



‘Supporting the best start in life’

# Infant Mental Health Framework for Northern Ireland

April 2016

*Promoting positive social and emotional development from pre-birth to 3 years.*



Public Health  
Agency

**Foreword:**



**‘Supporting the**



## **This Infant Mental Health Framework represents a 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.**

The Framework aims to ensure that commissioners and policy makers are fully informed of the latest evidence and interventions and are supported to make the most appropriate decisions based on this knowledge. This Framework aims to provide practitioners across a wide range of health, social care and education disciplines with the skills to support parents and children aged 0-3 in the development of positive infant mental health. Finally, the Framework encourages and highlights the need for service development to ensure the optimum use of evidence based interventions with families with children aged 0-3 where there are significant developmental risks.

The Framework has been the subject of an extensive engagement and consultation process; engagement has involved parents, practitioners, policy makers, young people and a wide range of stakeholders across the statutory, voluntary and community sectors. The development of the Infant Mental Health Framework has been widely welcomed and we want to thank everyone who has provided constructive and valuable feedback, all of which has helped to shape this final version. .

### **Why is this important?**

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. There is now a wide body of evidence which demonstrates that disadvantage for some children starts before birth and accumulates throughout life. Consequently, this Framework considers actions required during pregnancy and up to three years, maximising potential for early

intervention. The promotion of positive infant mental health and wellbeing is a cornerstone of this Framework, as protecting and nurturing mental health in childhood contributes to productive social relationships, effective learning, and good physical health throughout life.

Becoming a parent and having a newborn is both fulfilling and challenging as new roles and responsibilities emerge within the family. For those facing adversities such as very premature births, domestic violence, mental health problems or drugs and alcohol misuse and for those who themselves have had very difficult starts to their own lives and/or are also living in difficult social and economic circumstances, these challenges can be even more considerable. It is therefore important to take an ecological approach to child development, considering the child in relation to their wider family and community circumstances and the impact that these factors may have.

When secure attachments are not established early in life children can be at greater risk of a number of detrimental outcomes, including poor physical and mental health, relationship problems, low educational attainment, emotional difficulties and conduct disorders.

A large body of evidence demonstrates that many children may face pronounced adverse experiences in infancy, including repeated exposure to neglect, chronic stress, and abuse. Such experiences may disrupt brain development and lead to 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

# **best start in life'**

cost there are increased economic costs to society in terms of healthcare, child welfare, education, unemployment, policing, juvenile justice and prisons. It should however also be recognised that for some people their mental health conditions are not in any way related to early childhood experiences; in addition, it is not always inevitable that early childhood trauma leads to mental ill-health in later life.

We know that warm, consistent, positive, and engaged parenting in a safe and secure environment enables the infant to grow into a child and adult who is more likely to have high self-esteem; strong psychological resilience, empathy and trust; the ability to learn; and reduced risk of adopting unhealthy lifestyle choices.

The development of this Framework has been significantly influenced by ongoing work across the UK. Notable examples of good practice include the work of the Wave Trust who developed the '1001 Critical Days' and 'Building Great Britons' reports; and the World Health Organisation's 'Investing in Children' report. The publication of the Marmot Review (2010) made a significant contribution to prioritising early years interventions as part of public health policy and practice, particularly the objective of 'giving every child the best start in life'. Of the six policy objectives identified, this was the 'highest policy recommendation' emphasising the Review's life course perspective. The Review also called for an increase in the proportion of overall expenditure allocated to the early years, and emphasised the need to reduce inequalities in the early development of physical and emotional health and in improving cognitive, linguistic and social skills - hence building resilience and wellbeing among young children. The new Public Health Strategic Framework for NI: Making Life Better (DHSSPS, 2014) makes a clear commitment to ensuring that the theme of 'giving every child the best start in life' will remain a key priority.

This Infant Mental Health Framework for Northern Ireland has 3 key priorities and outlines recommendations for action to:

- **Promote and disseminate evidence and research** on infant mental health to policy makers, practitioners and importantly, the wider population. Infant mental health should be everyone's business; consequently organisations across all sectors, including all NI government departments, should be in a position to consider and act on the compelling evidence and implications.
- **Inform workforce development** to ensure frontline staff have the necessary knowledge and skills to assess risks to the mental health of infants by early identification of factors associated with parent-infant interaction, and are adequately supported to put this knowledge into practice.
- **Inform service development** to ensure that universal and targeted services can respond as effectively as possible to maximise the optimal development of newborns and infants, particularly taking account of newborns facing the highest levels of risk and adversity. Given that infant mental health is fundamentally connected to the physical and mental health and wellbeing of the primary caregiver, as well as their ability to parent, service development is as relevant for those providing adult services as it is for children's services. Ideally there should be an increase in interventions that focus on supporting the parent – infant relationship where the parent faces challenges to their own emotional well-being. Services must also be informed by parent and practitioner feedback.



This Infant Mental Health Framework indicates the need to intervene at as early a stage as possible to support parents, build capacity, prevent problems arising and maximise outcomes for all children and families. Going forward, we will establish an Implementation Group to oversee the progress of this Framework through subsequent annual action plans. We are confident that considerable learning as well as measurable actions can be undertaken to collectively improve outcomes in later life as we seek to 'support the best start in life' for all babies.

**Dr Eddie Rooney, Public Health Agency.  
March 2016**





# Acknowledgments



The Framework acknowledges the considerable successes and good practice being led and undertaken across the statutory, voluntary and community sector on the infant mental health theme, and the many family support programmes and services that are currently available. The Framework does not seek to duplicate this work, rather to make best use of what is already available and in addition, to build on this where possible to provide the most effective and efficient family support possible.

AIMH, the Association for Infant Mental Health (NI), for example, has undertaken, over a number of years, a considerable amount of awareness raising through bringing UK and international experts to NI to present research and practice as well as policy advocacy on the need for the development of integrated pathways for families and infants in need.

Health and Social Care Trusts have all recognised the importance of focussing on the promotion of positive Infant Mental Health and have organised themselves through various working groups to develop integrated actions across Trust Directorates.

The Health and Social Care Board through the Childcare Partnerships and those involved in the Children and Young People Strategic Partnerships have also been undertaking considerable training and awareness, for example through inputs and dissemination of DVDs from early year's expert Suzanne Zeedyk as well as events focussing on infant development.

We also acknowledge the long experience and essential and wide reaching support that Sure Start provides to families, many of whom are hard to reach and often facing multiple adversities. In addition, Tinylife provides support for those who have experienced still birth, miscarriage or premature birth and works alongside healthcare practitioners and families in order to identify and address need. The Lifestart foundation provides a home visiting service to families and other voluntary and community organisations, such as Barnardo's NI, Action for Children, NSPCC, NIACRO, Aware and Replay Theatre Company who continue to deliver

support and services as well as innovations on the infant mental health theme. Over 8,000 families with babies and toddlers participated, for example, in the highly successful Baby Celebration Day, run as a collaboration last year between Replay Theatre Company, Sure Starts and Belfast City Council.

A wide number of organisations across all sectors contributed significantly to the development of this Framework and particular thanks are extended to representatives from Trusts, HSCB and PHA, members of the Infant Mental Health Association NI, QUB, Stranmillis College and Voluntary Sector who attended and supported the Plan Advisory Groups.

The Public Health Agency wish to acknowledge the key role played by NCB in facilitating these groups and ensuring effective stakeholder engagement throughout the development of the Framework. NCB's additional contribution to the drafting process, through the provision of evidence papers and technical support is also acknowledged.

These organisations represent only a small sample of those that are well positioned to progress actions on the infant mental health theme and will be critical to the successful implementation of the Framework and yearly action plans thereafter.

There are considerable implications and challenges to ensure full implementation of this Framework. Embedding Infant Mental Health in vocational training across Medicine, Nursing, Social Work, Psychology, Early Years, Teaching and Education, for example, will require champions, enablers and implementers across different sectors. However, as acknowledged here, much progress has already been made and a phased and staged approach will be undertaken to build on success to date.

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# Infant Mental Health Framework Vision





## **The aim of this framework is to ensure that all children have the best start in life by prioritising and supporting the development of positive social and emotional wellbeing**

### **This framework has the following objectives:**

- Parents and practitioners, and the wider population, better understand the importance of attachment and the essential elements of positive social and emotional health in infants.
- Parents and practitioners have improved skills to engage positively with infants to maximise their social and emotional development.
- Practitioners and parents are better able to respond to predictors of vulnerability in infants and families and identify early signs of delayed social and emotional development in infants and /or emotional distress.
- Appropriate services are in place with clear referral pathways and are available to respond to identified infant mental health and wellbeing needs across the region, on an equal basis for all.

# Introduction



# Infant Mental Health: a definition

Infant mental health is defined by the Association for Infant Mental Health UK as *'the study of mental health as it applies to infants and their families'*.

Infant mental health focuses on social and emotional development during the first three years of life for an infant and their family. This includes a child's ability to form relationships with other children and adults; to recognise and express emotions; and to explore and learn about their environment in a safe and happy way

## Why is it important to consider infant mental health?

A growing body of evidence from the clinical and social science fields shows that the areas of the brain that control social and emotional development are most active during the first 3 years of a child's life (and particularly active in the early months). Careful nurturing of a child's social and emotional health during their early years is vital to provide them with the skills necessary to form relationships and interact with society later in life. The quality of relationship between a child and their primary caregiver is central to this process.

The following theories form the basis of current discussions around infant mental health:

- **Attachment:** A strong bond between an infant and a primary caregiver is developed through positive and responsive behaviours from the care-giver, including mirrored behaviours, physical contact and proximity. A securely attached infant will have the social and emotional confidence to build relationships and explore the world around them (Barlow and Svanberg, 2009).

- **Self-regulation:** Neuropsychologists have expanded the link between social development theories and neuroscience, including the central importance of self-regulation (Schore, 2004); that is an infant's ability to regulate its own internal emotional states, soothing itself rather than requiring parental soothing. This then forms the building blocks of healthy external relationships.
- **Building resilience:** Self-regulation is also central to building resilience, which is an infant's ability to 'bounce-back' from difficult or traumatic experiences, and to learn from them. Development of resilience in the first three years of life is essential to dealing with adversities later in life (Newman, 2004).

The key timeframe for healthy attachment and hence healthy social and emotional development is considered to be between **0 and 3 years**, when brain development is in its optimal phase. However it should be noted that these considerations begin long before birth. Development starts during pregnancy and the choices and experiences of the mother during this period can have a significant impact on maternal and infant social and emotional health. Promotion of antenatal bonding with the bump, preparation for parenthood and early detection of antenatal depression are all crucial, and the midwife can play a key role in this.



After birth, key factors such as feeding, skin to skin contact, mirroring behaviours, responsive parenting, and a stimulating play environment can also contribute positively to overall healthy development and relationship building between infant and caregiver. All parents/carers play a critical role in ensuring good mental health development for their children and in preventing poor developmental outcomes. However, parents facing adverse circumstances may on occasion need additional support and it is essential that suitable provision is available when required.

### The Ecological or 'whole child' approach

Bronfenbrenner (1979) developed the ecological approach to child development, theorising that the child sits at the centre of a series of structures and systems which collectively impact on his/her development. These structures include the family, school, friends, health and social care services and systems, and indeed the wider community, and continually interact with one another as they shape a child's life.

In this regard, it is particularly important to recognise the unique social and cultural context in Northern Ireland, and the very real impact that this may have on parenting and/or child outcomes. In the report 'Towards a better future: the trans-generational impact of the troubles on mental health' (March 2015), the Commission for Victims and Survivors highlights the particular impact that the legacy of conflict in Northern Ireland may have on the early development of children.

It is clear then that we need to consider the child 'in context'. The 'whole child' approach is referenced across a range of health and social care strategies and policies, and recognises that services must work together in order to provide the most efficient and effective support for children and families. Infant mental health is therefore **'everybody's business'**. A joined up approach to service development and delivery is central. It is critical that practitioners across the full range of services in health, social care and education are equipped to support healthy social and emotional development and that a common message is given out by all.

*"If we intervene early enough, we can give children a vital social and emotional foundation which will help to keep them happy, healthy and achieving throughout their lives and, above all, equip them to raise children of their own, who will also enjoy higher levels of well-being."*

Graham Allen MP (Early Intervention: The next steps, 2011)



# The Current Policy Context



**All policy relevant to children in Northern Ireland (NI) falls under the Children (Northern Ireland) Order (1995) which lays the foundations for all those who work with or care for children and young people. Underpinning the Order is the principle that parents should be, whenever possible, supported to bring up their children in their own home.**

The UN Commission on the Rights of the Child (UNCRC) also recognises the primary role of the family, with article 18 stating that both parents share responsibility for their child and should consider what is best for him or her; however the government is responsible for providing support services to help parents to do this. Likewise, the UN Convention on the Rights of Persons with a Disability recognises the family as 'the natural and fundamental group unit of society' and should therefore be given the necessary support and assistance.

Health is a key priority right across the policy arena. The current **'Our Children and Young People - Our Pledge: A ten year strategy for children and young people in Northern Ireland 2006-2016'** (OFMDFM, 2006) identifies 'healthy' as the first of the high level outcomes for all children and young people. In addition, as research advances and policy develops, early intervention and support for the antenatal to three years of age period is increasingly highlighted, both here in Northern Ireland and across the UK, and sets the context for this investment in promoting positive infant mental health. The 10 year strategy is due to end in 2016 and a new 'children's strategy' is in the early stages of development; it is essential that the NI Executive's commitment to prevention and early intervention is prioritised in this new strategy.

**DHSSPS (2010) Healthy Child: Healthy Future** sets out the universal child health services delivered to all parents and children in Northern Ireland. It is recognised as being central to securing improvements in child health across a range of issues. Effective implementation by health care professionals including GPs, midwives and health visitors will promote positive parenting and the importance of strong parent child attachments for a child's healthy social and emotional health and wellbeing.

**DHSSPS (2014) Making Life Better: a Whole System Strategic Framework for Public Health** takes a life course approach to health and wellbeing, hence one of its key themes is 'Giving every child the best start in life'. This theme identifies the following long term outcomes:

- Good quality parenting and family support
- Healthy and confident children and young people
- Children and young people skilled for life

In particular the framework recognises the central roles that parenting and family support play in the healthy physical, social and emotional development of children. The implementation of an Infant Mental Health plan is a key first action of the 'Making life better' framework. Other key actions which contribute to the promotion of positive infant mental health include the roll out of the Family Nurse Partnership; implementation of the breastfeeding strategy and promotion of universal health and maternity services.



Alongside this Public Health Framework, early intervention is prioritised in a number of key government strategies, for example **DHSSPS (2009) 'Families Matter: Supporting Families in Northern Ireland'**; **Department of Education (2012) 'Learning to Learn: a framework for early year's education and learning'**; and the **DHSSPS (2012) Strategy for Maternity Care in Northern Ireland (2012-2018)**. The DHSSPS is also developing a new **Protect Life: Positive Mental Health and Suicide Prevention Strategy (due 2016)**, which will have a life course approach with a significant emphasis on infant mental health. Each of these policies recognises that health, social care and education are inter-dependent in enabling the best possible outcomes for our children and families. Indeed, the Department of Education provides core funding for the Sure Start service across Northern Ireland; this service is underpinned by policy and aims to deliver health, education and parenting support for families with children aged 0-3 in a coordinated way across the most disadvantaged areas of NI.

## Putting Policy Into Practice

Various structures are already in place to take forward the key theme of prevention and early intervention. The Children and Young People's Strategic Partnership (CYPSP) is a multi-agency partnership that brings together the leadership of key statutory, community and voluntary agencies, working to improve outcomes for children and young people. Early intervention is one of the key themes of this work. Through the CYPSP, there are currently 5 outcomes groups, 29 Family Support Hubs and 26 Locality Planning Groups in place across Northern Ireland.

Building on the universal services already delivered to children and families, a collaborative approach to early intervention funding is being taken forward through the newly established **Early Intervention Transformation Programme (EITP)**. The programme seeks to:

- Build on the Child Health Promotion Programme and the NI Maternity Strategy to equip all parents with the skills needed to give their child the best start in life
- Provide additional support for families when problems first emerge, outside of the statutory system
- Positively address the impact of adversity on children by intervening both earlier & more effectively, if and when required, to reduce the risk of poor outcomes later in life.

Children and families do not all have the same level of need, nor do individual families have the same level of need through the lifecourse. The DHSSPS (2012) policy document; **'Child and adolescent mental health services: A service model'** outlines the stepped care model of service provision (see appendix 2) and provides commissioners and service providers with a framework against which to remodel CAMHS service provision. At the centre of this framework is a stepped-care approach whereby; *'the appropriate level of care is provided at the earliest point that best meets the assessed needs of the infant, child and young person whilst also enabling them to move up or down the steps as their need changes'*. (DHSSPS, 2012.)

The stepped care model shifts the focus of therapeutic intervention from service description, to the provision of a needs-based service. This model of service delivery is aimed at the development of integrated care pathways with a focus on skills-based and evidence-based practice aligned to the needs of children and their families/carers. Care interventions are agreed and delivered at the most appropriate step with movement up or down to other services as clinically required. The model is recommended by the National Institute for Health and Clinical Excellence (NICE) on the basis that it promotes a continuum of care approach.



Some of the key priorities within the continuum of care approach include:

- Support of parents and carers, recommended to continue into the adolescent years, in recognition that it is primarily within the family that the mental health and emotional wellbeing of children is secured.
- Multi-agency interventions across the sectors, with services configured on the principle of 'recovery' within the context of provision of wrap around care for the individual child/ young person and their families.
- Better collaborative working with parents/ carers, community & voluntary sector, education sector and other organisations.
- Development of protocols between CAMHS services, adult services, the criminal justice system, and youth services and other stakeholders.
- Development of an effective referral process enabling defined and simplified points of entry to specialist services which are integrated with other referral pathways including child and family services.

Set against this backdrop, securing a strategic approach to early child development and family support is a key priority for the Public Health Agency (PHA). To that end the PHA established the Child Development Project Board (CDPB) in June 2010. Through the CDPB, chaired by the PHA and including members from the Health and Social Care Board, Health and Social Care Trusts, academia and the community and voluntary sector, the PHA has taken a strategic life course approach to child development and family support. Working from an evidence based perspective, the CDPB has identified needs of children and young people, aged 0-18, who experience inequalities, and initiated and supported a range of programmes and services to address these needs. The development of an Infant Mental Health Framework is one of a number of key workstrands.

This Framework is aimed at supporting parents, early years practitioners across a wide range of health, social care and education disciplines and organisations who support parents and children aged 0-3, as well as ensuring that commissioners and policy makers are fully informed and therefore supported to make the most appropriate decisions. Through annual implementation plans the Infant Mental Health Framework will require an extensive range of organisations and stakeholders to contribute to actions across the three identified themes. The PHA is committed to working closely with Departments, Trusts, Local Government, voluntary and community sector organisations and others in the outworking of this framework, taking a holistic approach to ensure the best outcomes for children and families. It is important to note that many families have additional needs and it is critical that the framework is relevant and supportive of all children and families.

## Framework Development Process

**To date the following activities have been undertaken to inform this regional Infant Mental Health Framework:**

- **Audit Phase 1** - In June 2012 an audit of infant mental health training and resources available in Northern Ireland was undertaken with key policy makers, practitioners and researchers from the statutory, community, voluntary and academic sectors. The aim of this activity was to establish the extent and sources of current training, target audiences, funders and the uptake of training amongst the statutory, community and voluntary sectors.
- **Gap analysis** - Following on from the phase 1 audit, a similar group of policy makers, practitioners and researchers were asked to identify gaps in the current provision of training on infant mental health
- **Audit Phase 2** - A second phase of the audit was completed in September 2013 which tracked the progress of key infant mental health training developmental areas that were identified in the phase 1 audit and the gap analysis.

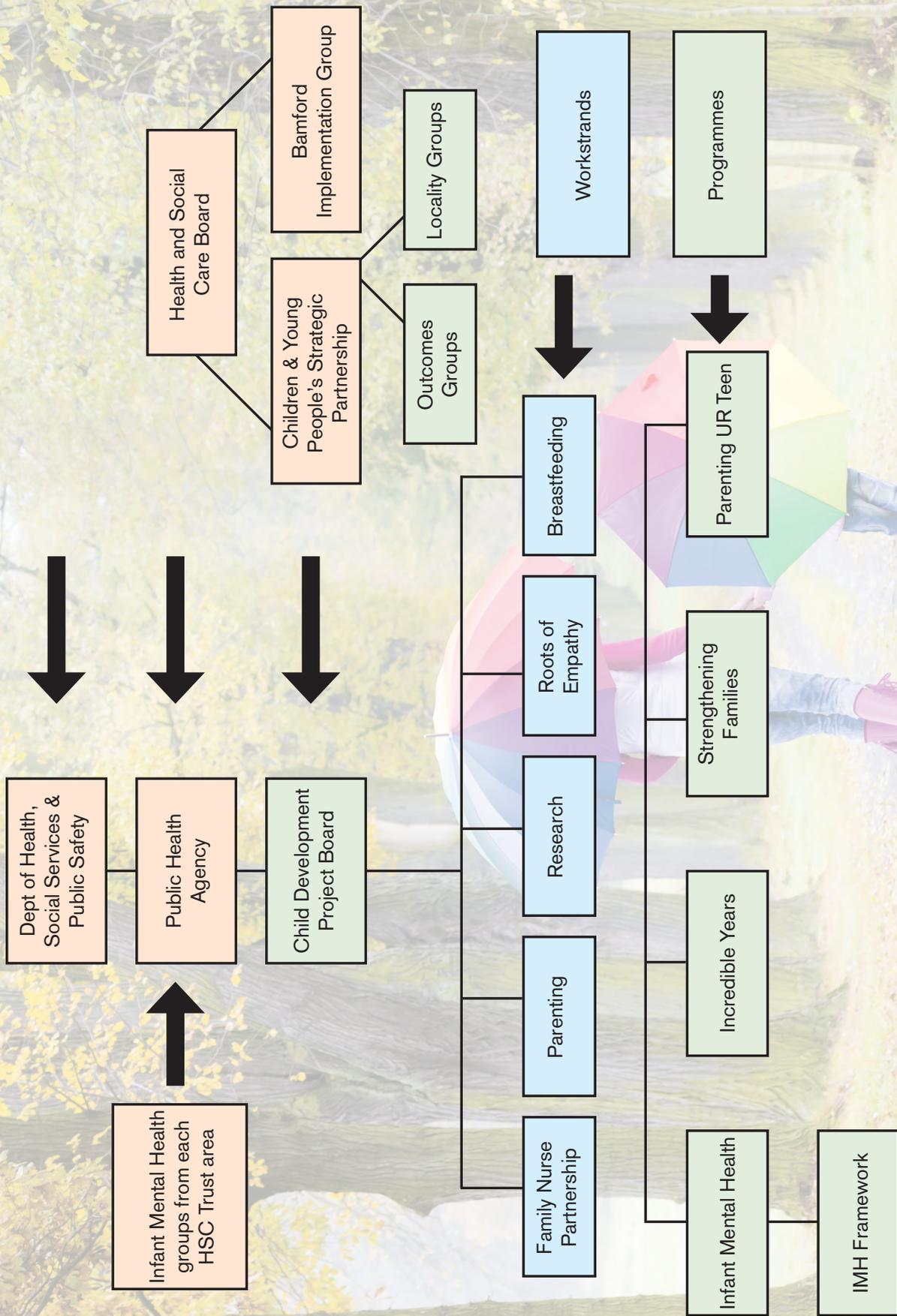


- **Stakeholder engagement** - Since June 2010 numerous seminars have been organised in order to share good practice and provide feedback on the progress made towards the development of this Framework. Key speakers at these events included Suzanne Zeedyk, George Hosking, Dr Bruce Perry, Dr Ian Manion and Professor Terence Stephenson. These seminars were attended by over 500 different delegates from across the statutory, community, voluntary and academic sectors. An outline draft was presented to a workshop of over 150 people and their comments have been incorporated in this Framework.
- **Case study visit to Finland** - In September 2013 a delegation of 25 policy makers, commissioners and high-level practitioners participated in a case study visit to Finland. The primary aim of the visit was to increase knowledge on the early education and early years sector in Finland in order to inform the infant mental health agenda and parenting support in Northern Ireland.
- **Regional Infant Mental Health Planning Group** - This group has been working to inform the production and implementation of this Infant Mental Health Framework as well as providing specialist input on infant mental health for the new 'Protect Life: Suicide Prevention strategy from DHSSPS (in development). Members include the PHA, HSC Trusts, HSCB and DHSSPS.
- **Regional Infant Mental Health Reference Group** - This group supports the work of the Infant Mental Health Planning Group. Members represent the voluntary and community sector, as well as academia.
- **Formal 12 week consultation period (March – May 2015)** - the draft framework and initial action plan was released for public consultation between March and May 2015. Thirty three written consultation responses were submitted, from a range of voluntary and statutory organisations as well as three from individual practitioners. In addition, focus groups were held with 56 parents at six Sure Start groups across Northern Ireland, as well as a focus group with 5 members of NCB Young Parents group. A thematic analysis of consultation responses was carried out using NVivo, a qualitative software package used to support analysis of a large volume of text-based information. Following analysis, the Framework was revised accordingly.

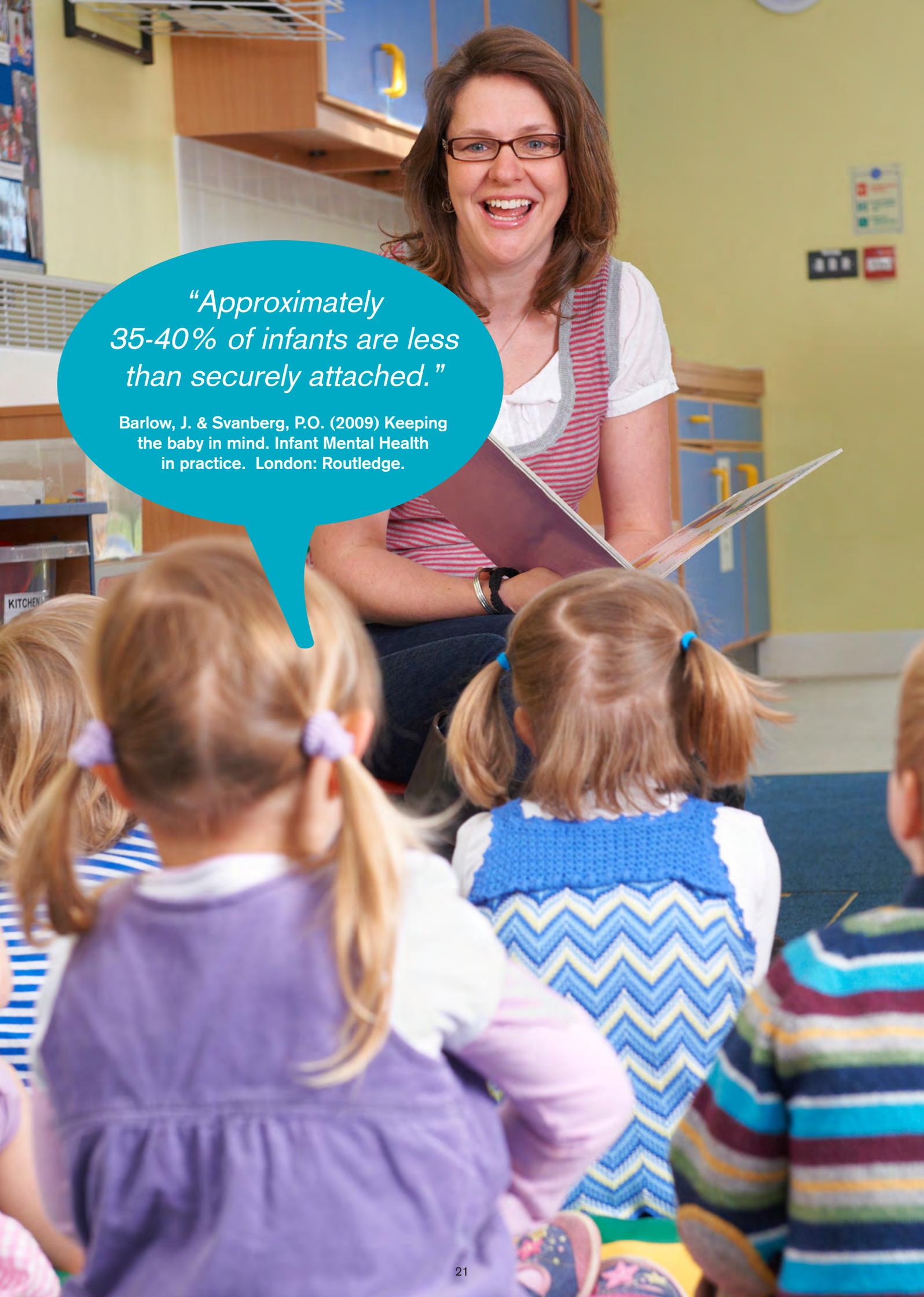


*“A young child’s experience of an encouraging, supportive, and co-operative mother, and a little later, father, gives him a sense of worth, a belief in the helpfulness of others, and a favourable model on which to build future relationships... by enabling him to explore his environment with confidence and to deal with it effectively, such experiences also promote his sense of competence.”*

Bowlby, J. (1982). Attachment and loss. Vol. 1: Attachment (2nd Ed.). New York: Basic Books



## Support path for development of Infant Mental Health Framework and Action Plan

A woman with brown hair and glasses, wearing a red and white striped shirt, is sitting on the floor and reading a large book to a group of young children. The children are sitting on the floor, facing her. The setting appears to be a classroom or a playroom with colorful walls and shelves in the background.

*“Approximately  
35-40% of infants are less  
than securely attached.”*

Barlow, J. & Svanberg, P.O. (2009) Keeping the baby in mind. Infant Mental Health in practice. London: Routledge.

# Infant Mental Health in Northern Ireland: Key Statistics



# 24,394

**No. of Births in NI**  
(NISRA, 2014)



**Child Population**  
**433,161**  
(HSCB, 2015)

**24,255** Age 0-1 (6%)

**101,526** Age 1-4 (24%)



**No. of Births to Teenage mothers**  
(under 20 years)  
(HSCB, 2015)

# 84

Births to mothers aged under 17 reached a new record low in 2015 with 84 births recorded, a rate of **2.4 per 1,000** females aged under 17.



**Premature or Low Birth Weight**

(NICORE Database 2012, QUB)

**6.3%** of babies were born with low birth weight (i.e. less than 2500 g)

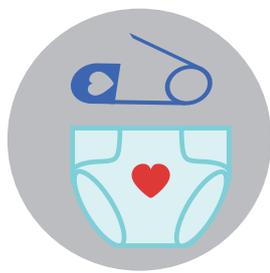
**7.3%** In 2012, 1877 babies (7.3% of live births) spent time in a neonatal unit



**Postnatal depression**

'Of 25,273 births in 2011 in Northern Ireland, 2527 women developed antenatal depression, 3790 women developed postnatal depression, 50 mothers developed puerperal psychosis and 50 were admitted as a result of relapsing' (DHSSPS, 2013)

It should be noted that Postnatal depression often goes unreported and therefore the figure could be much higher than this (Royal College of Psychiatrists, 2011)

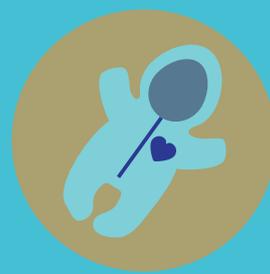


## Child Protection Register

(HSCB, 2015)

# 1969

children on the child protection register. This figure has fallen from 2,401 in 2011. 226 of these are under 1 year of age. 519 of these are between 1 & 4 years of age



## Children Looked After in Care

(HSCB, 2015)

# 2,875

children in care, 76.2% - Foster Care, 11.8% - Placed with Family, 6.7% in Residential Care. 112 of these are under 1 year old. 581 of these are between 1 and 4 years old



## Smoking during pregnancy

(NINIS, 2013)

NI total: 15.7%



## Breastfeeding rate at discharge

NIMATS (2014)

NI total: 45.7%



## Child poverty

(DSD, 2015)

# 101,000

(23%) children living in poverty in Northern Ireland, however, child poverty rate varies widely across the region



## Breastfeeding exclusively at 6 mths

(Infant Feeding Survey, 2010)\*

Less than  
**1%**

\*note this survey has been discontinued and therefore updated statistics not currently available

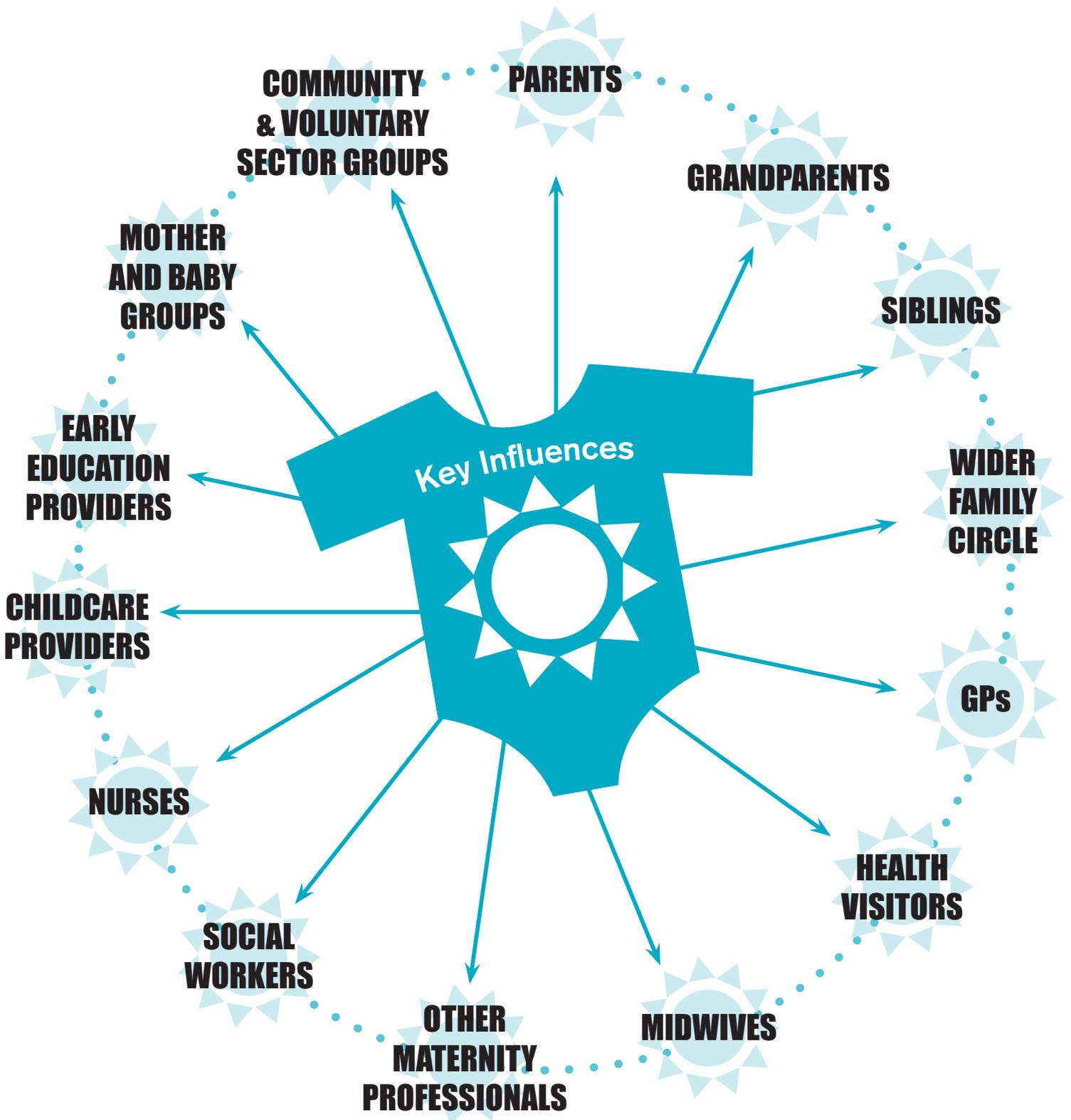


## Baby's key influences





This Infant Mental Health Framework proposes a whole child approach, where infant mental health is ‘everybody’s business’. This means that practitioners across a wide range of disciplines including health, social care and education can have an influence over a child’s social and emotional development. In addition, parents, siblings and the wider family circle, as well as friends, neighbours and the wider community can all play their part.



# Key Priority Areas





## Priority 1: Evidence and Policy

**We believe that investment in services must be firmly based on existing and emerging evidence, ensuring best possible outcomes for all children, young people and families. There is an ever growing body of evidence on the impact of adverse pre-birth, baby and infant experiences on later development, and in addition, evidence on ‘what works’ to address these needs and to prevent further issues developing.**

The Infant Mental Health Framework includes a commitment to utilising the most up-to-date findings when developing services; and to ensuring that emerging local policy development acknowledges this evidence on infant mental health and the critical influence of the early years to later life outcomes. Where possible, new and emerging research and evidence will be disseminated to commissioners, policy makers, practitioners and the wider population to inform support for families with children aged 0-3.



### Key recommendations: Evidence and policy

- There is a need for agreement on a common language around infant mental health that is accessible to all, including policy makers, practitioners, and importantly parents and the wider community, ensuring consistency of messaging across all departments and services.
- Infant mental health should be regarded as ‘everyone’s business’, and those in a position to do so should use opportunities for dissemination of essential key messages and evidence on infant mental health to practitioners, parents, policy makers and the wider population. It is critical that this information is accessible by all, particularly those with additional needs.
- All concerned with promoting key messages on support for parents in caring for their newborns should consider how new technologies and use of social media can be utilised alongside traditional methods to disseminate key messages.
- In seeking to understand need, we must listen to and engage with those who know best. The diverse voices of children (where possible), parents and practitioners must be heard in gathering evidence, ensuring that they have every opportunity to help shape service development.
- The UNICEF UK Baby Friendly Initiative will be promoted as a model of best practice.
- While acknowledging the importance of international evidence on what works for children and families, a commitment is needed to gathering evidence of local practice, including qualitative evidence of local programme delivery.
- Where appropriate, policies and strategies at Department, Health and Social Care Board/ Trust level and NI wide, should utilise the evidence base on infant mental health and the importance of the early years on later child and adult outcomes.
- Individual Trusts should develop an Action Plan to identify relevant actions informed by the Infant Mental Health Framework.

# 2

## Priority 2: Workforce development

**Central to the early identification of infant mental health issues is ensuring that all practitioners working with babies, pregnant or new mothers, fathers (who are often overlooked) and young infants, are fully equipped to promote positive social and emotional learning, as well as to identify the early signs of infant mental health problems and to seek timely help for those families at risk.**

This Framework focuses on the need for capacity building of frontline practitioners across all relevant disciplines, ensuring they have the necessary knowledge and skills to support and encourage positive parenting, assess infant mental health and identify any issues and causes in a timely manner so that additional support may be provided.

As already stressed, infant mental health is 'everybody's business', with consistency of messaging a priority, therefore workforce development will be directly relevant to a wide range of health, social care and education practitioners across statutory, community and voluntary sector services. In addition, the link between child and adult services must be recognised, therefore training in infant mental health should be extended to practitioners working in relevant adult mental health settings (in particular those working with expectant parents). We recognise that not every practitioner will require the same level of knowledge in infant mental health so alongside a common baseline of knowledge, we propose a tiered level of training relevant to the CAMHS stepped care model of service delivery (see appendix 2).

In addition to increasing workforce skills, we understand that practitioners need to have the opportunity to consolidate their new skills, attending appropriate follow up networks and practice sharing sessions, and have the opportunity for regular supervision and peer support, hence maximising impact for children and families.





## Key recommendations: Workforce development

- Upskilling of practitioners across a wide range of universal and specialist services, including health, education and social care practitioners in both statutory and voluntary/community organisations: This should include a core baseline knowledge of infant mental health for all relevant practitioners, with consistency of message, and appropriate specialist training for those delivering specialist services to both infants and families.
- Training should be provided at as early a stage as possible in a practitioner's career, considering options for inclusion in further/higher education syllabuses for appropriate health, education and social care courses.
- Commitment has already been made to supporting infant mental health training including the Solihull Approach, Video Interaction Guidance and the Tavistock diploma in Infant Mental Health and Child Development and this investment should be embedded and further built upon.
- Alongside training, practitioner support to embed new learning in practice is essential to ensure that investment has an impact on children and families. This Continued Professional Development should include regular supervision, peer networking and support and access to up to date evidence and information to support practice. Buy-in for the process at management level is therefore essential.
- Continuity of care in provision of universal services is essential in order to allow practitioners to build relationships with families and best meet their needs, and this should be considered when allocating resources.
- In addition, a preventative approach is recommended, with provision of key information on developing positive infant mental health to young people via personal, social and health education (PSHE).





## Priority 3: Service development

**Increased capacity of practitioners to identify additional needs around infant mental health will necessitate not only a clear referral pathway to identify appropriate support, but increased service capacity to meet this need. Workforce development and service development must therefore go hand in hand.**

First and foremost we understand that building positive social and emotional wellbeing in a child begins at conception, hence practitioners working within universal services are best placed to disseminate information and identify potential infant mental health issues early. This Framework therefore acknowledges all current universal provision as outlined in Healthy Child, Healthy Future and the Maternity Strategy for NI, and seeks to add value. However, sometimes despite best efforts, additional issues for families arise and universal support is not enough. For those families, it is essential that appropriate targeted interventions are also in place to allow timely referrals and treatment interventions, thereby preventing issues from escalating.

Service development therefore reflects both universal and targeted support. For all services we recognise the need for consistency and continuity of care, and a whole family approach to interventions. It is particularly important that fathers are recognised as a key part of the family unit. The level of need should be based on the CAMHS Stepped Care model (see appendix 2).

It is important to acknowledge the numerous services already being provided across Northern Ireland by statutory, community and voluntary sector organisations; the Framework seeks to build on existing work rather than to duplicate.



### Key recommendations: Service development

- Initial priority should be given to maximising opportunities provided for supporting positive infant mental health development through the universal Healthy Child: Healthy Future programme.
- A multi-disciplinary, joined up approach to service development will maximise use of existing resources and support a whole child approach. This should include dissemination of existing opportunities as well as development of new ones.
- Service planning and development must recognise the need for a balance between prevention and intervention, with a range of services to cover all levels of need.
- In line with a joined up approach, links should be made with existing services across CAMHS and perinatal pathways.
- The voice of practitioners and parents as service user must be central to development of services.
- In addition to roll out of globally evidence-based programmes and services, it is important to invest in our locally developed programmes, supporting them to evaluate their own services.



# Implementation

## Implementation Group

To support actions indicated in this Infant Mental Health Framework being taken forward, an implementation group will be established. The Implementation Group will consist of representatives from health, social care and education and include the voluntary, community and statutory sectors in order to facilitate a joined up approach to delivery.

## Annual implementation plan

The key role of the Implementation Group will be to develop an annual action plan which will set out key actions relevant to a wide range of organisations and across all sectors. Appendix 1 includes the initial action plan for 2016-2017 and provides details of key first actions already taken. Further yearly action plans will build upon these first actions.



# Appendix 1: Action Plan 2016 - 2017





The following provides an overview of initial actions taken under the 3 key headings of 'evidence and policy', 'workforce development', and 'service development' during the period 2016/17. Subsequent yearly action plans will be developed in line with implementation plans going forward.



## 1. Evidence and policy: Key Actions

Key Actions	Timescale	Partners
<b>Support, as appropriate, the strengthening and reinforcement of strategy, legislation, guidance/regulations and policy/programme formulation linked to infant mental health research, evidence and practice through:</b>		
<ul style="list-style-type: none"> <li>Informing the development of DHSSPS 'Positive mental health and suicide prevention' strategy' to ensure that infant mental health is comprehensively included. This includes the identification of any equality issues and ways of addressing these.</li> </ul>	Input submitted. Document being released for consultation 2016	DHSSPS
<ul style="list-style-type: none"> <li>Development of a local plan in each Health &amp; Social Care Trust to implement the regional infant mental health strategy that embeds infant mental health approaches. This plan should be incorporated within each Trust's Local Implementation Team's Action Plan.</li> </ul>	Ongoing	Individual HSC Trust areas
<b>Support dissemination of information on key infant mental health issues by:</b>		
<ul style="list-style-type: none"> <li>Implementation of regional networking events for infant mental health lead practitioners to allow sharing of good practice across HSC Trust areas, as well as across programmes of care.</li> </ul>	Ongoing	Trusts PHA
<ul style="list-style-type: none"> <li>Provision of user friendly information and up to date evidence for practitioners, parents and the wider population, using a common accessible language (including dissemination of IMH Framework and Action Plan.)</li> </ul>	Ongoing	PHA
<ul style="list-style-type: none"> <li>Supporting development of Trust level information flyers/booklets and individual communication plans as appropriate, and encouraging Trusts to ensure that their plans consider and address the specific information and communication needs of particular equality groupings.</li> </ul>	Ongoing	Individual HSC Trusts
<ul style="list-style-type: none"> <li>Promotion of best practice standards within universal services such as UNICEF UK Baby Friendly Initiative and provide parent resources such as 'UNICEF: Building a happy baby'.</li> </ul>	Ongoing	PHA/Trusts
<ul style="list-style-type: none"> <li>Dissemination of emerging evidence regarding what's best for baby and family</li> </ul>	Ongoing	PHA
<ul style="list-style-type: none"> <li>Establish links with parenting networks to ensure parental engagement on perspectives on Infant Mental Health, and encouraging networks to ensure that a wide range of diverse voices are heard.</li> </ul>	Ongoing	PHA/Trusts



## 2. Workforce Development: Key Actions

Key Actions	Timescale	Partners
Audit of current infant mental health training across NI	Completed	NCB/PHA
<b>Universal (Step 1)</b>		
<p>Expansion of Solihull Approach and Solihull Plus training across the region targeting 1500 health and social care practitioners to complete training and attend practice network meetings. Training for Trainers model used.</p> <p>This will be further complemented through Solihull Combined Foundation and Ante Natal training programme supporting Midwives taking part in group based ante natal care and education.</p> <p>DE also funding the roll out of Solihull training across all Sure Starts in NI.</p> <p>Development of a regional Solihull Approach Plan.</p> <p>Introduce teaching of Solihull Approach to Health Visiting Postgraduate students.</p> <p>Expansion of IMH focus within core education curriculum (in particular Undergraduate level) for those providing vocational training for early years (Stranmillis BA (Hons) Early Childhood Studies).</p> <p>Influence development of IMH on curriculum for nursing, social work, midwifery, Health Visiting and psychology.</p>	<p>2016/17</p> <p>2015 – 2016 academic year</p> <p>Ongoing discussions</p>	<p>Funded by PHA; Training provided by Clinical Education Centre</p> <p>Funded through PHA under Early Intervention Transformation Programme</p> <p>HSCB/Childcare Partnership progressing Solihull training Department of Education</p> <p>PHA/Trusts</p> <p>PHA/Further and Higher Education Colleges</p> <p>Stranmillis University College, Queen's University Belfast, University of Ulster</p>
Support the development of Mental Health and Emotional Wellbeing education programme for families with newborns.	2016/17	PHA/Aware
Consider the opportunities for roll out of infant mental health training to GPs, Consultants and other key clinicians.	Ongoing discussions	PHA In conjunction with NIMDTA
<b>Targeted (Steps 2-5)</b>		
Expansion of psychoanalytically-informed training (Tavistock M7 & M9) for advanced practitioners working across all children's services. On completion, these skilled practitioners will embed learning within their own areas of work and offer advice and support to practitioners working within universal services in order to reduce the need for referral to specialist services.	15 Places to be supported within 2016/17	Funded jointly by PHA and HSCB; Training is delivered locally by the Child and Adolescent Psychoanalytical Psychotherapists in NI (CAPPNI).
Further implementation of Video Interaction Guidance and ongoing support for supervision requirements of practitioners.	2016-2017	

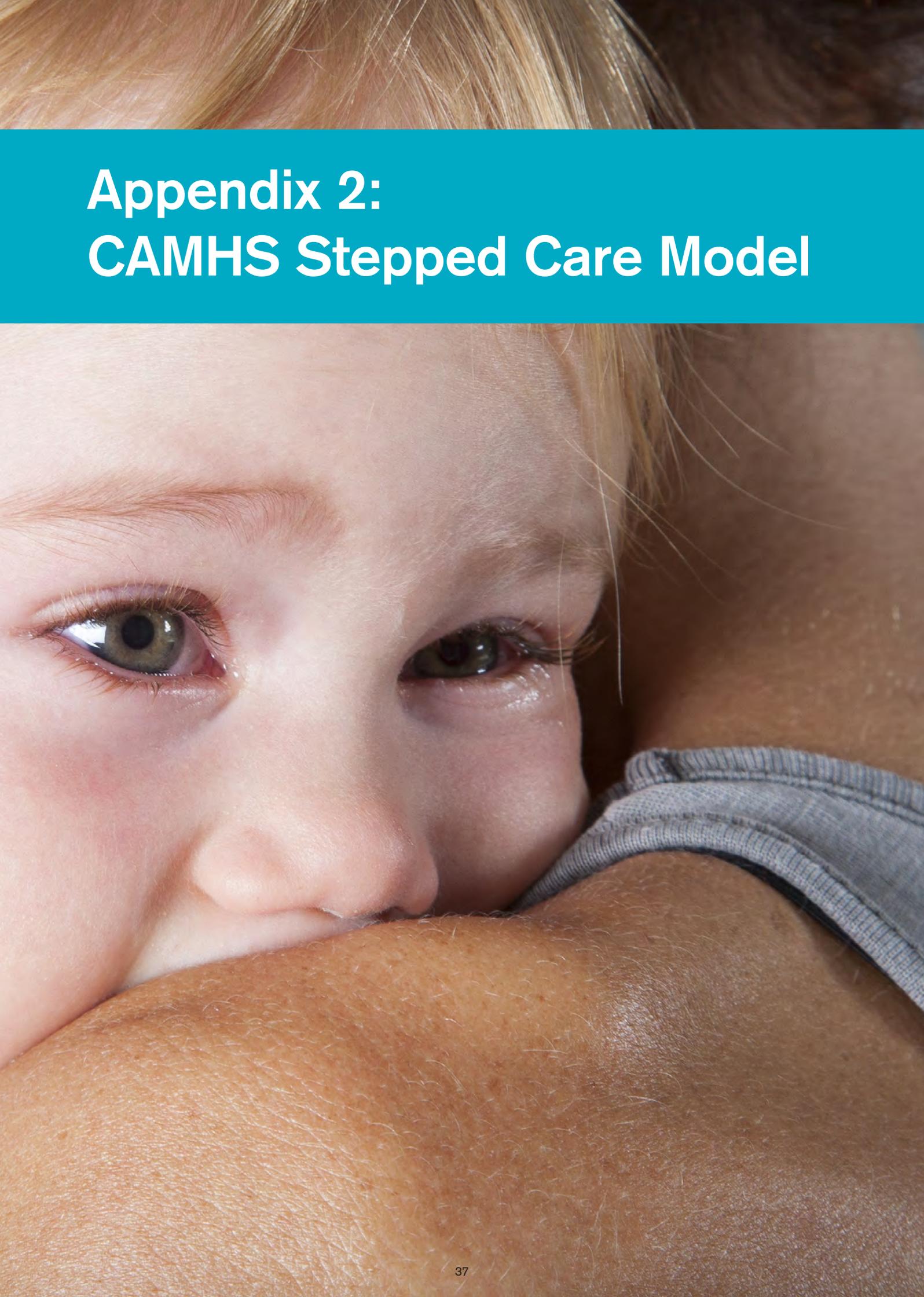


### 3. Service Development: Key Actions

Key Actions	Timescale	Lead Body
<b>Universal Services (Step 1)</b>		
Increase the emphasis on IMH during the ante-natal and post natal period including revised ante-natal parent education content, giving particular consideration to equality of access for all.	2016/17	PHA via Workstream 1: Early Intervention Transformation Programme and PHA/ HSCB through Maternity Strategy
Breastfeeding support and guidance through implementation of the Breastfeeding strategy for NI.	Ongoing	PHA
Expansion and adoption of Baby Friendly Initiative standards including support and advice for breastfeeding and non-breastfeeding mothers.	Ongoing	PHA
Expansion of Incredible Years Parent Programmes (0-3 yrs) and increase of trained and accredited Group Leaders and Peer Coaches.	Ongoing	PHA
Employ 5 Child Development Intervention Co-ordinator – these postholders will support improved implementation of parenting programmes across Northern Ireland including those related to Infant Mental Health.	Ongoing	PHA/Trusts
Revision of guidance on Relationship and Sex Education currently ongoing by DE.	Ongoing	DE
<b>Targeted Services (Step 2 &amp; 3)</b>		
Review of maternal mental health provision.	December 2015	HSCB/PHA
Include IMH within the development of eCAT for health visiting service so that interventions relating to IMH can be monitored.	2016/17	PHA
Revise the Perinatal Care Pathway in light of the new Perinatal and Antenatal Mental Health NICE Guidelines 45 (December 2014) and develop proposals to ensure implementation in all Local Commissioning Group areas by addressing gaps in current service.	2016/17	PHA
Identify gaps in our knowledge of data and service delivery and ensure this information is provided to relevant commissioners, in particular the current antenatal and post-natal data collected from new parents. There will be a follow up with a sample of women who have indicated a need for support in the antenatal period and to assess the extent of support provided.	March 2016	PHA
Implementation of Family Nurse Partnership Services across all Health and Social Care Trusts.	Ongoing	PHA



Key Actions	Timescale	Lead Body
<b>Targeted Services (Step 2 &amp; 3)</b>		
In line with the DHSSPS CAMHS Guidance framework, and the HSCB 'Working Together Learning Development Framework', develop the capacity of CAMHS practitioners to deliver evidence based interventions/NICE approved therapies.	Ongoing	HSCB/Trusts/LIGs
Embedding infant mental health approaches within Primary Mental Health Teams in each Trust CAMH Service, in line with the DHSSPS Service Model Guidance for CAMHS.	Ongoing	HSCB/Trusts/LIGs
Introduction of 5 Early Intervention Teams across NI focused on supporting families with emerging problems, including families with newborns and infants.	August 2015 - March 2018	PHA/Outcomes Groups/Trusts via Workstream 2: Early Intervention Transformation Programme
Introduction of mental health and wellbeing HUBs providing relevant support for target clients including those families and adults with newborns.	Ongoing	HSCB/Trusts
Implementation of parenting support programmes including those relevant to parents with newborns and infants.	Ongoing	PHA/HSCB/Trusts via Workstream 2: Early Intervention Transformation Programme
Support the development and application of an Adversity Matrix and related assessment for families with 0-3 year olds and development of a programme of support for families identified. The model, if successful, can be potentially implemented across all HSC localities.	2016/17	CAWT. HSCB, PHA, Southern and Western HSCT's



## Appendix 2: CAMHS Stepped Care Model

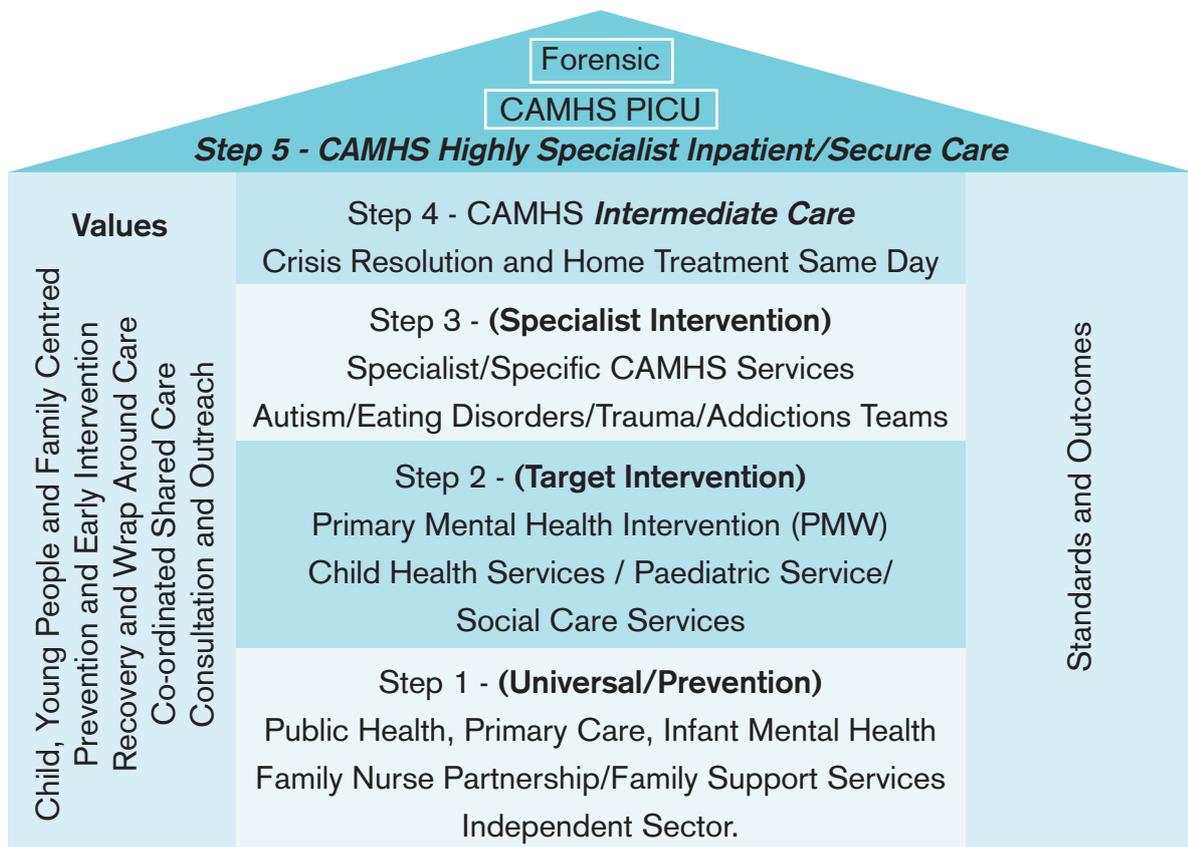


The regional strategy for the development of Psychological Therapy services recommends the adoption of stepped care approaches across CAMHS. This model aims to shift the focus from care interventions based on the service descriptors to a model of care which is needs based.

The model is underpinned by the following:

- Provision of child, young person and family centred care
- Focus on prevention and early intervention
- Provision of recovery and wrap around care
- Embedding coordinated provision
- Active promotion of outreach
- Ensuring services are effective

### CAMHS Stepped Care Service Model



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*“In the first three years, babies’ brains make 700 new connections every second.”*

Charles A. Nelson, *Neurons to neighbourhoods*.  
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# For further Information



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