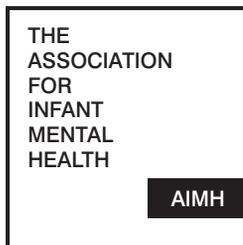


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Infant Mental Health Competencies Framework

(Pregnancy to 2 years)



Infant mental health

Infant mental health (IMH) refers to the developing capacity of the child from birth to form close relationships, manage and express emotions, and explore the environment and learn (Osofsky & Thomas, Zero to Three, 2012). The capacity for self-regulation develops when parent/s/caregivers provide patterns of care that have been shown to be growth promoting (e.g. sensitivity; attuned and contingent interaction; marked mirroring etc). Infant mental health problems occur within the context of a parent-infant/care-giver-infant relationship.

The emphasis in infant mental health is the promotion of infant social and emotional well-being and the prevention of mental health problems, as well as therapeutic intervention. The practice of infant mental health is not exclusively therapeutic; the promotion of social and emotional well-being in infancy and the prevention of mental health problems are as relevant as treatment and intervention (Weatherson., 2000).

Infant mental health is a multi-disciplinary field and involves practitioners from different disciplines collaborating effectively across teams and networks. Although some infant mental health services and programmes are provided by specialist

Infant mental health continued...

mental health professionals and target clinically referred populations, others are delivered in universal health, education or social care settings and are available to the broader population. Therefore, the remit of infant mental health competencies is more wide-reaching than for many other competency frameworks. The IMH competency framework reflects this, and is structured to include competencies for practitioners working with families with wide-ranging needs related to infant mental health.

About this framework

Competencies are the skills, knowledge and behaviours that enable practitioners to deliver high quality care and the continuous improvement of services. This competency framework has been developed for all staff working with infants and their parent/s/caregivers from pregnancy to the second year of life, to support parent/s/caregiver to promote healthy infant development. It is informed by research, theory and evidence-based practice, and designed to raise standards of care for families by supporting all staff to optimize their learning and skills.

It has been developed to standardize competencies for infant mental health practice. This will help to ensure the workforce is suitably skilled to identify need and deliver care to parent/s/caregiver who are pregnant or have a baby, and to both promote the mental health of the baby and provide access to appropriate evidence-based treatment where there are problems, as outlined in the Healthy Child Programme (DH, 2009; 2014).

The IMH competency framework (IMHCF) lists a number of competencies over three levels. The three levels distinguish between (1) general knowledge and skills, (2) advanced knowledge and skills, and (3) the knowledge and skills required to supervise and manage. Thus, for example, if you are working as an early year's practitioner you would be aiming to achieve the competencies at Level 1; whereas nursery managers or those in supervisory roles would be expected to achieve a higher level of competency. If you are a medic, health visitor, midwife or social worker you would be expected to be achieving the competencies at Level 2. Specialist practitioners such as parent-infant psychotherapists and specialist health visitors should be working at Level 3.

Self-assessment against the IMHCF

The IMHCF will help you identify whether you have acquired the range of skills and knowledge necessary to work effectively with parent/s/caregivers and babies at your practice level, and identify gaps and areas in which further training is needed. Self-assessment grids are provided for each level. Practitioners should use the grids to record if they have “achieved” a competence or are “working towards” it. An “evidence” box has been included to record examples of your IMH practice as required.

1.

Level 1

Level 1, requires the practitioner to have an understanding of the knowledge base related to each individual competence. Many of the competencies refer to the ability to use this knowledge to identify possible problems and discuss with appropriate colleagues as required. Some competencies will identify specific ability/skills you are required to demonstrate for the competency. An example of this is competency 1.07. This competency expects you to have “Knowledge of the importance of recognizing infant verbal and non-verbal behaviour as communication.”

This competency then states that you should also have the:
“Ability to use the above knowledge to observe, understand and communicate effectively with infants”.

When you have completed self-assessing your practice level against the IMHCF you will have identified your strengths and weaknesses related to your IMH practice, and understand the specific areas in which you need to extend your knowledge, understanding and skills. These IMH learning goals can be shared with your employer (i.e. at your yearly appraisal to support your continuous professional development in IMH).

2.

Level 2

It is expected that practitioners should be competent at all Level 1 content before progressing to Level 2. At Level 2 you will be expected to know the knowledge base of each competence and have the ability to apply this knowledge to your professional practice. You will need to be competent in the specific skills identified in the IMHCF. Practitioners at Level 2 will be expected to train/support and supervise practitioners at Level 1.

3. Level 3

It is expected that practitioners should be competent at Level 1 & 2 competencies before progressing to Level 3. At Level 3 practitioners will need to have the knowledge base, be able to apply it and supervise and manage. These practitioners will be specialist mental health practitioners and will be expected to inform the provision of therapeutic services, train/support and supervise other practitioners, and contribute to the development of services locally.

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Please note that the IMHCF does not supersede your core professional competencies but should be used alongside them. Standard competencies around information governance, safeguarding, managing risk, equality and diversity, communication and professional standards may not be repeated here, but are crucial to effective infant mental health work. Furthermore, professional groups may have additional specific competency sets that are not covered in this framework and this document should be used alongside them.

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The core infant mental health competency

The core infant mental health competency required by practitioners is an ability to hold an “infant mental health frame of mind”. This refers to the capacity of staff working with parents and babies to be able to maintain the perspective not only of the parent but also that of the baby, to be able to use observations in order to imagine Practitioners need a capacity to maintain a focus on the parent-infant relationship as a dynamic system, and to be able to apply interventions flexibly in-line with the strengths, vulnerabilities and wider social context of each infant, parent and family. The seven domains in this framework define the key aspects of working that are part of this mind-set. To support you to begin to focus your “infant mental health frame of mind” the following key terms have been included to aid understanding of infant mental health concepts pertinent to the competencies.

Key Terms

Agency

The infant's sense that they are able to influence events and situations.

Attachment

The primary affective relationship between parent and infant that is structured, initially experienced, and encoded at a bodily level and becomes structured through development as internal templates of expectations in relationships (Internal Working Models).

Attunement

The cross-modal sharing of positive emotional states. Parents are not attuned to their infants all of the time. It is through the healthy "ruptures" and "repairs" to attunement that learning about interaction and the regulation of emotions takes place.

Bonding

The process of intense emotional connection that takes place between a mother/father/carer and a baby.

Contingent responsivity

The provision by the caretaking adult of a response that corresponds to the baby's specific emotions and needs, such that the baby has an experience of being recognised, effective and safe. The baby's experience of control over his environment, through eliciting a contingent response, can serve to regulate emotional arousal. This is why responding contingently (sensitively) appears often to sooth the infant.

Disorganised attachment

A category of attachment, which describes the absence of a coherent strategy for dealing with anxiety provoking situations relating to attachment relationships. Disorganised attachment appears to develop out of situations where the infant/child has been exposed to specific forms of distorted parenting and unusual caregiving behaviours that are "atypical", e.g. frightening, frightened, hostile, dissociated, sexualized. Such atypical parenting is thought to be associated with unresolved trauma and overwhelming negative affect in the parent's history.

Dyad

Mother and infant or father and infant as a unit.

Ecological context of parenting

Parenting takes place within a multiplicity of contexts, such as familial, cultural, socio-economic, legal. These different environmental systems influence the way the parent/s believe they should parent and their parenting behaviours and, thus, the development of the baby.

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Emotional regulation and dysregulation

The process by which the levels of positive and negative emotions are kept within manageable bounds, so that they are registered but not experienced as overwhelming. The regulation of the baby's emotions is co-constructed by parent and baby, through sensitive and contingent interactions. If the emotions are too stimulating or frightening s/he may have to defend against the emotions and blank them out altogether. Parents may be in similar states in relation to their own emotional arousal and thus risk dysregulating their babies.

“Ghosts in the nursery”

Negative and painful feelings from the parent's past that are associated with early relational disturbance that are, transferring into the relationship with the new-born baby, and can significantly distort it. The unresolved emotionally laden “ghosts” get in the way of the baby being seen by the parent in terms of who the baby really is.

Health Prevention

Health prevention is defined as the plans for, and the measures taken, to prevent the onset of a disease or other health problem. There are three distinct levels of prevention:

- a) Primary prevention includes those measures that prevent the onset of problems before the problems occur and can be universal (e.g. health prevention work of health visitors) or targeted (e.g. interventions targeting at risk families)
- b) Secondary prevention includes methods that involve working with parents where problems have already been identified (e.g. interventions for women with pre or postnatal depression).
- c) Tertiary prevention involves rehabilitation of those who have already been affected by a health problem such as activities to prevent an established disease from becoming worse (e.g. interventions for women with significant mental health problems; substance dependence or domestic abuse).

Infant

The first 365 days of a baby's life.

Insecure attachment

The situation wherein a child's strategy for managing threat and anxiety is a compromise in that it brings a response from the parent but does not provide the child with a sense of safety and comfort.

Interactions

The bi-directional to-and-fro of exchanges, in this case between parent and infant. The quality of interactions is determined by factors such as emotional tone, rhythm, matchedness and interactive repair. Parental infant interactions have a protective or risk-triggering influence on child developmental outcomes.

Marked mirroring

A process by which the parent demonstrates to the infant that s/he understands how the baby is feeling and is not frightened or overwhelmed by those feelings. Marked mirroring happens when a parent shows a contingent response to their baby such as looking sad when the baby is crying. When parents mirror the emotion, babies recognise that their feelings are understood. "Marked mirroring" refers to the way in which parents re-enact a modified or exaggerated facial expression, which indicates to the baby that his/her distress is not the parent's distress, and can be understood and contained by them.

Maternal representations (of her baby)

The mother's mental images about the baby. They may reflect the actual baby or be highly tinged by attributions to the baby that originated in another set of relationships.

Mentalization

Mentalization refers to the psychological capacity to make sense of actions and behaviours in oneself and in others in terms of underlying feelings and thoughts. Without this process human behaviour can be experienced as meaningless and random. Attributing mental states as guiding the actions of others gives meaning to social interaction.

Mind-mindedness

The ability to accurately infer or understand others' mental states.

Reflective Function

The capacity of the parent/s to experience the baby (or any other person) as an "intentional being" rather than simply viewing them in terms of physical characteristics or behavior. This helps the child to develop an understanding of mental states in other people, and to regulate their own internal experiences.

Reflective Practice

The ability to take a step back to think about one's practice and undertake self-appraisal, to consider what is taking place and why, and whether this meets the intentions of the intervention, is serving any other purposes, should be continued as is or rethought. It also involves supervision, and ongoing continuing professional development. To work reflectively means to have an awareness of one's own thoughts and feelings and to question one's assumptions and be able to monitor these and reflect on the way in which they may help/hinder work with parents/infants and professional colleagues.

Regulatory disorders

The infant's/child's difficulties in regulating their behavior and physiological, sensory, motor or affective processes and in achieving a calm, alert, or affectively positive state.

Resilience

The ability of a person to overcome adverse environmental experiences.

Risk

The probability of an unfavorable developmental outcome for the baby. In the contents of this competency framework risk factors refer to relational environmental factors that impinge on development.

Secure attachment

The quality of the child's relationship with him/her parent/caregiver that enables him/her to obtain comfort from the caregiver when distressed and 'use' this to explore him/her environment with a sense of agency.

Self

The person's subjective sense of who he/she is, which has coherence over space and time. The baby's sense of self is constructed in interaction with his/her parent/s and through the experience of feeling known in the mind of his/her parent/s. The parent's self-representation is changed with the birth of a child.

Unresolved trauma

Preoccupied states of mind that are unremitting in relation to overwhelming negative experiences and are likely to distort the way in which the current situations are responded to. Parents who have experienced overwhelming trauma may experience states of dissociation in the relationship with the baby, thus re-creating a traumatic experience for the baby.

Temperament

A baby's natural disposition with regard to their mental, physical, and emotional traits and reaction.

Team around the child (TAC)

The team around the child is a model of multi-agency service provision, and brings together a range of practitioners from across the children and young people's workforce to support an individual child or young person and their family.

Perinatal

Describes the period surrounding birth, and traditionally includes the time from foetal viability from about 24 weeks of gestation up to either 7 or 28 days of life.

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