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NORFOLK PARENT-INFANT MENTAL HEALTH ATTACHMENT PROJECT (PIMHAP)

Working towards integration in attachment, mental health and social care

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Introduction

The Norfolk Parent-Infant Mental Health Attachment Project (PIMHAP) was developed to address the needs of 'at risk' families in keeping with previous innovations within the area of parent-infant mental health both in the United Kingdom and internationally (Galbriath, Balbernie &White, 2015; Hosman, van Doesum & van Santvoort, 2009). This account highlights the need for 'transformational change' at individual, family and structural levels. Of particular importance to the successes of this project has been the shared negotiation of risk and effort to integrate safeguarding and therapeutic tasks. Broadly PIMHAP can be seen as a localised response to the imperative to provide early intervention to 'high-risk' families (Leadsom et al., 2013) with recognition that such work needs to be multidimensional (Galbriath, Balbernie & White, 2015) and in many cases intensive (Sadler et al., 2013).

PIMHAP was commissioned to reduce the number of babies removed from their families, as part of a wider Looked After and Adopted Children (LAAC) reduction scheme. This need within the county was translated into the development of a therapeutic service that would be of direct benefit to families. PIMHAP was made possible by Transformational Challenge funding provided by The Department of Communities and Local Government.

The aim of offering intensive support in the first 1001 days to 'at risk' families was informed by evidence that outcomes are poor for Looked After Children (Dozier et al., 2008); that within the United Kingdom and specifically within

Norfolk there were higher than average rates of children, including infants, taken into care (United Nations, 2009; HM Government: Department for Education, 2015). In addition, a high proportion of families working with the project come from significant disadvantage in communities of heightened inequality (Wilkinson & Pickett, 2010; Rowlingson, 2011). It was proposed that if PIMHAP could increase number of infants safely held within their families there would be measurable benefits in terms of wellbeing and economics.

PIMHAP was commissioned to offer psychiatric, psychotherapeutic and systemic interventions for 45 high-risk families across Norfolk, in addition to providing consultation with their professional network. PIMHAP's inclusion criteria specify significant concerns regarding attachment relationships, parental mental health and safeguarding. PIMHAP operates on the basis that developmental trauma underpins many adult mental health problems in this population. The origins of such trauma in past neglect and abuse, including sexual abuse, are confirmed by the experiences of the parents with whom PIMHAP worked. It was recognised that the majority of parents have significant mental health difficulties but due to the nature of their difficulties many were unable to access adult mental health services.

Of central importance to the success of PIMHAP was the shared vision between children's services and the mental health trust. Senior members of both organisations were involved at inception and throughout implementation. In this respect the transformational element was breaking down some of the barriers between organisations and cultures. Contextually the County Council and the Trust were under scrutiny and used this to change practice (in this respect perhaps mirroring the experience of the families with whom PIMHAP was working). Senior members of the team were asked to join the county council panel that made decisions about packages of 'edge of care' provision and thus had a closer part in decision making and an influence on the way families were discussed by bringing in a more psychologically minded perspective.

Typically, the local authority would commission independent assessments of 'edge of care' families. This sometimes led to decontextualised recommendations that could not reflect knowledge of local services. One advantage of a local therapeutic service is that the assessments PIMHAP completed could better take into account such factors and follow through the interventions. By regularly meeting in local groups the professional network is able to review and develop this understanding which is also informed by the active involvement of families. Further, meeting at specific children's centres in high risk areas enabled families to link in with local groups and provide a step down to known universal services following intervention. Working closely with children's services, some reciprocal understanding occurred through dialogue and use of some procedures implemented by children's services such as 'Signs of Safety' (Turnell, 1998). The method of Signs of Safety, if successfully employed, allows for transparency in managing risk with families, ensuring all views are heard (including the parents) and identifying strengths as well as risks.

The PIMHAP team includes clinical psychologists, assistant psychologists, child and adult psychiatrists, psychotherapists and community mental health practitioners and is underpinned by attachment, psychodynamic and systemic approaches. PIMHAP work is carried on from three bases across the county in wider networks that include link social workers, children's centre leads, specialist midwives and health visitors. From the initial point of referral PIMHAP works to achieve integration across agencies through formulating an appropriate package of support with input from psychotherapy, psychiatry, social care and local children's centres. This multidisciplinary cooperation allows a key feature of the project: the offer of assessment and treatment of both adult mental health difficulties and parent-infant attachment. A referral pathway is shown below.

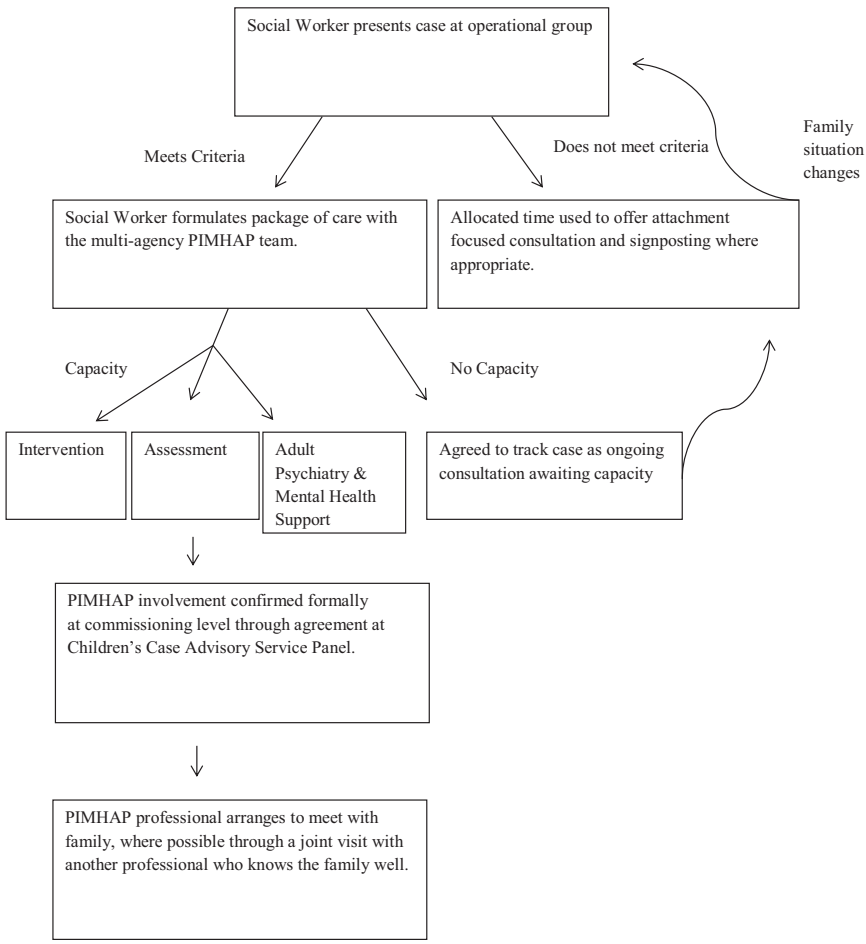

FIGURE 26.1 Referral pathway

Assessment

The use of nuanced assessment approaches that seek to engage the parents enabled the service to formulate a clear understanding of need. Assessments routinely included CARE Index (Crittenden, 2007), a video-based measure of the parent-infant relationship pattern and risk in terms of later difficulties for the infant, and the Meaning of the Child Interview (Grey, 2014) that provided an indication of parental reflective functioning and the way parents represented their infant and their relationships. Alongside the assessment of parental mental health this enabled PIMHAP to gain an understanding of the areas of resource and need to focus upon. For some parents the service was able to ensure a review with a psychiatrist (who would see parents in their homes or community setting) and the allocated worker. Together they were able to provide a developmental context for current difficulties. Appropriate diagnosis and medication at this stage made a significant difference to some parents quite quickly. The very wide range of interventions offered is summarised below.

Intervention	Description
Perinatal Psychiatry Support, including Community Mental Health Support	• Regular appointments with a mental health practitioner and perinatal psychiatrist. • Time given to think about experiences. • Care Co-ordination. • A helpful way to come alongside families who are not ready to engage in a more intensive therapy.
Video Interaction Guidance (VIG)	• A strength based video intervention. • The practitioner edits film for moments that fit a developed 'helping question' and explores it with the parent in the shared review. • VIG specific supervision.
Attachment Focused Therapy	• An individualised combination of play sessions and talking about relationships. • All interventions place a focus on parents' early experiences as a starting point to think about attachment strategies. • Making links between different relationships is intense and long term work. • Aim to promote increased attunement and consistency in the care of infants and to promote parents ability to think reflectively about their experiences.

FIGURE 26.2 Offered interventions

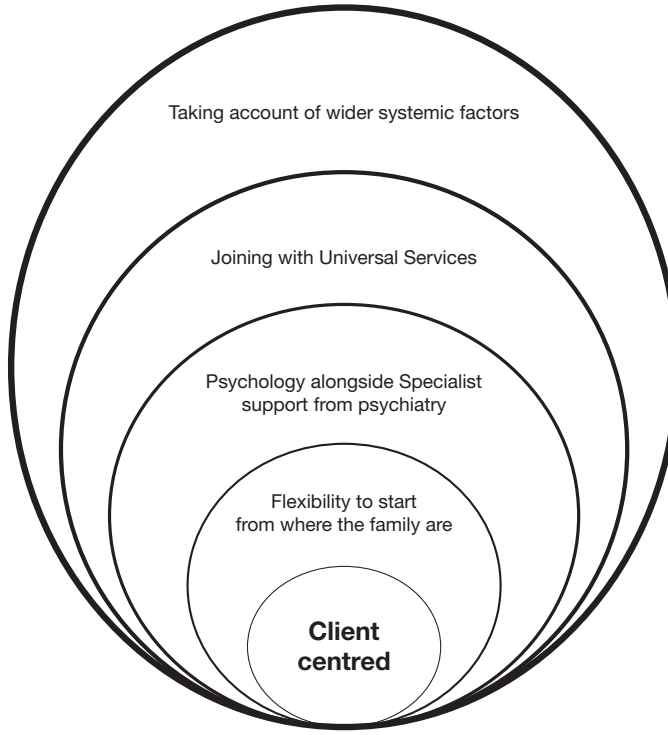

FIGURE 26.3 PIMHAP team's conceptualisation of 'What is distinct'

Relationships

PIMHAP emphasises an outreach working model, aiming to come alongside the families in their homes and in local resources. The relationships established with the families by key professionals are seen as the main vehicle of change. This enables shared understanding and also provides a way in which differences can be recognised and tolerated. There are many instances, particularly in the early phases of engagement, where team members' response to the immediate needs of families helped to establish trust. For people who have no experience of secure attachment or felt safety, an emphasis on forming a relationship is not only the first step but, when working well, is also the safe base to return to after periods of uncertainty, fear and crisis. The threat of removal of their infant into care will often trigger parents' dysfunctional attachment strategies regularly and unpredictably. Maintenance of the therapeutic relationship in these circumstances is an ongoing challenge.

Coming alongside individuals in a way that is neither intrusive nor procedurally 'done to' is a delicate balance. Through team formulation, PIMHAP decide how to intervene at a level the family can tolerate, and review the family's progress regularly. Through engagement, reflection and review, the intervention extends

further than treating a series of traumas, to include the meaning they hold for the parent and their relationship with their infant. As the therapeutic relationship becomes richer there are opportunities to work at more deep-seated levels, working symbolically with more mundane everyday issues, and thus for example opening up the meaning behind household conditions, as opposed to organising support to help clean up.

There is recognition of the importance of self-awareness across professionals' disciplines and a need for reflective supervision which explores the roles of unconscious processes. A weekly reflection group provides an additional space for sharing video work, making links and reflecting on what is evoked in members of the team.

Outcomes

£623,395 was invested in the project. It was hypothesised that PIMHAP would recoup that investment if 33.3 per cent of infants remained safely in the care of their parents. It was calculated that the annual average cost of a Looked After child in Norfolk is £51,000 and on these figures, the annual savings minus the cost of project operation would be £309,605. Data collected in June 2016, show 75 per cent of infants remaining safely in parental care, more than doubling the hypothesised figure for cost saving. Assuming these infants would otherwise have been taken into care, the savings would be considerably higher. However, this calculation fails to acknowledge that while there was a likelihood of infants being taken into care this was not a certainty. Furthermore it must be recognised that while PIMHAP was a central intervention it was most often in combination with other services, notably children's centres.

PIMHAP has achieved a reduction of risk for families, as measured by level of safeguarding through social care structures. The level of safeguarding has reduced for 46 per cent of our families, increased for 26 per cent and remained the same for 27 per cent (one piece of data missing). It is important to hold in mind when interpreting these numbers that interventions sometimes highlight risk thus ensuring infants do not remain in unsafe homes (Barlow et al., 2007).

Infant Outcomes	Frequency	Percentage
Remained with Parents	41	74.5%
With Extended Family	6	10.9%
Foster Placement	5	9.1%
Adoption Plan	2	3.6%
Reunification Plan	1	1.8%

FIGURE 26.4 Infant outcomes

Nature of Removal	Frequency	Percentage
Remained with parents	41	74.5%
Removed before project involved	2	3.6%
Removed during project	9	16.4%
Removed after disengagement	3	5.5%

FIGURE 26.5 Nature of removal

	Referral		Discharge	
Level of Safeguarding	**Frequency**	**Percentage**	**Frequency**	**Percentage**
Section 17	16	29.1	11	20.4
Section 47	35	63.6	10	18.5
Interim Care Order	2	3.6	6	11.1
LAC	1	1.8	2	3.7
Closed to Children's Services	0	0	16	29.5
Foster Care	1	1.8	2	3.6
Kinship Care	0	0	3	5.4
Family Support Plan	0	0	1	1.8
Supported Accommodation	0	0	1	1.8

FIGURE 26.6 Change in safeguarding status

These robust findings indicate the effectiveness of the service and suggest that therapeutic services that closely link in to safeguarding processes and provide interventions that match need can promote infant safety.

The findings using relational and psychological measures are less clear largely due to the difficulties of gathering full sets of pre and postfindings in the context of safeguarding where levels of parental trust are low. In order to build up a therapeutic alliance there was in some cases delay in complete initial assessment meaning that change had already started with some families. In other cases there may have been with self-report questionnaires a degree of 'false positive' responses as either parents were wary of being open within a safeguarding context or due to their own defensive strategies lacking, into the level of difficulties.

Challenges

While PIMHAP is relationally focused, the child protection mandate is focused upon the child. At times social work colleagues have experienced the service as advocating for the parent and underestimating the risks for the infant. This is recognised as important although the service maintains that the needs of the infant are dependent upon the needs of the parent. Often the team is able, through close dialogue with social workers and parents, to have enough shared understanding to safely manage these differences but there have been occasions where differences are not reconciled. Observations suggest that the further cases are down the 'legal route', with associated truncated time scales, the less possible it is to work therapeutically.

Conversely because PIMHAP provides thorough assessments there have been occasions where PIMHAP has identified a higher level of risk (in attachment terms) than social work colleagues. For the infant this can potentially be helpful particularly where there are indications of compulsivity (inhibited need) that aren't evident. However it has meant that at times the role in amplifying concern has prevented PIMHAP from engaging with families therapeutically.

PIMHAP conceptualises intervention through an ongoing commitment to integration at individual, parent-infant and structural levels. That is, to respond to the lack of psychic integration in people who have experienced developmental trauma, to the lack of integration within relationships and lack of integration in terms of service delivery and the wider community. It is through an acknowledgement of the fragmentation at all levels that there is an opportunity to move away from a procedural-based care and towards a process of need based upon some degree of shared understanding. Linked to this is the role of 'epistemic trust' (Fonagy et al., 2014) in the process of change within a safeguarding context.

It is not possible to identify a case that is fully representative of the work since families and needs are complex and varied. However the case outlined below illustrates some key features.

Sara, Henry, Summer age 5 and Mia 18 months, were referred into PIMHAP by their local children's centre. Summer and Mia were made subject to a child protection plan. Sara and Henry had difficulty in being available for their children or each other, being preoccupied with their own unmet mental health needs.

Combined with initial reluctance towards professional help, this resulted in concerns around neglect and a hypothesis that the family were often 'alone together'. There were also concerns about Summer's low school attendance and her aggression towards staff and other children, and about Mia's attempts to meet her attachment needs through indiscriminate affection towards less known adults.

Sara and Henry met with PIMHAP's consultant adult psychiatrist. For Henry, a diagnosis was given of complex post-traumatic stress disorder, through a combination of developmental trauma, including a period of time spent in the military. Sara spoke about her experiences of low mood, and times of irritability alongside periods of feeling disconnected and 'spaced out'. Both parents were prescribed medication for their mental health, under regular review.

The parents' individual needs were also understood through developmental history taking. Both Sara and Henry engaged with The Meaning of The Child Interview (Grey, 2014) and spoke about difficult childhood experiences, characterised by a combination of punitive and unresponsive caregiving. Themes for Sara and Henry were fathers who were punishing and controlling and mothers who were often unable to be protective. Sara spoke about past relationships characterised by domestic violence. Henry discussed struggling with what he had witnessed in the army as well a difficult separation from his ex-wife and from his son. The PIMHAP team developed a formulation using the Dynamic Maturational Model of Attachment (Crittenden, 2005) that both Sara and Henry had developed high 'A type' attachment strategies, where cognition held dominance over affect. These strategies had been important in promoting safety historically; however difficulties integrating cognition and affect were impacting on their current relationships. The intervention began here for Sara and Henry on the basis that once parent(s) have capacity for more reflective functioning and safe integration of the self they are better able to understand the needs of their child. Therefore offering responsive adult psychiatry time is an essential step in recognising and supporting parental need, so that ultimately PIMHAP support the needs of parent-infant relationships.

PIMHAP addressed relational integration through attachment therapy. While there were challenges facilitating moments of connection at home, the sensory room at the family's local children's centre offered containment and opportunities for playful states to emerge. The team shared moments of sensitivity using the language of The Circle of Security (Powell et al., 2013). Providing Sara and Henry with time in sessions to talk about their feelings enabled them to provide more opportunities for connection with Summer and Mia. In time more integrated parental roles developed, whereas historically Sara would have provided more comfort and gentle play and Henry provided boundaries. Mia and Summer showed us that they could move flexibly between their parents for their comfort and exploratory needs. Over time the team observed that the parents' ability to regulate themselves enabled them to watch over the girls in a way which supported Summer's regulation in play and enabled Mia to emerge as expressive and appropriately demanding. A strength for Sara and Henry was their creative and humorous use of language. This emerged as an opportunity to develop a joint 'playfulness in thought' in order to make sense of different issues, and allowing feelings to have an increased awareness in sessions.

PIMHAP observed fragmentation in the professional system, characterised by contrasting interpretations of safety, need and progress. There have been opportunities for celebrating successes and communicating about concerns in sensitive ways, although it has felt difficult to join these up. Firm position-holding impacted on the ability for the group to think about issues in nuanced ways. Sara and Henry's role with the professional system seems at times to be defined around defending and rationalising pre-existing points of discussion. During periods of increased anxiety or uncertainty opportunities for collaboration and the group meeting in open adult states were diminished, as Sara and Henry respond in child-like ways, to excuse themselves or to make promises which they often cannot achieve, as if

in relation to a powerful or parental other. As work progressed, however, there have been times where the parents have been able to advocate. They have raised concerns about the professional system, for example the impact of the child protection process on their sense of intimacy as a family and their freedom to express feelings. Henry has spoken about times when he has felt disempowered by the system as well as times when he has felt pressurised and 'cornered'. Recently Sara and Henry have expressed a wish for further collaborative thinking, suggesting that responsibilities for decisions should be shared.

Structural intervention represents further integration through facilitating capacity to think more flexibly about the complexity of the system. This in turn allows a more relational understanding, the beginning of making sense of roles as professionals and individuals in relation to a case. Integration is key at this level because it is in part through jointly holding a worry and thinking together about the ranging implications of a specific constellation of risk, that there is opportunity for openness and curiosity. This can be understood as a series of dialogues, enabling opportunity to share different perspectives across individuals, theoretical perspectives, organisations and professional accountability. From a psychological perspective, this can be understood as a decrease in vigilance and an increase in mentalising and trust across systems brought about through the therapeutic relationship (Fomagy et al., 2014).

Conclusion

PIMHAP attempted to address the needs of 'high-risk' families. The outcomes of PIMHAP were positive enough for the County Council to commit to ongoing funding.

Key features of its success are the intensity of the work influenced by the specific needs of families within particular communities, and the attempt to integrate the needs of parents and infants. Perhaps most distinctive is the collaborative nature of the project as outcomes for infants are not just due to the resources and difficulties 'within' individuals and families but also influenced by the services available and the way systems communicate with one another. The challenge of providing effective services and maintaining dialogues at all levels is ongoing and PIMHAP remain hopeful to continue with them in order to better serve parents and infants.

This project highlights the need for further development in the following areas:

- seamless access to integrated, accessible care for a wider range of parents and infants,
- perinatal services aspiring to interagency integration in service delivery for parents and infants,
- long-term follow-up comparison studies of high-risk infants who remain with their parents or are removed,
- emphasis on outreach approaches with higly vulnerable families.

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