Norfolk Parent Infant Mental Health Attachment Project
An attachment perspective on alcohol and substance misuse

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Why?

- “The child’s first relationship...acts as a template...(for) all later emotional relationships” Schore (2000)
- pregnancy and the birth of a baby is a critical ‘window of opportunity’
- Babies are disproportionately vulnerable to abuse and neglect. (1001 Critical Days, 2013)
- Emotional and financial cost of children taken into care
Who?

• Range of Mental Health Practitioners – Psychiatrists, Clinical Psychologists, Psychological Therapists, Primary Mental Health Workers

• Link Social Workers, Family Support Workers

• Community Early Years services – Children’s Centre workers, Health Visitors
Norfolk Parent Infant Mental Health Attachment Project

• Joint venture between Norfolk County Council and Norfolk and Suffolk NHS Foundation Trust

• Aims to provide attachment therapy and integrated mental health support to ensure infants at risk who are at the edge of care (0-2 years) remain safely with their parents
Distinctive Approaches

• Outreach “alongside family” in community - more “accessible”

• High level of inter-agency communication – shared risk, safe uncertainty

• Targeting areas of highest socio-economic need

• Flexible – based on specific needs of each family – variety of approaches – adult psychotherapy, video interactive guidance

• Underpinned by Attachment Theory – creating “safe base” – promoting mentalizing

• Collaborative and integrating adult mental health, parent-infant mental health and social care
Our families

35% of families accepted onto PIMHAP included a record of substance or alcohol misuse in the referral.

Lots of families presented with current or past use of multiple substances or a combination of substances, alcohol and prescribed medication.

4 families historic opiate use
2 families current opiate use
4 families past amphetamine use
5 families current cannabis use
3 families past cannabis use
3 families past alcohol dependency

Actual consumption is probably higher than this, although a combination of safeguarding status and some families historic difficulties with trust may have impacted upon openness.
Impact

When craving or under the influence of alcohol or a substance parents might:

Be unable to provide appropriate supervision
Be too physical unwell to look after their baby
(substance impact on eating, immune system and sleeping)
Be financially unable to provide for their baby
Be unable to be emotional available (risk of self-preoccupation)
Be unable to metalise for their baby
Have difficulty regulating their baby’s emotional states (especially if they are struggling to regulate their own)
Put themselves and their baby at risk due to potential criminality
Risk the baby’s physical health and risk of being born with withdrawal to a substance if using during pregnancy
Be less sensitive to the natural mood enhancing chemicals the body produces in relation to attachment and togetherness, and as a result might feel less bonded with their baby.
Attachment to a substance
(with Acknowledgement to Amanda Jones)

Primary attachment to a substance is much like an infant attaches to a parent, used to seek for help and comfort in times of distress.

Attachment is powerful:

“I will seek you out”
“I can’t let you go”
“I can’t survive without you”

Requires a professional to be trustworthy through acting with authenticity and authority, likened to the way a parent is to a child.

To introduce the professional as an alternative attachment figure, for those attached to a substance this will heighten stress and heighten the craving.
Attachment to a substance:

The substance provides pseudo-comfort for:

**Seeking stimulation** - craving not to be alone with their thoughts and craving to be away from feelings of emptiness

**Seeking Oblivion** – craving to feel at one, craving for a sense of harmony - control feelings of grief and panic and escape from anxiety or fear.
Attachment to a substance

• Withdrawal from the substance evokes attachment behaviour and strategies
• The loss of a substance for some will be a significant bereavement as well as an opportunity for the brain to begin to reorganise.
Case Study

- Mother poor early attachments – lack of engagements – OCD hoarding features
- She experienced neglectful – inconsistent parenting – lead to “high” A (Avoidant) strategy
- Father (partner) ex-user but now clean and distressed but helpless regarding partner’s drug use
- Son autistic features at least in part due to inadequate care
- Use of drugs - amphetamines when young - started cocaine to manage stress of parenthood – prescription to wean off cocaine became addicted - later pain complaint – morphine now methadone - now dependent upon
- Challenge to therapy when seek to address
Substance use at point of referral

• Topic of medication was out of bounds on assessment.
• Offer of medication review triggered - red face, hot flush, rage at the threat of loss of attachment figure.
• Preoccupation with methadone left her unable to plan for the future and there was no conscious wish for things to be different.
• Denial was so strong there were many excuses and reasons to blame others for its use
• History of overdoses, risk of future overdoses both intentional and unintentional by varying amounts according to emotional need.
Substance use 8 months into therapy

- Withdrawal symptoms sometimes serve as an excuse for inaction and are sometimes denied completely.
- Medication is used to manage challenges which inhibits integration of positive change.
- NRP’s story of this client being a special case and the prescription being for pain supports the denial of addiction.
- There is some conscious hope that things could be different and a reduction plan is in place- self managed.
- Risk of overdose has increased as she manages own reduction.
- Risk to familial relationships increases as decreased dose allows for more affect to be felt and expressed i.e. anger, despair.
- Child’s symptoms of developmental delay due to opiate use in utero becoming more apparent.
Approach

• Intensive – 2 therapists one with Family Therapy training one with child psychotherapy
• “Alongsidedness” – engagement
• Creating space – literally and metaphorically
• Trust – more openness / awareness of son
• Ruptures when felt “criticised”
• Dilemma currently over plan to reduce use of methadone and amount held in house
• Seeking to involve NRP more
• Rupture and repair (new experience)
Achievements

• PIMHAP is working with 48 Families in areas of high deprivation across Norfolk

• 83.33% of infants remain the full time care of their birth families.

• Safeguarding level reduced for 25% of accepted families.
• 4 families no longer on safeguarding plans
• Change in LAC:
  - 2014 1:4 of Infants on Safeguarding Plans were taken into care
  - 1:10 of Infants involved with project have been taken into care

• The Project has recouped the money invested and provided additional savings to the local authority.
“The parent and infant mental health service attachment project is a good example of partnership working between children’s social care and mental health services. This service is beginning to demonstrate evidence of impact in preventing children becoming looked after and in promoting better quality relationships for children.”

“...the Parental Infant Mental Health (PIMH) and COMPASS project, demonstrate effective support in keeping children in the care of their families”
Without Funding, Losses which...

- Increase the risk for families with long term ongoing needs
- Increase potential of infant removal
- Reduce developed infrastructure in local areas
- Reduce specialist integrated support for families, where there is no current equivalent
- Reduce staffing resource, including specialist knowledge and skills
- Increase the pressure on other services, that might result in commissioning of more private work
- Reduce the number of embedded assessments
- Reduce joined up working across specialist mental health and children’s services
- Fail to promote health and social care working together
With Funding, Opportunities to...

• Continue to provide an integrated and specialist service for vulnerable families across Norfolk
• Use skills to develop more “across continuum” PIMHS provision (currently gap at Tier 3 level)
• To build on networks already created through project
• To extend therapeutic interventions for parents following a child being taken into care
• Increase the geographical reach (develop hubs in children’s centres)
• Increase links to “Early Help”
• Disseminate learning and knowledge
• Jointly commissioned, jointly delivered integrative “Attachment aware” services
• Link in more with drug & alcohol services
Summary & Conclusion

Interim findings show that the project has met the three identified requirements of Transformational Challenge funding:

1) The project has recouped the money invested

2) The project has involved a genuine collaboration between agencies – systemic change

3) The project has reduced rate of infants taken into care by addressing mental health needs of family.

83.33% of infants at risk of harm and removal are in the safe care of their birth families.