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The Association of Child Psychotherapists' response to the Health and Social Care Committee Inquiry into the First 1000 Days of Life

About the ACP

The Association of Child Psychotherapists (ACP) is the professional body for Psychoanalytic Child and Adolescent Psychotherapists in the UK. Child and adolescent psychotherapy is a core NHS profession with members completing a four year full-time training in NHS child and adolescent mental health services. This includes extended training in infant observation and child development. This enables them to develop high level competencies and to provide specialist psychotherapy across a range of settings to some of the most vulnerable infants, children and young people in society. Psychoanalytic Child and Adolescent Psychotherapists have a key role in supporting other professionals who work with infants, children and young people, and their families, across the health, care, education and justice sectors. The ACP is responsible for regulating the training and practice standards of child and adolescent psychotherapy and is an accredited registered of the Professional Standards Authority (PSA).

Publication and Queries

We are content for our response, as well as our name and address, to be made public. We are also content for the committee to contact us in the future in relation to this inquiry.

Please direct all queries to:-

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Health and Social Care Committee Inquiry into the First 1000 Days of Life

SUMMARY OF ACP RECOMMENDATIONS

ACP recommendations in relation to national strategy and spending

1. There is need for the development and implementation of a national strategy from conception to age 2 that enables joined-up strategy and investment, both across Whitehall and at a local level. This should encompass universal services for all families but, crucially, recognise the need for specialist services appropriate to the complex challenges faced in providing services to the most vulnerable families.
2. There should be greater recognition and investment in the highly specialist workforce that is required to assess and treat emotional and mental health difficulties in parents and infant, as well as their role in training, supervising and support those working in universal services.

ACP recommendations for a high-quality evidence-based approach to service provision for the first 1000 days of life

1. All CAMHS should include specialist provision for the early years of life including parent-infant psychotherapy and support for staff in universal services working with families and carers of infants. The competence framework for child and adolescent psychoanalytic psychotherapists developed by the ACP is a starting point for such services.
2. CAMHS resources should include specialists with appropriate training and expertise such as child psychotherapists to provide training, consultation and supervision to professionals and practitioners in children's centres, early years services, primary care and third sector to improve early identification, early intervention and development of integrated multi-agency care pathways
3. The funding of perinatal mental health services by the government should be expanded to include parent-infant psychotherapy or other proven service models that address the needs of infants and young children whose parents are experiencing moderate to severe mental difficulties in the perinatal period.
4. Adult psychiatric services that are expanding mother and baby units and community perinatal mental health teams should ensure that their workforce is equipped with training in child development and parent-infant relationships and have competence to understand the emotional state and needs of the infant.
5. Better integration of adult perinatal mental health services with CAMHS and the inclusion of child psychotherapists and parent-infant psychotherapists within dedicated perinatal mental health teams
6. Dedicated provision for young parents, especially those who have been looked-after in childhood, to try and interrupt the transgenerational transmission of severe attachment difficulties
7. The expansion of specialist perinatal and infant mental health Health Visitor posts and Specialist Perinatal Midwives in all maternity services
8. Acton to increase understanding that the needs of the infant as a unique individual need to be recognised and any sign of withdrawal or delay addressed as quickly as possible.

ACP RESPONSE TO QUESTIONS RAISED BY THE INQUIRY INTO THE FIRST 1000 DAYS OF LIFE

1. Support for the aims of the inquiry

1.1. Recognition of significance of adverse early experiences and opportunities to address them

The ACP welcomes the Health and Social Care Committee inquiry into the First 1000 Days of Life. As frontline clinicians, working across health and social care, ACP child psychotherapists have always recognised and understood the central importance of the early years of a child's life, from conception to age 2, as being vital to their ongoing physical, mental and emotional health and development. We have been encouraged that, in recent years, the importance of the first 1001 critical days, and the impact of adverse experiences during that period, have been increasingly recognised both by national policy makers and local service commissioners and providers. Yet, as the committee acknowledges, there is still much work to be done and still significant harm occurring during these critical days that has far reaching and serious outcomes for individual children, their families and for us as a society. As the terms of reference for the inquiry note, preventing these adverse childhood experiences could reduce hard drug use by 59%, incarceration by 53%, violence by 51% and unplanned teen pregnancies by 38%.

The evidence for the crucial importance of the period from conception to age 2, and thus the need to provide effective services that ensure the wellbeing of the child and family during this period, is well known and has been described in many publications and reports. We would particularly refer to the evidence gathered together in the volume edited by Penelope Leach[1].

1.2 Focus on specialist expertise to reduce harm and support positive developmental

The ACP's response draws on our detailed understanding of the factors that may promote or hinder healthy child development, our intensive training in infant observation, and also from our experience as frontline clinicians of what high quality services in the early years should look like. The focus of the response is on what is needed in terms of specialist expertise and interventions to prevent and reduce harm or to support a return to a more positive developmental trajectory. This is in the context of an understanding that investment and development is required across a range of universal and targeted services, to which child psychotherapists and other specialist clinicians are able to make a contribution. Examples of such work are provided in Appendix 2.

2. National Strategy and Spending

2.1 The vital importance of joined-up policy in the first 1001 days

The inquiry asks questions about national strategy, current spending and barriers to investment. The ACP wishes to emphasise the point that, perhaps more so than in any other area of public policy, joined-up planning and investment is especially important, but also equally challenging, in the early years. The determinants of good child development are complex, multiple and cut-across many individual, relational and social factors. There are therefore potentially multiple divisions and splits through which policy-making and investment focused on the baby's wellbeing and the parent-infant relationship can fall. Individual services may focus on the needs of the mother, or perhaps the parental couple, others may focus on the needs of the infant, but these are often not brought together. Similarly, some

[1] Leach, P. (Ed.) (2017). 'Transforming Infant Wellbeing: Research, Policy and Practice for the First 1001 Critical Day', Routledge.

services might focus on physical health needs, some on emotional and mental health needs (of mother or child but rarely both simultaneously) and others on social and economic circumstances. Because these factors are all connected and inter-related, focusing on one risks losing sight of the whole. This means that some problems and opportunities will be 'invisible' if they do not fit with the remit of the service.

Problems of invisibility
For example, a member who works as a volunteer for a charity (offering six sessions of subsidised work for children and families to try and avoid worsening problems having to go to over-loaded CAMHS) spoke to a local GP surgery to explain the sorts of referrals with which they could help by offering parent-infant work. She reports being 'very shocked' to learn that many GPs no longer see their mothers-to-be or their mothers and babies post-delivery where they could spot difficulties of this type. Their care is separated off under health visiting but there is no liaison with GP's. Her view was that health visitors might not notice these issues in the way a GP might because they are overloaded with severe safeguarding work.

2.2. The vital importance of joined-up service delivery in the first 1001 days

No one organisation takes responsibility or ownership of the whole situation as it relates to parent-infant development within its social context. As such, resources are potentially wasted in not taking opportunities for addressing the needs of the family in a co-ordinated manner. Individual services may make decisions that make sense in a narrow context but not when considered in relation to their wider impact, such as the long-term impact of cuts in health visiting or Children's Centres. A truly joined-up system that understood the likely outcomes of these cuts, both in terms of their impact on individual families and on the socio-economic costs to this generation and beyond, would never have made such a decision.

2.3 Impact of the loss of Children's Centres

Specifically in relation to Children's Centres, the ACP wishes to highlight our members' experience that cuts have seriously affected the availability and accessibility of preventative universal services as well as targeted services delivered from them. For mental health services in the community this has serious consequences in terms of acceptability, engagement and delivering services in a non-stigmatising environment. Cuts have also reversed the progress that had been made since the expansion in Children's Centres in relation to social isolation, take up of universal parenting programmes and in providing access to more specialist services such as those provided by child psychotherapists.

Impact of loss of children's centres on specialist care
In one London borough, the number of children's centres was reduced from 11 to 3 'hubs' between 2015 - 17. This meant that a local parent-infant psychotherapy service that had been delivering therapy to families across the borough was unable to provide this within reasonable distance of people's homes. This created further obstacles to engagement and stretched family budgets with additional transport costs.

This is just one example of how changes to a universal community service have knock-on effects for specialist mental health services and thus adverse consequences for those children and families who are most in need and have the most complex difficulties. Our ongoing experience is that it is often those families with the most complex and hard to address needs, who require specialist, possibly intensive or long-term support, who are repeatedly failed in local service 'transformations'.

3. ACP recommendations in relation to national strategy and spending

1. There is need for the development and implementation of a national strategy from conception to age 2 that enables joined-up strategy and investment, both across Whitehall and at a local level. This should encompass universal services for all families but, crucially, recognise the need for specialist services appropriate to the complex challenges faced in providing services to the most vulnerable families.
2. There should be greater recognition and investment in the highly specialist workforce that is required to assess and treat emotional and mental health difficulties in parents and infant, as well as their role in training, supervising and support those working in universal services.

4. Local provision: barriers and concerns

The scope, scale and current performance of provision for First 1000 Days of life, including universal and targeted approaches.
Barriers to delivery (e.g. workforce shortages, financial constraints on councils)

In this section we raise some key issues about local delivery that impact on the provision of effective services.

4.1 Child psychotherapists' role in infant mental health services

ACP registered child psychotherapists, with their in-depth training in early social and emotional life, and in infant observation, are key professionals in the multi-disciplinary early years field, both in terms of direct work with infants and families, and in training, supervising and consulting to a wide range of professionals and agencies in health, social care and the third sector. Undertaking sustained and intensive work with infants and parents continues to be a major element of child psychotherapy training. All child psychotherapists at the point of qualification will have the ability to offer either psychoanalytically informed perinatal and parent-infant work, family work or group work[2]. This is a core element of the competence framework for child and adolescent psychoanalytic psychotherapists developed by the ACP[3].

4.2 Impact of the loss of under-5s provision in CAMHS

However, the last decade of cuts and down-banding in CAMHS and other settings which employ child psychotherapists has hit the profession and has impacted on our ability to provide the direct work, training and consultation which used to be possible. We refer the inquiry to our recent report 'Silent Catastrophe: responding to the danger signs of children and young people's mental health services in trouble'[4]. This demonstrates that the downsizing and re-design of many services has led to a loss of clinical leadership and specialist services and a shift towards more crisis-led and short-term interventions, primarily with adolescents. This often diverts resources from early intervention, infant and under-5s services. In the survey which informs the report, ACP members describe services having very little capacity to undertake in-depth work with children who have been traumatised or abused and often no early intervention with infants and under-fives. One case study in the report states:

[2] The specific competences that are developed during the training in relation to psychoanalytically informed perinatal and parent-infant work are listed in Appendix 1 to this submission.
[3] https://childpsychotherapy.org.uk/competence-map-child-and-adolescent-psychoanalytic-psychotherapists-point-qualification
[4] https://childpsychotherapy.org.uk/news/acp-report-silent-catastrophe

Case Study: loss of under-5s CAMHS
Senior staff are not able to work to their competencies to meet the needs of CYP referred to the service. For example, the Trust has stopped all work with under-5s. A senior CAPt has a long-standing supervision relationships with health visitors dealing with some very severe needs. When they have done all they can and need additional support they try to refer to CAMHS but are told that this isn't necessary. The children need specialist intervention, are often in care, and exhibiting very difficult behaviour. The understanding of child development and mental health in the system has deteriorated.

4.3 The adult psychiatry focus of perinatal mental health service investment

The government's recent investment in NHS perinatal mental health services[5] is to be welcomed. However, NHS England has stipulated that this is earmarked for adult psychiatric services to expand mother and baby units and create community perinatal mental health teams in more parts of the country, but not for parent-infant psychotherapy or other services that address the needs of infants and young children whose parents are experiencing moderate to severe mental difficulties in the perinatal period. This means that provision is still very patchy and inadequate. PIP UK[6] is one organization that is trying to address this and child psychotherapists are well represented in most PIP UK teams, and its work is strongly influenced by a psychoanalytic understanding of child development. In many areas there is no dedicated PIP provision or other models of effective early intervention. These gaps mean that parents and infants in most parts of the country do not have access to services that can address relational/attachment and developmental difficulties at an early stage, as well as providing training and consultation to professionals and practitioners in primary care, early years services and adult mental health teams. These difficulties are often associated with parental mental ill health, domestic abuse or substance abuse; and prematurity, disability and physical illness in infants.

4.3 Lack of attention to the needs of the infant in perinatal mental health services

An additional concern about the focusing of perinatal resources in adult service providers is that they primarily attend to the mental health of the mother, with less attention given to the emotional state and needs of the infant. Help focused on the mother is to be welcomed, but the need of the baby in the first 1001 days is urgent: what is needed is an approach that treats the mother and baby in relation to one another, recognizing and responding to developmental difficulties that might be emerging in the baby as well as working with the mother in relation to her difficulties; and that treats the mother and baby in the context of their family, community and other agencies – a approach that is at the heart of good CAMH services. Child psychotherapists consider the health of the mother and baby in relation to each other, as a dyad, and not in isolation.

As such, the input of child psychotherapists into mother and baby units can help provide training and consultation to members of staff whose training in child development and parent-infant attachment may be limited. The ACP is concerned that few of the people working in perinatal services have specialist training in infant and child development, or in understanding attachment relationships, and as such this aspect of the work is likely to be undervalued, to the detriment of the mother-infant relationship and hence the baby's wellbeing. It is known that the majority of costs (72%, see Bauer et

[5] https://www.england.nhs.uk/mental-health/perinatal/
[6] https://www.pipuk.org.uk/

al., 2014[7]) arising from maternal depression relate to adverse outcomes in respect of the child, rather than the mother.

4.4 Competency in recognizing the needs of the infant

'The Competency Framework for Professionals working with Women who have Mental Health Problems in the Perinatal Period'[8] was commissioned by Health Education England (HEE) from the Tavistock & Portman NHS Foundation Trust. This document was produced by an expert reference group which included an experienced child psychotherapist. The framework is underpinned by an idea of there being a "perinatal state of mind" which should be common across the workforce. The three elements are identified as the Mother, the Baby and the Mother-Baby Couple.

At the acute end of perinatal services for seriously ill mothers, adult psychiatry is clearly a priority. We have already mentioned the contribution child psychotherapists can make to the wellbeing of the parent- infant couple (also including fathers/family). In our view, the particular needs of the infant can sometimes be overlooked if there are serious concerns about a mother's state of mind. This is troubling to child psychotherapists who are trained in infant observation and who recognise that babies need "live company" from the outset in order to engage with the world of relationships; to play and to learn. Child psychotherapists are very well placed to identify early signs of emotional withdrawal and developmental delay. This kind of lively interaction may be offered by father, other family members, friends, voluntary bodies etc. It does not necessarily mean another drain on statutory services, but the danger does need to be recognised.

5. Local provision: what child psychotherapists contribute to high-quality services

What a high-quality evidence-based approach to service provision would look like for the First 1000 Days of life.

In response to this inquiry the ACP has gathered examples from around the country of the many ways in which child psychotherapists are contributing to effective services in the first 1001 days. These examples are provided in Appendix 2 and cover the full range of provision in many different types of service.

In this section of the response we describe just some of the ways in which child psychotherapists can help children and families in the first 1001 days of life.

5.1 Provision of specialist assessments

During the perinatal period and the early years of a child's life brief therapeutic interventions are often highly effective and can reduce the likelihood of problems becoming chronic, and far more difficult and expensive to address. A specialist assessment by a child psychotherapist will explore the issues that may contribute to the presenting symptoms in the infant, and the parent's thoughts and feelings about their relationship with their baby in the context of wider family relationships. Experiences in the parents' own childhood which resurface in the transition to parenthood can seriously disrupt the process of bonding with the baby. Specialist training in the establishment of a baby's early relationship

[7] Annette Bauer, Michael Parsonage, Martin Knapp, Valentina Iemmi & Bayo Adelaja. (2014). The costs of perinatal mental health problems: Report summary, Centre for Mental Health and London School of Economics.
[8] https://www.hee.nhs.uk/our-work/mental-health/perinatal-mental-health/competency-framework-perinatal-mental-health

with its parents and how this contributes to subsequent development equips child psychotherapists to identify and understand these kinds of difficulties and to think with the family about the kind of intervention which is likely to be helpful for them.

Case example: Beatrice[9]
Beatrice is a young mother who was referred with her four-week-old baby Leone to the Parent Infant Psychotherapy project in a CAMH Service. Beatrice had disclosed to her perinatal psychiatrist that she did not love her baby. She suffered from severe depression throughout her pregnancy and since the baby's birth was expressing suicidal thoughts and described herself as 'a very bad mother'. She found Leone's crying very hard to bear. She and Leone were seen for weekly sessions and sometimes Leone's father, Orson, also attended. During the sessions Beatrice was able to explore her experience of feeling unloved and abused by her own mother, which has in turn, coloured her own parenting. She was helped to observe her baby and think about what she might be communicating. Beatrice and her partner had time to reflect on the changes in their relationship since Leone came along. Gradually Beatrice grew in confidence and found that she was able to respond more readily to her baby. Leone in turn became less fretful and began sleeping better at night. After only six sessions Beatrice said: "I love looking after her now. I never thought I'd feel like this. I want to have the kind of relationship with Leone that I never had with my own mum."

5.2 Provision of therapeutic interventions

Child psychotherapists working with the under-fives use a variety of approaches for which there is a growing evidence base[10],[11]. Interventions typically involve the baby or young child as a crucial partner in the therapeutic work and both parents are encouraged to participate in sessions whenever possible. Mothers and fathers have the opportunity to talk over their thoughts and feelings about the pregnancy, labour and the developing relationship with the baby. They are helped to make links between the developing relationship with their child and their own experience of being parented. This is because, in the context of the intense feelings and vulnerability felt by parents of new-borns, aspects of past relationships are often unconsciously rekindled and have a way of repeating themselves, despite parents' conscious wishes to do things differently and better with their own children. Exploring the relationship between the parents and extended family is also crucial to understanding and modifying difficulties between parent and infant. This may relieve distressing symptoms in the infant and enable a shift in the parent-infant relationship which can then take a different developmental path. One of the many strengths of such work is the rapid pace of change that is possible in the early stages of a baby or young child's life. While some cases will need weekly work over an extended period of time, these tend to be in the minority and many families will benefit significantly from a relatively brief intervention and/or an intervention which does not require weekly appointments after the initial phase of engagement and assessment.

5.3 Work with young parents who are/have been looked after

Child psychotherapists have a particularly important role in working with the complexity of young parents who themselves are looked after or adopted, and with vulnerable, traumatised and

[9] The case studies included in this submission are fully anonymous and appropriate permissions were gained at the time they were produced.
[10] Barlow, J. et al, (2010) Health-Led Interventions in the Early Years to enhance Infant and Maternal Mental health: A Review of Reviews'. Child and Adolescent Mental Health, Vol 15, (4) 178 -185.
[11] Nick Midgley, Sally O'Keeffe, Lorna French & Eilis Kennedy. (2017). 'Psychodynamic psychotherapy for children and adolescents: an updated narrative review of the evidence base', Journal of Child Psychotherapy 43 (3) pp. 307-329.

abused parents more generally, and their babies. In addition to infant/parent psychotherapeutic work, including work being undertaken in residential children's homes, a key part of the child psychotherapist's role can be representing the rights and needs of the infant and infant/parent relationship to other professionals, such as in relation to safeguarding processes. The training of child psychotherapists provides an in-depth knowledge of child development and the needs of the infant, enabling them to recognise and advocate the needs of babies and parents in these complex situations.

5.4 Consultation and training

As well as direct work with the infant and family, child psychotherapists have an important role in providing consultation and training to other professionals working in primary care, Children's Centres and Early Years settings. Through this work they help professionals involved with the family gain insight into the child's view of the world and what the child's behavioural symptoms may reveal about underlying anxieties. These ways of disseminating the understanding gained from the in-depth training of the child psychotherapy profession help to build the capacity of the children's workforce to understand and respond to the mental health needs of infants, young children and their families and to identify those families who will need referral to Specialist Child and Adolescent Mental Health Services.

Case example: Ahmed
Ahmed is 18 months old. The health visitor (HV) asked for a consultation with the child psychotherapist because Ahmed screamed if he felt his mother was too far away and physically need to firmly grip her at all times, even during the night. The HV relayed that the parents are refugees from a war-torn country with no extended family. The father worked long hours away from home. The mother said she became pregnant here because she was lonely. The child psychotherapist explored with the HV what the child's behaviour meant for this mother. The little boy was frightened that his mother would disappear out of his reach, despite his mother's constant reassurance. Through discussion they understood this little boy's need to physically hold on to his mother might be linked with his mother's own depression at the loss of her country and family which meant that she was not emotionally available for him. The HV was then able to attend to the mother's loneliness and depression and helped the parents to come together as a parental couple and support each other. This enabled the parents to feel better about separation, and the mother became more responsive to Ahmed who then became less clingy. The parents were then able move Ahmed into his own cot.

Many child psychotherapists are actively involved in providing supervision, training and CPD for the wider perinatal workforce. This work ranges from University validated, postgraduate programmes in infant observation and Infant Mental Health to the delivery of brief courses and CPD. One current example is the planning and delivery of Action Learning Sets for Perinatal Champions, commissioned through the Tavistock and Portman NHS FT.

6. The ACP's recommendations for a high-quality evidence-based approach to service provision for the first 1000 days of life

1. All CAMHS should include specialist provision for the early years of life including parent-infant psychotherapy and support for staff in universal services working with families and carers of infants. The competence framework for child and adolescent psychoanalytic psychotherapists developed by the ACP is a starting point for such services.
2. CAMHS resources should include specialists with appropriate training and expertise such as child psychotherapists to provide training, consultation and supervision to professionals and

practitioners in children's centres, early years services, primary care and third sector to improve early identification, early intervention and development of integrated multi-agency care pathways

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4. Adult psychiatric services that are expanding mother and baby units and community perinatal mental health teams should ensure that their workforce is equipped with training in child development and parent-infant relationships and have competence to understand the emotional state and needs of the infant.
5. Better integration of adult perinatal mental health services with CAMHS and the inclusion of child psychotherapists and parent-infant psychotherapists within dedicated perinatal mental health teams
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7. The expansion of specialist perinatal and infant mental health Health Visitor posts and Specialist Perinatal Midwives in all maternity services
8. Acton to increase understanding that the needs of the infant as a unique individual need to be recognised and any sign of withdrawal or delay addressed as quickly as possible.