specialist community perinatal mental health service.
* Universal Services including health Visiting
* Children’s Services i.e. Children’s Centres
* Third sector information, advice, support and advocacy providers.
* Drug and Alcohol services
* Generic children health and social care locality teams
* Tertiary health providers and Mother and Baby Units
* Early intervention services
1. **Applicable Service Standards**

**4.1 Applicable national standards e.g. NICE, Royal College**

* **AIMH IMH Competencies**

**4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)**

**4.3 Applicable local standards**

N/A

**4.4 Safeguarding**

The PIP service may identify safeguarding issues. These concerns may relate directly to the patient or the welfare and safety of other adults or children. These adults or children may reside at the patient’s place of residence or may have regular contact with them.

SET and other local safeguarding policies must be followed involving Multi-Agency Safeguarding Hubs (MASH) or Multi-agency Public Protection Arrangement (MAPPA) as necessary.

1. **Key Service Outcomes**

See section 2.2

To be confirmed

**6.1 Applicable quality requirements**

To be confirmed

Appendix 1.

Assessment and evaluation within a PIP team.

**Introduction.**

The Social and Emotional Assessment Group that contributed to the recent report from the DoE and WAVE, ‘Conception to Age 2 - The Age of Opportunity’ listed the principles behind the selection of methods for assessment in the early years. They were:

1. The purpose with all assessments of a child’s social and emotional wellbeing should be to establish the level of social and emotional functioning of the infant in addition to the sensitivity/responsiveness of relevant carers in order to guide the family and the practitioner towards the most appropriate support and intervention for the family within the context of a gradient of need.
2. Assessment tools should be practical as well as valid and reliable, based not only on sound research and evaluation but also on a high likelihood of it being implementable as part of a busy practice.
3. All assessment tools need therefore to make sense to parents and carers, and to be seen as supportive rather than judgemental; this requires that such tools be implemented as part of a promotional and partnership model of working.
4. Measures and methods must be usable across the whole spectrum of ability including social disadvantage, disability, culture and language
5. Finally training in any proposed assessments must be easily accessible and not prohibitively time consuming or expensive.

Beyond validity, there may be other questions to answer to see if a parenting assessment tool will be useful:

1. Does it document outcomes that match agreed service goals? i.e. Will it make sense to clinicians, parents and commissioners?
2. Is it clinically useful, identifying the parent's individual strengths as well as any areas needing improvement? Are the assessed behaviors potentially changeable and the changes measurable?
3. Will it provide information relevant to quality of parenting?
4. Can the answers / behaviours being measured be easily simulated? This applies to the child as well, as by 15 months a toddler is capable of faking false positive behaviours and affect
5. Is it sensitive enough to note parents’ progress, or where further work needs to be done?  Is the assessment information useful in planning and promoting services?
6. Is it designed so the information makes sense to a parent and can be used to reinforce a parent's progress and build their confidence?
7. Does it highlight parent-child interaction?
8. Does it provide easy to understand language that can be shared with parents, team members, and other agencies alike?
9. Does the assessment information support reflective practice, promoting both ‘mind-mindedness’ and reflective supervision?
10. Does it provide information and data that will be helpful in continuous improvement of both the staff and the service?

**Methods of evaluation used by PIP teams.**

These are all entered on the Portal system.

1)*Stresses on the caregiving relationship.* These are noted using a simple check list which then gives a quick profile of the difficulties a family faces. This enables intervention to be put in on the basis of risk (before maltreatment may have occurred), makes clear other targets for intervention besides direct clinical work and provides both an anonymous description for comparison and data for commissioners and partner agencies. These are risks in the ecology of parents’ lives that will have a deleterious impact on the caregiving relationship. It cannot be assumed that such a list will invariably identify all children at risk; also, there is a socio-economic bias and, of course, a child might be maltreated with no obvious family risks being visible. This check list is integral to our ‘request for service’ form, ensuring that referrals carry a range of appropriate information. It also can be used to demonstrate how early intervention work is usually highly complex, needing to deal with a wide range of factors where families are struggling with multiple adverse circumstances. It makes clear that there are no quick fixes.

*2) Behavior within the caregiving relationship.* The Keys to Interactive Parenting Scale (generally known as KIPS). This is video-based and gives a way of evaluating 12 different aspects of parenting behavior from analyzing about 10 to 15 minutes of interaction. Can be used from age 2 months on. The scores on 12 scales may be recorded and provide a quick profile for evaluating changes. KIPS produces clinically useful information that can be fed back to caregiver, and can pinpoint clearly defined strengths and thus be used as a basis for video feedback. This measure concentrates rather more on actual parenting behavior and does not specifically look for markers for problems or disorganized attachment in the child. The scores can be used to show changes during treatment.

*3a) The quality of the caregiving relationship / attachment.* For the new approach used by PIP teams to assessing the caregiving relationship see: *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC:0-5).* (2016) Zero to Three. Washington: DC. Pages 134 to 148. Firstly they have defined ‘relationship-specific disorders of early childhood’ in much more detail. Infants show different patterns of behaviour with different caregivers within a few months after birth, and any problems are likely to be relationship-specific. A disorder cannot be diagnosed if the concerning behaviours are observed in more than a single relationship. In order to assess a level of adaptive functioning this is specific about what aspects of caregiving and the child’s contribution to the relationship must be considered, along with the criteria of what constitutes a relationship specific disorder of infancy. The end is a scale of four ‘levels of adaptive functioning’: 1. Well adapted to good enough relationships; 2. Strained or concerning relationships; 3. Compromised to disturbed relationships; and 4. Disordered to dangerous relationships. This scale should only be applied at the end of the assessment process, and all steps are recorded. Also, the levels of adaptive functioning of the caregiving environment may then be similarly evaluated on four levels.

*4) The child’s development.* The two Ages and Stages Questionnaires are useful here, and widely used in infant mental health / early intervention services in America and elsewhere. They can be parent completed alone, but are far better done by a practitioner with the parent (after a few meetings) as all the questions can open up aspects of the child’s behavior and the parent’s anxieties. They do not take very long to complete, and parents like having a copy and this can be shared with other agencies. The ASQ-3 begins at age 2 months and covers communication, gross and fine motor skills, problem-solving and personal-social skills. The scoring and how this relates to a developmental norm are both clear. This is useful if there is a suspicion that the infant may have a developmental delay, showing up the need for a further referral, and there are allowances made for prematurity. The ASQ:SE2 (second edition) complements the ASQ-3 and focuses on social and emotional development and produces a score which can be compared to their benchmark cut-off score for each age. It can first be used at age two months; and the time taken increases a bit with age as the child can do more things. A reduction in mean score, regardless of whether or not this is below or above the cut off, indicates an improvement. Many questions link to behaviours one would expect to see if the attachment system is activated. No training needed to administer either of these – but for the developmental ASQ-3 you are often stuck for a clear bottle and a Cheerio! (Use a smartie.) Comes with clear and useful handouts appropriate for each age.

*5) The state of mind / mental health of the parent(s).* PIP teams use theHospital Anxiety and Depression. This carries 7 questions each for anxiety and depression and takes about 5 minutes to complete. It is meant to enable early identification of both. Might be easy to fake positives if you really wanted to, but apparently this rarely happens, and it is widely used and makes sense to parents. Has the advantage of combining two issues and has been recommended.

*6) Parent feedback at end of contact.* PIP UK has developed a parent-completed evaluation form that can be scored as well as having space for free format comments. The Likert rating scales used in a range of questions can be entered on the Portal. The same form, with a change of tense, can be used to gather parental feedback after a few sessions.

Appendix 2

Examples of Evidence Based Modalities of Intervention

Interaction Guidance/video feedback work (VIPP,VIG, and KIPs)

Parent-infant psychotherapy

Watch, Wait and Wonder

Mellow Bumps and babies

Attachment and Biobehavioural Catchup

Circle of Security

Developmental Guidance

The Neonatal Behavioural Assessment Scale ( NBAS).

Reference : Evidence based interventions Steele, H.& Steele, M (2018)

Handbook of Attachment- Based Interventions, New York: The Guildford Press