Cumann Síceolaithe Éireann
Perinatal and Infant Mental Health
Special Interest Group

Perinatal and Infant Mental Health: Position Paper & Recommendations

The Psychological Society of Ireland (PSI) Perinatal and Infant Mental Health Special Interest Group (SIG)

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INTRODUCTION

This paper describes the PSI and PIMHSIG's position that Psychological services are a vital element of multidisciplinary service provision in the areas of perinatal and infant mental health. While there is growing recognition regarding the importance of the perinatal period in terms of both the physical and psychological development of infants there has been little apparent impetus to establish comprehensive perinatal and infant mental health services both internationally (Nelson & Mann, 2011) and in the Republic of Ireland.

Mental wellbeing is related to a number of social factors, including income, education, employment, gender, race, ability, ethnic status, housing and early childhood development (EYS, 2013; OCECYMH; 2014). Furthermore, mental wellbeing during infancy is predicated upon a secure attachment between a baby and a primary caregiving adult (EYS, 2013; OCECYMH; 2014). Empirical research has demonstrated that changing societal trends (including the rise of single-parent families, increasing identification of child abuse, family violence and drug abuse, leading to poor socio-economic and psychosocial circumstances) are presenting infants and young children with environmental challenges, which can have harmful, long-term effects on their development (Macdonald, Mohay, Sorensen, Alcorn, McDermott & Lee, 2005). There is also a growing body of evidence demonstrating that women who experience perinatal mental health difficulties are at a higher risk of delivering pre-term, lower birth weight infants and of experiencing a disruption of the maternal-infant bond, leading to emotional, behavioural and even physical disturbance in offspring (Bauer, Parsonage, Knapp, Iemmi & Adelaja, 2014; Hendrick, Altshuler, Cohen & Stowe, 1998; Macdonald et al., 2005; Mihalopoulos, Vos, Pirkis & Carter, 2012; OCECYMH; 2014; RANZCP, 2010).

Neuroscience continues to demonstrate the dramatic nature of brain development in the first three years of life and continues to highlight the predisposed nature of the infant's brain to develop relationships with their primary caregivers in order to optimise the neurodevelopment of the brain (Lyman, Holt & Dougherty, 2010; Schore, 1997; ZERO TO THREE, 2012; 2009). We know from neuroscience that the brain is most plastic and flexible early in life. However as the brain matures and continues to functionally specialise through the process of synaptic pruning, it becomes less capable of reorganising and adapting to new or unexpected challenges (ZERO TO THREE, 2012; 2009). Therefore, when infants are exposed to chronic stress in early childhood (such as that related to poverty, abuse, and severe parental mental illness), there is a detrimental disruption in the optimal development of the brain (Lyman, Holt & Dougherty, 2010; ZERO TO THREE, 2012; 2009), leading to lifelong and intergenerational psychological difficulties (Macdonald et al., 2005; Mihalopoulos, Vos, Pirkis & Carter, 2012; Nelson & Mann, 2011; NZMHC, 2011; RANZCP, 2010).

Therefore, as a number of international strategy documents have stated (e.g. BeyondBlue, 2008; NICE 2014; ZERO TO THREE, 2012; 2009), the perinatal period provides a unique opportunity for the promotion and prevention of perinatal mental health difficulties in addition to the early intervention of mental health challenges with which parents and infants present. While effective intervention strategies and assessment tools exist in Ireland to identify perinatal and infant mental health difficulties, there is a significant gap within our current health system regarding the routine training of health professionals, identification of perinatal and infant mental health difficulties and clearly defined pathways of care.

Perinatal mental health services typically relate to services, strategies and initiatives concerned with the prevention, detection and treatment of perinatal mental health difficulties that negatively impact the perinatal period (including the antenatal, birth

experience and postnatal periods), whilst simultaneously prompting optimal parental mental wellbeing and the emotional and physical wellbeing and development of the infant (JCPMH, 2012).

To this end, the PSI has developed a position statement setting out key recommendations necessary to further promote and develop preventative and early intervention strategies to promote the mental wellbeing of parents and infants, both in the short and long term. In line with those proposed in the BeyondBlue (2008) policy document, this paper is written based on a number of key assumptions, namely that every parent wants to offer their child the best start in life; the first months and years of life are critical in the long-term health and wellbeing of children; the perinatal period can be detrimentally affected by stress, anxiety, depression and related disorders; and the availability of effective low- and no-cost preventative strategies promotes optimal parent-child wellbeing, infant mental health and parental mental health.

PARENTAL PERINATAL INFANT MENTAL HEALTH

The term 'perinatal' describes the period from conception to twelve months postpartum. Perinatal mental health refers to the health and wellbeing of parents and primary caregivers in the period preceding and following the arrival of a new baby into a family system. Perinatal distress usually refers to prenatal and postnatal symptoms of anxiety and depression, with a historical focus in particular on postnatal depression. A large volume of research has determined that maternal postnatal depression is related to impaired bonding between a mother and her infant, and is correlated with an infant's ability to regulate sleep, emotions and impulsivity (BeyondBlue, 2008).

Cross-culturally, women are twice as likely to experience depressive episodes compared to men, with longer episodes and lower rates of remission (BeyondBlue, 2008). It is estimated that 10 – 20% of women experience perinatal distress including major depressive symptoms, which is similar to that observed in non-gravid women (Bauer et al., 2014; Hendrick et al., 1998; NICE, 2014). Other perinatal conditions include antenatal and postnatal depression, obsessive-compulsive disorder, binge eating disorder, tokophobia (an extreme fear of childbirth), post-traumatic stress disorder (PTSD) and postpartum psychosis (Bauer et al., 2014; NICE, 2014). Crucially, the first onset of depressive episodes peaks in childbearing years with the highest risk of hospitalisation for mental illness perinatally in the first three months postpartum (BeyondBlue, 2008). Specifically, research continues to demonstrate that childbirth can be associated with significant psychological distress, causing further difficulties in the quality of attachment between a mother and her baby, and in a small number of cases resulting in serious mental illness including postpartum psychosis and severe depressive symptoms (JCPMH, 2012; NICE, 2014). For women with pre-existing mental health difficulties or mental illnesses (such as psychotic disorders), pregnancy and childbirth can further exacerbate symptoms and increase the risk of a recurrence of symptoms (JCPMH, 2012). Furthermore, a review of research from Australia has reported significant rates of maternal suicide in both pregnancy and the postnatal period (Austin et al., 2007; cited in BeyondBlue, 2008; Bauer et al., 2014). Despite an emerging evidence base identifying the importance of psychological outcomes with regard to the interplay between physical and mental health during the perinatal period; assessment of birthing outcomes, both in an international and Irish context, are weighted on physical outcomes whilst psychological and emotional outcomes are marginalised and unrecognised in terms of their importance (BeyondBlue, 2008).

Maternal mental health difficulties whether mild, moderate or severe are recognised to negatively impact on all aspects of a woman's life (BeyondBlue, 2008). As previously

described, maternal psychological distress impacts significantly on foetal development, birthing outcomes, the establishment of good emotional health and attachment relationships, the physical and social development of infants and healthy family systems (Bauer et al., 2014; BeyondBlue, 2008). Psychiatric illness is the leading cause of indirect maternal death in the perinatal period (BeyondBlue, 2008).

Symptoms of depression and anxiety are common during pregnancy and following birth (JCPMH, 2012), and while for most women, these symptoms alleviate, the risk of new onset mental illness is elevated in the weeks following delivery, and tends to present as a psychiatric emergency in the days and weeks following birth (BeyondBlue, 2008; JCPMH, 2012; NICE, 2014). Women who experience obstetric loss, infant admission to neonatal intensive care units, and serious medical disorders are also at increased risk of postpartum mental illness. Birth-related Post Traumatic Stress Disorder (PTSD) is estimated to occur in approximately three percent of women following natural birth and six percent of women following emergency caesarean section (JCPMH, 2012). Those with acute mental illness usually present to emergency services and require inpatient care, at which time a mother and infant are separated for a period of time, which interrupts the developing mother-infant attachment (Bauer et al., 2014; JCPMH, 2012). This may be difficult to reverse and have longstanding effects on both child and mother (JCPMH, 2012). Furthermore, the potentially adverse outcomes for parents and infants associated with children being born into families with a history of loss relating to miscarriage, stillbirth and early neonatal loss are often overlooked. Research carried out by Theut and colleagues (1992) reported that infants born following prenatal loss demonstrated higher rates of disorganised attachment patterns to their mothers, compared to children born into families without a loss history. Thus, even if there is no persistence of mood disturbance into the perinatal period, there may still be adverse effects of a previous prenatal loss on the parent–child relationship and child outcomes.

While the vast majority of research has focused on the experience of women in the role transition to parenthood, and their experiences of pregnancy, childbirth and the postnatal period, little research has explored the experience for men during the perinatal period. Indeed the experience of fathers in the perinatal period has remained largely unrecognised (BeyondBlue, 2008). Recent research from Australia indicated that one in twenty new fathers experience clinically significant symptoms of depression and/or anxiety in the perinatal period (QMHC, 2014). The incidence of paternal mental health difficulties across the perinatal period is also believed to negatively impact upon a child's social and emotional development (BeyondBlue, 2008).

Internationally, it is recognised that a serious disparity exists between the prevalence of maternal perinatal mental health difficulties and the number of women receiving appropriate treatment with related access to perinatal mental health services (QMHC, 2014). While perinatal mental health difficulties are considered to be among the most preventable and treatable of all mental illness (QMHC, 2014), the lack of appropriate services means such conditions can become entrenched, multi-faceted, intergenerational and treatment resistant (Bauer et al., 2014).

INFANT MENTAL HEALTH

The term "Infant mental health" was first coined by Selma Freiberg in 1980, with 'infant' referring to children under the age of three years, 'mental' referring to their social, emotional and cognitive development, and 'health' indicating wellbeing of the child and family (IMH-NG, 2015). In 2001, the National Center for Infants, Toddlers and Families published the following definition: "'infant mental health' refers to the capacity of children

from birth to age three to experience, regulate, and express emotions; form close, secure interpersonal relationships; and explore the environment and learn – all in the context of family, community, and cultural expectations for young children. Infant mental health is synonymous with healthy social and emotional development" (ZERO TO THREE, Infant Mental Health Task Force, 2002, p. 1; cited in Nelson & Mann, 2011). Therefore, infant mental health describes the state of social and emotional wellbeing of the child whilst also describing a field of practice and research, involving the child, their family context and wider community (ICTA, 2000).

Although the initial focus on 'infancy' implied the study of children from birth to three years, the concept of infant mental health has variously been defined as referring to children from birth to aged two, three and up to six years. Indeed, many early childhood services, both internationally and in Ireland, focus on supporting children from birth up until six years of age and/or beginning primary school (Nelson & Mann, 2011). International research has consistently identified the first six years of life as being of crucial importance with regard to the healthy brain development of children in terms of their social, emotional, physical and cognitive process (Centre on the Developing Child at Harvard, 2010 cited in OCECYMH; 2014). Childhood adversity in the first five years has been found to account for more than 30% of psychosis in adulthood, predicts the onset of smoking and illicit drug use in adolescence and is related to an increased risk of involvement in the criminal justice system (QMHC, 2014). Indeed longitudinal research has demonstrated that mental health intervention before two years of age reduced by 75% the likelihood of arrest or conviction for a crime in late adolescence (QMHC, 2014).

Given the importance of a child's early environment, the role of primary caregivers cannot be underestimated in terms of providing the first experiences of healthy relationship which facilitate the skills and capabilities children need to regulate and express emotions, communicate and learn language and develop the complex social behaviours necessary to participate successfully in their world and society at large (Coyl et al, 2002; EYS, 2013; Nelson & Mann, 2011).

Reflecting the growing body of research focused on the first six years of life, the National Center for Infants, Toddlers and Families more recently coined the term 'infant-early childhood mental health' (I-ECMH) to refer to the developing capacity of children from birth to five years to develop close and secure relationships, experience and manage a full range of emotions and explore and learn from their environments in the context of their family, community and culture (ZERO TO THREE, 2012). In 2011, the number of children 0-6 years of age in Ireland was 486,242 (representing 11% of the population). This represented a 16% increase of this population group since the previous census of 2006 (CSO, 2012; cited in EYS, 2013). The birth rate in 2011 was approximately 16.7 per 1,000 inhabitants, which was the second highest birth rate in Europe (Eurostat, 2012; cited in EYS, 2013). It has been estimated that mental health problems affect one in every seven children, and when left untreated continue to manifest as emotional and behavioural symptoms, impacting on a child's family wellbeing and school performance (Lyman, Holt, & Dougherty, 2010; Mihalopoulos et al., 2012). Furthermore, studies demonstrate that difficult temperament, oppositional behaviour, aggression and hyperactivity in infancy and toddlerhood predict internalising and externalising psychiatric disorders at five years of age (OCECYMH; 2014; QMHC, 2014). Irish based research (The Clonmel Project) on the prevalence of psychological disorders in children under the age of 5 estimated that 14.98% met the criteria for at least one psychological disorder (Martin, Carr, Burke, Carroll & Byrne, 2006)

A commonly held belief, that children will outgrow early mental health difficulties (OCECYMH; 2014), has been comprehensively and consistently contradicted by research. Research has shown that infants raised in environments characterised by compromised parenting (resulting from mental illness and co-morbid drug and alcohol use), significant health issues in infancy (including prematurity, physical disability or intellectual impairment), social issues (including family violence) and inter-generational issues (including parents' own experience of less-than-optimal parenting), have poorer social and emotional developmental trajectories (BeyondBlue, 2008; Lyman, Holt, & Dougherty, 2010) that continue into adulthood (Lyman, Holt, & Dougherty, 2010; OCECYMH; 2014) and are more likely to be in receipt of services, including primary care, child and adolescent psychiatry and disabilities services. Conversely, research also indicates that the first symptoms of psychological and emotional difficulties, which tend to manifest as behavioural problems in the preceding two to four years, are highly responsive to early therapeutic interventions resulting in an amelioration and reduction in symptoms (RANZCP, 2010).

ECONOMIC AND SOCIAL COSTS

There is universal agreement that poor mental health during the perinatal period not only exacts a significant social cost to society but is also related to a large financial burden to a country (Bauer et al., 2014; BeyondBlue, 2008; Mihalopoulos et al., 2012; NZMHC, 2011; QMHC, 2014). According to the World Health Organization (WHO), the burden of mental health problems falls disproportionately on certain groups, including women, people living in extreme poverty, and children and adolescents with disrupted nurturing (O'Shea & Kennelly, 2008).

In 2013, the WHO advocated redirecting mental health spending from tertiary psychiatric hospital-based settings towards community-based services, including the integration of mental health into general health care settings, and through maternal, sexual, reproductive and child health, enabling access to better and more cost-effective interventions (WHO, 2013). In Ireland, the proportion of total health care expenditure dedicated to mental health, (approximately six percent) continues to be relatively low when compared to other European countries (O'Shea & Kennelly, 2008). Recent reports published in Ireland, including one commissioned by the Mental Health Commission in 2008 exploring the economics of mental health care in Ireland (O'Shea & Kennelly, 2008), concluded that there continues to be a serious dearth of research exploring the cost effectiveness of mental health treatment programmes in this country (Cannon, Coughlan, Clarke, Harley & Kelleher, 2013; O'Shea & Kennelly, 2008). The report suggested that the overall economic cost of mental health problems was just over €3 billion in 2006 (O'Shea & Kennelly, 2008), with the bulk of costs related to lost productivity, absenteeism, unemployment and premature retirement. Of note, the reports indicate that while there are insufficient data available to accurately breakdown expenditure within mental health services, there are inadequate resources targeted at children (EYS, 2013; O'Shea & Kennelly, 2008). Within the last two years, there has been some recognition of the importance of infant wellbeing. In the 2014 Budget, free GP care to those under five years of age was introduced. A Vision for Change (2006) recommended that the proportion of the overall health budget allocated to mental health should rise to 8% (O'Shea & Kennelly, 2008); however public spending on mental health in Ireland is just over 5% of the overall health budget (O'Shea & Kennelly, 2008). According to the European Commission, mental health funding below 5% of the total health budget may be insufficient in terms of adequately resourcing mental health services (O'Shea & Kennelly, 2008).

While there continues to be no available figures regarding the economic costs of perinatal and infant mental ill-health in Ireland, international research can serve as a reasonable

guideline. Research in the UK reported that the long-term cost to society of perinatal depression, anxiety and psychosis stands at about £8.1 billion for each one-year cohort of births, translating to just under £10,000 for every single birth in the country, with 72% of this cost relating to adverse impacts for the child rather than the parent (Bauer et al., 2014). Furthermore, the average cost to society of one case of perinatal depression was reported to be approximately £74,000, of which £23,000 related to the mother and £51,000 related to the child, while an individual case of perinatal anxiety (in the absence of perinatal depression) was reportedly approximately £35,000 per case, of which £21,000 related to the mother and £14,000 related to the child (Bauer et al., 2014). The cost of perinatal psychosis was reported to be under-estimated but approximated to double the cost to the mother and child, when compared to depression and anxiety (Bauer et al., 2014). While the vast majority of studies have focused on the economic costs of maternal perinatal mental health difficulties, research in Australia has reported that indirect economic costs of paternal perinatal depression are twice that of maternal depression. The research concluded that paternal mental health difficulties are a hidden social and economic problem (QMHC, 2014).

While the financial impact of neglecting the importance of laying strong foundations for infant mental health through promotion, prevention and intervention strategies are evident, the larger social impacts of such neglect cannot be underestimated (QMHC, 2014). The consequences of untreated perinatal and infant mental health problems on the individual, their families and the larger society include future parental mental illness, suicide, infanticide, child abuse and neglect, obesity, fostering and residential care, marital breakdown, economic disadvantage, delays in motor function, language acquisition and cognitive skills, disrupted attachment relationships, emotional dysregulation, social and behavioural problems, academic underachievement, substance abuse, juvenile delinquency and intergenerational effects (Mihalopoulos et al., 2012; NICE, 2014; QMHC, 2014). A child who does not develop a healthy attachment relationship to a primary caregiver, usually a biological parent, but including foster parents and adoptive parents, fails to internalise good working models of healthy relationship. Such negative early experiences inhibit the child's ability to engage in adaptive and functional relationships, which contribute to intergenerational cycles of mental health problems and social disadvantage (QMHC, 2014). Indeed, children who are emotionally healthy when they enter school have a significantly greater chance of academic success, including higher education, gainful employment, and social adjustment than those who are not (Lyman, Holt, & Dougherty, 2010; Mihalopoulos et al., 2012; Nelson & Mann, 2011).

Despite universal acknowledgement of the importance of perinatal and infant mental health in light of the social and economic costs when left untreated, the provision of services internationally is at best described as 'patchy' (Bauer et al., 2014) and at worst, non-existent. Currently in Ireland, despite pockets of service focused on the provision of care for parents and infants within existing Primary Care services (notably North Cork Child & Family Psychology Service and similar initiatives in South Tipperary, and North east Drogheda, and three services in Dublin: Childhood Development Initiative, Tallaght West; Preparing for Life, Dublin 17; YoungBallymun, Ballymun), the issue of perinatal and infant mental health is largely ignored. While it is not currently possible to quantify the cost of perinatal and infant mental health problems to the Irish exchequer, the estimated costs suggested internationally indicate the financial implications to be substantial. Economists and researchers unanimously agree that investing in perinatal and infant mental health services yield long-term savings, as opposed to short-term relief (Bauer et al., 2014; Lyman, Holt, & Dougherty, 2010; Mihalopoulos et al., 2012; Nelson & Mann, 2011). A recent evaluation of a

parenting programme in Ireland indicated that for every €1,463 spent per child, a saving of €4,599 per child was realised (EYS, 2013).

The Nobel Prize-winning economist James Joseph Heckman has demonstrated that returns on investment for early intervention programmes for perinatal and infant mental health can be as high as AUS$17 per dollar invested (based on a reduction in costs to the health, education, child safety and criminal justice systems over the life of the child from birth to early adulthood (QMHC, 2014). Therefore, developmental trajectories can be improved permanently if healthy development is promoted, risks are identified, and appropriate supports and interventions are put in place for those in need (Lyman, Holt & Dougherty, 2010).

The cost effectiveness of intervention strategies includes those that promote the importance of perinatal and infant mental health; those that prevent or minimise the risk of perinatal and infant mental health difficulties and those that intervene early to address emerging perinatal and infant mental health problems. International research has demonstrated that the effects of unfavourable early experiences can be mitigated and ameliorated by the provision of appropriate intervention programmes (Macdonald et al., 2005). The social and emotional health of infants can be promoted in the many environments that infants, toddlers and their parents encounter in their daily lives, including childcare and early education programmes, play groups, visits with public health nursing, primary care physicians and perinatal obstetric visits (Nelson & Mann, 2011). Promotion strategies usually involve programmes aimed at the public at large. Such strategies include awareness programmes relating to the use of drugs and alcohol during pregnancy, childhood obesity, reducing stigma regarding mental health difficulties, and increasing awareness of domestic violence. Therefore, promoting perinatal and infant mental health and wellness involves the collaboration of clinicians, researchers and professionals across a range of disciplines to inform public campaigns and guide policy development (Nelson & Mann, 2011). Empirical research continues to demonstrate the benefits and cost-effectiveness of promotion, prevention and early intervention strategies as a way of preventing later problems or reducing the severity of developmental problems (Nelson & Mann, 2011; RANZCP, 2010).

Prevention strategies ensure that children and families have access to screening services that identify problems early and address concerns before the child develops more significant mental health difficulties (Nelson & Mann, 2011). Prevention strategies may provide extra support to targeted groups of infants and their families to establish and sustain secure, responsive relationships (Nelson & Mann, 2011). One of the current barriers to implementing prevention and intervenient strategies lies in health professionals' tendency to adopt a "wait and see" approach toward behaviours and symptoms of concern in very young children (Nelson & Mann, 2011). Furthermore, parents themselves may not engage with health services for their baby as they lack understanding regarding the warning signs of infant mental health difficulties, and possible internalised stigma related to mental health difficulties (Nelson & Mann, 2011).

The development of policy frameworks and service provision regarding perinatal and infant mental health cannot be completed without the empirical evidence to support such programmes. Therefore, to support such policy frameworks and provision of services, further research is needed in an Irish context to identify prevalence rates of perinatal and infant mental health problems and appropriate and effective evidence-based interventions. Nonetheless, researchers, clinicians and economists are in agreement that increasing expenditure on mental healthcare services, particular in the early years of life, through the implementation of promotion and prevention strategies and intervention services result in

long-term economic savings, enhanced social capital and individual gains (O'Shea & Kennelly, 2008; QMHC, 2014).

EXISTING SERVICE PROVISION IN IRELAND

As in many countries throughout the world, there are currently no dedicated specific or specialist perinatal and infant mental health services in Ireland (Lyman, Holt, & Dougherty, 2010; Macdonald et al., 2005). Perinatal mental health problems, when they are identified, present in a variety of health settings and are currently managed by many different services. Infants, their parents and families access services through a number of settings including maternity hospitals, GP antenatal schemes, midwife led schemes, primary care settings (involving Psychology), disability services (involving Psychology), child mental health services (involving Psychology), and adult mental health services (involving Psychology), both within the community and in-patient settings (Lyman, Holt, & Dougherty, 2010). However, since there are no dedicated, specialist perinatal and infant mental health services within these settings, service delivery generally tends to be ad-hoc and fragmented. Therefore, identifying mental health issues in young children ensuring access to needed services is a national problem (Lyman, Holt, & Dougherty, 2010).

In 2001, the WHO published a report entitled "New understanding, new hope" with the expressed desire to break down 'real and perceived barriers' to mental health care. The report particularly highlighted the importance of developing national policies aimed at preventing childhood mental health problems and disability through adequate nutrition, perinatal care, avoidance of alcohol and drug consumption during pregnancy, immunisation, child safety measures, treatment of common childhood medical disorders, early detection of mental health problems and health promotion (WHO, 2001). The report also reiterated the United Nations Convention on the Rights of the Child, recognising that children have the right to appropriate services (UN 1989; cited in WHO, 2001). While Ireland has made important strides in better supporting children and their families across a range of areas in the 15 years since this report was published, the earliest years of life in terms of promoting optimal psychological and emotional development continue to be ignored by public policy makers and related funding bodies. While infancy and toddlerhood present the best opportunities to identify developmental risks and address them before serious problems are entrenched, current mental health policies and funding have focused primarily on providing mental health treatment for older children and adults often ignoring or minimising important opportunities to promote, prevent, and treat the mental health needs of infants and toddlers (Nelson & Mann, 2011).

One example of such ignoble oversight relates to the fact that Ireland has no dedicated public beds for perinatal mental health admissions, and specialist mental health support is only provided by a handful of psychiatrists serving the entire country. In Ireland, a mother requiring inpatient treatment for perinatal mental illness is usually admitted to an acute mental health unit without her baby, despite international best practice guidelines unanimously recommending that, where possible, mothers and babies are admitted together to dedicated Parent Infant Units (NICE, 2014; QMHC, 2014). Nonetheless, a small number of community initiatives have begun to address the importance of perinatal and infant mental wellbeing. The Infant Mental Health Network Groups, based in North Cork, the first of which was established in 2006, published a report in 2015 demonstrating the impact of building a workforce capacity in infant mental health. Additionally it was noted that due to the level of uptake of services from parents and infants in the preceding 15 years, demand has now outstripped supply, demonstrating the public demand and need for such specialist services. Similarly, a report from the Prevention and Early Intervention Programme (encompassing the Childhood Development Initiative in Tallaght West; Preparing for Life

programme in Dublin 17; and the YoungBallymun programme) has demonstrated that when services are available to families promoting the mental wellbeing of parents and infants, there is significant uptake of such supports (YoungBallymun, 2012).

More recently, an expert advisory group convened by the Early Years Strategy, within the Department of Children and Youth Affairs, to assist in the development of strategy and policy directives published a report endorsing the importance of providing universal services to children from birth to six years (EYS, 2013). The group also highlighted the overarching Irish policies, including Vision for Change, the National Children's Strategy- Our Children, Our Lives, promoting the provision of services to children in order to promote their optimal physical and mental health (EYS, 2013). However, despite the importance of such policy documents, and initial efforts to invest in the period of early childhood, provision of services for infants and young children remains inadequate and under-resourced. In their pre-Budget submission for 2016, Mental Health Reform recognised that early intervention approaches incorporate not only a focus on an infant's physical needs but also their social and emotional health and well-being. Mental Health Reform highlighted that specific service gaps in the area of infant mental health including the absence of Psychologists in maternity hospitals; a lack of staff training on infant mental health among those working in maternity hospitals; under-staffed primary care psychology services and the absence of child specific Public Health Nursing posts (Mental Health Reform, 2015). In Better Outcomes Brighter Futures, The National Policy Framework for Children and Young People (2014-2020), the Irish Government committed to working to place increased emphasis on prevention and early intervention and enhancing maternal ante-natal and early childhood development services.

SUMMARY AND CONCLUSIONS

We know from international research that perinatal and infant mental health problems are a very real and current threat to the ongoing health of a nation, and that intervening at the earliest stages can mitigate such threats (BeyondBlue, 2008; NZ MHC, 2011; RANZCP, 2010). Therefore the benefit of a national strategy detailing promotion, prevention and early intervention approaches to perinatal and infant mental health in Ireland cannot be overstated. In many countries, including Ireland, perinatal mental health difficulties go unrecognised, undiagnosed and untreated, leading to avoidable suffering for women, men, infants and their families (Bauer et al., 2014; Mental Health Reform, 2015). As previously discussed, individuals benefit from increased spending on mental health care, but so do communities, society and the economy. For all of these reasons, mental health must become a national health priority, with specific targets for expenditure, evaluation and outcomes (O'Shea & Kennelly, 2008).

Supporting primary caregivers, infants and families to achieve optimum mental health and wellbeing across the perinatal period requires that consideration not only be given to the physical needs but the psychological, social, cultural and geographical issues facing women, men, infants and families (Mental Health Reform, 2015). The key driver in meeting these needs lies in the provision of universal, routine psychosocial assessment in addition to health promotion and early intervention that is delivered by well-trained and supported clinicians and health professionals, following clearly defined pathways to care (BeyondBlue, 2008; Mental Health Reform, 2015).

Effective policy frameworks recognise and support the fact that the social and emotional development of infants and toddlers occurs in the context of supportive early relationships with parents and other primary caregivers. Supporting infants must therefore begin with

access to high-quality maternity and perinatal community services (BeyondBlue, 2008; EYS, 2013; OCECYMH; 2014). Support at the earliest point of prenatal development is a critical component of supporting a child's physical and psychological development, and later cognitive, social and emotional development (EYS, 2013).

It is critically important to increase recognition of the fact that social and emotional wellbeing is an essential component of healthy infant development (Macdonald et al., 2005; O'Shea & Kennelly, 2008). To achieve this it is crucial not only to have comprehensive specialist infant mental health services but to also integrate infant mental health practices into all systems serving infants and their families (e.g., obstetrics, primary care, disability, child psychiatry and adult mental health services). Furthermore, in order to deliver such services in a cost-effective manner it is essential to identify existing services, reduce the gaps and overlaps in service provision, and formulate strategies to make services more accessible and comprehensive (Macdonald et al., 2005).

The PSI believes that Psychologists have an important role to play in advocating for infants and their families, raising public awareness regarding the optimal conditions for the healthy social, emotional and cognitive development of infants and engaging with policy-makers and key stakeholders to promote and create national policies to support such a vulnerable cohort. Psychologists can contribute to increasing public understanding by conducting research that addresses key policy questions. Psychologists can help to shape new policies that support infant mental health by conducting research and contributing to the knowledge base that informs policy decisions; by educating the public and policymakers about early childhood development and mental wellness; by promoting the use of efficient, reliable, and developmentally appropriate measures of social-emotional outcomes; by collaborating with paediatricians, health agencies, and child welfare agencies to develop early childhood mental health prevention and intervention services grounded in effective practice; and by participating in the development of policy recommendations that improve access to evidence-based practices in infant mental health (Nelson & Mann, 2011).

Psychologists are well positioned to develop and provide specific perinatal and infant mental health services, which provide psychological assessment of the parent-child relationship, parental and child wellbeing, and child development, as well as psychotherapeutic intervention. The need for perinatal and infant mental health services cannot be understated in terms of their importance regarding the physical, emotional, psychological and cognitive development of our citizens. The PSI calls for government agencies, relevant stakeholders and the public to engage in a consultation process with a view to establishing a national perinatal and infant mental health strategy. Such a strategy provides a framework for the establishment of national inter-disciplinary perinatal and infant mental health network teams.

In order to adequately staff the development of integrated PIMH approaches into current services, in addition to the staffing of future specialist PIMH services nationally, there is a need to ensure that Psychologists, and other health professionals, working with infants, toddlers, and their families have relevant core competencies and appropriate knowledge of early childhood development and an understanding of screening and diagnostic techniques for this age group. As part of their submission to government regarding the allocation of funding in the 2016 Budget, Mental Health Reform endorsed the provision of funds to train and staff in perinatal and infant mental health services (Mental Health Reform, 2015). Furthermore, ensuring that undergraduate, graduate, and continuing professional education programmes include content on perinatal and infant mental health is crucial for the future development of this specialist area.

Providers of specialist psychological assessment require access to continuing professional development and appropriate supervision in order to meet the professional competencies required to carry out direct therapeutic work with the parent- child dyad. Psychologists are well placed to provide complex psychological assessment and intervention and consultation to other professionals.

RECOMMENDATIONS

Based upon the available international evidence, current status of service provision in Ireland across the perinatal and early infancy periods, and in line with international best practice guidelines (e.g. National Depression Initiative & Perinatal Mental Health Consortium, Australia; NICE guidelines, UK; Advisory group to the Early Years Strategy; WHO; UN Convention on the Rights of the Child; YoungBallymun), the PSI have made the following recommendations.

Defining Perinatal and Infant Mental Health (PIMH)

In light of the various descriptions regarding the timeline accorded to the period of 'infancy', adopting and promoting an agreed definition of perinatal and infant mental health in order to promote the concept in a cohesive way is important.

Universal Screening

Universal routine screening addressing both current distress and the range of demographic, psychological and social factors known to affect perinatal mental health for parents and infants is recommended. While such screening is not intended to replace clinical diagnosis by mental health professionals, it offers opportunity to screen for family risk factors that might affect an infant's social, emotional and cognitive development, including, poverty, perinatal parental depression and anxiety disorders, family isolation and parental substance abuse.

Pathways of Care

The identification of quality local pathways to care is required to reinforce the implementation of universal screening in order to address the care and intervention needs of women identified as being 'at risk', experiencing mild or moderate difficulties to women experiencing complex and/or severe mental illness. This should include access to timely mental health care for all caregivers and family members. The wide range of agencies currently involved in mental health service provision require a system of care that is effectively networked, collaborative and responsive to the whole family.

Integrating PIMH into Existing Services

Integrating the principles and evidence base for PIMH principles into maternity, primary care, community, disability and mental health services is a necessary interim step in promoting the importance of perinatal and infant mental health within existing services. As the broader health system serving young children does not adequately incorporate infant mental health practices, creating a cross-network of service provision to support children and their families, in which expertise is shared and professional support offered, is imperative. For those parents with less severe mental health difficulties or those families either at risk for or with known infant mental health difficulties, specialist psychological therapy teams are also required. Thus primary care psychology should be adequately resourced to address the spectrum of psychosocial stressors and mental health needs.

Specialist PIMH Services

Specialist perinatal inpatient services should be designed specifically for mothers and babies, staffed by specialist perinatal mental health staff, including Psychologists, to provide inpatient care for mental health problems within 12 months of birth. A Mother and Baby/Parent Infant Unit can provide short to medium term inpatient care and specialist intervention for mothers, fathers, infants and families with severe and/or complex mental health needs. Research has demonstrated that women with acute and serious perinatal illness have better outcomes and better relationships with their infants if cared for in mother and baby units (JCPMH; 2012). Furthermore, when families receive specialised aftercare in dedicated PIMH services, they have shorter admissions and fewer readmissions (JCPMH; 2012). Women with pre-existing mental illness potentially complicating childbirth require the support of health professionals, including Psychologists, with specialist knowledge and skills. These skills include among others, specialist knowledge of the risks and benefits of medication during pregnancy, the physical, emotional and psychological challenges of pregnancy and education regarding the emotional and physical needs of their infants. Specialist community perinatal mental health teams are also required to support these families outside of an inpatient setting from pregnancy planning and across the perinatal period.

Workforce Development

In order to adequately staff the development of integrated PIMH approaches into current services, in addition to the staffing of future specialist PIMH services nationally, there is a need to ensure that Psychologists, and other health professionals, working with infants, toddlers, and their families have relevant core competencies and appropriate knowledge of early childhood development and an understanding of screening and diagnostic techniques for this age group. As part of their submission to government regarding the allocation of funding in the 2016 Budget, Mental Health Reform endorsed the provision of funds to train and staff in perinatal and infant mental health services (Mental Health Reform, 2015). Furthermore, ensuring that undergraduate, graduate, and continuing professional education programmes include content on perinatal and infant mental health is crucial for the future development of this specialist area.

Providers of specialist psychological assessment require access to continuing professional development and appropriate supervision in order to meet the professional competencies required to carry out direct therapeutic work with the parent- child dyad. Psychologists are well placed to provide complex psychological assessment and intervention and consultation to other professionals.

Social Marketing

Social marketing engages the general public and lawmakers in understanding and supporting system changes, and demonstrating the relevance of service provision to them (O'Shea & Kennelly, 2008). Health promotion, prevention, early intervention and recovery are essential components of a comprehensive plan aimed at promoting PIMH. Psychologists have an important role to play in promoting awareness of perinatal and infant mental health amongst the general public, and raising awareness amongst policy makers, medical practitioners, mental health professionals and other allied health professionals regarding the importance of PIMH and related skills and strategies that promote wellbeing in families.

Evaluation and Research

A key element underpinning the understanding of PIMH and effective strategies supporting wellbeing during the perinatal period and in early infancy relates to the implementation of evidence-based practice. Evidence-based practice involves conducting empirical research regarding the prevalence rates of perinatal and infant mental health difficulties;

understanding the conditions that promote mental wellness of infants and their families; determining the most effective indicators in monitoring the mental wellness of infants and primary caregivers; and clarifying effective interventions that support PIMH. Such empirical research can identify the needs of infants and their families in an Irish context and customise service delivery based on these needs. Such research also provides important information regarding the sustainability and efficacy of interventions, based on cost-benefit analyses of such interventions. National policies pertaining to perinatal and infant mental health need to be informed by empirical research carried out nationally and recognise international standards of best practice. Psychologists have an important role to play in developing an evidence base addressing these issues.

Funding and Investment

It is internationally recognised that perinatal mental health services require different resources to those of general adult mental health services. In support of this view, Mental Health Reform, as part of their submission to government regarding the allocation of funding in the 2016 Budget, endorsed the provision of funds for staffing of child and adolescent mental health services and called for a significant rise in the amount of public investment in young children and their families (Mental Health Reform, 2015).

Cross Disciplinary Approaches

In recognition of the inter-disciplinary nature of perinatal and infant mental health, a comprehensive and coordinated response to perinatal and infant mental health requires the collaboration and partnership of multiple public sectors including health and education. Such collaborative approaches ensure the provision of quality services to infants and families.

Governance

Insisting on good governance, accountability and quality in all services promotes accountability and communication regarding the provision of services to infants and their families. The publication of the National Maternity Strategy provides the opportunity to coordinate these efforts and ensure such governance is upheld.

Empowering Families

The ethos of empowering families and by extension their young children is an integral part of strategies promoting, preventing and responding to perinatal and infant mental health challenges. The strengths of parents and families need to be acknowledged and supported and services need to recognise families' right to care that is responsive to their differing needs. Empowering infants and children involves ensuring their right to the protection support and care necessary for their wellbeing.

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Appendix A: List of PSI Members who provided feedback on the position paper

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