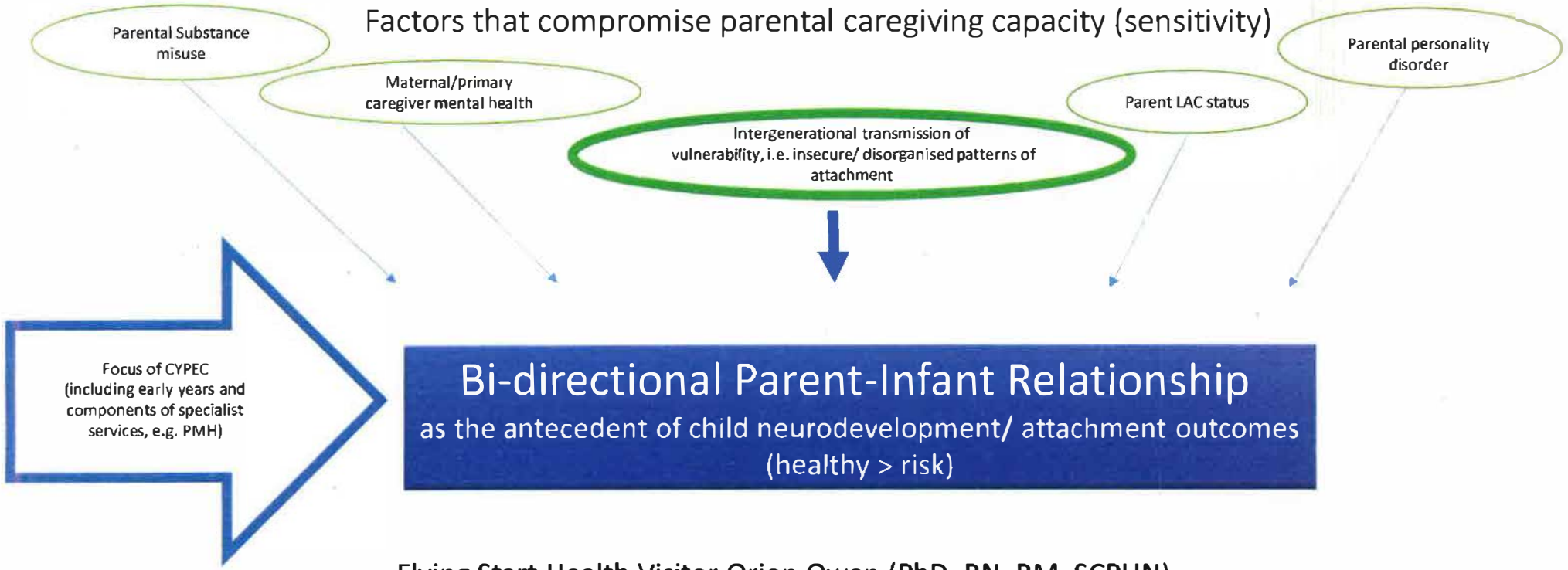
Focus on Infant Mental Health
(AKA neurobiology of affect regulation; attachment; neuro-development)



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Focus on Infant Mental Health

Re: WG update on the CYPEC Perinatal Mental Health report (Oct 2017) which is comprehensive in relation to PMH provision in Wales.

This response addresses both the PMH report and WG update.

Maternal mental illness represents only one risk factor for impaired maternal function with adverse consequences for infant mental health. Evidence confirms that therapeutic work targeting *at risk infants* in the context of PMH needs to respond to the bi-directional influence of the mother-infant relationship. Individual therapies e.g. C-BT counselling and MI may benefit features of adult MH disorder but these are not efficacious interventions for difficulties in the early mother-infant relationship. For example, improving maternal mental health can result in improved adult psychosocial function, but such improvement *does not inevitably improve maternal function.* Vulnerable adults (such as those with early years' trauma or a history of mental illness) may function well in general psychosocial situations but are compromised in the context of the parent-infant relationship (e.g. Slade 2008). Therefore, a PMH model centred on adult/ maternal mental illness is too narrow a focus to effectively meet short and long-term needs of vulnerable mothers and infants. Specialist IMH practitioners require an additional, different skill set/ knowledge to those utilised in an adult focused PMH model.

(See Association of Infant Mental Health (https://aimh.org.uk/) **Address:** AIMH UK, 27 Old Gloucester Street, London, WC1N 3AX. **Company registration number** : 3219779
Tel : 0208 144 2386 **Email** : info@aimh.org.uk Professor Jane Barlow (**President, Director and Trustee**) Dawn Cannon (**Director and Trustee**)

Response: Executive Summary Paragraph 8

Attachment is both a neurodevelopmental process *and* achievement relating to affect regulation (0-2 years). Modern attachment theory cites *affect regulation* as the most critical task of the early parent-infant (P-I) relationship (Schore 2015) associated with all domains of development (Porges 2017).

Interventions to address difficulties in P-I relationship and consequently individual child neurodevelopment, needs to be based on *assessment and formulation* of the specific difficulties in the P-I relationship (Crittenden 2008).

Therapeutic support and intervention targeting IMH (attachment etc) as a consequence of risk in the P-I relationship is a specialist field that is distinct from PMH. That said it is an essential compliment to PMH provision and similarly all services that respond to vulnerable adults with infants (0-2 years) (see diagram pg. 1).

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Response : 01. Background
Evidence does not support that didactic programs and literature designed to support parenting are effective in addressing risk to IMH (poor attachment outcomes) as a result of difficulties in the P-I relationship.

Response: 02. Government strategy
Point 15: PMH is a specialist, adult psychiatric model for women (antenatal > 1 year postnatal). Psychiatric treatment of PN women is essential but not in itself a therapeutic response to improve the P-I relationship and IMH/ attachment outcomes in the PMH arena. Therapeutic work targeting the P-I attachment relationship is recognised as an essential contribution to improve parental wellbeing and caregiving function (Fonagy 2008; Slade 2008)

Point 16: As for background. Specific attachment focused expertise based on , e.g. knowledge of infant neurodevelopment, assessment of P-I interactions alongside formulation of the problem is required to guide appropriate intervention.

For health and social care practitioners who work with parents and the preschool population, such as Health Visitors and social workers, knowledge of psychiatric disorders is not relevant (see above). Educational and training programmes re; infant attachment/ development in response to risk in the P-I relationship, regardless of eitiology, need to be specialist, attachment focused.

Response: 03. In-patient care
37. & 38. Community based PMH services cannot compensate for the lack of in-patient care for those mothers with babies who require hospitalisation. PMH community and in-patient provision meet different levels of clinical need/ risk. Evidence shows that hospitalising mothers with PM illness with their baby promotes the P-I relationship at the neurobiological level with long term benefits for that relationship as well as for IMH and associated development outcomes; it reduces significant risk of harm to infant neurodevelopment; it is not primarily a facility to develop parenting skills.

Response: Interventions
191. & 192. PMH is only one factor that compromises the P-I relationship and offspring attachment. PMH is not the specialist arena for addressing risk in the P-I relationship which requires a broader attachment focus. (see slide 2)

193. Specialist infant mental practitioners work with risk in the P-I relationship (assessment/formulation/ intervention) before outcomes are measureable in the infant by assessing parent-infant interactions. IMH is a separate theoretical arena to CAMHS which becomes relevant when a diagnosable mental health problem is manifest the child.

194. Please see response to In-patient care.