Taking action to keep the infant in mind

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It is well-established that practitioners working with children sometimes struggle to listen to and represent the voice of the child in assessments and decision-making processes (Care Quality Commission, 2016; Holland, 2004). It is often even harder for practitioners to see babies as individuals with needs and preferences. Indeed, the very word 'infant' derives from the Latin meaning 'not able to speak'. This reflects some of the difficulties in working to support good mental health in infancy. How can practitioners consider social and emotional wellbeing when babies are unable to verbalise their experiences? It is easy to ignore or deprioritise those who cannot speak. This article describes a resource that helps practitioners to hold infants in mind.
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Experiences early in life lay the foundations for a wide range of future outcomes throughout childhood and adulthood. The first 1001 days of a baby's life represent a critical period of development with more than one million new neural connections forming every second (Center on the Developing Child, 2017). Babies need good quality and reliable relationships with their caregivers for optimal brain architecture to develop (National Scientific Council on the Developing Child, 2004). Unsatisfying or absent early relationships are a primary chronic stressor, which dysregulate both psychological and biological processes (Institute of Medicine, 2000). Therefore, it is critically important to identify concerns in the parent-infant relationship early on and to offer support to families.

> Practitioners often struggle to discuss how parents feel about their relationship with their baby

It can often feel hard for practitioners to think about the baby's experience of being cared for, particularly if parents are experiencing distress. There are perhaps three main reasons why practitioners may not explore parent-infant relational issues or distress in infancy:

1. Babies rely on their behaviour to communicate their needs and cannot be asked about their experiences, feelings or preferences. Signs of distress in infancy can be subtle. For example, a baby who consistently does not have their needs met may quickly adapt and become a 'good baby' who rarely cries. This baby has learned that crying will not benefit them; indeed, in some cases it may harm them.
2. Asking about how parents feel about their new baby can feel like a 'taboo' that breaks the social narrative that having a baby is exclusively a time of joy.
3. Frontline practitioners may worry about whether they can appropriately manage any distress that arises from discussions about concerns in the parent-infant relationship.

Coupled with this, high caseloads, workforce shortages, and increased need and complexity in families result in an overwhelming time pressure in most frontline appointments. It is understandable that the focus of appointments becomes the parent, whose needs and emotions are often more easily shared, assessed, understood and supported. The cost of this is that valuable opportunities to support parents and babies together are missed.

INFANT MENTAL HEALTH SERVICES

The idea of specialist practitioners advocating on behalf of infants unable to share their needs with words has long been promoted (Emde, 1983). However, few professionals, including midwives and health visitors, are routinely trained in parent-infant relationship work as part of their core training (Hogg, 2019).

Infant mental health services have specialist knowledge of child development and understanding of infants' pre-verbal cues. This expertise can be helpfully shared with the early years workforce to better understand and support parent-infant relationships, to recognise difficulties and to respond appropriately.

One challenge that infant mental health services face is communicating complex ideas and approaches so that they can be readily included in the practice of over-stretched and under-resourced practitioners. Training is a key part of this, but 'classroom' learning should be considered as the first step in supporting practitioners to work with parent-infant relational difficulties.

With this in mind, at Bradford Infant Mental Health Service in the north of England, we wanted to create a simple and accessible resource that would help practitioners hear the infant's 'voice' in their routine visits.

The difficult context of early years services necessitated a pragmatic approach. We produced a resource, the Five Point Action Card, that would have the dual purpose of focusing practitioners' minds on the infant's perspective and providing them with concrete ideas about how to explore infant mental health with families.

To achieve this, we packaged existing key messages around infant mental health into a concise and practical 'action card'. We consulted with a steering group of experts in the field, including practitioners from the voluntary, community, health and infant mental health sectors. This process led us to develop four key themes and a question for practitioners to hold in mind. We paired questions to help practitioners find the words to begin conversations with simple explanations of why the questions are helpful. The explanations linked into the key messages that are delivered through existing infant mental health training.

It could be argued that this action card is too simple to be effective. However, feedback from practitioners has been positive. This suggests that the action card has merit and utility as a tool to support busy practitioners to better hold the infant's experience in mind.

By observing the world through infants' eyes, practitioners may be better able to identify their needs and to support families who are struggling to meet them. We hope that this action card will help those working with parents and babies to translate the silent baby into an individual who has a voice.

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