**Operational Policy template Example**

**Intake process**

Eligibility

XXX is a service for

* Infants unborn or under 2 and their parents/primary caregivers
* where a problem has been identified that is impinging on the infant’s socio-emotional development or is likely to.
* the preferred modality of intervention is to support the infant’s developmental pathway via the parent infant relationship

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| Types of problems that impinge on the infant’s socio-emotional development for which parent-infant psychotherapy is the preferred modality of treatment  Parental:   * Parental mental health problems * Personality disorder * Past and/or current trauma and/or loss * Social isolation/exclusion * Conception and/or birth complications   Infant:   * Birth complications * Infant illness and/or vulnerability (e.g. genetic syndrome)   Relationship:   * Couple relationship problems e.g. desertion, domestic violence * Parent infant problems (e.g. lack of bonding)   Systemic concerns:   * Child at risk/child in need |

Exclusions:

* The infant is over 2
* Out of area
* Statutory agencies refuse to collaborate
* Active substance misuse
* Social care involvement – level ?
* Court reports?

**-**

**Care Pathway**

Referral

Not appropriate

Team meeting

Further discussions

with

the referrer

1

st

Contact with family

Contact with the referrer and

the network

Waiting list

Allocation to therapist

Non engagement

End therapy

Engagement

1

-

3 sessions

Treatment

Review

Continue

Formulation of care

plan

Refer to another

service

Pregnant women/ fathers /

families with babies at risk 0-24

Self

**Referral process:**

Referrals are accepted by professionals, practitioners and agencies, and self-referrals. Includes: Health visiting, GPs, Specialist Perinatal Mental Health teams & IAPT.

Information required at the point of referral is demographic (form)- name and contact details of the patients (mother and child, father if appropriate), the referrer, the GP and health visitor, any other professionals/agencies involved with the family - and reason for referral. The referrer or family member fills in a REFERRAL form

Consent by family to be contacted must be included.

Action: This is brought to the weekly team allocations meeting (see below

Allocations meeting

Referrals are discussed at the weekly team meeting.

There are 4 possible outcomes:

1. the referral is accepted and either allocated to a therapist or put on the waiting list.
2. Further information from the network is required to assess eligibility or suitability
3. Further contact with the family is required to assess their motivation to attend where they may not have been adequately consulted
4. The case is not accepted because not eligible or suitable

Allocation of case to therapist

Cases are allocated to a therapist based on therapist availability and the complexity of his/her cases load (e.g. number of ongoing complex cases). In certain cases, a therapist may be building up a particular area of specialisation and this will be taken into account. ) When the date for the first appointment has been set with the family, the administrator will send a letter of confirmation and information pack includes a leaflet about the service.

Initial contact with the family and/or referrer

When a case is straightforward, the therapist will make phone contact with the family as soon as it is allocated to him/her to introduce him/herself, begin to make a relationship, talk over arrangements and set a date for the first appointment. Waiting time for the initial phone call is xx week and the first appointment should normally be within xx weeks.

When the case has been referred (rather than self-referred) the therapist will, in parallel, contact the referrer. Usually this will be a telephone conversation e.g. to establish whether there have been further developments in their involvement with the family, whether there are any additional concerns. In straightforward cases the therapist may write to the referrer to inform them of PIP accepting the case.

In certain cases, the therapist will contact the referrer before making contact with the family. These include situations where the referrer has requested to talk over the referral, where there is a crisis with other agencies involved in providing care, where there is statutory involvement. Sometimes the therapist may have a ‘hunch’ regarding complications and will wish to establish contact with the network before meeting the family.

**Engagement**

First session with the family

Both parent/s and infant attend the first session. Depending on the composition of the nuclear family and the expressed preference of the primary caregiver (usually mother), the partner (usually father) will be included from the beginning.

The first session will form part of any assessment:

The therapist will introduce her/himself to parent/s and to infant to model from the beginning that *the infant is an active participant in the treatment*. Therapist and family sit on the floor with the baby in the centre, so that *the baby is central to the proceedings of the session*. *The therapist will invite the parent/s to talk* about the referral problems, the background, their understanding of their situation, their thoughts about the impact on the baby. The *therapist will actively respond and reflect with all present in this discussion*. *Parents and baby are supported to interact with each* in the ordinary caretaking process of feeding, changing in the session and the therapist will introduce/support aspects *of play and playfulness* appropriate to the baby’s age.

Thy may follow an assessment protocol (Services will differ).

As the session proceeds the therapist will, as appropriate, complete the consent and ROMS forms (see below) with the patient/s. Towards the end of the session the therapist will *describe what the service can offer and what it entails* (including issues of confidentiality and conditions of contact with the professional network etc.) and what *options there are to proceed , different modalities or choices, or alternatively, to be referred* to another agency. The patient and therapist will discuss the family’s preferences. Depending on protocols, most assessments take place over 2 appointments.

The therapist’s record is written up in detail and the notes are kept in the patient file.

Incorporating research tasks and data collection

In addition to the consent form *the patient* will fill in the following measures during the first or second sessions:

* ROMS as per service

Introducing the questionnaires gives opportunity to explain the service policy regarding research and training and how this interfaces with patient confidentiality. Within the first 1-2 sessions, but outside the setting of the session, *the therapist* may also fill in the therapist report questionnaires: (as per service)

ROMS are completed again at the end of treatment.

Building a therapeutic alliance

In contracting to undertake the treatment, the therapist undertakes to offer *predictability, consistency, emotional responsivity, reflectiveness and clear boundaries*. The therapist also undertakes to *address the needs of both the parents and the baby* and will ensure that the baby is kept in mind throughout the therapy. S/he will create an emotional environment in which the baby feels safe and can express their attachment needs.

*Frequency of sessions* is adapted to patient needs, availability and circumstances and to building the therapeutic relationship. At the beginning of treatment, it is usual to offer weekly sessions (50 min).

*Missed sessions* are addressed by the therapist either immediately/soon after the session. The therapist may call the patient or write. If the family persists in missing sessions the therapist may contact the referrer to ask for their intervention. When sessions are missed regularly (3 or more) the therapist will discuss terminating the therapy and informing the network. This is decision is usually made with the Supervisor or lead and, where possible, with the patient.

Confidentiality

Confidentiality is a central issue in building the treatment alliance. It is discussed in the first session and revisited over the course of the therapy. *Confidentiality is assured* in all aspects of the treatment *except where concerns arise regarding the safety of the baby and/or the parent/s.* This is stated explicitly.

Patients are required to give signed permission to maintain routine contact with their GP and HV plus any other extended network. This is explained and discussed as needed in the first session (see above) copies of letters are provided to the family.

Setting up working relationships with the professional network

Where network involvement is limited the therapist will write to the referrer and GP/HV to inform them that the family is attending.

If the family is more closely involved with other professionals, such a psychiatrist, Social care, Family Support Worker; the therapist will discuss with the relevant professionals the service input to the family, and how the network may best function to support the family. This contact should be discussed with the family and a letter to the professional network should be copied to them. These communications may result in the therapist’s attendance at network, core group or other TAF type meetings.

All communications with the network are recorded in the patient file.

**Assessment process**

An assessment framework is followed, (\* This protocol will be individual to each service\*) in order to establish which treatment modality (if there is choice) will be most appropriate. Often this spans more than one sesson.

Information is gathered and collated by the therapist during her/his early contact with the family (telephone call, first session), with the referrer, and in completing the records and forms.

* The therapist is assessing the parent/s strengths and difficulties in relation to parenting their infant
* The status of the baby’s development and attachment behaviours
* Risk to the infant and/or parent/s
* Suitability for treatment (including motivation, reflective capacity)
* Consideration of modality and fit for the family and problem

Sources of information:

* Parent/s’ verbal communications
* Infant and parent/s’ non-verbal communications
* Demographic and research forms
* Therapist’s observations and responses to these
* Referrer and other professionals/practitioners’ impressions

Risk Assessment

The information gathered is collated on the Risk Assessment Form, at the end of the assessment sessions. Assessment of risk is an ongoing process and the therapist will review the risk assessment and update the RAF regularly.

Action plan with regards to risk

*No risk, or low risk* – no immediate action required in terms of allied agencies but concerns to be discussed with the family in the therapeutic process.

*Low to moderate risk* that the therapist considers *can be managed within the therapy*, will raised with the family early in the treatment and be recorded under action plan.

If the therapist considers that there is a *possibility of harm to* the *baby she will be required to act* in line with *service Child Protection policy*. Generally, this will involve contact with GP/HV and or Children’s Social Care (MASH). Actions will be documented as per policy guidance and reported to the Safeguarding Lead.

If the therapist considers that there is *a possibility of harm to* either of the *parents, she will be required to contact the GP as the relevant statutory service* responsible for the adult. Actions will be documented as per the service Child Protection policy guidance.

**Care plan**

The Care Plan pertains to what the family and therapist have agreed to work on together, how that work will be undertaken. If there are safeguarding concerns, the care plan will address the plan and actions to address these.

The Care Plan also includes a decision not to continue - sometimes by default, such as when the family unexpectedly moves. The decision not to contiue may be reached with the therapist, e.g. when the adult concludes s/he wants therapy for themselves, or the patient may make their decision known by not attending scheduled sessions and dropping out of contact. In either case, the referrer will be contacted and there will be a discussion as to whether the patient can be supported to return to the service.

The therapist and family may also decide that 1-2 sessions are sufficient to change the referral problem, so that the Care Plan is to discharge the case. The referrer is informed.

**Ongoing parent-infant psychotherapy**

Process

Description of the modality used in the service.

EXAMPLE: The process of parent infant psychotherapy is described in Chapter 6 of ‘The Practice of Psychoanalytic Parent Infant psychotherapy’ (Baradon et al. 2016, Routledge).

The aim is to build on the relationship with the therapist and the therapeutic alliance to effect positive changes in the parent infant relationship. Areas of change may be

* The parent/s’ self-representation as parents, leading to more positive feelings about parenting their baby
* The parent/s’ representations of their baby, leading to an acceptance of the needs and developmental dependency and vulnerability of their baby
* Reflective functioning in relation to self, other and baby to reduce intergenerational repetitions that are disruptive to development
* Behaviours towards their baby, reducing negative interactions
* Support attachment behaviours in the baby, necessary for his/her wellbeing and development (seeking safety, comfort, play and exploration)
* Reduce maladaptive behaviours in the infant, such as avoidance, dissociation, fragmentation
* The couple’s inter-relating in parenting their baby

The more specific emphases in the treatment process are shaped by the goals of the parents and their growing awareness of where their psychological impingements lie.

Supervision

*Peer supervision* is offered on a routine basis through the weekly team meetings.Thereapists also access *individual supervision* according to case load and days worked, and experience- usually monthly. *Psychiatric supervision* can be requested and consultation around *safeguarding* can be obtained (same day, if needed) from the Child Protection officers.

Supervision records are kept on file within the case notes.

**Review with the patients**

Patient outcomes are reviewed formally through revisiting the research questionnaires six months into treatment, and in discussion about the following.

1. Patient status with regards to their goals – to what extent they feel they have achieved the goals the set out at the beginning of treatment, have their aims changed, etc.
2. Reflection on how they are feeling within themselves and in relation to their baby
3. Reflection with the parent and baby on how baby is doing and how they are doing together.
4. There is also likely to be informal review of outcomes as the work progresses. E.g. the therapist may remind the parent how they felt/functioned in the past compared to the present, as a way of thinking about changes and progress. Or may question why things are not changing, thus opening up reflection on what is not being achieved.

**Ending treatment - discharge process**

The intention is to provide as short-term an intervention as possible. However, many patients come with highly disrupted attachment histories and may need time to build up trust and feel safe enough to allow change in habitual modes of relating. Furthermore, it is important to give time to consolidation of new patterns of relating. Thus, while the therapist may see sufficient change in the baby, s/he may feel that the parent is not yet secure in the changes that have unfolded and may consider the work with the dyad/triad unfinished.

On the other end of the spectrum, because of the severity of the attachment history and ongoing social difficulties, some patients may want to continue treatment longer than is necessary in terms of their goals and service remit to work with the parent infant relationship.

It is a complex balance between these factors, and parent and therapists need to bear in mind an ending throughout the treatment process and then build up to it as appropriate (see chapter 7 in ‘The Practice of Psychoanalytic Parent Infant psychotherapy’, Baradon et al, 2016).

When a date for ending is set, the therapist will also ensure that discussion takes place to include the baby re their feelings about ending, what has been gained, what has not been achieved. On occasion the ending will be reached by a process of less frequent meetings, spaced apart fortnightly, then monthly and so on. When therapy ends, the therapist will notify the GP and referrer by letter.

**Accountability**

Therapist accountability for their work and transparency in their patient activities.

Note keeping:

Keeping updated records is an important instrument of accountability and transparency. The therapist is responsible for keeping updated notes on patient attendance and a brief summary of the theme of the session, and of any supervision received, on file. Also records of all phone calls and copies of correspondence with patients and the network.

The guideline for this is that the team/line manager or administrator should be able to get a clear picture of the treatment activity from the file.

Termly review in team meeting:

At the of each term the team review all cases that are problematic in terms of risk, progress, etc. In this forum the Care Plan for the patient may be reconsidered.

Line management

The therapists are accountable to the team Manager. Termly meetings are held to review the work of the passed term and plan ahead, and once per year a formal Review and Development meeting is held as per policy.

The team manager is, in turn, accountable to xx and to the xx. Meetings with the xx are held as appropriate, and once per year a formal Review and Development meeting is held.

**Monitoring service outcomes**

Reports are prepared for commissioners quarterly.

Misc:

Placements and Honorary therapists