[redacted]

CONSULTATION QUESTIONS

Overall Approach

This consultation reflects a continuation and development of the Scottish Government's current approach for mental health. There is a general consensus that the broad direction is right but **we want to consult on:**

- The overall structure of the Strategy, which has been organised under 14 broad outcomes and whether these are the right outcomes;
- Whether there are any gaps in the key challenges identified;
- In addition to existing work, what further actions should be prioritised to help us to meet these challenges.

Comments
This is a Group Response from the following Child Mental Health and Child Health Professionals:

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We are writing as a group of professionals working in child mental health in Scotland to highlight **the major gap in specialist Child and Adolescent Mental Health Servic provision in Scotland in relation to infants and infant mental health**.
Our focus and comments are specifically with regard to CAMHS service planning, development and delivery for infant mental health, and the current profound inequality of access to CAMHS specialist services for the 0–2 years age range.

We wish to argue for a change from a fundamentally two category (i.e. children and adolescents) and two-dimensional paradigm of CAMHS to a three category (i.e. infant, child and adolescent) and three-dimensional paradigm of CAMHS. We set out our views and perspective below.

WHAT IS THE PROBLEM?

Off the radar: the 'invisibility' of severe mental health problems in infants

Case illustration
A young single mother with chronic severe depression and anxiety and extremely low self-esteem, an early history of severe attachment problems, serial abusive relationships with partners,

whose 2 older children were on the child protection register. A 9-week-old baby ***about whom there were no concerns in the professional network****, despite serious post-natal medical complications for the baby; the baby witnessing extreme parental conflict and repeated domestic violence by father towards mother, and mother fleeing the father; social work, public health nurse and adult mental health involvement, and regular CAMHS input for one of the older children.*

Systematic and detailed weekly observations of the baby in the home setting as part of a clinical intervention by a Child and Adolescent Psychotherapist over 4 weeks from 14 weeks of age, revealed severe impairment in the mother–infant attachment relationship and severe deficits in the infant's emotional and social development. This baby was showing extreme flatness of affect, and complete absence of liveliness; was mostly silent, with absence of vocalisation; and extremely limited interest and curiosity in people and his environment. The baby was systematically turning away from his mother, and looking blankly into space, and mother was failing to see and be aware of this.

CONTEXT

The absence of 'infant-centred' specialist infant mental health services

While CAMHS is the designated mental health service for the 0–16/18 years age range, historically the exclusive focus of CAMHS has been on children and adolescents. The evolution and planning, organisation and delivery of CAMHS has been that of a two-category (child and adolescent) rather than a three-category (infant, child and adolescent) service. Specialist Tier 3 infant-centred mental health services for infants from 0–2 years have therefore not been developed in the way that age-appropriate specialist mental health services for children and adolescents have been.

THE NEED FOR CHANGE: PERCEPTIONS

Starting at the beginning: critical periods of development and the need for early intervention

Research and clinical findings in infant development, attachment, neuroscience and infant mental health in the past two decades all overwhelmingly indicate that there are critical periods of development in the brain, in emotional and psychological functioning, and in attachment relationships, and that these areas are all closely interlinked. This is a guiding principle of the *Early Years Framework*.

The principle of early intervention encompasses both the need to intervene in the early years from birth onwards, as well as the need to intervene at an early stage in the development of problems in order to prevent them becoming more intractable and chronic. Alongside this, ***there needs to be an understanding that mental health problems can already be severe and entrenched even with very young babies***.

As Svanberg and Barlow (2009:186) have highlighted, "Society continues to portray [infants] as being primarily physiological beings with a range of physical needs that must be met in order for them to thrive." Furthermore, despite all the research findings, there remains a widespread belief that babies are merely the "passive recipients" of parental care, and that poor parenting is primarily the product of social deprivation and poverty. Whilst among professionals there is a relatively good understanding of risk factors in infancy related to parents and parenting, ***there is a lack of knowledge and training in being able to recognise the signs and symptoms in individual infants of serious mental health problems where these are already present***.

INFANT DEVELOPMENT: WHAT DO WE NEED TO KNOW?

Developmental psychology research has confirmed that from birth babies have a preference for their mother's voice; an innate and lively interest in their mother's face; are predisposed to relate, interact and communicate emotionally; are active participants and agents in these processes; and that for example "neonates can discriminate among surprise, fear and sadness expressions in caregivers, and produce corresponding facial expressions of their own" (Svanberg and Barlow, 2009: 187).

The findings of Trevarthen (1979) in relation to "intersubjectivity", of Stern (1995) in relation to "maternal attunement" and complex, subtle patterns of "reciprocity" between infant and mother, and of psychoanalytic infant observation studies (Rustin et al, 1978; Reid, 1998) provide a framework for the understanding and identification of normal emotional development in infants and normal emotional communication and interaction in infant–parent relationships.

The findings of Attachment Research (Main, Kaplan and Cassidy, 1985; Main and Solomon, 1986) in relation to insecure and disorganized attachments in infants identify complex patterns of disturbed and dysfunctional development in infant communication and interactions with mothers, and in patterns of attachment relationships. The research of Murray *et al* (Murray and Cooper, 1999) outlined the long-term effects of the impact of maternal depression on infant/child cognitive and emotional development.

The findings of neuroscience research have revealed that *brain development is experience dependent* (Perry et al, 1995); that babies' brains are highly adaptive to their environment and require social interaction to develop; that attachment relationships play a critical role in the 'wiring' of the brain (Schore, 1994) and that the earliest experiences in infancy are inscribed and in the deepest parts of the brain and are therefore beyond consciousness or conscious memory. These findings all highlight the invisible but lasting effects on the brain of disturbance in emotional and attachment relationships in infancy.

Recent longitudinal studies of both high risk (i.e. those with family history of disorder) and whole-population cohorts of infants have identified robust early behavioural indicators of high risk of psychiatric disorder in later life. Knowledge of these indicators among clinicians and the wider professional network is very limited.

THE NEED FOR CHANGE: SERVICE PLANNING AND DEVELOPMENT

Svanberg and Barlow (2009: 186) have highlighted the "need for a shift in the philosophy of both service providers and planners to enable the provision of more *infant-centred* services. Importantly, they identify 3 levels of services for infant mental health:

(i) universal programmes (for promotion and screening);
(ii) targeted programmes (for infants at increased risk); and
(iii) ***indicated programmes (for when serious problems have already developed).***

What this involves

(a) Designated services, either as part of a joint (Adult MH and CAMHS) Perinatal Mental Health Service, or as part of Tier 3 CAMHS, offering evidence based Parent–Infant Psychotherapy and similar highly specialist inputs.

(b) Suitably qualified and trained clinicians to provide such indicated programmes and approaches.

(c) ***Training to Tier 1 and 2 professionals who need the skills to be able to know and identify the signs of moderate to severe mental health problems or concerns in infants, and to know when to refer on.***

OBSTACLES TO CHANGE

Attitudes and perceptions:

- the painfulness of the subject
- the belief that there is 'no such thing as serious mental health problems in babies'

- political ideology and/or concern about stigma based on lack of awareness/understanding that some babies have moderate to severe mental health problems that cannot be redressed by universal or targeted services but require **indicated** specialist mental health service input
- 'it's not a priority' *within* CAMHS, because it's not seen as a government priority *for* CAMHS

Improvement Challenge Type 1

We know where we are trying to get to and what needs to happen to get us there, but there are significant challenges attached to implementing the changes. An example of this is the implementation of the Dementia Strategy. There is a consensus that services for people with dementia are often not good enough and we already know about a range of actions that will improve outcomes. However some of these changes involve redesigning the way services are provided across organisational boundaries and there are significant challenges attached to doing this.

Question 1: In these situations, we are keen to understand whether there is any additional action that could be taken at a national level to support local areas to implement the required changes.

Comments
A primary driver for service development is government performance targets. The government needs to take the lead in promoting the prioritisation within CAMHS of infants and Infant Mental Health by introducing CAMHS performance targets specifically for the infant population (0–2 years) e.g. in the Balanced Scorecard, there needs to be a key performance indicator asking *the number of infants and their parents receiving a direct clinical service from CAMHS*. There is a current key performance indicator asking this for the 16–17 years age range, and this gives the clear message of government expectation of prioritisation of that age range within CAMHS. The same government message needs to be given about the most vulnerable age range i.e. 0–2 years.

Improvement Challenge Type 2

We know we need to improve service provision or that there is a gap in existing provision, but we do not yet know what changes would deliver better outcomes. Supporting services to improve care for people with developmental disorders or trauma are two areas where further work is needed to identify exactly what needs to happen to deliver improved outcomes.

Question 2: In these situations, we are keen to get your views on what needs to happen next to develop a better understanding of what changes would deliver better outcomes.

Comments

Outcome 1: People and communities act to protect and promote their mental health and reduce the likelihood that they will become unwell.

Question 3: Are there other actions we should be taking nationally to reduce self harm and suicide rates?

Comments

Question 4: What further action can we take to continue to reduce the stigma of mental illness and ill health and to reduce discrimination?

Comments

Question 5: How do we build on the progress that *see me* has made in addressing stigma to address the challenges in engaging services to address discrimination?

Comments

Question 6: What other actions should we be taking to support promotion of mental wellbeing for individuals and within communities?

Comments

Outcome 2: Action is focused on early years and childhood to respond quickly and to improve both short and long term outcomes.

Question 7: What additional actions must we take to meet these challenges and improve access to CAMHS?

Comments

- National strategy for training professionals in primary care to be able to identify/recognize more severe mental health problems in infants and more severe disturbance/problems in infant−parent attachment relationships (e.g. for Health Visitors (Public Health Nurses), a foundation level training in infant mental health such as SIHR 10 week Introduction to Infant Mental Health Course)
- Need to establish "properly articulated links" between CAMHS and health visitors (Public Health Nurses), GPs and Paediatricians not just current focus on properly articulated links between CAMHS and schools (too late for infants).
- Systematic focus on ensuring suitably trained/qualified professionals in CAMHS able to deliver evidence based 'indicated' programmes (e.g. parent−infant psychotherapy)
- Government Targets that are specific to infant population
- More *infant specific* referral criteria both in routine (e.g. 'moderate difficulties/disturbance in mother−infant attachment relationship') and urgent (e.g. 'severe difficulties/disturbance in mother−infant attachment relationship') referral categories
- Requirement of Infant Specific Clincial Outcome Measure (e.g. ADBB) in CAMHS
- Infant specific Heat Target in recognition that 'one size does not fit all'

for acceptable maximum routine waiting time for infants

- Challenging political or party ideology/dogma that regard social care intervention as 'good' and specialist 'service' intervention as 'bad'.

Question 8: What additional national support do NHS Boards need to support implementation of the HEAT target on access to specialist CAMHS?

Comments

Outcome 3: People have an understanding of their own mental health and if they are not well take appropriate action themselves or by seeking help.

Question 9: What further action do we need to take to enable people to take actions themselves to maintain and improve their mental health?

Comments

Question 10: What approaches do we need to encourage people to seek help when they need to?

Comments

Outcome 4: First contact services work well for people seeking help, whether in crisis or otherwise, and people move on to assessment and treatment services quickly.

Question 11: What changes are needed to the way in which we design services so we can identify mental illness and disorder as early as possible and ensure quick access to treatment?

Comments

Need for infant centred services (Barlow and Svanberg, 2009) e.g. designated Infant Mental Health Service as part of CAMHS, or Perinatal Mental Health Services with joint Adult and CAMHS staffing

Outcome 5: Appropriate, evidence-based care and treatment for mental illness is available when required and treatments are delivered safely and efficiently.

Question 12: What support do NHS Boards and key partners need to apply service improvement approaches to reduce the amount of time spent on non-value adding activities?

Comments

Question 13: What support do NHS Boards and key partners need to put Integrated Care Pathways into practice?

Comments

Outcome 6: Care and treatment is focused on the whole person and their capability for growth, self-management and recovery.

Question 14: How do we continue to develop service user involvement in service design and delivery and in the care provided?

Comments
Active and systematic inclusion of ***parents and carers of infants*** *as a requirement* for service user involvement in service design and delivery.

Question 15: What tools are needed to support service users, families, carers and staff to achieve mutually beneficial partnerships?

Comments

Question 16: How do we further embed and demonstrate the outcomes of person-centred and values-based approaches to providing care in mental health settings?

Comments

Question 17: How do we encourage implementation of the new Scottish Recovery Indicator (SRI)?

Comments

Question 18: How can the Scottish Recovery Network develop its effectiveness to support embedding recovery approaches across different professional groups?

Comments

Outcome 7: The role of family and carers as part of a system of care is understood and supported by professional staff.

Question 19: How do we support families and carers to participate meaningfully in care and treatment?

Comments

Question 20: What support do staff need to help them provide information for families and carers to enable families and carers to be involved in their relative's care?

Comments

Outcome 8: The balance of community and inpatient services is appropriate to meet the needs of the population safely, efficiently and with good outcomes.

Question 21: How can we capitalise on the knowledge and experience developed in those areas that have redesigned services to build up a national picture of what works to deliver better outcomes?

Comments

Outcome 9: The reach of mental health services is improved to give better access to minority and high risk groups and those who might not otherwise access services.

Question 22: How do we ensure that information is used to monitor who is using services and to improve the accessibility of services?

Comments
Require collection of information on 0−2 years age group specifically.

Question 23: How do we disseminate learning about what is important to make services accessible?

Comments

Question 24: In addition to services for older people, developmental disorders and trauma, are there other significant gaps in service provision?

Comments Infant Mental Health.

Outcome 10: Mental health services work well with other services such as learning disability and substance misuse and are integrated in other settings such as prisons, care homes and general medical settings.

Question 25: In addition to the work already in place to support the National Dementia Demonstrator sites and Learning Disability CAMHS, what else do you think we should be doing nationally to support NHS Boards and their key partners to work together to deliver person centred care?

Comments

Question 26: In addition to the proposed work in acute hospitals around people with dementia and the work identified above with female prisoners, are there any other actions that you think should be national priorities over the next 4 years to meet the challenge of providing an integrated approach to mental health service delivery?

Comments
Developing articulated links between CAMHS and Health Visitors (Public Health Nurses) , with same level of priority as articulated links between CAMHS and schools.

Outcome 11: The health and social care workforce has the skills and knowledge to undertake its duties effectively and displays appropriate attitudes and behaviours in their work with service users and carers.

Question 27: How do we support implementation of *Promoting Excellence* across all health and social care settings?

Comments

Question 28: In addition to developing a survey to support NHS Boards' workforce planning around the psychological therapies HEAT target – are there any other surveys that would be helpful at a national level?

Comments

Question 29: What are the other priorities for workforce development and planning over the next 4 years? What is needed to support this?

Comments

Question 30: How do we ensure that we have sustainable training capacity to deliver better access to psychological therapies?

Outcome 12: We know how well the mental health system is functioning on the basis of national and local data on capacity, activity, outputs and outcomes.

Question 31: In addition to the current work to further develop national benchmarking resources, is there anything else we should be doing to enable us to meet this challenge.

Comments

Question 32: What would support services locally in their work to embed clinical outcomes reporting as a routine aspect of care delivery?

Comments

Outcome 13: The process of improvement is supported across all health and social care settings in the knowledge that change is complex and challenging and requires leadership, expertise and investment.

Question 33: Is there any other action that should be prioritised for attention in the next 4 years that would support services to meet this challenge?

Comments
More systematic focus on early intervention in infancy.

Question 34: What specifically needs to happen nationally and locally to ensure we effectively integrate the range of improvement work in mental health?

Comments

Outcome 14: The legal framework promotes and supports a rights based model in respect of the treatment, care and protection of individuals with mental illness, learning disability and personality disorders.

Question 35: How do we ensure that staff are supported so that care and treatment is delivered in line with legislative requirements?

Comments