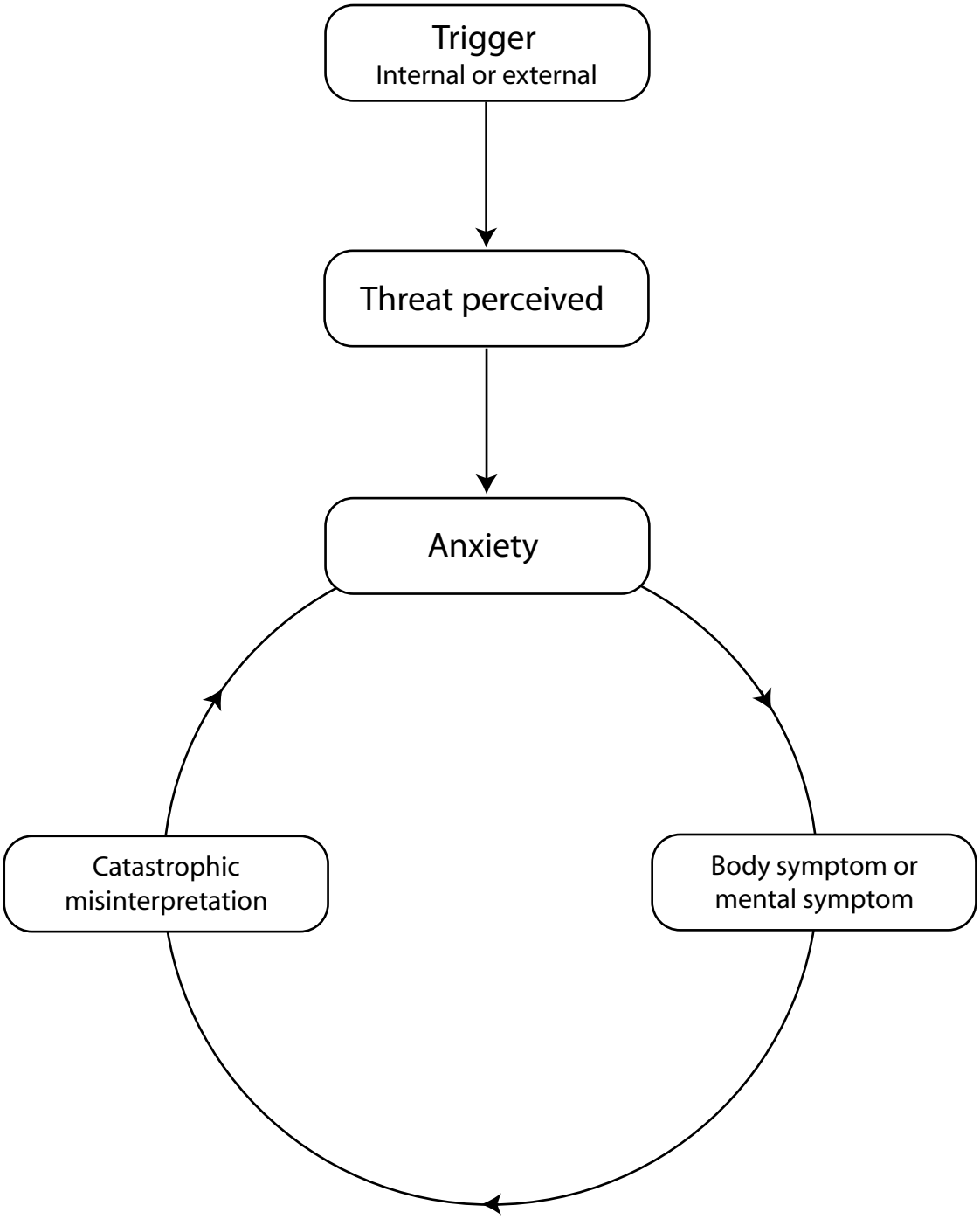
# Cognitive Model of Panic



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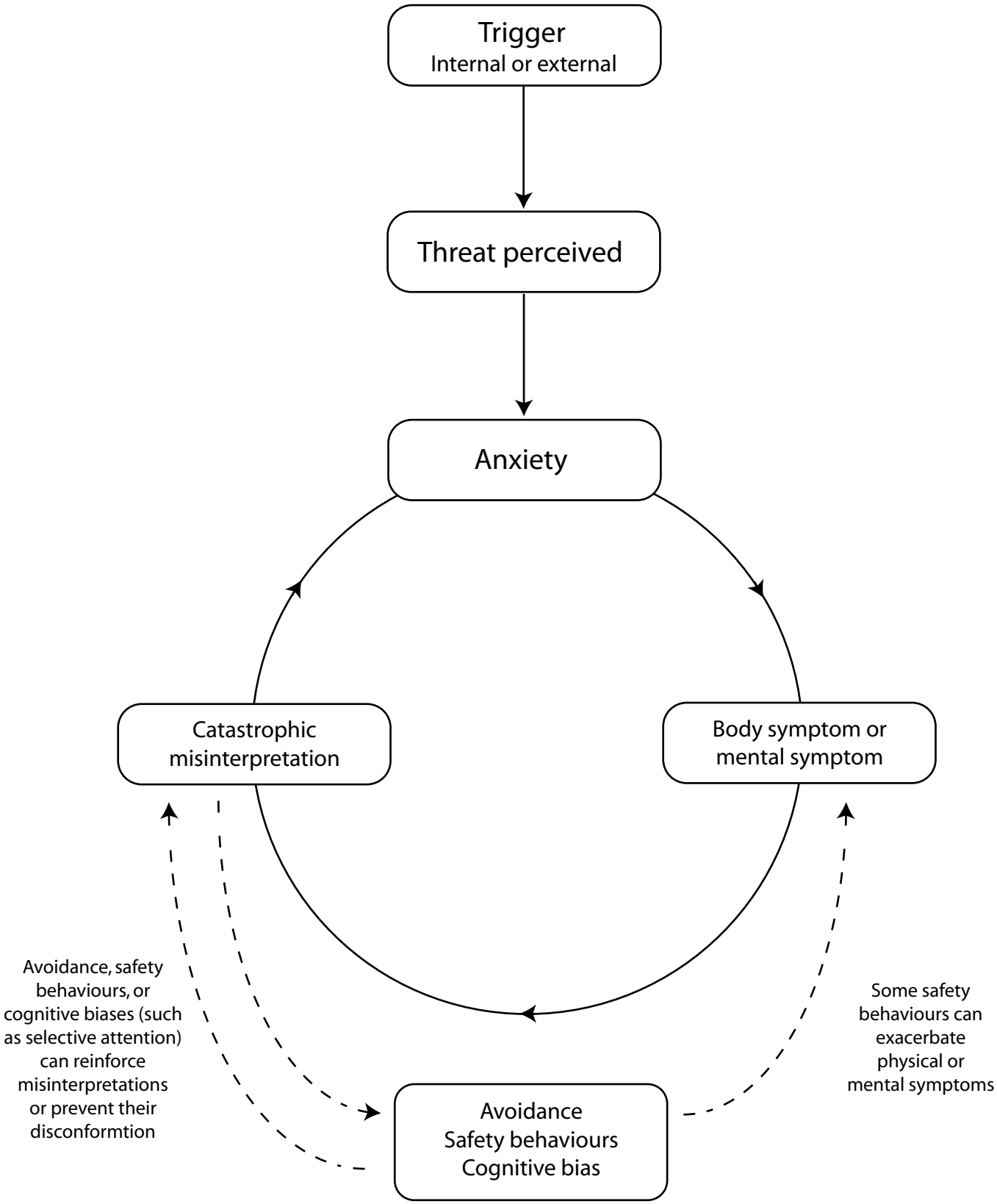

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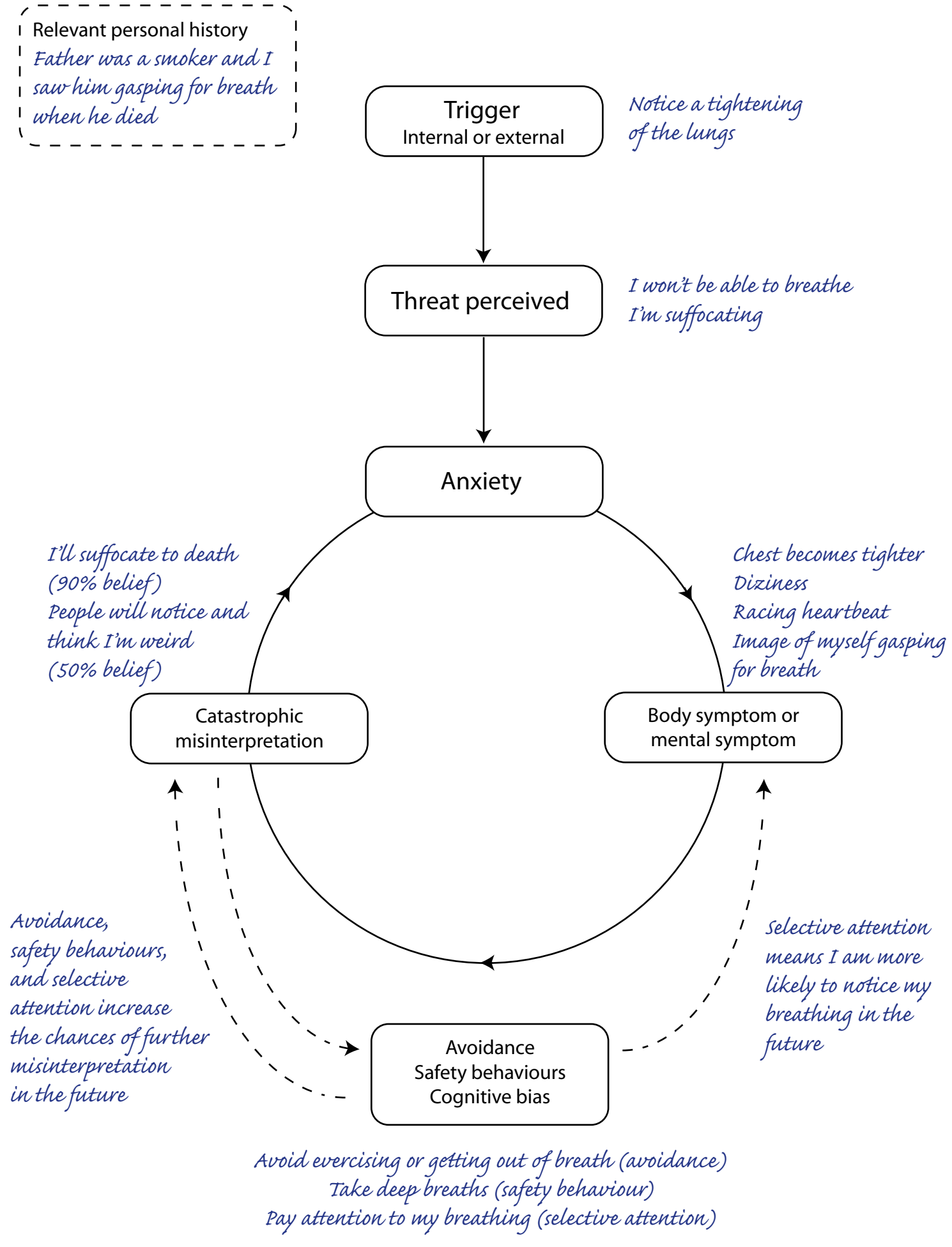

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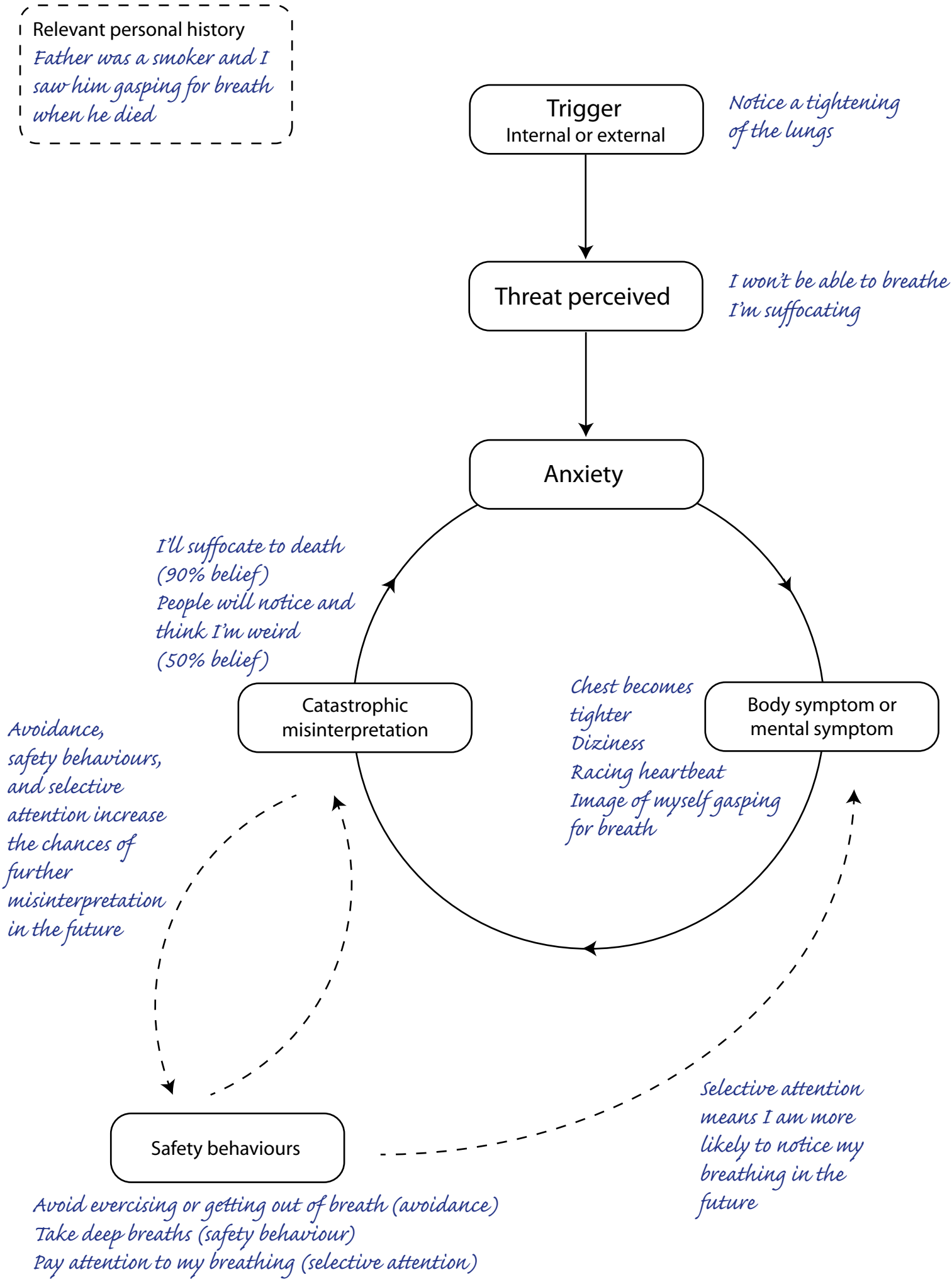
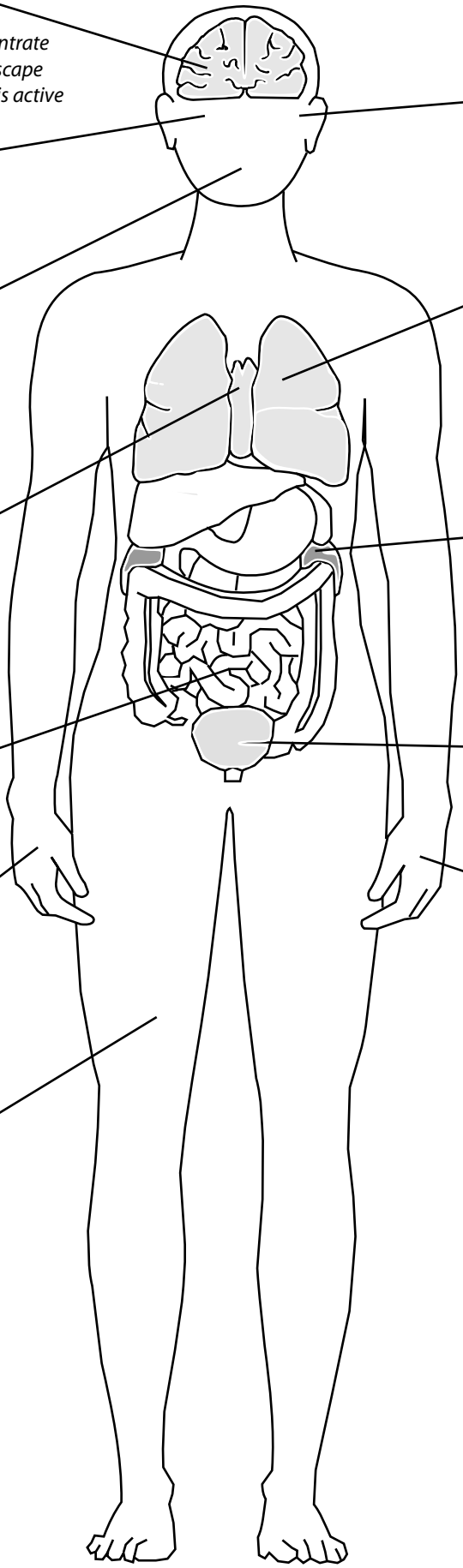


# Fight Or Flight Response

When faced with a life-threatening danger it often makes sense to run away or, if that is not possible, to fight. The *fight or flight response* is an *automatic* survival mechanism which prepares the body to take these actions. All of the body sensations produced are happening for good reasons – to prepare your body to run away or fight – but may be experienced as uncomfortable when you do not know why they are happening.



### Thoughts racing

*Quicker thinking helps us to evaluate danger and make rapid decisions. It can be very difficult to concentrate on anything apart from the danger (or escape routes) when the fight or flight response is active*

### Changes to vision

*Vision can become acute so that more attention can be paid to danger. You might notice 'tunnel vision', or vision becoming 'sharper'*

### Dry mouth

*The mouth is part of the digestive system. Digestion shuts down during dangerous situations as energy is diverted towards the muscles*

### Heart beats faster

*A faster heart beat feeds more blood to the muscles and enhances your ability to run away or fight*

### Nausea and 'butterflies' in the stomach

*Blood is diverted away from the digestive system which can lead to feelings of nausea or 'butterflies'*

### Hands get cold

*Blood vessels in the skin contract to force blood towards major muscle groups*

### Muscles tense

*Muscles all over the body tense in order to get you ready to run away or fight. Muscles may also shake or tremble, particularly if you stay still, as a way of staying 'ready for action'*

*If we don't exercise (e.g. run away or fight) to use up the extra oxygen then we can quickly start to feel dizzy or lightheaded*

### Dizzy or lightheaded

### Breathing becomes quicker and shallower

*Quicker breathing takes in more oxygen to power the muscles. This makes the body more able to fight or run away*

### Adrenal glands release adrenaline

*The adrenaline quickly signals other parts of the body to get ready to respond to danger*

### Bladder urgency

*Muscles in the bladder sometimes relax in response to extreme stress*

### Palms become sweaty

*When in danger the body sweats to keep cool. A cool machine is an efficient machine, so sweating makes the body more likely to survive a dangerous event*

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AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

# Healthy Child, Healthy Future

## A Framework for the Universal Child Health Promotion Programme in Northern Ireland

Pregnancy to 19 Years

May 2010

# *Healthy Child, Healthy Future*

**A Framework for the Universal Child Health Promotion Programme in Northern Ireland**

## Guidance to support the delivery of the Healthy Child, Healthy Future in Northern Ireland

This document should be read in conjunction with current standards and guidelines for practice.

# Healthy Child, Healthy Future

**A Framework for the Universal Child Health Promotion Programme in Northern Ireland**

## Contents

# Foreword

The existing Child Health Promotion Programme within Northern Ireland, introduced in 2006, is based on 'Health for All Children' (Hall and Elliman, 2006). Healthy Child, Healthy Future is intended to strengthen not replace the existing programme and is recognised as being central to securing improvements in child health across a range of issues. Effective implementation will lead to:

- Strong parent - child attachments, positive parenting resulting in better social and emotional wellbeing.
- Care that helps keep children healthy and safe.
- Healthy eating and increased activity leading to a reduction in obesity.
- Prevention of serious and communicable diseases.
- Increased rates of initiation and maintenance of breastfeeding.
- Readiness for school and increased learning.
- Early recognition of growth disorders and risk factors for obesity.
- Early detection of and actions to address developmental delay, abnormalities and ill health, and concerns about safety.
- Identification of factors that could influence health and well being in families.
- Better short and long term outcomes for children who are at risk of social exclusion.

The framework sets out a clear core programme of child health contacts that every family can expect, wherever they live in Northern Ireland, recognising that individual families are different and that there is a need to be flexible and innovative to ensure that all families are able to access and benefit from the advice, support and services that are available to them.

We are enormously grateful to all the professionals involved in the development of this guidance or who have commented on it. Their input has been invaluable.

Margaret Boyle

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NURSING OFFICER

# Acknowledgements

This document has been endorsed by the Regional Health for All Children Steering Group (Hall 4) and by key stakeholders and practitioners within local and regional multi-professional fora including the project team and through focus groups with practitioners.

The members of the CHPP project board and project team who developed and edited this work are gratefully acknowledged for their contribution to the development of this document.

Particular thanks to Bernie Hartley, Nurse Manager (Health Visiting), Northerrn Health and Social Care Trust, who led in taking this work forward and to Susan Gault, Head of Public Health Nursing, Northern Health and Social Care Trust, for her support to this and broader programmes of work.

# Introduction

The First Minister and Deputy First Minister, through the OFMDFM Strategy, 'Our Children and Young People - Our Pledge', (2006), aim to improve the life chances for children and young people to ensure that every child, irrespective of race, gender, religious belief, age, sexual orientation, disability, background or circumstances gets the best start in life and the support they need to fulfil their potential.

The fourth edition of Health for All Children (Hall 4), published in December 2002, promoted the gradual shift from a highly medical model of screening, to one with a greater emphasis on health promotion, primary prevention and active intervention for children at risk. This provided a framework for connecting the range of different policies and spheres of activity that support children and young people's health and development in the early years and beyond. Health for All Children: Guidance and Principles of Practice for Professional Staff (2006) set out a universal core programme of child health contacts for every family, wherever they lived in Northern Ireland. It recognised that as individual families are unique there was a need to be flexible and innovative to ensure that all families were able to access and benefit from the advice, support and services that are available to them.

# Context

The Health for All Children (Hall 4) programme currently provided in Northern Ireland has required the skills and expertise of a range of professionals to link effective child health promotion, prevention and care. More recently* there have been developments and changes in the knowledge about how infants develop, including neurological development and what interventions work, which has influenced the landscape of children's policy and service development.

In addition public health priorities and responses now focus more specifically on issues such as obesity in childhood, the increase in emotional and behavioural problems among children and young people and the poor outcomes experienced by children in the most at risk families.

In March 2008 the Department of Health in England, launched the updated *Child Health Promotion Programme* (CHPP and now known as the 'Healthy Child Programme'), which adopted new knowledge, public health priorities and changes in the way in which services are delivered. The updated CHPP which builds on the revised fourth edition of *Health for All Children* (Hall and Elliman, 2006), is intended to strengthen not replace *Health for All Children* (HFAC).

*Hosking, G. The Hand That Rocks the Cradle, **http://www.childrensproject.co.uk/cradle.asp**

The advances in neuroscience and genetics along with a greater understanding of how early childhood can be both promoted and damaged, create an imperative for the CHPP to begin in early pregnancy. The CHPP is essential to optimising health and development and supporting parenting in the first years of life.

In response to the launch of the CHPP in England the Department of Health, Social Services and Public Safety, Northern Ireland (DHSSPS), through the Regional Health for All Children (Hall 4) Steering Group, commissioned work to review the current Hall 4 programme within Northern Ireland from pregnancy to 19 years of age, and to recommend an updated child health promotion programme for Northern Ireland. The focus from pregnancy to 19 years (19th birthday) ensures that all children including those who are 'Looked After Children (LAC)' or who have a disability and require special education provision are included.

The age of 19 also provides flexibility where policy might be developed in the future to extend provision beyond the traditional model within schools and into further education settings, drop-in and other facilities where young people can access preventive services.

**The Northern Ireland Programme**

As a result of the review of the current Hall 4 programme and taking account of the CHPP developed by the Department of Health in England, this framework for the Universal Child Health Promotion Programme in Northern Ireland has been developed. The programme will be commissioned as one programme covering all the stages of childhood.

The Northern Ireland child health promotion programme, **Healthy Child, Healthy Future,** continues to adopt HFAC as the core universal child health promotion programme. It will continue to be updated as new evidence and best practice emerge, including *National Institute for Clinical Excellence* (NICE) guidance as it is adopted within Northern Ireland.

It details the universal services to be delivered to all children and their families, including health led parenting programmes and preventative initiatives in pregnancy. Comprehensive assessment of need will identify where additional support and interventions are to be offered. Where this is the case these must be done within clear care pathways, which continue to be developed within the UNOCINI framework.

# Model for Delivery of Healthy Child, Healthy Future

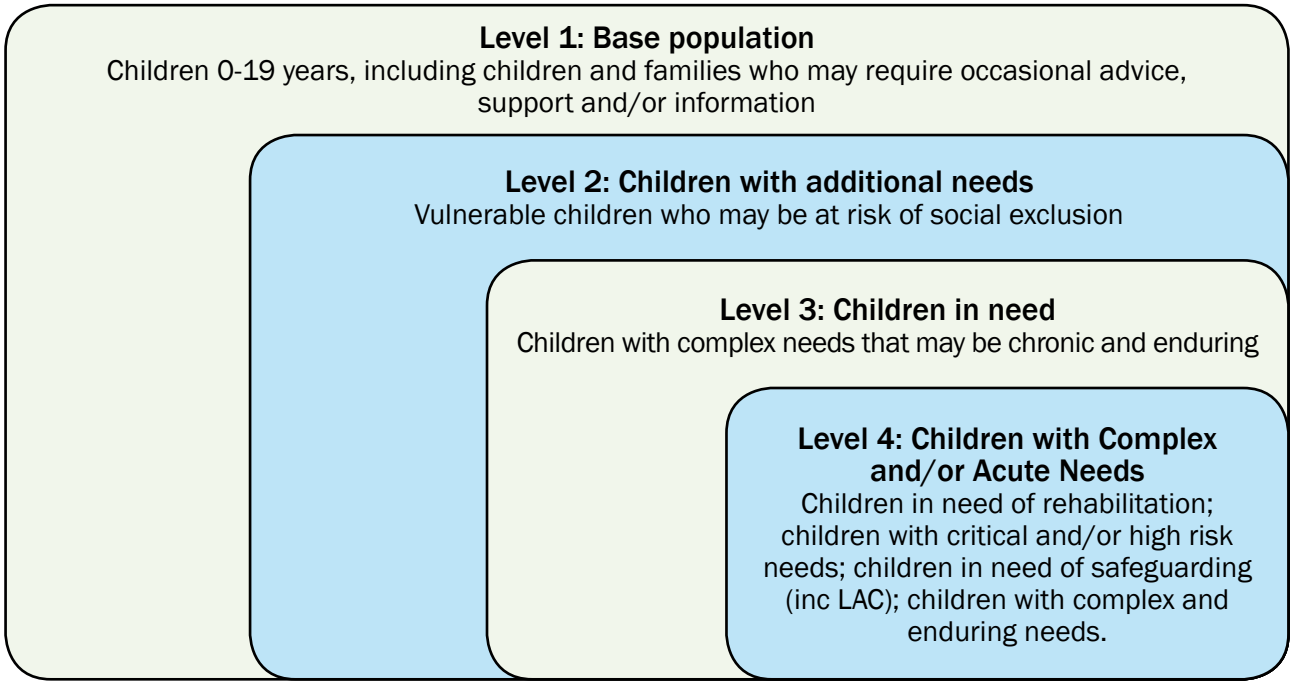
The Healthy Child, Healthy Future programme is provided to the total population of children and young people aged 0-19 years, irrespective of need. In addition some children and families will receive a targeted service, e.g. those children who are 'Looked After' or have special educational needs.

The programme is a universal service which requires a number of set contacts to be made with each family to identify health need, through a holistic assessment which includes screening and surveillance, and where necessary provide early intervention to ameliorate the potential early negative impact of any physical, social or emotional factor. Where early intervention is unable to address need, children/families are escalated to a more progressive level of intervention.

The Healthy Child, Healthy Future programme is delivered to all families from Level 1 to Level 4 of the 'Understanding the Needs of Children in Northern Ireland', (UNOCINI) Thresholds of Need Model (DHSSPS, 2008), (Figure 1). Some families will require only the minimum number of set contacts in level 1. Additional services will be targeted, according to need, to those families in Level 2-4. The nature of family life will mean that families will move in and out of the levels and services will be adjusted accordingly. Working within this model will secure an effective and co-ordinated approach to assessment and identification of needs within integrated children's services.

Health professionals should also ensure that the initial family health assessment carried out by the health visitor is regularly updated during the period of working with the family.

**Figure 1* Based on UNOCINI Thresholds of Need Model (DHSSPS, 2008)**




*Varied model due to the age range up to 19 years as opposed to 18 years within UNOCINI

**UNOCINI Thresholds**

The thresholds enable practitioners and their agencies to identify needs and communicate concerns about children using a common format, language and understanding of the levels of need, concern or risk for all children across Northern Ireland. The model should be used to support effective working within integrated children's services. The thresholds and subsequent levels of service can be described as follows:

**Level One: Base Population**

Children and families typically self-refer and access universal and community resources as part of everyday life, for example, the Healthy Child, Healthy Future programme, attending their G.P. for minor ailments, attending school, joining a club, attending a community meeting or play group. Additionally, many agencies undertake preventative and awareness raising work at this level, for example, health promotion activities.

**Level Two: Children with Additional Needs**

In recognition of their vulnerability or potential for social exclusion, some children and families will be offered enhanced assistance from universal services or through community and voluntary organisations, for example, additional breastfeeding support, Surestart services, counselling or parenting support group. In relation to health visiting and school nursing services, this can include the provision of evidence based parenting and/or other programmes for teenage mothers and families with complex needs or challenging behaviours who have been identified through Family Health Assessment undertaken through the delivery of Level 1 universal services.

Targeting of pregnant teenagers is vitally important due to the risk of poorer health outcomes for mother and baby including low birth weight babies, higher infant mortality rate, low incidence of breastfeeding, high childhood accident rate and higher rate of postnatal depression. Level 2 services should be provided within a model of service which progressively responds to the level of identified need (progressive universalism) to target and respond effectively to the needs of children, young people and families. These should fit within the pathways of the UNOCINI Thresholds of Need model.

**Level Three: Children in Need**

Where children have been identified as children in need under Article 18 of the Children (NI) Order 1995, the Health and Social Care Trust (the Trust) will be required to provide community based social care services to promote and safeguard their welfare. Children in need, include disabled children whose families may require additional services to enable them to care for their child. Relevant professionals including health visitors, school nurses and education staff will normally be asked to provide input to the UNOCINI assessment process. This may also

indicate the need for further assessments to be undertaken for example, a statutory assessment under the Education (Northern Ireland) Order 1996 with a view to determining whether a Statement of Special Education Needs may be required. Children who are vulnerable due to their family situations may need to be added to the child protection register and an appropriate multi-disciplinary child protection plan established. Support for children in need and their families can be provided by a range of professionals and by voluntary and statutory agencies. Services may include sponsored playgroup or child minding places, short break care (formerly known as "respite care" and special programmes provided by family centres to help parents manage behaviour or take part in further assessments.

**Level Four: Children with Complex and/or Acute Needs**

Children experiencing the most acute, intense or complex difficulties because of health, disability or vulnerability due to their family situations will normally be provided with co-ordinated support and intervention that may involve a multi-agency response. This will include children with serious medical conditions and those with mental health needs who may require prolonged care in hospital or intense support within the community. Others may be looked after by Trusts in foster care, kinship or residential care placements or be the subject of child protection supervision and monitoring. Children in secure placements and youth justice establishments will also fall within this intense level of support and intervention. Care and support plans will most likely require input and agreed actions by a range of professionals including social workers, education welfare officers, health visitors, GP and other medical services, psychologists, school nurses and mental health workers.

For children with disabilities or special educational needs, child health services should work in partnership with others to:

- Strengthen human rights.
- Promote the inclusion of children with a disability in society in order to enable them to achieve their full potential.
- Reduce health inequalities.
- Offer more support and greater choice for children and their families.
- Reduce poverty among families with children who have a disability.

Not all children with disability have special needs, neither are all special needs due to disability.

*'One child in six has learning difficulties at some time in his/her school career and one child in 60 has severe and persistent needs'.*

*Health for All Children, 4th Edition, David M. B. Hall & David Elliman, Oxford Medical Publications, 2003, Chapter 13*

# Section 1:
## Healthy Child, Healthy Future - The Child Health Promotion Programme for Northern Ireland (2010)

Healthy Child, Healthy Future, the Child Health Promotion Programme for Northern Ireland, is a public health programme that offers every family with children a programme of screening, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices so that children and families achieve their optimum health and wellbeing.

The universal programme is a vehicle which provides an invaluable opportunity to identify families who are in need of additional support, and children who are at risk of poorer outcomes. The development of a progressive programme for such families, which is to be further defined in the near future, is based on robust Family Health Assessment (FHA) as part of the UNOCINI Thresholds of Need Model (DHSSPS, 2008).

**Objectives of the Programme**

- To ensure that all parents and children have access to, and understanding of all relevant health care messages that are evidence-based and shown to be beneficial.
- To arrange and deliver immunisations.
- To carry out the agreed screening procedures and ensure follow-up of abnormal results.
- To enable parents with worries about their child to locate the help they need promptly and efficiently.
- To support the local community in creating an environment at home and at school in which the child can be safe, grow, and thrive physically and emotionally.
- To identify vulnerable children and families who may benefit from additional support or services beyond the core programme and negotiate whatever is needed.
- To ensure that as far as possible children who have or may have special educational needs are identified and referred to the education services and to the appropriate voluntary and statutory agencies.

# Principles of the Programme

The 7 principles of the Child Health Promotion Programme for Northern Ireland are:

1. A Whole Child Model with an emphasis on improving outcomes for children and young people through integrated planning of services for children, young people and families. *(Families Matter: Supporting Families in Northern Ireland 2009)*.
2. A major emphasis on parenting support and positive parenting.
3. The application of new information about neurological development and child development.
4. The inclusion of changing public health priorities.
5. An increased focus on vulnerable families, underpinned by a model of progressive universalism.
6. An emphasis on integrated services.
7. The use of new technologies and scientific developments.

## 1.1 A Whole Child approach

The 'Whole Child' model approach puts the child at the centre of care delivery.

"Focus should be on the capacity of all universal service providers to take a whole child view towards assessment, identification of need and provision of services to meet need, which must include assessing, identifying and providing for the support needs of parents and families" Families Matter: Supporting Families in Northern Ireland (March 2009).

## 1.2 A major emphasis on parenting support and positive parenting

Healthy Child, Healthy Future looks beyond the child to their family, by reviewing family health including the father and/or partner's health behaviours and involving them directly where possible, e.g. in relation to diet, smoking and alcohol or drug use (Hidden Harm Strategy, 2009) as these behaviours have a direct impact on the mother and the child. Fathers and/or partners should be routinely invited to participate in child health reviews and to have their needs assessed.

**Parenting support will include:**

- Supporting mothers and fathers or those within a caring role to provide sensitive attuned parenting, in particular during the first months and years of life, using regionally agreed evidence based programmes to support specific work (eg. Solihull).
- Supporting strong couple relationships and stable positive relationships within families.
- Services which develop a whole child perspective that are aware of the interacting relationships between child, family and community (Families Matter: Supporting Families in Northern Ireland (March 2009)).
- Ensuring contact with the family routinely involves and supports fathers/ partners, including non-resident fathers/partners.
- Supporting the transition to parenthood, especially for first-time mothers and fathers.

## 1.3 The application of new information about neurological development and child development

Healthy Child, Healthy Future, reflects new evidence* that has emerged about neurological development and the importance of forming strong parent-child attachment in the first years of life. More is also known about the adverse effects of maternal stress in pregnancy on child development and about the neurological development of infants. The brain develops rapidly in the first 2 years and is influenced by the emotional and physical environment as well as genetic factors.

Early interactions directly affect the way the brain is wired and early relationships set the 'thermostat' for later control of the stress response. These findings underline the need for mothers and fathers to be supported during pregnancy and the first years of the infants life.

Rapid scientific advances are taking place in the study of neuroscience and child development and in our understanding of the effectiveness of early childhood programmes.

**Healthy Child, Healthy Future reflects this new knowledge by:**

- Stressing the importance of attachment and positive parenting in the first years of life in determining future outcomes for children.
- A greater focus on pregnancy.
- Recognising the specific impact that mothers and fathers have on their children, as well as their combined influence.
- Building a progressive universal programme that responds to the different risk factors on children's future life chances, including the effects of multiple parental risk factors.
- Integrating NICE guidelines on promoting changes in behaviours that affect health, maternal mental health, and antenatal and postnatal care.
- Incorporating interventions, where emerging evidence shows they can help, to build resilience and improve outcomes.
- Applying evidence based knowledge regarding the development of the brain in adolescence.

*Hosking, G. The Hand That Rocks the Cradle, **http://www.childrensproject.co.uk/cradle.asp**

## 1.4 The inclusion of changing public health priorities

The programme aims to improve health and reduce inequalities for children and includes a full range of public health initiatives. Public health priorities will change over time and will continue to be addressed within the programme. At present obesity and being overweight represents a major public health challenge that is comparable to smoking in its significance and scale. In 2004/05 more than 5% of Primary 1 children were obese with 22% being classified as overweight or obese. It has been projected that without significant intervention over 7% of children aged 4 ½ to 5 ½ years, will be obese with 27% overweight or obese by 2010, *Fit Futures* (2007).

Children who are obese in childhood are likely to remain obese into adulthood. Only 3 per cent of overweight or obese children have parents who are not overweight or obese.

It is vital to work with parents using a whole-family approach. *"The Fit Futures implementation plan takes a population approach to tackling the issue of obesity in children and young people living in Northern Ireland.... the plan recognises the need to work closely with families, schools and communities..." Fit Futures, (2007).*

**Public Health priorities which will continue to change currently focus on the need to:**

- Increase the number of mothers who start breastfeeding and continue for 6 to 8 weeks or longer.
- Focus on the early identification and the prevention of obesity in childhood through an emphasis on breastfeeding, delaying weaning until babies are around 6 months old, introducing children to healthy foods, controlling portion size, limiting snacking on foods high in fat and sugar, and encouraging an active lifestyle for the whole family.
- Take a pro-active role in promoting the social and emotional development of children.
- Support parents to get the balance right between encouraging play and physical activity whilst minimising the risk of injury. (Health and Safety Executive NI).

## 1.5 An increased focus on vulnerable families, underpinned by a model of progressive universalism

Healthy Child, Healthy Future is a progressive universal service that is offered to all families with additional services for those with specific needs and risks. One of the challenges of implementing the programme is balancing the universal elements of the programme with selective approaches to reduce inequalities. A model of progressive universalism means offering a range of preventative and intervention services for different levels of risk, need and protective factors. Implementing a model of progressive universalism and allocating resources accordingly, is essential to reducing inequalities. Future work will continue to be developed to support a progressive programme at level 2 to support children and families with additional needs.

## 1.6 An emphasis on integrated services

This programme will promote:

- Collaborative working within integrated children's services in partnership with key stakeholders including local Sure Start projects to improve outcomes for children and families in disadvantaged areas.
- Collaborative working with local voluntary and community groups in promoting community development that will enhance services and support children and families.
- Working closely with early years services and community groups.
- Working closely with Department of Education Northern Ireland (DENI), schools and colleges.

## 1.7 New technologies and scientific developments

Healthy Child, Healthy Future, will introduce and adopt new technologies and scientific developments such as:

- New vaccination and immunisation programmes.
- New tests, such as expanding the newborn bloodspot screening programme.
- Maximising the potential of technologies such as internet, help lines and text messaging services to provide parents with information and guidance, and to offer them more choice on how to access child health promotion information and services.
- Improved data collection systems and electronic records.

## Outcome of the Healthy Child, Healthy Future programme

Effective implementation of Healthy Child, Healthy Future aims to secure the following outcomes:

- Strong parent-child attachment and positive parenting, leading to better social and emotional wellbeing among children.
- Care that helps to keep children healthy and safe.
- Healthy eating and increased activity.
- Prevention and reduction of some serious diseases and communicable diseases.
- Increased rates of initiation and continuation of breastfeeding.
- Readiness for school and improved learning.
- Early recognition of growth disorders and risk factors for obesity.
- Early detection and actions (including early intervention/referral) to address developmental delay and ill health and concerns about safety.
- Identification of factors that could influence health and wellbeing in families.
- Better short and long term outcomes for children who are at risk of social exclusion.

# Section 2:
# Delivery of Healthy Child, Healthy Future

Health professionals, including midwives, health visitors, school nurses and GPs are the first point of contact for families during pregnancy, the first years of life and throughout childhood.

Successful delivery of Healthy Child, Healthy Future, relies on the contribution of a wider range of practitioners. The key to success is a shared understanding by both parents and practitioners of the roles and responsibilities of the different members of the team.

Healthy Child, Healthy Future, includes the following core elements:

1. Health Improvement
2. Health Protection

## 2.1. Health Improvement

Health Improvement includes:

- Support for parenting including early intervention and prevention programmes for children and families.
- Engaging fathers/partners.
- Health promotion such as, promotion of breastfeeding, nutrition and exercise and the prevention/reduction of obesity, smoking cessation, drugs and alcohol, sexual health and improved mental health and wellbeing within the family.
- Promotion of social and emotional development e.g. personal development in school.
- Safeguarding – accident prevention, attachment and bonding, parent-child interaction and health.
- School health profiling.

The Family Health Assessment (FHA) currently used by health visitors and school nurses uses a holistic approach to identify the health of individuals, families and communities in support of the delivery of a client centred service. The FHA focuses on encouraging families to acknowledge their health needs and jointly plan appropriate interventions to address identified needs. Health reviews provide the basis for agreeing with each family how they will access the Child Health Promotion Programme over the next stage of their child's life.

### 2.1.1 Support for parenting: Early intervention and prevention programmes for children and families

One of the core functions of Healthy Child, Healthy Future, is to support parents using evidence-based programmes provided by trained practitioners. Core features of successful parenting programmes include:

- Establishing a relationship with both parents based on trust and respect.
- Considering the whole family and the impact of wider family issues on the child.
- Focusing on parents strengths.
- Focusing on empowering parents - understanding that self-efficacy is an essential part of behavioural change.
- The ability to promote attachment, laying the foundations for a child's trust in the world, and its later capacity for empathy and responsiveness.
- An understanding of family relationships and the impact of becoming a parent.
- An appreciation of the factors that affect parenting capacity and health, and an understanding of the interplay between risk and resilience.
- Ensuring that practitioners have consultation skills and the ability to assess risk and protective factors.

There are a number of parenting support programmes available which can be used in both the universal and the progressive programme such as:

- Solihull www.solihull.nhs.uk/solihullapproach/
- Incredible Years Programme www.incredibleyears.com
- Mellow parenting www.mellowparenting.org/
- The Social Baby book/video (Murray and Andrews, 2005)
- Baby Express Newsletters www.thechildrensfoundation.co.uk

Parenting programmes must be outcome focused and evidence based. Within Northern Ireland a menu of such programmes should be agreed which fit within locally agreed pathways and across levels 1-4 of the UNOCINI Thresholds of Need Model. Training for health visitors and school nurses should include these within programmes.

### 2.1.2 Engaging Fathers/Partners

Delivery of Healthy Child, Healthy Future, needs to look beyond the child to their family, reviewing family health as a whole, building family strengths and resources; the programme is there for the whole family - including the father/partner. Where possible the father/partner should be encouraged to participate fully and directly in the programme. Assessment of the father/partner's needs and health behaviours (e.g. in relation to diet, smoking, alcohol or drug use) should be undertaken as this will have a direct impact on both the mother and the child. Fathers/partners should be directly signposted to relevant services (rather than second-hand via the mother) and should be given information about health improving behaviours incorporating how their health behaviour impacts on their child. Non-resident fathers/partners details should also be recorded. For further information on engaging father see the Fatherhood Institute website at www.fatherhoodinstitute.org

## 2.1.3 Health Promotion

Health for All Children defines health promotion as *'any planned and informed intervention, which is designed to improve physical or mental health, or prevent disease, disability and premature death'.*

*Health for All Children, 4thEdition, David M. B. Hall & David Elliman, Oxford Medical Publications, 2003*

Health promotion should be integral to the day-to-day work of all health professionals engaged in caring for children. It should include information on antenatal care and early support after childbirth with particular reference to breastfeeding, as well as providing information, advice and support to parent(s) as the child grows and develops.

Whilst health promotion should be tailored to the family's needs, the health professional should also ensure that parent(s) are given the appropriate knowledge on prevention, for example, sudden unexpected death in infancy (SUDI), alcohol use, passive smoking and accidents.

There should be strong links and closer communication with community development programmes and other initiatives aimed at reducing inequalities, social exclusion, eliminating poverty and improving educational outcomes.

There are many opportunities for primary prevention and health promotion which should be incorporated into all developmental assessments and contacts with parents. The following are examples of topics to be covered within the programme and should be delivered within national and local guidance to inform practice:

- *Nutrition including promotion and support for breastfeeding.*
- *Prevention of Sudden Unexpected Death in Infants.*
- *Reducing smoking by parents.*
- *Childhood Injury Prevention.*
- *Promotion of oral health.*
- *Control of communicable diseases.*
- *Sexual Health.*
- *Maternal Mental Health.*
- *Supporting Speech and Language development.*

## 2.1.4 Promotion of Social and Emotional Development

The prevalence of mental health problems amongst children and adolescents is currently estimated at 20%. In the pre-school years, problematic childhood behaviours include waking and crying at night, over-activity, food refusal and difficulty settling at night which if unresolved may indicate potential/future mental health problems.

Promoting mental health is a core component of all health professionals' work. They have an important role to play in supporting parents and children and developing community provision to prevent mental health problems.

## 2.1.5 Safeguarding

Safeguarding remains a key element of Healthy Child, Healthy Future with the focus being on prevention, assessment, identification, and support for identified needs and vulnerable families. Additional services and support should be targeted at those assessed as having identified needs.

Implementation of Healthy Child, Healthy Future, will provide information systems and processes to enable health and social care professionals to identify and record the needs of children and ensure appropriate planning and referral for support when necessary.

The introduction of the Family Health Assessment Model (FHA) and the UNOCINI multi-agency assessment provides a structured framework to assess, plan, deliver and evaluate services to vulnerable children, children in need and children in need of protection. The associated Thresholds of Need Model, (Figure 1) will assist professionals in determining levels of need for targeted intervention.

**(i) Child Protection**

Child protection is a shared responsibility. Co-operation between agencies and disciplines and working in partnership with parents must be the central focus.

*'Child abuse occurs when a child is neglected, harmed, or not provided with proper care. Children may be abused in many settings, in a family, in an institutional or community setting, by those known to them, or more rarely by a stranger.*
*There are different types of abuse:*

- *Physical*
- *Emotional*
- *Sexual*
- *Neglect*

*A child may suffer more than one of them'.*

*NI ACPC Regional Policy & Procedures 2005, Chp2, 2.3*

Child protection must be viewed as high priority requiring enhanced service intervention above and beyond the core programme. Children categorised as 'in need' or 'in need of protection' are among the most vulnerable in the child population and have the highest levels of health needs. Collaborative working is essential if these children are to benefit from the processes designated to safeguard their welfare. Health and social care professionals are well placed to identify children in need of protection. They should be aware of the indicators of abuse (e.g. neglect, emotional, physical and sexual abuse) and the procedures to follow in the event of child care concerns.

The systems in place for child protection are primarily to protect the interests of children considered to be at risk/potential risk of significant harm. The DHSSPS guidance "Co-operating to Protect Children" (2003) and the Northern Ireland Area Child Protection Committees' Regional Policy and Procedures (2005) provide the framework within which all agencies and professionals should co-operate to protect children. The key principles are:

- ***The child's welfare must always be paramount - this overrides all other considerations.***
- ***Children must be protected where they are at risk of 'significant harm'. This means ill treatment and/or impairment of health or development.***
- ***All professionals caring for children and their families have a duty to protect children from abuse or neglect.***
- ***Professionals must work together and share relevant information about children who may be at risk.***
- ***Whenever possible, professionals must work in partnership with parents.***

*NI ACPC Regional Policy & Procedures, 2005*

***All agencies should:***

- ***Be alert to potential indicators of abuse.***
- ***Be alert to the risks which individual abusers or potential abusers, may pose to children.***
- ***Share and help analyse information so that informed assessments can be made of each child's needs and circumstances.***
- ***Contribute to whatever actions are required to safeguard the individual child and promote his/her welfare.***
- ***Regularly review the outcomes for the child against specific shared objectives.***
- ***Work in co-operation with parents unless this is inconsistent with safeguarding the child.***

*Co-operating to Safeguard Children DHSSPS 2003*

***'The people in your care must be able to trust you with their health and wellbeing. To justify that trust, you must .....work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community'***

*NMC. The Code:Standards of Conduct, Performance and Ethics for Nurses and Midwives, May 2008 Code*

The principles and guidance set out in the DHSSPS Co-operating to Safeguard Children (May 2003) should be adhered to when developing strategies, policies and procedures to safeguard children who are assessed to be at risk of significant harm.

## (ii) Looked After Children (LAC) and Children Placed for Adoption

*'Looked After Children' are amongst the most socially excluded of our child population. A series of Government reports have highlighted the extent to which health neglect, unhealthy lifestyle and mental health needs characterise children and young people living in public care. Their health may not only be jeopardised by abusive and neglectful parenting, but public care itself may fail to repair and protect health and may even exacerbate damage and abuse.*

*Health for All Children, 4th Edition,*
*David M. B. Hall & David Elliman Oxford Medical Publications, 2003 page 300*

The Children (NI) Order 1995 (the Children Order) defines a "looked after child" as a child who is accommodated by a Trust for a period of 24 hours or more. A looked after child may be placed in a "care" setting such as with foster carers or in a children's home, or indeed may be placed by the Trust with extended family or relatives. A child can become looked after as the result of a voluntary agreement between the Trust and the child's parents (or others who have parental responsibility) or as a consequence of a care order granted to the Trust by a court, usually in a situation where it is deemed that the child has suffered or is likely to suffer significant harm. Where a care order is in force, parental responsibility for the child is shared between the Trust and the parents, although, under the Children Order, the Trust is able to determine the extent to which parents will be permitted to exercise their parental responsibility.

The regulations made under the Children Order require a Trust, in the case of each looked after child, to include the arrangements for the child's health in his/her care plan. Foster carers and residential children's homes must also meet specific requirements in relation to the health of children in their care. Looked After Children, (dependent on their age and ability to consent or refuse consent), must have a medical examination at least once a year and the child's health must be reviewed within a statutory review process at initial periods specified in the regulations and at least every six months for those under 5 years and yearly thereafter (to be reviewed). The contribution of nurses and other health professionals will therefore be vital to this process.

Nurses also have an important role in relation to the adoption of children and those leaving care who require additional support during the period of transition (up to 21 years). Where prospective adopters have young children (by birth or previously adopted) health visitors and school nurses will be asked by the Trust's or voluntary adoption society's adoption panel to contribute to the assessment process in relation to the prospective adopters' care of their existing children. When a child is being considered for adoption, the child's health visitor/ school nurse report will be included in the information to be viewed by the adoption panel members. At the point of the child's placement, the health visitor is responsible for ensuring that the prospective adoptive parents have access to a parent held record ("the red book") which has been issued in accordance with the regionally agreed protocol, currently in the final stages of development.

Health visitors also make a significant contribution to the support of families and children who are the subject of intercountry adoption processes. The Board's current regional adoption policy and procedures and the Departmental guidance "Implementing the Adoption (Intercountry Aspects) Act (NI) 2001 - A summary of the regulations and procedures" (DHSS 2003) requires the health visitor to visit the child within 7 days of the child's arrival in Northern Ireland and to contribute to the formal post placement support plan to be drawn up by the social worker within 28 days.

Children who are adopted both domestically and as a result of an inter-country adoption process are most likely to have ongoing health and developmental needs. The nursing input is therefore likely to be long term and a significant source of support for the family.

## (iii) Identification of Domestic Abuse/Hidden Harm

Domestic violence and abuse is a pattern of behaviours that is characterised by the exercise of control and the misuse of power by one person (male or female) over another within an intimate or family relationship. It is usually frequent and persistent. While domestic violence and abuse most commonly refers to that perpetrated against a partner, it also includes abuse by ex-partners, and abuse by a son, daughter, parent or parent-in-law or any other person who has a close or family relationship with the victim.

A definition of domestic abuse: *"Threatening behaviour, violence or abuse (psychological, physical, verbal, financial or emotional) inflicted on one person by another where they are or have been intimate family members, irrespectively of gender or sexual orientation"* (DHSSPS 2005).

It is important to note that domestic violence has more than one victim as it can impact adversely upon children and the wider family unit. The 5-year inter-agency strategy for tackling domestic violence 'Tackling Violence at Home' (NIO/DHSSPS, 2005) more recently during 2009 as part of this initiative, has supported the introduction of a Multi-Agency Risk Assessment Conferencing (MARAC) process, which includes a risk assessment tool to identify those in the higher risk categories and reduce the risk of serious harm. An implementation plan and training programme is currently being developed to include health visitors and school nurses.

### *Routine Enquiry*

Departmental Policy (DHSSPS 2006) required that from March 2007 routine enquiry for domestic violence is carried out on all pregnant women (regardless of race, ethnicity and ability) and must include women who have experienced miscarriage or stillbirth. However routine enquiry should never be treated as a one off activity and should be part of family health assessment.

Routine enquiry should be carried out as recommended by regional protocols and professional judgement in the antenatal and immediate postnatal period and throughout preschool and school-age years. Whilst routine enquiry is associated with domestic abuse it should also cover other appropriate issues including alcohol/substance misuse, domestic abuse and mental health issues.

Enquiry at specified intervals increases the likelihood of a women feeling safe enough to talk about her abuse. All staff should be aware of local Trust operational protocols and policies in relation to domestic abuse.

## 2.1.6 School Health Profiling

Health profiling should be used to identify the needs of the school age population. Information from individual health assessment should be utilised to develop prevention and early intervention programmes to address the needs of this population within the school setting and within local communities.

Innovative responses and approaches (e.g. peer education programmes) should be encouraged and designed in partnership with stakeholders (including education, young people, voluntary sector, etc).

The Public Health Agency should lead in identifying one tool to be used which should be supported by robust information technology.

## 2.2 Health Protection

There are three main strands to health protection:

- surveillance,
- screening
- immunisation

## 2.2.1 Surveillance

Ongoing surveillance of the general health and development of the child is an integral part of health protection. Health professionals must listen to parental concerns and respond appropriately including onward referral and future assessment. They should work in partnership with parents to support them in making healthy choices for their children. That partnership should be based on trust. It is also essential that parents know where to go for advice when they have a concern about their child.

Where there is a concern about a child's development, formal assessment to confirm or refute these initial suspicions is essential. This should be undertaken as part of a more comprehensive assessment involving a network of child development services and should include consideration of referral to a community paediatrician.

Prevention, early identification and intervention are key to optimising the outcomes for individual children and their families across the spectrum of health and social issues.

Local care pathways and protocols should be monitored and evaluated on an ongoing basis to ensure their effectiveness.

### *Health and development reviews*

Universal health and development reviews are a key feature of Healthy Child, Healthy Future. They provide the most appropriate opportunities for screening tests, developmental surveillance, discussing social and emotional development with parents and children, and for linking children to early years services. In partnership with parents and children the core purpose of reviews is to:

1. Identify opportunities for improving health.
2. Assess growth and development.
3. Identify risk factors and abnormalities e.g.
   - o Identification of and referral of babies with prolonged jaundice
   - o Speech and language delay
   - o TB.
4. Give parents the opportunity to discuss their concerns and aspirations.
5. Assess family strengths, needs, risks, protective and resilience factors.
6. Review uptake of screening programmes and inform parents of results as appropriate.

Practitioners carrying out health reviews will have knowledge and understanding of normal child development and the factors that influence health and wellbeing. They will be able to recognise the normal range of development. The early recognition of disability, developmental delay and health disorders is a core function of Healthy Child, Healthy Future and brings with it a responsibility to provide support, guidance, advice and signposting to other local services,

resources and agencies as well as onward referral and notification to others as required. Health and Development reviews will take place as follows:

- By the twelfth week of pregnancy.
- At the neonatal examination.
- At the new baby review (between 10-14 days old).
- At six to eight weeks of age.
- At 14-16 weeks of age.
- At one year old.
- At 2-2½ years of age .
- In primary 1.
- In year 8 of post primary school.

Health reviews provide the opportunity to assess the strengths and needs of the individual child and family, to plan for the next stage of childhood and to evaluate services received to date. The topics covered and the depth of each review depends on the experience and confidence of the mothers and father and/or partner, as well as their choice and the professional's judgement. Most children do well and, given information, most parents are good judges of their child's progress and needs. Others may need more support and guidance and a small minority need intensive preventive input. Reviews provide an opportunity to update the family health assessment which will enable a package of support to be developed using local services, such as those provided by Sure Start or referral to specialist services if required. Many children will have contact with a variety of early years practitioners all of whom need to be alert to possible concerns.

## 2.2.2 Screening

Screening is defined by the UK National Screening Committee as a *'public health service in which members of a defined population, who do not necessarily perceive they are at risk of, or are already affected by a disease or its complications, are asked a question or offered a test, to identify those individuals who are more likely to be helped than harmed by further tests or treatment to reduce the risk of a disease or its complications'.* www.nsc.nhs.uk

Those with a positive screening result require access to diagnostic and management services. Screening services should have a nominated lead who is responsible for monitoring and quality assuring the programme. All screening programmes should meet the standards set by the National Screening Committee. Healthy Child, Healthy Future should be supported by guidelines, standards, pathways and frameworks.

Responsibility for ensuring appropriate referral and follow up of a 'failed' or abnormal screening test result lies with the health professional who carried out the screening test.

The following screening programmes are in place in Northern Ireland:

- **Antenatal Infection screening for Hepatitis B, HIV, Syphilis and Rubella susceptibility.**
- **Ultrasound Foetal Anomaly (scope to be extended in the future).**
- **Newborn examination including eyes, heart, hips and testes in boys (EHHT).**
- **Neonatal hearing screening.**
- **Newborn bloodspot screening.**
- **Early identification of Developmental Dysplasia of Hips (DDH).**
- **Vision Screening.**

Local and regional protocols in relation to the delivery of these programmes must be followed at all times. They must continue to be developed and amended as appropriate.

## 2.2.3 Immunisations

Health professionals contribute to improving the health and quality of life of children by promoting the uptake of safe and effective vaccines. All children should be offered immunisation in line with the current local immunisation schedule.

Immunisations should be offered to all children and their parents where necessary and local initiatives should aim to target those hard to reach families including refugees, homeless, Traveller families, very young mothers, those not registered with a GP and those newly moved to the area. The current routine immunisation schedule, together with additional vaccines recommended for some groups, can be found on www.immunisation.nhs.uk

At every contact all practitioners involved in the delivery of the Healthy Child, Healthy Future Programme should identify the immunisation status of the child and parents/carers should be provided with good quality evidence based information and advice on immunisations including the benefits and possible adverse reactions.

Every contact should be used to promote immunisation. In addition, at every immunisation parents should have the opportunity to raise concerns about caring for their baby and their health and development, and should be provided with information or sources of advice.

# Section 3:
# Professional Guidance to Support the Healthy Child, Healthy Future, Programme

The guidance in this section on the schedule of contacts is not intended to be prescriptive and does not over-ride the responsibility of health practitioners to make judgements appropriate to the circumstances of individual families and children where additional support is required. It is the responsibility of practitioners to ensure that as new information becomes available (e.g. introduction of new guidance) it is used appropriately to support best practice. In relation to the venue for contact with clients, the preferred option is included in this guidance, however, based on professional assessment particularly in the preschool period, this may vary, particularly when children and family health assessment is up to date.

The personal child health record (PCHR) will provide the parent(s) with a comprehensive health record for their child. It will also provide a core child health data set.

The delivery of an effective programme must be supported by practitioners who have the right skills and expertise. In securing safe and effective care, opportunities for skill mix at local level should be encouraged within a robust framework of accountability and clinical governance.

**In each Trust, it must be clear who has professional and managerial responsibility for screening programmes, maintenance and reporting of immunisation uptake, introduction of new immunisation programmes, health promotion, care pathways for children with health or developmental problems, socially excluded groups, child protection, looked after children, links with education, staff training and data management.**

## Children educated outside school settings

Children may be educated outside the school setting for a number of reasons including:

- Chronic illness.
- Parental choice.
- Disciplinary measures (behaviour problems).

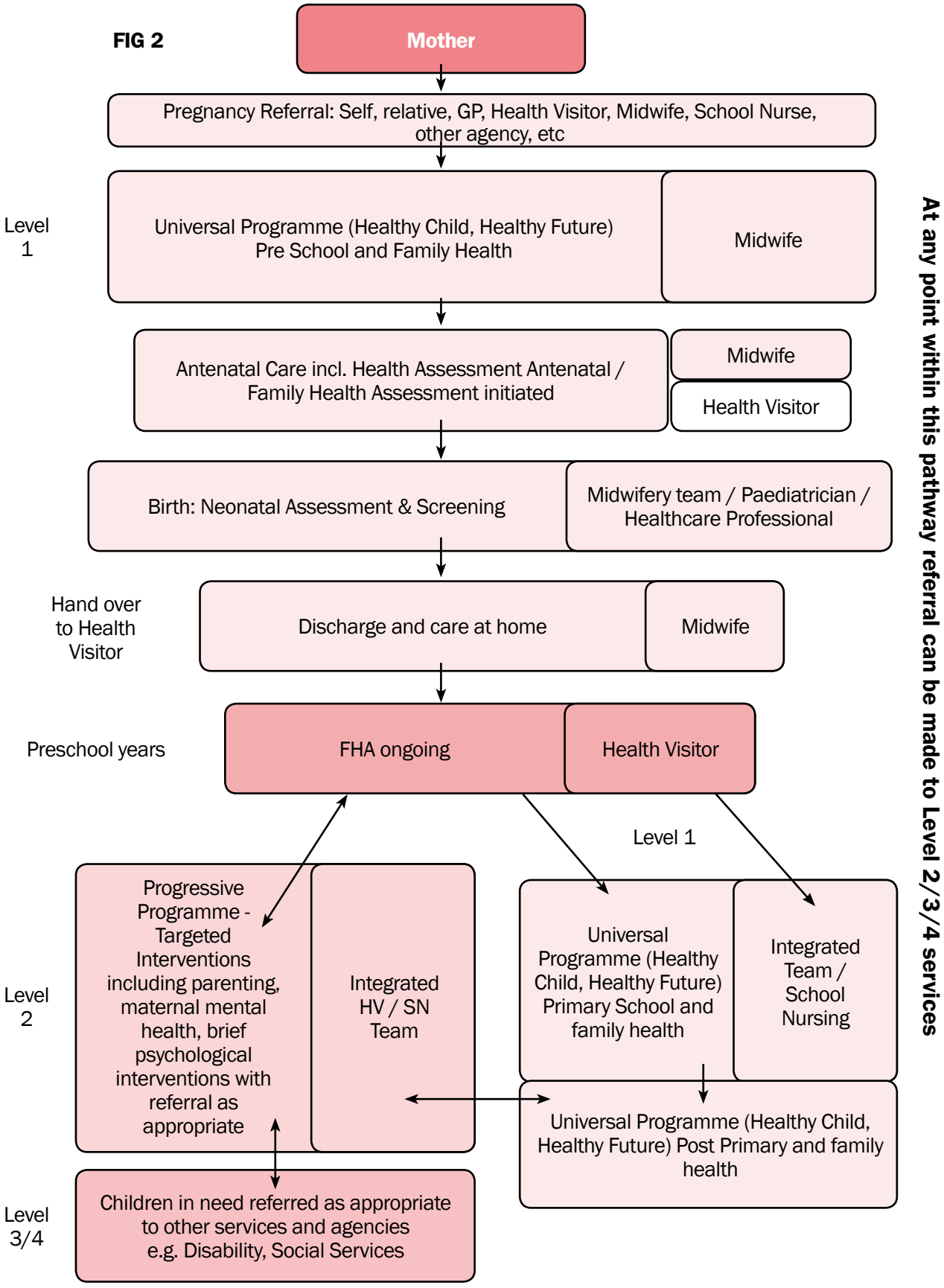
When children/young people are educated outside the school setting they may miss out on access to screening programmes, immunisations and health promotion. The impact of this life situation on an individual's mental health and family relationships may also be compounded by isolation, reduced self-esteem and missed education.

Systems should be in place to ensure communication links are established with local Education and Library Boards in order to identify children who do not attend school.

Figure 2 demonstrates the pathway for the provision of progressive services within the universal services provided to all 0-19 year olds and their families which is underpinned by this guidance.

## 3.1 Pathway for Provision of Services from Pregnancy to 19 years

FIG 2



# 3.2 The Universal Preschool Programme

## Flowchart

Antenatal care by MW/GP/Obstetrician throughout pregnancy

Antenatal home visit by health visitor after 28 weeks

Newborn physical exam by 72hrs

Newborn hearing screening
Newborn blood spot screening (5th day)

New baby review at home by health visitor (10-14 days)

6-8 week health review at home by health visitor

8-week comprehensive physical exam by GP including 1st primary immunisations

14/16 week health review at home by health visitor

Immunisations at 3 months and at 4 months by GP practice

7-9 months home visit by health visiting team member (Bookstart, health improvement)

1-year health review at home by health visitor

Immunisations at 12 months and at 15 months by GP practice

2 - 2 ½ yr health review at home by health visitor

From 3 yrs of age planned and opportunistic contact by CHPP team in various locations, including early years and local groups

Preschool immunisations by GP

4-4 ½ yr record review led by health visitor prior to handover to school nurse

**Ongoing Family Health Assessment and Provision of Targeted Services as appropriate**

# 3.3 The Universal Preschool Programme

## From 12 weeks of pregnancy to Term

| **Action: Midwife/GP/maternity health care staff**<br>From the notification of pregnancy to Term, maternity care professionals including midwives and GPs will provide a universal programme in the clinic or home/ various locations. | **Venue:**<br>Clinic/home/other |
|---|---|

**Activity:**

- Discuss role of midwife.
- Develop a relationship between the family and the primary healthcare team involved in the care of the mother and local community support networks.
- Discuss confidentiality and consent.
- A full health and social care assessment of needs, risks and choices by 12 weeks of pregnancy by a midwife.
- Routine enquiry into domestic abuse/parental substance abuse.
- Maternal mental health prediction and detection.
- BMI measurement.
- Advise on examinations which can identify pregnancies at risk.
- Health and lifestyle advice.
- Risk management e.g. STI's, infectious diseases.
- Routine antenatal care and screening including maternal infections, rubella susceptibility, blood disorders and foetal anomalies.
- Notification to the GP and health visitor of prospective parents requiring additional early intervention and prevention.
- Identify and prevent pregnancy complications and refer to appropriate professionals.
- Distribute and discuss *The Pregnancy Book* to first time parents.
- Support for families whose first language is not English.
- Sharing of information and communication or referral to other professionals and/or agencies as required.
- Distribute and discuss the new hand held maternity record.

**After 28 weeks**

- Introduction to resources and benefits including *The Parent's Guide to Money* information pack, Sure Start Centres, primary healthcare teams, and benefits and housing advice.
- Check that the Health and Pregnancy grant has been applied for.
- Identify risk factors for Hep B, TB, DDH, congenital heart disease, hearing, vision.
- Offer routine Anti D prophylaxis to Rhesus negative blood group women.
- Discuss and assess requirement for neonatal BCG and provide appropriate advice and guidance.

- Discussion on benefits and management of breastfeeding with prospective parents - and disadvantages of not breastfeeding.
- Provide newborn hearing screening parental information leaflet and promote the NHS programme (hospital/community midwife).
- Provide and discuss Newborn Bloodspot Screening leaflet.
- Inform parent(s) about the birth and options available.
- Discuss oral health including dental registration.
- Recognise social circumstances that may affect the parent's ability to provide optimal care for the infant.

**Preparation for parenthood to begin early in pregnancy and to include:**

- Information on services and choices, maternal/paternal rights and benefits, use of prescription drugs during pregnancy, dietary considerations, travel safety, maternal self-care, etc.
- Social support using group-based antenatal classes in community or healthcare settings that respond to the priorities of parents and cover:
  - ❑ The transition to parenthood (particularly for first-time parents); relationship issues and preparation for new roles and responsibilities; the parent-infant relationship; problem-solving skills (based on programmes such as Preparation for Parenting, First Steps in Parenting).
  - ❑ The specific concerns of fathers, including advice about supporting their partner during pregnancy and labour, care of infants, emotional and practical preparation for fatherhood, particularly for first-time fathers.
  - ❑ Interactive group work and/or peer support programmes to support health promotion e.g. breastfeeding.

**Risk Factors: Appropriate Risk factors to be considered**

Identify and review risk factors and respond within local and regional guidelines, protocols and pathways.

**Health Promotion**

A regionally agreed menu to be provided which should include topics such as:

| | | |
|---|---|---|
| Breastfeeding | Nutrition/diet/weight control | Oral Health |
| Parent Craft | Personal Safety | Physical Activity |
| Physical, emotional and mental wellbeing | | Smoking cessation |
| Substance Misuse | | |

## After 28 weeks of pregnancy

| **Action: Health visitor**<br>Health visitors will offer an antenatal review at home to all prospective parents after 28 weeks pregnancy (or earlier if indicated). | **Venue:**<br>Home |
|---|---|

**Activity**

- Commencement or review and update of FHA including:
  - Routine enquiry into domestic abuse/parental substance use/misuse
  - The prediction and detection of maternal mental health (NICE, 2007).
- A focus on emotional preparation for birth, carer-infant relationship, care of the baby, parenting and attachment.
- Identify those in need of further support during the postnatal period; and establish what their support needs are.
- Advise about sources of information on infant development and parenting, the Healthy Child, Healthy Futures Programme and Healthy Start.
- Provide information in line with DHSSPS guidance on reducing the risk of sudden unexpected death in infancy (SUDI).
- Discussion on breastfeeding with both prospective parents including:
  - Benefits to mother and child
  - The potential risks of not breastfeeding
  - Management of breastfeeding
  - Breastfeeding when out and about.
- Discuss and assess requirement for neonatal BCG and provide appropriate advice and guidance.
- Discuss neonatal jaundice.
- Introduce the concept and explain the use of the Personal Child Health Record (PCHR).

**Risk Factors: Appropriate Risk factors to be considered**
Identify and review risk factors and respond within local and regional guidelines, protocols and pathways.

**Health Promotion**
A regionally agreed menu to be provided which should include topics such as:

| | | | |
|---|---|---|---|
| Allergies | Breastfeeding | Nutrition | Oral Health |
| Parent Craft | Personal Safety | Physical, emotional and mental wellbeing | |
| Smoking cessation | Substance Misuse | SUDI | |

## Birth to 10 Days

| **Action: Midwife/GP/maternity healthcare staff**<br>Midwives, GPs and other maternity health care staff in hospital and home settings will provide a universal programme. | **Venue:**<br>Hospital/community/ home |
|---|---|

**Activity**

**Infant feeding:**

- All new mothers to have the opportunity to experience early skin-to-skin contact and the offer of help with a first breastfeed soon after delivery. Both breast and bottle-feeding parents will room-in 24 hours a day and be encouraged to practice baby led feeding. Skin-to-skin contact will also be promoted later as a way of soothing babies and encouraging feeding. Support should be culturally appropriate and should include both parents.
- Breastfeeding mothers will be provided with ongoing, consistent, effective support with positioning and attachment from healthcare professionals. Where available contact with a peer support mother within 48 hours of discharge from hospital or before will be encouraged.
- Use the Baby Friendly Initiative or a similar externally evaluated programme to promote breastfeeding.
- Provide information about professional, local and national breastfeeding support before discharge from hospital.
- Parents and carers of formula fed infants should be offered appropriate and tailored information on how to safely prepare and store formula milk.
- Provide information on vitamin supplements and Healthy Start.
- Provide information and advice to fathers/partners, to encourage their support for breastfeeding.

**Promotion of health and wellbeing:**

- A review and update of the health and social care assessment of needs, risks and choices by a midwife.
- Distribution and explanation of Personal Child Health Record soon after birth, complete PCHR as appropriate.
- Record feeding method on PCHR.
- Distribution of Birth to Five book to all mothers.
- Injury prevention.
- Routine enquiry into domestic abuse/parental substance use/misuse.
- SUDI including discussion on bed-sharing.

- Sharing of information and communication or referral to other professionals and/or agencies as required.

**Maintaining infant health:**

- Anticipatory, practical guidance on reality of early days with an infant, healthy sleep practices and bath, book, bed routine to increase parent-infant interaction, using a range of media (e.g. Baby Express newsletters).
- Administer IM Vitamin K.
- Observation of jaundice.

**Birth experiences:**

- Provide an opportunity for the father, as well as the mother, to talk about pregnancy and birth experiences, if appropriate.

**Promoting sensitive parenting:**

- Introduce parents to the 'social baby', by providing them with information about the sensory and perceptual capabilities of their baby using a range of media (e.g. *The Social Baby book/video* (Murray and Andrews, 2005) or *Baby Express* age-paced newsletters).
- Promote closeness and sensitive, attuned parenting, by encouraging skin-to-skin care and the use of baby carriers.
- Provide information and support to fathers, as well as mothers, that responds to their individual concerns and involves active participation with, or observation of, their baby - over several sessions, if possible.

**Hearing screening:**

- Newborn hearing screening soon after birth, preferably prior to discharge home.

**Risk Factors: Appropriate Risk factors to be considered**

Identify and review risk factors and respond within local and regional guidelines, protocols and pathways.

**Health Promotion**

A regionally agreed menu to be provided which should include topics such as:

Accident Prevention
Attachment, stimulation
Birth to Five Book
Breastfeeding Support
Developmental expectations
Infant Feeding
Maternal health & wellbeing, diet, rest, pelvic floor, oral health
Parenting skills /behaviour management (eg: sleep, crying)
PCHR book
PND
Safe Handling
Sexual health and Family Planning
SUDI

## By 72 hours

| **Action: Midwife/GP/maternity healthcare staff**<br>Midwives, GPs and other maternity healthcare staff in hospital and home settings will provide a universal programme. | **Venue:**<br>Hospital/community/ home |
|---|---|

**Activity**

- A comprehensive newborn physical examination to identify any anomalies that present in the newborn will be carried out by a suitably trained and competent maternity healthcare professional. This includes clinical observation and assessment of the eyes, heart and hips (pathway to be reviewed) and testes for boys, as well as a general examination. Where a woman is discharged from hospital before the physical examination has taken place, fail-safe arrangements should be in place to ensure that the baby is examined.
- Complete risk assessment of factors: to be carried out by midwives and recorded in PCHR.
- Following identification of babies with health or developmental problems, early referral to specialist team, advice to parents on benefits that may be available, and invitation to join parent groups.

**Risk Factors: Appropriate Risk factors to be considered**

Identify and review risk factors and respond within local and regional guidelines, protocols and pathways.

**Health Promotion**

A regionally agreed menu to be provided which should include topics such as:

| | | |
|---|---|---|
| Accident Prevention | Attachment, stimulation | Birth to five book |
| Breastfeeding Support | Contraception | |
| Developmental expectations | | |
| Infant Feeding | | |
| Maternal health & wellbeing, diet, rest, pelvic floor, oral health | | |
| Parenting skills/behaviour management (eg: sleep, crying) | | |
| PCHR Book | PND | |
| Safe Handling | SUDI | |

## By 5-8 days (ideally 5th day)

| **Action: Midwife/GP/maternity health care staff**<br>Midwives, GPs and other maternity health care staff in hospital and home settings will provide a universal programme. | **Venue:**<br>Hospital/community/ home |
|---|---|

**Activity:**

- Newborn bloodspot screening test for hypothyroidism, phenylketonuria, cystic fibrosis, medium chain acyl-coA dehydrogenase definiency (MCADD) and Sickle cell.
- Support with infant feeding.
- Ongoing review and monitoring of baby's health, to include important health problems, such as neonatal jaundice and/or weight loss.
- Safeguarding.

**Risk Factors: Appropriate Risk factors to be considered**
Identify and review risk factors and respond within local and regional guidelines, protocols and pathways.

**Health Promotion**
A regionally agreed menu to be provided which should include topics such as:

| | | |
|---|---|---|
| Accident Prevention | Attachment, stimulation | Birth to five book |
| Breastfeeding Support | Contraception | Developmental expectations |
| Infant Feeding | | |
| Maternal health & wellbeing, diet, rest, pelvic floor, oral health | | |
| Parenting skills /behaviour management (eg: sleep, crying) | | |
| PCHR Book | PND | |
| Safe Handling | SUDI | |

## Within 10-14 days

| **Action: Health visitor**<br>New baby review between 10-14 days face-to-face with parents at home by the health visitor. | **Venue:**<br>Home |
|---|---|

**Activity:**

- Review and update of the FHA including routine enquiry into domestic abuse/parental substance abuse.
- Review and update risk factors.
- Record feeding method in PCHR.
- Review newborn hearing screening results.

Infant feeding:

- Use of the UNICEF UK Baby Friendly Initiative evidence-based best practice programme for community settings to support the continuation of breastfeeding.
- Feeding assessment undertaken to ensure signs of adequate milk intake.
- Individual support and access to advice to promote exclusive breastfeeding.
- Provide information and advice to fathers/partners to encourage their support for breastfeeding.
- Provide information about local and national support groups and contacts.
- Provide information on Healthy Start and vitamin supplements.
- Provide information on delaying the introduction of solids until six months old.
- Parents and carers who feed with infant formula should be offered appropriate and tailored advice on safe feeding.
- Provide information on breastfeeding outside and local places where breastfeeding families are welcome.

Promoting sensitive parenting:

- Introduce both parents to the 'social baby' by providing them with information about the sensory and perceptual capabilities of their baby using media based tools (e.g *Baby Express newsletters* or *The Social Baby book/DVD* (Murray and Andrews, 2005).
- Promote closeness and sensitive attuned parenting by encouraging skin-to-skin contact and the use of soft baby carriers.
- Encourage use of baby transport (facing towards carer buggies and prams) which facilitate eye contact and interactive communication between parents and children.
- Invite parents to discuss the impact of the new baby on partner and family relationships.

- Provide temperament-based anticipatory guidance by giving advice to help parents think about and understand their individual infants' temperament and listening to their concerns. Topics that may be discussed are:
    - Interacting with the baby with songs, music and books
    - Colic, sleep, crying
    - Establishing a routine
    - Safety and car seats
    - The prevention of SUDI
    - Changes in relationships
    - Sex and intimacy after birth
    - The division of domestic chores.

- Provide parents with information about the Child Health Promotion Programme in Northern Ireland and the roles of the general practice, Sure Start and other local resources.

Promoting development:

- Encourage the use of books, music and interactive activities to promote development and the parent-baby relationship.
- Where apropriate, consider referral of families whose first language is not English to 'English as a second language services' to support equitable access.

Safeguarding:

- Raise awareness of accident prevention, especially the dangers of hot water, baby bouncers and travel safety in the pram and the car.
- Be alert to the risk factors and signs and symptoms of child abuse and neglect and follow local safeguarding procedures where there is concern.

Newborn baseline clinical assessment and observation of:

- Skin
- Colour (inc. jaundice, stool and urine colour). The identification of prolonged jaundice should be referred as per local protocol
- Muscle tone
- Fontanelle
- Umbilicus
- Hips (pathway to be reviewed).

Growth monitoring:

- An assessment of the infant's growth will be carried out which will involve accurate measurement, recording, interpretation and explanation of the infant's weight in relation to length, the growth potential and the growth pattern.

Check Vitamin K status:
The health visitor should take the opportunity to check that the child has received the appropriate dose of Vitamin K and record the PCHR accordingly.

Assessing maternal mental health:

- Women should be asked appropriate and sensitive questions by the health visitor to identify depression or other significant mental health problems as recommended by *NICE* (2007) guidelines on antenatal and postnatal mental health.

**Risk Factors: Appropriate Risk factors to be considered**
Identify and review risk factors and respond within local and regional guidelines, protocols and pathways.

**Health Promotion** (the following health promotion topics should be discussed with parents as appropriate and in line with guidance between birth of baby and 16 week contact based on parents immediate needs and ability to understand information being presented).

A regionally agreed menu to be provided which should include topics such as:

| | | |
|---|---|---|
| Accident prevention | Attachment, stimulation | Birth to five book |
| Breastfeeding support | Contraception | Developmental expectations |
| Immunisation schedule | Infant feeding/nutrition | |
| Maternal health & wellbeing, diet, rest, pelvic floor, oral health | | Meningitis |
| Parenting skills/behaviour management (eg: sleep, crying)/stimulation and play | | |
| PCHR Book | PND | |
| Safe handling | SUDI | |

## Between 6-8 weeks

| **Action: Health visitor**<br>Contact between 6-8 weeks of age by the health visitor, preferably prior to the immunisation and comprehensive physical examination by the general practice at 8 weeks. | **Venue:**<br>Home |
|---|---|

**Activity:**

- Review and update of the FHA including routine enquiry into domestic abuse/parental substance abuse.
- Review and update risk factors.
- Report results from newborn bloodspot screen if not already given to parents.
- Reassess maternal mental health (NICE, 2007).
- Provide ongoing breastfeeding support including recording the infant's feeding status in the PCHR.
- Monitor growth.
- In collaboration with GPs, include DDH age appropriate exam where this is currently carried out by the health visitor (pathway to be reviewed).
- Safeguarding.
- Encourage the uptake of local services e.g. Sure Start.
- Promote the uptake of immunisations.
- Revisit the prevention of SUDI.
- Give health information including guidance help lines and websites.
- Deliver key messages:
    - Parenting
    - Reinforce bath, book, bed routines
    - Infant health and wellbeing
    - Delayed weaning until 6 months old
    - Accident prevention
    - Temperament-based anticipatory guidance
    - Promoting infant development and the parent-baby relationship.

**Risk Factors: Appropriate Risk factors to be considered**
Identify and review risk factors and respond within local and regional guidelines, protocols and pathways.

**Health Promotion** (the following health promotion topics should be discussed with parents as appropriate and in line with guidance between birth of baby and 16 week contact based on parents immediate needs and ability to understand information being presented).

A regionally agreed menu to be provided which should include topics such as:

| | | |
|---|---|---|
| Accident prevention | Attachment, stimulation | Birth to five book |
| Breastfeeding support | Contraception | Developmental expectations |
| Immunisation schedule | Infant feeding/nutrition | |

Maternal health & wellbeing, diet, rest, pelvic floor, oral health
Meningitis
Parenting skills /behaviour management (eg: sleep, crying)/stimulation and play

| | |
|---|---|
| PCHR Book | PND |
| Safe handling | SUDI |

## At 8 weeks old

| **Action: GP**<br>A health review and first immunisation by the General Practice at 8 weeks | **Venue:**<br>Clinic |
|---|---|

**Activity:**

- A comprehensive physical examination by the GP with emphasis on the eyes, heart, hips in collaboration with health visitors, include DDH age appropriate exam where this is currently carried out by the GP-(pathway to be reviewed) and testes for boys.
- Social awareness; smile; intently regards mothers face; follows dangling object.
- Gross motor development; pull to sit; ventral suspension; moro reflex and muscle tone.
- Immunisation at 8 weeks as per Regional immunisation schedule.
- At every immunisation parents should have the opportunity to raise concerns about caring for their baby and their health and development, and should be provided with information or sources of advice.
- Safeguarding.

## 14-16 weeks

| **Action: Health visitor**<br>Contact at 14-16 weeks of age by the health visitor. | **Venue:**<br>Home or as appropriate if FHA completed up to date |
|---|---|

**Activity:**

- Review and update of the FHA including routine enquiry into domestic abuse/parental substance abuse first summary to be completed by 16 weeks.
- Review and update risk factors.
- Reassess maternal mental health (NICE, 2007).
- Provide ongoing breastfeeding support including recording the infant's feeding status in the PCHR.
- Monitor growth.
- DDH age appropriate exam-(pathway to be reviewed).
- Safeguarding.
- Encourage the uptake of local services e.g. Sure Start.
- Promote the uptake of immunisations.
- Revisit the prevention of SUDI.
- Give health information including guidance help lines and websites.
- Deliver key messages:
    - Parenting
    - Reinforce bath, book, bed routines
    - Infant health and wellbeing
    - Temperament-based anticipatory guidance
    - Promoting infant development and the parent-baby relationship
    - Benefits of staying with breastfeeding
    - Delayed weaning until 6 months old
    - Oral health
    - Accident prevention
    - Brief intervention for smoking cessation.

**Risk Factors: Appropriate Risk factors to be considered**
Identify and review risk factors and respond within local and regional guidelines, protocols and pathways.

**Health Promotion** (the following health promotion topics should be discussed with parents as appropriate and in line with guidance between birth of baby and 16 week contact based on parents immediate needs and ability to understand information being presented).

A regionally agreed menu to be provided which should include topics such as:

| | | |
|---|---|---|
| Accident prevention | Attachment, stimulation | Birth to five book |
| Breastfeeding support | Contraception | Developmental expectations |
| Immunisation schedule | Infant feeding/nutrition | |

Maternal health & wellbeing, diet, rest, pelvic floor, oral health
Meningitis
Parenting skills/behaviour management (eg: sleep, crying)/stimulation and play

| | |
|---|---|
| PCHR Book | PND |
| Safe handling | SUDI |

## At 3 and 4 months

| **Action: General Practice**<br>Immunisation by the General Practice at 3 months and at 4 months | **Venue:**<br>Clinic |
|---|---|

**Activity:**

- Immunisation at 3 months and again at 4 months as per Regional immunisation schedule.
- At every immunisation parents should have the opportunity to raise concerns about caring for their baby and their health and development, and should be provided with information or sources of advice.
- Safeguarding.

## Between 6-9 months old

| | |
|---|---|
| **Action: Health visitor led**<br>Contact between 6-9 months of age by a member of the health visiting team (usually home based however group activity may be appropriate where family health needs have been fully assessed, including, where appropriate a home safety assessment). | **Venue:**<br>Home or as appropriate if FHA completed and up to date |

**Activity:**

- Discuss and distribute the Bookstart pack.
- Provide ongoing breastfeeding support including recording the infant's feeding status in the PCHR.
- Encourage the uptake of local services e.g. Sure Start.
- Promote the uptake of immunisations.
- Revisit the prevention of SUDI.
- Give health information including guidance help lines and websites.
- Deliver key messages:
    - Infant health and wellbeing
    - Parenting
    - Reinforce bath, book, bed routines
    - Temperament-based anticipatory guidance
    - Promoting infant development and the parent-baby relationship
    - Benefits of breastfeeding after introduction of solids
    - 2nd stage weaning
    - Oral health
    - Accident prevention, eg home safety checklist/assessment including the use of basic safety equipment and the facilitation to access local schemes for the provision of safety equipment, information about thermal injuries, road and farm safety ,etc
    - Brief intervention for smoking cessation.

**Health Promotion**

A regionally agreed menu to be provided which should include topics such as:

Accident prevention/safety (relating to mobility/sun/home/farm safety etc)
Behaviour
Brief Intervention
Developmental expectations
Diet/nutrition/health eating
Immunisations
Oral health
Play/stimulation
Speech and language development

## 1 year of age

| **Action: Health visitor**<br>A home visit at 1 year of age will be undertaken by the health visitor. | **Venue:**<br>Home |
|---|---|

**Activity:**

- Review and update of the FHA.
- Review and update risk factors.
- Provide ongoing breastfeeding support including recording the infant's feeding status in the PCHR.
- Monitor growth.
- Review speech and language development.
- Encourage the uptake of local services e.g. Sure Start.
- Promote the uptake of immunisations.
- Promote key oral health messages incl. dental registration/regular dental attendance.
- Parenting support including temperament-based anticipatory guidance:
    - Encourage parent-infant interaction
    - Bath, book, bed routines
    - Healthy sleep practices including revisiting the prevention of SIDS
    - Managing crying
    - Attachment including age appropriate development issues such as clinginess, separation anxiety.
- Give health information including guidance help lines and websites.
- Safeguarding.

**Risk Factors: Appropriate Risk factors to be considered**
Identify and review risk factors and respond within local and regional guidelines, protocols and pathways.

**Health Promotion**
A regionally agreed menu to be provided which should include topics such as:

Accident prevention/safety (relating to mobility/sun/home/farm safety etc)
Behaviour
Brief Intervention
Developmental expectations
Diet/nutrition/health eating
Immunisations
Oral health
Play/stimulation
Speech and language development

## 1 year of age

| **Action: General Practice**<br>Immunisation by the General Practice at 1 year old | **Venue:**<br>Clinic |
|---|---|

**Activity:**

- Immunisation at 1 year as per Regional immunisation schedule.
- At every immunisation parents should have the opportunity to raise concerns about caring for their baby and their health and development, and should be provided with information or sources of advice.
- Safeguarding.

## At 15 months

| **Action: General Practice**<br>Immunisation by the General Practice at 15 months | **Venue:**<br>Clinic |
|---|---|

**Activity:**

- Immunisation at 15 months for MMR as per Regional immunisation schedule.
- At every immunisation parents should have the opportunity to raise concerns about caring for their baby and their health and development, and should be provided with information or sources of advice.
- Safeguarding.

## At 2 years (no later than 2 yrs 6 months)

| **Action: Health visitor**<br>A home visit at 2 years of age will be undertaken by the health visitor. | **Venue:**<br>Home |
|---|---|

**Activity:**

- Review and update of the FHA.
- Review and update risk factors.
- Monitor growth.
- Monitor child's social, emotional, speech & language (as per referral guidance where appropriate) and behavioural development and signpost to other services where appropriate e.g. group based parenting programmes.
- Review development and respond to parents concerns regarding physical health, growth, development and in particular note any early indications where referral may be required, e.g. concerns re autism etc.
- Monitor vision and hearing.
- Offer guidance on behaviour management.
- Promote language development through book sharing, groups for interactive activities e.g. songs, music and early years librarian sessions.
- Give health information including guidance help lines and websites.
- Encourage the uptake of local services e.g. Sure Start.
- Preview immunisation status and promote the uptake of immunisations including any missed immunisations.
- Promote key oral health messages incl. dental registration/regular dental attendance.
- Toilet training.
- Parenting support including temperament-based anticipatory guidance:
    - Encourage parent-infant interaction
    - Bath, book, bed routine
    - Healthy sleep practices and sleep management
    - Managing crying.
- Safeguarding.

**Risk Factors: Appropriate Risk factors to be considered**

Identify and review risk factors and respond within local and regional guidelines, protocols and pathways.

**Health Promotion**

A regionally agreed menu to be provided which should include topics such as:

Accident prevention/safety –use of safety equipment, access to local schemes, thermal injuries, farm safety

| | | |
|---|---|---|
| Behaviour | Brief Intervention | Developmental expectations |
| Diet/nutrition/health eating - portion sizes | | |
| Immunisations | Oral health | Play/stimulation |
| Speech and language | | |

## From 3 years

| **Action: Health visitor led**<br>The delivery of key messages from 3 years of age by a member of the health visiting team. | **Venue:**<br>Early years and group settings |
|---|---|

**Activity:**

- Support both parents by providing access to and information about early years services, Sure Start, health and guidance help lines and websites.
- Promote child's social, emotional and behavioural development and signposting to other services where appropriate e.g. group based parenting programmes.
- Delivery of key health messages (by early years services with health professional support) about:
    - Healthy lifestyles
    - Nutrition
    - Active play
    - Accident prevention (incl. home, road, farm etc)
    - Oral health.
- Safeguarding.

**Health Promotion**

A regionally agreed menu to be provided which should include topics such as:

Accident prevention/safety –use of safety equipment, access to local schemes, thermal injuries, farm safety

| | | |
|---|---|---|
| Behaviour | Brief Intervention | |
| Developmental expectations | | |
| Diet/nutrition/health eating - portion sizes | | |
| Immunisations | Oral health | Play/stimulation |
| Speech and language | | |

## Preschool Immunisation

| **Action: General Practice**<br>Immunisation by the General Practice | **Venue:**<br>Clinic |
|---|---|

**Activity:**

- Immunisation as per Regional immunisation schedule.
- At every immunisation parents should have the opportunity to raise concerns about caring for their baby and their health and development, and should be provided with information or sources of advice.
- Safeguarding.

## Between 4-4½ years (prior to handover to school nursing service)

| | |
|---|---|
| **Action: Health visitor led**<br>A record review will be undertaken by the health visiting team to identify those children not seen by them since the 2 year health review and a decision will be made if a home, clinic or phone contact is required. | **Venue:**<br>Clinic or telephone contact as appropriate |

**Activity:**

- Review and update FHA.
- Review immunisation status and promote the uptake of immunisations including any missed immunisations.
- Promote key oral health messages incl. dental registration/regular dental attendance.
- Support parenting by providing access to health information and guidance help lines and websites.
- Monitor child's social, emotional, speech & language and behavioural development and signposting to other services where appropriate e.g. (group based parenting programmes).
- Respond to parents concerns about their child's health and development.
- Safeguarding.
- Clarify school of enrolment.

The health visitor should prepare records for transfer to the school health department. Arrangements should be in place to ensure a smooth transition from the health visiting service to the school health service, i.e. health visiting record and/or summary report. The health visitor must highlight to the school nurse children/families who require a progressive service from the school health team e.g. vulnerable families, looked after children, children on the child protection register. If the health visitor is retaining a record and/or a child protection file, local protocol and policy regarding records management and safeguarding must be adhered to and the school health department and the school nurse should be informed as per local protocol and policy.

# The Universal School Age Programme Flowchart

**PRIMARY**

Primary 1: Health promotion and health appraisal inc BMI and TB risk assessment

Primary 1-7: Targeted Reviews including long-term conditions managment and TB risk assessment for transfers in

**POST PRIMARY**

Year 8: Health promotion, health protection and health appraisal

Year 8-14: Targeted Reviews including long-term conditions managment and TB risk assessment for transfers in

Year 9: HPV immunisation

Year 11 school leaver immunisation

**Family health assessment**

# 3.5 The Universal School Programme

## Primary School

### Primary 1 Health Promotion and Health Appraisal (preferably in the 1st or 2nd term)

| | |
|---|---|
| **Action: School nursing team**<br>The school nurse will undertake a health appraisal with the parents invited to attend in P1 which will include: | **Venue:**<br>School |

**Activity:**

- Review and update the FHA if parents attend.
- Individual health assessment, including any mental or emotional health issues and parental concerns.
- Height, weight, BMI.
- Hearing screening.
- Vision screening.
- Speech and language development.
- Signpost to other services for new or existing physical, emotional or developmental problems which are not being addressed.
- Oral health, including access to family dental services.
- Safety (road and farm).
- Safeguarding.
- Long term conditions management.
- Health protection-reminder regarding overdue immunisations, particularly those who have not received a second MMR. TB risk assessment in P1 and for all new entrants to primary school P1-P7.
- Review access to primary care.
- School profiling.

**Risk Factors: Appropriate Risk factors to be considered**
Identify and review risk factors and respond within local and regional guidelines, protocols and pathways.

**Health Promotion**
Fuller regionally agreed menu to be agreed including above activities.

## Primary 1 - 7 targeted reviews including long-term conditions management and TB risk assessment for transfer-ins

| | |
|---|---|
| **Action: School nurse led**<br>School nursing team led by the school nurse targeted reviews P1-P7 | **Venue:**<br>School |

**Activity:**

- Long term conditions management.
- Signpost to other services for new or existing physical, emotional or developmental problems which are not being addressed.
- Safeguarding.
- Health protection, reminder regarding overdue immunisations, TB risk assessment for new entrants throughout primary school P1-P7.
- Health appraisal for all new entrants if required throughout primary school from P1-P7.

**Health Promotion**

Fuller regionally agreed menu to be agreed including above activities.

## Post Primary School

## Year 8 Health Promotion, Health Protection and Health Appraisal

| | |
|---|---|
| **Action: School nurse led**<br>School nursing team led by school nurse (consider working within school peer education programmes). | **Venue:**<br>School |

**Activity:**

The school nurse will carry out a health appraisal which will include:

- Height, weight, BMI.
- Individual health assessment, including any mental or emotional health issues and parental concerns.
- Health protection - reminder regarding overdue immunisations, TB risk assessment.
- Personal Development (PD), Relationships and Sexuality Education (RSE).
- Safeguarding.
- Long term conditions management.
- Signpost to other services for new or existing physical, emotional or developmental problems which are not being addressed.
- School profiling.
- Transition to adolescence, post primary environment.

**Health Promotion**

- Smoking cessation.
- Safety/accident prevention (incl. home, road, farm etc).
- Promote key oral health messages incl. dental registration/regular dental attendance.

Fuller regionally agreed menu to be agreed including above activities.

## Year 8 - 14: Targeted reviews including long-term conditions management and TB risk assessment for transfer-ins

| **Action: School nursing team and consider working within school peer education programmes** | **Venue:**<br>School |
|---|---|

**Activity:**

- Long term conditions management.
- RSE programme offered tailored to the ethos of the school.
- Smoking cessation.
- Safeguarding.
- Health protection-reminder regarding overdue immunisations, TB risk assessment for new entrants throughout post primary years 8-14.
- Promote key oral health messages incl. dental registration/regular dental attendance.
- Signpost to other services for new or existing physical, emotional or developmental problems which are not being addressed.

**Health Promotion**

Fuller regionally agreed menu to be agreed including above activities.

## Year 9: HPV immunisation

| Action: School nursing immunisation team | Venue:<br>School |
|---|---|

**Activity:**

- HPV immunisation, reminder regarding overdue immunisations and related health promotion.

## Year 11: post primary school immunisations DT&P

| Action: School nursing immunisation team | Venue:<br>School |
|---|---|

**Activity:**

- DT & P immunisation and reminder regarding any overdue immunisations. Refer to GP and/or offer HPV as appropriate.

# Appendix 1

**Risk Factors**

These may be clinical or social in nature many of which are detailed within the DHSSPS, (2008), '*Understanding the Needs of Children in Northern Ireland*' (UNOCINI).
Thresholds of Need Model

For example
Concerns about the pregnancy/child
Low Self Esteem
Relationship difficulties
Maternal Anxiety/depression
Smoking
Nutrition
Overweight/obesity
Breastfeeding
SUDI
TB
Congenital Heart disease
Hepatitis B
DDH
Hearing
Vision

**Higher risk factors**

Alcohol/Substance abuse
At risk first time mothers
Parents with learning difficulties/disability
Domestic violence and abuse
Serious mental illness
Previous /known child protection issues
Review and follow up of previously identified concerns identifying in partnership with parents/ young people plans of action with agreed timescales where appropriate
Identify and follow up incomplete screening, non-compliance with reviews and referrals.

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# *Healthy Child, Healthy Future*

## A Framework for the Universal Child Health Promotion Programme in Northern Ireland

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May 2010

‘Supporting the best start in life’

# Infant Mental Health Framework for Northern Ireland

**April 2016**

*Promoting positive social and emotional development from pre-birth to 3 years.*

HSC Public Health Agency

# Foreword:

‘Supporting the

## This Infant Mental Health Framework represents a commitment by the Public Health Agency, Health and Social Care Board and Trusts, as well as academic, research, voluntary and community organisations across Northern Ireland, to improve interventions from the ante-natal period through to children aged 3 years old.

The Framework aims to ensure that commissioners and policy makers are fully informed of the latest evidence and interventions and are supported to make the most appropriate decisions based on this knowledge. This Framework aims to provide practitioners across a wide range of health, social care and education disciplines with the skills to support parents and children aged 0-3 in the development of positive infant mental health. Finally, the Framework encourages and highlights the need for service development to ensure the optimum use of evidence based interventions with families with children aged 0-3 where there are significant developmental risks.

The Framework has been the subject of an extensive engagement and consultation process; engagement has involved parents, practitioners, policy makers, young people and a wide range of stakeholders across the statutory, voluntary and community sectors. The development of the Infant Mental Health Framework has been widely welcomed and we want to thank everyone who has provided constructive and valuable feedback, all of which has helped to shape this final version. .

### Why is this important?

Improving long-term outcomes for the whole population begins with ensuring that every child has the best possible start in life, with a focus on ensuring that children who are the most vulnerable and at risk are especially supported. There is now a wide body of evidence which demonstrates that disadvantage for some children starts before birth and accumulates throughout life. Consequently, this Framework considers actions required during pregnancy and up to three years, maximising potential for early intervention. The promotion of positive infant mental health and wellbeing is a cornerstone of this Framework, as protecting and nurturing mental health in childhood contributes to productive social relationships, effective learning, and good physical health throughout life.

Becoming a parent and having a newborn is both fulfilling and challenging as new roles and responsibilities emerge within the family. For those facing adversities such as very premature births, domestic violence, mental health problems or drugs and alcohol misuse and for those who themselves have had very difficult starts to their own lives and/or are also living in difficult social and economic circumstances, these challenges can be even more considerable. It is therefore important to take an ecological approach to child development, considering the child in relation to their wider family and community circumstances and the impact that these factors may have.

When secure attachments are not established early in life children can be at greater risk of a number of detrimental outcomes, including poor physical and mental health, relationship problems, low educational attainment, emotional difficulties and conduct disorders.

A large body of evidence demonstrates that many children may face pronounced adverse experiences in infancy, including repeated exposure to neglect, chronic stress, and abuse. Such experiences may disrupt brain development and lead to emotional problems and potential life-long difficulties with self-control, engagement in high-risk health behaviours, aggressive behaviour, lack of empathy, physical and mental ill-health and increased risk of later self-harm or suicide. As well as the human

# best start in life’



cost there are increased economic costs to society in terms of healthcare, child welfare, education, unemployment, policing, juvenile justice and prisons. It should however also be recognised that for some people their mental health conditions are not in any way related to early childhood experiences; in addition, it is not always inevitable that early childhood trauma leads to mental ill-health in later life.

We know that warm, consistent, positive, and engaged parenting in a safe and secure environment enables the infant to grow into a child and adult who is more likely to have high self-esteem; strong psychological resilience, empathy and trust; the ability to learn; and reduced risk of adopting unhealthy lifestyle choices.

The development of this Framework has been significantly influenced by ongoing work across the UK. Notable examples of good practice include the work of the Wave Trust who developed the '1001 Critical Days' and 'Building Great Britons' reports; and the World Health Organisation's 'Investing in Children' report. The publication of the Marmot Review (2010) made a significant contribution to prioritising early years interventions as part of public health policy and practice, particularly the objective of 'giving every child the best start in life'. Of the six policy objectives identified, this was the 'highest policy recommendation' emphasising the Review's life course perspective. The Review also called for an increase in the proportion of overall expenditure allocated to the early years, and emphasised the need to reduce inequalities in the early development of physical and emotional health and in improving cognitive, linguistic and social skills - hence building resilience and wellbeing among young children. The new Public Health Strategic Framework for NI: Making Life Better (DHSSPS, 2014) makes a clear commitment to ensuring that the theme of 'giving every child the best start in life' will remain a key priority.

This Infant Mental Health Framework for Northern Ireland has 3 key priorities and outlines recommendations for action to:

- **Promote and disseminate evidence and research** on infant mental health to policy makers, practitioners and importantly, the wider population. Infant mental health should be everyone's business; consequently organisations across all sectors, including all NI government departments, should be in a position to consider and act on the compelling evidence and implications.

- **Inform workforce development** to ensure frontline staff have the necessary knowledge and skills to assess risks to the mental health of infants by early identification of factors associated with parent-infant interaction, and are adequately supported to put this knowledge into practice.

- **Inform service development** to ensure that universal and targeted services can respond as effectively as possible to maximise the optimal development of newborns and infants, particularly taking account of newborns facing the highest levels of risk and adversity. Given that infant mental health is fundamentally connected to the physical and mental health and wellbeing of the primary caregiver, as well as their ability to parent, service development is as relevant for those providing adult services as it is for children's services. Ideally there should be an increase in interventions that focus on supporting the parent – infant relationship where the parent faces challenges to their own emotional well-being. Services must also be informed by parent and practitioner feedback.

This Infant Mental Health Framework indicates the need to intervene at as early a stage as possible to support parents, build capacity, prevent problems arising and maximise outcomes for all children and families. Going forward, we will establish an Implementation Group to oversee the progress of this Framework through subsequent annual action plans. We are confident that considerable learning as well as measurable actions can be undertaken to collectively improve outcomes in later life as we seek to 'support the best start in life' for all babies.

**Dr Eddie Rooney, Public Health Agency.**
**March 2016**

# Acknowledgments

The Framework acknowledges the considerable successes and good practice being led and undertaken across the statutory, voluntary and community sector on the infant mental health theme, and the many family support programmes and services that are currently available. The Framework does not seek to duplicate this work, rather to make best use of what is already available and in addition, to build on this where possible to provide the most effective and efficient family support possible.

AIMH, the Association for Infant Mental Health (NI), for example, has undertaken, over a number of years, a considerable amount of awareness raising through bringing UK and international experts to NI to present research and practice as well as policy advocacy on the need for the development of integrated pathways for families and infants in need.

Health and Social Care Trusts have all recognised the importance of focussing on the promotion of positive Infant Mental Health and have organised themselves through various working groups to develop integrated actions across Trust Directorates.

The Health and Social Care Board through the Childcare Partnerships and those involved in the Children and Young People Strategic Partnerships have also been undertaking considerable training and awareness, for example through inputs and dissemination of DVDs from early year's expert Suzanne Zeedyk as well as events focussing on infant development.

We also acknowledge the long experience and essential and wide reaching support that Sure Start provides to families, many of whom are hard to reach and often facing multiple adversities. In addition, Tinylife provides support for those who have experienced still birth, miscarriage or premature birth and works alongside healthcare practitioners and families in order to identify and address need. The Lifestart foundation provides a home visiting service to families and other voluntary and community organisations, such as Barnardo's NI, Action for Children, NSPCC, NIACRO, Aware and Replay Theatre Company who continue to deliver support and services as well as innovations on the infant mental health theme. Over 8,000 families with babies and toddlers participated, for example, in the highly successful Baby Celebration Day, run as a collaboration last year between Replay Theatre Company, Sure Starts and Belfast City Council.

A wide number or organisations across all sectors contributed significantly to the development of this Framework and particular thanks are extended to representatives from Trusts, HSCB and PHA, members of the Infant Mental Health Association NI, QUB, Stranmillis College and Voluntary Sector who attended and supported the Plan Advisory Groups.

The Public Health Agency wish to acknowledge the key role played by NCB in facilitating these groups and ensuring effective stakeholder engagement throughout the development of the Framework. NCB's additional contribution to the drafting process, through the provision of evidence papers and technical support is also acknowledged.

These organisations represent only a small sample of those that are well positioned to progress actions on the infant mental health theme and will be critical to the successful implementation of the Framework and yearly action plans thereafter.

There are considerable implications and challenges to ensure full implementation of this Framework. Embedding Infant Mental Health in vocational training across Medicine, Nursing, Social Work, Psychology, Early Years, Teaching and Education, for example, will require champions, enablers and implementers across different sectors. However, as acknowledged here, much progress has already been made and a phased and staged approach will be undertaken to build on success to date.

# Index

# Infant Mental Health Framework Vision



# The aim of this framework is to ensure that all children have the best start in life by prioritising and supporting the development of positive social and emotional wellbeing

**This framework has the following objectives:**

- Parents and practitioners, and the wider population, better understand the importance of attachment and the essential elements of positive social and emotional health in infants.
- Parents and practitioners have improved skills to engage positively with infants to maximise their social and emotional development.
- Practitioners and parents are better able to respond to predictors of vulnerability in infants and families and identify early signs of delayed social and emotional development in infants and /or emotional distress.
- Appropriate services are in place with clear referral pathways and are available to respond to identified infant mental health and wellbeing needs across the region, on an equal basis for all.

# Introduction



# Infant Mental Health: a definition

**Infant mental health is defined by the Association for Infant Mental Health UK as *'the study of mental health as it applies to infants and their families'.***

**Infant mental health focuses on social and emotional development during the first three years of life for an infant and their family. This includes a child's ability to form relationships with other children and adults; to recognise and express emotions; and to explore and learn about their environment in a safe and happy way**

## Why is it important to consider infant mental health?

A growing body of evidence from the clinical and social science fields shows that the areas of the brain that control social and emotional development are most active during the first 3 years of a child's life (and particularly active in the early months). Careful nurturing of a child's social and emotional health during their early years is vital to provide them with the skills necessary to form relationships and interact with society later in life. The quality of relationship between a child and their primary caregiver is central to this process.

The following theories form the basis of current discussions around infant mental health:

- **Attachment:** A strong bond between an infant and a primary caregiver is developed though positive and responsive behaviours from the care-giver, including mirrored behaviours, physical contact and proximity. A securely attached infant will have the social and emotional confidence to build relationships and explore the world around them (Barlow and Svanberg, 2009).

- **Self-regulation:** Neuropsychologists have expanded the link between social development theories and neuroscience, including the central importance of self-regulation (Schore, 2004); that is an infant's ability to regulate its own internal emotional states, soothing itself rather than requiring parental soothing. This then forms the building blocks of healthy external relationships.

- **Building resilience:** Self-regulation is also central to building resilience, which is an infant's ability to 'bounce-back' from difficult or traumatic experiences, and to learn from them. Development of resilience in the first three years of life is essential to dealing with adversities later in life (Newman, 2004).

The key timeframe for healthy attachment and hence healthy social and emotional development is considered to be between **0 and 3 years**, when brain development is in its optimal phase. However it should be noted that these considerations begin long before birth. Development starts during pregnancy and the choices and experiences of the mother during this period can have a significant impact on maternal and infant social and emotional health. Promotion of antenatal bonding with the bump, preparation for parenthood and early detection of antenatal depression are all crucial, and the midwife can play a key role in this.

After birth, key factors such as feeding, skin to skin contact, mirroring behaviours, responsive parenting, and a stimulating play environment can also contribute positively to overall healthy development and relationship building between infant and caregiver. All parents/carers play a critical role in ensuring good mental health development for their children and in preventing poor developmental outcomes. However, parents facing adverse circumstances may on occasion need additional support and it is essential that suitable provision is available when required.

## The Ecological or 'whole child' approach

Bronfenbrenner (1979) developed the ecological approach to child development, theorising that the child sits at the centre of a series of structures and systems which collectively impact on his/her development. These structures include the family, school, friends, health and social care services and systems, and indeed the wider community, and continually interact with one another as they shape a child's life.

In this regard, it is particularly important to recognise the unique social and cultural context in Northern Ireland, and the very real impact that this may have on parenting and/or child outcomes. In the report 'Towards a better future: the trans-generational impact of the troubles on mental health' (March 2015), the Commission for Victims and Survivors highlights the particular impact that the legacy of conflict in Northern Ireland may have on the early development of children.

It is clear then that we need to consider the child 'in context'. The 'whole child' approach is referenced across a range of health and social care strategies and policies, and recognises that services must work together in order to provide the most efficient and effective support for children and families. Infant mental health is therefore **'everybody's business'**. A joined up approach to service development and delivery is central. It is critical that practitioners across the full range of services in health, social care and education are equipped to support healthy social and emotional development and that a common message is given out by all.

*"If we intervene early enough, we can give children a vital social and emotional foundation which will help to keep them happy, healthy and achieving throughout their lives and, above all, equip them to raise children of their own, who will also enjoy higher levels of well-being."*

**Graham Allen MP (Early Intervention: The next steps, 2011)**

# The Current Policy Context

## All policy relevant to children in Northern Ireland (NI) falls under the Children (Northern Ireland) Order (1995) which lays the foundations for all those who work with or care for children and young people. Underpinning the Order is the principle that parents should be, whenever possible, supported to bring up their children in their own home.

The UN Commission on the Rights of the Child (UNCRC) also recognises the primary role of the family, with article 18 stating that both parents share responsibility for their child and should consider what is best for him or her; however the government is responsible for providing support services to help parents to do this. Likewise, the UN Convention on the Rights of Persons with a Disability recognises the family as 'the natural and fundamental group unit of society' and should therefore be given the necessary support and assistance.

Health is a key priority right across the policy arena. The current ***'Our Children and Young People - Our Pledge: A ten year strategy for children and young people in Northern Ireland 2006-2016' (OFMDFM, 2006)*** identifies 'healthy' as the first of the high level outcomes for all children and young people. In addition, as research advances and policy develops, early intervention and support for the antenatal to three years of age period is increasingly highlighted, both here in Northern Ireland and across the UK, and sets the context for this investment in promoting positive infant mental health. The 10 year strategy is due to end in 2016 and a new 'children's strategy' is in the early stages of development; it is essential that the NI Executive's commitment to prevention and early intervention is prioritised in this new strategy.

***DHSSPS (2010) Healthy Child: Healthy Future*** sets out the universal child health services delivered to all parents and children in Northern Ireland. It is recognised as being central to securing improvements in child health across a range of issues. Effective implementation by health care professionals including GPs, midwives and health visitors will promote positive parenting and the importance of strong parent child attachments for a child's healthy social and emotional health and wellbeing.

***DHSSPS (2014) Making Life Better: a Whole System Strategic Framework for Public Health*** takes a life course approach to health and wellbeing, hence one of its key themes is 'Giving every child the best start in life'. This theme identifies the following long term outcomes:

- Good quality parenting and family support
- Healthy and confident children and young people
- Children and young people skilled for life

In particular the framework recognises the central roles that parenting and family support play in the healthy physical, social and emotional development of children. The implementation of an Infant Mental Health plan is a key first action of the 'Making life better' framework. Other key actions which contribute to the promotion of positive infant mental health include the roll out of the Family Nurse Partnership; implementation of the breastfeeding strategy and promotion of universal health and maternity services.



Alongside this Public Health Framework, early intervention is prioritised in a number of key government strategies, for example **DHSSPS (2009)** ***'Families Matter: Supporting Families in Northern Ireland;*** **Department of Education (2012)** ***'Learning to Learn: a framework for early year's education and learning;*** **and the DHSSPS (2012)** ***Strategy for Maternity Care in Northern Ireland*** **(2012-2018)**. The DHSSPS is also developing a new ***Protect Life: Positive Mental Health and Suicide Prevention Strategy*** **(due 2016)**, which will have a life course approach with a significant emphasis on infant mental health. Each of these policies recognises that health, social care and education are inter-dependent in enabling the best possible outcomes for our children and families. Indeed, the Department of Education provides core funding for the Sure Start service across Northern Ireland; this service is underpinned by policy and aims to deliver health, education and parenting support for families with children aged 0-3 in a coordinated way across the most disadvantaged areas of NI.

## Putting Policy Into Practice

Various structures are already in place to take forward the key theme of prevention and early intervention. The Children and Young People's Strategic Partnership (CYPSP) is a multi-agency partnership that brings together the leadership of key statutory, community and voluntary agencies, working to improve outcomes for children and young people. Early intervention is one of the key themes of this work. Through the CYPSP, there are currently 5 outcomes groups, 29 Family Support Hubs and 26 Locality Planning Groups in place across Northern Ireland.

Building on the universal services already delivered to children and families, a collaborative approach to early intervention funding is being taken forward through the newly established **Early Intervention Transformation Programme (EITP)**. The programme seeks to:

- Build on the Child Health Promotion Programme and the NI Maternity Strategy to equip all parents with the skills needed to give their child the best start in life
- Provide additional support for families when problems first emerge, outside of the statutory system
- Positively address the impact of adversity on children by intervening both earlier & more effectively, if and when required, to reduce the risk of poor outcomes later in life.

Children and families do not all have the same level of need, nor do individual families have the same level of need through the lifecourse. The DHSSPS (2012) policy document; ***'Child and adolescent mental health services: A service model'*** outlines the stepped care model of service provision (see appendix 2) and provides commissioners and service providers with a framework against which to remodel CAMHS service provision. At the centre of this framework is a stepped-care approach whereby; *'the appropriate level of care is provided at the earliest point that best meets the assessed needs of the infant, child and young person whilst also enabling them to move up or down the steps as their need changes'.* (DHSSPS, 2012.)

The stepped care model shifts the focus of therapeutic intervention from service description, to the provision of a needs-based service. This model of service delivery is aimed at the development of integrated care pathways with a focus on skills-based and evidence-based practice aligned to the needs of children and their families/carers. Care interventions are agreed and delivered at the most appropriate step with movement up or down to other services as clinically required. The model is recommended by the National Institute for Health and Clinical Excellence (NICE) on the basis that it promotes a continuum of care approach.

Some of the key priorities within the continuum of care approach include:

- Support of parents and carers, recommended to continue into the adolescent years, in recognition that it is primarily within the family that the mental health and emotional wellbeing of children is secured.
- Multi-agency interventions across the sectors, with services configured on the principle of 'recovery' within the context of provision of wrap around care for the individual child/ young person and their families.
- Better collaborative working with parents/ carers, community & voluntary sector, education sector and other organisations.
- Development of protocols between CAMHS services, adult services, the criminal justice system, and youth services and other stakeholders.
- Development of an effective referral process enabling defined and simplified points of entry to specialist services which are integrated with other referral pathways including child and family services.

Set against this backdrop, securing a strategic approach to early child development and family support is a key priority for the Public Health Agency (PHA). To that end the PHA established the Child Development Project Board (CDPB) in June 2010. Through the CDPB, chaired by the PHA and including members from the Health and Social Care Board, Health and Social Care Trusts, academia and the community and voluntary sector, the PHA has taken a strategic life course approach to child development and family support. Working from an evidence based perspective, the CDPB has identified needs of children and young people, aged 0-18, who experience inequalities, and initiated and supported a range of programmes and services to address these needs. The development of an Infant Mental Health Framework is one of a number of key workstrands.

This Framework is aimed at supporting parents, early years practitioners across a wide range of health, social care and education disciplines and organisations who support parents and children aged 0-3, as well as ensuring that commissioners and policy makers are fully informed and therefore supported to make the most appropriate decisions. Through annual implementation plans the Infant Mental Health Framework will require an extensive range of organisations and stakeholders to contribute to actions across the three identified themes. The PHA is committed to working closely with Departments, Trusts, Local Government, voluntary and community sector organisations and others in the outworking of this framework, taking a holistic approach to ensure the best outcomes for children and families. It is important to note that many families have additional needs and it is critical that the framework is relevant and supportive of all children and families.

## Framework Development Process

**To date the following activities have been undertaken to inform this regional Infant Mental Health Framework:**

- **Audit Phase 1** - In June 2012 an audit of infant mental health training and resources available in Northern Ireland was undertaken with key policy makers, practitioners and researchers from the statutory, community, voluntary and academic sectors. The aim of this activity was to establish the extent and sources of current training, target audiences, funders and the uptake of training amongst the statutory, community and voluntary sectors.
- **Gap analysis** - Following on from the phase 1 audit, a similar group of policy makers, practitioners and researchers were asked to identify gaps in the current provision of training on infant mental health
- **Audit Phase 2** - A second phase of the audit was completed in September 2013 which tracked the progress of key infant mental health training developmental areas that were identified in the phase 1 audit and the gap analysis.



- **Stakeholder engagement** - Since June 2010 numerous seminars have been organised in order to share good practice and provide feedback on the progress made towards the development of this Framework. Key speakers at these events included Suzanne Zeedyk, George Hosking, Dr Bruce Perry, Dr Ian Manion and Professor Terence Stephenson. These seminars were attended by over 500 different delegates from across the statutory, community, voluntary and academic sectors. An outline draft was presented to a workshop of over 150 people and their comments have been incorporated in this Framework.

- **Case study visit to Finland** - In September 2013 a delegation of 25 policy makers, commissioners and high-level practitioners participated in a case study visit to Finland. The primary aim of the visit was to increase knowledge on the early education and early years sector in Finland in order to inform the infant mental health agenda and parenting support in Northern Ireland.

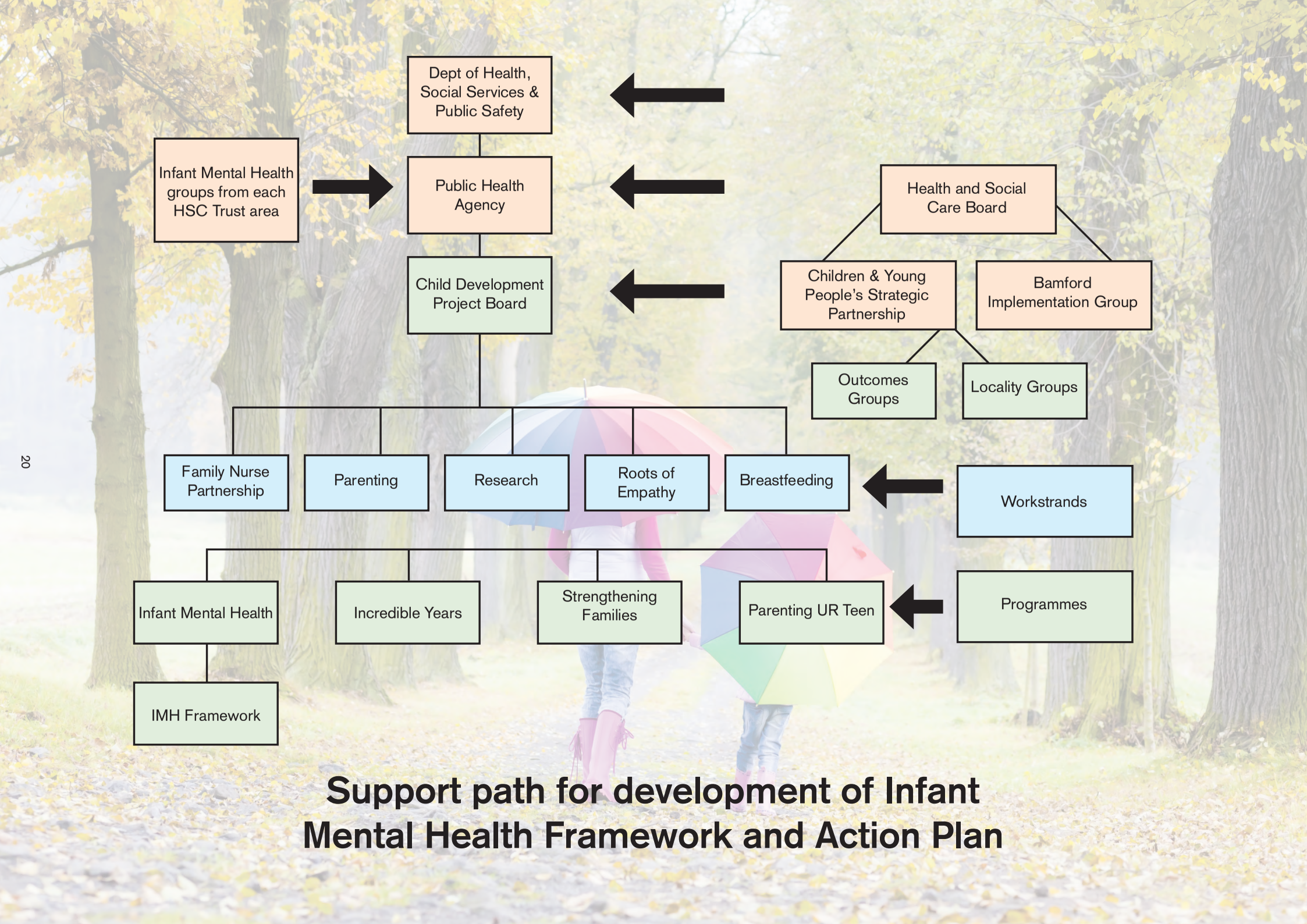
- **Regional Infant Mental Health Planning Group** - This group has been working to inform the production and implementation of this Infant Mental Health Framework as well as providing specialist input on infant mental health for the new 'Protect Life: Suicide Prevention strategy from DHSSPS (in development). Members include the PHA, HSC Trusts, HSCB and DHSSPS.

- **Regional Infant Mental Health Reference Group** - This group supports the work of the Infant Mental Health Planning Group. Members represent the voluntary and community sector, as well as academia.

- **Formal 12 week consultation period (March – May 2015)** - the draft framework and initial action plan was released for public consultation between March and May 2015. Thirty three written consultation responses were submitted, from a range of voluntary and statutory organisations as well as three from individual practitioners. In addition, focus groups were held with 56 parents at six Sure Start groups across Northern Ireland, as well as a focus group with 5 members of NCB Young Parents group. A thematic analysis of consultation responses was carried out using NVivo, a qualitative software package used to support analysis of a large volume of text-based information. Following analysis, the Framework was revised accordingly.

*"A young child's experience of an encouraging, supportive, and co-operative mother, and a little later, father, gives him a sense of worth, a belief in the helpfulness of others, and a favourable model on which to build future relationships… by enabling him to explore his environment with confidence and to deal with it effectively, such experiences also promote his sense of competence."*

**Bowlby, J. (1982). Attachment and loss. Vol. 1: Attachment (2nd Ed.). New York: Basic Books**




# Support path for development of Infant Mental Health Framework and Action Plan


"Approximately 35-40% of infants are less than securely attached."
Barlow, J. & Svanberg, P.O. (2009) Keeping the baby in mind. Infant Mental Health in practice. London: Routledge.

# Infant Mental Health in Northern Ireland: Key Statistics

## 24,394

**No. of Births in NI**
(NISRA, 2014)

## Child Population 433,161

(HSCB, 2015)

**24,255** Age 0-1 (6%)

**101,526** Age 1-4 (24%)

## No. of Births to Teenage mothers

(under 20 years)
(HSCB, 2015)

**84**

Births to mothers aged under 17 reached a new record low in 2015 with 84 births recorded, a rate of 2.4 per 1,000 females aged under 17.

## Premature or Low Birth Weight

(NICORE Database 2012, QUB)

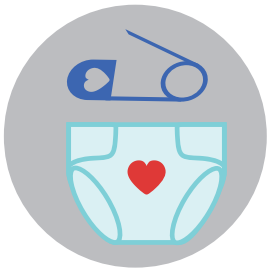
**6.3%** of babies were born with low birth weight (i.e. less than 2500 g)

**7.3%** In 2012, 1877 babies (7.3% of live births) spent time in a neonatal unit

## Postnatal depression

'Of 25,273 births in 2011 in Northern Ireland, 2527 women developed antenatal depression, 3790 women developed postnatal depression, 50 mothers developed puerperal psychosis and 50 were admitted as a result of relapsing' (DHSSPS, 2013)

It should be noted that Postnatal depression often goes unreported and therefore the figure could be much higher than this (Royal College of Psychiatrists, 2011)



## Child Protection Register

(HSCB, 2015)

# 1969

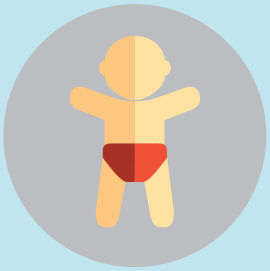
children on the child protection register. This figure has fallen from 2,401 in 2011. 226 of these are under 1 year of age. 519 of these are between 1 & 4 years of age

## Children Looked After in Care

(HSCB, 2015)

# 2,875

children in care, 76.2% - Foster Care, 11.8% - Placed with Family, 6.7% in Residential Care. 112 of these are under 1 year old. 581 of these are between 1 and 4 years old



## Smoking during pregnancy

(NINIS, 2013)

NI total: 15.7%

| Most deprived areas: | Least deprived areas: |
|---|---|
| 29.7% | 9.0% |

## Breastfeeding rate at discharge

NIMATS (2014)

NI total: 45.7%

Most deprived areas: 33.1%

Least deprived areas: 59.4%

Mothers under 20: 19.9%

## Child poverty

(DSD, 2015)

# 101,000

(23%) children living in poverty in Northern Ireland, however, child poverty rate varies widely across the region

## Breastfeeding exclusively at 6 mths

(Infant Feeding Survey, 2010)*

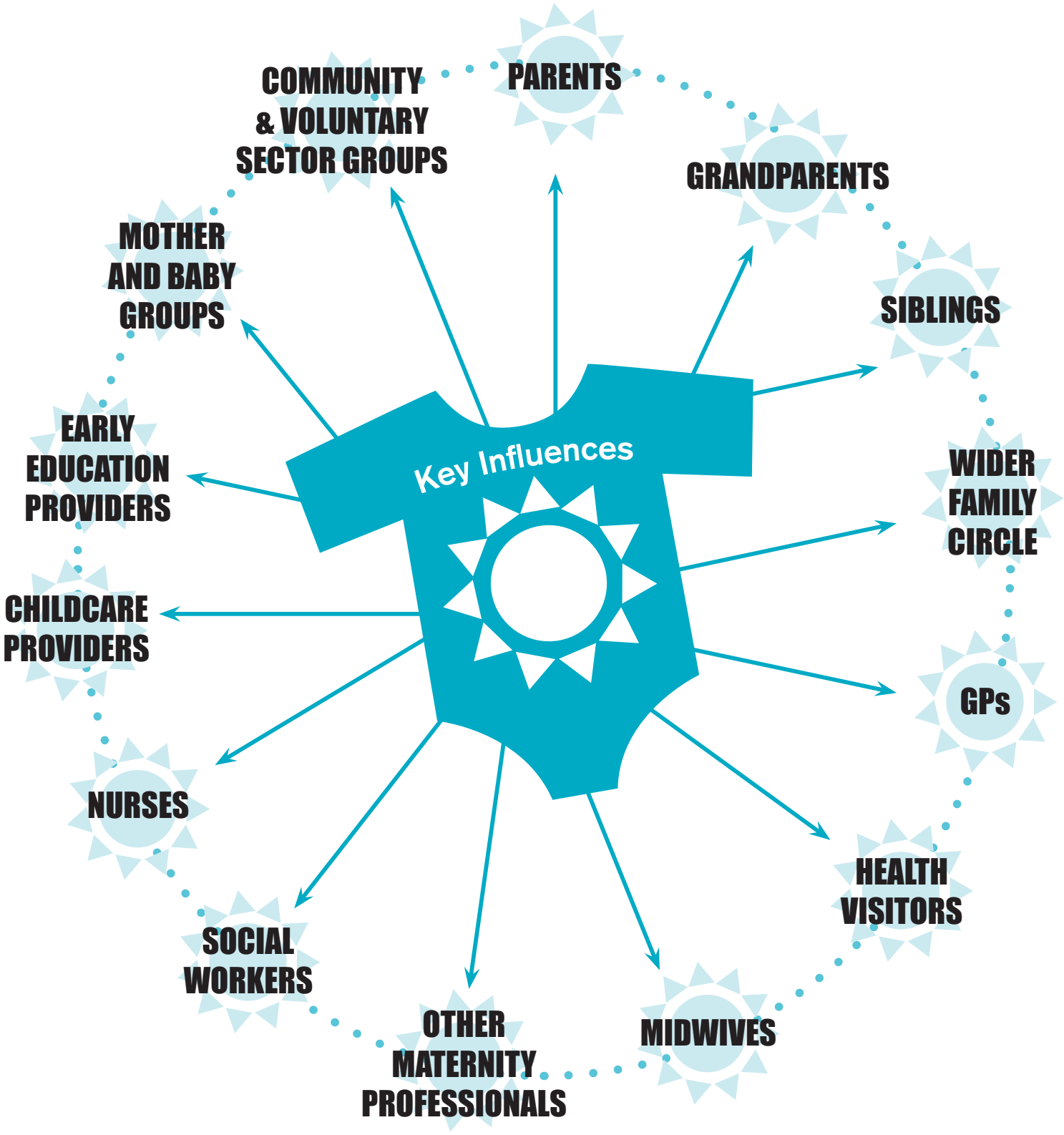
Less than

# 1%

*note this survey has been discontinued and therefore updated statistics not currently available

# Baby's key influences

**This Infant Mental Health Framework proposes a whole child approach, where infant mental health is 'everybody's business'. This means that practitioners across a wide range of disciplines including health, social care and education can have an influence over a child's social and emotional development. In addition, parents, siblings and the wider family circle, as well as friends, neighbours and the wider community can all play their part.**



# Key Priority Areas

# Priority 1: Evidence and Policy

**We believe that investment in services must be firmly based on existing and emerging evidence, ensuring best possible outcomes for all children, young people and families. There is an ever growing body of evidence on the impact of adverse pre-birth, baby and infant experiences on later development, and in addition, evidence on 'what works' to address these needs and to prevent further issues developing.**

The Infant Mental Health Framework includes a commitment to utilising the most up-to-date findings when developing services; and to ensuring that emerging local policy development acknowledges this evidence on infant mental health and the critical influence of the early years to later life outcomes. Where possible, new and emerging research and evidence will be disseminated to commissioners, policy makers, practitioners and the wider population to inform support for families with children aged 0-3.

## Key recommendations: Evidence and policy

- There is a need for agreement on a common language around infant mental health that is accessible to all, including policy makers, practitioners, and importantly parents and the wider community, ensuring consistency of messaging across all departments and services.
- Infant mental health should be regarded as 'everyone's business', and those in a position to do so should use opportunities for dissemination of essential key messages and evidence on infant mental health to practitioners, parents, policy makers and the wider population. It is critical that this information is accessible by all, particularly those with additional needs.
- All concerned with promoting key messages on support for parents in caring for their newborns should consider how new technologies and use of social media can be utilised alongside traditional methods to disseminate key messages.
- In seeking to understand need, we must listen to and engage with those who know best. The diverse voices of children (where possible), parents and practitioners must be heard in gathering evidence, ensuring that they have every opportunity to help shape service development.
- The UNICEF UK Baby Friendly Initiative will be promoted as a model of best practice.
- While acknowledging the importance of international evidence on what works for children and families, a commitment is needed to gathering evidence of local practice, including qualitative evidence of local programme delivery.
- Where appropriate, policies and strategies at Department, Health and Social Care Board/ Trust level and NI wide, should utilise the evidence base on infant mental health and the importance of the early years on later child and adult outcomes.
- Individual Trusts should develop an Action Plan to identify relevant actions informed by the Infant Mental Health Framework.



# Priority 2: Workforce development

**Central to the early identification of infant mental health issues is ensuring that all practitioners working with babies, pregnant or new mothers, fathers (who are often overlooked) and young infants, are fully equipped to promote positive social and emotional learning, as well as to identify the early signs of infant mental health problems and to seek timely help for those families at risk.**

This Framework focuses on the need for capacity building of frontline practitioners across all relevant disciplines, ensuring they have the necessary knowledge and skills to support and encourage positive parenting, assess infant mental health and identify any issues and causes in a timely manner so that additional support may be provided.

As already stressed, infant mental health is 'everybody's business', with consistency of messaging a priority, therefore workforce development will be directly relevant to a wide range of health, social care and education practitioners across statutory, community and voluntary sector services. In addition, the link between child and adult services must be recognised, therefore training in infant mental health should be extended to practitioners working in relevant adult mental health settings (in particular those working with expectant parents). We recognise that not every practitioner will require the same level of knowledge in infant mental health so alongside a common baseline of knowledge, we propose a tiered level of training relevant to the CAMHS stepped care model of service delivery (see appendix 2).

In addition to increasing workforce skills, we understand that practitioners need to have the opportunity to consolidate their new skills, attending appropriate follow up networks and practice sharing sessions, and have the opportunity for regular supervision and peer support, hence maximising impact for children and families.

## Key recommendations: Workforce development

- Upskilling of practitioners across a wide range of universal and specialist services, including health, education and social care practitioners in both statutory and voluntary/community organisations: This should include a core baseline knowledge of infant mental health for all relevant practitioners, with consistency of message, and appropriate specialist training for those delivering specialist services to both infants and families.
- Training should be provided at as early a stage as possible in a practitioner's career, considering options for inclusion in further/ higher education syllabuses for appropriate heath, education and social care courses.
- Commitment has already been made to supporting infant mental health training including the Solihull Approach, Video Interaction Guidance and the Tavistock diploma in Infant Mental Health and Child Development and this investment should be embedded and further built upon.
- Alongside training, practitioner support to embed new learning in practice is essential to ensure that investment has an impact on children and families. This Continued Professional Development should include regular supervision, peer networking and support and access to up to date evidence and information to support practice. Buy-in for the process at management level is therefore essential.
- Continuity of care in provision of universal services is essential in order to allow practitioners to build relationships with families and best meet their needs, and this should be considered when allocating resources.
- In addition, a preventative approach is recommended, with provision of key information on developing positive infant mental health to young people via personal, social and health education (PSHE).



# Priority 3: Service development

**Increased capacity of practitioners to identify additional needs around infant mental health will necessitate not only a clear referral pathway to identify appropriate support, but increased service capacity to meet this need. Workforce development and service development must therefore go hand in hand.**

First and foremost we understand that building positive social and emotional wellbeing in a child begins at conception, hence practitioners working within universal services are best placed to disseminate information and identify potential infant mental health issues early. This Framework therefore acknowledges all current universal provision as outlined in Healthy Child, Healthy Future and the Maternity Strategy for NI, and seeks to add value. However, sometimes despite best efforts, additional issues for families arise and universal support is not enough. For those families, it is essential that appropriate targeted interventions are also in place to allow timely referrals and treatment interventions, thereby preventing issues from escalating.

Service development therefore reflects both universal and targeted support. For all services we recognise the need for consistency and continuity of care, and a whole family approach to interventions. It is particularly important that fathers are recognised as a key part of the family unit. The level of need should be based on the CAMHS Stepped Care model (see appendix 2).

It is important to acknowledge the numerous services already being provided across Northern Ireland by statutory, community and voluntary sector organisations; the Framework seeks to build on existing work rather than to duplicate.

## Key recommendations: Service development

- Initial priority should be given to maximising opportunities provided for supporting positive infant mental health development through the universal Healthy Child: Healthy Future programme.
- A multi-disciplinary, joined up approach to service development will maximise use of existing resources and support a whole child approach. This should include dissemination of existing opportunities as well as development of new ones.
- Service planning and development must recognise the need for a balance between prevention and intervention, with a range of services to cover all levels of need.
- In line with a joined up approach, links should be made with existing services across CAMHS and perinatal pathways.
- The voice of practitioners and parents as service user must be central to development of services.
- In addition to roll out of globally evidence-based programmes and services, it is important to invest in our locally developed programmes, supporting them to evaluate their own services.

# Implementation

## Implementation Group

To support actions indicated in this Infant Mental Health Framework being taken forward, an implementation group will be established. The Implementation Group will consist of representatives from health, social care and education and include the voluntary, community and statutory sectors in order to facilitate a joined up approach to delivery.

## Annual implementation plan

The key role of the Implementation Group will be to develop an annual action plan which will set out key actions relevant to a wide range of organisations and across all sectors. Appendix 1 includes the initial action plan for 2016-2017 and provides details of key first actions already taken. Further yearly action plans will build upon these first actions.

# Appendix 1:
# Action Plan 2016 - 2017

The following provides an overview of initial actions taken under the 3 key headings of 'evidence and policy', 'workforce development', and 'service development' during the period 2016/17. Subsequent yearly action plans will be developed in line with implementation plans going forward.

## 1. Evidence and policy: Key Actions

| Key Actions | Timescale | Partners |
|---|---|---|
| **Support, as appropriate, the strengthening and reinforcement of strategy, legislation, guidance/regulations and policy/programme formulation linked to infant mental health research, evidence and practice through:** | | |
| • Informing the development of DHSSPS 'Positive mental health and suicide prevention' strategy' to ensure that infant mental health is comprehensively included. This includes the identification of any equality issues and ways of addressing these. | Input submitted. Document being released for consultation 2016 | DHSSPS |
| • Development of a local plan in each Health & Social Care Trust to implement the regional infant mental health strategy that embeds infant mental health approaches. This plan should be incorporated within each Trust's Local Implementation Team's Action Plan. | Ongoing | Individual HSC Trust areas |
| **Support dissemination of information on key infant mental health issues by:** | | |
| • Implementation of regional networking events for infant mental health lead practitioners to allow sharing of good practice across HSC Trust areas, as well as across programmes of care. | Ongoing | Trusts PHA |
| • Provision of user friendly information and up to date evidence for practitioners, parents and the wider population, using a common accessible language (including dissemination of IMH Framework and Action Plan.) | Ongoing | PHA |
| • Supporting development of Trust level information flyers/booklets and individual communication plans as appropriate, and encouraging Trusts to ensure that their plans consider and address the specific information and communication needs of particular equality groupings. | Ongoing | Individual HSC Trusts |
| • Promotion of best practice standards within universal services such as UNICEF UK Baby Friendly Initiative and provide parent resources such as 'UNICEF: Building a happy baby'. | Ongoing | PHA/Trusts |
| • Dissemination of emerging evidence regarding what's best for baby and family | Ongoing | PHA |
| • Establish links with parenting networks to ensure parental engagement on perspectives on Infant Mental Health, and encouraging networks to ensure that a wide range of diverse voices are heard. | Ongoing | PHA/Trusts |



## 2. Workforce Development: Key Actions

| Key Actions | Timescale | Partners |
|---|---|---|
| Audit of current infant mental health training across NI | Completed | NCB/PHA |
| **Universal (Step 1)** | | |
| Expansion of Solihull Approach and Solihull Plus training across the region targeting 1500 health and social care practitioners to complete training and attend practice network meetings. Training for Trainers model used.<br><br>This will be further complemented through Solihull Combined Foundation and Ante Natal training programme supporting Midwives taking part in group based ante natal care and education.<br><br>DE also funding the roll out of Solihull training across all Sure Starts in NI.<br><br>Development of a regional Solihull Approach Plan.<br><br>Introduce teaching of Solihull Approach to Health Visiting Postgraduate students.<br><br>Expansion of IMH focus within core education curriculum (in particular Undergraduate level) for those providing vocational training for early years (Stranmillis BA (Hons) Early Childhood Studies).<br><br>Influence development of IMH on curriculum for nursing, social work, midwifery, Health Visiting and psychology. | 2016/17<br><br>2015 – 2016 academic year<br><br>Ongoing discussions | Funded by PHA; Training provided by Clinical Education Centre<br><br>Funded through PHA under Early Intervention Transformation Programme<br><br>HSCB/Childcare Partnership progressing Solihull training Department of Education<br><br>PHA/Trusts<br><br>PHA/Further and Higher Education Colleges<br><br>Stranmillis University College, Queen's University Belfast, University of Ulster |
| Support the development of Mental Health and Emotional Wellbeing education programme for families with newborns. | 2016/17 | PHA/Aware |
| Consider the opportunities for roll out of infant mental health training to GPs, Consultants and other key clinicians. | Ongoing discussions | PHA In conjunction with NIMDTA |
| **Targeted (Steps 2-5)** | | |
| Expansion of psychoanalytically-informed training (Tavistock M7 & M9) for advanced practitioners working across all children's services. On completion, these skilled practitioners will embed learning within their own areas of work and offer advice and support to practitioners working within universal services in order to reduce the need for referral to specialist services. | 15 Places to be supported within 2016/17 | Funded jointly by PHA and HSCB; Training is delivered locally by the Child and Adolescent Psychoanalytical Psychotherapists in NI (CAPPNI). |
| Further implementation of Video Interaction Guidance and ongoing support for supervision requirements of practitioners. | 2016-2017 | |

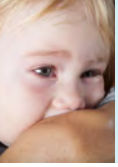
## 3. Service Development: Key Actions

| Key Actions | Timescale | Lead Body |
|---|---|---|
| **Universal Services (Step 1)** | | |
| Increase the emphasis on IMH during the ante-natal and post natal period including revised ante-natal parent education content, giving particular consideration to equality of access for all. | 2016/17 | PHA via Workstream 1: Early Intervention Transformation Programme and PHA/ HSCB through Maternity Strategy |
| Breastfeeding support and guidance through implementation of the Breastfeeding strategy for NI. | Ongoing | PHA |
| Expansion and adoption of Baby Friendly Initiative standards including support and advice for breastfeeding and non-breastfeeding mothers. | Ongoing | PHA |
| Expansion of Incredible Years Parent Programmes (0-3 yrs) and increase of trained and accredited Group Leaders and Peer Coaches. | Ongoing | PHA |
| Employ 5 Child Development Intervention Co-ordinator – these postholders will support improved implementation of parenting programmes across Northern Ireland including those related to Infant Mental Health. | Ongoing | PHA/Trusts |
| Revision of guidance on Relationship and Sex Education currently ongoing by DE. | Ongoing | DE |
| **Targeted Services (Step 2 & 3)** | | |
| Review of maternal mental health provision. | December 2015 | HSCB/PHA |
| Include IMH within the development of eCAT for health visiting service so that interventions relating to IMH can be monitored. | 2016/17 | PHA |
| Revise the Perinatal Care Pathway in light of the new Perinatal and Antenatal Mental Health NICE Guidelines 45 (December 2014) and develop proposals to ensure implementation in all Local Commissioning Group areas by addressing gaps in current service. | 2016/17 | PHA |
| Identify gaps in our knowledge of data and service delivery and ensure this information is provided to relevant commissioners, in particular the current antenatal and post-natal data collected from new parents. There will be a follow up with a sample of women who have indicated a need for support in the antenatal period and to assess the extent of support provided. | March 2016 | PHA |
| Implementation of Family Nurse Partnership Services across all Health and Social Care Trusts. | Ongoing | PHA |



| Key Actions | Timescale | Lead Body |
|---|---|---|
| **Targeted Services (Step 2 & 3)** | | |
| In line with the DHSSPS CAMHS Guidance framework, and the HSCB 'Working Together Learning Development Framework', develop the capacity of CAMHS practitioners to deliver evidence based interventions/NICE approved therapies. | Ongoing | HSCB/Trusts/LIGs |
| Embedding infant mental health approaches within Primary Mental Health Teams in each Trust CAMH Service, in line with the DHSSPS Service Model Guidance for CAMHS. | Ongoing | HSCB/Trusts/LIGs |
| Introduction of 5 Early Intervention Teams across NI focused on supporting families with emerging problems, including families with newborns and infants. | August 2015 - March 2018 | PHA/Outcomes Groups/Trusts via Workstream 2: Early Intervention Transformation Programme |
| Introduction of mental health and wellbeing HUBs providing relevant support for target clients including those families and adults with newborns. | Ongoing | HSCB/Trusts |
| Implementation of parenting support programmes including those relevant to parents with newborns and infants. | Ongoing | PHA/HSCB/Trusts via Workstream 2: Early Intervention Transformation Programme |
| Support the development and application of an Adversity Matrix and related assessment for families with 0-3 year olds and development of a programme of support for families identified. The model, if successful, can be potentially implemented across all HSC localities. | 2016/17 | CAWT. HSCB, PHA, Southern and Western HSCT's |

# Appendix 2: CAMHS Stepped Care Model



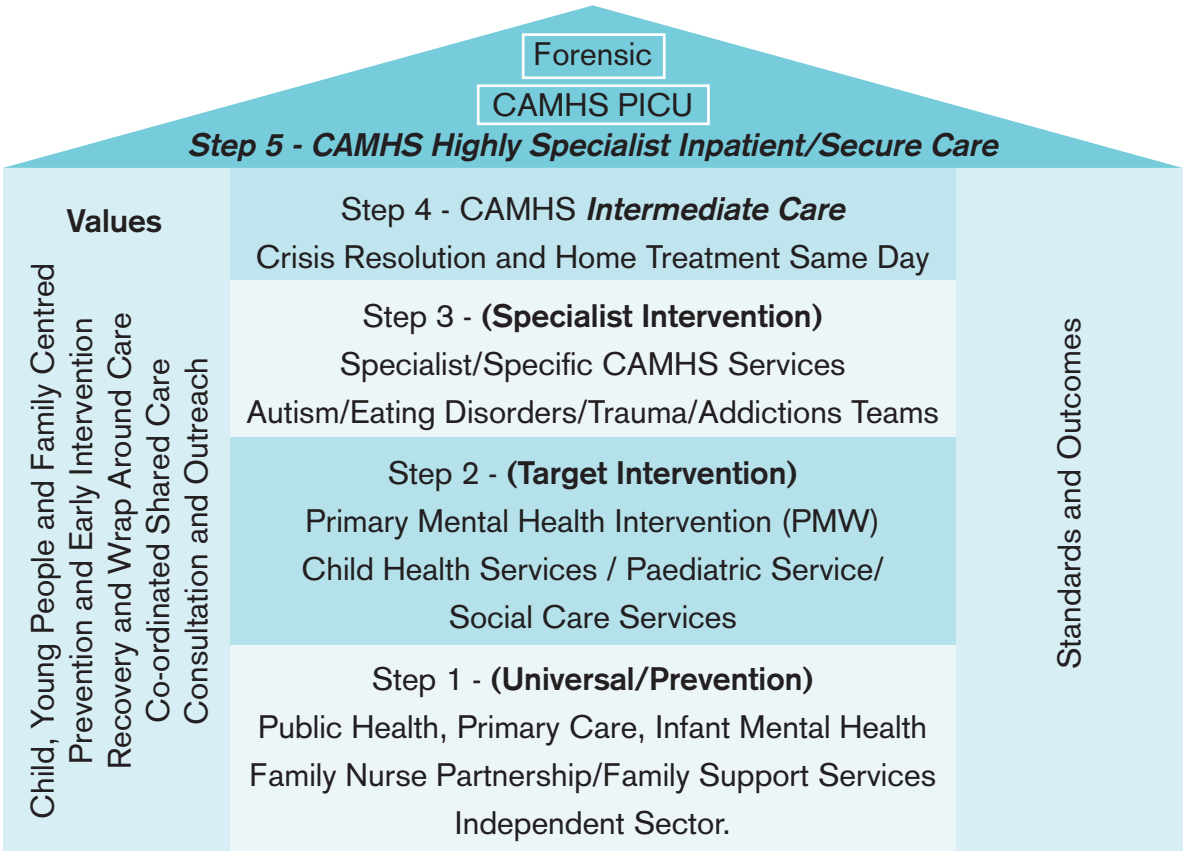


**The regional strategy for the development of Psychological Therapy services recommends the adoption of stepped care approaches across CAMHS. This model aims to shift the focus from care interventions based on the service descriptors to a model of care which is needs based.**

The model is underpinned by the following:

- Provision of child, young person and family centred care
- Focus on prevention and early intervention
- Provision of recovery and wrap around care
- Embedding coordinated provision
- Active promotion of outreach
- Ensuring services are effective

***CAMHS Stepped Care Service Model***



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*"In the first three years, babies' brains make 700 new connections every second."*

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04/16


# IMPACT: Improving mental health pathways and care for adolescents in transition to adult services in Northern Ireland.

*Funded by Public Health Agency, R&D*

Prof Gerry Leavey & Sheena McGrellis, University of Ulster

## Introduction and background to the study

Young people face many significant and challenging transitions in their adolescent and teenage years, at a social, biological and psychological level. Adolescence is typically regarded as a time of transition from childhood dependency to adult responsibility, when young people move from school into further or higher education, or into work or training. Thus, it is generally regarded as an emotionally intense and often stressful period. Importantly, some young people are more resilient and better equipped, socially and emotionally, to deal with adversity and the key transitions of adolescence. Recent epidemiological studies (Meltzer et al., 2003) highlight that increasing numbers of children and young people experience poor mental health, with prevalence rates of between 20 and 25% of mental disorder being reported in the general population of children and young people worldwide (Gore et al., 2011, Patel et al., 2007). It is recognised as a time of increased risk for developing mental health problems such as depression (Goodyer et al., 2009), with research suggesting that approximately half of all mental disorders begin in middle teenage years and three quarters by the mid twenties (Kessler et al, 2007).

Other evidence suggests that 50% of adolescents may be at moderate to high risk of adverse health outcomes due to risk-taking sexual behaviour, psychosocial problems, substance abuse and life style choices, (Anderson and Lowen, 2010, Brindis C et al., 2002, Brindis et al., 2007) and a recent study in Northern Ireland (O'Connor et al., 2010) indicated that 10% of young people aged 15 and 16 years have self-harmed. A survey of mental health disorders in 2004 across England, Scotland and Wales found that one in ten children and young people aged 5-16 years suffer from a diagnosable mental health disorder, and that nearly 80,000 children and young people suffer from severe depression (Green et al., 2005).
As with physical ill health, increased risk of mental illness is associated with social disadvantage and relative poverty. Children from poorer backgrounds, children in care, asylum seekers and children who witnessed domestic violence were all at higher risk of developing mental health problems, as are children and young people in contact with the criminal justice system (BMA, 2006; Murphy & Fonagy, 2012). Similarly the 2004 B-CAMHS survey found the prevalence of mental health disorder was greater in children and young people living in a lone parent family (16%) compared to those in a two parent family (8%); in families with neither parent working (20%) compared to a household with both parents working (8%) and in families where the weekly household income was less than £100 a week (16%) compared to households with an income of £600 or more (5%) (Green et al, 2004).

**Child and Adolescent Mental Health in Northern Ireland**

While little epidemiological data exists on the mental health of children and young people living in Northern Ireland, it is estimated that the rates of mental disorder are at least comparable to those reported for Great Britain and may be higher, taking into account the higher levels of socio-economic deprivation, the legacy of the conflict (Gallagher, 2004) and higher rates of psychiatric morbidity in the adult population in Northern Ireland (McConnell et al., 2002). In the 2009 Young Life and Times survey 29% of 16 year old respondents reported serious personal emotional or mental health problems, with a much higher percentage (43%) from 'not well off backgrounds' doing so. Young people with caring responsibilities or with a longstanding illness or disability were also more likely to report such emotional and mental health problems (Schubotz & McMullan, 2010). The number of young people, particularly young men who die by suicide in Northern Ireland has increased steadily over recent years. Across the UK, Northern Ireland has the second highest suicide rate per 100,000 of the population, (278 recorded deaths in 2012) with the number of males taking their own life approximately five times higher than females (Samaritans, 2013). Not meeting the mental health needs of young people has significant long term financial costs. The human cost is immeasurable.

Extrapolating figures from British and international studies it is estimated that (at least) 10% of approximately 45,000 children and young people aged 5-15 in Northern Ireland will have a moderate to severe mental health disorder requiring intervention from specialist CAMH services (Meltzer et al, 2003). Many young people who receive such an intervention will require mental health care beyond the CAMHS transition boundary. This transition from CAMHS to AMHS has been long identified as a policy concern, affecting service users, carers, families and practitioners (DCSF, 2008, DH/DCSF, 2010). There is evidence that some young people are lost to services at this crucial time, that many struggle to move between services, and others, particularly those with learning disabilities, and neurodevelopmental disorders (ASD, ADHD) find that their needs are not catered for within adult mental health (Pugh & Meier, 2006; Marcer, Finlay & Baverstock, 2008). Evidence suggests that between 30-60% of young people drop out of treatment with young socially isolated males most likely to disengage (Harpaz-Rotem et al., 2004). Many of these young people come into contact with services later, including the criminal justice system, with complex, compounded and harder to manage problems. Thus, the costs incurred by poor engagement and untreated adolescent mental illness are considerable, impacting as they do on the individual, their families and communities (Knapp et al., 2002). More widely there are considerable costs to education, employment, health, welfare and the criminal justice system (Stengård and Appelqvist-Schmidlechner, 2010, Suhrcke et al., 2007). For the year 2008/09 the cost of mental illness to the Northern Ireland economy was estimated at £3.5 billion (DHSSPS, 2010). Despite these consequences, "there is very little evidence about the magnitude of the problem, outcomes of people who fall through such care gaps, interventions that might improve the process, and the experiences of service users and carers about transition"(Singh et al., 2005).

**Making the transition from CAMHS to AMHS**

While guidance for transition is outlined in the DHSSPS Service Framework for Mental Health and Wellbeing (2010) there is currently no regional framework or policy governing the transition from CAMHS to AMHS in Northern Ireland. The structure of services, and procedures and protocols for transition between services differs across each of the Trusts. The Bamford Review of Mental Health and Learning Disability (Bamford, 2006) made a number of recommendations for CAMH service development, including greater interagency working and arrangements. The Review questioned the strength of effective liaison and collaboration between services such as AMHS, education, social services, criminal justice and primary care and noted the failure within Tiers 1 & 2 to engage with the education and voluntary sectors of which "many of these services and projects do not yet conceptualise themselves as part of CAMH services". The

review found that CAMH services in NI may be under resourced, patchy and inconsistent in their approach to adolescent care and service transition.

The RQIA review of Child and Adolescent Mental Health Services in Northern Ireland (RQIA, 2011) found that progress has been made in relation to some of the Bamford recommendations. The development of a purpose-built child and adolescent inpatient service (Beechcroft) has improved capacity and service. The review also welcomed the development of crisis intervention and eating disorder services as an alternative to hospital admission, although noted that these services were not equally distributed across Northern Ireland. Consultation with service users and carers on their CAMHS experience was generally positive, and for those who had experience of making the transition from CAMHS to AMHS most reported a positive experience. Not all service users had contact with staff from the Adult Services, however, before their transition took place. The RQIA states that 'the interface between CAMHS and adult mental health must be addressed' and that 'more effective collaboration arrangements [be] established to ensure that the suffering in a child or parent does not go undetected or untreated' (pg 199).

The Bamford Review also recommended flexibility in terms of the age at which a young person is transferred from child and adolescent services to adult services, stating that this should be in the best interest of the child. It is argued that CAMHS and AMHS are overly rigid in defining the appropriate age cut-offs to demarcate service territory, cut-offs that often do not reflect individual emotional development or needs (Singh, 2009). Significantly, there is no consensus as to where CAMHS ends and AMHS begins, with variable cut-offs in the UK between 16 and 18 years and although transition policies advocate flexibility, anecdotal evidence suggests otherwise; that is, holistic approaches tend to get jettisoned when services are under pressure in order to maintain manageable caseloads.

**The IMPACT study**

The IMPACT study is funded by the R&D division of the Public Health Agency. It is a collaborative project with key partners from the statutory and community and voluntary sector. The research team includes experienced health service researchers, including academic psychiarists from the UK, Northern Ireland and the Republic of Ireland who have expertise in CAMHS and early intervention services. The project is supported by the five Health and Social Care Trusts. It has the backing of the Bamford CAMHS Implementation Group and the study will be incorporated within and supported by the newly established Northern Ireland Clinical Research Network for Mental Health. It is funded for 36 months, from April 2013 to end March 2016.

**Methodology**

The IMPACT study models and extends the methodology used in the TRACK study in England as developed by Prof Swaran Singh and colleagues (Singh et al, 2010). They used a four stage approach to: (i) map CAMHS services and audit transition policies in six UK trusts; (ii) track the pathways and outcomes of all users who crossed transition boundary in a given year; (iii) conduct a diagnostic analysis across health services and voluntary sector and (iv) conduct qualitative interviews with service users, carers and care co-ordinators. A summary of their findings indicate that on the whole transition from CAMHS to AMHS is 'poorly executed and poorly experienced' and that even where protocols exist 'there is a policy-practice gap,' and many young people, especially those with neurodevelopmental, emotional or personality disorders fall through the gap between CAMHS and AMHS (Singh et al, 2010). In the Republic of Ireland, Professor Fiona McNicholas and colleagues also used the TRACK methodology to look at the CAMHS/AMHS transition process in Ireland. Findings from the first stage of their study indicate that this process is underdeveloped in Ireland, and that variation exists in the level of contact and quality of relationship between child and adolescent mental health services and adult services. Much of this variation they found to be underpinned by different service cultures and limited resources (McNamara, 2012).

**Research Questions**

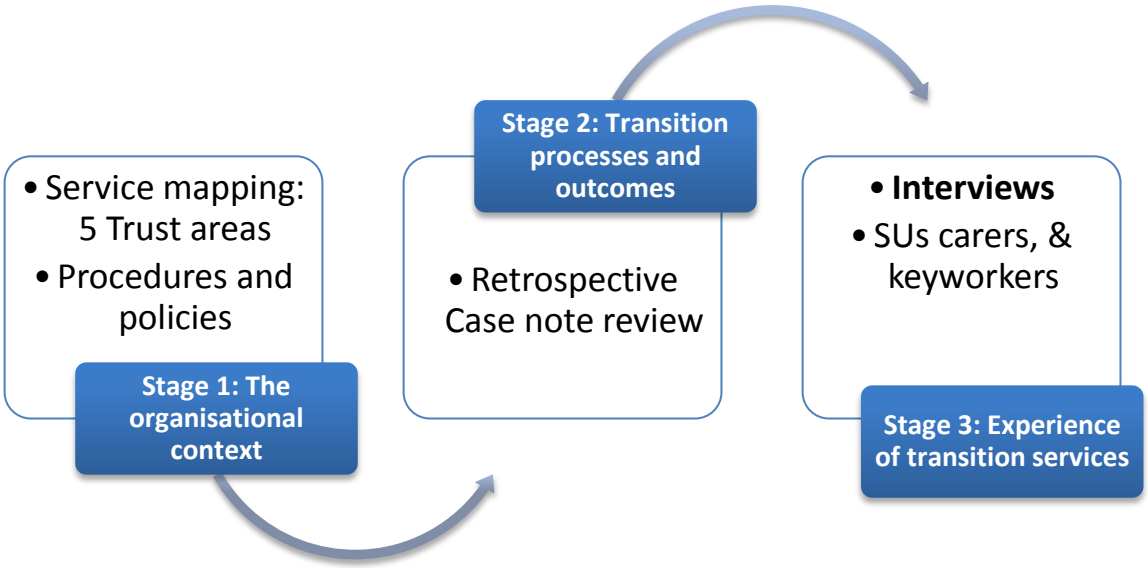
The IMPACT study will provide data in a similar format to that gathered by the TRACK and ITRACK studies and create a potentially rich opportunity for cross comparison and analysis. It will address a number of questions, the key one being: What is the best way to organise mental health services for young people in Northern Ireland as they make the transition from CAMHS to adult mental health care?

The dominant subsidiary questions relate to the following:

- How do mental health services in the Health and Social Care Trusts NI differ in their policies and provision of care for young people in the transition to adult services?
- How does social disadvantage influence health pathways and outcomes among young people?
- Which factors influence adolescents' engagement with services and continuity of care?
- What are the barriers and facilitators to CAMHS collaboration with adult mental health service, primary care and relevant community based agencies?

The study is designed in three stages, and evidence generated from each stage will address the research questions from multiple perspectives and detail the transition pathways and experiences using qualitative and quantitative approaches.

**Plan of investigation:**




Improving our understanding of health inequalities related to disadvantaged communities, their engagement with services and related health and social outcomes are of particular interest to the IMPACT study. We need to ascertain if the needs of young people from different backgrounds may be accommodated more efficiently through an enhanced involvement with voluntary and community based organisations and improved liaison with general practice (Department for Children Schools and Families and Department of Health, 2008). Additionally, we consider this to be an ideal opportunity to explore the needs of young service users in terms of recovery "to hear their experiences and aspirations and translate these experiences into service design, planning, commissioning and delivery. People who use services and their family members will be involved in the planning, commissioning and implementation of services" (Social Care Institute for Excellence (SCIE), 2007: p20).

In the qualitative interviews with the service users we will record their experiences of CAMHS, what they find helpful and challenging; how they get on with staff, the level of support they feel they have, and their expectations and concerns about leaving CAMHS. We hope to interview each young person (n=15) three times over the transitional period.

The data produced from all parts of this study will combine to give a greater insight into experience of young people with mental health problems (who are known to services); the challenges they face in accessing and staying in contact with services; and what is the experience of those who are in need of care beyond CAMHS.

**Where we are now**

We have engaged with key personnel in mental health in each of the five Health and Social Care Trusts, who have welcomed this study as necessary and timely. The collaboration of senior NHS managers and mental health clinicians is central to the success of this project, both in terms of facilitating the project across the Trusts and providing expert guidance.

We are currently working within Stage 1 and Stage 2 of the project. A Critical Interpretative Synthesis of the literature has been carried out to locate the study within current research and practice. The mapping of CAMHS services is underway and will be complete when interviews with key stakeholders are completed. The Case Note Review is due to start shortly in the Belfast Trust. This part of the project will chart service user pathways through transition boundaries and examine their outcomes in terms of referral process and level of engagement with services. It will review the care pathways, and referral outcomes, of young people who reach the transition boundary. Audit staff, trainee psychiatrists and a Clinical Studies Officer will be involved in the Case Note Review.

**Plan for knowledge transfer of findings benefit health or social care.**

The transfer of knowledge gained from the study for the benefit of health and social care is an explicit objective of the applicants and collaborators. The ultimate goal of the study is to address many of the deficiencies of transitional care, bringing a greater degree of consistency and coherence across the NI Trusts. This study is well supported by the stakeholders and committee members who will also be instrumental in fulfilling the recommendations arising from the study. Thus, the findings will be presented to health and social care staff at key gatherings and workshops. It will have considerable value to practitioners and commissioners.

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