Healthy mother-infant relationship: Assessment of risk in mothers with serious mental illness was developed by Dr Johana Stefan (Princess Margaret Hospital & North Metropolitan Child and Adolescent Mental Health Services) in collaboration with Professor Yvonne Hauck (University of Western Australia & Clinical Applications Unit, North Metropolitan Area Health Service (NMAHS) Mental Health), Dr Deb Faulkner (Clinical Applications Unit, NMAHS Mental Health) and Professor Daniel Rock (Clinical Applications Unit, NMAHS Mental Health & Centre for Clinical Research in Neurospsychiatry).


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1. Introduction

The aim of the mother-infant relationship project has been to develop a risk assessment resource for adult community mental health clinicians working with mothers with a serious mental illness (SMI). This mother-infant relationship project is a continuation of an initial project where an antenatal resource was developed for community mental health clinicians and others involved with the case management of women with SMI of childbearing age. The aim was to reduce the obstetric and neonatal risks whilst improving the reproductive health outcomes for these women with SMI and their infants. The framework entitled *Healthy Babies for Mothers with Serious Mental Illness: A case management framework for mental health clinicians* was launched in July 2008 and is available from North Metropolitan Area Health Service Mental Health at:

Similar to the initial project, this mother-infant relationship project has involved the development of a practical resource entitled *Healthy mother-infant relationship: Assessment of risk in mothers with serious mental illness* that focuses upon a dynamic model of risk identification and appropriate referral within existing services.

The mother-infant relationship project is in keeping with the Council of Australian Governments' objective of providing coordinated care to people with SMI and complex needs who are most at risk of falling through the gaps in the system (Council of Australian Governments, 2006, National Action Plan on Mental Health 2006-2011).

The mother-infant relationship framework is targeted towards mental health clinicians caring for female clients with young infants of less than 1 year of age. However, clinicians may need to modify the recommendations to suit the individual needs of their client.

The key elements incorporated in this framework are:

- Recognition of the vital role of the case manager in the assessment of risk and incorporation of the mother-baby dyad in the case management of these clients;
- Early risk assessment for disrupted mother-infant relationship, prioritising of risk and appropriate referral using a dynamic model through consultation with other health care professionals; and
- Creating a professional support network by creating communication pathways and linkages with specialist services, with focus on referral, consultation and education for more effective use of existing resources.
2. Background

A large proportion of women with schizophrenia and other SMI have children. With deinstitutionalisation and the advent of newer psychotropic medications, coupled with changes in societal context, women with SMI are having babies at similar rates to other women of childbearing age (Miller & Finnerty, 1996). More attention has therefore turned towards maternal mental health in relation to the mother-infant relationship, as well as child physical and mental health outcomes.

Jablensky and colleagues found that children of mothers with mental illness were at increased risk of having a learning disability as well as developmental disorders such as autism and Rett syndrome and had higher than expected rates of some rare congenital syndromes (Jablensky, 2004). In a population-based data linkage study, Jablensky et al (2005) identified all women with mental illness who gave birth in Western Australia between 1980 and 1992 and compared their rates of obstetric and neonatal complications with those of a cohort of mothers without mental illness. Mothers with schizophrenia had higher rates of complications during pregnancy, labour, and delivery. Smaller increases in complication rates also occurred in mothers with bipolar disorder and depression. In addition, the babies of mothers with schizophrenia were more likely to be small for gestational age and had a higher incidence of birth defects. These findings suggest that children of mothers with mental illness represent a particularly vulnerable population in terms of physical health outcomes.

The Childbirth and Mental Illness (CAMI) antenatal clinic at King Edward Memorial Hospital for Women was established in 2007 to provide obstetric care and neonatal support for pregnant women with severe mental illness. As a service in Western Australia the CAMI clinic aims to increase access to antenatal care, facilitate communication between obstetric and psychiatric services, provide specialist support for complex cases, highlight the postnatal needs of each individual, and coordinate and organise appropriate follow-up postnatal services.

Recent research suggests that “the health status of an infant at birth is both determined by multiple medical, obstetric and psychological events during pregnancy, and is prospectively a determinant of long-term health and quality of life” (O'Keane & Scott, 2005, p. 368). Furthermore, brain development is influenced by the quality of relationships formed early in life, particularly between the infant and the primary care giver (Balbernie, 2001). The importance of these relationships on the developing infant is outlined below.

Attachment theory

The importance of the mother-infant interaction for the emotional development of the child is well recognised as is the fact that attachment security is protective against poor developmental outcomes. The attachment theory emphasises the importance of intimate emotional bonds between individuals. The first manifestation of such a bond is the need for physical proximity of an infant with the caregiver. This increases the infant’s chance of protection and survival and the caregiver is said to operate as a “secure base” and a “safe haven” for the infant.
**Bonding** refers to the caregiver’s emotional connection to the infant. Bonding occurs within minutes of the birth and involves an instinctual response.

**Attachment** refers to the relationship between the infant and her/his main caregivers. Attachment is also instinctual, develops over the first month of the infant’s life and is usually established as a pattern by the time the infant is 12 months. Patterns of attachment are internalised by infants as “internal working models” of the self and others and will become the basis of future interpersonal relationships. These patterns, which can be reliably measured, are specific to each caregiver and tend to persist throughout life. However, attachment can change if the caregiver alters their caregiving style.

The attachment figure is perceived as available, able and willing to respond to the infant’s need for both protection and exploration. Caregivers respond in different ways to these needs, influencing how infants act in the presence of the attachment figure.

**Importance of attachment**

Children’s lifelong learning and behaviour is connected to their early brain development. Evidence from neuroscience shows that most of the ‘wiring’ in the human brain that supports lifelong learning and behaviour is in place by the age of 6. Children’s earliest experiences and interactions with adults and other children, especially during the first three years of life, are far more important for brain development than previously realised (McCain & Mustard, 1999). Patterns of attachment are internalised by infants as “internal working models” of the self and others and become the basis of future interpersonal relationships.

Interpersonal relationships are important determinants of young people’s behaviour. In school-aged children, attachment styles, attitudes, and conflict within the family, school and wider community, have been shown to be predictive of young people’s involvement in problem behaviours such as substance abuse and antisocial behaviour (Bond, Thomas, Toumbourou, Patton, & Catalano, 2000).

Healthy attachment is an important protective factor for child development. Securely attached children:

- Enjoy more happiness with their parents
- Feel less anger at their parents
- Turn to their parents for help when in trouble
- Solve problems on their own
- Get along better with friends
- Have lasting friendships
- Solve problems with friends
- Have better relationships with brothers and sisters
- Have higher self-esteem
- Know that most problems will have an answer
- Trust that good things will come their way
- Have happier marriages when they grow up
- Trust the people they love
- Know how to be kind to those around them
Patterns of attachment

By 1 year of age, distinct patterns of attachment behaviour emerge, as described by Ainsworth (1978). The four styles of attachment described are: secure, resistant or ambivalent, avoidant, and disorganised (Ainsworth, et al., 1978; Main & Solomon, 1990). The assessment of attachment is based on observation of the parent-infant dyad. The Strange Situation (SS), developed by Mary Ainsworth, is a laboratory procedure used to test attachment style. In this test, the behaviours of the child are observed while in the presence of the parent, on separation from parent, in the presence of a stranger and on re-union with the parent.

Characteristics of the four attachment styles: Secure, Resistant/Ambivalent, Avoidant, and Disorganised attachment.

<table>
<thead>
<tr>
<th>Attachment style</th>
<th>% of children</th>
<th>Characteristics of child behaviour</th>
</tr>
</thead>
</table>
| Secure                 | 50% to 75%    | Not significantly distressed when separated from parent  
Seek parent for comfort when frightened  
Warm interaction when reunited with parent  
Prefers parent to stranger |
| Resistant/Ambivalent   | 7% to 15%     | Distressed when separated from parent  
May reject comfort from parent  
Ambivalent towards parent when reunited (seek close contact but avoid interaction)  
May be wary of stranger |
| Avoidant               | 15% to 30%    | Show limited/no distress when separated from parent  
Avoid contact with parent when reunited  
Child shows no preference between parent and stranger |
| Disorganised           | 15% to 25%    | Inconsistent responses when separated from parent – avoidant/resistant  
Idiosyncratic response when reunited with parent; may freeze, rise from floor, fall to floor, or cling to caregiver  
Often display sequential contradictory patterns of behaviour in presence of parent |

Secure attachment

In a research situation, one measure of the child’s level of attachment is the Strange Situation (SS) Test, in which the child explores the room prior to separation from the caregiver. For securely attached infants, when their caregiver leaves, the child shows distress, and then when they are reunited, both the caregiver and the child seem pleased to see each other and begin to interact again.

When observing the home environment, research has identified certain characteristics associated with secure attachment:

- Child does not seem afraid to express anger; communication between caregiver and child seems to be warm and sensitive
• Flexibility in proximity: child and caregiver operate independently and touch base with each other from time to time; caregiver permits age-appropriate autonomy and exploration
• Caregiver understands the nature of attachment and recognises its importance to the child
• Caregiver and child seem to enjoy being with each other

**Resistant or ambivalent attachment**

In resistant/ambivalent attachment, the child is very distressed when separated from their caregiver in the SS Test, and is not reassured or comforted by the parent’s return.

In the home environment, the following characteristics of resistant/ambivalent attachment have been identified:
• Caregiver seems committed to the task of nurturing but is often emotionally unavailable
• Child stays in close proximity to the caregiver and persists in seeking attention
• Child takes ‘care’ of parent as a means of fostering interaction
• Child is anxious of exploration and of strangers even when mother is present
• Child’s needs sometimes ignored until some other parental activity is completed

**Avoidant attachment**

In avoidant attachment, when the child participates in the SS Test they will explore the room after separation showing limited or no distress. When the caregiver returns, the child turns away from the caregiver and moves toward a toy in the room. The caregiver often pays more attention to objects in the room than the child, and if the child is picked up by the caregiver, they make motions to be put down. Research suggests that while this may be seen by the parent as healthy independence, the child will remain aroused much longer than a securely-attached child. The avoidant child continues to show physiological signs of anxiety, and withdrawal from the caregiver may indicate that the child is attempting to deactivate feelings of insecurity by focusing on objects.

In the home environment, the following characteristics may be indications of avoidant attachment:
• Caregiver withdraws when the child is sad; responds negatively to the child’s attempts to make contact
• Caregiver may demonstrate more rejecting behaviours
• Child demonstrates more anger at home than in the lab setting
• Play behavior seems to serve as a distraction from attachment needs
• Child’s needs are frequently not met; mothering style is more disengaged

**Disorganised attachment**

Disorganised attachment may be a sign of maltreatment. In the SS Test, some children did not respond systematically to the reunion part of the experience. In the presence of caregivers, these children may freeze with a trance-like expression, rise when caregivers enter the room, fall to the floor, or cling to the caregiver while simultaneously leaning away from them. These idiosyncratic responses are confirmed by home observation, which may be related to how the child protects
themselves from abuse: for example, a child who cowers on the floor in the SS Test may have cultivated this cowering behavior as a way to protect themselves from injury.

**Attachment and maternal mental illness**

The offspring of women with mental illness represent a particularly vulnerable group with a high risk of emotional, behavioural and cognitive difficulties as well as psychopathology later in life. Disorganised patterns of attachment occur in 10% of the general population; however, this rate increases up to 80% in high risk populations. Disrupted attachment during infancy and early childhood (especially the disorganised type) is a component of the cumulative risk factors for childhood socio-emotional problems and future academic and psychiatric problems.

Sameroff (1998) incorporated the findings of the Rochester Longitudinal study and described the detrimental impact of multiple environmental risk factors on child development. Sameroff supported Rutter’s (1979) earlier argument that it was not any particular risk factor but the number of risk factors in a child’s background that may be associated with subsequent psychiatric disorders. Psychiatric risk increased up to tenfold in families with four or more environmental risk factors including:

- Maternal mental illness
- Maternal anxiety
- Few observed positive interactions with infant
- Rigid attitudes regarding parenting
- Mother has many children
- Single parenthood
- Stressful life events
- Maternal education curtailed
- Low income
- Disadvantaged minority group

Accessing and providing assistance to children who are at risk of disrupted attachment is a challenging task; therefore strategies to facilitate the identification of these children are needed. Adult Mental Health Services who provide ongoing support to childbearing women with SMI offer an opportunity to identify infants and children at risk of disrupted attachment.

There are an estimated 80 to 100 women with SMI giving birth in WA every year and the developmental needs of their babies are serviced by a variety of agencies, many of which work in isolation, without coordination or a clear line of communication between agencies. Services involved in the care of these women and their babies are diverse as demonstrated in Women and Newborn Health Service’s directory of Perinatal Emotional Health and Wellbeing Community Support Resources in Western Australia ([www.kemh.health.wa.gov.au/brochures/consumers/wnhs0282.pdf](http://www.kemh.health.wa.gov.au/brochures/consumers/wnhs0282.pdf)).

The majority of women under the umbrella of community mental health services will have a community mental health clinician or case manager. Adult mental health clinicians are experts in risk assessment and management, as part of their everyday clinical duties. In addition, these clinicians have relatively frequent contact with their clients, leading to opportunities to observe and/or enquire about mother-infant interactions. Women with SMI and their babies present as very complex and difficult to manage cases that require intense use of resources, consequently, case managers often deal with such cases without adequate support.
3. Purpose of the framework for assessment of risk for disrupted mother-infant relationship

**Develop a resource for community mental health clinicians** as a strategy to improve developmental outcomes in children of women with SMI.
- This framework should assist clinicians in managing female clients who have young infants. The framework does not advocate that clinicians deliver care to the infants, but rather provides recommendations for early identification of relationship difficulties and to make timely referrals to the appropriate services.
- The risk assessment suggested would be carried out during routine review sessions with the woman.

**Liaise with community support providers in early parenting**
The woman’s General Practitioner (GP) and Child Health Nurse (CHN) are recognised community support providers in early parenting and will be aware of local resources and appropriate referral procedures. Every woman who attended the Childbirth and Mental Illness (CAMI) Antenatal Clinic will have had a referral letter sent to her CHN, GP, and Community Mental Health practitioner (i.e. community mental health clinic or private psychiatrist) in the antenatal period to facilitate liaison between these key support providers. A copy of the referral form has been included in Appendix A.

4. Assessment of risk for disrupted mother-infant relationship resource

The resource included in Appendix B provides a list of prompts to assess risk for disrupted mother-infant relationship across the following domains: psychosocial factors; maternal behaviour towards infant; infant factors; mother-infant interaction; and protective factors. The list is not exhaustive and is not intended to be used as a checklist, scoring sheet or formal assessment tool. Rather, the list indicates areas of functioning which are important to the mother-infant relationship. If any concerns arise in these domains during the course of considering your client’s relationship with her infant, you should consider consulting with and/or referring to the appropriate specialist service.
5. Key community support providers in early parenting

The woman’s GP and CHN are supportive professional colleagues for community mental health clinicians working with women with SMI who have infants/children. Therefore to capitalise on their expertise and the multidisciplinary referral process initiated by the CAMI antenatal clinic at King Edward Memorial Hospital, mental health clinicians should consider the following recommendations:

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>If there is no General Practitioner (GP) listed on the CAMI referral form, determine if your client has regular contact with a GP.</td>
<td>All women should have postpartum GP care to address both maternal and infant issues.</td>
</tr>
<tr>
<td>If your client does not have a GP, provide names and contacts of GPs in the area. Offer to make an appointment for your client if she does not have the capacity to do so. With her permission, provide a letter for your client to take to the appointment, outlining the client's history.</td>
<td>The GP will provide general medical follow up for the mother and will assess the various developmental needs of the baby and offer infant health care services such as immunisations.</td>
</tr>
<tr>
<td>Maintain regular contact with the GP, especially in relation to concerns with mother-infant relationship.</td>
<td>Continued liaison with the GP will provide a collaborative approach and will assist the mental health clinician in managing the mother’s ongoing mental health.</td>
</tr>
<tr>
<td>Once the CAMI referral is received identifying the client’s local Child Health Nurse (CHN), make contact prior to the anticipated due date for the birth (i.e. estimated date of confinement on the form).</td>
<td>The mental health clinician's knowledge of the client can assist the CHN in planning the most appropriate way to make contact with the woman and facilitates building rapport during pregnancy. Good rapport is especially necessary after the birth of the baby and into the early parenting years.</td>
</tr>
<tr>
<td>Maintain regular contact with the CHN for updates on the baby’s development so you can assess the impact upon the mother’s mental health and refine your management/support.</td>
<td>CHN can allocate clients to either a universal or targeted program (according to the level of risk) and are aware of available resources for parents with mother-infant relationship concerns.</td>
</tr>
<tr>
<td>Explore the possibility of the CHN attending review meetings at the clinic should mother-infant relationship concerns indicate a collaborative approach might be appropriate.</td>
<td>CHN are trained in infant development and have knowledge that could assist mental health clinicians in promoting strategies that could enhance the mother-infant relationship.</td>
</tr>
<tr>
<td>Be available as a resource (email, phone or face-to-face depending upon the situation) to provide support and information for the CHN in relation to mental health issues.</td>
<td>CHN do not have mental health training and may need support to understand some of the mother’s difficulties.</td>
</tr>
</tbody>
</table>
6. Resources available in WA


Please be alert to the fact that the client’s General Practitioner and Child Health Nurse may also be aware of local resources that are not listed in the WA Perinatal directory. Ongoing liaisons with all practitioners/clinicians who have key roles in providing support will be an asset to your management of the client and her family.
Additional Reading

Child Health Record (Purple book)

Every mother is supplied with a Child Health Record in which important health related information is recorded (including immunisation and growth details). The book provides information about appropriate development for different age ranges.

Welcome to Your New Baby.

A magazine developed by the Department of Health, Western Australia, and supplied to all new mothers by their Child Health Nurse. The magazine provides information on infant development, attachment, feeding, and other parenting issues. It is available for download from: http://www.health.wa.gov.au/docreg/Education/Population/Child_Health/HP002850_welcome_your_new_baby.pdf

First Connections…make all the difference.

This is an online resource kit on infant attachment developed by Health Canada in conjunction with experts in attachment and parenting. Resource sheets on infant attachment are available for health professionals, parents and caregivers: http://www.phac-aspc.gc.ca/mh-sm/mhp-psm/pub/fc-pc/index-eng.php


Sameroff summarises the findings of the Rochester Longitudinal Study which examined the role of environment in shaping development across the age range from newborn to adolescent. Many environmental factors important for development are identified; the most detrimental effects on development occur when individual infants have multiple risk factors. Full text available online via Psychiatric Services Library.


Provides an overview of attachment theory, key findings of attachment research, and the relationship between attachment theory and psychoanalysis. Available from the Psychiatric Services Library, Graylands Campus.


Provides a comprehensive examination of the evidence on attachment, development, and attachment disorders, including cross-cultural issues, an overview of instruments used to assess attachment, the influence of attachment security on the child’s functioning, and evidence-based interventions to encourage secure attachment. Available from the Psychiatric Services Library, Graylands Campus.


Presents a “Developmental, Individual-Differences, Relationship-Based” model for working with infant and early childhood challenges, outlining the development of core capacities in infancy and childhood, assessment, an approach to individually tailoring intervention, case studies, and a model of early intervention and prevention. Available from Murdoch University library, Rockingham Campus.


Covers the origins and development of attachment theory, biological and evolutionary perspectives, and the role of attachment processes in personality, relationships, and mental health across the lifespan. Available from Fremantle Hospital and Health Service Library; first edition (1999) available from Psychiatric Services Library, Graylands Campus.


References


Special Referral from the Childbirth and Mental Illness Antenatal Clinic

The patients/pregnant women attending this clinic have a diagnosed Serious Mental Illness. The purpose of this referral is to ensure health care professionals (i.e. GP, child health nurse, case manager and/or psychiatrist) are able to collaborate to better support this woman during her childbearing period. To facilitate best care we are requesting the Child Health Nurse, who may not be familiar to the woman, undertake an ante natal visit to develop a rapport with the woman.

Estimated Date of Confinement __________
Other Children (names and DOB)

Ethnicity

English Speaking: Interpreter required:

Mother’s History: include diagnosis, medication, who her supports are, who lives with her
Any salient risk factors:

Other Agencies involved: please include contact person’s name and contact

<table>
<thead>
<tr>
<th>General Practitioner</th>
<th>Child Health Nurse</th>
<th>Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Name:</td>
<td>(i.e. psychiatrist, case manager)</td>
</tr>
<tr>
<td>Location (suburb/clinic):</td>
<td>Location (suburb/clinic):</td>
<td>Name:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Phone:</td>
<td>Location (suburb/clinic):</td>
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<td>Email:</td>
<td>Email:</td>
<td>FAX:</td>
</tr>
</tbody>
</table>

Signatures
Patient Consent □ Verbal (original on file KEMH)
CAMI clinician Contact detail: Dept of Clinical Psychology 93401521

Sent to:  □ GP  □ CHN  □ Mental Health
Healthy Mother-Infant Relationship
Assessment of Risk in Mothers with Serious Mental Illness

Mental Health Clinician continues to monitor/identify

- Psychosocial factors (Sameroff)
- Relationship factors
- Infant factors
- Maternal factors
- Protective factors

CASE MANAGEMENT

High risk management
Consult

Risk of harm
Risk to relationship

Refer to appropriate agencies for child protection and/or maternal management
- Mother and Baby Unit at King Edward Memorial Hospital (KEMH)
- Department for Child Protection (DCP)
- Adult inpatient Wanslea Family Services

Liaise with General Practitioner (GP), Child Health Nurse (CHN) and consult with appropriate agencies for support with mother-infant relationship concerns

- GP: All women should have post-partum GP care. Your continued liaison with the GP provides a collaborative approach and assists in management of your client’s ongoing mental health.
- CHN: CHNs are trained in infant development and have knowledge that could assist mental health clinicians in promoting strategies that could foster mother-infant relationships. CHN can allocate clients to either a universal or targeted program, according to the level of risk and are aware of available resources for parents with relationship concerns

Support agencies: e.g. Best Beginnings, Private Clinical Psychologist, Mother and Baby Unit at KEMH, Raphael Centre, Ngala.

Specialist services: Child Development Centre, Raphael Centre, Child and Adolescent Mental Health Services.

Is judgement of low risk stable over time?

Yes

No

For additional resources go to:
This website hosts a pdf entitled: Perinatal Emotional Health and Wellbeing - Community Support and Resources

Assessment and Management of Risk for Disrupted Mother-Infant Relationship

North Metropolitan Area Health Service Mental Health Clinical Applications Unit

Delivering a Healthy WA
### Psychosocial risk factors

- Unresolved family of origin issues
- History of physical/sexual abuse, domestic violence, childhood neglect
- Past pregnancy loss or pregnancy concern
- Unplanned or unwanted pregnancy
- Was the mother able to touch the baby on the day of birth?
- Did the mother have responsibility for infant care during the first week of life?
- Who is involved in the baby’s care?
- Availability of emotional/social/practical support
- How much time does the mother spend away from the baby on average?

### Infant factors

- Is baby achieving normal developmental milestones?
- Is the baby growing adequately?
- Are there feeding difficulties, reflux, gastric distress, sleep difficulties?

**Liaise with the mother’s child health nurse and/or her general practitioner for this information**

### Behaviour of concern (observed or reported)

- Gaze avoidance
- Flat affect
- Lack of crying
- Limited vocalising
- Emotionally under-responsive
- Interacts too easily with strangers (age dependent)
- Unsettled sleep or feeding
- Difficult to console when distressed
- Irritable, constant crying
- Difficulty separating from parent (age dependent)

### Relationship factors (observed or reported)

- Is the mother thoughtful about her baby?
- Can the mother describe the baby’s daily routine?
- Is the mother able to reflect on the baby’s needs?
- Does the mother express empathy for the baby?
- Does the mother engage in enjoyable activities with the baby?
- Does the mother play/talk appropriately to the baby?
- Does she delight in her baby?
- Does the baby ever make her feel uncomfortable, unhappy or enraged?
- Is the mother excessively worried about the baby?
- Does the mother cope with the baby’s distress?
- Does she respond and attend appropriately to the baby’s cues?
- Are her responses consistent?
- Is she protective of the baby?

### Maternal factors

**Current maternal psychopathology**

- Antenatal or postnatal mood disorder
- Psychosis
- Diagnosed personality disorder
- Suicidal or homicidal ideation
- Negative symptoms (low motivation, anhedonia, blunted affect, poverty of thought/speech)
- Medication side-effects
- Substance abuse

### Protective factors

- Mother is sensitive to the baby
- Mother is responsive to the baby
- Mother has a close relationship with at least one other adult
- Mother is able to monitor the baby’s well being adequately
- Mother is able to cope with flexibility in her routine
- Mother is thoughtful about what might be going on in the baby’s mind
Assessment and Management of Risk for Disrupted Mother-Infant Relationship

Mental Health Clinician continues to monitor/identify

Psychosocial factors (Sameroff)  Relationship factors  Infant factors  Maternal factors  Protective factors

Risk of harm  Risk to relationship

High risk management  Consult

Refer to appropriate agencies for child protection and/or maternal management:
- Mother and Baby Unit at King Edward Memorial Hospital (KEMH)
- Department for Child Protection (DCP)
- Adult inpatient Wanslea Family Services

Liaise with General Practitioner (GP), Child Health Nurse (CHN) and consult with appropriate agencies for support with mother-infant relationship concerns:
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- Support agencies: e.g. Best Beginnings, Private Clinical Psychologist, Mother and Baby Unit at KEMH, Raphael Centre, Ngala.
- Specialist services: Child Development Centre, Raphael Centre, Child and Adolescent Mental Health Services.

Is judgement of low risk stable over time?

Yes  No

For additional resources go to:
This website hosts a pdf entitled: Perinatal Emotional Health and Wellbeing - Community Support and Resources
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- Did the mother have responsibility for infant care during the first week of life?
- Who is involved in the baby’s care?
- Availability of emotional/social/practical support
- How much time does the mother spend away from the baby on average?

### Infant factors

- Is baby achieving normal developmental milestones?
- Is the baby growing adequately?
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*Liaise with the mother’s child health nurse and/or her general practitioner for this information*

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- Irritable, constant crying
- Difficulty separating from parent (age dependent)

### Relationship factors (observed or reported)

- Is the mother thoughtful about her baby?
- Can the mother describe the baby’s daily routine?
- Is the mother able to reflect on the baby’s needs?
- Does the mother express empathy for the baby?
- Does the mother engage in enjoyable activities with the baby?
- Does the mother play/talk appropriately to the baby?
- Does she delight in her baby?
- Does the baby ever make her feel uncomfortable, unhappy or enraged?
- Is the mother excessively worried about the baby?
- Does the mother cope with the baby’s distress?
- Does she respond and attend appropriately to the baby’s cues?
- Are her responses consistent?
- Is she protective of the baby?

### Maternal factors

#### Current maternal psychopathology

- Antenatal or postnatal mood disorder
- Psychosis
- Diagnosed personality disorder
- Suicidal or homicidal ideation
- Negative symptoms (low motivation, anhedonia, blunted affect, poverty of thought/speech)
- Medication side-effects
- Substance abuse

### Protective factors

- Mother is sensitive to the baby
- Mother is responsive to the baby
- Mother has a close relationship with at least one other adult
- Mother is able to monitor the baby’s well being adequately
- Mother is able to cope with flexibility in her routine
- Mother is thoughtful about what might be going on in the baby’s mind