IMHAANZ
INFANT MENTAL HEALTH ASSOCIATION AOTEAROA NEW ZEALAND

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SUBMISSION to the MENTAL HEALTH AND ADDICTIONS INQUIRY

Infant's (0-4th birthday) social and emotional development - also referred to as infant mental health (IMH) - "is foundational to other aspects of early development. Social-emotional development is defined as the capacity to form secure relationships; experience, express, and manage a range of emotions; and learn and explore one's environment - and influences infants' and toddlers' early cognitive development and later health and mental health outcomes."[1]

Infant Mental Health is additionally, the discipline of practice and research that focuses on the promotion of healthy social and emotional development, the prevention of mental health problems and the treatment of the mental health disorders of very young children in the context of their family. The New Zealand IMH Association was accepted as an Affiliate of the World Association of Infant Mental Health (WAIMH) in 2006 and is the organisation bringing together the multi-disciplinary workforce supporting infant and early childhood social and emotional development. With around 110 members and seven regional groups, IMHAANZ supports communication, coordination and workforce development including holding a successful conference every three years. It is supported by colleagues and organisations internationally including WAIMH and its affiliates.

In 2017 the Task Force of WAIMH produced an editorial addressing the worldwide burden of infant mental and emotional disorder.[2] The introduction noted

- There is a widespread lack of recognition of disorders of infancy.
- At the level of service delivery systems and social policy the *concept* of mental disorders in infancy is not widely recognised.
- Costs associated with mental disorders in infancy have remained largely invisible with little investigation.

These statements are mostly applicable to New Zealand with limited attention to social and emotional wellbeing and disorders in the delivery of our midwifery care antenatally, universal WellChild/Tamariki Ora programmes including Plunket and early intervention Home Visiting programmes including Family Start. The 2011 MOH guidelines for developing perinatal and IMH intervention services in New Zealand (Healthy Beginnings[13]) lacked an implementation strategy and had minimal additional funding. The development of IMH Teams/Services across DHBs is predominantly unchanged and many DHBs have no specialist services. These services need to be at least partially developed alongside/with perinatal MHS given the "consistent research findings that perinatal mental health problems can have lasting effects

on the emotional, behavioural, intellectual and social development of children exposed as foetuses or infants".[3] (pg. 91)
Systems to support the mental health of infants, young children and their families where an infant has developmental difficulties or a disability; the early childhood education sector, Department of Corrections (with mothers and babies in prison) and Oranga Tamariki are minimally developed.

> "Young children's healthy development depends on nurturing care - care which ensures health, nutrition, responsive caregiving, safety and security, and early learning."[4]

Like every new parent New Zealanders have good intent to support infants with the best care and at least one nurturing relationship. There is widespread understanding that intervening early is a good idea and that the quality of caregiving in the early months and years effects the infant's developing brain and mind. However, we have been slow in recognising and supporting the discipline of IMH with its focus on social and emotional wellbeing and disorder.

An example of this would be the recommendations for *Early Intervention Programs* made in the 'Inquiry into improving child health outcomes and preventing child abuse with a focus from preconception until three years of age'[15] none of which reference perinatal and infant mental health. There is a similar lack of reference to mental health in recommendations around *Determinants of Health and Well-Being* and *Leadership, Whole of Government Approach and Vulnerable Children.* Investing in early childhood education, home visiting programmes and WellChild/Tamariki Ora was supported. All areas that benefit from infant and early childhood mental health consultation and a workforce with some IMH knowledge.

There has been inadequate funding in mental health for parents, infants and young children. Many CAMHS have not had additional funding for 0-4 years and although providing such a service is part of their service specifications it has been difficult for managers and clinicians to support funding and clinician time to this work. In some cases, funding has been problematically used. For example, with one off trainings that are not followed up with the necessary supervision to embed learnings.

There has been fragmented incorporation of IMH knowledge and skills across the systems seeing young children and families; limited consultation and service development and a small workforce vulnerable to burnout.

Actions have not matched the increased knowledge and understanding of perinatal, infant and early childhood development.

Critical Beginnings – It starts from Conception

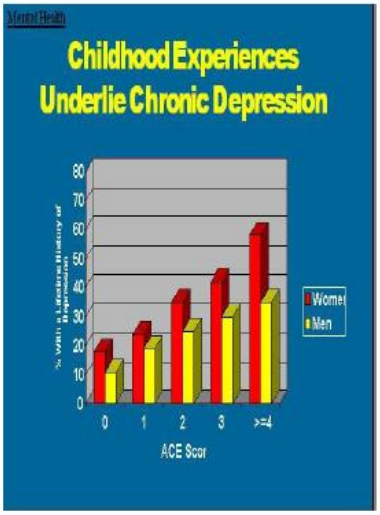
For the purposes of this submission a few examples from current understandings will be given. There are now a number of publications addressing the first 1000 or 1001 days and in 2013 the United Kingdom launched the 1001 Critical Days Campaign a cross party initiative which continues with support from almost every UK charity concerned with the early years. These initiatives focus on the evidence showing that experiences during this period can have life-long consequences for health and wellbeing. The 2017 Australian document[5] (Moore et. al.) is currently one of the most comprehensive.

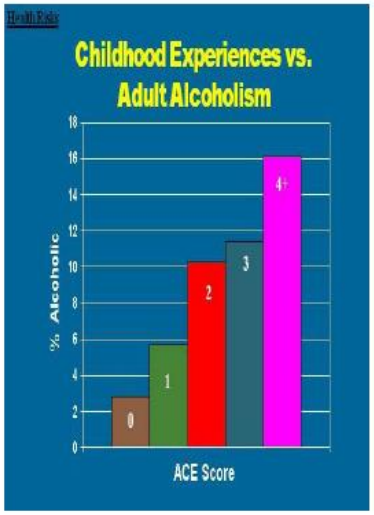
Prenatal stress
For the developing foetus this includes maternal symptoms of depression and anxiety and exposure to raised maternal cortisol levels which may be a consequence of stressful life events and/or a natural disaster. In terms of foetal effects consideration is given to the timing, severity and duration of this exposure. The number of studies looking at effects on the child's brain are small but the main findings are of changes in brain areas all linked with depression

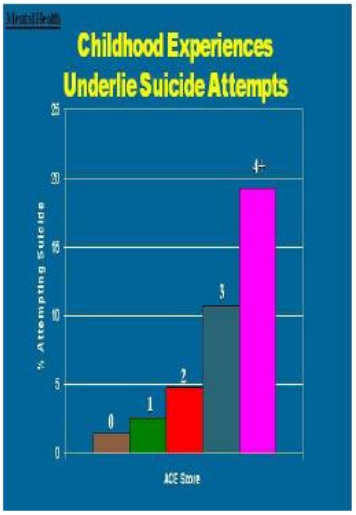
and anxiety disorders (amygdala, hippocampus, Insula and pre-frontal gyrus). Another finding is that maternal anxiety and stress is related to a child's early negative reactivity and emotional reactivity both of which may stress parenting capacity. Research is beginning to look at whether changes reverse with intervention antenatally and certainly the message is 'Protect the development of the child's brain by attending holistically to the wellbeing of the pregnant mother" (WAIMH presentation[2]). Antenatal care is much more than physical care.

Infant and Early Childhood Exposure to Stress

While positive early childhood experiences promote strong emotional health, negative experiences can adversely impact brain development, with serious lifelong consequences. In situations of chronic stress - poverty, parental loss, addiction, mental illness, emotional, physical and/or sexual abuse, neglect and exposure to family violence these figures increase. However, it is both the number of stressors and the experience of these stressors referred to as adverse childhood experiences (ACEs) in the absence of nurturing care that is particularly toxic with immediate and long term effects on physical and mental health. The following figures are 3 of many noting the correlations between numbers of ACES and later health problems.

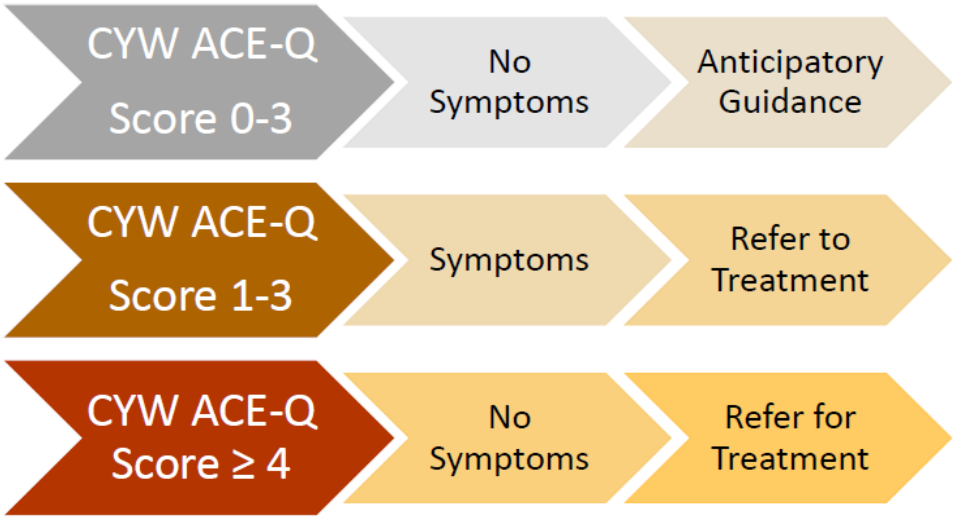






In 2014, the Pakeha and Pacific streams of the home visiting service Naku Enei Tamariki in the Hutt Valley audited files and noted that of those families enrolled in Family Start 55% of the infants and young children in the Pacific service and 64% of that group in the Pakeha service had experienced ≥ 4 ACEs. This was a conservative finding. Increasingly assessment needs to include ACEs and interventions directed to reducing stress and improving the caregiving relationships these children have. This is a key prevention and intervention point.

The Center for Youth Wellness (San Francisco) has integrated ACEs and evidence-based IMH interventions into their programme and working with the National Trauma Network (USA) to validate their screening questionnaires. They have developed a decision tree for planning intervention using a multi-disciplinary approach focused on addressing the neuro-endocrine-immune (NEI) network which is being researched.[6]



With this approach infants and toddlers seen who have an ACE score of between 1-3 and symptoms or a ACE score of 4 or more are directed to IMH services (Tier 2/3)

Parents parenting with experiences of early childhood trauma, mental health problems and addictions – 'the mind that is keeping the baby in mind'

The literature noting the range of mental health problems for mothers and fathers antenatally through the first years is growing and with it the evidence of its effects on infants and young children.

The intervention literature is explicit in the need for 'Two generational' interventions – working with the baby or young child and their parent.

The Burden of Infant Mental Health document concisely addresses why Infancy is unique and how vulnerable infants are to problematic care. "The infant's immature systems place him or her in a unique state of dependence upon the care of attentive adults. … This early dependence on caregivers requires different modes of mental health intervention that involve both the infant and to the caregiver. The caregivers' presence and attentiveness to infant cues is a critical regulator of the infant's development. … The infant needs to be treated *within the caregiving relationship"* (pg. 698)[1]

Given the high prevalence of mental health problems during pregnancy (13%) and postnatally (22% in the first year), the effects on children make this a substantial public health issue and the economic implications are considerable.

Bauer et al (2014)[7] conducted an economic analysis of data relating to the outcomes for mother and child for just three conditions, postpartum psychosis, depression and antenatal anxiety in relation to the UK. They found that the costs attributable to these conditions was £8.1 billion, of which approximately ¾ related to the economic burden of the adverse outcomes for children over the subsequent 10 years only (where its evidence now indicates that these outcomes persist at least into their twenties).
The average cost of depression after a woman has given birth is around £74,000, of which £23,000 relates to the mother and £51,000 relates to the impacts on the child.

Recent research provides more evidence for the link between maternal childhood trauma, perinatal mental health disorders and outcomes for children. Mothers with histories of

maltreatment are at risk of depression. Their children are at risk of maltreatment and mental health disorders themselves.

Parents parenting with other vulnerabilities and/or stressors

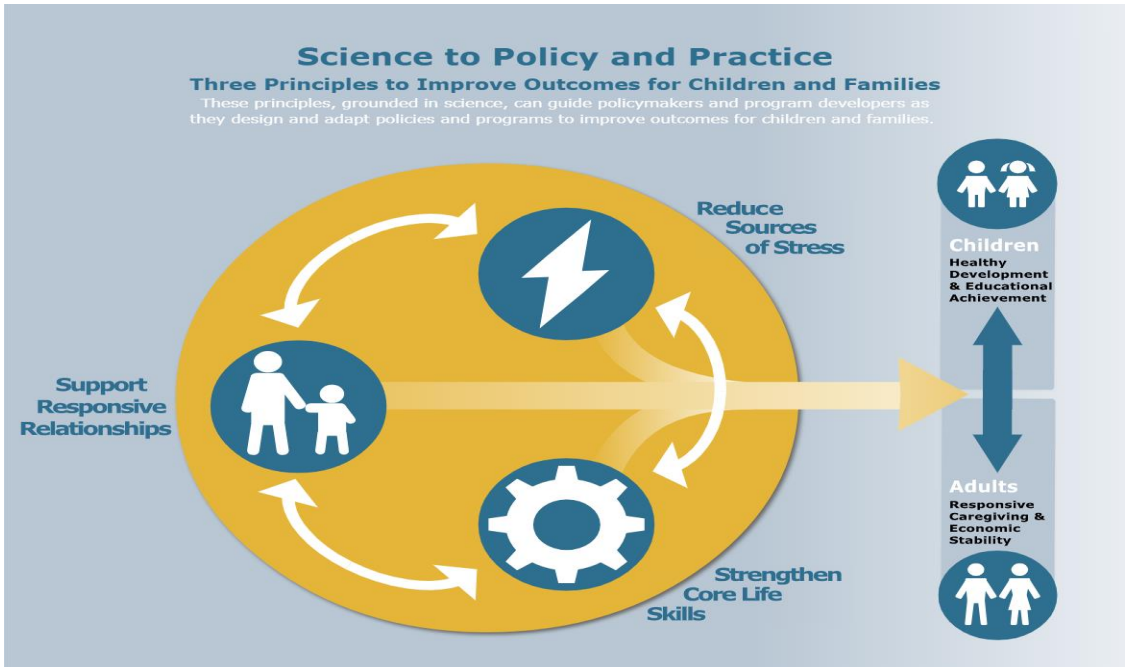
This is not a comprehensive list and it is not the case that parents with particular vulnerabilities will all struggle with parenting and have offspring with mental health problems. However, across these groups parents, early child care staff, developmental practitioners, home visitors, WellChild/Tamariki Ora providers need to strengthen their skills so they can support the healthy development of infants and young children. Access to IMH consultation with experienced clinicians would be helpful.

Teen parents -
Mothers with birth trauma
Mothers and partners with disabilities
Parents in prison
Separated parents with infants and young children

Vulnerable Infants

Infants and young children separated from their parents and in care and protection out of home placements - **in 2014** there were 486 0-1 years and 735 2-4 years. Most of these would have high ACE scores and experienced problematic caregiving.
Fussy Babies
Premature Babies
Babies with developmental disabilities including Foetal Alcohol related disabilities

The Center on the Developing Child, Harvard has invested amongst other things in producing succinct, evidence based documents for policymakers and practitioners. The following graphic notes key points for improving outcomes.



Epidemiology:

When an infant or young child's emotional health deteriorates significantly, they can, and do, experience mental health problems.

Studies demonstrate a 16-18% prevalence of mental disorders among children aged 1 to 4 years with around 9% being severely affected. 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.

If untreated, these disorders can have detrimental effects on every aspect of a child's development (i.e., physical, cognitive, communication, sensory, emotional, social, and motor skills) and the child's ability to succeed in school and in life.

The Counties Manukau IMH scoping document (2009) looked at the studies available and considered the levels of adversity in their population sufficient to conservatively account for a 15% prevalence of MH disorders in the 0-4 population. In 2009 approximately 28,400 children were 3 years of age or younger. Almost one in three of those children were Māori and over 25 per cent were from Pacific families. 50% of these children lived in decile 9 and 10 areas. This meant services needed to be configured to address problems in 4250 infants.

2013

0-4 Years	16% Prevalence of MH Disorders	9% Severe MH Disorders	Number seen in MHS
311,930	49,908.8	28,073.7	1,293 **(0.41%)**

MOH pooled data 2014-17 for children 2-4 years (no data accessible for 0-2 years) with emotional and/or behavioural problems seen in the DHB = **0.8%**

2018 Projected Figures

0-4 Years	16% Prevalence of MH Disorders	16% Prevalence of MH Disorders	Number seen in MHS
298, 740	47,798.4	26,886.6	Unknown

These first years are unique developmentally and require the use of age appropriate diagnostic systems – the most recent revision being the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5). Attention is given to the emotional, social, behavioural and developmental symptoms when attending to diagnosis (Axis I) and to disturbances in caregiving (Axis II).

Disturbances in Caregiving:

The security of an infant's attachment relationship with their caregivers is related to the consistency, predictability and capacity of that attentive care to regulate the infant's distress during the early weeks and months. A sizeable minority of infants have caregivers who are not able to predictably comfort and regulate their infants fear and distress and in a "meta-analysis of 6000 infants, such disturbances in the caregiver infant relationship, termed *disorganised attachment behaviour,* were found in 15% of infants in the general population." (pg. 701)[2] This figure rises in studies where there are increased risks for example; 24% with poverty, 48 - 72% in maltreated infants and toddlers.

The Center for Disease Control and Prevention (USA) estimates that childhood abuse and neglect results in a lifetime cost of more than $200,000US per child.

In New Zealand in the year 2013-14 there were 3,027 babies (0-1 year) and 3,862 2-4 year olds with findings of abuse or neglect following assessment/investigation very few of whom receive any IMH input directly or indirectly via consultation with child protection staff.

"We now have compelling research evidence indicating that attachment is malleable, and that interventions in childhood can result in children previously showing disorganised or organised/insecure attachment patterns coming to be measured as secure (Cicchetti, Rogosch and Toth, 2006)."

Intervention –

IMH Services in DHB's are typically being provided through CAMHS.
In 2011 the MOH documented the current situation with regard to specialist maternal and infant mental health services (pg. 39). Hutt Valley (Zero to Five), Auckland (Koanga Tupu) and Counties Manukau (Whakatupu Ora) DHB's had multi-disciplinary IMH services. Whakatupu Ora was the only full time service with allocated FTE and support for workforce development and evaluation. It was funded along with other initiatives that this DHB[1] took to address the social and emotional wellbeing of infants and young children in Counties Manukau. This was innovative at that time and has not been replicated in any other DHB.

Currently ADHB and CMDHB continue to have specialist IMH Teams. ADHB began with 5 clinicians doing 1 day a week; that is 1 FTE. In 2016 they operated over a day and a half and currently with pro-active management and a need to address increasing demand they will have capacity to cover a full week with part time staff. In 2016 Waitemata was able to utilise new funding directed to maternal and IMH in the Northern region to develop a standalone infant service Mātua Tūhonongā. It is very relevant that the only 2 full time IMH services in New Zealand have had new funding and have a Team of clinicians. The Hutt Valley IMH specialty service has gone.

The situation across the rest of New Zealand is concerning. In general, DHB's have not directed funding from their current budgets to attend to the specialist requirements for assessing and intervening with infants and young children although providing a service for this group is part of CAMHS service specifications. If they have it has been limited, not attached to specific FTE, not supportive of workforce development and has minimal provision for IMH supervision. The programmes are not stable and are often reliant on one clinician.

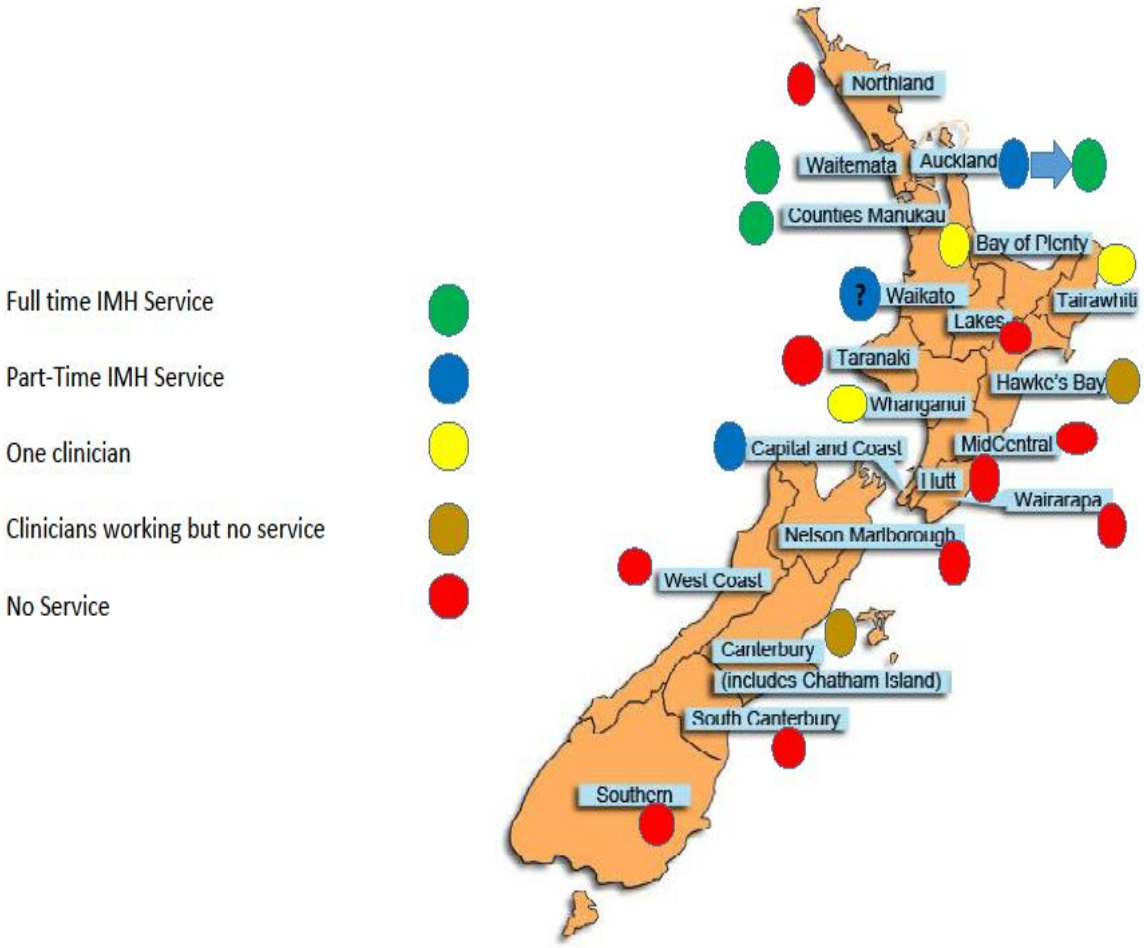
It is problematic that a number of CAMHS have designated one clinician to attend to the 0-4 year olds in the DHB. IMHAANZ does not view this as adequate service or safe practice no matter how skilled that one clinician is. Services have varied from appointing skilled clinicians into this position and those with interest but no training.

There are two tertiary services for Mothers and Babies (Christchurch and Auckland) and each has some specialist IMH clinician capacity.

The following figure is IMHAANZ's current understanding of the NZ situation. It does change; for example, earlier in the year one clinician was doing some IMH work in Northland and some

[1] 'Aroha Atu Aroha Mai, Look at You' DVD for parents and professionals addressing the social communication capacities infants have in the first 3 months of life.
Mellow Parenting – Supported implementation by Ohomairangi and Anglican Trust for Women. Hoki ki te Rito is the Maori adaptation which has been delivered to many groups and evaluated with positive results

progress is being made to develop a service in CAMHS in Christchurch (this is probably the 3-4th attempt to do so). At this time the South Island has no specialty IMH services in its DHB's.



One framework for addressing IMH is to look at "Promotion, Prevention, and Intervention"

Zero To Three has a superb range of resources for parents, practitioners and policy makers. They have more recently moved to the acronym I-ECMH (Infant and Early Childhood Mental Health). They have the following summary[8]

Promotion:

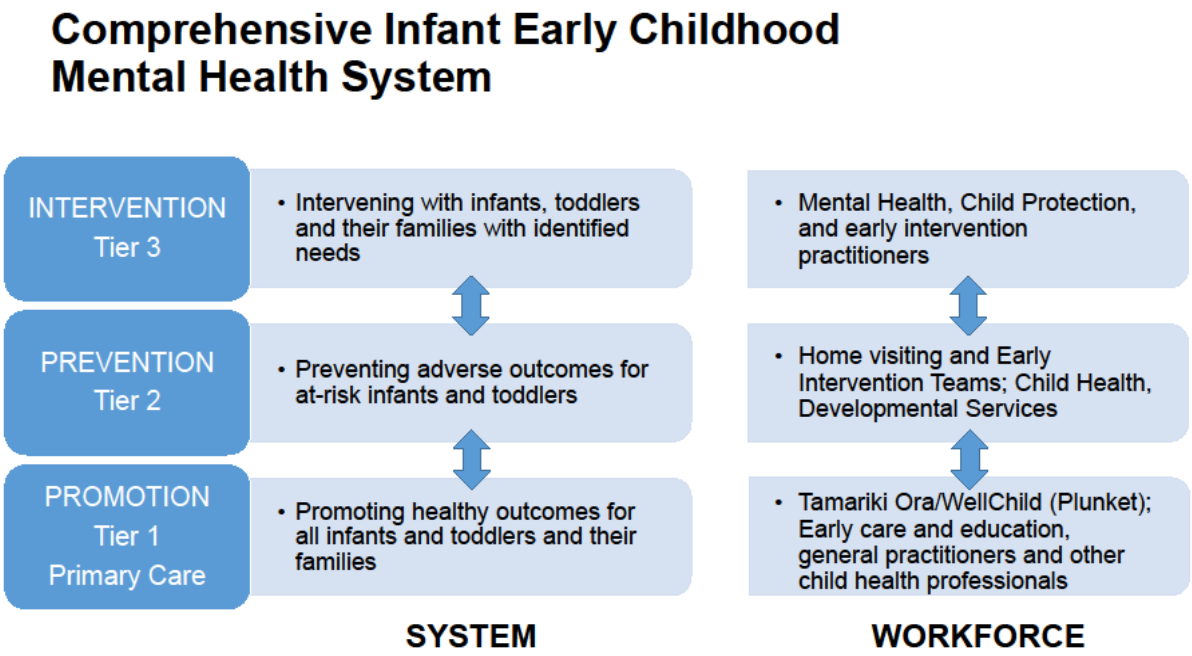
> Strategies that aim to encourage positive I-ECMH development may include public awareness campaigns that encourage parents to speak to their preverbal children and "help lines" for parents to seek advice on child development.

Prevention:

> Prevention services, delivered in diverse settings, seek to identify risk factors, mitigate the impacts of ACEs, and intervene in child/caregiver dynamics that threaten healthy development; they may include parenting education, home visiting services, and referrals to community and social services.

Intervention:

Effective, evidence-informed treatment provides services and supports intended to directly address mental health disorders. Children's parents or primary caregivers are typically involved in treatment.



Adapted from Mamet - David Willis — WAIMH Presentation[1]

Using this framework - What's Going Well in IMH in New Zealand

We have a growing literature addressing Maori and IMH including Penehira and Doherty's (2013)[14] Kaupapa Model of IMH. This provides guidance for workforce development, adaptation of non-Maori approaches for Maori, delivered by Maori and research.

We have two IMH Services and one IMH Team within CAMHS all in the Auckland area that are providing a multi-disciplinary IMH service.

<u>Promotion and prevention</u> –

A. IMHAANZ Initiative – In collaboration with the Michigan Infant Mental Health Association we are developing a resource for parents and practitioners "Supporting Relationships for Infants and Toddlers with Two Homes". The Growing Up in New Zealand study found that 40% of pregnancies were unplanned and by nine months 4% of infants are living with the parent who has separated. At two years 7.4% of infants are living with the parent who has separated. In this age group solo parenting is associated with adversity including low income, poor housing, and multiple moves contributing to poor health and mental health outcomes.

   Contact with the non-custodial parent is typically difficult to negotiate and sustain in a meaningful way for the young child. Shared care or parenting plans for the under 3year olds requires sensitivity to the capacity of the infant to remain secure and settled. This booklet will provide much needed information with a focus on the infant's social and emotional needs.

Parents and NZ Courts would benefit from specialist support from an FDR mediator who has infant and young children's developmental needs, temperamental capacities and felt security in mind.

B. Other Initiatives -

With the International Initiative for Mental Health Leadership (IIMHL) – **Films on IMH** with Deborah Weatherston and Denise Guy "IMH – The Gift of Love". Dr Weatherston in particular provides clear information on the framework for infant mental health and the components of practice

Counties Manukau DHB and the Auckland University of Technology produced the first of a planned series of four DVDs based on films developed at the New South Wales Institute of psychiatry addressing the capacity for infants in the first three months to communicate their social and emotional needs. **This film 'Aroha Atu Aroha Mai - Look at You'** was given to all new parents and Counties Manukau and is used by midwives, WellChild providers, home visiting services, perinatal and infant mental health services. There was a small qualitative evaluation with the key finding that the majority of parents changed something about their parenting practice having viewed the film once.

The second film in English and Te Reo was almost finished and a third film in five languages for Pacific is probably 80% finished. The final film which was to support practitioners earn its use either with individual parents or groups was not begun. **Completing these films would be a significant piece of prevention and promotion work.**

Prevention and Intervention

C. IMHAANZ Initiative – in 2015, Prof Linda Gilkerson from the Erikson Institute in Chicago was a keynote speaker at our conference and introduced the **Fussy Baby Network (FBN) and Facilitating Attuned Interaction** approach to New Zealand audience. Subsequently IMHAANZ has become one of two international members of the FBN and the first to have trained trainers. We have begun the programme with a Maori Early Intervention Service(Ohomairangi), A Pakeha and Pacific Home Visiting Service (Naku Enei Tamariki) and a small group of clinicians from the Family Start Team on the West Coast. A Team from ADHB NICU, community practitioners from Queenstown and a small group from Plunket complete the first trainees.

This training is directed to teams or services who attend with their supervisor. The supervisor is mentored through 5 to 6 months supervision of individual members of their team. This attention to fidelity of the model and support of practitioners sets the FAN approach ahead of many other intervention trainings. We have been excited by the positive responses the various teams and services have made which are in line with the research findings from Erikson.

"The mission of the Fussy Baby Network (FBN) is to promote well-being and reduce risk for infants, toddlers, and their families during the early years of life. The purpose of FBN training and dissemination is to infuse infant mental health principles and practices into programs and systems of care for infants and toddlers through training in the Facilitating Attuned Interaction (FAN) approach to relationship- based, reflective practice.

At the national level, the FBN now includes 35 sites in 17 states and three countries: United States, Israel and New Zealand. The greatest growth in the USA is in the highest priority area: state systems of care (Home Visiting and Early Head Start). FAN training reached over 1,000 trainees serving over 15,600 families. To address needs of higher risk families and highlight FAN as a foundation for trauma-informed practice, the High-Risk FAN was integrated into Level I Practitioner training. Four new advanced half-day trainings: FAN and Fathers, FAN and Substance Abuse, FAN and Domestic Violence, FAN and Perinatal Mental Health have been developed.
https://www.erikson.edu/professional-development/facilitating-attuned-interactions/

IMHAANZ would like to promote the FAN approach as a tool for workforce development in New Zealand. We see it as having applicability for all practitioners working with infants and young children and their families.

Prevention:

Workforce development initiative:
Naku Enei Tamariki is a home visiting service which has proactively sought infant mental health consultation and reflective supervision for a number of years. This has been a small number of hours over 10 years and has made a significant difference to the practitioner's confidence in their work and the work they do. This initiative could be considered by other Home Visiting or Early Intervention programmes.

Promotion, Prevention and Intervention:

Across New Zealand there is resource for workforce training that includes general infant mental health and particular evidence-based assessment tools and interventions

General Infant Mental Health:
The Department of Psychological Medicine, Christchurch, Otago University offers a Perinatal paper and an Infant Mental Health paper.
Werry Workforce Whāraurau has an E-learning module involving infant mental health

Assessment tools and evidence-based interventions.

First weeks and months:
Neonatal Behavioural Organisation and Neonatal Behavioural Assessment Scales

First weeks onwards:
Nursing Child Assessment Satellite Training (NCAST) using the parent child teaching and feeding scales

4 months – 5 years:
Complete training in the Watch Wait and Wonder intervention. A dyadic psychotherapeutic intervention addressing problems in infants and young children with relationship difficulties generally insecure and disorganised attachment. This is an intervention that was developed in Dunedin and researched and manualised in Toronto Canada.

Antenatal – Five Years:
Mellow Parenting as an intensive group based program for parents and their children. This program has been adapted for Maori and delivered by Maori. Hoki ki te Rito - Mellow Parenting has been researched in New Zealand with positive findings for mothers and fathers and caregivers. It includes an antenatal programme Mellow Bumps and are we have New Zealand trainers.

Circle of Security-Parenting group. A 6 week group based educational programme

Pre-schoolers – Training from Werry Workforce Whāraurau

Incredible Years parenting programme - a group based programme for parents of children from 3 to 6; and more recently Incredible Years Toddler Programme (2-4) and Incredible Years Autism (3-5)
Parent-Child Interaction Therapy for children from 3 years
Triple P parenting programmes

Recommendations

The November 2013 report of the Health Committee enquiry into improving child health outcomes and preventing child abuse with a focus from preconception until three years of age has an excellent chapter on the economics of early intervention with children.

Failing to deal with infant and early childhood MH disorders early increases the need for intervention across multiple programs over the life of a child and into adulthood. This includes health care, education, child welfare, and criminal justice, as well as economic productivity.

Mental Health not just Health, MSD and Education needs to fund Perinatal and Infant Mental Health.

Assess sources of stress on parents, infants and young children – this has a congruence with the Governments focus on wellbeing. Address stressors at the individual level – for example attending to parental mental health disorders and at a systemic level – for example reducing the numbers of children in poverty.

Research findings addressing the collection of ACE data, and decision making regarding intervention and **consider implementing collecting ACE data**. This is important for all levels of health care but may be particularly helpful in primary care and WellChild/Tamariki Ora Providers.

An infant's mental health is integrally connected with their parent's mental health so some of the recommendations specifically focus on attending to parent's mental health and addictions.

Update the 2011 Ministry of Health guideline for Perinatal and Infant Mental Health Services

Develop an implementation plan alongside the guideline that has dedicated new funding or capacity to compel DHB's to fund both perinatal and IMH service development.

The antenatal period provides a window of opportunity for women to discuss their own childhood experiences and to be appropriately supported with interventions. Upskill midwifery workforce and support with MH consultation. Look at programmes/therapies available for parents individually and group based like "Hoki ki te Rito Mellow Parenting Bumps".

Extend Perinatal Mental Health Services beyond 12 months to at least 2 years

Improve access and treatment of parental mental health disorders, personality disorders and addictions in the first four years

Where parents of infants and young children have a moderate to severe mental health disorder ensure dyadic/family assessment and intervention is available (two Generation Intervention). The evidence is clear that attending only to the parent does not ameliorate the effects on the infant and young child.

Where a DHB has no IMH service in CAMHS fund IMH practitioners within Perinatal MHS who have capacity to provide Two Generational interventions and consultation to relevant services (ECE, Home Visiting Programmes, Oranga Tamariki).

Provide perinatal services for mothers and partners when a baby dies

Support DHB collaborations/contracts with NGO's or private practitioners when the expertise is held outside of the DHB. This may be a place to begin in smaller DHBs

A collaborative approach bringing training in the latest Diagnostic Classification system DC:0-5 to NZ Perinatal and IMH workforce – led and funded by Ministry of Health.

IMHAANZ supported to implement FAN Approach across systems and services involved with infants and families. Pilot programmes and be supported with evaluation as the MOE has done in supporting Incredible Years parenting programmes

Recommendations from Zero To Three that could be considered in New Zealand

Establish cross-agency I-ECMH leadership to drive the strategic direction of I-ECMH efforts

Fund a system of mental health consultants who are integrated, on-site or by on-call consult, into all Early Intervention (EI) programs, home visiting, primary care and early care and education settings, as well as non-traditional settings, such as domestic violence shelters.

Invest in prevention through mental health consultation embedded in early childhood settings to promote positive social and emotional development and identify and address mental health issues among at-risk children.

Train workforce on I-ECMH to ensure all professionals working with infants, young children and their families are equipped to identify early warning signs and connect families to support.

Raise public awareness of I-ECMH, including why it is important for all infants, young children and their families and what can be done to support children's healthy development.

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Presentations WAIMH 2018

Effects of Prenatal Stress on Child Brain Development: Implications for later Health
Hasse Karlsson (Finland)

International Perspectives on Public Policy and Infant Mental Health Chaired by Hiram Fitzgerald (USA) with C Maguire (Ireland), Jane Barlow (England) C Furmak (Nordic Countries) and David Willis (USA)

Submitted on behalf of IMHAANZ

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