ABC PiP

Attachment, Bonding & Communication
Parent Infant Partnership

Annual Report 2019 - 2020

HSC South Eastern Health and Social Care Trust

Believe in children
Barnardo's Northern Ireland

Acknowledgements

The development of the ABC PiP team is the result of contributions from many professionals and practitioners. We are immensely grateful to them. Without the investment of their time and effort we would not have had the opportunity to take forward this exciting venture or have been able to offer this much needed support to our families over the last year.

We would like to extend particular thanks to:

Julia Lewis and **Paul Millar** for collaborating to drive to fruition the specialist team that was long discussed and hoped for.

Parent Infant Foundation (formerly PiP UK) for their buoyancy, guidance and expertise on establishing a specialist parent-infant team.

Karen Elwood for her ongoing support in overseeing service delivery and development.

Robin Balbernie for his enormous generosity of that which is most important to the development of any new venture, or indeed new human, time, filled with expert guidance and encouragement.

Croydon PiP, LivPiP and **NewPiP** for sharing examples of their work and learning with us and for their positivity as we got started.

TinyLife, SureStart and **HomeStart,** for helping us to consider the gaps in provision to families in the Trust area and plan where our efforts would be best placed, to use resource wisely and effectively in collaboration with our partner organisations.

The contributions of our colleagues in other services, including **Family Nurse Partnership**, **New Parent Programme** and **Barnardo's Parent and Infant Programme** in helping us to look after our most vulnerable babies and their families in our Trust area.

Eamonn McMahon for his "undersung" efforts over many years, in bringing together like minded individuals to create a group of professionals with a shared purpose, to better the lot of our littlest and most vulnerable.

PiP
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"Not only can babies not wait, but they also cannot stand up for themselves either. In addition, babies have no comparisons and the quality of the caregiving relationship is the major component of their world. Active, satisfying and reciprocal relationships with parents create the largely undetected origin of a sense of identity, self-esteem, appreciation of others on all levels, ethical behaviour and self-control" (AIMH, 2020)

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1. Introduction and Service Context

Within the Northern Ireland (NI) context and the SE Trust area, there has long been an understanding of the need to promote good Infant Mental Health (IMH). This in part originates from concerns about our troubled history, what its heavy legacy might mean for our young and hence a wish amongst those committed to the work of child welfare, to try to improve the conditions to be inherited by our infants. Over the past twenty years, a number of dedicated professionals across both statutory and voluntary sectors had been meeting to try to advance an infant mental health agenda. The foresight of this group of professionals was that of the need to progress work on early intervention. The wish was that difficulties presenting in families of babies could be addressed early on, at a point when parents would be in contact with universal health services and the need for more intensive intervention later in life, when the complexity of issues would otherwise escalate, could be lessened. In 2016, the Public Health Agency's '*Supporting the best start in life' IMH Framework for NI April 2016* was published. The publication of this document underscored the fundamental importance of promoting infant emotional wellbeing in Northern Ireland. The framework noted the commitment by the Public Health Agency, Health and Social Care Board and Trusts, as well as academic, research, voluntary and community organisations across Northern Ireland, to improve interventions from the ante-natal period through to children aged 3 years old.

It acknowledged:

- Improving long-term outcomes for the whole population begins with ensuring that every child has the best possible start in life, with a focus on ensuring that children who are the most vulnerable and at risk are especially supported.
- The necessity of interventions beginning in pregnancy and continuing up to three years, to maximise the potential for impact. This is due to the wide body of evidence which demonstrates that disadvantage for some children starts before birth and accumulates throughout life.
- Many children face pronounced adverse experiences in infancy, including repeated exposure to neglect, chronic stress, and abuse. Such experiences can detrimentally disrupt brain development, which in infancy is more sensitive and vulnerable than at any other stage in human development. This can lead to children and adolescents presenting with emotional problems and potential life-long difficulties with self-control, engagement in high-risk health behaviours, aggressive behaviour, lack of empathy, physical and mental ill-health and increased risk of later self-harm or suicide. As well as the human cost there are increased economic costs to society in terms of healthcare, child welfare, court processes where children come into care, education, unemployment, policing, juvenile justice and prisons.

The document also highlighted the need for:

- **Service development** with a focus on supporting parent-infant relationships early intervention and preventive approaches.
- **Capacity building** so that professionals working with families are sensitive to the specific and unique social and emotional developmental needs of infants.
- Each Health & Social Care Trust in NI to develop an **Action Plan** to better provide services responsive to the unique needs of infants and their families.

Barnardo's have a long history of delivering Early Years Services within the SEHSCT area and were actively involved in the early developments regarding infant mental health, therefore in response to the Infant Mental Health Framework Julia Lewis, Assistant Director for Child Health, SEHSCT approached Paul Millar, ADCS in Barnardo's, about working in partnership to deliver actions for the betterment of infants and families. There was discussion about how best to achieve this and a decision was taken to form a Strategic Partnership between SEHSCT, Barnardo's and Parent Infant Foundation (PIF), as it was recognised PIF had considerable knowledge and expertise on the development of infant mental health services due to their experience of supporting Specialist Parent Infant Relationship Teams throughout the UK. In addition, their model advocated a multi-factored approach including provision of specialised services directly for the most vulnerable families, alongside systems change to promote the wellbeing of infants more widely – this reflected the overall vision held for the development of IMH provision throughout SEHSCT area. Tiny Life were included as partners within the Strategic Partnership in recognition of the particular difficulties and vulnerabilities around attachment, bonding and communication with preterm babies.

An event was held in January 2019 at the Island centre in Lisburn to launch an **Infant Mental Health Strategy for the South Eastern Health and Social Care Trust.** The event also launched the **Attachment, Bonding and Communication Parent Infant Partnership (ABC PiP)** - our specialist infant mental health team. The team is included in **Parent Infant Foundation's (2019) "*Rare Jewels Report*"** as the only one of its kind in Northern Ireland.

The **three main aims** of the SEHSCT IMH Strategy (2019), the Strategic Partnership and the ABC PiP team are:

- To review systems related to Infant Metal Health in the SEHSCT and identify what areas are working well or where gaps in provision exist.
- To build capacity in the Infant Mental Health workforce through education, training and support.
- To provide a Specialist Infant Mental Health service for families experiencing difficulties and requiring direct support and intervention.

1a. The ABC PiP Team

"Specialised parent-infant relationship teams are multidisciplinary teams with expertise in supporting and strengthening the important relationships between babies and their parents. These teams work at multiple levels; They are expert advisors and champions for all parent-infant relationships, driving change across their local systems and empowering professionals to turn families' lives around" (Rare Jewels Report, 2019).

The ABC PiP team base is in Ballygowan with specialist therapeutic services being provided across the South Eastern Trust. The majority of direct therapeutic support is delivered in people's homes. This makes the service accessible to families who feel unable to attend community supports at the time of referral, either due to the difficulties they are experiencing in coping with life and parenting, or lack of provision of community services in their area.

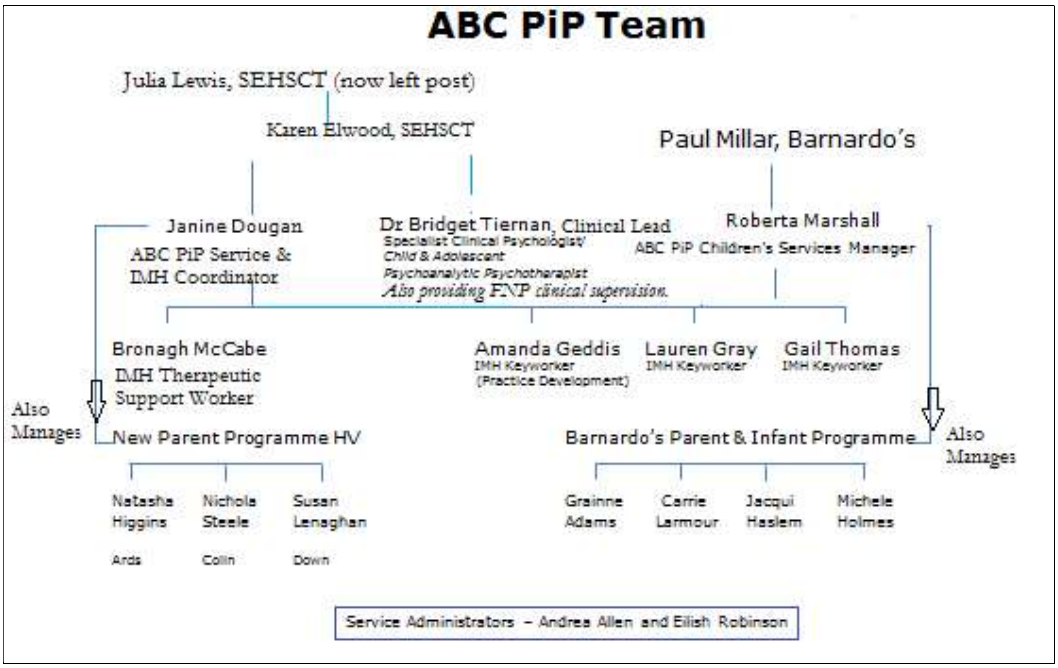
Staff (Jan 2019- Apr 2020) Our staff team for the report period are listed below. Amanda Geddis' role was temporary and her term has now come to an end. Gail Thomas has left post and there will be recruitment to fill this vacancy.

- Roberta Marshall, Children's Service Manager Barnardo's -- WTE – 0.9
- Janine Dougan, Infant Mental Health Coordinator for ABC PiP and NPP -- 1.0 WTE
- Lauren Gray, Infant Mental Health Key Worker, Barnardo's -- WTE 0.5
- Gail Thomas, Infant Mental Health Key Worker, Barnardo's -- WTE 0.5
- Amanda Geddis, Systems Change Worker, Barnardo's -- WTE 0.6
- Bronagh McCabe, Infant Mental Health Therapeutic Support Worker -- 1.0 WTE
- Andrea Allen, Service Administrator -- WTE
- Dr Bridget Tiernan, Clinical Lead – Specialist Clinical Psychologist, Child and Adolescent Psychoanalytic Psychotherapist -- 0.2 WTE

Pictured: ABC PiP team with Robin Balbernie.

1b. Team Roles

- **Clinical Lead (SEHSCT)** with training in clinical psychology and child and adolescent psychoanalytic therapy to ensure competency in working knowledge of early child development, attachment theory and an awareness of the importance of the unconscious dynamics of parenting (e.g. intergenerational issues/trauma in families and how this impacts on parents trying to form bonds with and care for their children). The clinical lead provides monthly, clinical supervision to staff from Barnardo's and SEHSCT who are carrying a clinical caseload and holds a small number of more complex clinical cases.
- **Infant Mental Health Coordinator (SEHSCT)**, responsible for overseeing and managing the service, case management supervision of Trust workers and holding a caseload of more complex cases. Has additional supervisor's training in Video Interactive Guidance and M9 early years, Infant Observation.
- **Service Manager (Barnardo's)**, responsible for overseeing and managing service and case management for Barnardo's staff. Leading on advancing systems change agenda for the service.
- **Infant Mental Health Therapeutic Support Worker (SEHSCT)** with additional training in M9 early years, infant observation. Holds more complex clinical cases.
- **Infant Mental Health Key Workers (Barnardo's)** offering direct intervention and support to families, as well as signposting and support to engage in community based services. Supporting ongoing role out of coproduction activity in the service.



2. Model of Service Delivery

The agreed service model is informed by the knowledge and guidance provided by the Parent Infant Foundation (PIF) and advice from specialist Infant Mental Health Teams who are members of their network, including Croydon PiP, LivPiP, and NewPiP. The model outlined by PIF highlights Theory of Change in identifying short, medium and long-term service outcomes at the direct level with babies and families and at the wider level of systems and the general population. A Logic Model was completed noting service goals for ABC PiP and is included in Appendix 1.3.

2a. Direct Therapeutic Interventions

"It is not the infant who is the target of intervention but rather the parent-infant relationship… Instead of the problem or disturbance being understood as within the child or parent or within the parent, the problem may be understood as between the child and caregiver" (Zeanah and Zeanah, 2010: 234).

Families referred to the service can receive a range of the interventions below during the course of their period of involvement with us:

Parent-Infant Psychotherapy is a psychoanalytic and attachment based intervention that aims to help parents reflect on past and/or current experiences impacting on their relationship with their baby. Particular emphasis is paid to factors out of the parents' conscious awareness that may be impacting parenting. Parents are supported to become more aware of the non-verbal aspects of communication between them and their baby. The approach is broad and can include work on a couple's parenting relationship, as well as work with either or both parents and the baby. Duration, content and focus of therapy varies according to the needs of the family as identified at assessment. Psychoanalytic and attachment thinking is weaved through all of the other interventions delivered by the service to maximise impact of intervention and remove any emotional blocks families may have around engaging in therapeutic work. NICE guidance has specifically recommended parent-infant psychotherapy for parents at risk of maltreating pre-school age children. There is evidence for its effectiveness in high risk family situations with maternal depression (Cicchetti, 2006), in reduction in family stress and improvement in parental coping (Anagnostaki, Kollia and Layiou, 2019: 64).

Community Resiliency Model is an intervention used with parents, given the local context and the legacy of the Troubles for many of our families. It supports parents to better understand their own emotion regulation needs and gives tools for coping with stress so that they are better regulated. This allows parents under stress to become more stable so that further therapeutic work can be progressed safely, with the assurance that the parent already has some tools available to them to manage difficult feelings that may arise during the course of the therapeutic work on their relationship with their baby.

Video Interactive Guidance is a strengths-based intervention which aims to enhance sensitivity of parents to their baby's cues through video feedback. The parent is filmed with the baby during everyday interactions, such as play time or during meals. Videos are watched back along with the practitioner and moments of attuned and responsive parenting are highlighted and discussed to promote generalisation of skills evident when the parent-infant relationship is at its best.

Infant Massage and Yoga offer good engagement tools, as they provide a starting point for building relationships with families and

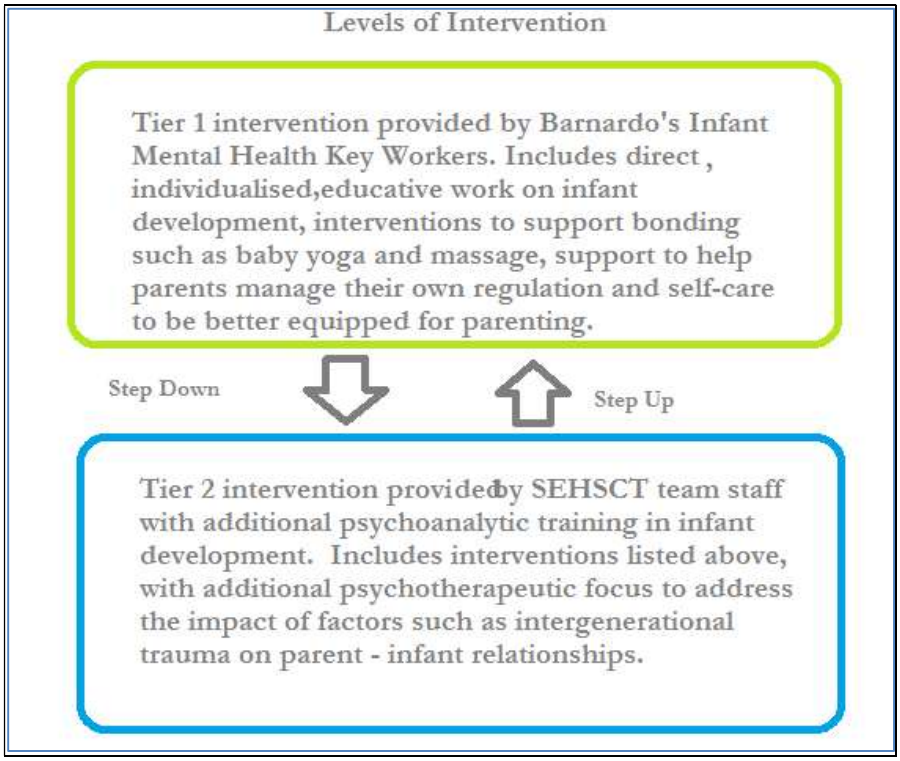
facilitate thinking about the baby's emotional life and experiences of the environment around them. Gentle and calm touch is soothing to infants and parents report improved feelings of closeness and attunement to babies following infant massage (Glover, 2002). Caution is taken in terms of timing of these interventions in terms of more "at risk" families, so that they are only progressed when parents are sufficiently able to regulate themselves. There is evidence suggesting infant massage may be of particular benefit to medium-risk depressed mothers, in enhancing sensitivity to their baby's needs (Underdown et al., 2013).

Five to Thrive is a psychoeducation programme for parents to support understanding of an infant's socio-emotional development from the antenatal stages up to two. It helps deliver accessible messages to parents about supporting brain development and relationships with their infants through the building blocks of "Talk, Cuddle, Respond, Play and Relax."

Consultation is offered when families whose presenting needs are considered high risk are referred to the service. This allows for deeper thought about the infant's emotional needs amid a complex number of issues, as well as better consistency and understanding of roles where multiple professionals are working with a family.

Members of the team also have other trainings which inform practice. These include but are not limited to **Mellow Babies**, **Brazelton**, **Sleep Scotland** and **Solihull**.

Levels of Intervention



Two levels of support are available to families of infants.

These include:

- Key work support for parents experiencing issues such as anxiety and depression, which are impacting on parenting and the infant's social/emotional development, but who may have some other positive coping skills/resources available to them.
- More intensive therapeutic support for families with more complex difficulties, where parenting is significantly impacted by parental mental health (e.g. parents with a history of psychosis) or complex trauma history (e.g. parents who have been in foster care).

There are times when families will move across these levels of intervention, such as when improvements are made at Tier 2 and support is stepped down. In addition, some parents with more complex needs might begin with key work involvement at Tier 1 to help them stabilise and become more ready for intensive therapeutic work at Tier 2. Families at both levels of intervention are always supported to make links with community organisations promoting infant wellbeing in their area wherever these are available.

2b. Systems Change

Systems change holds the vision that a strategy based on holistic understanding of factors impacting our most vulnerable families is needed in order to bring about more fundamental, long-term changes, in which families are sufficiently resourced so that fewer need high intensity, specialist interventions. In order to sufficiently impact infant emotional wellbeing, the various services interfacing with families need to be thought about together and a shared vision of the best ways to meet our families' needs must be held. This thinking has been central in the setting up of ABC PiP and in considering its functions going forward. Figure 1 below notes other services interfacing regularly with infants and families, with whom we have been working to align agendas for the improvement of conditions to foster infant wellbeing.

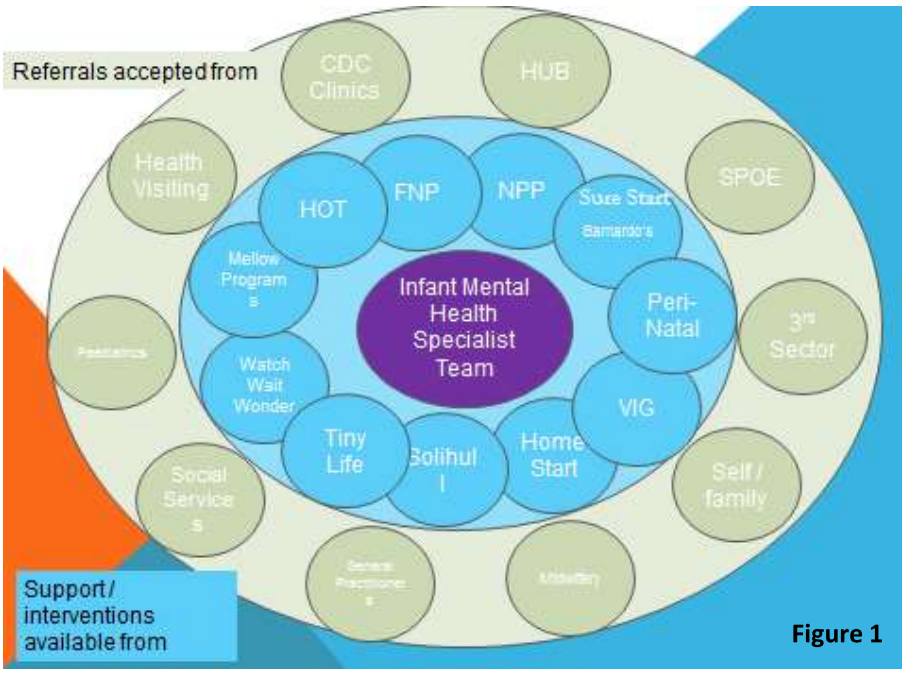


Figure 1

The service has developed an implementation plan for systems change, in keeping with the Four Phases of the Implementation, presented the Figure 2 below and noted in our logic model in Appendix 1.1. Our Barnardo's Service Manager is currently leading on this, to focus on the longer term goals of raising the infant mental health agenda in collaboration with partner organisations, as well as ensuring that it is understood, with policies actioned and sufficient funding. Other aspects of the systems change strategy will include networking to educate others on the role of the strategic partnership and ABC PiP. We hope to promote the team and share our learning regionally and nationally. We wish to share expertise and support delivery of Best Practice across all NI Trust areas. We are also working with the Mental Health Foundation to consider how we can amplify the voices of our families through Co-production within these processes. We are well set up in terms of our reach in this endeavour due to the unique partnership of statutory (SEHSCT) and non-statutory (Barnardo's) organisations forming the ABC PiP team. At management and clinical lead level within the team, Roberta, Janine and Bridget are all directly carrying responsibility for other teams working with infants –this includes fostering and adoption services, New Parent Programme (support for parents in areas of social deprivation), Family Nurse Partnership (interventions for teenage and first time mums up to 18/19 years), as well as

Barnardo's Parent and Infant Programme (delivering parenting groups incommunity settings for example church halls, community centres and schools) and so, for a relatively small team, we are well equipped in that our capacity for "reach" is considerably wide. Roberta additionally sits on the Association of Infant Mental Health Northern Ireland (AIMH NI) as Chair. We will continue to maximise the influence we can have through these links and as we develop others.

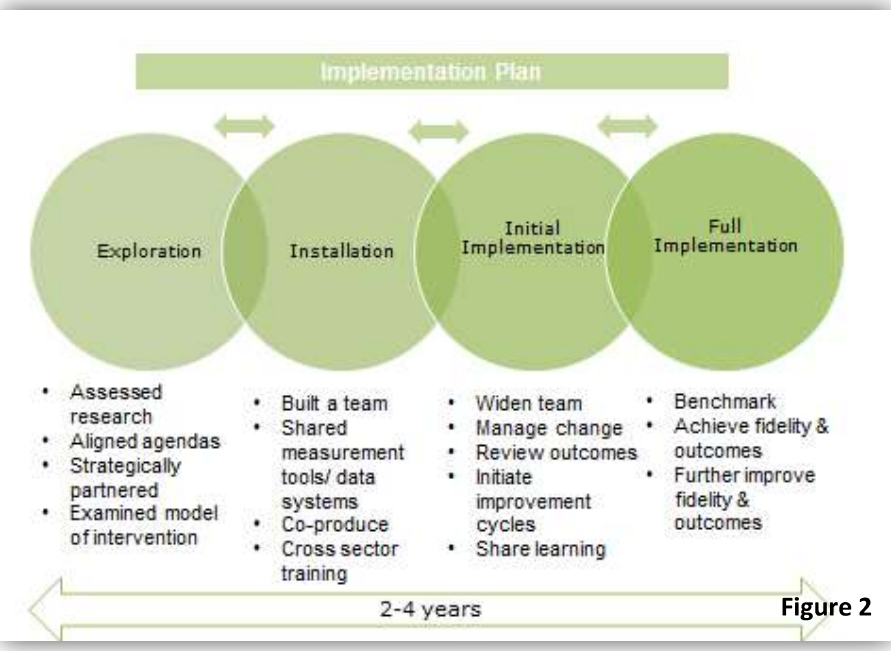


Figure 2

Some activities that are being undertaken to promote the infant mental health agenda include involvement with:

- Board membership, steering groups and management committees.
- Expert talks have been delivered at events relevant to infant mental health.
- There is ongoing work to build networks to influence policy and action.
- Other HSC Trusts are being supported to consider how to take infant mental health services forward within their own Trust areas.
- We are reviewing current systems with services who have a shared interest in infant wellbeing to identify needs within our current systems and working to address any gaps in provision that are identified.

Capacity Building and Workforce Development

The service has been working to identify training needs amongst practitioners who are working with infants and their families. We are aiming to ensure the practitioners with the biggest reach to impact infant wellbeing are aware of best practice, have access to the best quality information/interventions and are consistent in key messages delivered to families. We have been working over the past year to ensure key practitioners across the three sectors of SEHSCT are trained in:

-Bonding & Attachment - Baby Brain Development - Trauma & Resilience - Speech & Language-

3. Referral Information

Referral Information to date cumulative and (monthly) at 31st March 2020

Total number of referrals received to date	212 (8)			*Barnardo's*	*Trust*
Total number of referrals accepted	**44** **23** **5** **2** **0**		***referrals currently active*** ***waiting list*** ***for triage*** ***need more information*** ***need prof consultation***	***10***	***34***
Total number of referrals discussed /declined – not appropriate	**25**				
Total number of referrals closed	**75**	**(6)**		**34 (5)**	**41 (1)**
Total number who declined the service	**26** **(1)**			**14 (0)**	**12 (1)**
Total number- chose not engage the service/no response	**11** **(1)**			**7 (1)**	**4 (0)**
Total number – moved out of area	**1**				**1 (0)**

Referrals to the service were received in the main by health visitors, followed by social workers. Some families also self-referred into the service. The main reasons for referrals being considered not appropriate were that issues related primarily to perinatal mental health concerns of the mother, with no evidence that there was an impact on the relationship or bond with the baby. Referrals are accepted via iConnect for Trust staff, via post or email. Referral Guidance is provided on iConnect and circulated to referrers as needed.

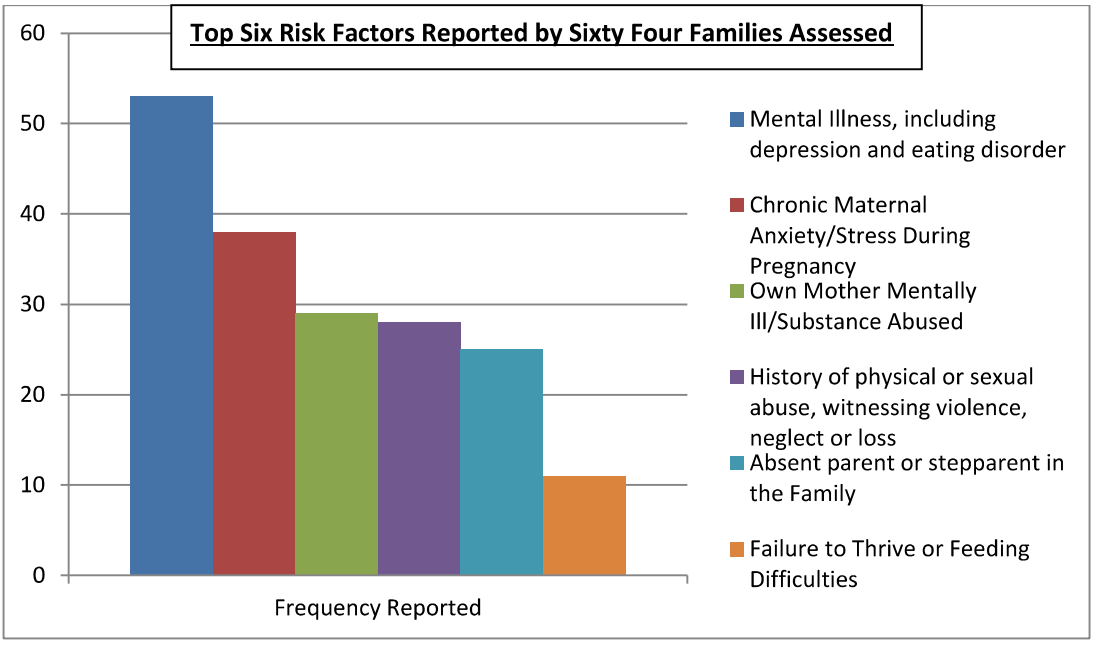
Demographics of Service Users Referred to the Service

Referrals have been varied in terms of stage of infancy. We received a high number of referrals for antenatal work. Twenty six percent of cases were referred antenatally with a spread of between two and twenty five weeks, and an average of ten weeks, pregnant at point of referral. The average age at point of referral for infants postnatally was 5 months. Twenty three percent of referrals postnatally were for infants under one month old. There was a spread of between three days and twenty-four months for infant age at point of referral. The spread of age for parents referred to the service is wide for the reporting year. The minimum age of a parent referred was sixteen years old and the maximum age was fifty two years old with a mean age of twenty nine years at referral.

We endeavour to include partners in our work as much as possible. In the time period of the report, **fathers** have participated in **at least one therapeutic session for 31 infants**, with as many as fourteen being attended by one father. One referral was for a father specifically. We will continue to try to promote the service to fathers to boost engagement. We are working to consider Equality and Diversity in respect of the families we are seeing, who of course present in many different constellations. We have engaged the Trust's interpreting service for one family in our first year.

Risk Assessment for Vulnerabilities in Parent Infant Relationship

A Risk Assessment Tool (see Appendix 1.1) devised by Robin Balbernie is used for service-users accessing the service. This has so far been piloted by Trust staff only but is to be rolled out for use across the team. It is completed in the later stages of work and reviewed on discharge, as the clinical judgement is that this allows for better accuracy of reporting. The tool is helpful in identifying the issues most commonly affecting families accessing our service, as well as the level of vulnerability present, given that many families present with multiple risk factors which has a cumulative effect on the potential for difficulties in parent-infant relationships. The table below indicates the six most commonly reported relationship risk factors for sixty four infants referred to the service, with whom the Risk Assessment Tool was used.



For families referred to the service, the **average** number of risk factors reported was **eight**. This is considered high in comparison to levels reported by UK Parent-Infant Teams. Families on average reported **three risk factors in the red risk category** which carry particularly high loading in terms of the potential for the parent-infant relationship to be negatively impacted. The number of risk factors being reported for families is an indicator of the complexity of some of the issues presented to the service by families and of the need for work to be undertaken that addresses cumulative layers of vulnerability and intergenerational trauma in families. The prevalence of mental illness in parents supports the need for development of Perinatal Mental Health Services that work in collaboration with Infant Mental Health teams. This partnership working will help to ensure parents are in a stable and safe position with regards to their own mental health, so that they can undertake

specialist therapeutic parenting work with us to better understand and meet the needs of their infants.

It is noted in the literature that "Low income creates a particularly stressful context in which positive interactions with children are threatened" (Shankhoff and Phillips, 2000). We also know from the Adverse Childhood Experiences Study, that there can be a build up of risks in even middle-class, affluent families. To date, our service-users are presenting from a range of socio-economic backgrounds. In referrals for middle-class families, we are seeing a trend indicating that whilst practically resourced, they can lack in social and emotional support when parenting a baby. This can in part stem from moving to access job opportunities making them more isolated from family and friends, or because whilst they have access to practical resources, the quality of their family relationships has not been emotionally supportive. It is important to recognise these needs going forward to ensure that our service is able to meet the emotional needs of infants from wide-ranging, family circumstances. Feedback from these families at the point of referral has highlighted the lack of provision for some middle-class families who voiced no clear way to previously access services addressing the emotional issues they may be experiencing in their parenting journeys.

4. Outcomes Based Accountability

We have worked alongside our colleagues at Parent Infant Foundation, with Robin Balbernie and additionally sought local advice from Helga Sneddon (Outcome Imps) in considering how we gauge the impact of the service at both the levels of Direct Service Delivery and Systems Change. We continue to review the most appropriate way to measure impact, using our experiences with our local population to ensure what we are using is appropriate to capture their hopes from the service.

4a. Direct Service Delivery

Direct service delivery impact is indicated through:

- ABC PiP Feedback form.
- Parent and Baby Outcome Star (used at Level 1 Intervention).
- Hospital Anxiety and Depression Scale (HADS) (used for some Level 1 and all Level 2).
- Parenting Stress Index (PSI) subscale (Piloted at Level 1 and Level 2).

The OBA scorecard 1 for the ABC PiP feedback form (See Appendix 1.2) is presented below. The service user feedback form is included in Appendix 1.2. The scorecard notes a high level of satisfaction with services provided and a high willingness to recommend the service to others. It is important to note that whilst we are working with families reporting high levels of risk factors, eighty nine percent of families felt their relationship with their babies had improved as a result of intervention by the service. A number of families provided additional qualitative feedback in the comments section reflecting on how the service had helped them in relating to their bumps and babies. Some of these are noted below:

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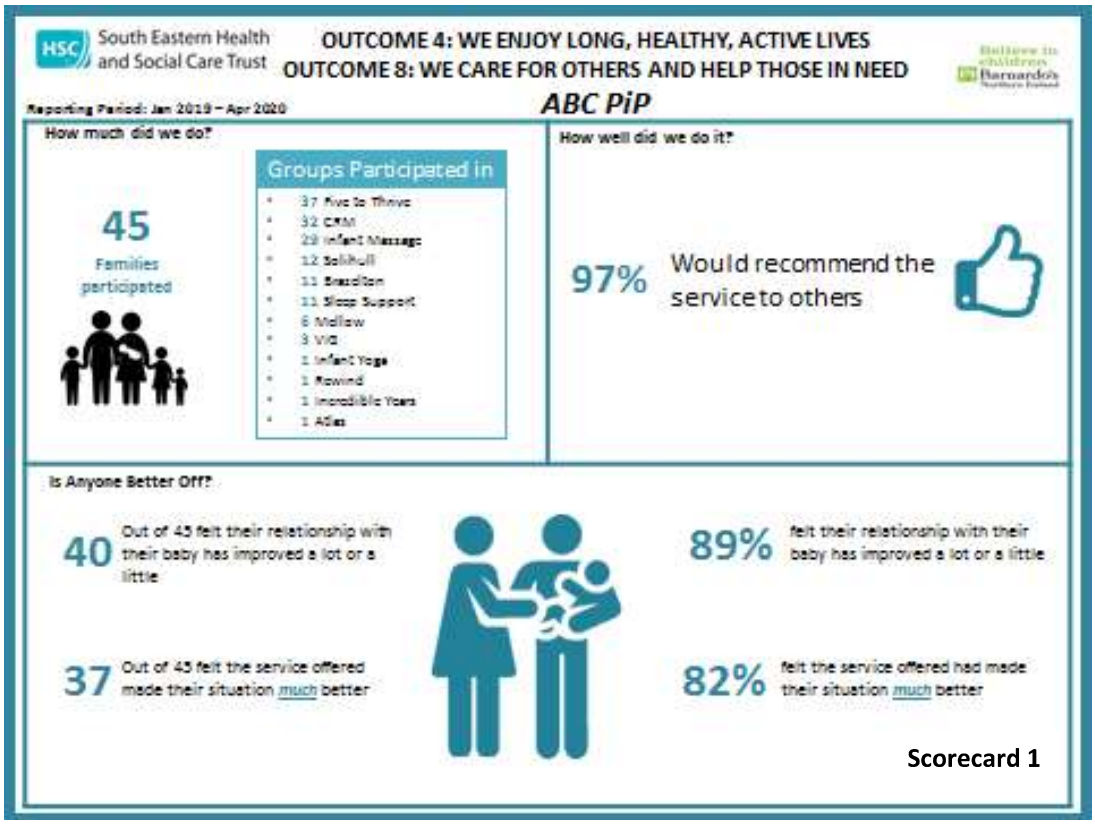
Having the opportunity to avail of the service and be referred to others to discuss concerns about pregnancy and the relationship between myself and baby helped me enormously. It meant by the time the baby arrived I felt more connected to him and prepared for all the challenges that can come emotionally with a new baby.

I found the service very beneficial and have already recommended to others. I got a lot of reassurance from worker, she made me feel as though "I wasn't cracking up". The service was brilliant and what was even better was that you come to the house which takes away the stress of having to get the kids ready to go out and being late. It was something to look forward to, I also liked watching how you would play with my kids, it gave me ideas.

I really enjoyed how worker helped and guided me through the first few months of my child's life. It made a lot of difference to me.



Direct Service Delivery - Outcome Measures

The Parent Baby Star

Figure 3 notes shifts in scores in the seven domains measured by the Parent-Baby Star. The Parent-Baby Star has been helpful in terms of both assessment and outcomes as it helps identify factors which promote greater stability in quality of living for families. These factors (such as housing and essentials) can then be targeted at the early stages of intervention through liaison with services such as the Family Support Hubs which alleviate immediate sources of stress in daily living and allow more room for the important therapeutic work between parents and infants to be progressed. Positive shifts in Mental and Emotional Health and Connecting with your Baby were most marked following service intervention.

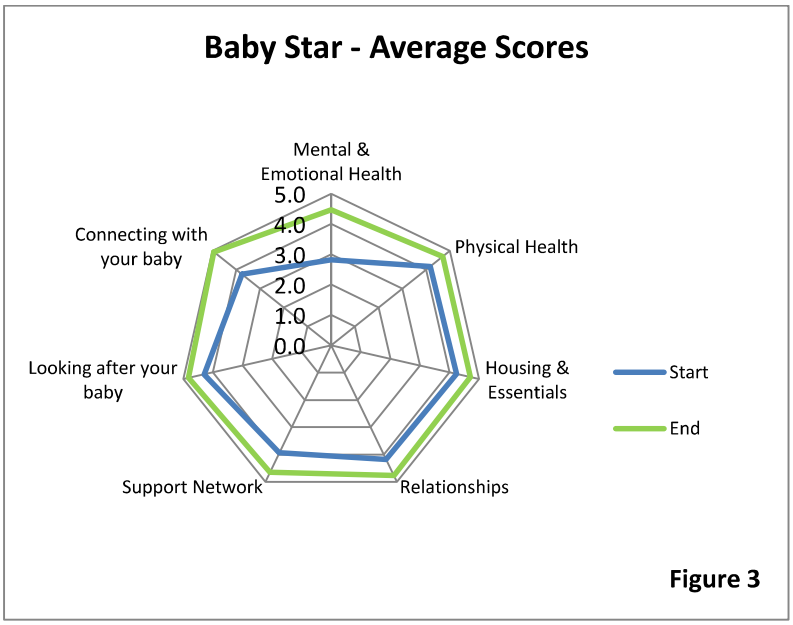


Figure 3

Parenting Stress Index

A subscale of the Parenting Stress Index was used to try to capture change in the main target of our interventions, the parent-infant relationship. We have piloted use of this measure with some families this year to help us consider whether it meets our needs. There have been some difficulties indicated in use of the measure. First of all, it is a challenge generally to access a measure that captures shift in relating to "bump" at the antenatal stages of development. However, the PSI also presents some issues in terms of young infants as some of the items require developmental milestones, such as smiling, to have been met. The measure is self-report and the statements are negatively loaded which has felt uncomfortable to some parents, particularly in the earlier stages of working relationships with their practitioner. In addition, some "defensive responding" is indicated in use of the measure, where families with higher child protection concerns have rated particularly high self-reported parenting skills. We will therefore be reviewing outcomes measure that better capture shifts in the parent-infant relationship and consider use of the LOAF outcome measure, which is a clinician rated tool, in the next year.

The Hospital Anxiety and Depression Scale is used with parents communicating more marked difficulties with mood. Data was collected for twenty one parents. Figure 4 notes shifts in anxiety scores reported before and after service intervention. The average reported score for anxiety prior to intervention was 11 which reduced to 5 on discharge. Figure 5 illustrates shifts in reported levels of depression before and after service intervention. The average reported score for depression prior to intervention was 8, which reduced to average of 4 at discharge.

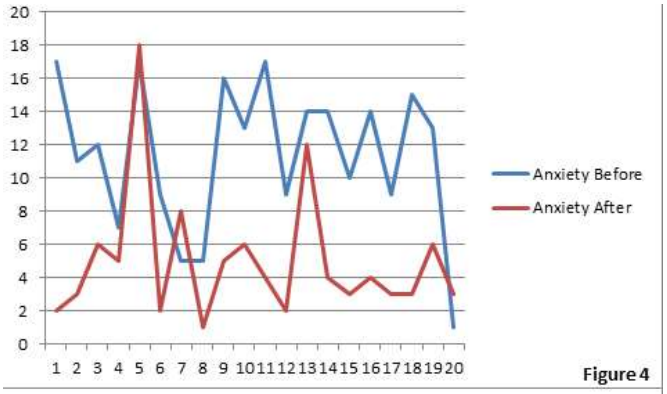


Figure 4

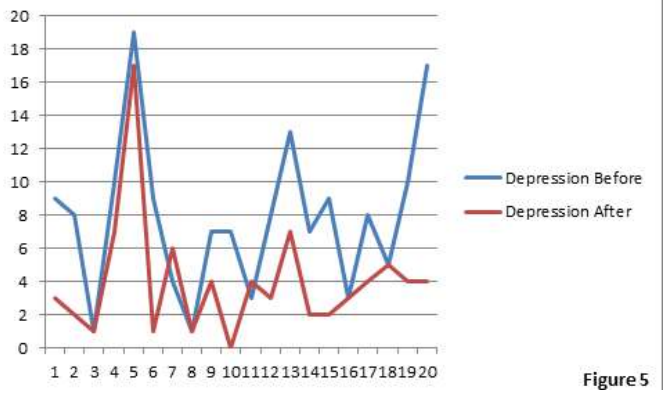
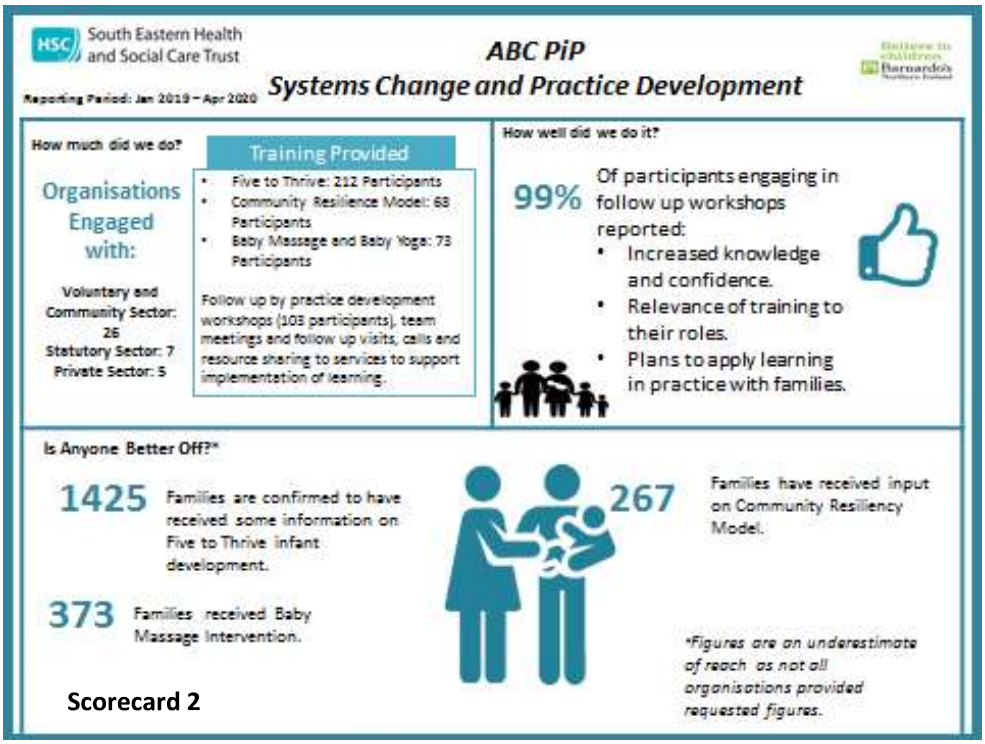


Figure 5

4b. Systems Change and Workforce Development



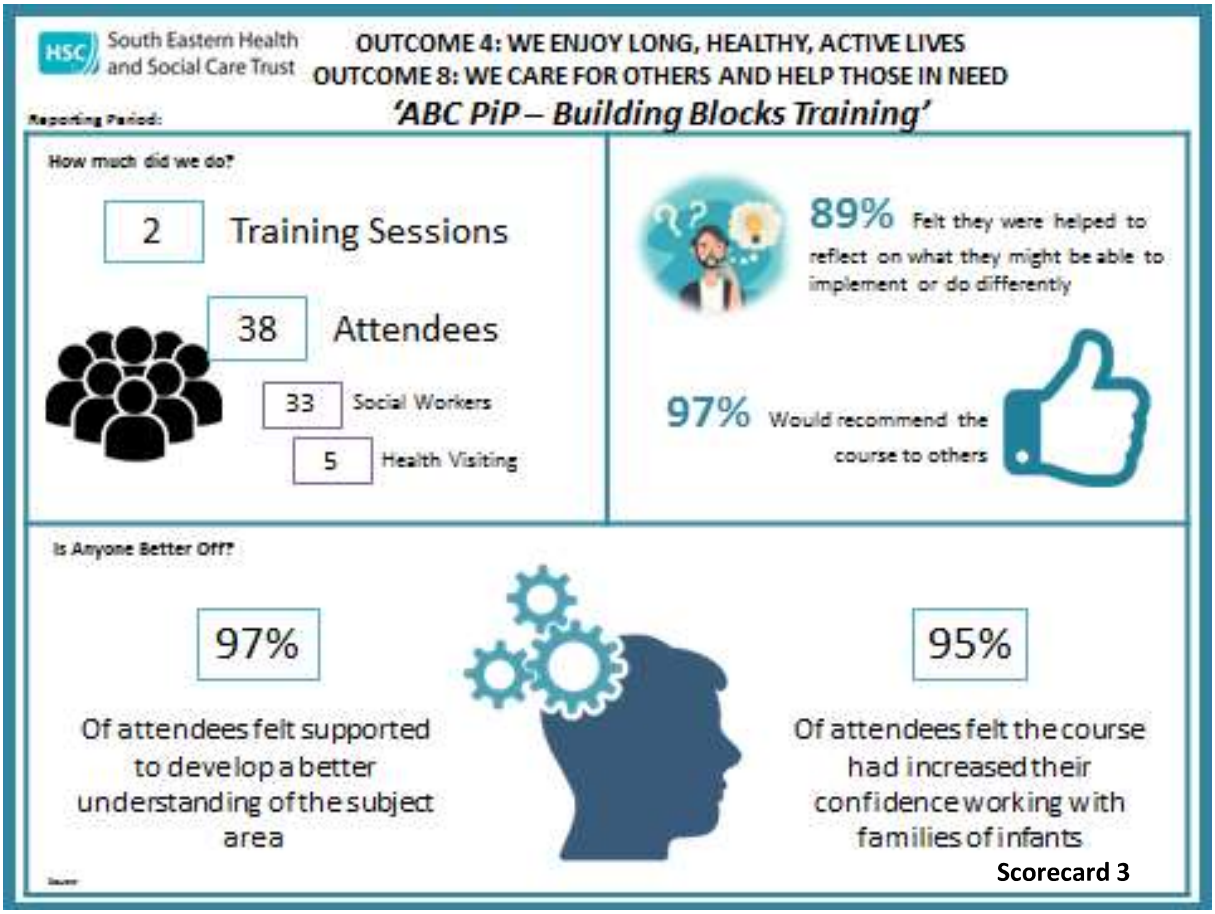
Scorecard 2 notes advances in training to support workforce development and systems change. For the statutory sector, professionals attending training were in the main from a health visiting background. Other professionals came from social work, specialist nursing, or midwifery. For Voluntary and Community Sectors, those attending training tended in the main to come from Sure Start and Home Start settings who were disseminating information to colleagues within their organisations, as well as to families. For the Private sector, attendees were from Nursery and Childminding backgrounds. The figures indicating reach of intervention are conservative as these figures were not provided by all teams at follow up (e.g. some of the health visiting teams). Qualitative information on implementing the approaches was also provided by professionals who took part in trainings. For **Five to Thrive**, it was frequently communicated that the approach conceptualised key concepts linked to infant development in a very accessible way for families: "*The workshop has given good examples of how to share the knowledge with parents*" and " *I will introduce it to families on interaction days to make them more aware of how to use the five building blocks in everyday situations with their children.*" Attendees also reflected on how to support colleagues to use the model within their organisation "*I hope to encourage the staff to use the Five to Thrive Model, in particular the developmental programme during stay and play sessions*." Other feedback noted "*Families became more aware of the importance of connecting and interacting through play and positive communication and how this strengthens secure bonds within the home*."

For **Baby Massage** qualitative feedback indicated that professionals found the training to offer a good engagement tool for families and a way to begin to help parents understand their babies feedback "*I am using baby massage and encouraging parents to chat and interact with babies during massage. I always stress the importance of massage being baby led – ensuring parents are aware of the baby's cues. This helps the parent to tune into how the baby is and helps them respond to this."* Other professionals

referenced benefits of baby massage in helping parents *get on floor level to engage with their babies, develop better eye contact, and improve interactions*. Professionals reported that parents felt more competent in having an extra tool to offer soothing to stressed babies suffering from issues such as *sleep difficulties and colic*. Parents reported enjoying learning strokes and positive ways to interact with their baby through gentle touch, which supported confidence in handling and being close to their babies. Some parents shared that the massage techniques contributed to them feeling more relaxed. Baby Massage was offered in a range of settings, with one service making use of the approach in a prison with fathers and noting a high level of interest from fathers to be.

Professionals who trained in the **Community Resiliency Model** provided feedback that indicated the approach helped them feel safer in their work because they knew parents had some resources to help them cope with stress and anxiety. This was indicated as particularly important when working with parents who had experienced a lot of trauma within their lives which continued to impact coping. They noted that in the progression of intervention with families, they could take breaks to allow parents to regulate using CRM strategies as needed. One professional commented on specific feedback from parents who found CRM "*Very useful in regulating themselves and staying in a calm zone, that improved their relationships with their children and helped them to manage*." General feedback from professionals has indicated the view that the approach helped parents to be more aware of their feelings, develop emotional literacy, manage stressors and regulate themselves. Parents were subsequently helped to consider their child's emotion regulation needs through the model. There was also some use of the model by professionals themselves to help stay regulated to better meet the needs of their work and families "*Workers use it for self-care when working with families so they are in the best place to work effectively with parents and children*."

Scorecard 3 notes outcomes for training delivered within the Trust through professional workshops on "Building Blocks to Infant Wellbeing". This training was delivered through two half days and was advertised by the Trust's social work Training and Development team. Outcomes indicate high ratings for better understanding infant mental health needs in families and relevance to working roles with infants.



The ABC PiP team sit on a number of steering groups and committees which enable us to influence the **systems change** around IMH within the SEHSCT and Northern Ireland.

These include:

- The Association for Infant Mental Health in NI (AIMHNI)
- SET Solihull Early Years Development Group
- Perinatal Mental Health Team
- IMH Teams in Belfast Trust
- Help Kids Talk – SET Community Wide Speech and Language Initiative.
- iCAMHS team in Southern Health & Social Care Trust
- HV team in Northern Trust
- Social Services, Child Health and Barnardo's communication and update meetings

There have been direct changes as a result of this for example:

- Infant Mental Health being specifically mentioned within the Perinatal Mental Health Policy for the Ulster Hospital.
- Infant Mental Health messages (Five to Thrive) being included in Speech & Language Basic Awareness training which will be rolled out to 1100 practitioners and parents within SEH&SCT

We recently established research links with Queen's University Belfast, Doctorate in Clinical Psychology training course and a project has been proposed by a trainee which looks at the experiences of mothers parenting an infant, without the presence of their own mothers in their lives. It is also anticipated that a trainee will join the team for a clinical placement from September 2020-April 2021.

The ABC PiP team also subscribes to the **1001 Critical Days Movement**, which is a group of organisations and professionals working together to campaign about the importance of the emotional wellbeing of babies. The mission is to drive change by inspiring, supporting and challenging national and local decision makers to value and invest in babies' emotional wellbeing and development in the first 1001days. This has been pertinent to recent action taken to contact the Health Minister, Health Committee, Mental Health Champion for NI and PHA to ensure the needs of infants and their families in NI are specifically addressed as we move through and out of the pandemic. AIMHNI have asked that in the revised Mental Health Action Plan and Strategy there is reference to the importance of the First 1001 Days for mental health and wellbeing throughout the life span.

We continue to work with the Mental Health Foundation to consider how to strengthen **co-production** within the team. We have had service user involvement in promotion of infant mental health during Infant Mental Health Awareness Week. We have also had service user involvement in the recent Babies in Lockdown Report (2020), which highlighted the particular issues faced by families of infants during Covid-19. In our CPD activity, we have engaged with a parent of a child with a learning disability and a foster-parent, to consider how the needs of particularly vulnerable infant groups in service developments going forward. We have had a high expression of willingness from parents on discharge from the service to engage in further discussion about service development through direct feedback, focus groups and other coproduction activity.

Service Objectives 2020-2021

Service objectives are laid out in the Logic Model in Appendix 1.3. These are listed under short, medium and long term categories.

Additional goals that we hope to achieve within the service in the next reporting year include:

Goal	
Adaptation of Direct Service delivery during Covid-19	Consideration of adapted provision of Mellow Bumps via Zoom.
Continue work on Co-production	Consideration of ongoing work on father engagement.
Capturing Outcomes	Review of Outcome Measures to be used by the service and local database to be developed to facilitate collation.
Clinical Psychology Training Links	Support Trainee Research Project
	Support Trainee Placement
	Explore capacity for involvement with Quality Improvement Project alongside fostering colleagues.

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Appendix 1.1

Stressors on the Caregiving Relationship: A Risk / Vulnerability Analysis.

Infant mental health teams use a risk model to guide referral and treatment; this also identifies some more distal points for intervention, away from the immediate family. Serious conditions that merit interventions on their own are in red in the list below. Since risks are cumulative, it is suggested that four or more less serious risks will also need attention.

1. Potential Biological Vulnerability in the Infant:

Mother substance abused (including alcohol) during pregnancy.	☐
Very low birth weight / extremely premature.	☐
Non-organic failure to thrive / malnutrition.	☐
Extreme feeding / sleeping difficulties	……
Congenital problems / poor health / serious developmental delay.	……
Baby has a very difficult temperament / extreme crying.	……
Chronic maternal anxiety / stress during pregnancy.	……
Regulatory / sensory integration disorder / hypersensitive to stimuli.	……

2. Parental Social and Emotional History and Current Functioning:

All forms of mental illness, including eating disorder & PTSD.	☐
A serious medical condition / physical disability.	☐
Own mother was mentally ill / substance abused.	☐
Alcohol and / or drug abuse (current or past).	☐
History of trauma, witnessing violence, neglect, abuse or loss.	☐
Parents seem incoherent or confused when describing relationships.	……
Parent was in care or adopted (often signifies maltreatment).	……
A serious lack of preparation during pregnancy or denial of pregnancy.	……

Learning disability / low educational achievement. .....

A previous child has been placed in foster care or adopted. .....

Mother has experienced the death of a child (including stillbirth). .....

A previous child has shown very difficult behaviour problems. .....

The presence of an acute family crisis. .....

3. Interactional or Parenting Variables:

A lack of sensitivity and responsiveness to the infant's cries or signals. .....

Signs of being physically punitive or harsh towards the child. .....

Lack of vocalisation to the infant, few serve and return 'conversations'. .....

A consistent lack, or avoidance, of eye-to-eye contact. .....

Regular negative attributions made towards child, even if 'jokey'. .....

Lacks everyday knowledge of parenting and child development. .....

The infant has poor care (e.g. dirty and unkempt), physical neglect. .....

Is unable to anticipate or encourage the child's development. .....

Quality of partner relationship; may be undermined or unsupported. .....

Infant a victim of maltreatment, emotional abuse or neglect. ☐

Infant regularly rejects being held or touched by caregiver. ☐

Any violence reported in the family, especially if witnessed by infant. ☐

Infant prefers a 'stranger' to a familiar caregiver. ☐

Negative affect / verbal abuse openly shown towards child. ☐

4. Socio-demographic Factors:

Homelessness or housing instability. ☐

Chronic unemployment and / or insufficient income. .....

Food insecurity and / or inadequate housing and hygiene. .....

A single teenage mother *without* family support. .....

Absent parent, or stepparent in family (i.e. not biologically related). ……

Severe family dysfunction, current and in background. ……

Lack of supportive relationships / social isolation. ……

Recent life stress (e.g. bereavement, birth trauma, racial prejudice, etc.). ……

Appendix 1.2

ABC PiP Feedback Form

1. **Please tick:** ☐ **Mother** ☐ **Father** **Other Family Member:**_____

2. **Has the service offered:**

Made the situation much worse

Made the situation a little worse

Made no difference

Made the situation a little better

Made the situation much better

3. **Do you feel that your relationship with your baby:**

Has become much More difficult

Has become a little more difficult

Has stayed the same

Has improved a little

Has improved a lot

4. **Please circle which of the following topics you covered with us and found helpful:**

Pregnancy.	Thinking about what influences the relationship between you and your baby.	Information on child development.	A chance to think about how your life experiences have influenced you.
Know what your baby needs.	A sense of being understood.	Birth	Connecting and bonding with my baby
Anxious or worried feelings	Down or depressed feelings	Separating from your baby.	Angry or frustrated feelings.
Feeling alone and unsupported	Coping with my own feelings	Coping with my baby's feelings	Thinking about how the world looks to your baby.

5. **Has the service helped you to feel more able to link in with other services who offer support to families?**

YES NO

6. **Would you recommend this service to another parent?**

YES NO

7. **Do you have any more comments about your experience of the service?**

_____
_____
_____
_____
_____

8. **Can we contact you in the future to help us learn from your experience of the service and think about how to improve as we develop?**

YES NO

Thank you for your feedback and helping us think about how we deliver our service.

For Completion by ABC PiP worker:

Work Completed at Service Level: Tier 1 ☐ Tier 2 ☐

Interventions included (Please circle):

VIG	5 toThrive	Solihull	Brazelton	Infant Massage	Infant Yoga	CRM
			Mellow	Sleep Support		

Appendix 1.3 - Logic Model for Service

Name of Service: ABC - PiP

Situation Analysis

-30-35% of representative populations are insecurely attached (NICE, 2015)

-A secure attachment allows children the secure base to explore, learn and relate and the well-being, motivation and opportunity to do so. It is important for safety, stress regulation, adaptability and resilience throughout the life span.
When considering how secure attachments develop a large body of evidence shows:
-Critical importance of the first 1001 days
-Extraordinary pace of neural growth conception – age 2
-The relationship between an infant and its primary caregiver becomes a template for all other relationships.

'Supporting the best start in life' IMH Framework for NI (PHA 2016) presents the Framework for promoting good infant mental health throughout NI. As part of this a comprehensive need analysis was completed and actions identified re Evidence and Policy, Workforce development and Service Development.

The Infant Mental Health Strategy SEHSCT (2018) outlines how good Infant Mental Health is promoted within the Trust area in response to the IMH Framework for NI

Strategies

Achieve systems change to improve best practice re IMH by Strategically Partnering between

- South Eastern Trust
- Barnardo's
- Parent Infant Foundation
- Tiny life

Co-production with parents and other professionals central to service design

Evidence based/ informed working

- Staying informed of new evidence, and policy developments
- Sharing knowledge
- Sharing good practice
- Open to new ways of working
- Working in a strengths based way with parents and professionals
- Independent evaluation- MHF

Parent & family focused

- Capacity building
- Using a variety of approaches to improve parent/ infant relationship
- Delivering a service that is needs led

Inputs (Resources)

Strategic Partnership Barnardo's, SET, Parent Infant Foundation and Tiny Life

Service Co-ordinator for Infant Mental Health, SET

Children's Services Manager, Barnardo's

Child and Adolescent Psychoanalytic Psychotherapist

Specialist Infant Mental Health Key Worker

2 x Infant Mental Health Key Workers

1 Infant Mental Health Key Worker (Practice Development)

Data Manager (9 hours)

Administrative Assistant

Clinical Supervision (external and internal)

Knowledge of local Support Networks

Outputs (Activities)

SERVICE DELIVERY

Specialist IMH Service provision for infants under 2

- Home Visiting Model
- Assessment of Parent-Infant Relationship
- Interventions to improve Parent Infant Relationship for example Five to Thrive; Video Interactive Guidance; Community Resilience Model; Baby Massage; Solihull & Parent Infant Psychotherapy
- Signposting/support to access other services

CAPACITY BUILDING

IMH practitioners in all sectors across SET trained in:

- Bonding & attachment
- Baby Brain Development
- Trauma & Resilience
- Speech & Language

Prospective adoptive parents, foster carers and Kinship carers trained in

- Bonding & attachment
- Baby Brain Development
- Trauma & Resilience

SYSTEMS CHANGE

Service promotion
Educating on the role of the Strategic Partnership and ABC PiP
Share learning across Region & Nationally

Board membership

- Steering groups
- Management committees
- Expert talks – Infant Mental Health (IMH)

Service Delivery

Systems review

Short-term Outcomes

Parent

- Parent more aware of own mental health & well-being in relation to their infant
- Parent is prepared to work on the issues identified
- Parent has clearer understanding of their relationship with their infant
- Parent is given strategies to improve parent infant relationship

Increased knowledge in all sectors across SET on promoting good Infant Mental Health

IMH workforce trained in relevant approaches/interventions to improve IMH

Seen as experts in field to enable further systems development

Networks built for influencing

Knowledge transfer across HSCT Trust(s)

Knowledge from service delivery and data gathered influences further systems change

Needs analysis in current systems
Gaps in the systems are identified

Medium-term Outcomes

Child

- Infant learns to self-regulate
- Infant has more secure attachment

Parent

- Parent uses strategies to improve relationship with infant
- Parent less isolated and supported
- Parents engage with other appropriate services

Positive changes/developments in practice re IMH

Consistency of approach within the workforce re IMH

Consistent message/language used with parents by all professionals in SET

Systems change wider than strategic partnership

Positive changes/developments in practice across organisations wider than strategic partnership

IMH is seen as an essential element in the EH&WB spectrum

Services are designed holistically using a multi-sector approach

Long-term Outcomes

Child

- More resilient
- Forms positive relationships
- Experiences Emotional wellness
- Fewer children access other specialist services
- has positive childhood experiences and is a responsive future parent

Parent
-better able to manage stress/anxiety in relationship with their children
-has knowledge and positive experience to transfer to further infant relationships

Services more able to support parent/infant relationships at all levels of intervention

Families get consistent messages from all professionals

Fewer children need to access specialist IMH services

IMH recognised and appropriately resourced and funded in NI

Best practice is agreed and developed across all NI Trust areas

Every parent and infant will receive the right support for their relationship at the right time

Fewer children need to access specialist services

Children receive the best start in life