IMHAANZ

INFANT MENTAL HEALTH ASSOCIATION AOTEAROA NEW ZEALAND

The State of Our Specialist Mental Health Services for Infants, Young Children and their Families in District Health Boards across New Zealand

A STOCKTAKE BY THE NEW ZEALAND AFFILIATE OF THE WORLD ASSOCIATION OF INFANT MENTAL HEALTH (WAIMH)

AUGUST 2022

SUMMARY

Disinvestment in infant and young children's emotional health and development persists in Aotearoa New Zealand (NZ) despite overwhelming evidence for economic and health benefits.

This stocktake was conducted prior to the disestablishment of the District Health Boards (DHB), and as such, the report will use DHB's to convey the results. In this report the Infant Mental Health Association Aotearoa New Zealand (IMHAANZ) looked at specialist services and workforce in District Health Boards.

There is no clear NZ data for the numbers of infants and young children (0-4 Years) seen in these services.

There is no clear NZ data addressing workforce in this area.

There was senior level support across DHB's for services to respond to this stocktake.

Seven of the 22 DHB services responded, two of these were local responses from within a larger DHB. IMHAANZ was aware that in some DHBs requests to respond to the stocktake did not come to frontline services.

Key Findings

- There is persisting systemic neglect of the mental health needs of pēpi (0-4 years).
- Pēpi are being "left out of the mental health conversation".
- The Infant Mental Health (IMH) workforce is limited in Aotearoa.
- Access to IMH training for the workforce is extremely limited.

INTRODUCTION

Who Are We?

Infant Mental Health Association of Aotearoa New Zealand (IMHAANZ) is the New Zealand affiliate of the World Association for Infant Mental Health (WAIMH). It was given WAIMH affiliation status in May 2006 and was officially launched in April 2007. It is one of 58 Affiliates. IMHAANZ is a registered Charitable Trust.

IMHAANZ has an Executive Committee who work voluntarily to network nationally and internationally and focus on relevant local issues. The aims of IMHAANZ are:

1. Promotion of an increased recognition of the mental health needs of infants (0-4th birthday) within their families
2. Dissemination of resources on infant mental health, from a wide variety of disciplines, through seminars, workshops and conferences
3. Strengthening the links between New Zealand professionals working with infants and their families
4. Discussion and sharing of questions, problems, issues, information, and theories regarding the field of infant mental health
5. Linking New Zealand professionals to international research and practice in infant mental health, infancy and family studies
6. Promotion of the development of scientifically based programs of care, primary prevention and intervention in infancy
7. Supporting and generating New Zealand research accessible to all.

Why a 'Stocktake'?

For many years IMHAANZ has been concerned at the lack of progress in developing mental health services for infants/pēpi and young children/tamariki and their families/whānau. The organisation had input into ***Healthy Beginnings – Developing perinatal and infant mental health services in NZ (2011) Ministry of Health*** that aimed at supporting service development in this area**.** This document referenced the gaps in specialist service provision including maternal and infant mental health in *Te Raukura – Mental health and alcohol and other drugs: Improving outcomes for children and youth (Ministry of Health 2007)* and its companion document *Whakarato Whānau Ora: Whānau Wellbeing is Central to Māori Wellbeing.(Ihimaera 2008)*.

IMHAANZ has seen minimal service development across NZ in the intervening years. A formal stocktake was an appropriate next step. The Stocktake was to provide a clear picture of current services being provided by DHB's across Aotearoa for infants/pēpi and young children/tamariki and their families/whānau.

What Is IMH?

The phrase *Infant Mental Health* was coined in the 1960's by Selma Fraiberg who defined Infant Mental Health (IMH) as the "social, emotional, and cognitive well-

being of a baby who is under three years of age, within the context of a caregiving relationship (Fraiberg, 1980).

The scope of IMH practice has a focus on the developing relationships of pēpi with their caregivers".

Why Is IMH Important?

There is a wealth of research from a wide range of disciplines that addresses the importance of IMH, including neuroscience, psychology, psychiatry, paediatrics, medicine, and social work. This research clearly demonstrates that early adverse experiences can have profound long-term physical and mental consequences. In addition, the impact and extent of these impacts is mediated by the quality of early caregiving.

The Practice of infant mental health is unique in that it works with the "relationship" between the pēpi and caregiver. The core beliefs of practice are based on research and include:

- "Optimal growth and development occur within nurturing relationships
- The birth and care of a baby offer a family the possibility of new relationships, growth, and change.
- What happens in the early years affects the course of development across the lifespan.
- Early developing attachment relationships may be distorted by parental histories of unresolved losses or traumatic life events.
- The therapeutic presence of an infant mental health practitioner may reduce the risk of early relationship failure and offer hopefulness for change." (Weatherston, 2005)

It is important to intervene across two generations especially where parents have mental health, addiction and/or complex trauma experiences. These problems can make it difficult for parents to provide the relational care infants need. There is considerable research demonstrating that intervention in these years must be two generational to impact the adverse impacts on the infant's development.

The MOH document Supporting Parents, Healthy Children directed to improving care for the children of parents with a mental health and/or addiction problems noted:

> "Systems and guidelines are in place to ensure that pregnant and postpartum service users have access to appropriate supports and services, including:
>
> - access to consult-liaison, assessment and intervention services from specialised perinatal and infant mental health and addiction services as required. (Pg. 10)"

Why Are We Concerned?

IMHAANZ has qualitative information about Infant Mental Health (IMH) services and has for a number of years wanted specific data in regard to IMH services and its workforce. IMHAANZ is aware of Whāraurau ICAMHS Stocktake that collates information on a two-yearly cycle. The Whāraurau Stocktake does not specifically record data on services for 0-4 years. The data is folded into information for children/tamariki of 0 - 9 years of age. There is no data on the IMH workforce.

Therefore, there is no data available to evaluate services, workforce training and retention and forward planning. This is despite an increasing body of evidence that IMH has a significant impact on health and wellbeing across the lifespan. IMH appears to be left out of the mental health conversation and is probably the most underfunded area of practice for services for pēpi and whānau and for practitioners' access to training.

Left Out Of The Mental Health Conversation

He Ara Oranga - Report of the Government Inquiry into Mental Health and Addiction (MOH, 2018) comments on "Increasing numbers of children and young people are showing signs of mental distress and intentionally self-harming" and "a tidal wave of increased referrals to Child and Adolescent Mental Health Services and Behaviour Support Teams". It does not, however, directly comment on the mental distress of infants. Nor does it acknowledge that many of the leading causes of chronic illnesses, youth and adult mental health disorders can be traced back to early childhood adversity and infant mental health challenges (Zeanah Jr, C.H., 2018).

Te Huringa: Change and Transformation. Mental Health Service and Addiction Service Monitoring Report 2022 found:

- The mental health and addiction sector is continuing to provide services at pre-pandemic levels. Access to specialist mental health services and addiction services has not changed over the past five years. Use of telehealth and digital supports is increasing as they become more available, and access to primary mental health services has increased over the past year (in addition to the Access and Choice programme).
- There is a lack of current prevalence data on mental health needs and addiction needs
- Wait times for young people to access specialist mental health services continue to be high
- Māori continue to disproportionately experience higher rates of community treatment orders and solitary confinement (seclusion)
- The number of community treatment orders has increased proportionately with specialist mental health service use over the past five years
- There has been an overall increase in the use of solitary confinement from 2016 to 2020. Progress toward zero seclusion differs between DHBs
- 1 in 5 people are not followed up after discharge from acute inpatient mental health units, with 1 in 6 re-admitted to hospital within 28 days of discharge

Again, "there is no information or findings for our pēpi.

Te Rau Tira Wellbeing Outcomes Report 2021 found:

- most communities in Aotearoa New Zealand tend to experience good wellbeing, most of the time
- a concerningly large minority of people and communities experience persistently poor wellbeing
- most marginalised groups looked at, such as young people, veterans, rainbow communities, Māori, Pacific peoples, former refugees and migrants, children in state care, older people, rural communities, disabled people, prisoners, and children experiencing adverse childhood events, felt life is less worthwhile, and reported less security, poorer mental and overall health, and greater discrimination and barriers to wellbeing
- there is a positive story of the growth of Māori collective strength, and oranga / wellbeing
- there continues to be a disproportionate number of Māori individuals and whānau who are not doing well and are experiencing poor wellbeing across multiple dimensions.

Concerningly, groups of marginalised and minority people often have pēpi, but our pēpi are not mentioned or seemingly considered in this Wellbeing Outcome report, again they appear to be "left out of the conversation".

There is an increased focus on "The First Thousand Days", with Te Hiringa Hauora/Health Promotion Agency, the South Island Hauora Alliance's project group, and other organisations working in this domain. We commend these initiatives, however, there is a distinct lack of specific training for the parent-infant relationship which is struggling and infant mental health difficulties and a lack of trained clinicians for pēpi and their whānau needing infant mental health assessment and intervention.

The qualitative information held by IMHAANZ shows that:

- There are very few DHB's that are providing mental health services to infants, young children and their families;
- There are very few clinicians specifically trained to work in the field of Infant Mental Health;
- There is limited specific IMH supervision for practitioners;
- There is limited financial support for clinicians to access training in the field

The quantitative information held by IMHAANZ from the stocktake supports the qualitative information, albeit based on very few respondents.

Background To The Stocktake

Stocktakes of Services conducted by Whāraurau (the funded by government service to deliver workforce development initiatives for the infant, child and adolescent mental health and/or addictions sector) 2012 – 2020 have:

- No specific reported data on infants 0-4 years being seen in ICAMHS across New Zealand
- No reported data on the infant workforce employed to address what is a complex area of assessment and intervention.

Ministry of Health (MOH) Service Specifications – clearly include Infants and expect they will receive services

> "Tier two and tier three service specification for Infant, Child, Adolescent and Youth Mental Health Alcohol and or other Drugs Services (the Service) is the overarching document for a range of mental health, alcohol and/or other drugs (addiction) It defines the services and their objectives in the delivery of a range of secondary and tertiary services for infants, children, adolescents and youth, in the mental health and addiction sector."

The following MOH documents – clearly support services for infants.

- Healthy Beginnings: Developing Perinatal and Infant Mental Health Services in New Zealand; 2011 Ministry of Health
- Supporting Parents, Healthy Children. 2015 Wellington: Ministry of Health.
- He Ara Oranga - Report of the Government Inquiry into Mental Health and Addiction. 2018 Wellington: Ministry of Health.

IMHAANZ made submissions to the Mental Health and Addictions Enquiry and the Child and Youth Wellbeing Strategy (available www.imhaanz.org.nz) highlighting lack of services and workforce.

METHODOLOGY

Stocktake Plan

I. IMHAANZ communicated with Whāraurau and Child and Adolescent Mental Health, Ministry of Health about our plans for a Stocktake.

II. Questionnaire developed and a letter backgrounding the request for completion of the questionnaire and providing a link to the President and Secretary of IMHAANZ for questions or concerns (Attach as Appendix)

III. Communication with DHB's – who the questionnaire was sent to; reminders and extension of time to complete

IV. Response

RESULTS

IMHAANZ received seven (7) responses from the 22 DHB's. Two of the responses were local responses from within a larger DHB. IMHAANZ was aware that in some DHB's the requests to respond were not distributed to frontline services, which may account for the low response rate.

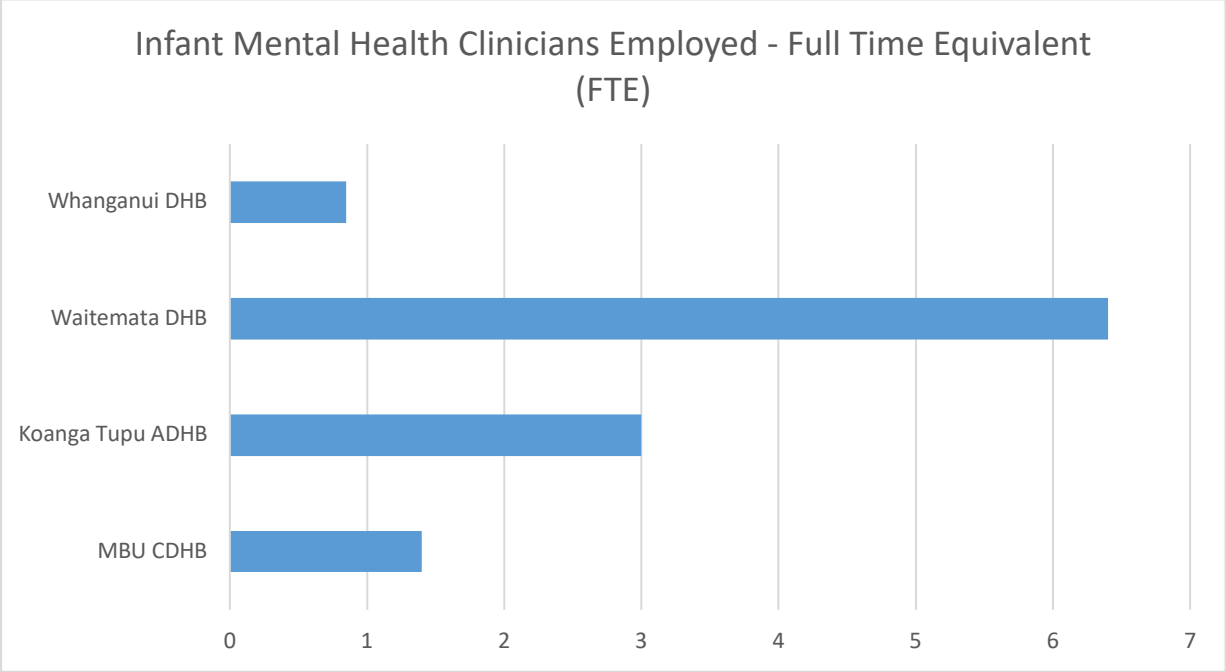
Summary

Four (4) of the seven (7) responses were unable to provide a full set of data due to either not having designated IMH staff (3 of the 7) or not keeping data on the infant or both. Therefore, reporting has been challenging. In this document it has been decided to report on the IMH specific services and staffing.

Staffing

KEY	
Aronui Ora MMH ADHB	Aronui Ora Maternal Mental Health Auckland District Health Board
Northland	Northland District Health Board
Southland	Southern District Health Board
Whanganui DHB	Whanganui District Health Board
Waitemata DHB	Waitemata District Health Board
MBU CDHB	Mothers and Babies Unit Canterbury District Health Board
Koanga Tupu ADHB	Koanga Tupu, Auckland District Health Board

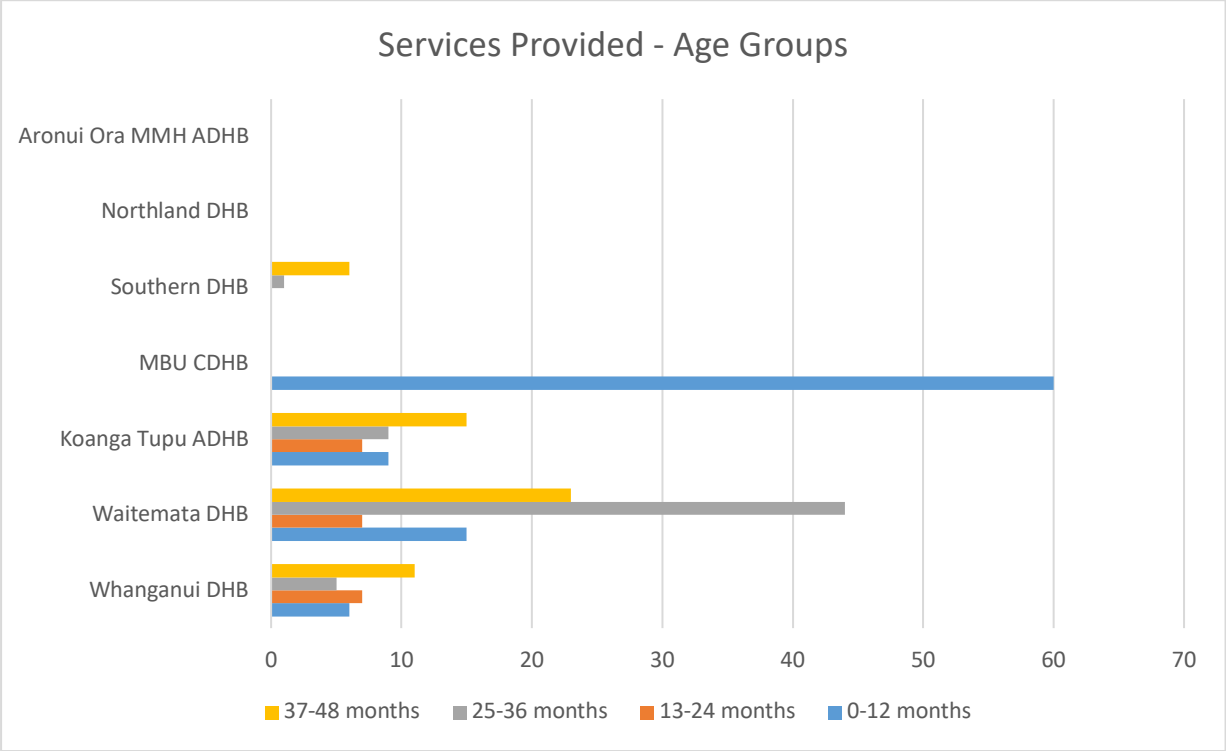
The services reported on the number of 'Full Time Equivalent' (FTE) designated IMH staff. This ranged from 0 FTE (Aronui Ora, Northland, Southland), 0.85 FTE (Whanganui DHB), 1.4 FTE (MBU CDHB), 3 FTE (Koanga Tupu, ADHB), 6.4 FTE (Waitemata DHB)



Services Provided

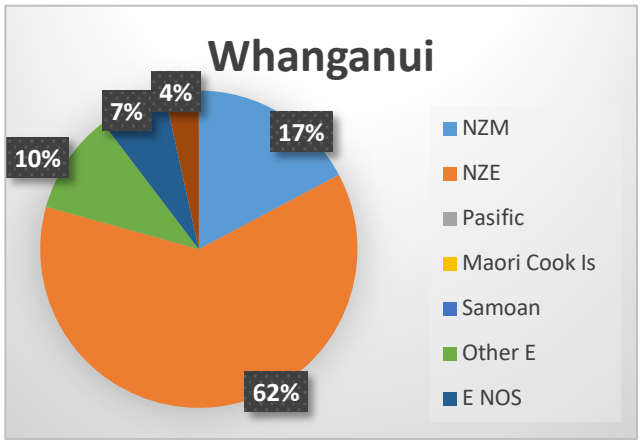
Each service reported on the number of infants that had been seen within their service. A total of 235 infants aged 0 to 4 years were seen in these 7 services over a 12-month period. MBU CDHB provides inpatient services for māmā and their pēpi under the age of 12 months, the māmā is the identified patient. MBU CDHB accounts for 60 of the infants. This somewhat distorts the data as 60% of the infants aged 0-12 months are not the identified client.

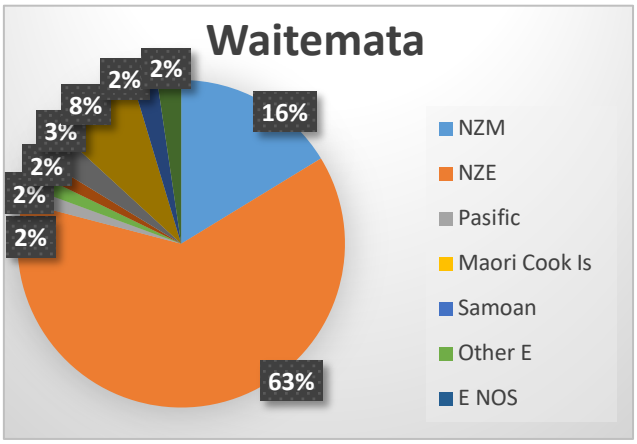
- Infants aged 0 – 12 months account for 100 of the infants seen (60 from MBU CDHB)
- Infants aged 13 – 24 months account for 21 of the infants seen
- Infants aged 25 – 36 months account for 59 of the infants seen
- Infants aged 37 – 48 months account for 55 of the infants seen.

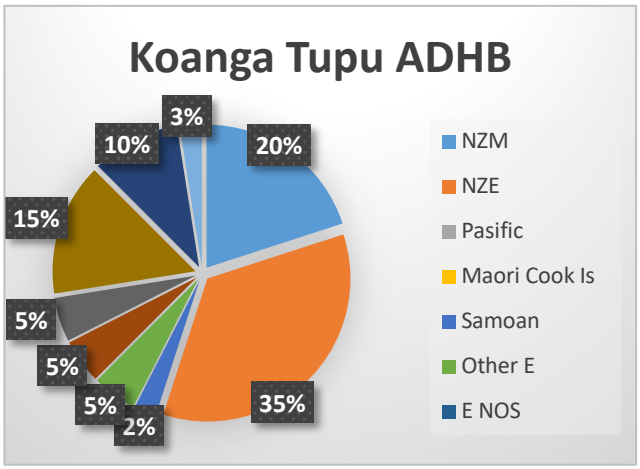


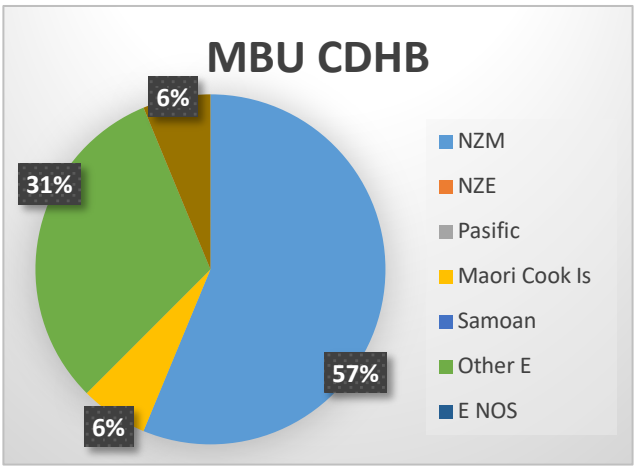
Ethnicity

Services reported on the ethnicity of the infants seen in their services.





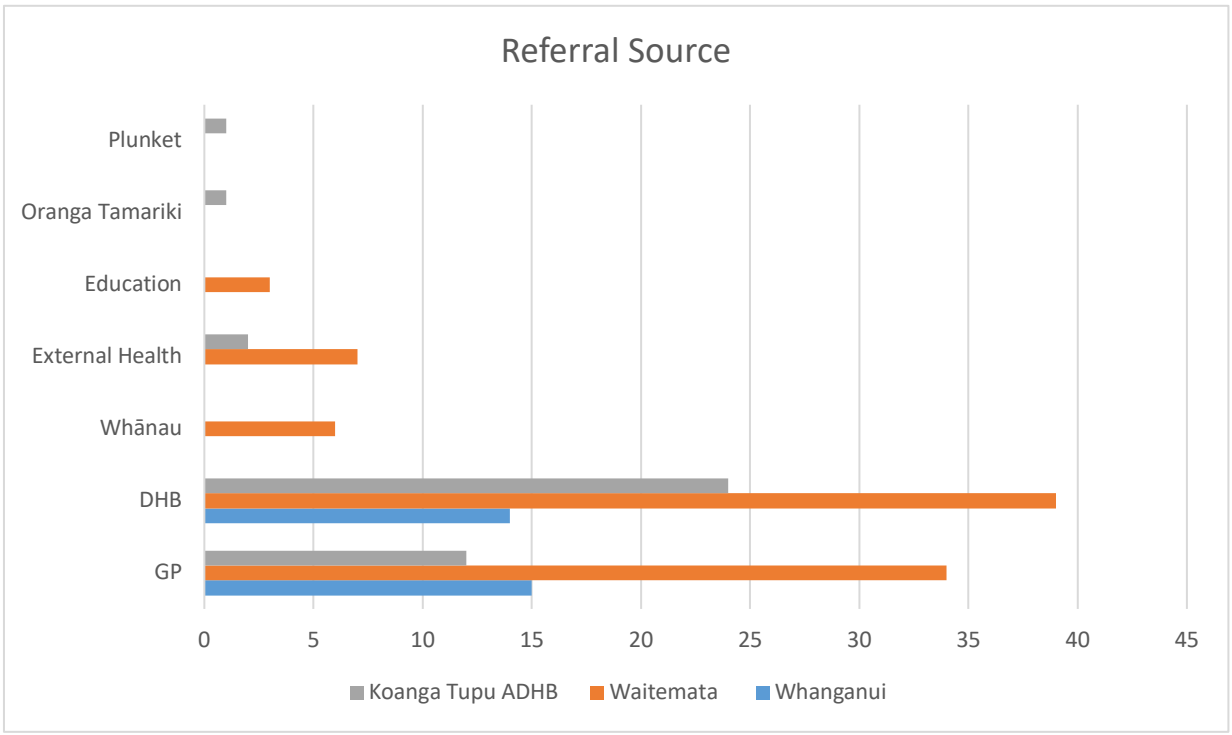




Referral source

The services provided information on the source of their referrals, the categories have been simplified for reporting purposes to:

- *General Practitioner (GP),*
- *DHB services,*
- *Whānau,*
- *External Health Providers,*
- *Education,*
- *Oranga Tamariki*
- *Plunket.*



Further work

Following the disappointing response from the DHB's, Whāraurau provided IMHAANZ with a breakdown of their 2020 Stocktake data for the 0 – 4 population, (Whāraurau. 2021). This data only provided information on the clients, not the workforce.

The data was, unfortunately, difficult to use. This was due to a number of factors including:

- Source of information – it is not clear where the data has come from, IMHAANZ's stocktake was limited to DHB services and was specific to IMH services
- The data included Infants with diagnoses that would not be seen as a mental health diagnosis, for example:
    - Unspecified operation on bone injury of other specified bone = Total 489 clients
    - Occupant of heavy transport vehicle injured in collision with pedestrian cyclist = Total 1391 clients
    - Other permanent tracheostomy = Total 71 clients
- The numbers were not in line with known epidemiology and ethnicity, for example:
    - Oppositional disorder of childhood or adolescence = Total 18 clients
    - Impulse control disorder unspecified; cases identified only in Asian ethnicity
    - Child Abuse – only in Pacific and all in the 2-3 years age bracket
    - Transient Organic Mental Disorder = Total 75 clients
- Observation for other suspected mental conditions constitutes large numbers across the age range = Total 4,948 clients. There is no clarification what this refers to and where these infants are.
- No recorded referrals from Well Child Tamariki Ora Services, MSD Home Visiting Services (Family Start), Midwives.

This data is at odds with the data received by IMHAANZ from the DHB services that responded. This data suggests that it is not gathered just from Infant Mental Health services, it is more likely to include data from Emergency Departments, Paediatrics, Social Work Departments, or from Consult Liaison Psychiatry Services in Children's hospitals. This would be in line with the unusual diagnoses recorded on the Whāraurau stocktake data for IMH services (Whāraurau,2021), the limited capacity of clinicians to assess and code appropriately (thus high percentage of infant coded in the 'observation for other suspected mental condition'), low numbers in areas traditionally seen within IMH services, and no referrals from services that work in the community with infants.

IMH services within the DHB's have been extremely difficult to "stocktake" with a significant absence of responding from DHB services . The stocktake data from the Whāraurau stocktake is not capturing infants within the reporting framework and the raw data breakdown for infants includes data that is probably not from IMH services.

CONCLUSIONS / IMPLICATIONS

There is a lack of "real" data on the DHB funded Infant Mental Health Services. Most DHB's do not have designated services or clinicians for pēpi and young tamariki. There is a dearth of trained clinicians to work with this vulnerable population in Aotearoa. Our pēpi are simply flying under the radar. They are often placed on an ever-increasing wait list for child and adolescent mental health services. This unfortunate position of competing with children and adolescents, dictates that our pēpi will never reach the top of the list. A month, on the waitlist, in the life of a 3-month-old is a third of her/his life. Babies **cannot** wait.

Service Provision

IMHAANZ Stocktake, whilst not providing comprehensive data on IMH services across Aotearoa, has reinforced the qualitative information IMHAANZ has; ie. that there are limited IMH services in Aotearoa. It has also confirmed that there is no reliable data regarding mental health services provided for our pēpi and their whānau within the DHB's.

Research, both from Aotearoa (Dunedin Multidisciplinary Health & Development Research) and overseas, clearly shows the need, the value, and the positive outcomes of early intervention.

Studies have shown a 16-18% prevalence of mental disorders among children aged 1 to 5 years, with more than half being severely affected (Von Klitzing et al, 2015).

The majority of these disorders do not go away with time – it is a myth to think that as infants grow the difficulties go away. These pēpi and toddlers are likely to be developmentally off track, the emotional communication and social relating with one or both parents may be very conflicted, the baby may be very withdrawn, the toddler angry, aggressive, and unhappy. It is particularly concerning when we observe an infant or young child who does not seek comfort when distressed.

At the 2018 IMHAANZ Conference, Helen Minnis, Professor of Child and Adolescent Psychiatry at the University of Glasgow, discussed research and intervention with infants and toddlers who had experienced early abuse and neglect. She proposed that **"failure to seek comfort"** and/or **"extreme parental stress"** have equal risk status to suicidality and that appropriate intervention must be available.

Whereas qualitative information and the information from the stocktake suggests that the majority of mothers and fathers, with moderate to severe mental health / addictions / complex trauma experiences who have infants and toddlers do not have access to IMH Services for their pēpi. This is despite the evidence that the negative implications for pēpi are lifelong, if there is no specialist intervention.

Workforce

Again, there is also no "real" data on the IMH workforce within Aotearoa. IMHAANZ qualitative information suggests that there is limited specifically training IMH clinicians providing services for our pēpi and whānau. IMH clinicians are working in isolation, with limited access to training, supervision and support.

RECOMMENDATIONS

- ***Including Pēpi in the Mental Health Conversation***

Including pēpi in the mental health conversation is essential across all sectors and at all levels, from the top down and from the bottom up. Thus, all MOH mental health conversations need to start with pēpi and whānau. It is well established through robust research that pregnancy and the first four years of life is crucial for lifelong health and wellbeing. Aotearoa's own longitudinal study - The Dunedin Multidisciplinary Health and Development Study clearly shows this. The implications are not only a health (physical and psychological) concern, but are also a social, education, employment and justice sector concern. The costs, across multiple domains, are incalculable.

- ***Address the Service Inequalities***

The quantitative and qualitative data shows the major gaps in DHB funded mental health services for pēpi and whānau. There are four IMH services across Aotearoa and services where clinicians are working in isolation and often in part-time roles in other areas and there are some DHB who do not have IMH clinicians. This inequality needs to be named and addressed. (Some of the other recommendations could begin to address this inequality).

- ***Stocktake of Services and Workforce***

A comprehensive "stocktake" of IMH services and the workforce, with clear parameters which are identifiable.

The Whāraurau Stocktake is a useful document of ICAMH services. For information on IMH services, infants need to be in a category of their own, not in a category for 0-9 year olds. As this crosses several developmental stages, and therefore, requires different interventions, and workforce skills. Work with Whāraurau to refine their stocktake for infants and toddlers will be important going forward and a way to gain a comprehensive stocktake of IMH services and the workforce.

- ***Services for pēpi and whānau***

Access to and availability of appropriate services for our pēpi and whānau across Aotearoa. This will involve ensuring all DHB ICAMH services provide an infant service as contracted. It will also involve having staff that are trained in IMH assessments and interventions.

- ***Workforce Development / Training***

Access to and availability of funded IMH training, including foundation level courses through to advanced training in IMH assessments and interventions.

- ***Reflective Practice Facilitation / Supervision for IMH practitioners***

Reflective Practice Facilitation is a capacity-building and problem-solving intervention for practitioners. The Reflective Supervisor develops a collaborative and reflective relationship with the supervisees. This support for practitioners is essential.

Additional Recommendations

The review of Maternal Mental Health Services needs to be widened to include Perinatal and Infant MHS: the presence of the pēpi is central to all perinatal and parental mental health services. This will also, in turn, ensure that the focus is on whānau mental health and can proactively begin to support intergenerational mental health and well-being, reversing negative cycles of harm and disadvantage.

Sarah Haskell, IMHAANZ President

On behalf of the IMHAANZ Executive

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APPENDIX 1 – LETTER TO DHBS

IMHAANZ
INFANT MENTAL HEALTH ASSOCIATION AOTEAROA NEW ZEALAND

P O BOX 1628, QUEENSTOWN 9348, NEW ZEALAND
Patrons: Dr Patricia Champion MBE and Mrs Elisabeth Muir

20.04.2021

Tēnā koe

We are writing to you to introduce our organisation and to request that your organisation complete a questionnaire about the Infant Mental Health services you provide. This is the services for infants and young children, birth through to 4 years, in DHB Perinatal and Child and Adolescent MHS.

IMHAANZ (Infant Mental Health Association of Aotearoa New Zealand) is the New Zealand affiliate of the World Association for Infant Mental Health (WAIMH). It was given WAIMH affiliation status in May 2006 and was officially launched in April 2007. IMHAANZ is a registered charitable trust.

The aims of IMHAANZ are:

1. Promotion of an increased recognition of the mental health needs of infants within their families
2. Dissemination of resources on infant mental health, from a wide variety of disciplines, through seminars, workshops and conferences
3. Strengthening the links between New Zealand professionals working with infants and their families
4. Discussion and sharing of questions, problems, issues, information, and theories regarding the field of infant mental health
5. Linking New Zealand professionals to international research and practice in infant mental health, infancy and family studies
6. Promotion of the development of scientifically based programs of care, primary prevention and intervention in infancy
7. Supporting and generating New Zealand research accessible to all.

This questionnaire is aimed at getting baseline information about services provided within DHBs and who is providing the services. By gathering this preliminary information, it is hoped to generate recommendations about further information required, strengths and gaps in services, training, knowledge, and skills.

While we are aware that you do complete a "stocktake" questionnaire for the Werry Workforce Whāraurau about Child and Adolescent services, this stocktake is to pull out information specifically about our infants and toddlers, whereas information reported on by the Werry Workforce Whāraurau is collated under 0–9-year-olds and therefore gives no specific data about 0-4 years.

We appreciate that you may not be the best person to answer the questionnaire and, therefore, would ask that you determine the best reporter from your DHB. Having read the attached questionnaire, please can you forward to the person responsible for completing the document and send us (at IMHAANZ) their contact details and whether they will complete independently or would like to be interviewed.

If this would be able to be completed before Monday May10th, we would be very grateful.

Please do not hesitate to contact us if you have any queries and please direct all answers and correspondence to IMHAANZ (rather than the MH secretariat) through the following -

- secretary - Marion Doherty secretary@imhaanz@org.nz
- president - Sarah Haskell president@imhaanz.org.nz

Ngā mihi,

Sarah Haskell
President IMHAANZ

APPENDIX 2: Questionnaire

IMHAANZ
INFANT MENTAL HEALTH ASSOCIATION AOTEAROA NEW ZEALAND

P O BOX 1628, QUEENSTOWN 9348, NEW ZEALAND
Patrons: Dr Patricia Champion MBE and Mrs Elisabeth Muir

Stocktake Questionnaire

Tēnā koe

This survey aims to provide preliminary data on services for infants and young children in our DHB Perinatal and Child and Adolescent MHS; on behalf of our membership and infants and their whānau in New Zealand. The findings will guide development of an in-depth stocktake.

The overall goal is to highlight the importance and value in having specialised services available to intervene early and innovatively, alongside universal and primary programmes, and to advocate for these services.

IMHAANZ is the New Zealand Affiliate of the World Association for Infant Mental Health (WAIMH) and the goals for affiliate organisations include:

- Promoting cooperation to support the optimal development of infants and infant caregiver relationships.
- Support networking and meetings that encourage discussion and education, showcasing practice and research.
- Building diverse connections across cultures, disciplines and sectors

The IMHAANZ Executive is appreciative of you taking the time to complete this survey and we will provide a report on our preliminary findings.

Māuruuru.

Definitions:[1]

Infant – 0-3 years of age (up to 4th birthday)

Perinatal – from pregnancy to one year postpartum.

Section 1: The Infant Mental Health (IMH) Workforce in your Service/Team

Please tell us about the current make-up of your IMH workforce

- Numbers of staff
- Time allocated on a weekly basis to providing IMH services
- Is this time documented, dedicated FTE (Full Time Equivalent)?
- Vacant positions

Any other comments you would like to make.

[1] Ministry of Health (2011) *Healthy Beginnings: Developing perinatal and infant mental health services in New Zealand.* Wellington: Ministry of Health. ISBN 978-478-0-37374-5

Section 2: Services Provided

Please can you give us a snapshot of

- How many infants were seen in the last 12 months across the following age ranges?
    - 0-12 months
    - 13-24 months
    - 25-36 months
    - 37-48 months
- The referral sources for these cases/clients
- Average time in the service
- Ethnicity of infants seen in the service

Any other comments you would like to make.

Section 3: The Infant Mental Health specific training of your workforce

Please can you describe the IMH specific training that the clinicians working in this area in this Team/Service have had?

Any other comments you would like to make.

Section 4: The Infant Mental Health specific supervision provided to your workforce

Please can you describe the current IMH specific supervision provided to the clinicians working in this area in this Team/Service?

Any other comments you would like to make.