Early intervention programmes for mental health from the NSPCC: Part 2

The NSPCC is dedicated to perinatal wellbeing and advocating for a preventive model of care that has the potential to improve the mental health for parents, families and communities. Here in the second of two articles, Camilla Sanger, Alice Haynes, Gary Mountain and Naomi Bonett-Healy describe two evidence-based perinatal NSPCC services facilitated by midwives.

Early interventions for antenatal mental health difficulties

Midwives have a critical role to play in not only identifying women with mental health difficulties but also in referring them on to specialist services. Within the NSPCC, a number of innovative interventions have been developed to support parents with mental health difficulties, with midwives taking a central and essential role in their delivery. Two of these programmes are discussed below.

Minding the Baby

Minding the Baby is an evidence-based and preventive home-visitation intervention programme for vulnerable first-time young parents and their babies. It was originally developed by Yale University in 2002, and has been found to have a positive impact for parents and children (Sadler et al, 2013). The NSPCC has slightly adapted the programme for pragmatic use in the UK and it is being evaluated in a multi-centre randomised control trial in England and Scotland.

Minding the Baby is a relationship-based, interdisciplinary, and trauma-informed programme. It combines two well-researched early-intervention models; home visiting and infant–parent psychotherapy, in order to meet the holistic, complex, multiple-layered care needs of vulnerable families. Midwives work in close alliance with a social worker/psychotherapist to provide the programme from mid-pregnancy through to 2 years postpartum.

Evidence shows that improving parental mental health on its own will not necessarily improve parent–infant relationships or infant outcomes, and any treatment of parental difficulties should focus both on improving symptoms as well as parent–infant interaction quality (Forman et al, 2007). The programme is therefore grounded in attachment theory (Bowlby, 1969) and parental reflective functioning (Slade, 2005), and focuses on addressing parent–infant mental health issues as well as the evolving parent–infant relationship, positive parenting and developmental outcomes.

A key feature of the Minding the Baby model is a focus on the development and enhancement of parental reflective functioning, which is defined as an intra- and interpersonal capacity that allows a parent to envision the baby's (as well as their own) internal experience, specifically her or his emotions, thoughts and intentions. The emphasis on the enhancement of parental reflective functioning stems from the morass of literature that identifies clear concordance between parental reflective functioning and the intergenerational transmission of attachment, and particularly to the development of secure infant–parent attachment (Fonagy et al, 1995; Grienenberger et al, 2005). Parents who are able to use reflective functioning capacity are not simply reacting to their infant's behaviour; they are responding to the infant's mental states (e.g. emotions, needs, desires) in a reflective manner. This is associated with a range of positive developmental outcomes for the child (Slade, 2005; Slade et al, 2005).

Baby Steps

Baby Steps is an innovative nine-session perinatal psychoeducational programme co-developed by the NSPCC and Professor Angela Underdown from Warwick University. Following a home visit, parents attend weekly group sessions in the 6 weeks leading up to the birth, another home visit and a further 3 sessions after the baby is born. The programme is delivered by a midwife or health visitor together with a children's services practitioner, bringing a crucial combination of skills to address the emotional, social and physical needs of expectant parents.

Baby Steps is based on the Department of Health's Preparation for Birth and Beyond

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framework (DH, 2012) and the systematic review of Schrader McMillan et al (2009) that preceded it. It was designed with the needs of disadvantaged parents in mind—such as those with learning disabilities, social care involvement, drug and alcohol problems, mood difficulties, relationship conflict, and those from minority ethnic backgrounds. As these parents are less likely to attend appointments (National Institute for Health and Care Excellence, 2010), Baby Steps facilitators visit parents at home before the programme in order to engage parents.

Baby Steps has a number of key themes at its core, such as:

- Strengthening the parent–infant relationship by encouraging the development of sensitive, reflective interactions
- Targeting the couple relationship

Box 1. Baby Steps case study by Naomi-Bonett-Healy

'I was first introduced to 19-year old A* and her boyfriend when they were referred to the Baby Steps team at 16 weeks gestation. The referral explained that she was experiencing heightened anxiety, had a previous history of being on medication for anxiety and depression, and was very isolated after moving to the island 5 months previously with no family or friends locally—A* did not like leaving the house unless her partner was there to escort her.

'Further assessment at the first home-visit revealed that the couple had money difficulties, their living arrangements were too small to home a baby and they were experiencing poor working environments—all risk factors for mental health problems. A* told me that she was diagnosed with bipolar in England and used to be on medication, but was unable to pay the GP fee (required in the Channel Islands) to discuss her condition and medication. She consequently had no support from the local mental health team and was not willing to discuss this further. I felt it was important to ensure that A*'s obstetrician was aware of her previous mental heath diagnoses, and it was confirmed that they were also aware but that A* declined to be referred to specialist services.

'During that first visit, A*'s mood could be observed as fluctuating from high to low—she spoke rapidly of her excitement of having a baby and asked many questions but would not await the answer. Then her body language and voice would drop and she would say how she categorically did not want a certain sex, and did not want her partner dressing the baby in a certain way. A* said that she was absolutely convinced that she was going to be advised to have a caesarean due to her small frame and her heightened anxieties. A* also spoke of her disgust with the thought of breastfeeding. Honestly, I felt absolutely exhausted at the end of the session as [I had] never encountered someone who spoke so fast!

'A* and her partner attended the first Baby Steps session together, and A* joined in with all group activities although she had previously stated "I will come but I will not say anything". Through the weeks, friendships could be seen forming between A* and other group members, and A* appeared less reliant on her partner. At week 3 she attended the group alone due to her partner's work commitments. Her confidence appeared to grow. I felt that this was a significant session for A* because it explored the impact of stress, depression and anxiety in pregnancy. We stood behind a wall of boxes with risk factors written on them, for example; housing issues, poor relations with family and friends. The activity is to show group members that although facilitators and other health professionals cannot resolve the problems, we can offer support and give advice to reduce the wall of problems so that parents can look out and move forward. We also discussed how mental health difficulties do not only affect mum but the whole family including baby. These exercises provided a really normalising and valuable framework for A* and after this session she agreed to be referred to the adult mental health team.

'In the next sessions, we discussed labour, what happens during birth, analgesia options, breathing and mindfulness techniques, and breastfeeding. A* appeared interested and asked many appropriate questions, but was adamant that she was having a caesarean, did not want skin-to-skin, and was going to bottle-feed.

'I was very fortunate to be on shift when AB* and CA* came into the unit in early labour—and she agreed to give a vaginal birth a go. At first, A* appeared stressed and anxious, but she readily took advice and calmed and labour progressed well for a primigravida. When she was progressing to full dilation, A* had a very controlled vaginal birth, in which she had immediate skin-to-skin contact. A* consented to be sutured, and she remained very calm; softly talking and reassuring baby. It was then to my delight, she said "Do you know what? I want to breastfeed her". A* was supported initiating breastfeeding and baby latched on and fed well.

'The next time I saw A* was 3 weeks later on her post-birth home visit. During the visit, A* spoke of her low mood but also identified her learnt coping strategies. To my delight, A* was continuing to breastfeed and the bond between mother and child was great. Three further group sessions took place and A* appeared confident and a more-than-capable mother. She continued to breastfeed, even in public.

'In my professional opinion, A* attending a Baby Steps programme had a significant impact on her relationship with her baby and her partner—and felt like a real success story.'

by encouraging listening, developing conflict resolution skills, and helping parents to manage relationship changes
- Providing coping techniques for parental stress, anxiety and depression
- Building self-confidence by supporting mothers and fathers to negotiate the emotional and physical transition to parenthood and helping them to keep healthy and relaxed.

Early evaluation of the service indicates that a number of positive outcomes are achieved, including improved obstetric outcomes, reduced anxiety and maintained stability in the couple relationship (Coster et al, 2015).

Conclusions

The NSPCC is dedicated to ameliorating psychological distress during the perinatal period, advocating for a preventive model of care that has the potential to pave the way for increased wellbeing at an individual, family, community and societal level. The perinatal period represents a time frame with particularly frequent input from health professionals, and therefore provides an incomparable opportunity to prevent this intergenerational transmission of disadvantage. Midwives and other front line staff are in a pivotal position to contribute to family-focused and integrated care that can increase detection, management and treatment of families in need. BJM

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