The Tameside and Glossop Early Attachment Service: Meeting the emotional needs of parents and their babies

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ABSTRACT
Parent-infant emotional health is probably one of the most complex arenas in which mental health, maternity and health visiting services operate. This critical period can be highly emotionally charged, not only for the infant but also be for the parent. While most parents essentially "get it right", severe ruptures in the parent-infant relationship can occur, and can have serious consequences. This paper describes a comprehensive and cost-effective parent infant mental health service based on a psychodynamic model. The service aims to meet the needs of all parents from those with a high level of need through to a universal provision. Strategic and theoretical underpinnings of the service model are described.

KEY WORDS
parent-infant, perinatal, early intervention, prevention

THE IMPORTANCE OF PARENT-INFANT MENTAL HEALTH SERVICES

The health and care of parents and their babies are usually provided by a range of services and professionals who not only have different focuses and training, but who also may have different understandings of mental health. Some of this care may focus on the health and development of the infant and some may focus on the parent's problems and anxieties. No arena is more complex than that of parent-infant mental health. Infants start to be influenced by their emotional and physical environment from the moment of conception, and the two years following birth is fundamental to the subsequent development of the individual (Schore, 2004; Stroufe et al. 2005; Wave Trust, 2012).

The fact that many different professionals and agencies are inevitably involved during this period presents a challenge to provide a coherent, shared understanding, and a seamless, integrated service for families. There is the question of how much of these resources should be devoted to the help and guidance for *all* parents and infants, compared with the amount that should be allocated to those who have specific emotional or mental health problems.

Holding the baby in mind

The overarching principle of the Tameside and Glossop Early Attachment Service (EAS) is "holding the baby in mind", from a universal level to targeted individual parent-infant relationships, from the antenatal to postnatal period, across services, and with all professionals and families; placing it at the centre of everyone's thinking in the community. *Holding the baby in mind* means also *holding* the parent-infant relationship in mind. When things go awry, the central focus is on neither solely on the parent/s nor the baby, but on their relationship. Winnicott (1964) was one of the first to point out the interdependence. 'At this early state it is not logical to think of an individual. If you set out to describe a baby, you will find that you are describing a baby and someone. A baby cannot exist alone but is essentially part of a relationship'.

One cannot think of physically holding a baby without thinking about the psychological meaning for the infant and the parent. The way we hold a baby reflects how we understand his/her state of mind, and his/her feelings, thoughts and needs. Sometimes, our own experiences of being "held" interfere with holding our own baby. The experience of being held physically and psychologically allows the baby to feel contained within his/her own body and mind. 'We know that as babies the way we are held, talked to, and cared for each teaches us about who we are and how we are valued. This profoundly shapes who we will be become' (Brazelton, 2013).

The importance of parents' own early experiences

Our service focuses on both the inner and outer worlds of expectant and new parents and how they adapt to the changes and react to the emotions that are stirred

during the perinatal period. Neither parent nor infant is a passive recipient of what is going on. While the infant is affected by the parent, the parent also is deeply affected by infant. We were all once infants ourselves and we carry unprocessed residues of our own childhood experience (Raphael-Leff, 2000). Fraiberg, Adelson & Shapiro (1975) referred to the experience as 'Ghosts in the nursery', where a parent's current issues, as well as their own unresolved experience of childhood, may be stirred and interfere with the relationship to the infant. Thus intergenerational factors, the antenatal experience, and the mental health of both parents are intrinsically linked. While during the perinatal period there is potential for breakdown, there is also potential for breakthrough. It is a time when both the parent and infant are open to new learning and change, making parent-infant intervention vital.

THE TAMESIDE AND GLOSSOP EAS

The service is jointly run by two NHS Trusts. EAS is led by the Clinical Manager who is a Consultant Clinical Psychologist. There is another clinical psychologist and two infant mental health specialists who come from health visiting and midwifery backgrounds, and a Child Psychotherapist. We also have a senior mental health practitioner who is based in Primary Care in Adult Mental Health. We have a partnership with Home Start and have appointed a parent-infant mental health coordinator who supports volunteers working with families with babies.

The service works with families from pregnancy through to the child's third birthday.

Although our staffing contingent is relatively small (4.77 wte), EAS has been able to develop a strong service through building links with partner agencies, and training staff. In particular, we have developed close working partnerships with midwifery and health visiting, raised their awareness and skills in parent-infant mental health, enabling them to become proficient in the use of a range of universal interventions, and also in identifying early when problems emerge. Also, we provide consultation to many staff. The general principle is for the less qualified staff to deal with many of the universal interventions, and work with families whose problems are less severe, enabling the core staff to work with those who have serious issues parent-infant mental health concerns.

THE INTEGRATED PARENT INFANT MENTAL HEALTH (PIMH) CARE PATHWAY

Central to the operation of the EAS is the Integrated PIMH care pathway which was developed in 2011 to provide an early, comprehensive assessment of parent mental health problems and infant attachment problems, appropriate to individual needs, and accessible to all who need it. Parents with mental health difficulties during the perinatal period are prioritised in Primary Care Adult Mental Health for psychological therapy (IAPT) services. The PIMH pathway was developed through a multi agency working group which consisted of representation from Adult Mental Health (both primary and secondary), Children's Social Care, Health Visiting, Midwifery, GPs, and Early Attachment. Unlike other perinatal pathways around the country there was a focus not only on adult mental health but parent-infant mental health (Hogg – NSPCC, 2013).

All mothers and fathers who present during the perinatal period are asked the 3 Whooley questions. In addition they are asked, 'Are you worried about bonding with your baby'.

Depending on the parent's history and response to the questions, their care follows one of three pathways: Green, amber or red. The majority of families, while potentially able to benefit from information and guidance, basically "get it right" (Svanberg, 2006) and fall in the green pathway. The amber pathway is triggered for families who have problems that are judged to be mild to moderate, of a less pressing or serious nature, while the red pathway is for those with more serious issues.

Evaluation of the pathway: In 2012 we evaluated the pathway and asked both professionals and parents to complete a brief survey on their experience. In particular, the performance indicators were: Effective multi-agency care planning for parents on the red pathway, effective communication between maternity and Health visiting for parents on the amber pathway, and service user experience of ante- and post-natal provision. The results indicated that there was very good multi-agency care planning for parents. Discussions in the group were helpful in gaining experience of the pathway, how each service works, enhanced multi-agency working and communication, and also learning from the experience of service users. The PIMH pathway is currently under review in consideration of the new NICE guidelines for antenatal and postnatal mental health (NICE, 2014).

The earliest possible intervention

Proactive interventions beginning either ante-natally or at birth have the greatest most sustained effect (MacLeod & Nelson, 2000). EAS has worked closely with midwifery colleagues to better support them in providing ante-natal education to parents, so that not just the physical preparation, but psychological preparation and adjustment, is shared and communicated.

In the period of 2014-2015, 41% of our referrals were parents presenting ante-natally. 80% of infants were seen at eight weeks or younger, 96% infants were seen at 1 year or younger. In general, we continue to see parents and infants very early in the perinatal phase. This is a stable trend that has been reported over the past few years. It suggests professionals are recognising problems in the parent infant relationship very early, and are also acknowledging the importance of early intervention and support.

Most consultations and referrals to EAS come from Health Visiting, Midwifery and Children's Social Care, but consultations are also conducted with a range of other services. The consultation service has become an effective and essential method of ensuring that the limited availability of the EAS team for direct clinical work is used most effectively. It also represents another opportunity to influence professionals thinking. Many families seen by EAS are overburdened with risk and in these cases with so many professionals are involved, it can be so easy for the baby to get lost in people's minds. EAS has devised a parent-infant risk assessment that is used at all consultations and with all families seen by

the service. The risk assessment looks at parent/s, the infant and the parent-infant relationship; it focuses on both risk and protective factors.

Specialist training of staff
We place great emphasis on the need for staff who work routinely with infants and parents to be proficient in promoting and facilitating the parent-infant relationship and also in identifying, at the earliest possible stage, problems in the parent/infant relationship. This has partly been achieved through training sessions conducted by the EAS to Health Visitors, Midwives, Community Nursery Nurses, Social Workers and Early Years Workers.

The Brazelton Influence
It is particularly important to mention training in the Brazelton (Neonatal Behaviour Assessment Scale - NBAS, Brazelton, 1972 and Newborn Observation System, – NBO, Nugent et al. 2007) interventions. Since the 1960s Brazelton has recognised the fundamental role that babies themselves play in cementing the relationship with their parents. Babies from the earliest age communicate with their parents through their behaviours and individuality. The Brazelton interventions are first and foremost interactive, and provide a way to understand the infant, and how it must feel to parent the baby, thereby promoting the development of the parent-infant relationship. While ultimately we can never know really what a baby is thinking, the Brazelton interventions provide a way to provide meaning to what parents are observing, and facilitate their understanding and contribution to the development of the baby's mind (thoughts and feelings) (Brazelton and Cramer, 1990).

EAS commissioned training in the NBO and NBAS to all health visitors, community nursery nurses, a representative group of midwives, Home Start Coordinators, Community Nursery Nurses and specialist perinatal adult mental health workers. The NBO is offered universally to all families in Tameside and Glossop. It is recommended in the Healthy Child Programme (Department of Health, 2009) and also in the national 2015-2016 Health Visitor Service Specification (NHS England, 2014).

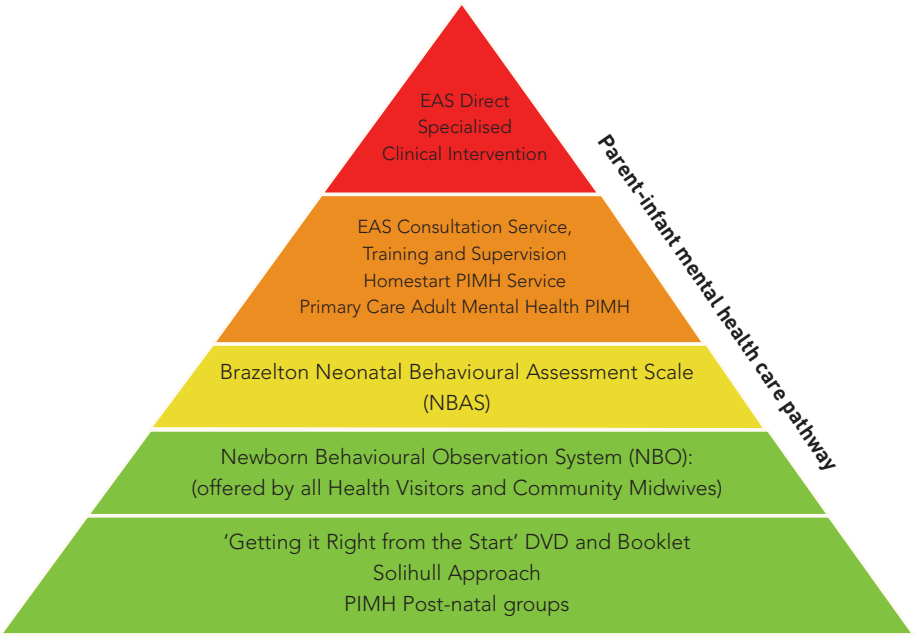

Figure 1: Parent Infant Mental Health Provision in Tameside and Glossop

While the NBO/NBAS provides an important framework to help professionals facilitate increased sensitivity between parents and infants, EAS provides additional learning and support to Health Visitors to help them further tune into and understand the emotional register between a parent and infant, and between themselves and the parent-infant relationship. We also seek to help Health Visitors understand emotional stirrings in themselves that may emerge as a result of the contact with the family.

Pyramid of support and intervention
Figure 1 illustrates parent-infant mental health provision in Tameside. It is a guide on the different levels of support and intervention we provide. Interventions need to be tailored to the specific needs of the parent-infant relationship to ensure better outcomes (Shonkoff & Phillips 2000), so the model is flexible and inclusive and services are guided by the individual parent-infant needs.

Each tier represents a different level of intervention and level of access. The EAS has placed a strong emphasis on promoting understanding of parent-infant mental health from the 'bottom up', rather than providing a service from the 'top down'. Culture change can be achieved through communities owning, valuing and sharing an understanding of infant communication, and the importance of that first relationship between infant and parent. This has meant developing resources for parents that are universally available, and organising and facilitating training for practitioners from a wide range of settings. Health visitors and midwives take responsibility for the less serious parent-infant relationship difficulties and, through receiving support from EAS in this work, grow in confidence, knowledge and skill in this vital area. This frees up the time of more specialised clinicians to see those parents who are most in need of their attention.

EXAMPLES OF THE THREE INTERVENTION LEVELS

Green: Universal
EAS has developed a universal post-natal programme, 'Early Start' for parents and infants up to 1 year of age, that is evidence based and focuses on enhancing the parent-infant relationship. The programme is based on key theoretical concepts in parent-infant mental health: Sensitivity, reflective functioning, regulation of affect, and self and mutual interactive regulation (Slade, 2005; Beebe, 1998).

All new parents in Tameside and Glossop receive our purpose-designed DVD and booklet, "Getting it right from the start" at their 20 week scan. The resource was

developed to promote sensitive and responsive early parenting and infant communication. The resource is based on evidence from research and clinical studies in infant development and infant mental health (Brazelton, 1972; Schore, 2004; Douglas & Ginty,2001). A recent evaluation of the resource (Lee et al, 2013) indicated that 'Getting it right from the start' represents an effective method of reaching all parents during the perinatal period.

Since 2011 Tameside has invested in training in NBO to ensure that it is offered universally. In 2013 an evaluation of the NBO was conducted in Tameside and Glossop to explore its use in the everyday practice of Health Visitors. The majority of health visitors reported marking changes to their working practice as a result of the NBO training. For some health visitors, the NBO as an intervention has freed them to refocus their attention on the parent-infant relationship.

Also offered is the Solihull Approach. This approach to supporting families is based on the principles of containment, reciprocity and behaviour management (Douglas & Ginty, 2001). More recently, Tameside has invested in Solihull Parenting, offering it to all parents with children from 1-2 years of age. Preliminary findings suggest parents are significantly benefiting from the groups and are reporting reduced levels of stress.

Amber: Mild to Moderate Intervention

Families placed on the Amber pathway are typically those with mild to moderate mental health concerns and/or parent-infant relationship concerns.

Since 2012 EAS has formed a close partnership with Primary Care Adult Mental Health. We appointed a perinatal adult mental health specialist whose role includes: Consultation with professionals, liaison, prioritising assessment and treatment of pregnant women and their partners who were presenting with mental health concerns, and raising awareness of parent-infant mental health in adult services. The perinatal specialist has also expanded her work to focus on groups for parents with mental health problems during the antenatal period and also parents and babies post-natally.

In 2015 Tameside established a 'Babies Can't Wait' agreement which means that all pregnant women or those with children under the age of two years and their partners can access Healthy Minds (IAPT) service directly following referral, avoiding any wait. This has meant it is possible for parents to receive support for their own mental health. With the close partnership between Adult Mental Health and EAS, we have raised the importance of parents needing to access help for their mental health during the perinatal period, and also raise the importance of the parent-infant relationship.

Whilst specialist support from Mental Health, Maternity, Health Visiting and EAS is available for these parents, we have found that what was particularly missing was low level support for parents individually and to engage them into local children's centre and other community provision. To try to meet this need, we appointed a Coordinator based in Home Start to work with the volunteers to support parents and infants. The partnership with EAS, has meant together we provide parent-infant mental health training and supervision to staff and volunteers in Home Start. Health visitors also have a key role in training Homestart volunteers in parent- infant mental health for their work as befrienders with vulnerable families.

For Health visitors, any concerns raised through carrying out a routine NBO with a parent-infant may then be referred on for a more in-depth Brazelton intervention, namely the NBAS. In addition, if a baby is identified with additional needs, a NBAS may be provided first.

Red: Direct Specialised Clinical Intervention

EAS offers a direct clinical service across Tameside and Glossop. The team also works closely with the Post-Natal Ward and Neonatal Intensive Care Unit at the local hospital, attends the Ante-Natal Clinic as needed, has provided and influenced change in Ante-Natal classes, works with Specialist Midwives for Mental Health, Safeguarding and Young Parents, and offers support to the Fostering and Adoption team.

The service offers a wide range of interventions that include: Interaction guidance, video feedback, adult psychotherapy, and parent-infant psychotherapy. There is a particular focus on parent-infant psychotherapy. The therapy typically shifts back and forth on several registers. It focuses on present concerns and also moves back and forth between past and present, between parent and infant, and back to the parent's own past, hopefully helping the parent understand what they are feeling, but also what the baby is feeling. Together, the clinician and parents explore both the "ghosts", the painful memories that can upset the parent-infant relationship, and the "angels", the early benevolent experiences with parents that can be protective factors (Leiberman et al, 2005). The therapy provides a space to contain and treat the parent's anxieties and distress, and also supports the infant at a time when the parent may be finding this more difficult to do so. The clinician can also be the voice of the baby especially, when the parent cannot see the baby in his/her own right.

It is not unusual for families to receive a range of interventions depending on their individual and changing needs. There is no restriction on the length of time a family receives an intervention.

More recently, Tameside has invested in Mellow Parenting. We have trained staff from EAS, Home Start, Health Visiting, CAMHS, and Early Years. All the staff meet as a group to discuss and plan the delivery of Mellow groups which are co facilitated by two staff, one of whom is a senior mental health clinician. Mellow Parenting is for families who have experienced serious adversity

Figure 2: Example of 3 questions asked in the service questionnaire

1.	I learned something new about my baby/child	100% agreed
2.	I feel more tuned in to my baby/child	90% agreed
3.	I feel more confident about my ability to care for my baby/child	100% agreed

Key points

- Tameside and Glossop has a unique service model for promoting parent-infant mental health.
- Our aim is that emotional well-being, and the importance of that first relationship between infant and parent, is understood and valued, and placed at the centre of everyone's thinking and practice.
- Our service is based on a psychodynamic model, and considers how a parent's current issues, as well as their own unresolved experience of childhood, may stir and interfere with the relationship to the infant.
- Parents, the voluntary sector, midwifery, health visiting, wider children's workforce, adult mental health services and early attachment specialists promote parent-infant mental health, in an integrated way that actively crosses organisational boundaries.

to the extent that they are struggling to establish or maintain a positive relationship with their children.

SERVICE EVALUATION

EAS has a wide range of data, evaluations, and performance measures to demonstrate the impact of its work with families. All families who are seen receive pre and post measures. These include: PHQ-9, GAD-7, Mothers' Object Relations Scale, Parenting Stress Index, Parent-Infant relationship - Global Assessment Scale, and Parent Infant Relational Assessment Tool. Parents presenting during the ante-natal period are given a series of different measures looking at their thoughts and feelings towards the unborn infant.

The following are some brief extracts from our annual report.

Mothers' Object Relations Scale (MORS): This is a 14 item questionnaire which assesses a mother's representation of her infant. A mother's perceptions of her infant derive partly from the infant's characteristics and behaviour but also from the mother's projections which stem from her own inner world (e.g., her feelings, behaviour, identification and attachment). Based on the completed scales there was 80% decrease in parents reporting hostile feelings towards their baby after treatment.

Parent-Infant relationship Global Assessment Scale (PIR-GAS): The relationship between parents and infant/child was rated before and after treatment by the Clinician using the PIR-GAS. This scale measures functioning in various domains on ten levels. In total 92% of parents showed an improvement in their PIR-GAS rating after treatment. This is consistent with previous reporting. 31% of the families showed improvement by two categories, and 24% showed improvement by three categories.

Experience of Service Questionnaire

All parents who receive a direct clinical service are given a service questionnaire asking about their experience of the Service and the impact of the intervention. This service evaluation has been used since 2009.

CONCLUSIONS

It clearly makes sense to focus attention on the fundamental bedrock of child development – the parent-infant relationship. From this basic union stems every relationship that the person makes in the rest of life, and how the person interacts with the wider society. There is a recognition of this in current research and service development, and it is to be hoped that this will translate into the setting up of many more such services in the future. It must always be remembered, however, that a comprehensive parent-infant mental health service needs highly trained staff, and an infant mental health model to ensure continuity, shared understanding, and capacity to respond to the wide range of needs that must be addressed.

The EAS model delivers a comprehensive, cost effective and sustainable service. We have found this model allows the service to flex and respond to changing demands within a framework of both targeted and universal service provision. It allows us to recognise the importance of broad workforce and service development and collaborative approaches in sustainability, rather than investing only in a high degree of specialism.

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