



**An Exploration into the Activities, Perceptions, and Understandings of
the Role of the Psychologist in Infant Mental Health Service Provision**

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Abstract

Aims: Research in the field of Infant Mental Health (IMH) suggests a lack of clarity and understanding regarding the practice of IMH and the boundaries that define the roles of professionals who work in this area. The overarching aim of this thesis is to explore professional roles and practices within multidisciplinary IMH service provision, with a particular focus on demystifying the role of the psychologist in their work with young infants and their families.

Method: This study adopted a convergent parallel mixed methods approach to data collection, with Activity Theory being utilised as a guiding psychological framework. Quantitative data was gathered from psychologists working in multidisciplinary teams across Ireland using an online questionnaire. Semi-structured interviews were utilised to gather qualitative data from both psychologists and other professionals working with young infants and their families. Findings were analysed using descriptive statistics and thematic analysis.

Results: Results offer a descriptive picture of the role of the psychologist through the creation of an Activity System model. Key findings include how psychologists meet the social and emotional needs of young infants by adopting an IMH framework. Moreover, findings indicate that a multidisciplinary approach to IMH is considered valuable, yet role boundaries between professionals in this area are not clearly defined. Finally, perceptions of the psychologist's role and aspects of practice that are distinctive to the discipline of psychology are explored. A critical examination of the 'unique contribution' of the psychologist to IMH contexts is discussed.

Conclusions: This small-scale exploratory study provides insight into professional roles in IMH contexts and has identified potential considerations for psychology practice and for multidisciplinary services dedicated to supporting the emotional wellbeing of infants.

Declaration of Originality

College: Mary Immaculate College, University of Limerick

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Degree: Doctorate in Educational and Child Psychology

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Declaration: I hereby declare that this thesis is the result of my own original research and does not contain the work of any other individual.

All sources that have been consulted have been identified and acknowledged in the appropriate way.

Signature of Candidate: _____

Kayleigh Sheerin

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Dedication

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List of Abbreviations

| | |
|------------------|--|
| ACE..... | Adverse Childhood Experience |
| ASD..... | Autism Spectrum Disorder |
| AT..... | Activity Theory |
| BPS..... | British Psychological Society |
| CAMHS..... | Child and Adolescent Mental Health Service |
| CPD..... | Continual Professional Development |
| CHAT..... | Cultural-historical Activity Theory |
| DES..... | Department of Education and Skills |
| DWR..... | Developmental Work Research |
| EP..... | Educational Psychologist |
| GOI..... | Government of Ireland |
| HSE..... | Health Service Executive |
| IAMH..... | Irish Association of Infant Mental Health |
| IMH..... | Infant Mental Health |
| IMH-NG..... | Infant Mental Health Network Groups |
| IPA..... | Interpretative Phenomenological Analysis |
| MAT..... | Multi-Agency Team |
| NCCA..... | National Council for Curriculum and Assessment |
| NICE..... | National Institute of Clinical Excellence |
| PIMH..... | Perinatal and Infant Mental Health |
| PSI..... | Psychological Society of Ireland |
| PSI PIMHSIG..... | Psychological Society of Ireland Perinatal and Infant Mental Health Special Interest Group |

| | |
|------------|---|
| QMHC..... | Queensland Mental Health Commission |
| RSG..... | Ready Steady Grow |
| VIG..... | Video Interactive Guidance |
| WAIMH..... | World Association for Infant Mental Health |
| WHO..... | World Health Organisation |

Chapter One: Introduction and Overview

Psychology has a longstanding history of being a “force for positive change” within society through the promotion, implementation, and dissemination of innovative and contemporary practices (Cameron, 2006, p. 298). An insightful article by Zimbardo (2012) highlights some of the most pervasive and powerful contributions applied research in psychology has made to modern society, including the concept of positive reinforcement, the impact of stress on our bodies, and the development of psychometric testing, to name but a few. However, Zimbardo notes that one of psychology’s proudest impacts regards the research and evidence on brain development in the early years. In the past few decades, the field of psychology has observed “an explosion” of research into the biological, social, and cognitive understandings of early brain development (Phillips & Shonkoff, 2000, p.1) and the conditions necessary to provide children with an optimal head start in life. In particular this research provided a deeper understanding into the importance of positive early life experiences, the intricate social and emotional skills that develop within the earliest years, as well as the absolute centrality of warm and nurturing early relationships in shaping brain development (Phillips & Shonkoff, 2000). This propelled a new school of thought among researchers and practitioners: that children were no longer “little adults” (McCoy, 1988, p.45), yet were evolving human beings who required the necessary stimulation, interaction, and environment to develop optimally. This research has culminated to the identification of a novel and exciting field of research and practice, concerned with supporting the emotional and social wellbeing of young infants. This field of interest has been coined Infant Mental Health (IMH) and is the focus of study for this thesis.

IMH has been formally described in the literature as the capacity of children to “experience, regulate, and express emotions; form close, secure interpersonal relationships; and explore the environment and learn” (Zero to Three, 2002, p.1). As originally conceptualised by Selma Fraiberg in her notorious article “Ghosts in the Nursery” (Fraiberg, Adelson, & Shapiro, 1975), “infant” refers to children aged between birth and three years of age, “mental” relates to social emotional functioning, and “health” equates to wellness in this area (Fraiberg, et al., 1975). IMH has become synonymous with healthy social and emotional functioning, and is a cornerstone for

successful psychological development (Zero to Three, 2012). In addition to defining IMH as a foundation for a child's social and emotional development, IMH also incorporates the field of practice and research involving the child, their family, and the wider community (Osofsky, 2016). This growing field of research and practice is dedicated to the promotion, prevention, and treatment of IMH difficulties (Zeanah & Zeanah, 2009). IMH practice encompasses a multidisciplinary field of inquiry as the complex and multifaceted nature of early years development "requires expertise and conceptualizations beyond the capabilities of any particular discipline" (Zeanah & Zeanah, 2009, p.6). Thus, providing effective IMH services requires the knowledge and skills from a range of professional disciplines, working collaboratively to support the child and their family.

1.1 National Context of the Research

This research is being conducted in the midst of a national policy climate of wellbeing and mental health promotion of children and young people. Whilst there exists debate within the field on the definitions of the term wellbeing (Dodge, Daly, Huyton, & Sanders, 2012), the concept is of a multi-dimensional nature, involving "many interrelated aspects including being active, responsible, connected, resilient, appreciated, respected and aware" (Department of Education and Skills [DES], 2018, p.10). A definition provided by the National Council for Curriculum and Assessment (NCCA, 2017, p.17) explains wellbeing as "when students realise their abilities, take care of their physical wellbeing, can cope with the normal stresses of life, and have a sense of purpose and belonging to a wider community". The concepts of mental health and wellbeing are inextricably linked, with the term mental health being recognised as a "state" of wellbeing (World Health Organisation, 2014, para.1). Throughout the past number of year the Irish Department of Education and Skills has strived to develop and fortify wellbeing promotion in all schools and centres of education, with the overarching aim of Ireland being "recognised as a leader in this area" (DES, 2018, p.5). Wellbeing promotion has thus been identified as a key priority area in the national Action Plan for Education (DES, 2016; DES, 2019), culminating in the production of a national policy document entitled "Wellbeing Policy Statement and Framework for Practice" (DES, 2018). Government publications and resources have been produced and disseminated to education centres across Ireland, in an attempt to support the

development and promotion of wellbeing across both primary schools (DES and Department of Health, 2015) and post-primary schools (NCCA, 2017). Of particular relevance to the current research, wellbeing has been outlined as a key theme in the Irish early childhood framework “*Aistear*”, that being, the national curriculum for children aged 0-6 years (NCCA, 2009). This curriculum, which is implemented across crèches, pre-schools, and infant classes in primary schools, recognises the importance of a secure attachment with a primary caregiver in providing “the foundation for the child’s wellbeing, and help him/her to develop a sense of self and an identity, making learning more enjoyable, rewarding and successful” (NCCA, 2009, p.41).

Whilst there have been strides made in mental health promotion and prevention in Irish educational settings through various wellbeing initiatives and policy guidelines, the development of similar initiatives across community and other health care settings are only recently emerging. Ireland has the second highest birth-rate in Europe and the population of the number of children aged between 0-6 has steadily increased over the past number of years (Early Years Strategy [EYS], 2013). Considering this statistic, it may be inferred that Perinatal and Infant Mental Health (PIMH) would be a leading concern for an Irish health care context, yet in fact, the area has only lately gained traction and attention. Research indicates how Irish children are by no means immune to the consequences of inadequate IMH services. The “Growing up in Ireland” study noted that difficulties in infant temperament at nine months were associated with problematic behaviours at three years of age (Quail, Williams, McCrory, Murray, & Thornton, 2011), mirroring the findings of international research (e.g. Shah, 2010). Although research advocates for interventions to occur at the earliest possible period, current Irish mental health policies, funding, and research have focused on providing treatment and intervention for children of school age, or older (e.g. Malla et al., 2016; O’Keeffe, O’Reilly, O’Brien, Buckley, & Illback, 2015). Currently, IMH services are only being offered at community level (e.g. YoungBallymun, 2012), only providing services to local parent and infant dyads despite impressive uptake and outcomes of said programmes (Psychological Society of Ireland Perinatal and Infant Mental Health Special Interest Group [PSI PIMHSIG], 2015).

Irish psychologists are in an optimal position to provide IMH services as part of a multidisciplinary approach. Psychologists hold specialised skills and knowledge in

the areas of child development and disability, and work individually with children or at a systemic level in supporting parents, teachers, social workers or other professionals (Feehan & Hutton, 2003). They are regularly employed in a wide range of settings including community settings, schools, and specialist services such as those provided for youth at risk and children in care (Health Service Executive [HSE], 2013). They also play a key role as part of multi-disciplinary teams such as Early Intervention Teams and School Age Disability Teams (HSE, 2013). However, the practice of psychology and IMH in Ireland remains a grey and under-researched area. Various national bodies have highlighted specific gaps in psychology services provided to young children and their families; including the absence of psychologists in maternity hospitals, lack of psychologists working in primary care, no specific care pathways for IMH cases, and absence of specialised IMH services (Mental Health Reform, 2015; PSI PIMHSIG, 2015). Thus, whilst on paper psychologists have a range of services to contribute to IMH care in Ireland, significant ambiguity exists regarding psychology practice within IMH contexts.

1.2 Research Focus

It is well recognised in the field of IMH that best practice for provision of IMH services comprises of multidisciplinary inputs (Osofsky, 2016). However, this in itself brings challenges. Many practitioners and professionals, who work with young children and their families, originate from diverse disciplines and may vary in their level of training and skill in IMH. Professionals who are best placed to work with IMH cases may have varying levels of training, skills, and experience (Hinshaw-Fuselier, Zeanah & Larrieu, 2009). In light of the recent upsurge in acknowledgement and interest in IMH principles, many practitioners who work with young children will be expected to promote and facilitate IMH, without consideration of their role in this field or their skill and preparedness to do so (Osofsky, 2016). As IMH services are in an emergent stage of development, it is suggested that there is “room for confusion regarding the practice of IMH and the boundaries that define the roles of the professionals who practice it” (Hinshaw-Fuselier et al., 2009, p. 533).

These blurred roles and boundaries also apply to psychologists. Whilst the field of psychology has made renowned contributions to the theoretical base of IMH (e.g.

Shore, 2002; Ainsworth, 1969), it is suggested that there is limited ground-up research on what the practical involvement of a psychologist with IMH cases entails. Current Irish practice has seen a change in the role of the psychologist over the past number of years. Previously, psychologists were operating under a medical model, concerned with the assessment in the identification and placement of children with additional needs. More recently, psychology practice in Ireland has evolved to working in a systemic and collaborative model, whereby the psychologist engages in “a collaborative process with the people in the individual’s bio-psycho-social system” (Feehan & Hutton, 2003, p.1). Due to this new diversity in practice and policy, the role of the psychologist has changed, however a decrease in role clarity may be a logical consequence of this role expansion (Ashton & Roberts, 2006). In addition to this, it may be argued that other professionals (e.g. public health nurses, psychiatrists) can adopt a similar role to that of the psychologist, particularly in the early years practice (Kelly & Gray, 2000). This raises further questions: do psychologists have a role in IMH practice? What does their involvement entail? Do other professionals provide similar services to psychologists? What makes their contribution to an IMH team unique? This research hopes to address some of the aforementioned questions, through exploring professional roles in IMH contexts in Ireland.

1.3 Research Questions

The overarching aim of the current study is to explore professional roles within multidisciplinary IMH services, with a particular focus on the role of the psychologist. The study is led by the following research questions:

1. How do psychologists use an IMH framework in their practice?
2. How do psychologists, and other relevant professionals, view the role of the psychologist in Infant Mental Health service provision?
3. How do psychologists, and other relevant professionals, view the roles of others in Infant Mental Health service provision?
4. What are the distinctive attributes of the psychologist’s role that make their roles unique within multidisciplinary Infant Mental Health service provision?

1.4 Purpose of the Study

The purpose of this study is to elicit and de-mystify professional roles in IMH service provision, particularly the role of the psychologist. The study's sample has been drawn from professionals from different and diverse disciplines, who provide services to young children (aged 0-3) and their families. A convergent parallel mixed methods design was utilised to explore this phenomenon from both a qualitative and quantitative perspective. Online questionnaires were provided to practising psychologists, to explore their current work with IMH cases. Semi-structured interviews were also conducted from a range of professionals who provide IMH services in Ireland. A detailed description of the data collection and analysis procedures will be provided in Chapter 3.

1.5 Relevance and Potential Significance of the Study

It is hoped that the findings of this study will make a contribution to the research, policies, and practices of IMH, both at a national and international level. Firstly, this research will be the first of its kind in exploring professional roles within IMH services in Ireland. More specifically, this research will also address an identified gap in the literature by offering an empirical insight into the role of the psychologist in IMH. The contribution of psychology has been examined in the literature in relation to other aspects of mental health service provision, including adult community mental health services (Peck & Norman, 1999), rural mental health services (Jameson & Blank, 2007), and school-based mental health services (DeMers, 1995). Thus, primarily, this study aims to address the gap in the literature on professional roles within IMH services, in particular the role of the psychologist.

Regarding policy, the empirical data provided within this research may influence government policies on IMH by providing information on the nature of current IMH service provision in Ireland. Firstly, the findings of this research may support or shape the development of a specific IMH policy in Ireland. National bodies have been advocating for a national policy pertaining specifically to IMH (PSI PIMHSIG, 2015), therefore this research may offer some practitioner perspectives and insights to inform this policy. Secondly, the findings may have an impact for recruitment or economic policies within multidisciplinary health care. Due to the increased financial pressures on health services, it will be beneficial to provide information on the discrete role of

various team members, in order to justify economic costs to stakeholders (MacKay, 2002). As psychologists are expensive resources, an insight into the contribution of psychologists to IMH teams will also be of note for future government and health sector planning.

Finally, the findings of this study may support more fluid and holistic multidisciplinary operational practices in IMH practice. Research in the field of multidisciplinary services, emphasise the need for each service to have clarity in terms of role and expectations for each professional in order to ensure effective working and avoid gaps or overlaps within service provision (Kelly & Gray, 2000). Therefore, the findings of this study may support a blueprint for professional roles with IMH services to ensure the complimentary disciplines are working effectively together. Additionally, having role clarity has been theoretically linked with reduced levels of anxiety (Kerry, 2003), and a practitioner willingness to reform one's professional practice (Stobie, 2002). If Irish practice is to move towards a more specialised IMH service, these factors will be important to consider during the transition phase.

1.6 Definition of Key Terms

1.6.1 Infant mental health. The definition of IMH that is considered most pertinent for the current research study is “the developing capacity from birth to 3 to experience, regulate, and express emotions; to form close relationships; and to explore the environment and learn, all in the context of family, community, and cultural expectations for young children” (Zero to Three, 2002, p.1). There is variation within the literature regarding the age bracket that encompasses IMH, with some definitions including children from birth to age five (Centre on the Developing Child at Harvard University, 2007) or from birth to age six (Michigan Association for Infant Mental Health, 2014). This research has chosen to operationalise IMH as the timeframe from birth to age three, as this is the age bracket considered most frequently in the literature, and is also the range defined within the definition of IMH provided by HSE (HSE, 2015a).

There is also significant variety in the term IMH within the literature. Many publications refer to “Perinatal and Infant Mental Health”, that being the social and

emotional wellbeing of mother and infant, beginning from the point of conception (PSI PIMHSIG, 2015). Whilst perinatal mental health is not a concept being explored within this study, some of the literature referred to within this research includes both perinatal and IMH services. These studies were chosen to be included in this research as the outcomes of studies were still considered relevant, i.e. provided measures of infant and parent wellbeing. Additionally, some literature adopts the term “Infant and Early Childhood Mental Health”; referring to the social and emotional development of children aged 0-5 (Upshur, Wenz-Gross, & Reed, 2009). Thus, while some publications highlighted during relevant searches utilised this term, these studies were discarded, as the scope of the service extended beyond the age range being considered for this study.

In light of the diversity within the definitions of IMH, it may be useful for researchers to propose their own definitions of a concept. Some researchers argue that the term IMH can evoke negative reactions among parents and caregivers, due to the stigma of mental illness (Centre for Early Childhood Mental Health Consultation, 2013). Furthermore, it is also proposed that the term IMH could be misconstrued as “translating psychological problems in infancy and early childhood into ‘mental illnesses’” (Osofsky, 2016, p. 45). It could be therefore suggested that the term mental health be replaced with the phrase “mental wellbeing”, to eradicate the aforementioned concerns. Moreover, as definitions of the age parameters of the term infant vary in the literature, it may be more useful to define the concept in developmental stages (i.e. babies, toddlers, and/or young children) as opposed to chronological age (i.e. 0-5, 0-6, etc.). Having reviewed literature and various definitions of the term IMH, it could be argued that there are two key principles that remain present across a variety of definitions. These include the centrality of a relationship with a primary caregiver, and the consideration of the child within their diverse environments. Thus, incorporating the above information, the researcher proposes their own definition of IMH as the following:

Infant mental wellbeing concerns the development of the social and emotional competence of babies, toddlers, and/or young children, as best achieved through a positive relationship with a sensitive and nurturing caregiver and best understood in the context of the child’s wider environment.

1.6.2 Multidisciplinary team. The HSE defines a multidisciplinary team as a group of health care workers who are members of different disciplines (professions e.g.

Psychiatrists, Social Workers, etc.), each providing specific services to the patient. The team members independently treat various concerns a patient may have, focusing on the practices in which they specialise (HSE, 2012). A description of the primary multidisciplinary children's health care teams that employ psychologists in Ireland can be found in Appendix A.

1.6.3 Service provision. The World Health Organisation (2010, p.2) defines service provision as “an immediate output of the inputs into the health system, such as the health workforce, procurement and supplies, and financing.”

1.6.4 Role: The meaning of the term role is multifaceted. However, this research defines the term as “a function or part performed especially in a particular operation or process” (Role, n.d., para.1).

1.6.5 Wellbeing: Wellbeing is acknowledged as a complex and multifaceted concept, making it difficult to provide a universal definition of the term (Gillett-Swan and Sargeant, 2015). Whilst a range of definitions are presented in the literature, the definition by Gillett-Swan and Sargeant (2015) will be used for this study. This definition refers to “accrued” wellbeing, that is, “an individual's capacity to manage over time, the range of inputs, both constructive and undesirable that can, in isolation, affect a person's emotional, physical and cognitive state in response to a given context” (Gillett-Swan and Sargeant 2015, p. 143). This definition was considered appropriate for the current study as it takes a lifespan perspective and proposes that wellbeing is something that begins at early childhood and “continues to develop until death” (Gillett-Swan and Sargeant, 2015, p.143). It could be proposed that infancy presents an optimal time to begin this accrual of wellbeing through sharing positive experiences, exploring the environment, building relationships, and developing secure attachments.

The literature on wellbeing presents research on different components or subcategories of wellbeing, including physical wellbeing (Peterson & Bossio, 2001), economic wellbeing (Curran, Wolman, Hill, & Furdell, 2006), and emotional wellbeing (Charles, 2010). Within the current study, three different components of wellbeing are discussed: mental or psychological wellbeing, emotional wellbeing, and social wellbeing. The definitions of said components are taken from the public health guidelines “Social and Emotional Wellbeing: The early years” produced by the National Institute for Healthcare and Excellence (NICE, 2012). These definitions were chosen as

they are tailored to the infant cohort and have been produced by an internationally recognised body for healthcare.

- *Mental/psychological wellbeing*: “this includes the ability to be autonomous, problem-solve, manage emotions, experience empathy, be resilient and attentive” (NICE, 2012, p.30).
- *Emotional wellbeing*: “this includes being happy and confident and not anxious or depressed” (NICE, 2012, p.30).
- *Social wellbeing*: “has good relationships with others and does not have behavioural problems, that is, they are not disruptive, violent or a bully” (NICE, 2012, p.30).

1.7 Researcher Positionality

At this juncture, it may be relevant to provide an insight into the researcher’s positionality and personal interest in the topic of IMH. Some researchers argue that educational researchers are highly influenced by their own values and experiences, which have an impact on both what they research and how it is interpreted (Mortimore, 2000). While it is accepted that a value-neutral research process is not feasible or realistic (Greenbank, 2003), it is suggested that researchers accommodate for their personal beliefs and experiences within their work in order to provide transparency within the research process. One such way this is recommended is to include biographical details, provide a statement about the researcher’s underlying values, and give information on the experiences that influenced the research to date (Berg, 2001). Although this does not necessarily eliminate the influence of these factors, it facilitates the reader to take these factors into account when evaluating the work (Gummesson, 1991).

The positionality of this research stems from the influence of both my personal and professional experiences. With regards professional experiences, this project was highly influenced by my work as a primary school teacher, whereby I worked closely with children who were experiencing attachment difficulties. Within this work, I gained an understanding how attachment difficulties can present in a school-aged child and the impact this can have across their development. As I moved into my career as a trainee psychologist, I undertook my first training placement in an Early Intervention Disability

Service, where I encountered many young children experiencing attachment and IMH difficulties. What struck me in this placement was how attachment difficulties and other developmental difficulties (e.g. Autism Spectrum Disorder [ASD]) can present very similarly in practice. The overlaps in presentations have been documented in the literature (e.g. Moran, 2010), yet I found this fascinating to observe in a real-life context. Moreover, I found it very interesting to observe the dynamics of professionals within the multidisciplinary team during the differential diagnosis process of these cases. These observations provided me with inspiration regarding professional roles and IMH casework, which subsequently formed an investigative component of this research project. On a personal level, I find myself continuously drawn to the concept of IMH in my personal reading and individual research activities. As a person as well as a practitioner, I value and advocate for the concept of early intervention as a means to providing children with the best start to life. Having researched potential employment opportunities that would offer me the opportunity to work in this capacity, it became clear that the work of the psychologist and IMH in Ireland was an under-researched area. This led me to question whether Irish psychologists engage in IMH work, and if so, what this type of work entails. This exploration further sharpened my research aims and provided me with personal inspiration and motivation to engage in this research project.

These experiences impact and shape my positionality as researcher. My experiences also reflect my membership in the group or area being studied, which is important to acknowledge as “the researcher plays such a direct and intimate role in both data collection and analysis” (Dwyer & Buckle, 2009, p. 55). The literature broadly conceptualises this membership as being an “insider” or an “outsider” in the research process (Adler & Adler, 1987). In considering my own stance, I consider myself an insider having worked with children with attachment difficulties across my teaching career and also my placement experiences as a trainee psychologist. My previous professional encounters provide me with a somewhat comparable experiential base to the professionals of this study, whom have also worked with children with attachment difficulties. Furthermore, as I am a trainee psychologist, I share some qualities with the psychologists with whom I gathered data from. For example, I may share similar educational experiences (e.g. a Bachelors degree in psychology), training experiences (e.g. a mental health placement), as well as a shared language (e.g.

knowledge of commonly used abbreviations or terms in psychology). Yet, I am also an outsider in this research process as I am not a parent, which therefore gives me a different lens in viewing the parent-child relationship. Moreover, while I may be considered an insider to the psychology participants of this study, I may be considered an outsider to the other professionals of other training backgrounds who took part in the research. In light of recognising my positionality in both insider and outsider perspectives, my overarching position may be best described as an “intersection” researcher, that being, one that occupies the “space between” both standpoints of insider and outsider (Dwyer & Buckle, 2009, p.60). Other reflections on the philosophical underpinnings of this research study will be discussed further in Chapter Three.

1.8 Overview of Thesis

This study aims to elucidate and explore professional roles within IMH service provision in Ireland, with a particular focus on the role of the psychologist. This opening chapter provided an introduction to the thesis topic, as well as clarification on the purpose and potential significance of the research. The gap in the literature, which this study will attempt to fill, is identified through a systematic review presented in Chapter Two. This systematic review is preceded by a critical appraisal of the research on the impact of IMH on development, as well as an analysis of relevant theoretical perspectives within the field. This chapter will embed the current study in an Irish context through an examination of relevant Irish policies and current IMH practices, as well as providing a brief insight into the international context of IMH. Furthermore, a historical discussion on the role of the psychologist in an Irish setting will clarify the relationship between IMH service provision and psychology practice in Ireland. Chapter Three will provide detail on the epistemology and theoretical framework underpinning the research. Information will be provided on the research design, participants, measures, and procedures used. Following this, Chapter Four will offer a presentation and analysis of the research findings. Chapter Five includes a discussion on the main findings related to the research questions, as well as a reflection on the limitations of the study and the potential implications for future policy and practice. The final chapter, to close the thesis, will offer a review of the key findings and recommendations, and will discuss future plans regarding dissemination of the research.

Chapter Two: Literature Review

2.1 Introduction

This chapter is presented in two sections. The first section will provide an insight into IMH research and theory. The chapter will begin with a critical discussion on the validity of IMH as a field of specialism within psychology. A brief history of the role of the educational psychologist in Ireland will follow, which will provide a rationale for the integration of IMH into Irish educational psychology practice. Theoretical perspectives on IMH will be explored, which will lead to a discussion on the development of IMH frameworks as an approach to service delivery. An overview of IMH on an international basis will be discussed, followed by a review of current Irish policies and IMH initiatives.

The second half of this chapter presents a systematic review. This review was conducted at the initial stages of the research process, in order to evaluate the empirical research on IMH service provision to date, and highlight any gaps in the knowledge base that may be filled by the current study. This systematic review was conducted in two stages. The first stage of the review evaluates the literature on components of effective IMH services. The findings discussed following this stage flagged a potential area for more detailed exploration, which led to the second stage of the review. The second stage subsequently aimed to appraise the empirical literature on the activities of psychologists in IMH contexts. This chapter will conclude with a summary of relevant empirical findings and will highlight the gap in the literature that this research aims to fill.

2.2 Validity of IMH as a Field of Specialism

To open this literature review, it may be first pertinent to discuss the importance of IMH and why its conceptualisation as a field of specialism within psychology is of relevance. The concept of IMH is not necessarily a new field of study, with the origins of the practice dating back to the 1970s. IMH practice is becoming increasingly more relevant in today's modern world. Recent societal trends such as an increase in single-parent families, an increase in time spent in non-parental childcare, the role of

technology, and a rise in the reports of violence and drug abuse can create significant adversity in the environment of the child (Macdonald, et al., 2005; Quail et al., 2011) . Exposure to these experiences can threaten a secure attachment between the infant and caregiver, as well have detrimental knock-on effects to the child's subsequent development (Macdonald et al., 2005). Research on the developmental impact of early years experiences, as well as contrasting evidence, will be subsequently explored through the use of a bio-psycho-social lens (Ranson & Urichuk, 2008).

2.2.1 Biological factors. There exists a wealth of research from the field of neuroscience regarding the exponential growth and development of the infant brain during the first few years of life (Dubous et al., 2014; Fox, Levitt & Nelson, 2010; Glaser, 2018). A nurturing early relationship between an infant and caregiver can directly impact the wiring of the neural circuits of the child's brain. These early neural developments form a "roadmap" that set the foundation for their future social and emotional brain development (Schoore, 2001). There exist windows of opportunity during childhood, referred to as "critical" or "sensitive" periods, whereby the young brain experiences increased plasticity, synaptogenesis, and dendritic growth (Crowe, Catroppa, Babl, Rosenfeld, & Anderson, 2012). Many of these critical periods occur during the first few months of life where there is rapid neural growth as the child is learning from new experiences almost every day (Crowe et al., 2012). An alteration in brain development as result of trauma, abuse, or neglect during these critical periods can have detrimental effects; causing "cessation of this development or [alter] it's course" (Anderson, Spencer-Smith & Wood, 2011, p.4). For example, a study conducted by Bremner et al. (1997) demonstrated how adults who had a history of childhood maltreatment had reduced hippocampal volume; impacting on their memory capacity. Another study noted how infants who experienced distress displayed impairments to the functioning of the right frontal area; a brain region associated with emotional regulation and processing (Schoore, 2001).

The neurological concept of brain plasticity may provide a hopeful opportunity to rectify the impacts of a hostile childhood environment and a tense parent-child bond. Plasticity refers to the brains ability to change in response to repeated stimulation. Although this plasticity will vary with developmental level and age, an infant's brain is notably more "plastic". For example, children from Romanian institutions who had

experienced neglect during infancy, demonstrated a greater attachment response if they were placed in foster care with a responsive caregiver before the age of two (Smyke, Zeanah, Fox, Nelson, & Guthrie, 2010). This creates a strong case for early intervention in the form of IMH promotion and treatment. If an at-risk attachment relationship obtains the necessary supports to provide appropriate stimulation and sensitivities, the infant's brain may obtain the opportunity to strengthen and fortify necessary synaptic connections. However if this support is not put in place, the synaptic connections may be pruned away and thus will make it more difficult in later life to regain these neuron pathways (Schoore, 2001). Thus, while it is argued that brain plasticity should not be considered the panacea to early deprivation (Bindschaedler, Peter-Favre, Maeder, Hirsbrunner & Clarke, 2011), its contribution to our understanding of brain development is noteworthy and emphasises the importance of early intervention during the infancy period.

2.2.2 Psychological factors. The impact of IMH difficulties on psychological wellbeing is well documented within the literature (Allen, Hauser & Borman-Spurrell, 1996; Brown & Wright, 2001; Malekpour, 2007). According to the World Health Organization (WHO, 2017), mental health difficulties and disorders tend to fall unduly on three cohorts: women, people living in poverty, and (of particular relevance) children and adolescents with disrupted nurturing (O'Shea & Kenneally, 2008). This disruption to the parent-child relationship can happen at any point in the infant's life, and has the potential to impact on both the parent and the child's psychological wellbeing. The National Institute of Clinical Excellence (NICE) highlights how even the experience of childbirth can be linked with psychological distress for a parent. This distress can not only have negative impacts on the attachment bond between baby and caregiver, but also on the mental wellbeing of the parent, particularly for women with pre-existing mental health issues (NICE, 2014). Moreover, women who have a traumatic birthing experience (e.g. emergency caesarean section or infant admission to neo-natal unit) or women with a history of miscarriages or stillbirths are at an increased risk of a disruption to the attachment bond (Joint Commission Panel for Mental Health, 2012; Theut et al., 1992). It is interesting to note that assessment of a birth in Ireland (and internationally) focuses primarily on physical outcomes, such as maternal blood pressure or temperature. The psychological wellbeing of the mother after birth is not

considered as important as physical wellbeing, despite the emerging evidence recognising the relationship between the two factors (Beyond Blue, 2008).

Evidence that relates experiences during infancy and future psychological outcomes is found at length in the seminal Adverse Childhood Experience (ACE) study (Felitti et al., 1998). The original ACE study was carried out in the years 1995 to 1997 in America, whereby over 17,000 participants completed confidential surveys regarding their childhood experiences. The participants provided frequent updates about their health and wellbeing status and behaviours. ACEs included events such as abuse, neglect or family/household challenges. Interpretation of this longitudinal data demonstrated several interesting findings that have major relevance for the field of IMH. Firstly, the number of ACEs experienced in childhood increased the risk of depression in adulthood (Chapman et al., 2004). Persons who had experienced four or more ACEs during childhood had a 4 to 12-fold increased health risks for alcoholism, depression, and suicide attempt (Felitti et al., 1998). Similar ACE studies were subsequently replicated in the U.K, whose findings may generalise better to an Irish population. Data from the British population indicated that people who had experienced over four ACEs at childhood were sixteen times more likely to have used cocaine or heroin, and twenty times more likely to have been in prison at some point in their lives (Bellis et al., 2015). Interestingly, the ACEs study noted a graded dose-response in its findings; meaning that as the number of ACEs increased the intensity of adverse outcomes also increased. (Felitti et al., 1998). However, it must be noted that not all children who experience ACEs will follow such unfavourable pathways. A secure attachment with a warm and sensitive caregiver may mitigate the effect of an ACE. Yet, if the caregiver is the source of the ACE, the child's attachment relationship is a high risk and thus has the potential to have adverse knock-on effects to the child's future emotional development (Aspelmeier, Elliott, & Smith, 2007; Riggs & Riggs, 2011).

2.2.3 Social factors. The effects of IMH practices can also have an economic impact on society. The work of Nobel prize-winning economist, James Heckman (2011), substantiates investment in early years education and services. His influential research makes a strong economic case for investment in early childhood prevention and intervention initiatives starting before birth, with statistics suggesting that providing health care and education from birth produces a 13% return on investment per child per

annum (Heckman, 2011). This is a substantial higher return on investment, when compared to the cost of intervention at later developmental stages. Although there is no formal Irish research, a tentative hypothetical exploration into the economics of IMH intervention was carried out by Maguire (2011). An illustration of Maguire's (2011) hypothesis can be found in Table 1.

In addition to an economic impact, an absence of sufficient support at this level can have detrimental long-term effects for society. Inadequate IMH and early-intervention supports can result in a range of community problems, including child abuse, marital breakdown, developmental delay, behavioural problems, and substance abuse (Mihalopoulos, Vos, Pirkis, & Carter, 2012; NICE, 2014; Queensland Mental Health Commission [QMHC], 2014). It has been proposed that unfavourable childhood experiences occurring in the first five years of life can account for more than 30% of psychosis in adulthood, can predict the onset of drug use in adolescence, and is related to risk of involvement in the criminal justice system (QMHC, 2014). As a result, lack of suitable services can create and perpetuate an intergenerational cycle of adversity. A child who has not experienced a positive attachment will have a disrupted blueprint of what a healthy relationship looks like. The negative working models created as a result, can give rise to difficulties in entering and maintaining meaningful and functional relationships, thus furthering the intergenerational cycles of social and emotional difficulties (QMHC, 2014). However, it must be noted that research indicates that other societal factors, such as the impact and quality of schooling (Gomez & Brown, 2006) or potential to develop secondary attachment figures (Van Ryzin, 2010), can act as buffers to the potential adverse social impacts of attachment difficulties. Thus, the evidence base may suggest that while the relationship between adversity in childhood and negative social outcomes later in life may not be a direct linear relationship, it should still be a focal area for intervention and support in our communities.

Table 1

Illustration of Cost-Benefit Analysis of IMH Casework (Maguire, 2011)

| | Intervention | Cost | Outcomes |
|--------|--|---|--|
| Case A | Case identified by Clinician with IMH skills Baby & Mother commenced intervention when Baby 2 months old Denial regarding her pregnancy, absence of support Overwhelming feeling of ambivalence for her newborn Mother's own dysregulation & unresolved early childhood experiences IMH model of service provision implemented | 92 clinical hours of Psychologist time 20 hours in travel time Clinical Supervision | Parent child relationship is repaired Family intact Child remains in his Community |
| Case B | Case not identified until 13 months (child taken into care) Unplanned pregnancy, difficult early childhood, ambivalent relationship with her baby Mother known to Social Work Department as an adolescent Mother places baby in foster care at beginning second year of life 2 years later, her toddler is unable to manage a relationship with her Child in long term foster placement until 18yrs No relationship based therapeutic intervention to date | Cost of Foster Care (17yrs) at €350 approx. per week Clinical skills of Social Work Foster Social Worker, Legal costs to HSE. | Child in secure placement Parent –child relationship disrupted Family no longer in intact Child removed from their community must adjust to new surroundings Society will be required to support their mental health needs for some time to come |

2.2.4 Evidence from resilience research. While the aforementioned research presents adversity at infancy as a singular pathway to continuing vulnerability and psychopathology, research into resilience in children presents an interesting alternative. Although it would be difficult to dispute the negative effects of childhood adversity, research highlights how some vulnerable, neglected, or abused children present with the capacities to function competently despite the adversities they have faced (Luthar, Cicchetti, & Becker, 2000). For example, studies have demonstrated how some children of mothers experiencing depression were reported to display appropriate levels of competence (Downey & Coyne, 1990). Additionally Rutter (1985) highlights how of

children who have been subject to very severe adversities, no more than half the studied cohort displayed negative outcomes. Thus, despite the presence of notable “risk factors” research has presented evidence for “protective factors” that can mitigate the potential deleterious effects posed by the risk. The intricate balance between these risk and protective factors as a means of overcoming adversity has been coined “resilience” (Rutter, 1985), and has created stimulating debate in the field of child development. In the context of early infancy, potential risks may include parental mental illness, parental substance abuse, neglect or abuse, or parents who have not experienced nurturing parenting themselves (Zeanah & Zeanah, 2009). The detrimental impacts these risk factors can have on attachment and subsequent development have been discussed in the previous section.

As aforementioned, resilience research has noted some protective factors that may be present in the child’s life at this age. A secure attachment to a secondary figure, such as a grandparent or sibling can act as a buffer when attachment to primary caregiver is ruptured (Bowlby, 2007). This concept of “one good adult” as an attachment figure is reiterated in studies of children across developmental stages (Dooley, Fitzgerald, & Giollabhui, 2015, p.9). A study carried out by McDonald, Kehler & Tough (2016) noted some protective factors within the family system that can support young infants resilience indirectly; including good social support for parents, parents having high levels of optimism, as well as the ability for a parent to maintain a work-life balance. Another recent study carried out by Sattler & Font (2018) noted how early self-regulation capacities in infants can be an individual or within-child protective factor during their early development. When considering IMH practice it is of utmost importance for practitioners to identify and bolster these protective factors as a means of a strengths-based intervention to promote and facilitate positive outcomes.

While evidence from research on resilience points to potential risk and protective factors, debates still exist regarding how robust this literature actually is. Firstly, outcomes that researchers have equated to demonstrating resilience have largely focused on social outcomes, such as school grades or parent ratings, as it was considered a good indicator of general coping ability (Luthar & Zigler, 1991). However, alternative research carried out by Radke-Yarrow and Sherman (1990) highlighted how some at-risk children displayed vulnerabilities for significant psychological disorders

(e.g. depression) despite outwardly appearing to function in everyday life. Thus, children may appear resilient at one point in development but not another (Luthar et al., 2000). From a scientific standpoint, there is also heated discussion regarding the integrity of the research base on resilience, due to inconsistency in terminologies, variations in definitions, as well as difficulties in measurement of risk within empirical studies. Luthar et al. (2000) note that while research into this area is of extreme value there is a need for enhanced scientific rigor to the study of the concept. Thus, while childhood resilience and the evaluation of risk and protective factors ought to be considered in IMH service provision, practitioners ought to remain critical of the evidence base. Instead, a focus ought to be placed on fostering the child-parent relationship as a key influence in a child's capacity for resilience.

Yet, overall, it is argued that there exists a relatively thin evidence base on resilience capacities of very young children and infants, particularly in relation to protective factors. Instead it is widely acknowledged that a secure attachment and a positive parent-child relationship are powerful protective factors in themselves (Beeghly & Tronick, 2011; McDonald et al., 2016). However, a child's relationship with their caregiver can be a double edged sword: while resilience research promotes secure attachment as a strong protective factor, having a ruptured attachment can leave infants with few alternative factors to support them in their development of resilience. Herein lies the importance of positive IMH in providing infants with a powerful resource in their ability to cope with adversity in the future. While research suggests that not all children will experience negative outcomes from environmental adversity such as parental depression or insensitive caregiving (Luthar et al., 2000); it is argued that the social and emotional development is too significant a concept to approach in this manner.

2.3 Rationale and Relevance to Educational Psychology

IMH is recognised as a multidisciplinary field of service, psychologists are well placed to provide services to this cohort of young infants and their families (Osofsky, 2016). Working in an IMH-informed framework of service delivery is an exciting yet novel practice for educational psychologists (EP) in Ireland. Employment in early intervention and child psychology capacities is a new venture for Irish EPs, therefore it

may be pertinent to firstly review the role of the educational psychologist through a historical lens, in order to set the context and rationale for the current study.

2.3.1 Inauguration of the profession. The role of the educational psychologist in Ireland has moved through several political and societal transformations throughout history, and continues to evolve to the current day. The profession of educational psychology in Ireland was formally established in the early 1960s. A key influence in the professions inauguration was an announcement made by then Minister for Education Dr Patrick Hillary, that mental handicap was an educational as well as a health problem (Swan, 2014). This statement prompted the appointment of the first three psychologists to the Department of Education in 1965. Parallel movements that were vital to the fortification of the discipline of educational psychology were the establishment of the City of Dublin Vocational Education Committee's Psychological Service, and the establishment of the Diploma in Psychology at University College Dublin in 1958 (Swan, 2014). Within these roles, psychologists worked solely with children at post-primary level, providing advice and support to guidance and remedial teachers. This remained the case until 1999 when The National Educational Psychology Service was established by Minister Michael Martin (Crowley, 2007). Within this service, the psychologist's role evolved to now working with students from both primary and secondary school levels. The first training programme in an Irish university was subsequently established at University College Dublin in 1995 (Swan, 2014). The longevity and significance of the profession was confirmed in 2005 with the Psychological Society of Ireland establishing a discrete division for Educational Psychology within the organisation (Crowley, 2007).

2.3.2 Historical work activities of the EP. Swan (2014) notes that the role of the educational psychologist was never confined to special educational needs. In addition to assessment work, psychologists have a long withstanding history of being involved in pupil counselling and guidance in schools as well as providing teacher training (Chamberlain, 1985). In fact, the first teacher training courses for teachers providing special education were designed by psychologists (Swan, 2014). Nonetheless, a notable component of the psychologist's role was assessment for the purpose of school placements or special education provisions. The psychologist's reports were reported to ascertain whether children were in the "remedial" category (having a deficit

in learning) or the “specials” category (requiring special education provision) (Swan, 2014). Additionally, the psychologist’s work may also involve assessment for the purpose of recommending a special school placement, although this was met with significant reluctance from parents (Swan, 2014). Finally, educational psychologists in Ireland have a historical role in the production of research on both national and international platforms, which has been vital to informing educational policy and practice. For example, empirical research conducted by an Irish psychologist in the 1960s (MacNamara, 1966) created significant controversy by proposing that immersion education (i.e. education delivered through a child’s second language) had the potential to cause delays in children’s academic performance in their home language. This piece of research created doubt in the public regarding the current compulsory Irish language policy of the state and subsequently resulted in changes to this state policy (Swan, 2014). Although MacNamara’s findings have since been challenged (e.g. Cummins, 1977), his findings mark the first time empirical research in psychology came to “public prominence” in Ireland (Swan, 2014, p.29).

2.3.3 Policy discourses that have shaped the EP’s role. The role of the educational psychologist is closely linked with special education policy and discourse. There are several key political influences that have shaped the work of the educational psychologist in Ireland: firstly, the Special Education Review Committee Report was published in 1993, delineating that integration was the most desirable option in the education for children with special educational needs (Government of Ireland [GOI], 1993). Additionally, this report advocated for a school psychological service to be linked with existing school health services, to assist with assessment and planning (GOI, 1993). Following this, the Education Act (GOI, 1998) made it a statutory requirement that all persons with or without special educational needs have access to support services and are entitled to an education that meets their needs and abilities. Finally, the Education of Persons with Special Educational Needs Act (GOI, 2004) was a key document in the inclusion movement, emphasising that children with special educational needs should be supported, where possible, in an inclusive environment unless an assessment highlights that this would not be in the best interests of the child or other children. These statutory policies and laws resulted in psychologists providing assessments for the purpose of access to suitable education teaching or placements. Additionally, the psychologist’s report was also used as a means of accessing other

supports such as income tax relief for families of a child with special educational needs (Swan, 2014). This historical role of the psychologist as a ‘gatekeeper’ to resources is only recently being dismantled. Recent government circulars have relinquished the administrative and assessment pressures on psychologists to provide assessments for the purpose of accessing resources (GOI, 2017). Currently, there is a move towards more school-based assessments to ascertain level of resources and support at both primary and secondary level. This has freed up psychologists to work in a more consultative and systemic manner; however there is no research to date on the effectiveness of this latest approach.

2.3.4 EPs induction to Irish healthcare settings. The history of educational psychology in the health sector of Ireland is another recent yet positive movement. Traditionally, the work of an educational psychologist was perceived to take place in exclusively educational contexts, including primary schools, post-primary schools, special schools, and/or third level institutions. However, recent socio-political changes in Ireland have resulted in the expansion of the employment opportunities for educational psychologists. The HSE (2017a) has recently published a report detailing how educational psychologists are now entitled to apply for posts in health care settings, including Child Disability services, Primary Care services, and Child and Adolescent Mental Health Services (CAMHS). Currently, EPs play a key role as part of many multi-disciplinary teams, for example, Early Intervention teams. In light of this change in employment prospects, Educational and Child Psychology programmes are also providing suitable training to address the diversity in potential work opportunities. For example, the inclusion of a child psychology placement has become a new addition to the current training programme in Mary Immaculate College (2016), so that trainees who complete the course are eligible to apply for jobs in this area.

2.3.5 EPs and multi-disciplinary working. EPs venture into the field of health services not only offered additional employment opportunities, but also a vastly different model of working. As most Irish health care is operationalised through multidisciplinary teams, EPs were now presented with an additional challenge of learning how to work in a multidisciplinary, as opposed to uni-disciplinary, fashion. Whilst the work of an EP always included a component of professional collaboration (e.g. with teachers, parents, etc.), the introduction to joint working with other health

care professionals such as occupational therapists, nurses, etc., was uncharted territory for the discipline as a whole. Even the practice of providing health services from a multidisciplinary perspective is a relatively novel concept in Ireland in general, stemming from a government publication in 2006 suggesting that the practice of health care in the community should involve “skilled professionals who combine their unique expertise to provide integrated care to service users in the context of their local community,” (GOI, 2006, p.78). Prior to this, Irish health care was still relatively “hierarchical and doctor led” (Deady, 2012, p. 178). The research pool on the effectiveness of this approach to health care in Ireland is small in quantity yet yields interesting results. Maddock’s (2015) study highlights how multidisciplinary teams are still hierarchical in nature, with the medical staff members dominating decision making (e.g. psychiatrist). Additionally, this study also noted that role blurring was common due to lack of understanding about other professionals’ roles (Maddock, 2015). Deady’s (2012) study also highlights how the structure and composition of multidisciplinary teams across Ireland lack consistency and clarity. Although these studies focused specifically on multidisciplinary mental health teams, the findings regarding the challenges of multidisciplinary work emphasise the additional challenge faced by EPs now employed in these settings. To date, there is no research conducted on the EPs involvement in multidisciplinary teams in Ireland, accentuating the contemporary nature of the EP as a member of multidisciplinary teams in Ireland.

2.3.6 EPs and the 0-3 age cohort. Before discussing the relevance of the topic of IMH to the practice of Educational Psychology, it may be useful to explore definitions of an EP as provided by various national and international bodies. The HSE (2013, para.4) note that EPs are trained to assess the needs of children who have “behavioural, learning, social or emotional problems and provide appropriate interventions which may include therapies, counselling or learning support programmes”. They have specialised skills and knowledge in the areas of child development and disability, and work individually with children or at a systemic level in supporting parents, teachers, or other professionals (HSE, 2013). The PSI (2017, p.3) notes how EPs provide services to children of “all ages”. Additionally, the British Psychological Society (BPS, 2015a) note that EPs work exclusively with children aged 0-24 years. Therefore, it is proposed that the cohort of children aged between 0-3 years, are well within the remits of the age range of services provided by EPs, and that these

professionals have the necessary skills, knowledge, and experience to support these young infants and their families.

2.4 Theoretical Underpinnings of IMH

2.4.1 Ecological systems theory. A key theory underpinning IMH practice is ecological systems theory (Bronfenbrenner, 1979). This seminal theory reflects the importance of studying a child in the context of the multiple environments or “systems” they are a part of (Bronfenbrenner, 1979). For example, a child will find itself as part of an intimate family “microsystem”, moving outward toward a larger “mesosystem” of the school environment, while also being part of an environment or “macrosystem” under the influence of various societal and cultural influences (Bronfenbrenner, 1979). This theory has been recently enhanced by Bronfenbrenner and Morris (2006) to include a “bioecological” approach. This updated Bioecological Systems Theory acknowledges the biology and genetic make-up of the child, and how the child’s development is a product of the enduring interplay between these factors and the alternate systems of the child (Bronfenbrenner & Morris, 2006). IMH adopts an ecological perspective in understanding and formulating the social wellbeing of infants. While it is acknowledged that genetics and biological influences can have an impact on IMH, the wellbeing of young infants is heavily reflective of the caregiving environment in which they are embedded (National Scientific Council on the Developing Child, 2004). Taking an ecological systems perspective to IMH, conceptualises the infant’s wellbeing as a balance of environmental risks and resources available to them and their family (Osofsky & Thompson, 2000). As aforementioned, positive parent-child relationship has been repeatedly considered a powerful resource in the development of childhood resilience (e.g. MacDonald et al., 2016).

When taking an eco-systemic approach to IMH, it is considered best practice, both nationally and internationally, for the early intervention service to incorporate a “family-centred” approach (Kirkby, Dunst, & Sukkar, 2016; Moore & Larkin, 2005). Adopting a family-centred approach to service delivery involves the inclusion of families in the planning, delivery, management, monitoring, and evaluation of their child’s treatment plan (Moore & Larkin, 2005). This represents a move in service from the professional being perceived as the expert, to instead placing an increased emphasis

on the values and desires of the families in a collaborative process (Department of Health and Children, 2003). Thus, the child's intervention should address the problems identified by the families themselves and thus the intervention should make sense to the client (Gilligan, 2000). As the primary goal of IMH is to support the parent-child relationship, it is important that practitioners are sensitive to what the family identify as their main concern or difficulty. This may not directly be related to their child, yet may be impacting on the quality of the relationship. Such environmental risks or stressors within the infant's systems may include parental health problems, economic difficulties, or a parent's own traumas (Shonkoff & Marshall, 2000). Intervention targeting these identified concerns within the ecosystem may reduce caregiver stress and thus indirectly affect the parent-child relationship.

Moreover, viewing IMH through an ecological systems theory lens can help identify factors that may promote and inhibit the security within the parent-child relationship (Coyl, Roggman, & Newman, 2002). By examining the infant's interaction with their various systems, potential risk factors that may be impacting on the relationship may be identified. These risk factors could include lack of social support for parents, violence within the community in which the child is living, or quality of community services available (Osofsky & Thompson, 2000). While highlighting potential areas of risk for an infant, an ecological perspective also lends itself to identifying protective factors, which can be important to consider for the child's future treatment plan. For example, a child's mesosystem may include a very dedicated set of grandparents or a highly trained childcare staff, which could be then utilised as a source of support for the family. IMH is often described as a strengths-based model (e.g. IMH-NG, 2015) therefore an ecological framework may be of particular relevance in identifying and fortifying these strengths as a pathway for intervention.

2.4.2 Attachment theory. One cannot discuss the theoretical foundations of IMH without reference to John Bowlby's (1980) theory of attachment. Attachment theory has provided a useful framework for evaluating both immediate and long-term effects of the caregiving relationship on development. Bowlby's original work took an evolutionary perspective, in that the infant's survival was based upon the proximity of a nurturing caregiver. This attachment relationship was founded upon the premise that an adult will respond in a warm, nurturing, and attentive way to the infant's signals. The

infant thus becomes confident that the caregiver will always meet their needs and feels safe and nurtured in the relationship, and can now feel free to explore and interact with the environment, using the caregiver as their “secure base” (Bowlby, 2008, p.11) . Attachment relationships are typically described as “secure” or “insecure” (Bowlby, 2008, p.9). Insecurely attached children who do not view their caregiver as this secure base, can display adverse social responses such as withdrawal, hesitation, or fear when engaged in their environment. This primary relationship between infant and caregiver helps the child to develop an internal working model of relationships, which acts as a blueprint for their social interactions as they grow and develop (Waters & Waters, 2006).

Mary Ainsworth was a student of Bowlby’s who developed an experiment to further explore and investigate this attachment relationship. Ainsworth (1969) and her colleagues observed a cohort of young mothers and their children on a monthly basis during the child’s first year, taking notes on the interactions between the mother and baby. Following this, Ainsworth and her team invited the mother-infant dyads into a lab setting when the child was 12 months of age. Here, they observed the mother and infant in four different circumstances. Firstly, they observed the mother and infant together in the room. After this, they watched how the infant responded when a “stranger” entered the room. Following on, the mother was asked to exit the room on her own, leaving the infant alone in the room with the stranger. Finally, they observed the interactions as the mother re-entered the room and was reunited with her child. This experiment became known as the “Strange Situation Paradigm”, and became a highly-influential piece of research in IMH. Observations of the responses and interactions of both infant and caregiver, led Ainsworth to identify attachment patterns of “secure” and “anxious”. The latter soon was categorised into “avoidant” and “resistant” attachment styles. Ainsworth proposed that a secure attachment was linked to a history of nurturing and responsive caregiving. On the other hand, mothers who were less responsive and sensitive to their child’s needs resulted in their infant developing an insecure attachment.

While having a secure attachment is an important protective factor in the life of an infant; it does not necessarily guarantee positive IMH (Balbernie, 2013). Additionally, there are several researchers who critique attachment theory. Field (1996) criticizes the evaluation of a child’s attachment by their response in a stressful situation

(e.g. Strange Situation experiment as mentioned in the above paragraph). Instead she argues that researchers need to instead begin to conceptualise attachment in a broader capacity through “observation of how the mother and infant interact and what they provide for each other during natural, non-stressful situations” (Field, 1996, p.543). Additionally, Slater (2007) suggests that adopting an attachment theoretical perspective for high-risk children could result in professionals viewing the case as a self-fulfilling prophecy by querying if any interventions could possibly eradicate the detrimental impact of their early experiences. Slater (2007) also proposes that professionals operating under attachment theory are providing an avenue to invoke maternal guilt in that she caused her child’s behaviours, as opposed to the theory providing an avenue for support. There also exist critiques in the literature regarding the cultural and ethnic applicability of attachment research, arguing that attachment theory and research is primarily based on the “Western middle-class conception of development” (Keller, 2013, p.187). For example, a study carried out by Grossmann, Grossmann, Spangler, Suess, and Unzner (1985) highlighted how studied children in Northern German displayed significantly more features of an insecure attachment, when compared to children in middle class American studies. On reflection, Grossman et al. (1985) argue that these behaviours could be attributed the fact that the qualities of independence and self-sufficiency are valued in the German culture and are therefore instilled in children in German child-rearing practices. Thus, practitioners and researchers ought to be cognisant that conceptualisations of attachment behaviours are best considered through a culturally-informed framework.

However, the value of attachment theory to the field of IMH is well established. Various IMH programmes or frameworks target parent-child attachment as the focus of their work, conceptualising attachment as the main developmental task for infants (e.g. Bain, 2014). Additionally, attachment theory has also had major policy implications for childcare practices (Rutter & O’Connor, 1999), hospital care for children, adoption protocols (Hersov, 1994), as well as legal proceedings (e.g. custody agreements; Slater, 2007). Empirical evidence has demonstrated how attachment theory can have practical implications throughout the lifespan, including the child’s peer relations (Seibert & Kern, 2015), aggression (Dallaire, & Weinraub, 2007), self-regulation (Pallini et al., 2018), and even academic outcomes (Maltais, Duchesne, Ratelle, & Feng, 2015). Overall, despite some critique in the literature, attachment theory continues to offer a

robust theoretical lens to view the parent-child relationship, as well as providing a focus for desired outcomes of any dyadic intervention work (Clinton, Feller, & Williams, 2015).

2.4.3 Psychoanalytic theory. The field of IMH itself, developed by Selma Fraiberg, had its original foundations in psycho-analytic theory. The practices developed by Fraiberg using this theory continue to be relevant to current IMH practices. The theory originates with the work of Freud in the 1940s. Freud categorised early development into six psychosexual stages, and proposed that events of the early years were central to personality and temperament as one progressed into adulthood. Like many other theorists, Freud stresses the magnitude of the mother-baby relationship as one that is “unique, without parallel” (Freud, 1938, p.188). Within this relationship, Freud describes the infant as being full of needs that require attending. The person who attends to these needs becomes known as the infant’s primary object, and enters into a need-satisfying relationship. This relationship forms a cornerstone for future relationships that the infant experiences as they go through life. When these needs are not met, the infant enters into a state of conflict. This conflict can resurface over the life span, having detrimental effects on them as they grow and develop.

A notable tenet of psychoanalytic theory that is prominent in many contemporary IMH approaches and frameworks is the idea that relationship patterns can be passed down from one generation to another (Lyons-Ruth & Zeanah, 1993). This was referenced by Fraiberg in her notorious “Ghosts in the Nursery” article, whereby she highlights how parents can unknowingly repeat the patterns of interaction they themselves experienced at infancy (Fraiberg, Adelson, & Shapiro, 1975). While most of these patterns can be ones of warmth and nurture, others may be violent, neglectful, or abusive. Thus, a psychoanalytic approach to IMH practice would incorporate an intergenerational approach, in order to assist a caregiver to reflect on their own history and predispositions as a means of identifying and adequately meeting their child’s signals. Additionally, psychodynamic theory also reflects the importance of the therapeutic relationship between the client and the therapist. This theory suggests that if the caregiver has the opportunity to experience a more nurturing and warm relationship with another, they in turn will foster this type of experience with their child. Fraiberg (1980) considers this the parallel process of working in an IMH context.

Nonetheless, psychodynamic theory has been met with criticism within the field. Some researchers and psychologists query the validity of Freud's evidence and techniques in his original studies, highlighting significant shortcomings in his methods as well as potential bias in the production of his findings (Greenberg, 1986). Others have critiqued the principles of psychodynamic theory, with some arguing that some of Freud's principles are contradictory or that his approach cannot be considered a theory due to lack of predictability and lack of falsifiability (Skinner, 1954). Nonetheless, Freud's theory did influence the key founder of IMH practice, therefore its legacy will continue to remain entrenched in the field of IMH.

It was Selma Fraiberg (1980), a social worker and psychotherapist, who originally coined the phrase IMH. Fraiberg and colleagues constructed a service that integrated approaches from a variety of fields including psychology, education, social work, nursing, paediatrics, and psychiatry. This service was originally considered for parents and their infants up to age two. The key aim was to help facilitate early attachment relationships and interrupt intergenerational cycles of adverse care patterns. Interventions usually took place in the family's home, resulting in the intervention being known as "kitchen table therapy" (Fraiberg, 1980, p.27). Within these home visiting sessions, professionals were enabled to observe the interactions between parent and infant, offer strategies and resources to support the infant's development, as well as provide a therapeutic context and environment for the parent to seek support. Fraiberg's model of service provision provided a blueprint for the development of future IMH programmes in a multitude of contexts and cultures.

2.4.4 Additional theoretical insights. The work of Erikson is another vital theory when discussing early development. Erikson (1980) provided a framework for conceptualising development, with a particular focus on the impact of social experiences across one's lifespan. This framework consists of 8 different stages of development, each culminating with the infant experiencing a "crisis" or a developmental task to be mastered. The resolution of these crises is dependent on the actions of the primary caregiver. For example, the first stage (and stage of most relevance to IMH practice) is entitled "Trust vs Mistrust". If a caregiver can provide the infant with warmth, security, and predictability they will develop trust, that being, a

sense of hope that the social world is a safe and secure place. If the care provided is inconsistent or inadequate, the infant learns “basic mistrust” and can withdraw from the social world. Interestingly, both Erikson and Freud recognised the adverse effects of an infant’s needs not being met, but also their needs being overindulged. Thus, Erikson (1950) argues that the child should learn “trust” and “mistrust” but in the right proportions in order to succeed in the social world.

A more recent theory building on the mother-infant relationship was Daniel Stern (1995), who coined the concept of the “motherhood constellation”, that being, a series of challenges that a new mother faces when adapting to the care of her young baby. The first challenge or concept is the life growth theme, whereby Stern questions the new mother’s ability to sustain and support her child. Secondly, Stern queries primary relatedness and the new mother’s capacity to enter into a nurturing relationship to protect and comfort her baby. The third challenge comprises the mother’s capacity to utilise the support networks around her to help her during this new period of her life. The final theme or challenge is identity reorganisation. This theme queries the mother’s ability to assimilate her other identities as a wife, daughter, professional etc. into her new role as a mother. These four challenges or themes offer an interesting and unique insight into the mother-infant relationship and highlights how difficulties overcoming any of these challenges can put the relationship at risk. Stern suggests that through the mother’s experiences of this new relationship, old memories of her own early experiences can be awakened and can affect how she cares for her own child. In light of this, Stern (1995, p. 199) emphasises the use of parent psychotherapy as a cornerstone in IMH programmes, so this “present remembering context” can be used as a medium for change and transformation for the current mother-infant relationship.

2.5 Frameworks for Practice in IMH Service Delivery

In order to operationalise these theoretical perspectives into a psychologist’s casework, frameworks for practice are recommended as an essential professional resource in IMH (MacKay et al., 2016). As IMH is an emerging concept in psychology practice, it is argued that there are relatively few practice frameworks for practitioners to choose from. However, since the establishment of IMH, three key frameworks have emerged in the literature and will be subsequently discussed.

2.5.1 Fraiberg's (1980) framework. In addition to coining the term IMH, Fraiberg's legacy also provides a blueprint for IMH service delivery (Fraiberg, 1980). This framework consists of five key principles that are considered fundamental to practice of IMH (as summarised by Weatherston, 2012).

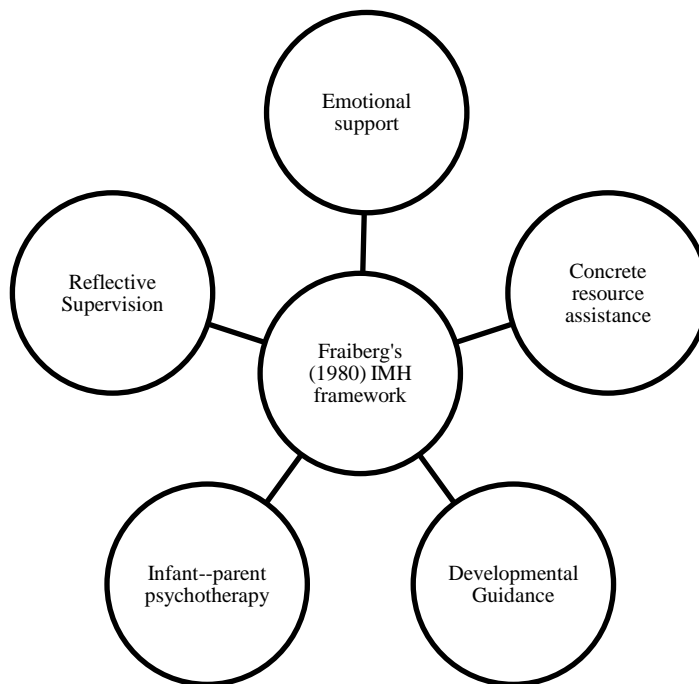


Figure 1: Fraiberg's (1980) IMH Framework

- *Emotional support:* This principle refers to a practitioner's role in listening, responding, and empathising with a distressed parent who is having difficulties in caring for their young infant.
- *Concrete resource assistance:* This principle involves meeting the family's basic needs of food, clothing, and housing. It is envisaged that by meeting these needs, the family will have more adequate mental and emotional resources available to care for their infant.
- *Developmental guidance:* This principle is concerned with the collaborative understanding of the infant's strengths and needs, according to their developmental stage. Through observation and simple language, the practitioner reflects on the child's behaviour and highlights notable qualities, characteristics, and identified needs that the child may be displaying.

- *Infant-parent psychotherapy*: This principle involves providing the parent with a space to reflect on their own thoughts and feelings that are evoked when in the presence of their child. This may provide parents with an opportunity to share their experiences of becoming a parent and may identify unresolved losses or traumas that may be impacting on their relationship with their new infant.
- *Reflective supervision*: This principle identifies the need for IMH practitioners to engage in their own supervision to share their thoughts and feelings about working with families in a potentially emotive, poignant, and evocative framework of practice.

2.5.2 Weatherston's (2012) IMH framework. Weatherston (2012) expanded on the principles outlined by Fraiberg (1980) by categorising IMH services along a continuum of promotion, prevention, intervention and treatment. A model of this framework can be found in Figure 2.

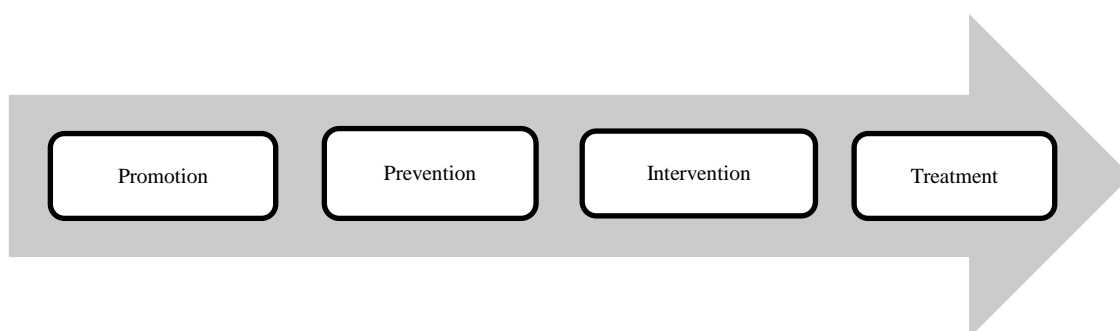


Figure 2: Weatherston's (2012) IMH framework

- *Promotion*: This component of the framework comprises education and training initiatives to promote the importance of IMH in the general public, as well as highlight general strategies and practices for parents to incorporate to support the emotional wellbeing of their infants.
- *Prevention*: This strand is concerned with the early identification of at-risk infants. This may be through use of screening assessments by health clinicians or placement in early intervention programmes to reduce the risks of adverse outcomes.
- *Intervention*: The Intervention aspect of the model regards providing targeted educational or psychotherapeutic strategies to the parent-infant dyad. Weatherston (2012) outlines that this stage of the model involves providing concrete resources assistance, emotional support, and developmental guidance.

- *Treatment*: This level of the model regards cases of high risk, including parents who have received a psychiatric diagnosis or have experienced a recent trauma. This level includes many of the features of the intervention stage, yet may warrant a multidisciplinary perspective or may require onward referral to relevant agencies (e.g. adult mental health).

2.5.3 Ahlers, Gilkerson and Onunaku's (2006) framework A comprehensive tiered approach to service delivery was identified by Ahlers et al. (2006). This model incorporated a macro-level perspective, highlighting the need for a policy focus within IMH frameworks. This approach can be found in Figure 3, and consists of five areas of support.

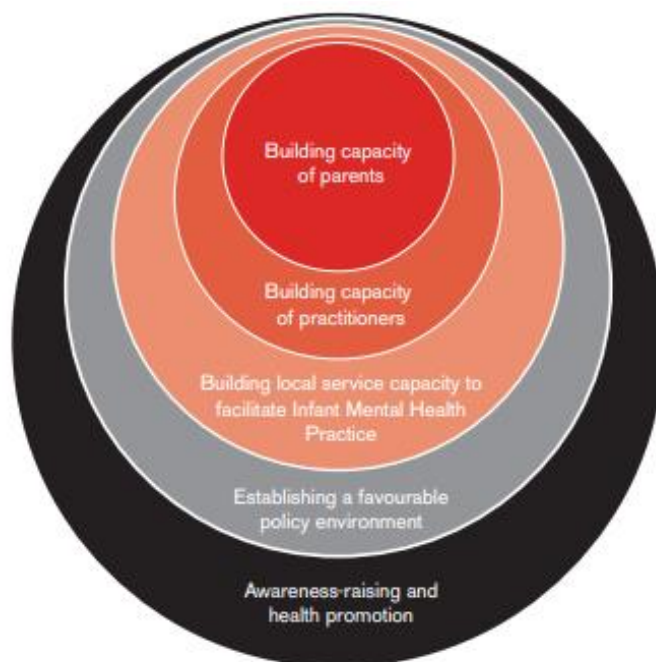


Figure 3: Ahlers et al.'s (2006) IMH framework

- *Building capacities of parents*: Central to the framework is the need to build parents' skills and confidence in their abilities to care for the social and emotional development of their children. Suggested activities at this level include information sessions for parents on topics such as post-natal depression, structured parenting programmes, or the establishment of baby development clinics that can offer consultations to parents if they have concerns regarding their infant.

- *Building capacities of practitioners:* This aspect of the framework concerns upskilling other practitioners within the service, to develop their competence in incorporating IMH principles into their work. This may be achieved through study groups, in-service trainings, or through reflective supervision.
- *Building local service capacity to facilitate IMH practice:* Developing on the previous point regarding building capacities of other team members, Ahlers et al. (2006) also emphasise that an effective IMH approach builds capacity among professionals in other relevant local services (e.g. Family Resource Centres, local crèches).
- *Establishing a favourable policy environment:* This aspect of Ahlers et al.'s (2006) framework concerns activities and efforts to integrate IMH principles into local, regional, and national policy change. These activities may include creation of position papers or engaging in small-scale research to inform policy makers.
- *Awareness-raising and health promotion:* The final layer to Ahlers et al.'s (2006) framework regards the promotion of the importance of IMH across statutory, education, judicial, and community services. Efforts at this level to promote IMH principles may direct campaigns at relevant policy makers, or specific government bodies.

2.6 The International Context of IMH

Prior to discussing current IMH practices and policies in an Irish context, it may be pertinent to first explore the IMH practices from an international perspective. In the past twenty years, there appears to have been increased interest in “shifting the balance” from intervention to prevention work with young children across international research, policy, and practice (Dunlop, Carwood-Edwards, Delafield-Butt, Ludke, & Lux, 2014, p.13). From a research perspective, reviews of the literature for the purpose of the current study highlight the international interest in the area of IMH. Of the top ten Cochrane systematic reviews of the literature pertaining to the search term “Infant Mental Health”, data was evaluated from a variety of nations including America, China, the United Kingdom, Scotland, and Australia. Research is also being disseminated internationally through various not-for-profit organisations, such as The World

Association of Infant Mental Health (WAIMH). The WAIMH is dedicated to the promotion of the “mental wellbeing and healthy development of infants throughout the world, taking into account cultural, regional, and environmental variations” (Peters & Silvestri, 2013, p.2). This organisation organises international congresses in IMH, sponsors the “Infant Mental Health Journal”, establishes task forces in IMH, and maintains an information repository website.

From a policy perspective, it is argued that government policy internationally is progressively recognising the importance of early intervention and the need for evidence-informed approaches to support vulnerable children and caregivers (Barlow, Bennett, Midgley, Larkin, & Wei, 2015). Peters and Silvestri (2013) have collated a document that summarises key policy data pertaining to IMH from a range of countries. For example, the Scottish government have embedded IMH principles into their policy framework “Towards a Mentally Flourishing Scotland” (Scottish Government, 2009). One of the key commitments within this policy is to “focus on infant mental health improvement” by improving the skills and knowledge of professionals in the Scottish healthcare system. (Scottish Government, 2009, p.20). Moreover, the Australian government present a similar commitment in their “Roadmap for National Mental Health Reform 2012-2022” (Council of Australia Governments, 2012). In this policy document, strategies are suggested to build the “competency of early childhood and education workers and institutions to identify and respond effectively to early signs of mental health issues” (Council of Australian Governments, 2012, p.23). Having government recognise the importance of IMH and early intervention on an international basis is a positive step within the field.

Similar to Irish practice, many international countries do not have specialised IMH services, yet attempt to address this gap through implement IMH into primary care services (Tsiannis, 1998). Moreover, discrete pockets of IMH work are being carried out on an international basis, funded by relative national bodies. One such project being carried out in Denmark is “The Copenhagen Infant Mental Health Project” (Vaeber, Smith-Nielsen, & Lange, 2016). This project consists of activities to promote the understanding of IMH among Danish professionals, screen young children for potential mental health difficulties, and deliver a range of evidence-based interventions such as Circle of Security (Vaeber et al., 2016). Similar local initiatives are taking place in other

countries, including the United Kingdom. For example, a partially government funded initiative entitled “Little Minds Matter” is currently being rolled out in the Bradford area (Dickerson et al., 2019). This project offers specialised training and therapeutic intervention from the perinatal period until children are two years of age, that live in the locality (Dickerson et al., 2019). These initiatives taking place in a variety of countries are both admirable and desirable, yet concerns regarding funding could put the longevity of said programmes into question.

2.7 The Current Status of IMH in Ireland

2.7.1 A policy perspective. Whilst currently Ireland does not have specific IMH policies or dedicated IMH services (PSI PIMHSIG, 2015), there are several positive movements taking place. In the past decade, a range of Irish legislation and strategy documentation has been developed, which has advocated for intervention at the earliest possible point in a child’s life. The Vision for Change policy paper (Government of Ireland [GOI], 2006) details a comprehensive framework for building and fostering positive mental health across the entire community in Ireland. A key recommendation of this paper is that “programmes addressing mental health promotion and primary prevention early in life should be targeted at child populations at risk” (GOI, 2006, p. 85, 10.4). They note programmes such as “Community Mothers” programmes and “Life Start” schemes as examples of supporting at-risk children in infancy. Additionally, they highlight the need for special attention to be given to children whose parents suffer from mental health difficulties, and that links between adult mental health and child mental health teams need to be reinforced. While this document came to the end of its ten-year term in 2016, an Oversight Group has been established to review and update the existing mental health policy, which will hopefully include a focus on early intervention and both perinatal and infant wellbeing.

An expert advisory group, convened by the Early Years Strategy (as part of the Department of Children and Youth Affairs), published a report detailing guidelines and recommendations to support the development of a national strategy and policy. Within this report, the advisory group noted that they viewed their task as addressing the “needs and opportunities of every child in Ireland from 0 to 6 years of age, encompassing the health of the mother during pregnancy” (Early Years Strategy, 2013, p.1). This

document proposes five “peaks” to be reached over a five year period, including increased investment in early years services, extended parental leave, and increasing governance and accountability among services. Additionally, the report advises integrated Child and Family and Primary Care teams, to provide support for parents and children from the ante-natal period through to the early years. They suggest that this service can provide more targeted support for children and families of high risk and with more complex developmental needs.

A model of care for Perinatal Mental Health was outlined in a recent document published by the HSE (2017b). Within this model, it is recommended that specialist perinatal mental health services are aligned with hospital groups, to provide support to mother-infant dyads through pregnancy and early infancy. They propose that this service operate on a “hub and spoke” basis, whereby the maternity service with the highest number of deliveries acts as the hub or base for the perinatal mental health team. The report recommends that this team is led by a consultant psychiatrist, and includes professionals from mental health nursing, psychology, occupational therapy, and social work. Nearby hospitals would act as the spokes in this model, which are linked with the specialist perinatal mental health team for trainings, consultations etc., yet still receive perinatal care from the consultant psychiatrist as usual. Services provided by the hub team, as outlined in this document, include offering clinical advice, providing education or training to other staff, as well as providing discipline specific services to at risk mothers and infants. Whilst this model of care, in theory, offers a relatively efficient method of implementing perinatal mental health care in hospitals in Ireland, post-discharge services are only provided up to six weeks. This model of care is currently being implemented in Cork, Limerick, Galway and Dublin with a review and evaluation of the model expected in the near future.

The most recent, and perhaps most relevant, government policy document is the “First 5 Strategy” (Department of Children and Youth Affairs, 2018). This national strategy is considered one of Ireland’s first ever cross-Departmental strategy to support babies, young children and their families (Department of Children and Youth Affairs, 2018, p.). The strategy encompasses a ten-year plan with the aim of ensuring children aged zero to five have positive early experiences (GOI, 2018). This document has its foundations in the broader policy “Better Outcomes, Brighter Futures”, which is a

national policy framework for children and young people (2014-2020) which set out an agenda across Government to improve outcomes for children and young people. The First 5 Strategy has been developed and informed by the Early Years Strategy's Report of the Expert Advisory Group and presents a number of proposed actions to fill gaps in current provision. There is a particular focus on children aged between birth and three years old, making it of particular relevance to the current study. In fact, one of the key goals that the strategy aims to promote includes "optimal physical and mental health" for these children (GOI, 2018, p.28). Within this goal, there is a particular objective; "for babies, young children and their parents to enjoy positive mental health" (GOI, 2018, p. 74). This objective recognises the value of mental health of parents and, in turn, their infants. The strategy calls for actions to be taken to support early identification of mental health difficulties and provide suitable services to support and promote early childhood mental health. Some examples of such actions include expanding the capacities of community CAMHS teams, carrying out public information campaigns to raise awareness of the importance of promoting social-emotional development, and including a social-emotional measure in the two-year developmental checks for all children (GOI, 2018). This national strategy, although only recently launched, provides a positive step forward in expanding Irish policy to include IMH.

2.7.2 Current IMH practices in Ireland. Although IMH practice is an emerging area for psychology in Ireland (PSI PIMSIG, 2015), several local and national programmes have developed in recent years. Said programmes, which will be outlined below, include promotional initiatives, early intervention and prevention initiatives, as well as training and development initiatives.

2.7.2.1 Promotional initiatives. A noteworthy promotional initiative has recently been developed by the Irish Government. The "Nurture Programme – Infant Health and Wellbeing" (HSE, 2018) is the first national programme delivered by the HSE, to provide services and professional supports to parents and infants from birth to three years of age. This programme is set to be integrated into the existing national child health programme in Ireland, and aims to build on existing services to promote the overall health and wellbeing of the child. With particular reference to IMH, the programme aims to provide information to the public on concepts such as baby

bonding, parent-child communication, and supporting the child's early learning and development. The implementation plan for this programme will consist of an explicit "infant mental health and supporting parents" team to provide IMH services. Although this is a timely and highly necessary national programme, it is still in its infancy. Services provided by the Nurture programme to date include a beta website providing information and resources for parents of children aged 0-3 (www.mychild.ie), as well as the development of a Child Safety Programme. Of most relevance, the Nurture programme recently produced a book that all parents will be provided with by their public health nurse (HSE, 2018). This book contains information about bonding with your baby, identifying post-natal anxiety and depression, as well as tips and ideas to support positive social and emotional development (HSE, 2018). Despite being a recent advance, having this information being delivered nationwide is a positive movement, which will provide parents with a concrete resource to support them and their new baby (HSE, 2018).

As well as national programmes, local promotional initiatives are also taking place across Ireland. A UNICEF-promoted, international campaign entitled "Building a Happy Baby" (UNICEF, 2014) was recently introduced in Co. Galway by the Early Years Subgroup of Galway Children and Young People's Services Committee. This campaign consists of four take-home messages to promote IMH, centring on the premise that communication and responding to the baby's needs are paramount to attachment and wellbeing. These messages include (1) "New babies have a strong need to be close to their parents, as this helps them to feel secure and loved, like they matter in the world!" (UNICEF, 2014, p.2); (2) "Holding a baby when they cry helps them to grow into a confident and trusting toddler" (UNICEF, 2014, p.5); (3) "Holding, smiling and talking to your baby releases a loving hormone in you and your baby. This makes you both feel calm and happier" (UNICEF, 2014, p. 2); (4) "Keep your baby close to you so that you can learn how to meet their needs and read their signals for hunger or comfort" (UNICEF, 2014, p.5). Within this Galway based programme, all new parents receive a copy of the key messages. These messages have also been translated into a number of languages. This campaign also has these messages displayed on posters in various family-frequented locations such as maternity hospitals. Overall, the importance of IMH and the implementation of IMH-based programmes are gaining traction in

Ireland, both at local and national level and will hopefully continue to progress and develop in coming years.

2.7.2.2 Prevention and early intervention initiatives. Although our national programme is at an embryonic stage, there are a range of local community initiatives specifically focusing on IMH that have demonstrated impressive uptake and efficacy. One such programme is the “Ready Steady Grow (RSG)” programme provided by the prevention and early intervention service “YoungBallymun”. The aim of RSG is to improve wellbeing among infants aged 0-2 in the Ballymun area in Co. Dublin (YoungBallymun, 2012). Some services that RSG provide in relation to IMH include antenatal classes, mom and baby play groups, training seminars for other professionals, and parent workshops. A recent evaluation of the RSG programme noted that the initiative made good progress in fostering collaboration with organisations and in building IMH capacities with other professionals. Additionally, it was noted that the RSG programme was enhancing the early identification and onward referral of children with serious IMH risks (YoungBallymun, 2012). The RSG previously ran a parent-child psychological support group, however this is no longer being offered within the service due to financial cutbacks. This might lead us to infer that while community initiatives have the energy and resources to engage in IMH work, the lack of financial and managerial support is infringing on the efficacy of these programmes.

A similar community-based initiative taking place in County Limerick, is the “ABC Start Right” programme being funded by the Paul Partnership (2015). ABC Start Right is an early intervention and preventative programme providing services to parents and infants from the antenatal to six year period (Paul Partnership, 2015). A key feature of this programme is the community wraparound process to ensure children in the antenatal to 3 years age-group and their families have access to integrated services, with the overarching aim of improved outcomes in health, social and emotional behaviour (Paul Partnership, 2015). Within this community wraparound approach, the ABC Start Right team have recently hired an “Infant Mental Health and Well Being Specialist”, in response to a noticed gap in the programme. The responsibilities of this IMH and Well Being Specialist involves providing training and specialist IMH information to parents and professionals, to provide mentoring and consultation to local practitioners on IMH theory and practices, and to promote IMH across all community-based services (Paul

Partnership, 2015). However, there is no information to date on the success of these newly introduced posts, or details on the efficacy of IMH practices being provided by this service. It is suggested that it will be important for the programme to complete some evaluative research on the service, in order to justify investments to stakeholders and ensure the sustainability of the programme.

2.7.2.3 Training and development initiatives. A notable IMH initiative that originated in County Cork is the development of “Infant Mental Health Network Groups” (IMH-NG). These network groups consist of a network of professionals involved in providing services to young children aged 0-3 and their families (IMH-NH, 2015). These groups came about following an observation among practitioners in Primary Care psychology regarding the increased number of referrals from parents regarding the social and emotional development of their young child. Additionally, they noticed a gap in service delivery for IMH practices, as well as an overall need to build a workforce with the knowledge and skills to respond to infants, toddlers and families. These practitioners developed a programme to equip other professionals to identify and support the IMH of young children and their families. This programme consisted of masterclasses being delivered to frontline professionals, with follow-up monthly meetings of the network group. Within the network group meetings members are encouraged “to share experiences, transfer knowledge and to develop a cross-disciplinary perspective on IMH theory and practice and their integration into service delivery across the community” (IMH-NG, 2015, p.5). An evaluation of this programme highlighted positive findings regarding members’ knowledge of IMH theory and research, improvements in clinical skills, as well as changes in model of service deliveries these professionals previously provided. However, significant challenges did emerge from these findings that challenged the efficacy of the groups. The challenges participants referred to included finding the time to attend these groups, accurately disseminating the content of the network groups back to their own local teams, and the difficulties in keeping up with new terminology discussed in the meetings (IMH-NG, 2015). Yet, despite these challenges, it is argued that the efforts of these network groups in addressing disparities in levels of training among relevant professionals is commendable, and ought to be considered as one of Ireland’s most progressive movements in IMH practice.

2.8 Purpose of the Systematic Review

This chapter to date has focused on a review of the literature on IMH theory, research, and practice, with a particular emphasis on IMH in an Irish psychology context. It is now pertinent to review the empirical evidence on IMH, as related to the current study. A systematic review of the literature was conducted prior to engagement in the research process, in order to synthesise existing knowledge as well as identify potential research gaps (Robinson, Saldana, & McKoy, 2011). By identifying gaps in knowledge or information within the literature, it is envisaged that this study will be an example of “evidence-based research” (Robinson et al., 2011, p.1328).

2.9 Research Strategy

Two discrete questions guided the systematic review for the current study.

1. *What do we know about effective IMH services?*

The results of this view highlighted a gap in the literature, which led to a second search strategy to be conducted on a more specific aspect of IMH service.

2. *What do we know about the role and activities of the psychologist when working in IMH contexts?*

This phase of the literature review aimed to explore the literature on the nature of the work undertaken by psychologists when working in an IMH framework.

2.9.1 Search strategy 1: What do we know about effective IMH services?

A comprehensive literature search was carried out in July 2017 of two databases: “Google Scholar” and “Psycharticles”. The timeframe for the studies to be considered was between 1980 and 2017. The term “Infant Mental Health” was initially defined by Selma Fraiberg in 1980, therefore the years following this would be the most pertinent time frame to examine this concept (Fraiberg, 1980). The search terms used were “infant mental health” “service” “model” “professional” “psychologist” “practitioner”. Initial screening of titles and abstracts, using predetermined inclusion and exclusion

criteria, yielded a total of 26 articles identified as being potentially suitable for review. These studies were retained and the full article text was subsequently examined. The inclusion and exclusion criteria were then systematically applied to these articles, whereby 5 studies were then identified as being suitable for the purpose of this review. Detailed elaboration of the inclusion and exclusion criteria, as well as justification for same, can be found in Appendix B.

2.9.2 Search strategy 2: What do we know about the roles and activities of the psychologist when working in IMH contexts? The second wave of the systematic review was carried out in August 2018 of two primary databases: “Psych Articles” and “Academic Search Complete”. The search terms used included “infant mental health” “psychologist” “intervention OR therapy OR strategies OR treatment OR programme”. The timeframe was limited to articles produced in the last ten years, to ensure up to date and relevant information. An additional search using the term “psychologist” or “service” was carried out in the *Infant Mental Health Journal*, with the same time parameters applied. Having reviewed the titles and abstracts of the articles gleaned from this search strategy, 21 articles were retained for review. These 21 articles were subsequently read in full and specific inclusion and exclusion criteria were applied to same. Again, more detail on the inclusion and exclusion criteria used can be found in Appendix B.

2.10 Criteria for Evaluating the Quality of the Literature

Having identified several papers of relevance to the two review questions, specific steps were undertaken to ascertain the quality and relevance of the literature. This process subsequently led to a judgement as to whether the study was included in the literature review.

The following steps were employed:

- The title and abstract was read to initially ascertain whether the article was of relevance to the review question.
- The inclusion and exclusion criteria were applied to the article
- The paper was read and notes were taken to evaluate the quality of the literature using Gough’s (2007) “Weight of Evidence” framework as a guide (Appendix C).

- The paper's methodology was appraised using specific coding protocols in accordance with the study's methodological choices, where relevant (Appendix D/Appendix E).
- The paper's conclusions were considered in light of methodological quality, methodology relevance, and appropriateness to the review question.
- A decision was made on the papers inclusion in the literature review, in light of the papers and weighting it received.

2.11 Review Question 1: What do we know about effective IMH services?

Following a thorough search of relevant databases and application of inclusion and exclusion criteria, five articles were highlighted as being of most relevance for the current review question. The small number of relevant studies is of note in itself; pointing to the novelty of this field in practice and the need for increased empirical research in the area. However, the limited number of available articles for inclusion is also acknowledged as an overall limitation of this systematic review. Of the five articles deemed appropriate for further examination, four studies were chosen to be included in this literature review. These four studies demonstrated sufficient methodological quality and topic relevance for inclusion, having obtained an overall score of "medium" across Gough's (2007) Weight of Evidence Criteria. One study that obtained an overall weighting of "low" was excluded from this literature review (Osofsky et al., 2007) as it lacked the methodological and topic relevance considered appropriate for this review. Results from all studies indicated several factors associated with effective IMH service provision. The findings of these studies were thematically organised by the researcher into two categories: "characteristics of effective IMH services" and "barriers to effective IMH services".

2.11.1 Characteristics of effective IMH services.

2.10.1.1 Therapeutic relationship. A notable element to effective services, from the perspective of service users, is the therapeutic relationship between service user and clinician. Studies included in the review noted how qualities such as effective listening, empathy, patience, non-judgemental stance, as well as the ability to create a "safe space" all contributed to the development of a positive relationship with clinicians

(Myors, Schmied, Johnson, & Cleary, 2014, Coates, Davies, & Campbell, 2017). Many of these qualities are also reflected in a range of psychological theory and literature (e.g. Rogers, 2000), emphasising their importance and effectiveness. One study emphasised the importance of the therapist displaying these qualities from the first point of contact, as one participant recalled a negative experience initially contacting a service, which thus deterred her from attending any subsequent meetings or therapy sessions (Myors et al., 2014). Another interesting finding from one study regards the value participants put on the therapist maintaining professionalism within the relationship. While participants noted how the clinician “was like a friend” (Coates et al., 2017, p. 93), they also valued the boundaries and safety of the professional relationship. This confiding relationship is an essential ingredient in providing effective services, as it is suggested that mothers who have a trusting relationship with their clinician are more open to adopting strategies than mothers with less trusting relationships (Corr, Rowe, & Fisher, 2015).

2.11.1.2 Facilitating empowerment. Another facilitator when working in IMH contexts concerned the clinician’s ability to foster empowerment in their clients (Myors et al., 2014; Coates et al., 2017). Myors et al.’s (2014) study noted how participants felt more confident as a mother or parent following support from the service. Coates et al. (2017) mirror this finding, with participants reporting that their experience with the service increased their confidence in seeking assistance when needed. This confidence was further enhanced by enabling parents to set their own goals and targets and make their own decisions (Coates et al., 2017). The concept of empowerment in parenting is something well documented in the literature and should be incorporated in all aspects of service provision (e.g. Nachshen & Minnes, 2005).

2.11.1.3 Effective communication. Effective communication was considered a vital component of perinatal and IMH services in studies included in this review. Having clear mechanisms for communication between clinicians fostered a more fluid approach to multidisciplinary working (Myors, Cleary, Johnson & Schmied, 2015; Macdonald et al., 2005). This communication may be either face-to-face or using communication tools such as email or skype calls. Multidisciplinary review meetings, joint working with other agencies, and case conferences were suggested as some effective ways to enhance communication both within team and with other agencies. Clear communication pathways ensure that knowledge is effectively disseminated in

order for clinicians to make informed decisions and actions, and is referred to in the literature as “one of the most critical goals of organisations” (Guo & Sanchez, 2005, p. 91).

2.11.1.4 Service flexibility. A final element of effective IMH services is flexibility. Some service users highlighted how if the clinician was not able to come to their home, they would not have been able to attend any appointments (Coates et al., 2017). Community outreach and home visiting were noted as strengths to service provision in MacDonald et al.’s (2005) study also. Delivering IMH related services in an infant’s own home is in-fact considered more effective, as it enables the clinician to view the parent -child interactions and activities in their most natural environment (Fraiberg et al., 1975). This outreach programme is something to consider for future service delivery, as it makes services more accessible to parents and may address some of the power imbalance some parents may feel (Dumbrill, 2006).

2.11.2 Barriers to effective IMH services.

2.11.2.1 Lack of training in IMH. A key barrier to effective IMH services identified in included studies regarded the lack of funding and training available for professionals in order to implement IMH principles (Macdonald et al, 2005; Coates et al., 2017). Participants in one study felt compromised as they did not feel confident in delivering interventions focusing on parent-child attachment or early relationship support. Thus, these professionals tended to focus more so on parenting skills and infant physical development. As a result, a large proportion of the services treated the parent and child separately, and had limited joint programmes. The relationship between the primary care giver and child is the core of successful attachment and a cornerstone for IMH. Therefore, in addressing parent and child in separate treatment plans, the service is overlooking the key relationship that requires support.

2.11.2.2 Premature discharge from service. Another significant barrier to effective IMH service provision regards premature discharge from the service. This was reflected in Myors et al.’s (2014, p.273) study, in their finding entitled “swimming or stranded: Feelings about leaving the service”. Many women service users felt they were not ready to be discharged from the service, thus resulting in feelings of anxiety and

isolation (Myors et al., 2014). This was also reflected in MacDonald's study (2005) as service providers interviewed stressed the need for sufficient duration of intervention to ensure an effective service. Akin to many other health services lengthy waiting lists and lack of funding resulted can result in patients being discharged from services prior to them being ready for same which can have a detrimental impact on their progress.

2.11.2.3 Ineffective collaboration. The concept of collaboration was noted in several studies as a potential barrier to effective services. Collaboration between services within the literature has been deemed important (e.g. Schmied et al., 2010), yet Twomey, Byrne and Leahy (2014) caution that collaboration does not always lead to positive outcomes. For example, in Myors et al.'s (2014) study, clients reported how they felt "bombarded" with information from different professionals (Myors et al., 2014). Parents and children attending a PIMH service may not wish to be receiving services from a big team. Instead, they may prefer small known team in order to avoid replication of information and loss of potential intervention time (Myors et al., 2015). From the perspective of clinicians, the need for enhanced collaboration was a high priority. For example, in MacDonald et al.'s (2005) study over 79% of service providers advocated the need to foster collaboration within and between services, and foster inter-agency links. In Myors et al.'s (2015) study, there were mixed findings with regards collaboration. Some professionals noted that their service did adopt a collaborative approach, yet others noted how they "sit in silos" and trust that other professionals are doing their part.

2.11.2.4 Lack of role clarity. A proposed reason for the difficulties in collaboration, therefore, may be presented as a lack of awareness of the function of PIMH services and the roles of various PIMH clinicians. Within Myors et al.'s (2015) study, a lack of role clarity was presented as a sub-theme within their findings on collaboration. Service providers interviewed noted how other services do not understand the role of the PIMH service, and how they do not understand the roles of other services (Myors et al., 2015). This confusion about what different services provide and look like, can result in fragmented care and unsuccessful collaboration. Additionally, Myors et al. (2015) also note that there appears to be confusion about the role of the different clinicians in an IMH team in case management for both themselves and for their clients, with some participants noting that she was referred to a professional but she wasn't sure

what the “service person was supposed to be doing so it was a bit confusing” (Myors et al., 2015, p. 8). Previous literature also notes that for collaboration to be truly successful, professions need to respect and understand each other’s roles and skills (Schmeid et al., 2010)

2.12 Review Question 2: What do we know about the role and activities of the psychologist working in IMH contexts?

In light of the findings from Search Strategy 1, a more detailed and focused review question was included in the systematic review: “*what do we know about the role and activities of the psychologist working in IMH contexts?*” As highlighted in the previous review question, a lack of role clarity was noted as a barrier to effective IMH service provision. Thus, this study aimed to review the role of the psychologist in IMH, to elaborate on this finding in more detail.

Following an in-depth search of databases “Psych Articles”, “Academic Search Complete”, and the “Infant Mental Health Journal”, it became apparent that there was no empirical data on the role of the psychologist in IMH contexts. That being, no studies have previously researched functions, responsibilities, perceptions, or activities of the psychologist in IMH contexts. In light of this, the review focused on empirical articles that involved a work activity of a psychologist, in an attempt to elucidate the roles of the psychologist. Said articles included randomised control trials of particular interventions, or evaluation of a particular assessment tool. However, similar to the previous wave of this systematic review, only a small number of articles were considered appropriate for inclusion (eight in total). This small sample size of suitable articles may question the validity and credibility of the findings of this review. Therefore, it is recommended that the findings of this systematic review ought to be considered and evaluated in light of this limitation.

Having explored said databases, 8 studies were chosen for inclusion. These studies provided an insight into a psychologist’s involvement in services supporting the social and emotional wellbeing of infants aged 0-3. Psychologists’ activities were subsequently grouped thematically. Themes included “provision of psychological intervention”, “assessment of social and emotional functioning” and “consultation in the

context of supervision”. However, it is acknowledged and understood that in practice, each work task undertaken by psychologists cannot adequately be categorised into an isolated role/activity. Instead, many of a psychologist’s tasks will interweave a variety of different roles and activities (i.e. a psychologist engaged in a training activity may be involved in pre/post assessment. Similarly, an intervention piece may consist of a number of parent consultations, etc.).

2.12.1 Provision of psycho-therapeutic intervention. Many studies encountered during the selection of articles for this review question involved the psychologist providing psychological intervention for parents and young children. Said interventions may include group psychotherapy to mother-infant dyads (Bain, 2014) or use of developmental guidance strategies (Aspoas & Amod, 2014). The overall aims of the interventions within these studies were to enhance the reflective functioning of the parent in an attempt to foster positive interactions with their child. This aim is reflected in the broader research on IMH (Zeanah & Zeanah, 2009) and is also mirrored in many IMH frameworks (e.g. Fraiberg, 1980). However, both studies employed a small sample size and did not provide any triangulation of data (Bain, 2014; Aspoas & Amod, 2014). Additionally, in one of the studies the psychologist facilitating the intervention was also the author of the study, which could lead to a risk of bias within findings (Aspoas & Amod, 2014). Therefore, while these studies shed a light on the type of intervention work psychologists may engage in within IMH contexts, the effectiveness of this intervention work ought to be interpreted with caution.

2.12.2 Psychometric assessment. A notable activity of the psychologist when providing services to young children and their families comprises assessment of a variety of IMH variables. Said variables may include assessment of the parent-infant relationship (Broughton, 2014), assessment of the child’s development, or assessment of current parenting skills (Ostler, 2010). Included studies alluded to several reasons for the use of psychometric assessment at this young age. Firstly, assessments may be used in individual case work as a means of gathering baseline data (Ostler, 2010). Secondly, psychometric data may provide clarification in discriminating between two potential conditions; a process entitled “differential diagnosis” (Ben-Sasson, Cermak, Orsmond, Carter & Fogg, 2007). Finally, assessment data may be warranted at this early stage to ascertain eligibility for early intervention services (Smith, Akai, Klerman, & Keltner,

2010). Interesting findings from the included studies indicated that while psychologists engaged in assessment activities, the psychometric tools they used often were not limited solely to psychologists. This would suggest that assessment screening of high risk children is a role for all healthcare providers. However, an interesting finding of Smith et al. (2010) highlighted how children who enter early intervention services often have not been previously identified by other professionals as having any developmental problems, despite having engaged with other clinicians since a young age. This raises concerns regarding the knowledge of other professionals on atypical development and questions the utility and efficacy of the use of these IMH screening tools in disciplines other than psychology.

2.12.3 Consultation in the context of supervision. Several articles derived from this search strategy report on the involvement of psychologists in consultations with other professionals. More frequently, these consultations were delivered in the form of supervision, also entitled reflective consultation (Harrison, 2016). This reflective consultation was facilitated through group sessions with professionals from alternative disciplines (e.g. occupational therapy, social work) or else through individual supervision (e.g. supervision of clinicians engaged in a home visiting programme) (Baradon & Bain, 2016; Harrison, 2016; Watson, Baily & Storm, 2016). Findings from included studies highlight how this collaborative and reflective process, facilitated by the psychologist, resulted in reduced feelings of isolation, increased ability to notice one's own biases, and enhanced confidence. However, while these studies highlight the psychologist's involvement in reflective consultation, it must be noted that in many of the samples there was only one psychologist supervisor. Thus, this role in reflective consultation or supervision may not be solely the preserve of the discipline of psychology.

2.13 Summary

This literature review began by clarifying the link between IMH and the practice of Educational and Child psychology, followed by an overview of the theoretical underpinnings of IMH. Subsequently, an insight into IMH in an Irish context was provided through detailing relevant policy documents and local and national IMH practices and services. Interestingly, although government policy documents clearly

advocate for intervention at the earliest point of a child's life, the reality is a disjointed and sparse approach to IMH in health care in Ireland. However, local initiatives have demonstrated many positive findings, and should be considered a catalyst for more wide-spread IMH initiatives from both government and community bodies.

A systematic review was subsequently carried out, and a summary of included studies can be found in Appendix F. This review highlighted several points of interest. As evidenced within the findings of the first review question "what do we know about effective IMH services", a lack of role clarity can be a significant barrier when working in IMH contexts. This lack of role clarity was probed within the second review question "what do we know about the roles and activities of the psychologist when working IMH contexts?" Findings of this review suggest that the role of the psychologist (as evidenced by their involvement within the included studies) entailed providing therapeutic intervention, psychometric assessment, and consultation in the context of reflective supervision.

However, it is argued that both the quality and relevance of these studies is questionable. Regarding quality, many included studies lacked methodological rigor and demonstrated poor generalisability (Gough, 2007). The included studies also lacked relevance in relation to the review question (Gough, 2007). As no study explicitly exploring the psychologist's role in IMH contexts could be found in detailed searches, the role of psychologist had to be extracted from empirical studies that included psychologists within their sample (e.g. studies evaluating interventions being ran by a psychologist). This questions the authority of the included studies in effectively answering the review question. However, this outcome also points to a notable gap in the evidence base. As there appears to be little to no studies conducted explicitly exploring the role of the psychologist in IMH contexts, this study aims to address and fill this gap. The next chapter will provide an overview of the methodology employed to address this gap in the research, as well as the research questions the study aims to answer.

Chapter Three: Methodology

3.1 Introduction

The purpose of this study is to explore the activities, understandings, and perceptions of psychologists working in IMH service provision. This chapter will set out the quantitative and qualitative phases of this research, providing details on the research questions, design, and procedures associated with each phase. An overview of the researcher's philosophical paradigm will be provided, as well as an outline of the overarching conceptual framework underpinning the current study. Details of the approach to data analysis will be discussed, as well as relevant ethical actions taken by the researcher. Finally, a critical reflection on the validity and reliability of the study will follow, highlighting the measures and steps undertaken to ensure the quality of this research project.

3.2 Research Questions and/or Hypotheses and their Rationales

It is proposed in the literature that there is “room for confusion regarding the practice of IMH and the boundaries that define the roles of the professionals who practice it” (Hinshaw-Fuselier et al., 2009, p. 533). This research has adopted a mixed methods design, in order to adequately address the research questions of this study.

3.2.1 Quantitative research questions. This study had one primary overarching quantitative research question.

Research question one: “how do psychologists use an IMH framework in their practice?”

This research question aims to gain insight into the nature of IMH work currently being undertaken in Ireland, across a range of multidisciplinary team services, including Child and Adolescent Mental Health, Early Intervention, and Primary Care. As IMH research in an Irish context is in its infancy, this study hopes to shed light on the positive IMH practice being undertaken, as well as potential areas for development.

Thus, it is hoped this research can inform future policy and practice by providing an overview of current IMH service provision and how psychologists are incorporating an IMH approach in their work.

Secondly, it is intended that the data gathered from this quantitative research question will also triangulate and embellish the data obtained from the qualitative phase of this study. By providing qualitative data to support quantitative information, it is hoped that this will strengthen and validate the findings of this project.

3.2.2 Qualitative research questions. There are three primary qualitative research questions involved in this study. The first qualitative research question concerns how psychologists and other relevant professionals view the role of the psychologist in IMH contexts.

Research question two: “how do psychologists, and other relevant professionals, view the role of the psychologist in Infant Mental Health service provision?”

Previous literature has explored the discrete role of the psychologist in a variety of contexts, including mental health services (DeMers, 1995) and multi-agency contexts (Gaskell & Leadbetter, 2009). The psychologist’s role in IMH contexts is a relatively novel concept and under-researched area, therefore the aforementioned research questions aim to address this gap in the literature. Moreover, previous research eliciting the discrete role of psychologists has focused on data from psychologists only (e.g. Gulliford, 1999; Thomson, 1996) or data from other professionals only (e.g. Imich, 1999). Very few studies have attempted to triangulate data from different professional inputs to seek clarity on the role of the psychologist. Triangulation of data is strongly recommended in qualitative research “as a strategy for the validation of the procedures and results of empirical social research” (Flick, 2004, p. 178), therefore it is hoped that doing so will lead to robust and informative data.

Conversely, the second research question regards how all participants view other professionals’ roles within IMH service provision.

Research question three: “how do psychologists, and other relevant professionals, view the roles of others in Infant Mental Health service provision?”

As aforementioned, research suggests that there is notable ambiguity in the boundaries of professional practice within IMH services (Hinshaw-Fuselier et al., 2009). This lack of role clarity could potentially lead to fragmented and disjointed multidisciplinary working. This hypothesis will be explored through interviews with psychologists and other professionals, including social workers, public health nurses, GPs and speech and language therapists.

The final qualitative research question is concerned with whether there are attributes of the psychologist’s role that make their roles distinctive within multidisciplinary IMH service provision.

Research question 4: “What are the distinctive attributes of the psychologist’s role that make their roles unique within multidisciplinary Infant Mental Health service provision?”

It is hypothesized that the perceived role of the psychologist will harmonize with the distinctive aspects of psychology practice, as outlined by Cameron (2006). These being (i) adopting a psychological perspective to human problems; (ii) uncovering mediating/psychological variables; (iii) application of psychological knowledge; (iv) using evidence-based strategies for change; and (v) sharing and promoting big ideas from psychology (Cameron, 2006). Discrepancies and similarities between the study’s findings and Cameron’s (2006) model will be explored and discussed in order to further disambiguate the role of the psychologist in IMH service provision

3.3 Research Paradigm

Prior to ascertaining the design and methodology that will be used to address the aforementioned research questions, it is considered important that researchers reflect on the research “paradigm” their study best aligns. A paradigm is defined as “a way of looking at the world” (Mertens, 2005, p. 7). The assumptions and philosophical

assumptions of one's research paradigm narrate the future actions of the research process and have implications for design and methodologies of a research study (Crotty, 1998). There are two primary theoretical concepts that underpin a research paradigm: "ontology" and "epistemology". Ontology is defined as the nature of reality (Mertens, 2005), whereas epistemology is described as the nature of knowledge and how knowledge is acquired (Hoffman, 1981).

3.3.1 Ontology. This study aligns itself within a "constructivist" ontological position. Constructivism regards reality as a socially constructed phenomenon, that being, reality is constructed through people's active experiences with it, and the meaning they attach to these experiences (Mertens, 2005). This lends itself well to the current study, as the concept of a role is something that cannot be entirely "true"; instead it is a socially constructed concept from those who are active in the process (Mertens, 2005).

Constructivist ontology also retains the belief that one reality does not exist. Instead, there are multiple realities which are worth understanding and exploring (Mertens, 2005). Each person's construction of reality is as valid as the next within a particular context (Rapmund & Moore, 2000). In terms of the current research, a range of professionals will be interviewed on their reality of a particular concept, namely their experiences and perceptions of working in IMH contexts. Equal weighting and validity will be given to each professional, and no critical interpretation will be undertaken in an attempt to reach an objective truth. This stands in stark contrast to alternative philosophical paradigms such as positivism and postmodernism which proclaim that one tangible external reality exists (Rolfe, 2013).

3.3.2 Epistemology. Epistemology describes how we come to know things or believe that they are true (Barker, Pistrang, & Elliot, 2016). The epistemology of the constructivist paradigm proposes that the research process is a collaborative activity between the researcher and participants in an attempt to develop new knowledge (Murphy, 1997). This opposes a more positivist view that knowledge exists to be discovered by the researcher (Mertens, 2005). More specifically, a constructivist epistemology assumes an attitude of curiosity and "not knowing" (Murphy, 1997, p.5).

This approach corresponds well with the exploratory nature of the under-researched phenomenon of the current study.

Additionally, findings within a constructivist epistemology are considered as a product of the current societal, historic, and local context in which the research is being conducted (Mertens, 2005). This position does not claim to produce information that is absolute or generalizable to wider audiences. The current study acknowledges that the findings are specific to the historical and cultural location in which they were explored, that being, an Irish health care context, and does not make claims that the data is generalizable or replicable in other contexts.

3.3.3 Alternative philosophical influences. In light of some criticisms of a constructivist approach (e.g. Alvesson, 2009; Cromby & Nightingale, 1999), the researcher was also influenced by a “critical realist” theoretical perspective. A critical realist perspective acknowledges that while our constructions of reality can be socially interpreted, these interpretations may be fallible (Madill, Jordan, & Shirley, 2000). This philosophical consideration was incorporated into the current study for two reasons. As this work is of a predominantly exploratory nature, there is also a need to consider matters of validity and reliability in empirical work. Thus, a critical realist perspective encourages researchers to make explicit claims about how their data was gathered and how conclusions were drawn (Barker et al., 2016). This consideration will be incorporated into the design and methodology of the study through the clarification of the methodological procedure (see section 3.8) transparency in data analysis (see section 3.9) and the inclusion of certain steps to ensure validity (see section 3.11). Furthermore, a critical realism perspective also encourages that the phenomenon being investigated should be approached from different perspectives. Barker et al. (2016) argue that this can be obtained through a process of “triangulation” of data. This process considers using multiple points of view to elucidate knowledge. This study aims to adopt this approach through using both quantitative and qualitative methods to explore the phenomenon of the psychologist’s role in IMH contexts.

In considering what paradigm for a research study, Chilsa and Kawulich (2012, p.2) argue that it is the researcher’s choice to “determine your own paradigmatic view and how that informs your research design to best answer the question under study.”

While it may be argued that critical realism and constructivism are competing paradigms, some research suggests that a constructivist paradigm can be complemented by a critical realist meta-theory. Fiaz (2014, p.507) proposes that by couching critical realist approaches in a constructivist philosophy, the study can be enhanced through “developing ontological, theoretical and methodological clarity, and in deepening constructivist explanations of a complex and multi-layered reality.”

With regards the current project, there were two key reasons the study adopted this approach to the research paradigm. Firstly, this study is an exploratory study of IMH service provision in an Irish context. As IMH services are in their infancy and professionals who work in IMH contexts vary in their level of knowledge and skill, it was considered important for the researcher to design a study that facilitated a “valid, reliable and diverse construction of realities” (Golafshani, 2013, p.604). Herein lay the rationale for the integration of critical realist principles such as triangulation and transparency. Secondly, this study is being undertaken as part of a recently developed Doctorate in Education and Child Psychology programme in Mary Immaculate College. In light of the newness of this programme, it was considered important to conduct research with methodological and conceptual rigor in order to present a thesis that had a “credible and defensible result” (Johnson, 1997, p. 283). This is referenced within the field, with some researchers argued that constructivist paradigms “have moved too far in abandoning traditional scientific methods associated with procedures of verification” (Leadbetter, 2002, p. 24). Thus, it was hoped that by embedding some critical realist principles within a broader constructivist paradigm, this research will provide a robust and comprehensive account of the social constructed realities of participants.

3.4 Activity Theory

A social constructivist theory that lends itself well to the current research is “Activity Theory”. Activity Theory (AT), also referred to in the literature as Cultural-historical Activity Theory (CHAT), provides a conceptual framework that lends itself as a useful approach to the “social construction of knowledge” (Engeström, 2001, p.301). Previous literature has pointed to AT’s utility in exploring understandings of roles and identities (Gaskell & Leadbetter, 2009; Robinson & Cottrell, 2005). Thus, AT was considered particularly relevant for the current study as it dovetails with both the

research paradigm of the current study and previous investigative traditions. A seminal writer in AT is Yrjo Engeström, who has classified AT as falling into three generations. An overview of the three generations of AT will subsequently be discussed.

3.4.1 First generation AT. The origins of AT stems from the seminal work of Vygotsky (1986). During a time of cultural and political turmoil in Russia, Vygotsky and colleagues began to explore learning and development with a particular emphasis on how they are intrinsically linked to cultural and social factors. The concept of an “activity” is the fundamental basis of this theoretical framework. Vygotsky (1986) theorised that human behaviour and interactions are always mediated in some way. This stands in stark contrast to the behaviourist concept of behaviour; stipulating that activities are simply an action being taken and an outcome being the result (Leadbetter, 2008). Instead, Vygotsky attempted to address the limitations of this stimulus-response approach by introducing the concept of “mediation” as an essential component to learning and development.

The first generation of AT was developed by Vygotsky in the 1920s, depicting a triangular model in which the “subject” and the “object” are mediated by a third point including “tools/artefacts” to produce an “outcome” (Daniels, 2001). The subject includes the individual or group performing the action, with the object being the focus of the activity and the motivation for the action. The tools or artefacts may include both concrete means (e.g. an object or instrument) and abstract means (e.g. language). It is suggested that these tools or artefacts mediate, prompt, or stimulate our actions. See Figure 4 for a model of first generation AT.

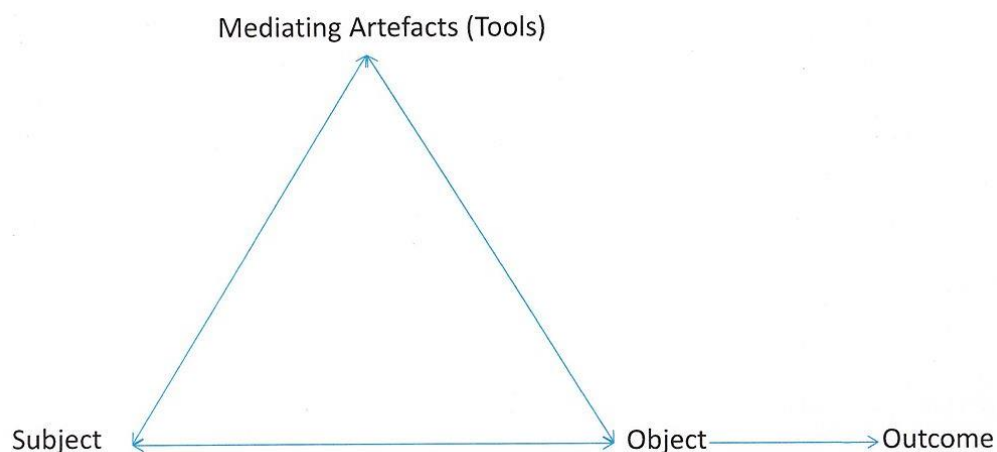


Figure 4: First Generation Activity Theory (taken from Engeström, 1999)

3.4.2 Second generation AT. Vygotsky's student Leont'ev further expanded First Generation AT by differentiating between the terms "action" and "activity" (Leont'ev, 1978). He suggests that while the term action describes the act of an individual to reach a goal, an activity regards the act of a community (Leont'ev, 1978). This community may have differing objects and motives for an action, therefore Leont'ev proposes that these terms are not interchangeable or synonymous terms, as Vygotsky's original theory suggested. Thus, it was Leont'ev (1978) who postulated that any activity is the product of the work of the collective, as opposed to solely the individual's efforts.

Engeström (1987) expanded on the work of both Vygotsky and Leont'ev, to create the model of Second Generation AT (See Figure 5). Engeström acknowledged how the subject and object are the central relationship (as conceptualised in the First Generation model) yet felt that this relationship can be influenced by other social, historic, and contextual factors. This thinking was directly influenced by Leont'ev's theory that an activity is a product of collective efforts (Leont'ev, 1978). In integrating this idea, the model of Second Generation of AT was born (Engeström, 1987). This model expands the bottom of the original triangular model to incorporate concepts of "community", "rules", and "division of labour". The community node refers to who else may be involved in the activity, the rules node refers to supporting or constraining factors, and the division of labour node refers to how work is shared among others (Leadbetter, 2008). The addition of these variables allow for a more systemic and macro-level support.

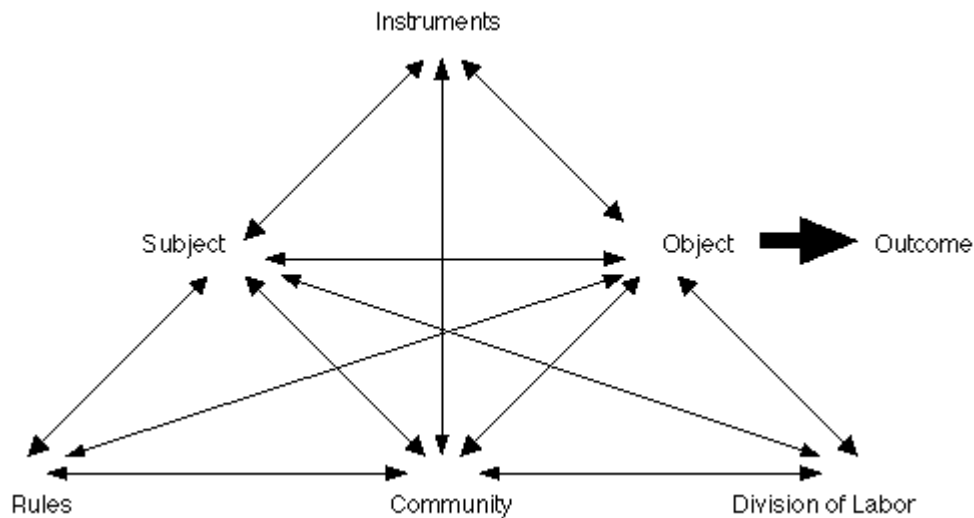


Figure 5: Second Generation Activity Theory (taken from Engeström, 1987)

3.4.3 Third generation AT. Engeström further elaborated on the previous generations of AT by creating a third generation model. This model represents Engeström's (2001) belief that "activity systems" are not isolated entities, yet engage and interact with other activity systems within society. The model of third generation AT highlights how often the object between two distinct activity systems may present as opposing or conflicting practices. Yet through negotiation and discussion of these contradictions, new objects or ways of working may be created (Engeström, 2001). A model of Third Generation AT can be found in Figure 6.

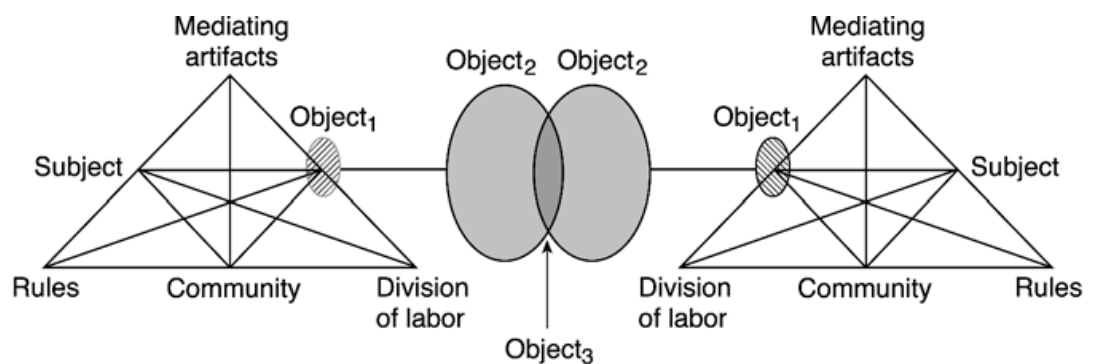


Figure 6: Third Generation Activity Theory (taken from Engeström, 2001)

3.4.4 Key concepts. AT is centred on five key principles, which act as a “manifesto” of the theory (Daniels, 2001, p.93). A summary of these principles, as outlined by Leadbetter (2008, p. 201-202) can be found in Table 2.

Table 2

Key principles of Activity Theory as summarised by Leadbetter (2008)

-
1. The prime unit of analysis in AT is ‘a collective, artefact-mediated and object-oriented activity system, seen in its network relations to other activity systems’ (Daniels, 2001, p.93).
 2. Activity Systems are usually multi-voiced as there is always a community of multiple viewpoints with differing interests and traditions.
 3. The historicity of Activity Systems is extremely important in that they develop over long periods of time and are constantly transformed and transforming. Through investigating the historical aspects (formation) of systems, new understandings can be brought to bear on current Activity Systems.
 4. Contradictions are central to an understanding of AT as they are sources of tension, disturbance and eventually change and development. By examining contradictions within and between Activity Systems, new objects can be created and new ways of working can be developed.
 5. Finally, the transformative nature of Activity Systems is emphasised, as Engeström (1999) maintains that through examination of contradictions participants may question established patterns of working and new motives and new objects may be formed. These transformations may occur over lengthy periods of time and result in a much wider range of possibilities for action.
-

3.4.5 Contradictions. Leadbetter (2008, p. 259) describes contradictions as “sources of tension, disturbance, and eventually change and development”. It is suggested that by studying these contradictions within activity systems, new ways of working can be developed. These contradictions have also been highlighted by Engeström (1999) as one of the five principles within AT, and he views them as having a key role as sources of change and development. These contradictions can be analysed

between and within activity systems. Engeström (1999) proposes four different levels of contradictions, which are described in Table 3 below.

Table 3

Engeström's (1999) four levels of contradictions within Activity Theory

| Level of contradiction | Definition |
|---|---|
| Level one: Primary inner contradictions | Contradictions existing within the component parts of one activity system e.g. in the division of labour section. |
| Level two: Secondary contradictions | Contradictions existing between the components of one activity system e.g. between the rules and community nodes. |
| Level three: Tertiary contradictions | Contradictions occurring between an activity and a culturally more advanced form of the central activity (e.g. pre- and post- introduction of new whole school literacy programme). |
| Level four: Quaternary contradictions | These contradictions exist between the central activity and its concurrent or co-existing neighbouring activities (e.g. the implementation of a new online eLearning activity in schools may initially disrupt the activity of administration). |

3.4.6 The cycle of expansive learning. Identifying contradictions within an Activity System can lead to a process known as the “Cycle of Expansive Learning”. Expansive learning is broadly defined as an organisational process that moves the “abstract to the concrete” (Engeström, 1999, p. 302). Engeström (2001) proposes that expansive learning concerns an activity system (such as a professional group or organisation) resolving contradictions by constructing and implementing new ways of working. It includes seven logical steps or learning actions, with the aim of forming new knowledge and practices. When research moves through the Cycle of Expansive

Learning, it becomes known as *Developmental Work Research* (DWR), a form of action research that is grounded in AT. The current research will move through the first two steps of the expansive learning cycle. The discussion chapter of this thesis will explore potential avenues to continue to progress through the cycle. The steps of the Cycle of Expansive Learning can be found in Figure 7.

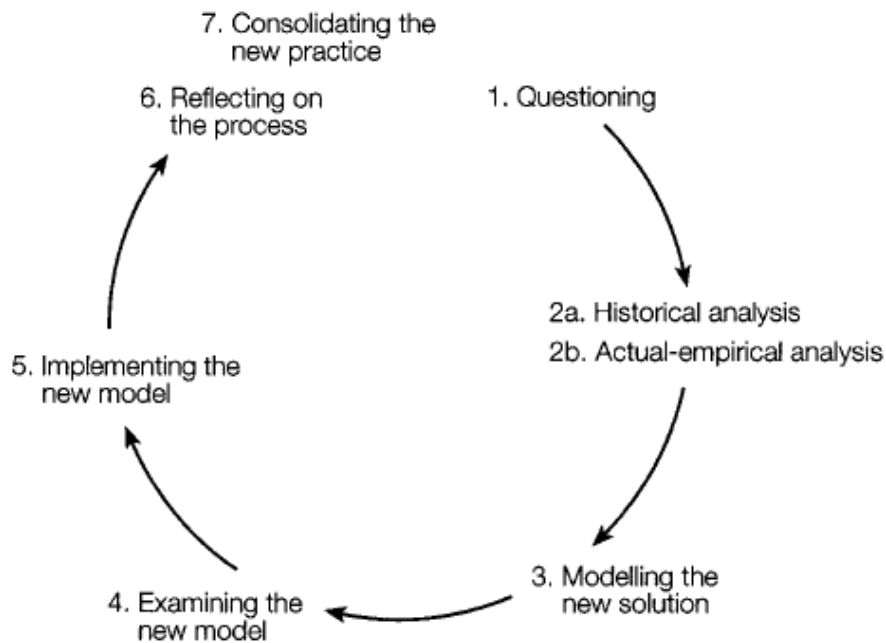


Figure 7: Cycle of Expansive Learning (Engestrom, 1999)

3.4.7 Applications of AT. Leadbetter (2008) highlights how AT can be used as a descriptive framework, an analytic device, and an organisational development approach. With regard the current research project, AT has been used as a conceptual framework to map the practices of multidisciplinary practitioners in IMH. Greenhouse (2013) used AT as a framework to engage in multi-agency work, with a particular focus on Behaviour and Education Support Teams. Greenhouse (2013) discussed potential tensions or contradictions within the activity system, and how they can impact on the quality of service provided. Of particular relevance to this study, Greenhouse (2013) highlights how within the division of labour component of an activity system, role clarity is a vital component of collaborative working. Greenhouse (2013) also notes that

role demarcation within a multidisciplinary team can result in loss of professional identity, blurred role boundaries, and limited opportunities to learn new knowledge or skills from colleagues.

Gaskell and Leadbetter (2009) used AT as a framework to explore the professional identities of psychologists working part-time within a multi-agency team (MAT) and part time in an Educational Psychology Service (EPS) in the United Kingdom. The themes of AT were used to facilitate a comparison of the psychologist's identities within their two work roles. Within the tensions and contradictions of the activity system, Gaskell and Leadbetter (2009) found that there was a sense of confusion over the psychologist's place in the MAT, with psychologists feeling that they didn't have anything new to offer to the MAT that wasn't already evident within the team. The study's findings also demonstrate how an understanding of other professional's roles within the MAT facilitated collaborative work. However, participants also noted that there were some roles that were "negotiable and get allocated according to strengths and preferences of the people in the team" (Gaskell & Leadbetter, 2009, p. 104). Although this was viewed positively by some, other participants found this lack of clarity resulted in a lack of confidence when working as part of the MAT.

Moreover, AT may be considered particularly relevant for the current project, as the framework has been previously utilised by students undertaking doctorate research. Durbin (2009), a student of the University of Birmingham, completed his doctorate research on professional learning and contributions to multidisciplinary teams, using AT as his methodological framework. Durbin (2009) carried out individual interviews and focus groups with EPs, family support workers, and primary mental health workers from a singular multidisciplinary child behaviour team. From this data, Durbin (2009) created activity systems for each professional cohort, identified contradictions within these systems, and compared the activity systems from each professional group. Durbin (2009) also incorporated DWR into his study, to continue the cycle of expansive learning and facilitate future change and development within this multidisciplinary team. Although Durbin's (2009) research may not be totally generalizable to an Irish context, this research demonstrates the utility of AT as a framework for doctorate research concerning multi-agency or multidisciplinary working.

3.5 Approach to the Research

The overarching research paradigm that this study employs is a convergent parallel mixed method approach (Johnson, Onwuegbuzie, & Turner, 2007). Traditionally, a constructivist epistemology has been linked solely to qualitative methodologies, in an attempt to understand and describe human experience (Mertens, 2005). However, researchers have proposed that a constructivist lens will also acknowledge support data from both qualitative and quantitative methods. Although not heavily presented in the literature, constructivist research may use quantitative data in a way that supports, expands, or embellishes qualitative data, in order to provide a deeper and richer description of the phenomenon in question (MacKenzie & Knipe, 2006). It is proposed that a qualitative-dominant mixed method paradigm offers a type of mixed methods research that encapsulates a “qualitative, constructivist-poststructuralist-critical view of the research process, while concurrently recognizing that the addition of quantitative data approaches are likely to benefit most research projects” (Johnson et al., 2007, p.124)

The rationale for utilising a mixed methods approach for the current study is twofold. Firstly, it was considered that quantitative methods were most relevant to address the first research question, that being, how do psychologists use an IMH framework in their practice. This question aimed to encapsulate current practice at a national level, thus requiring data collection procedures that can access a breadth of participants in a time and cost-efficient manner for both researcher and participant. Therefore, an online questionnaire was chosen as the most pertinent method to gather these data, as it is easily accessible for psychologists, is not limited by location restrictions of the researcher, and is a relatively fast method of gathering necessary information. This information aims to provide contextual information on the nature of work being undertaken by psychologists when working in IMH frameworks and may embellish qualitative findings on the role of the psychologist i.e. are perceptions of the psychologist being mirrored in practice?

Secondly, it was considered that qualitative methods were the most relevant to address other research questions of this study, regarding perceptions and understandings

of professional roles in IMH service provision. Semi-structured interviews were selected as a data collection tool, as the concept of a “role” is not something that can be easily extracted via quantitative means. Thus, a convergent parallel mixed methods design was considered to adequately address the purpose of this research. See Figure 7 for an outline of the research design.

3.6 Research Design

This study employed a convergent parallel mixed-methods design. This type of design is the most common approach to mixing methods (Creswell, 1999), as the design lends itself to “valid and well-substantiated conclusions about a single phenomenon” (Creswell & Clark, 2007, p. 65). This design consists of two distinct phases of data collection, both occurring simultaneously. The data are analysed separately and merged during the interpretation phase. The purpose of this design is “to obtain different but complementary data on the same topic” (Morse, 1991, p. 122). This design was considered appropriate for this study as a means of validating and corroborating qualitative findings with quantitative results and vice versa. See Figure 8 for a model of a convergent parallel mixed-methods design.

Convergent parallel mixed-methods designs have been used frequently in research in education (King, Dewey, & Borish, 2015), nursing (Beck, LoGiudice, & Gable, 2015), and medicine (Rosenkranz, Wang, & Hu, 2015) and is now considered the dominant approach in health care research (O’Cathain, Murphy, & Nicholl, 2007). There are many benefits to parallel mixed method approaches, including the ability to simultaneously explore “an actor and a structural perspective” (Bernardi, Keim, & Klärner, 2014, p.26). With this research design, one can essentially explore a phenomenon in two distinct capacities, offering a more complex formulation of the topic being explored. Data gathered from mixed methods study will also provide triangulation of information from differing data sources, resulting in a more robust interpretation of the phenomenon (Graff, 2014).

Nonetheless, no research design is flawless, and a parallel mixed methods approach has had its critiques within the literature. Some researchers have highlighted how the sampling criteria can lead to increased workload. As quantitative data requires

a significantly larger sample size than qualitative data to obtain a representative sample, additional time and resource constraints are thus placed on the researcher as they attempt to juggle gathering data from two samples simultaneously. Following on from this, the management of this data can also pose concerns as the researcher has to be deft in both quantitative and qualitative analysis procedures and have the ability to integrate both approaches in a meaningful way (Mertens, 2014). Finally, the parallel approach results in a noteworthy time pressured phase of data collection, which may be overwhelming for the researcher and result in an increase in human error (Bernardi, Keim, & Klärner, 2014).

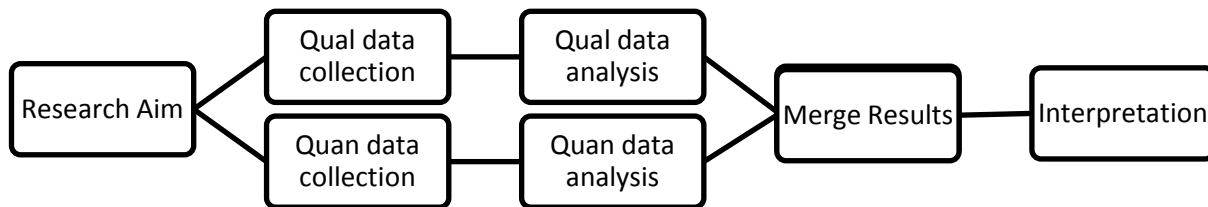


Figure 8: Convergent parallel research design

3.7 Participants

The current study utilised a purposeful sampling approach in the recruitment of participants. This approach comprises a “deliberate choice of a participant due to the qualities the participant possesses” (Etikan, Musa, & Alkassim, 2016, p.2). Purposeful sampling has an established history in qualitative research as a means of obtaining rich information from participants relevant to the topic of study (Patton, 2002). Specifically, criterion sampling was employed to identify and select participants that met pre-determined criteria of importance to effectively and validly address the research aims (Palinkas, et al., 2015). See Table 4 below for details on the sampling criteria and rationale for same. Demographic details of participants will be discussed in the subsequent results section.

Table 4

Sampling Criteria

| Phase | Sampling criteria | Rationale |
|--------------------|--|--|
| Quantitative Phase | Participants must be: Fully qualified psychologists Currently working in Early Intervention, Primary Care, or Child and Adolescent Mental Health teams in Ireland | To access psychologists who work with the relevant age for IMH practice (0-3), as per the age remit within their formal job description (e.g. Early intervention: 0-6; Child and Adolescent Mental Health: 0-18; Primary Care 0-18). |
| Qualitative Phase | Participants must: Include professionals who have experience working in a multidisciplinary manner Currently work with children in the 0-3 age group Be involved in developing the social and emotional development of the young child | To access professionals who currently work in IMH practice, alongside other practitioners, including psychologists. |

Sample sizes varied for both the quantitative and the qualitative phases of the research. With regards the quantitative phase of this research, it was envisaged that the sample would provide a representative sample of psychologists working in multidisciplinary teams in Ireland, providing services to children aged 0-18 years old. Thus, the online questionnaire was sent to relevant multidisciplinary teams across Ireland, where managerial email was publically available. A reminder email was sent within three weeks of the initial email, as this increased contact has been shown to enhance the likelihood of a response (McCull et al., 2001). A total of 35 invitation emails were sent with a response rate of 54%. While this low level of response rate is not uncommon (e.g. Nulty, 2008), the literature suggests that a response rate of between 60 and 70% is desirable to ensure external validity and that a representative sample has been reached (Burns et al., 2008). As this study's response rate falls slightly below the parameters outlined by Burns et al. (2008), concerns may be raised regarding selection bias and validity and reliability among respondents. This is acknowledged as a limitation within the current study.

Regarding the qualitative phase, the literature is ambiguous as to how to accurately ascertain sample sizes in qualitative research, with studies recommending sample sizes from five to fifty participants (Baker & Edwards, 2012). A generally well-accepted principle is that the sample size should provide adequate data for the purpose and research aims of the study (Mason, 2010). While the cut-off point for data collection in qualitative research has been obtaining “saturation”, this concept has recently been debated in the literature regarding the lack of transparency from researchers regarding how saturation was obtained from the data (Mason, 2010). In light of this, the current study ascertains its final sample size using a contemporary approach entitled “Information Power” (Malterud, Siersma, & Guassora, 2016). Malterud et al. (2016) propose that a sample size’s information power depends on (a) the aim of the study, that being how narrow or broad the scope of the study is; (b) sample specificity; (c) use of established theory; (d) quality of dialogue; and (e) analysis strategy. The higher the information power within the study, the lower the number of participants required.

Having applied Malterud et al.’s (2016) model of information power to the current study it was suggested that a sample of eight to twelve participants are initially recruited. This application can be found in Appendix G. These participants were sought from professional backgrounds that would constitute a specialised IMH team; including a psychologist, social worker, doctor, nurse, speech and language therapist, and community link worker/family support worker. The inclusion of these specific disciplines is modelled from the recommended key disciplines for Specialised Perinatal Mental Health teams as presented by the HSE (HSE, 2017b). The information gathered from the sample was continuously reviewed in order to ascertain whether the sample has sufficient information power. As this was an exploratory study, the ambition was not to obtain a complete description of multidisciplinary roles in IMH, yet to offer some new “insights that contribute substantially to or challenge current understandings” (Malterud et al., 2016, p. 7). Moreover, Malterud et al.’s (2016, p.1756) model is not necessarily for use as a “checklist to calculate N” yet is considered a systematic and logical method to consider during the recruitment process.

It is important to note that within the current study, psychologists will not be differentiated by their training backgrounds. That being, the term “psychologists” will

be exclusively used when referring to educational psychologists, counselling psychologists and/or clinical psychologists, unless otherwise stated from hereon in. The rationale for this is threefold: firstly, minimal information is provided in empirical literature as to the nature of the training background of the psychologist in question, be it clinical, counselling, or educational, and was therefore not possible to categorise the literature based on professional training. Secondly, as aforementioned, educational psychologists have recently been employed in the same settings and services as clinical or counselling psychologists, therefore it was considered that both categories were equally entitled to be included in this study (HSE, 2017a). Third of all, the training background of the psychologist is not a key research question within this study. It will be included as a question within the study's measures, yet will not form a major premise for this study's research questions or findings. Thus, it was not considered pertinent or relevant to categorise/recruit participants on the nature of their training background. Instead, all psychologists employed in contexts working with infants and their families were referred to as "psychologists" for the majority of this research.

3.8 Procedures

3.8.1 Participant recruitment. Regarding the quantitative component of this study, that being the online questionnaire, participants were actively recruited through the various national multidisciplinary health care teams. These included Early Intervention Disability teams, Primary Care teams, or Child and Adolescent Mental Health teams in the Republic of Ireland. An email was sent to the managers of said services, where access to managerial email was publically available. This email outlined the purpose of the study, the rationale for using an online questionnaire, as well as any ethical issues that had been considered and addressed. A request was made to the service manager to access the psychologist within the service to ask them to complete the online questionnaire. This access was granted by providing the direct work email address of the psychologist(s), or by forwarding on the initial email sent by the researcher (which included the online questionnaire link). Only the work emails of the professionals were used, in order to mitigate any concerns regarding confidential information being held by the researcher. The consent form (Appendix H) was attached as part of the online questionnaire, to reduce the administrative time for both researcher

and participant. Reminder emails were sent to the participants a month after the initial email was sent. No further contact was made after this point.

As response rates to online questionnaires are often low, the questionnaire was also distributed through additional mediums in an attempt to “push the survey” (Nulty, 2008, p. 304). Firstly, the questionnaire was posted on the online fora EPNET and CLINPSY. EPNET is an online forum for educational psychologists, across the United Kingdom and elsewhere to share ideas and information pertaining to the field of educational psychology. Similarly, CLINPSY is an online forum for professional, graduate and aspiring clinical psychologists to share information and advice. Secondly, the questionnaire was sent to the PSI PIMHSIG for distribution to its members. The PSI PIMHSIG is a discrete interest group within the Psychological Society of Ireland, dedicated to the promotion of the practice, education, and research of IMH among its members. This group provide training opportunities, create forums to share information and resources, as well as provide advice to policy makers on the importance of both perinatal and infant mental health. A similar procedure followed, by sending an email to the chairperson of the PSI PIMHSIG and to the moderators of the online fora to distribute the link of the online questionnaire to their members.

For the qualitative aspect of the research, the IMH-NG was used as a platform through which suitable interview candidates could be recruited. The IMG-NG were recently established as a hub for professionals to “share experiences, transfer knowledge and to develop a cross-disciplinary perspective on IMH theory and practice and their integration into service delivery across the community” (IMH-NG, 2015, p. 5). Members of these groups are professionals who work with children aged 0-3 years and their families to support their social and emotional development (IMH-NG, 2015), therefore match the sampling criteria for this study. A request was made via email to the manager of the network to contact members of the IMH-NG across Kerry and Cork.

Once consent was obtained from the manager of the IMH network, and contact details were provided, initial contact was made by the researcher. An email was sent to the individual participants to highlight the purpose of the study, what their participation would involve, and details of the researcher and the research supervisor, should anybody require additional information. Participants who were willing were contacted

regarding a suitable time, date, and place for the interview to commence. Where logistical restrictions made face-to-face interviews difficult to complete (e.g. large regional span), the choice was given to participants to complete the interview in person or by phone. The interviewee was asked to provide their work telephone number, which was removed from the researcher's phone after the interview. The interview was recorded using a speaker phone and a Dictaphone, which has been recommended by previous studies (Burke & Miller, 2001). Information sheets (Appendix I) and consent sheets were distributed prior to the interview taking place.

3.8.2 Data collection methods

3.8.2.1 Online questionnaire. Quantitative data was gathered using an online questionnaire. This questionnaire was designed using Google Forms (Appendix J). The purpose of this questionnaire, as aforementioned, was to address the first research question, that being, "*how do psychologists use an IMH framework in their practice?*" These data aimed to explore casework, training, as well as levels of confidence and competence in working with IMH cases. Questionnaires have been previously used as a means of exploring a particular model of service delivery in healthcare (e.g. Pirkis et al., 2006), and were therefore considered appropriate to address this research question, as well as provide demographic and contextual data regarding current IMH provision in Ireland (e.g. how often do psychologists engage in IMH casework?).

This questionnaire was designed using Farrell et al.'s (2006) questionnaire as a guide. Farrell et al.'s (2006) U.K. study incorporated a questionnaire into their exploration of the contribution of psychologists to key aims of the "Every Child Matters: Change for Children" legislation (Department for Education and Skills, 2004). It was adapted for the current study through the addition of other relevant questions for the purpose of this study (e.g. questions on knowledge of IMH theory/research) and the removal of questions that were not considered relevant for this study (e.g. How psychologist's work impacted on the five outcomes of the Every Child Matters policy). This questionnaire was reviewed by a practicing psychologist working in the early years setting, in order to ensure the questionnaire was valid and relevant.

3.8.2.2 Semi-structured interviews. Regarding the qualitative component of this research, semi-structured interviews were considered the most appropriate technique to gather data on professional roles in IMH, in light of the purpose and paradigm of the current study. These interviews were utilised in order to gather information to “construct” said roles, putting the researcher at the centre of a collaborative and interactive process, as per the constructivist paradigm (Mertens, 2005). Semi-structured interviews have previously been used in studies that have explored professional’s roles and are therefore considered a valuable method of data collection for this study (Novoa & de Valderrama, 2006; Philibin et al., 2010; Sheldon, 2000).

Interview questions were drawn from the psychological framework of Second Generation AT (Engstrom, 1999), which can be found in Figure 5. Specifically, questions were derived from the discrete nodes or elements within the activity system, and were modelled on those found in Leadbetter’s (2008) research. For example, the node of community comprised of questions such as “what professionals in the community do you feel should be involved in this case?” Moreover, the node of outcomes comprised questions concerning the anticipated result of the case e.g. “what would the desired outcome of your involvement with this case be?” Questions of particular relevance in exploring perceptions of the psychologist’s role were taken from Ashton and Robert’s (2006) study. These questions included items such as: “how do you perceive the role of the psychologist in this case?” and “if there were no psychologists working on this case, what would you miss?” See Appendix K for interview schedule.

A case vignette was also used to provide a platform for discussion (Appendix L). Case vignettes are considered beneficial as they allow actions in a specific context to be explored, can provide multiple interpretations of the same situation, and permit a less personal and/or threatening way to explore a topic (Barter & Reynold, 1999). The case vignette used was an adapted version of one found in Gart, Zamora & Williams (2016). The vignette was adapted to relate to the Irish cultural and health care setting. Such adaptations included change of cultural background from Romanian to Irish Traveller, in order to provide a more accurate reflection of current Irish social context (Central Statistics Office [CSO], 2017). Additionally, alterations were made within the case vignette to personnel making the referral (from “psychotherapist” in the original

article, to “General Practitioner” for the current study), to mirror the typical referral pathways of mental health in an Irish context (HSE, 2015b). Again, this vignette was reviewed by an independent IMH practitioner, in order to ensure that this case reflected a typical case referral.

3.8.3 Pilot study. A pilot study was also carried out for the current research. This pilot was conducted in order to identify any details that may need adjusting prior to the main data collection period (e.g. are questions specific enough to provide information to answer my research questions? Is any question proving difficult for participants to answer?). The online questionnaire was initially sent to psychologists working in the Connaught region. The literature is mixed in terms of how many participants are required for sample sizes for pilot studies (Johanson & Brooks, 2010). From the findings of the first three respondents, an additional question was incorporated into the questionnaire, pertaining to the frequency with which the psychologist provides IMH services on a group-basis. Questions involving the psychologist’s frequency engaged in IMH work on an individual and systems level had already been included in the questionnaire. Results from the pilot questionnaires highlighted how there was no question that documented psychologists’ work with group IMH cases (e.g. parent training groups, mother and baby groups).

In terms of the qualitative component of the pilot study, the interviewees were recruited in the same manner as the actual study. The first two interviews were determined as the pilot samples. Holloway (1997) argues that piloting is not usually necessary due to the progressive nature of qualitative data collection. It is suggested that interview schedules and ways of asking questions are improved on a continual basis, due to newly gained insights from previous interviews (Holloway, 1997). Therefore, these participants were considered pilot samples yet their data will be included as part of the main study. The main focus of this pilot was to improve the interview schedule in terms of phrasing of questions or order of questions, as well as improve interviewer competence (Holloway, 1997).

3.8.4 Data management. Data from online questionnaires was gathered online initially through the use of Google Forms. The data obtained were anonymous and could not link information back to the user’s email address or computer. Once this

phase of data collection was completed, the information was downloaded as an excel sheet. This excel sheet was then stored on the researcher's external hard drive, which was password protected.

Interviews were audio recorded using a Dictaphone. The participant was referred to by a unique code at the beginning of the interview. Only the researcher had access to the codes and real names of participants. The audio recording was held on an encrypted hard drive until it was transcribed. Data was transcribed verbatim by the researcher (see Appendix M for example of transcribed interview), and the audio recording was deleted following successful transcription. Transcriptions were held on the researcher's encrypted laptop, on the software "NVivo". Participants were informed in the participant information sheets that they were welcome to read the transcribed interviews, yet no participants took up this offer. Interview notes were also taken (see Appendix N for example). These notes included the time and date of the interview, as well as the participants' unique code. They also included a comment section to detail any feelings or reflections from the researcher after the interview had taken place (Guion, Diehl, & McDonald, 2001). The purpose of these interview notes was to provide a record of initial thoughts or ideas that may potentially be of use during the data analysis phase (Polkinghorne, 2005). Paper data (e.g. transcripts, consent forms, interview notes) were stored in a locked filing cabinet for the duration of the research project.

3.8.5 Research timeline

The timeline for the current research took place from June 2018 to October 2018. See Table 5 below for timeline of data collection.

Table 5

Data Collection Timeline

| Time | Activity |
|----------------------------|---|
| June 2018 | Initial invitation emails sent to participants Measures reviewed by IMH practitioner |
| July 2018 | Pilot study of online questionnaire |
| August 2018 – October 2018 | Completion of qualitative data collection via interviews Qualitative data collected via interviews Quantitative data collected via online questionnaire |

3.9 Approach to Data Analysis

This study incorporated a convergent parallel mixed method approach to the research design. Within this type of design, quantitative and qualitative data were analysed separately and subsequently merged. This section aims to describe in detail how data were analysed, merged, and organised as a preface to the empirical findings of the study.

3.9.1 Quantitative data analysis. Survey data were gathered on the frequency of the psychologists' work in IMH within the five core functions of the psychologist's role. These core functions included assessment work, intervention work, consultation work, training and development work, and research work (Farrell et al., 2006). Descriptive statistics were used to "describe the collated information" (Simpson, 2015, p. 312). Data were presented using grouped bar charts. These grouped bar charts displayed the frequency of the data across distinct subgroups (University of Leicester, 2009). Specifically, the grouped bar charts created for the current study, highlighted the frequency of the participants' involvement in a particular activity (e.g. assessment work) across three subgroups of "individual", "group", and "collaborative" work. The "mode" of the data was the primary method used to describe the data, that being, the

“most frequently occurring value in a dataset” (Byrne, 2007, p. 39). Inferential statistics that are typically used to “make comparisons and draw conclusions from the study data” were not considered relevant for the current research question (Simpson, 2015, p.312). This component of the research aims to describe how psychologists incorporate an IMH framework into their practice, as opposed to generalise and draw conclusions to the wider population (Byrne, 2007).

3.9.2 Qualitative data analysis. Thematic analysis was used as the data analysis technique for the qualitative component of this research, as it is considered an “accessible and theoretically flexible approach to analysing qualitative data” (Braun & Clarke, 2006, p. 77). Thus, this approach was considered appropriate to represent the data from this exploratory study, whilst also incorporating the theoretical framework of the research. Thematic analysis adopted both an inductive and deductive approach. An inductive approach to coding is defined as “a bottom-up approach and is driven by what is in the data” (Braun & Clarke, 2006, p.58). On the contrary, a deductive approach to coding is a “top-down approach where the researcher brings to the data a series of concepts, ideas, or topics that they use to code and interpret the data” (Braun & Clarke, 2006, p.58).

Although some researchers argue that Thematic Analysis can be too broad and flexible an approach (Braun & Clark, 2006), this was not considered relevant for the current data. As these data are underpinned and guided using AT, the themes that emerged from the data could be pinned to a robust theoretical framework therefore eliminating concerns that the researcher would be overwhelmed by emerging themes. TA has also been critiqued over its failure to acknowledge the denotations and subtle nuances of language use (Braun & Clark, 2006). However, Kowal and O’Connell (2004) suggest that the features of the data to be described (e.g. verbal, prosodic, paralinguistics, etc.) should be determined by the goals and research questions of the study. As sociolinguistics was not considered relevant in addressing the current research questions, data were transcribed and analysed solely at a verbal level (Kowal & O’Connell, 2004). The data were analysed using the sequential steps as suggested by Braun and Clark (2006). These steps are outlined in Table 6.

Table 6

Steps of Thematic Analysis outlined by Braun and Clarke (2006)

| | |
|----------------|--|
| Phase 1 | Become familiar with the data through the process of transcription and initial review and examination of the data. |
| Phase 2 | Generate initial codes systematically across the data. Collect data relevant to each code. |
| Phase 3 | Begin to identify themes by reviewing codes and grouping related codes together. Collect all data relevant to each potential theme. |
| Phase 4 | Review themes both relating to sections of the data and at the level of the entire data set, generating a ‘thematic map’ of the analysis. |
| Phase 5 | Define themes based on a process of reflecting on the themes and the overall analysis and clearly define and name each theme. |
| Phase 6 | Produce the report through the process of selecting quotes and / or examples and drawing the results back to the research questions. |

Due to the exploratory nature of this research, a “hybrid approach” was adopted to coding (Fereday & Muir-Cochrane, 2006, p. 82), combining both inductive and deductive coding approaches. Firstly, the data were coded using an inductive approach, whereby themes were derived from the content of the data itself. As this research was investigating a relatively under-explored area, it was proposed that this approach was essential in order to accurately capture the true meaning of the semantic data content, “as deductive knowledge alone cannot uncover new ideas” (Stebbins, 2001, p.8). This was completed using Braun and Clarke’s (2006) six step approach to Thematic Analysis. An account of how these steps were performed with regards to the data of the current study can be found in Appendix R. Example of a coding trail for a particular theme can be found in Appendix S. Following this, the themes gathered were subsequently mapped onto the *a priori* nodes of the Second Generation AT framework. An overview of the inductive themes as matched with the nodes of the AT framework can be found in Table 7.

Table 7

Inductive themes and Corresponding Activity Theory Nodes

| Activity Theory Node | Inductive theme |
|-----------------------------|--|
| Subject: | <p><i>Perceptions of Role of Psychologist:</i></p> <p>Perceived lack of understanding of role of psychologist Psychologists view themselves working in leadership capacities Psychologist as champion for the infant Psychologist is referred to in crisis situations Psychologist is not on the ground</p> <p><i>Distinctive aspects of psychologist's practice in IMH:</i></p> <p>Psychologists' high level of training Psychologists' skills in formulation Psychologists' knowledge of child development Psychologists' relationship with reflective practice</p> |
| Object | <p>Assessment work Intervention work Consultation work Training and Development work Research work</p> |
| Outcome | <p>Enhanced reflective capacity of caregiver Improvement in quality of relationship between infant and caregiver</p> |
| Rules | <p><i>Constraining factors:</i></p> <p>Service restrictions to IMH work Difficulties justifying outcomes Lack of resources can hinder IMH work Lack of understanding on IMH Stigma around IMH difficulties IMH work is evocative for practitioners Working with parents</p> <p><i>Supportive factors:</i></p> <p>Managerial support Colleague support Reflective supervision</p> |
| Community | <p>IMH is everybody's business Collaborative working is helpful in IMH contexts Multidisciplinary IMH team needs</p> |
| Division of Labour | <p>Roles can become blurred Lack of understanding on other's roles Strategies to clarify roles</p> |
| Tools/Artefacts | <p><i>Concrete tools and resources:</i></p> <p>Specialist groups Research publications Structured programmes Guidelines and policies</p> <p><i>Abstract tools:</i></p> <p>Guiding principles of an IMH framework</p> |

3.9.3 Creation of an activity system. Quantitative and qualitative data was subsequently collated to produce an “Activity System”. An Activity System is the prime unit of analysis within AT, and is the term used to describe the triangular model of a work activity (Hashim & Jones, 2007). The Activity System for the current research can be found in Figure 6. The purpose of the creation of an Activity System for this study is to provide a visual framework to display the key findings. Each node within the Activity System will subsequently be discussed with regards to the key themes and subthemes found within each node. The nodes are numbered within the Activity System diagram as found in Figure 6, therefore the discussion of subsequent findings will follow this order.

As this study incorporated a mixed-methods approach, quantitative data and qualitative data were merged within the object node of the Activity System. As the object node refers to “what is being worked on... or the focus of activity”, it was considered a suitable juncture to merge the findings of the online questionnaire, with relevant findings from semi-structured interviews (Leadbetter, 2008, p. 198). This method of merging data is broadly defined within the literature as a “joint display” (Guetterman, Fetters, & Creswell, 2015, p. 555). A joint display is a means of integrating data using visual means to assimilate information gained from quantitative and qualitative means (Guetterman et al., 2015). In the case of the current study, the joint display can be found in the object node, whereby the graphic information from the online questionnaire is jointly displayed with relevant themes from the qualitative data to provide a holistic picture of the focus of psychologists work within IMH contexts.

3.9.4 Identification of contradictions. Once the Activity System had been collated and analysed, it was considered pertinent to explore the key contradictions within the Activity System. Key contradictions have been described previously as “sources of tension, disturbance and eventually change and development” (Leadbetter, 2008, p. 201). These points of tension within an Activity System highlight priority areas for change within a system. Through the identification of contradictions, this study was able to highlight key areas for changes within the Activity System. These areas for change will be subsequently discussed in the discussion chapter, as potential implications for the research.

3.10 Ethics

Approval for this study was obtained from the DECPsy Ethics Committee in Mary Immaculate College in April 2018. This study is underpinned by the PSI's Code of Professional Ethics (PSI, 2010) and is guided by relevant legislation e.g. Data Protection Acts 1988 to 2018. A number of ethical considerations were posed by this study, and addressed by the researcher insofar as possible. An outline of said considerations and subsequent researcher actions can be found in Appendix O. A letter of approval from the DECPsy Ethics Committee of Mary Immaculate College can be found in Appendix P.

3.11 Validity

Validity has been described by Joppe (2000, p.1) as the ability to ascertain whether “the research truly measures that which it was intended to measure or how truthful the research results are.” Certain steps were taken by the researcher to ensure the validity of this research.

3.11.1 Content validity. Content validity is defined as the extent to which “different elements, skills and behaviours are adequately and effectively measured” (Zohrabi, 2013, p. 258). To ensure the content validity of this research, both data collection measures were reviewed by a practitioner in the field who works in an IMH context and who is a member of the PSI PIMHSIG (see Appendix Q). This was done to ensure measures were answerable and valid to a real-world professional. It was also to ascertain whether or not the case vignette was a plausible IMH referral that a service may typically encounter. Based on recommendations some items were then altered. For example, the question “what is your definition of IMH” was subsequently changed to “what is your understanding of IMH?”, based on the recommendation that some practitioners may not have a clear understanding of IMH and thus may feel under pressure to provide a formal definition. It was recommended that additional questions on the facilitators and barriers to working in IMH contexts be added to the interview schedule also. These modifications were subsequently made prior to the interview being piloted.

Undertaking a pilot study is also advocated in the literature as a means of enhancing a study's validity (Oppenheim, 1992). Engaging in a pilot study is considered an important step of the research process, in order to “identify potential problem areas and deficiencies in the research instruments and protocol prior to implementation during the full study” (Hassan, Schattner, & Mazza, 2006, p. 70). This study piloted both the quantitative and the qualitative components of this research, and relative changes were made following this as mentioned in the previous section. For example, an additional question was added to the online questionnaire regarding how often psychologists engage in group activities with IMH cases. Furthermore, piloting the semi-structured interview enabled the researcher reflect on the ordering and wording of questions, determine if there were any additional questions worth adding, and ascertain if the questions asked facilitated suitable responses (Dikko, 2016). It also enabled the researcher practice interview techniques and ensures the timing of the interview was reasonable (Berg, 2001).

3.11.2 Internal validity. Internal validity is concerned with how congruent the findings are with reality (Flick, 2004). Merriam (1998) recommends use of triangulation in the research process as a means of securing internal validity. This study incorporates both quantitative and qualitative means of gathering data on the role of the psychologist in IMH contexts. It is hoped that through corroborating the findings from both quantitative and qualitative methods, the strength and validity of the findings will be assured. Moreover, Merriam (1998) also recommends the use of peer examination as a means of supporting internal validity. Peer examination involves a process whereby “the research data and findings are reviewed and commented on by several nonparticipants in the field” (Zohrabi, 2013, p. 259). Two peer trainee psychologists reviewed the measures of this study and also blind coded a section of the data to ensure consistency and reliability of themes and categories within the analysis phase.

3.12 Reliability

Reliability in mixed-methods is concerned with the “consistency, dependability and replicability of the results obtained from a piece of research” (Nunan, 1999, p. 14). However, the concept of reliability is considered incompatible with social constructivist epistemology of the current research, which promotes the claim that there is no singular

truth (Mertens, 2005). For the quantitative component of this research, it is suggested that the data are easily replicable due to the numerical nature of the information. Yet, within the qualitative component, achieving identical results is a difficult and complex task due to the subjective nature of the data gathered (Lincoln & Guba, 1985). Instead, Lincoln and Guba (1985) suggest that reliability should be replaced with dependability of the research instead. The current study took several steps to ensure the dependability of findings.

Merriam suggests that a key method to ensure dependability and reliability in mixed methods research is to clearly explain the various processes, phases, and steps of the investigation. This study has attempted to demonstrate transparency throughout the research process, by clearly outlining each step of the methods and processes of this research within the current chapter. Regarding data analysis, the step-by-step approach to Thematic Analysis (Braun & Clark, 2006) was documented at each step of the process. A summary of this can be found in Appendix R. Examples of coding trails were provided (Appendix S) as a means of clarifying how specific themes were drawn from the data. As aforementioned, all qualitative information was blind coded by two peer trainee psychologists during the process, as recommended by Zohrabi (2013), to ensure consistency and reliability of themes and categories within the analysis phase.

3.13 Summary

Overall, this research employed a convergent parallel mixed-methods approach, operating under the constructivist paradigm. An online questionnaire used to ascertain demographic and descriptive information on how Irish psychologists use an IMH framework in their practice. The target sample for this phase of the research was psychologists working in multidisciplinary teams, including Early Intervention, Child and Family, Primary Care, and Child and Adolescent Mental Health. This data was analysed using primarily descriptive statistics.

Semi-structured interviews were used during the qualitative phase of this research, as a means of extracting perceptions of professional's own role in IMH service provision, and the role of the psychologist. The interview questions were drawn from the theoretical framework of AT, and an adapted case vignette was also utilised to

provide a platform for discussion. The sample was gathered from the IMG-NG across Ireland, and included professionals from a range of disciplines including psychology, social work, speech and language therapy, and nursing. This data was subsequently analysed using Thematic Analysis. The results of both phases will be discussed in the next chapter.

Chapter Four: Findings

4.1 Introduction

This chapter aims to outline the findings from all participants in this study. A total of 30 participants were involved in this study; 19 psychologists completed an online questionnaire and 11 professionals from a range of backgrounds took part in semi-structured interviews. The data was analysed with the aim of addressing the research questions for the current study:

1. How do psychologists use an IMH framework in their practice?
2. How do psychologists, and other relevant professionals, view the role of the psychologist in Infant Mental Health service provision?
3. How do psychologists, and other relevant professionals, view the roles of others in Infant Mental Health service provision?
4. What are the distinctive attributes of the psychologist's role that make their roles unique within multidisciplinary Infant Mental Health service provision?

4.2 Demographics

4.2.1 Quantitative data. With regards to the psychologists who completed the online questionnaire, 78.9% were female and 21.1% were male. All psychologists who completed this questionnaire were practising in Ireland. With regard to branch of psychology, 44.4% were clinical psychologists, 38.9% were educational psychologists, and 16.7% were counselling psychologists. In terms of level of training, 47.4% of this sample had obtained a PhD/Professional Doctorate, with the remaining sample having obtained a Masters Degree. Participants were all currently working in multidisciplinary contexts, with 36.8% working in disability services, 36.8% working in primary care, 15.8% working in CAMHS, and 10.6% working in child and family services.

4.2.2 Qualitative data. The professionals who partook in semi-structured interviews came from a variety of diverse backgrounds and disciplines. Information on participants and their job titles can be found in Table 8.

Table 8

Details of Interview Participants

| Participant Code | Current job title |
|-------------------------|--|
| P1 | Senior Clinical Psychologist working in CAMHS. |
| P2 | Senior Educational Psychologist working in Early Intervention. |
| P3 | Clinical Psychologist working in private practice. |
| P4 | Senior Clinical Psychologist working in CAMHS. |
| P5 | Principal Clinical Psychologist working in Primary Care. |
| P6 | Senior Clinical Psychologist working in Primary Care. |
| SLT1 | Senior Speech and Language Therapist working in Primary Care. |
| SW1 | Social Worker working in community based early intervention and prevention initiative. |
| DOC 1 | Paediatrician working in a maternity hospital. |
| N1 | Nurse with experience in public health and midwifery. Currently working as part of community-based early-intervention programme. |
| CM1 | Social Care worker employed as manager of Community Mother's programme. |

4.3 Results

As mentioned in section 3.9 of the previous chapter, quantitative data was analysed using descriptive statistics and qualitative data was analysed using TA. The findings were then organised and collated to produce an activity system. The activity system for the current study can be found in Figure 9, and provides a visual representation of the research findings. Each node will be subsequently discussed in detail with reference to the key themes and subthemes.

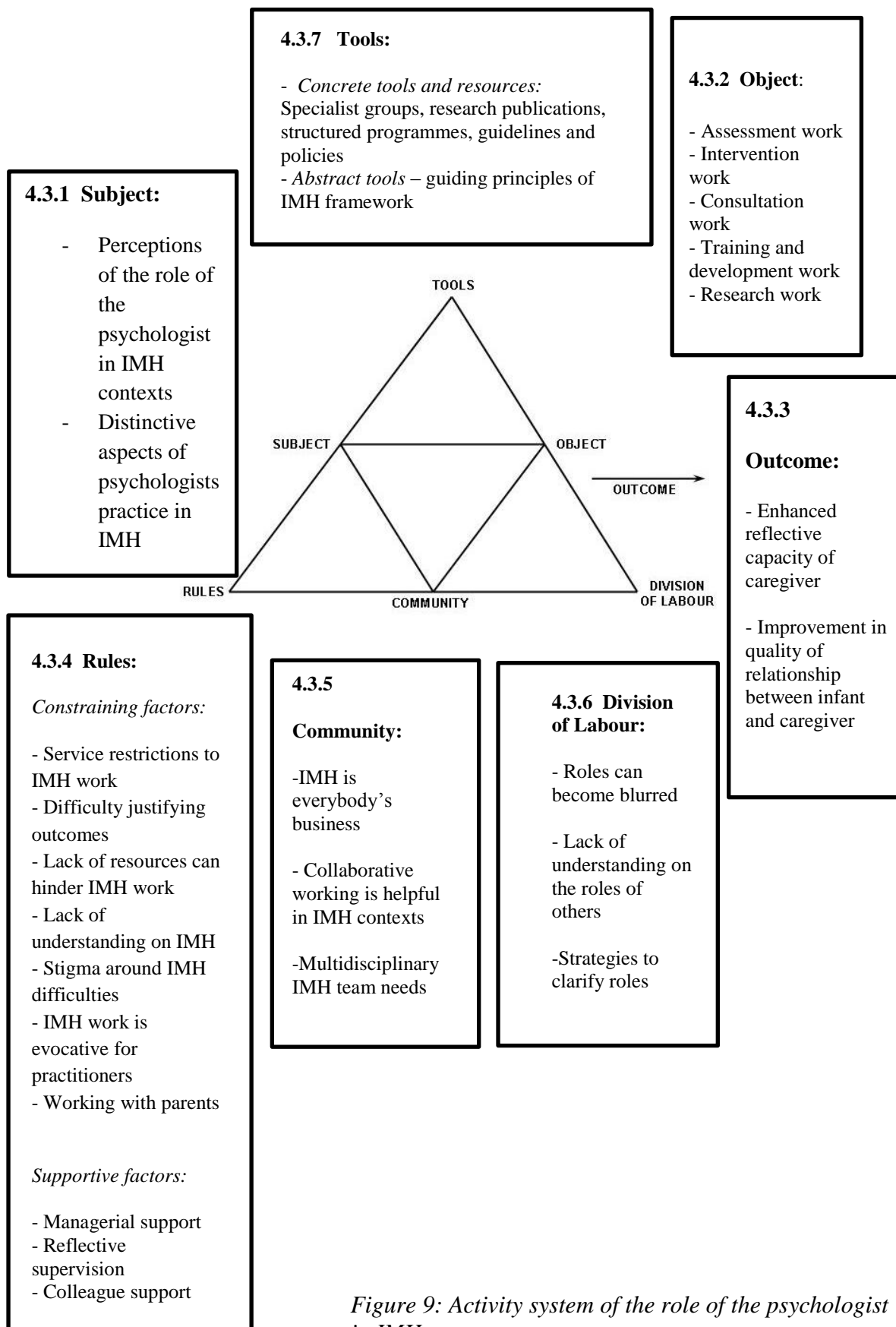


Figure 9: Activity system of the role of the psychologist in IMH

4.3.1 Subject. The “subject” of an activity system is the person whose perspective is being investigated (Leadbetter, 2008). This node consists of two main themes, each with a number of subthemes. A diagram depicting the subject node can be found in Figure 10 below.

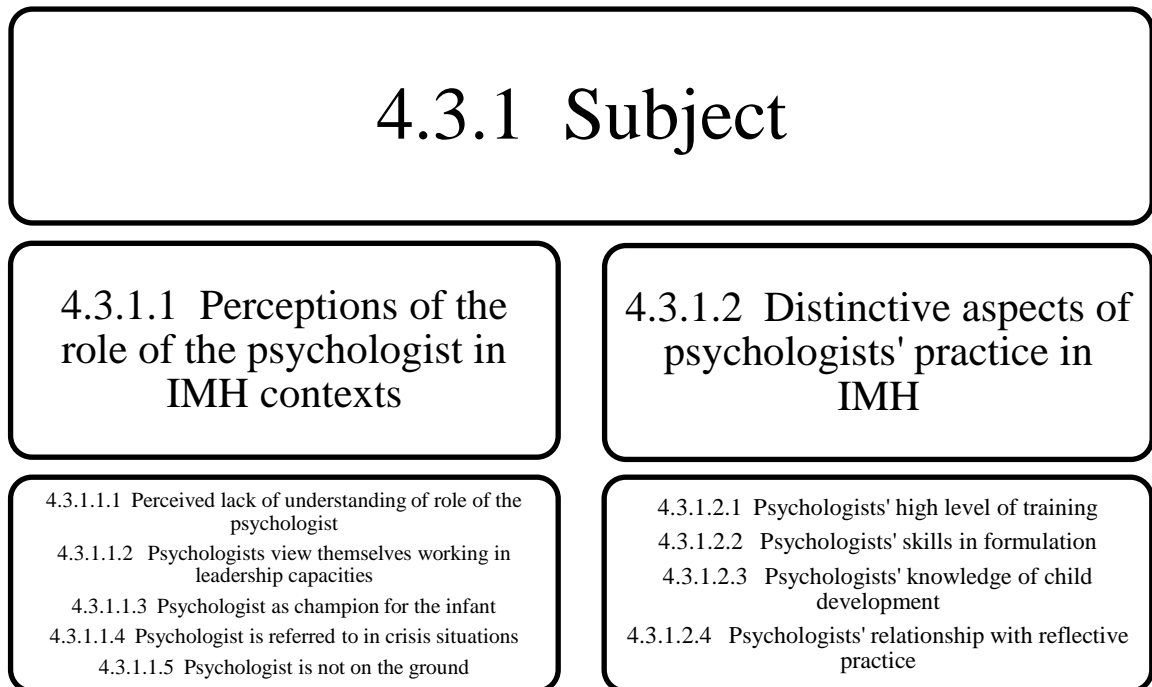


Figure 10: Diagram of subject node

4.3.1.1 Perceptions of the role of the psychologist in IMH contexts. This theme regards the understandings and interpretations of the role of the psychologist, encapsulating thoughts of both psychologists themselves and that of other professionals interviewed.

4.3.1.1.1 Perceived lack of understanding of role of psychologist. A recurring subtheme that emerged regarding the psychologists’ perception of their role involved their discernment that the role of a psychologist is not clearly understood. One psychologist felt that the traditional view of the psychologist as a school-based service, results in parents or other professionals not referring their children at younger ages.

Perceptions of what a psychologist's role was traditionally, is another barrier I think. Traditionally, psychologists weren't referred to until they went to preschool is my experience of working in EI in Ireland, they refer the kids at age 3 but that's gone. (P2)

A poor awareness among parents of young babies about the psychologist's role can result in feelings of fear and anxiety if a psychologist becomes involved in the case. Interviewees noted that parents are afraid that their child will be taken from them or that psychologists have a hidden agenda. One participant noted that when she used to work with new mothers, she would ask other team members not to refer to her by the term "psychologist" as she felt the name was a loaded term and would create unease among her clients, "We used to not say psychologist we used to say the lady, that the lady was coming to see you. The thing is they are all afraid of their babies being taken away" (P3).

Participants also reflected their opinion that there is an educational and promotional piece of work to be done regarding the work of the psychologist among the community in order to eradicate the negative connotations associated with the profession, "Yeah well, that's it I suppose, you know you're kinda de-mystifying the whole psychology piece, and like showing that you're really just there to help" (P5).

4.3.1.1.2 Psychologists view themselves working in leadership capacities. A subtheme that emerged from the interview data comprised the psychologists' perceptions of themselves in a leadership capacity in IMH casework. Interviewees highlighted that this leadership role was not necessarily appointed to them, yet organically arose as a result of their involvement with the family.

The way it has happened for me has been much more ad-hoc in the sense that I've been working with families and then had to get other people involved so I've maybe naturally led a team of people who have been put together simply with the specific purpose of meeting the needs of this particular family. (P1)

Additionally, psychologists interviewed emphasised that any professional with the appropriate skills and training could assume the leadership of IMH casework, yet they noted that often the psychologist is the best placed professional for this activity in terms of background knowledge and experience.

Well I would say psychologists are in an ideal place to provide the leadership on a team given our background and our training. But potentially anyone who is skilled and trained up as an IMH specialist could lead and govern the work. I just think in Ireland it's such a new area, and the only people at the moment that are IMH specialists are psychologists you know, so it might make sense if psychology took on that role of leading and governing. (P5)

4.3.1.1.3 Psychologist as champion for the infant. Data analysed from psychologists who participated in interviews indicated that psychologists perceive a major part of their role in IMH as being an advocate for the infant. This element of their role applied to both their work with individual cases, with the aim of giving the baby a “voice in the family” (P4), as well as championing for the infant at a systemic level in the community. One participant likened this part of her role to the symbol of the hands on the “Circle of Security” logo, symbolising the person “holding” the relationship, “it's almost that person that's holding the relationship within the network of agencies and just ensuring that that is actually that we are working within a relational context” (P6).

One psychologist noted that giving babies a voice can be achieved through use of reflection. This wonder and curiosity that can be facilitated through reflective practice, may enhance stakeholders understanding of IMH and the infant's needs. This also may be particularly relevant as a tool to progress services from operating as a medical model to a more reflective and ecological type model.

When we would receive referrals where, very like your vignette that you sent on, gosh you think this could be ASD you know this very diagnostic queries and trying to foster a curiosity like gosh I wonder what the baby's story is. (P5)

4.3.1.1.4 Psychologist is referred to in crisis situations. An interesting subtheme of the psychologists' perception of their role, involves their view that they are working as a crisis service. One psychologist highlighted how it is difficult to engage in sufficient preventative and promotional IMH work, due to the work of the psychologist being referred to in crisis situations, "Getting to the early years when you know difficulties aren't at crisis point, there's not as much of an emphasis on that. You know a lot of our services are on firefighting" (P5).

Additionally, the historical involvement of psychology solely at crisis points on a multidisciplinary team can result in children not being referred at an earlier age to allow for appropriate and authentic early intervention work to take place.

Kids are only referred when below aged 3 if there is an ASD diagnosis or if there is a particular problem. For example, the child suddenly stops feeding or if there is a lot of behavioural issues around feeding. So if there is a crisis, you will get referred a kid younger. (P2)

The type of service a psychologist is working in can also reinforce this understanding that psychology is a crisis service, thus limiting the amount of IMH work a psychologist is able to undertake. A psychologist interviewed who was working in CAMHS highlighted how the service she worked in dictated how she had to prioritise workload, "Yeah, and why would you prioritise [IMH work] over a suicidal teenager, which is life and death sort of a thing" (P4).

4.3.1.1.5 Psychologist is not on the ground. From the other professionals interviewed, there was a perception that the psychologist did not engage in practical, "on the ground" work with young children and their families. A participant working in the Community Mothers programme noted that psychologists often aren't aware of the daily struggles experienced by some families with young children, "Yes sometimes psychologists are quite surprised, there was a reflective practice meeting there a little while ago and it's amazing that they are often surprised at what goes on for a family on the ground" (CM1).

Another professional reinforced this opinion that a psychologist's role is not in the everyday, pragmatic support of young babies and families. Instead, they highlighted that psychology becomes involved in a case when more complex need arises.

We are very often working with the lower level kind of stuff and I suppose it would get routed up higher as needs be but certainly we would refer in if we felt there was an identified need from social work or whatever and the next layer was needed we would use that pathway. (SW1)

Psychologists themselves also reiterated this concept. One participant noted that she would use other professionals as a means of providing support to a family in an indirect way. She noted that she would formulate strategies for support, and ask different professionals to operationalise these plans. The concrete assistance that other professionals were able to offer appeared to be a valued asset in collaborative working.

So social work and/or family support workers are pivotal because it's that real on the ground sort of support and ...I can often work through them so I would often work with the family support worker so like okay we are going to support this mom to even spend more time with this baby or reduce her financial burden by doing this and they would actually go and make sure that happened. (P1)

4.3.1.2 *Distinctive aspects of psychologists' practice in IMH.* This theme in this research encompasses the characteristics of the psychologist that makes their contribution to IMH contexts distinct.

4.3.1.2.1 *Psychologists' high level of training.* The most prominent characteristic that participants highlighted as a distinctive asset of the psychologist was their level of training. All the psychologists who participated in the study had obtained qualifications to Masters or Doctoral level, with many having engaged in additional training and professional development in IMH. This level of training is something psychologists consider important and valuable.

I mean they don't have when you do a psychology degree and if you go on to do a doctorate after you do the masters you are looking at five or six years .. tough tough tough.. it's not the same as a midwifery course, you know.. (P3).

Other professionals also referred to the experience and training of psychologists as something they value, "Psychologists are highly trained and their high level of expertise, like I wouldn't want someone else doing their job" (SLT 1).

As well as the extent of a psychologist's training, the nature of this training also lends itself to IMH work. Psychologists have had the opportunity within their training to learn about key theories and approaches that lend themselves well within an IMH framework. Such learning may include attachment theory, psychodynamic theory, and early learning theories. Psychologists felt that the core training obtained by other professionals may not have had this level of input, a concept that has been discussed in other subthemes also. While other professionals may have obtained their skills in IMH from other sources (e.g. postgraduate training, desk based research), the nature of psychologists' basic training is distinctive from that of other professionals, "But if you just took core social work training, OT training, I don't think there is anybody that could take the place of the psychologist" (P5).

4.3.1.2.2 Psychologists' skills in formulation. Other professionals, as well as psychologists, identified the psychologist's ability to summarise and integrate relevant information to provide a cohesive picture of the child and their difficulties, as a distinctive professional skill. Within this formulation process, psychologists report using their knowledge of theory and research to assist in the formulation process, as well as assimilate information from a variety of sources to provide a holistic picture of the child's needs, "I think we are able to bring together information from a lot of different sources and maybe bring together a number of different theoretical models and see what takes for this particular family" (P1).

Other professionals report valuing the psychologist's ability to formulate and provide an overview of the client's needs. One participant noted how they will utilize a psychologist's ability to take an ecological approach to a case, in order to obtain a

comprehensive “picture” of the child, which will assist them in their work going forward.

Any developmental clinics that we do or we’d always refer to psychology and then we get letters back from them about their opinion and what they think cos psychology would maybe talk to the parents and do home visits and then give us a whole generalised picture. (DOC1)

4.3.1.2.3 Psychologists’ knowledge of child development. As aforementioned, the nature of a psychologist’s basic training lends itself well to an IMH context. More specifically, psychologists reported how their knowledge of child development places them in an optimal position to engage in IMH casework. In particular, it was noted that having a knowledge of both typical and atypical development, enabled psychologists to have a reference point for what is considered “normal” as well as an ability to identify when intervention is warranted.

I think a really good core understanding in what things look like when they’re going okay and actually when we need to be thinking about support and intervention. So yeah I think we are well placed to kind of hold that. (P6)

4.3.1.2.4 Psychologists’ relationship with reflective practice. Reflective practice was stressed as an important component of IMH practice in general, yet also as a practice that psychologists have skills and experience in. Psychologists noted how they value reflective supervision as a source of guidance and support when engaged in IMH casework. One psychologist noted that other professionals were envious of the psychologists’ experience in reflective practice and reflective supervision, yet were surprised to discover that psychologists source this support independently.

Talking to colleagues in that there’s almost an envy or an idea that psychologists have reflective supervision I’ve had this chat with nurses, social worker, GPs, that they have this perception that we do it that we have weekly reflective supervision as part of our core job they’re kind reassured when I tell them no we

have to fund that and seek that ourselves but it's kinda a core value or expectation that you will seek it or turn for it. (P6)

As well as engaging in reflective supervision themselves, psychologists noted that they use their skills in reflective practice to facilitate others to adopt a more reflective stance to a particular case. One psychologist noted that it becomes particularly relevant when a case creates a strong reaction among team members. This may be an over-reaction to a particular case or else a sense of desensitisation to the client also.

When stuff kicks off with us as a group, I ask why we are all reacting to something or even not reacting to something or being de sensitised to something... just to be curious about that and just to foster reflective thinking about things. (P6)

4.3.2 Object. The object is “what is being worked on, acted upon or the focus of activity” (Leadbetter, 2008, p. 198). The object node of this research concerned the activities undertaken by psychologists when working in IMH frameworks. This data was gathered through both quantitative and qualitative methods. A diagram depicting the object node can be found in Figure 11.

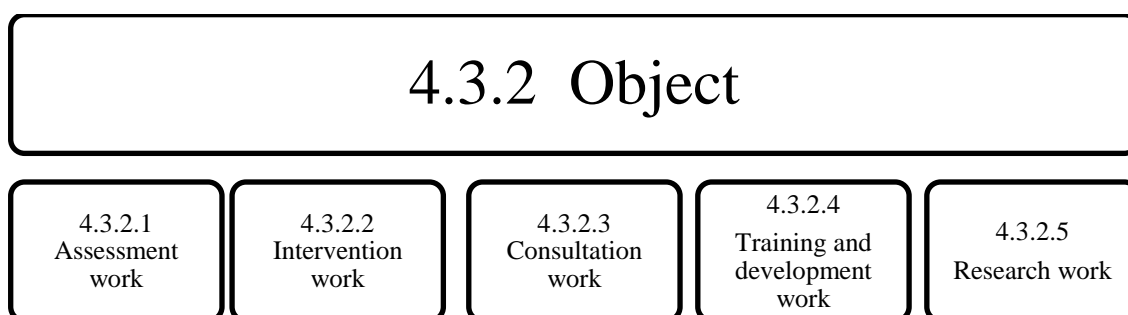


Figure 11: Diagram of object node

4.3.2.1 Assessment work.

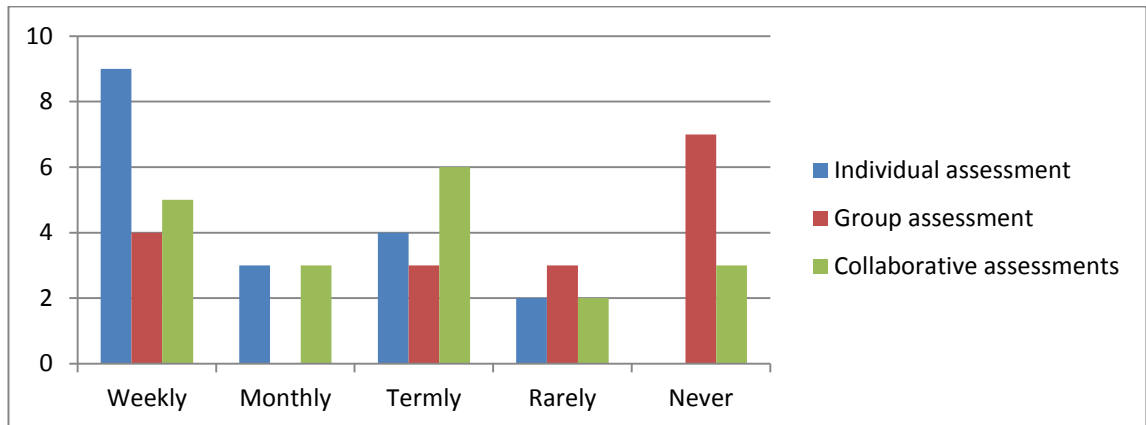


Figure 12: Bar chart of assessment work

The information gleaned from the online questionnaire and presented in Figure 12, highlights how the most common form of assessment work was assessment with individual IMH cases. Examples of this individual assessment work, as provided within the questionnaire, included “observation of parent-child relationship”, “developmental assessments”, and “screening for disability/ASD”. Assessment with groups of IMH cases was most frequently reported as “never” occurring. Collaborative assessment activities were reported most frequently on a termly basis. These activities included joint observations, ASD assessments where there is a differential of query attachment difficulties.

The psychologist in their assessment role also occurred frequently in the qualitative interviews by both psychologists. Such assessment work mentioned included developmental assessments, in order to provide the parent with an understanding of their child’s level of functioning and how they can adapt their expectations and interactions to suit the needs of the child. Other professionals reinforced the assessment function of the psychologists for children who they are working with for the purpose of a diagnosis, “I would refer some children for assessment maybe that I think there might be something additional going on like autism or whatever so I would refer in for a diagnosis really” (N1).

The importance of assessment for the purpose of differential diagnosis was also highlighted frequently. Participants emphasised that there can be a significant overlap between the presentations of certain complex developmental needs (e.g. ASD, Attention

Deficit Hyperactivity Disorder [ADHD]) and attachment difficulties. Due to the general lack of understanding about IMH, psychologists noted that children were often referred to them to ascertain what was “wrong” with them, “sometimes that’s all the referral information would be ADHD question mark” (P6). The psychologist’s role in the assessment process can be to ascertain the root of the client’s difficulties, and provide an accurate differential diagnosis for the case.

You would often be referred children where there are emotional behavioural difficulties, they don’t necessarily meet the criteria for ASD or ADHD, but when you speak to the parents on their own you might find out about maybe post-natal depression or just a very traumatic birth experience and the difficulties that the child is presenting with would seem to be sort of stemming from that area of relationship and maintained by that relationship. (P1)

Nonetheless, this differential piece can create a sense of isolation for psychologists due to a limited understanding of IMH among team members. Psychologists felt that they can be “banging the drum alone” (P2) when they flag potential attachment difficulties.

What I have noticed as cases come in, and I am using the term IMH at meetings, new referrals saying I think there is IMH difficulties here and I think there is a primary need before we get to the ASD diagnosis, we need to address this because attachment presentations and ASD presentations can overlap and I think I am the alone voice in that because people don’t really understand what I am talking about. (P2)

4.3.2.2 Intervention work.

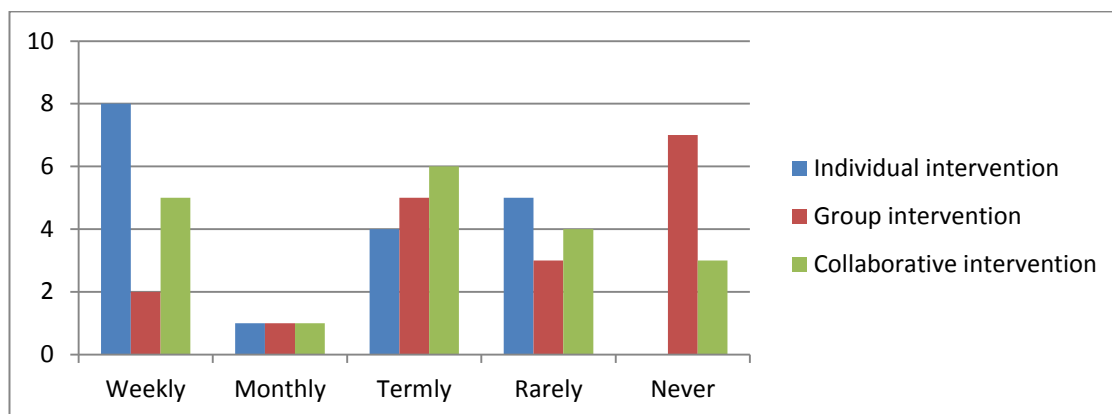


Figure 13: Bar chart of intervention work

Figure 13 shows participants' questionnaire responses regarding their intervention work with individual and/or group cases, and collaborative intervention delivered with another professional. Individual intervention occurred most frequently on a weekly basis, with participants referring to individual Theraplay sessions, use of Video Interactive Guidance (VIG) with parent and child, and infant-parent psychotherapy. Group intervention was most frequently reported as "never" occurring. Collaborative intervention was reported most frequently on a termly basis. Psychologists who completed the online questionnaire reported that they would engage in joint work to deliver a parent training programme such as Circle of Security, or jointly creating an intervention plan for a particular infant and family.

These intervention activities were also alluded to in the qualitative data. Psychologists viewed their role as providing one-to-one therapeutic intervention to parents, using evidence based strategies and approaches including attunement strategies, or parent-infant psychotherapy. Many interventions mentioned by psychologists involved joint working with another discipline, such as social work or speech and language therapy, to provide group or individual intervention work. Other professionals also valued the intervention work of the psychologist for young infants, and would refer them for intervention regarding behaviour or emotional development. However, one psychologist noted that the time to provide significant intervention work is limited due to the other demands of the role.

Capacity wise I probably don't have the scope [to do intervention work]. I could do bits ... but it's finding time..we should be doing it because what we know is

if the intervention doesn't happen there is going to be huge problems later on so we should be doing it (P2).

4.3.2.3 Consultation work.

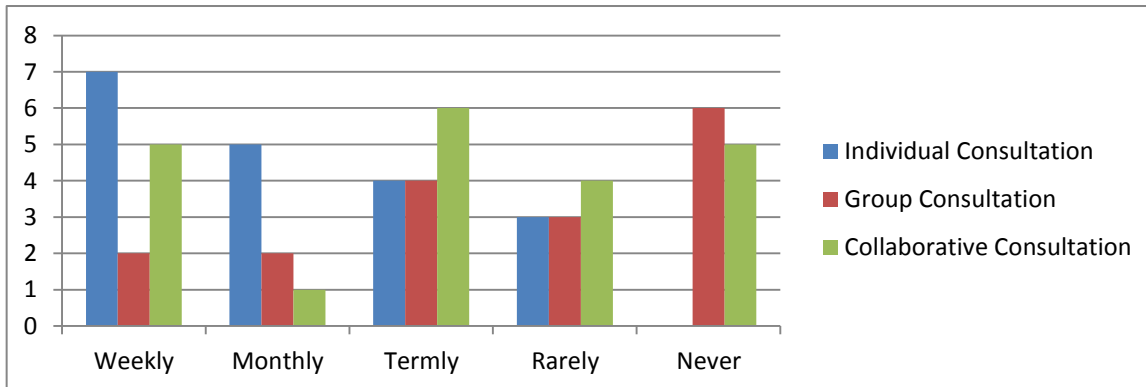


Figure 14: Bar chart of consultation work

Figure 14 highlights how psychologists engage in individual consultation most frequently on a weekly basis. Participants referred to their individual consultations with parents of an infant, or else consulting with other professionals regarding a specific case. Consultation with other professionals occurs most frequently on a termly basis. Examples of this type of work included drop in clinics with another professional, joint consultations with social work or speech and language therapy, consulting with others as part of the “Meitheal”¹ process, and providing supervision to other professionals or to assistant psychologists.

A psychologist's role as consultant was also reflected in the data, with other professionals appearing to value the collaboration with the psychologist, “I think that I have probably been drawn into it a lot by other professionals who have asked for my input with cases that are now looking at them were IMH cases” (P1). However, other professionals reported that it can at times be difficult to obtain formal consultation, thus relying on more informal and ad-hoc means.

I would love to have more of an input or relationship with a psychologist, even just to discuss clients with a psychologist.. It makes it so much easier when

¹ Meitheal is a “case co-ordination process for families with additional needs who require multi-agency intervention but who do not meet the threshold for referral to the Social Work Department” (TUSLA, 2019, para.1).

you're having a cup of coffee and someone is sitting beside them and you can say look I had this child before lunch what do you think I should do you know five minutes over coffee can help a lot .(SLT 1)

Providing consultation in the form of reflective supervision and facilitating reflective practices was also mentioned as an activity that psychology can provide, “I think staff need to be supported with that [reflective supervision] and I think psychology is in a good position for that”(P4).

4.3.2.4 Training and Development work.

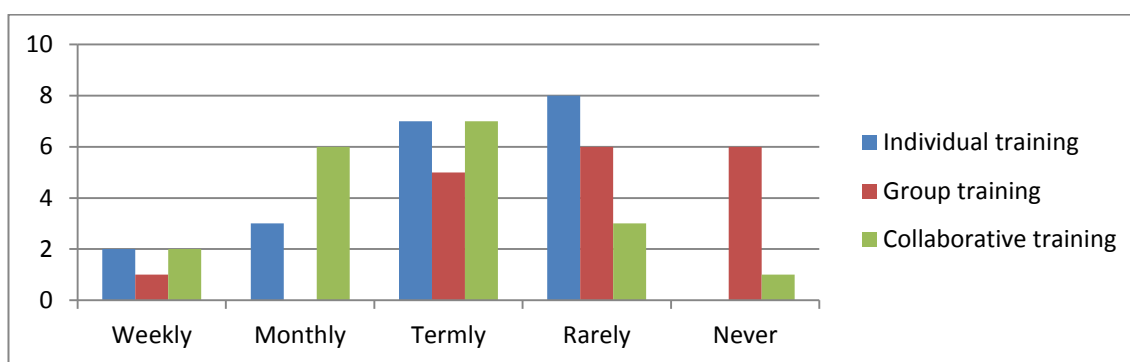


Figure 15: Bar chart of training and development work

Figure 15 depicts the psychologist's training activities. With regard to individual casework, training falls most frequently in the “rarely” category, suggesting individual training is not a frequent activity of psychologists in IMH. With regards to group training, psychologists reported that this mostly occurs “rarely” or “never”. However, collaborative training was reported on a termly basis. This training referred to both attendance at workshops with other professionals (e.g. attending IMH network meetings) or else providing training to parents.

The psychologist's activities in training also constitute continuing professional development related activities. Within this questionnaire, over 68% of respondents noted that the majority of their IMH knowledge came from post-graduate training opportunities such as Circle of Security training, Video Interactive Guidance training, or various online IMH courses. Only 26% of respondents reported obtaining IMH knowledge from their college material, suggesting that the topic is not covered in

sufficient detail in professional training courses. Upskilling in IMH was also reflected in qualitative findings, with many participants seeking additional training opportunities including “Solihull” training², the “Michigan Association of Infant Mental Health Endorsement Programme”³ or shadowing a practising psychologist.

Qualitative data also highlighted the psychologists work in providing training to other professionals or parents. The model of the IMG-NG (2015) were frequently referred to training activity facilitated by psychologists. These masterclasses are attended by a range of professionals in order to support them to use an IMH approach in their work. Moreover, the psychologist’s involvement in training at a universal or promotional level was referred to frequently in the data. The aim of this type of work is to enhance the awareness and importance of IMH in the community, as well as among workforces who engage with young children on a daily basis. This type of training work occurred both on a uni-discipline basis, or else in collaboration with another professional group, “The psychology team have gone and done some universal stuff with us they are developing universal services in XXXX they have assistant psychologists running workshops and early intervention type services for parents” (SW1).

4.3.2.5 Research work.

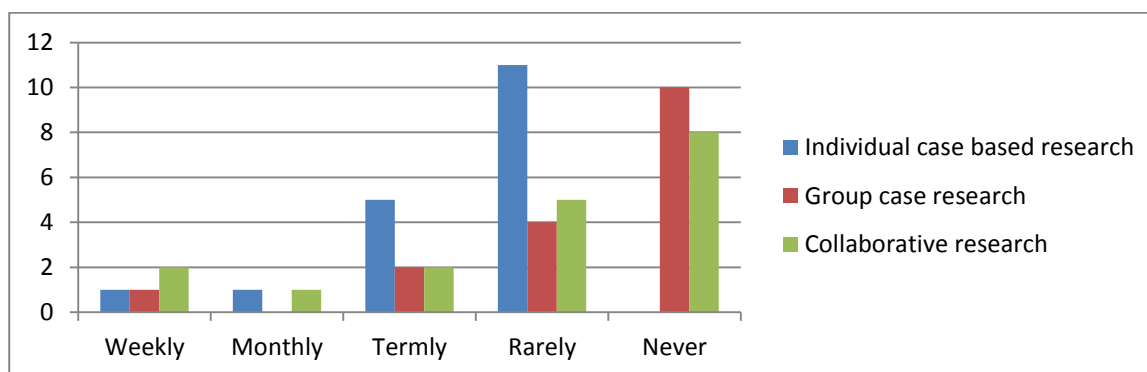


Figure 16: Bar chart of research work

² Solihull is an evidence-based and early intervention approach to working with families, which combines three theoretical concepts: “containment (psychoanalytic theory), reciprocity (child development) and behaviour management (behaviourism)” (Lancashire Children and Young People’s Trust, 2019, para.4).

³ The Michigan Association of Infant Mental Health Endorsement is a training programme designed to recognise “an individual’s efforts to specialize in the promotion/practice of IMH within his/her own chosen discipline” (Washington Association of Infant Mental Health, 2019, para. 1).

Figure 16 highlights the nature of psychologists' work in research related activities. It is clear from the above figure that psychologists "rarely" or "never" engage in research activities. It is postulated that lack of time and heavy caseloads limit their ability to engage in this type of work, something which has been alluded to frequently in the literature (Keith, 2000). Nonetheless, qualitative information demonstrated how, although psychologists may not have time to engage in specific research and evaluation type exercises, their research skills are something that they use frequently. One psychologist referred to her research skills in synthesizing, evaluating, and communicating psychological research in an appropriate manner as a skill that she values, "If you show the Strange Situation ..that you know being able to communicate the results of that in a way that is sensitive and useful and also being aware of the limitations of that" (P1).

4.3.3 Outcome. Within AT, the outcome is "what is hoped to be achieved" (Leadbetter, 2008, p. 199). There were two primary outcomes for IMH casework that derived from the data, which can be found in Figure 17.

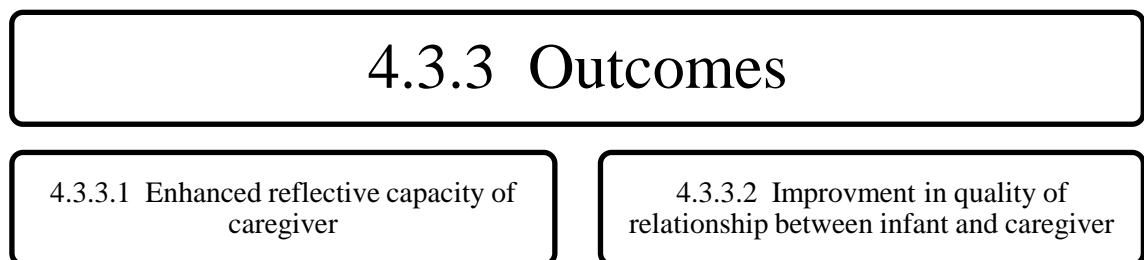


Figure 17: Diagram of outcome node

4.3.3.1 Enhanced reflective capacity of caregiver. Psychologists noted that a desired outcome from their involvement with an IMH case would be an increase in the reflective functioning of the infant's primary caregivers. One psychologist noted how she facilitates this by helping parents understand their child's development and what they can expect from their child at different stages, "working with the parent to help them understand you know what they can expect from their child from a developmental point of view so it's really helping that reflective functioning of the parent" (P5).

One psychologist noted how a change in the infant's behaviours isn't necessarily a goal of the psychologist's involvement, instead focusing on the caregiver's capacities

to understand the nature of these behaviours, “I’ve had a lot of parents saying ‘I’ve kinda noticed that his behaviour hasn’t really changed but actually I think I understand him more’, so those kind of outcomes are far more important than a Conners score or an SDQ” (P6).

4.3.3.2 Improvement in quality of relationship between infant and caregiver.

The second desired outcome for psychologist’s involvement in IMH casework is to enhance the relationship between infant and caregiver. One psychologist emphasised how if this relationship can be enhanced at an early stage, it can act as a protective factor for the child’s future development, “Then, we can mitigate or at least reduce the chances of further emotional behaviour difficulties as a child grows older” (P1). Moreover, others noted how strengthening the quality of the relationship is an intervention in itself, “The attachment between the parent and the child is the gateway to strategies and intervention. Because the intervention happens through the relationship.” (P2)

Enhancing this relationship may not always be through direct work with the infant-caregiver dyad, yet could also include an aspect of parental psychotherapy to see if any parental unresolved traumas were “interfering with how the parents were able to see their child at the moment” (P5). The parallel therapeutic process between the caregiver and clinician can indirectly support how the mother interacts and engages with her child.

Working with the mother in that parallel process ... to support her to nurture her sensitivity and her responsiveness... which in turn may foster that secure attachment to her child. So I would really value the parallel process between me and the mother. (P6)

4.3.4 Rules. The rules are supportive and/or constraining factors that “impinge on activities” (Leadbetter, 2008, p. 200). The diagram for the rules node can be found in Figure 18.

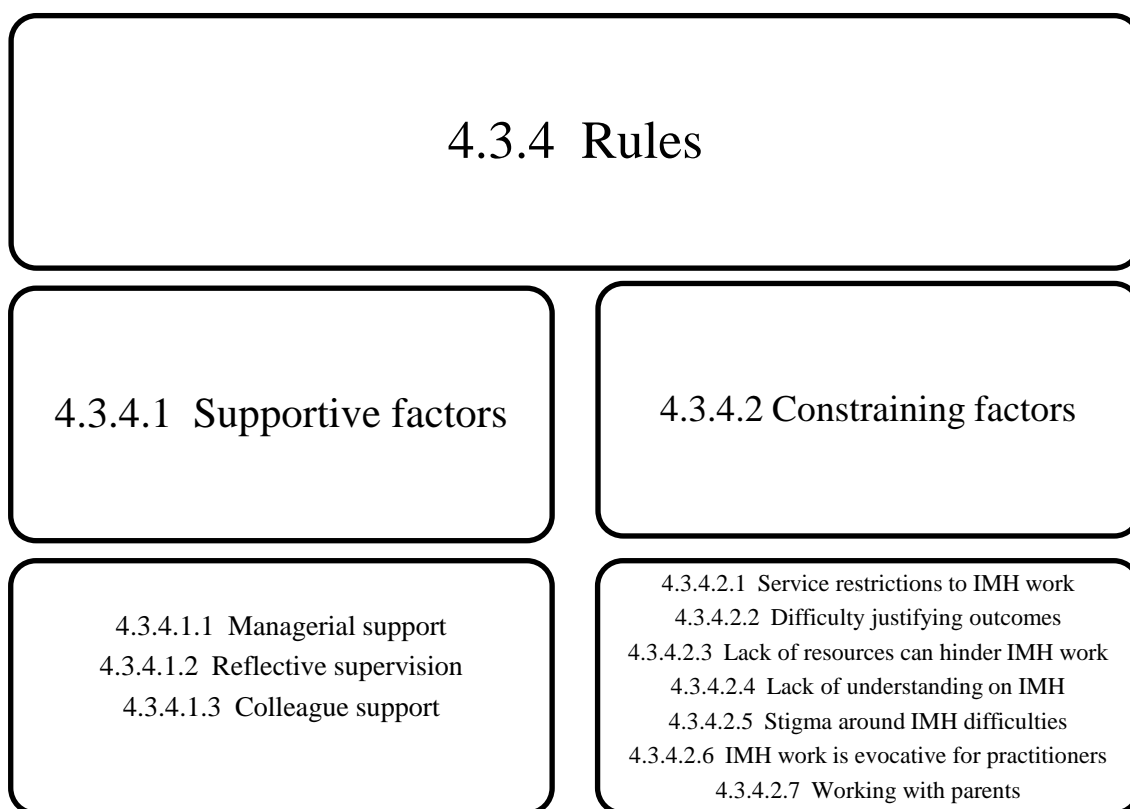


Figure 18: Diagram of rules node

4.3.4.1 Supportive factors. Supportive factors relate to the aspects of the psychologist's practice that enhance or facilitate their work in IMH contexts.

4.3.4.1.1 Managerial support. A key facilitator to IMH work was having managerial support. Due to the preventative nature of IMH, the outcomes of each case can be difficult to assess. Psychologists highlighted how having managers who understood and valued IMH made their working easier and that one "didn't feel under pressure to justify why you're working that way" (P4). This managerial support was referred to across line managers, psychology department managers, as well as government managers. One psychologist emphasised the importance of programmes and policies being endorsed and supported by government bodies as a means to validate a psychologist's work in IMH, "It's great that the HSE have acknowledged that this is important and this is in line with policy so it adds strength to what you're saying" (P1).

4.3.4.1.2 Reflective supervision. From a professional view, participants emphasised the importance of reflective supervision as a noteworthy facilitator to their work in IMH, “To really make sense of the work you need ongoing reflective supervision” (P6). The importance of reflective practice in IMH contexts is a concept that has reoccurred throughout this results section. Participants considered this important, as the nature of the work in IMH can often be distressing for a practitioner to manage. This level of stress could potentially negatively impact the practitioner’s ability to effectively engage with a case, “There’s a very understandable tendency to turn away from that and say god I can’t sit with this it’s too painful so I’ll just refer you on to someone ” (P6). As the nature of the work can be evocative for psychologists, having the capacity and service support to engage in reflective supervision was considered helpful in order to process one’s own feelings and experiences on the work, “Reflective supervision as well, I don’t think it would be possible to do the work without it. I just think it’s so key because we bring so much of ourselves to the work” (P5).

4.3.4.1.3 Colleague support. Additionally, the support from colleagues was considered of great help in their IMH casework. Participants noted that IMH is not “something you should do on your own” (P3). In particular, psychologists valued sharing of resources and tools, or attending trainings provided by colleagues, “Everybody who is kind of interested in the area tend to share resources so that is really helpful” (P1).

4.3.4.2 Constraining factors.

4.3.4.2.1 Service restrictions to IMH work. Psychologists interviewed noted how their capacity to engage in IMH work varied among services. Psychologists from CAMHS teams who were interviewed noted how they “don’t take many small babies or toddlers” (P4) due to their lengthy waiting lists and service demands for older children or adolescents. Similarly, psychologists working in disability services noted how these services may not recognise that children within their service may also have attachment or IMH difficulties also, “Children who have disabilities have insecure attachments too and it’s almost like the family and the relationships are not seen as important in disability services” (P2).

Over 70% of the participants who completed the online questionnaire highlighted that they work most frequently with the 6-12 year old cohort, despite their official age range of services being children aged 0-18. Moreover, as there is no discrete IMH service, psychologists noted how IMH cases can fall between two stools, as by the time they reach an appropriate service, the opportunity for early intervention has passed, “if you refer them onto child and family there is a 2 year waiting list ... So actually services for kids with attachment difficulties are really poor” (P2).

4.3.4.2.2 Difficulty justifying outcomes. Another systemic challenge when working in IMH, is the difficulties in assessing outcomes. Due to the preventative nature of IMH it can be “very hard to prove what you prevented” (P4). This has implications for government policies, as it is difficult to document the nature of the work effectively in monthly or annual statistics. One psychologist noted how her desired outcome would be increased reflective functioning of the parent yet putting this on paper can be a challenge, “The parents’ realisation like ahhh okay now I understand why he’s doing that so yeah I would more value those kind of outcomes but just unfortunately you can’t document those as well in your stats” (P6). This can have knock on effects in terms of government funding for future investment in the area, as one psychologist noted.

This is why IMH is not getting a lot of funding because it’s not like working with the spectrum where you get funding to do a certain amount of tests and then a certain amount of ABA intervention it’s so much more concrete this is difficult to conceptualise because you can’t write the blue print up because it’s written as they grow up. It’s ever evolving. (P3)

4.3.4.2.3 Lack of resources can hinder IMH work. In addition to service capacity, lack of resources can hinder the efficacy of IMH work being undertaken. Fifty three percent of psychologists who engaged in the online questionnaire noted lack of resources as being the most prominent barrier to IMH service provision. Psychologists noted how they would love to do more IMH work but they feel they do not have the resources to support them in doing so, “I do not think we are resourced well enough. I would love to be doing much more of it” (P2).

In particular, psychologists noted how the primary resource they are lacking for IMH casework is time, “we need more time and time is a precious commodity, and we are so busy” (P4). One psychologist noted how the lack of time allocated to IMH casework is due to the lengthy waitlists, which resulted in the service allocating a certain capacity for IMH casework per year, “We have a capacity here, each of the three specialists would have a max of two families at any one time. And that’s just the pressure of resources and the waiting lists for children 3-18” (P5).

4.3.4.2.4 Lack of understanding on IMH work. From a societal perspective, participants noted how a perceived lack of understanding on IMH can adversely impact providing an effective IMH service. It was noted how other professionals, as well as parents, may not have the knowledge of IMH to accurately detect any difficulties at an early stage, “I don’t think there’s enough out there. Parents don’t know about it, crèches don’t know about it” (P2).

4.3.4.2.5 Stigma around IMH difficulties. Another subtheme suggests that there may be a stigma around IMH difficulties, which may also present an additional challenge in providing IMH services. In particular, parents may be fearful of their child being taken away from them if they admit to having difficulties in their early days, “There is still a sense among woman that if they admit to having any difficulties, a social worker is going to take their baby. That’s a very real fear” (P1). Participants noted how it’s important to operate a strengths-based model to attempt to remove this perception, as well as reassure parents “that these feelings are all absolutely normal, you know to have them de-stigmatised and taken out of the shadows” (P3).

4.3.4.2.6 IMH work is evocative for practitioners. As aforementioned, the nature of the work can be extremely evocative for practitioners and can stir up difficult emotions that may have an adverse impact on the psychologist’s ability to manage their own reactions to the case, “it’s so evocative to observe and bear witness to an infant in distress and being neglected or being emotionally abused or whatever it might be ... I suppose all our defences are evoked” (P6).

4.3.4.2.7 Working with parents. Finally, participants noted that the nature of the work can be a challenge in itself, that being, working with parents when there is a

difficulty or trauma. One psychologist noted how parents can find it difficult to cope with the realisation that their child is presenting with difficulties, “It’s very difficult for them to deal with the fact that they may already have a challenge” (P3). This can result in the parents embarking on “a journey that might be painful” (P6) and which they will need additional support in dealing with.

4.3.5 Community. This node refers to who else is involved in the activity (Leadbetter, 2008). A diagram depicting this node and the relevant themes can be found in Figure 19.

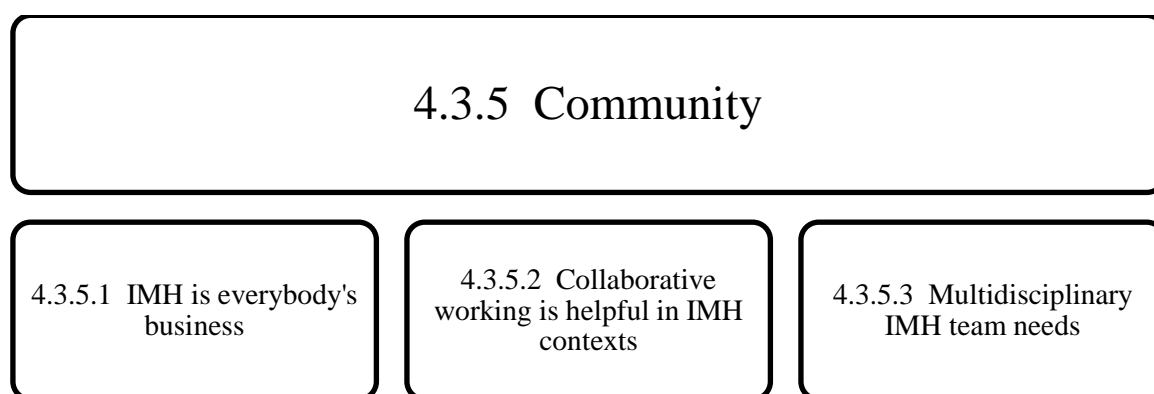


Figure 19: Diagram of community node

4.3.5.1 IMH is everybody’s business. Whilst the findings regarding the contribution of psychology has been discussed at length in this chapter, a notable outcome of the dataset regards how professionals interviewed considered their role in IMH more meaningful in the context of inter or multidisciplinary work, “I’m not just working in IMH so I’m not responsible for it all; it’s everybody’s business if you like” (SW1). Many participants noted that IMH is not the preserve of any one discipline. While psychologists are in a good place to engage in IMH work, participants noted that this type of work isn’t always best met by a psychologist, “I would think all disciplines have something different to offer and I wouldn’t like IMH to be just a psychologist or just a social work I think the strength is in the multi-agency specialist approach” (SW1).

One psychologist interviewed highlighted how psychology becomes the default professional involved in IMH casework on a multidisciplinary team. However, it is suggested that the practice of IMH encompasses a variety of disciplines at multiple

levels of involvement. Due to the fact that IMH is a relatively recent practice, other professionals may not see that they have a part to play in IMH casework, “I think when people hear infant mental health they think of psychology and they don’t see their role in it. But there are roles for everyone.... everyone has a responsibility at whatever level” (P2).

4.3.5.2 Collaborative working is helpful in IMH contexts. Collaborative working in IMH was considered an effective resource in facilitating IMH work. Both psychologists and other professionals felt that meeting other professionals with an interest in the area provided an opportunity to consult and seek advice from others, as well as potentially share tools and resources for future IMH work,

And even like I was saying the fact that I got to meet other multidisciplinary team members in the network groups like I suppose they were very specific to the IMH context but even just to meet colleagues in that way that you could grab someone for a few minutes it was beneficial in that way. (SLT1)

Working collaboratively in IMH casework can offer a sense of safety to both families and professionals working in these contexts. It is proposed that IMH work can be evocative for professionals thus having support of a network of professionals can alleviate some of the pressures created.

It’s lovely to come away from an interdisciplinary meeting where there’s a lot going on for a mother and baby trauma and adversity and to feel like actually I’m not on my own here that it’s just me holding all of this (P6).

Interviewees made reference to numerous professionals that they value in collaborative practice. Most participants reported that they would value all the disciplines that constitute a typical multidisciplinary team. These disciplines included psychology, speech and language therapy, social work, family support workers, occupational therapy, and physiotherapy. Some psychologists emphasised that links with adult mental health are of utmost importance in order to provide adequate support to the family around the infant. Additionally, one psychologist highlighted the value of a community dietician within her current role and felt that this discipline would be of

great use in an IMH setting with regards young children and potential feeding difficulties. A public health nurse was mentioned by a few participants as having a major role to play in IMH, particularly in their opportunities to observe the parent-child relationship during their initial mandated visits to new mothers. Similarly, early childcare workers were highlighted as being a key figure in IMH, as they often are the only professional interacting with the infant and parent on a regular basis, and may potentially be the only relevant contact a parent has to communicate any difficulties arising with their child. One participant summarised that she would ideally see IMH best met as an “early intervention team but with specialist training in IMH.” (P5)

4.3.5.3 Multidisciplinary IMH team needs. Although the professionals interviewed advocated for a multidisciplinary approach, the level of training and experience among general healthcare practitioners may limit their willingness to engage in this type of work. Among the psychologists who took part in the online questionnaire, the majority (68.4%) claimed that most of their knowledge of IMH came from Continual Professional Development (CPD) or else Post-graduate Trainings. Of the professionals outside psychology interviewed, none reported IMH or attachment being offered within their initial training, “They did talk about the importance of breastfeeding and bonding with the mom and they did reiterate that in obstetrics and gynaecology teaching too, but we didn’t specifically learn about infant attachment” (DOC1). Most had received their knowledge from additional trainings attended or the IMH network groups.

Participants noted that all professionals working with a 0-3 years age group should have an awareness of IMH, yet the limited knowledge and training in the area can create barriers to effective services. Such barriers include children not being identified by other professionals at an early stage, having to justify to managers why an IMH approach is being employed in said casework, or IMH cases falling between two stools. Thus, it emerged that an ideal IMH team would operate under a multidisciplinary model, with specialist IMH training provided to all team members. This universal IMH approach is then complemented by the discipline specific skills that the various professionals bring to bear on a team.

Like if I was to ask the disciplines in my own team now I would say a lot of

them wouldn't have a clue but if they were working in an IMH service or a team like I would expect that they .. might get extra training to bring them up to the same, you know, bring everybody onto the same page kinda thing. (P4)

4.3.6 Division of labour. The division of labour node regards the distribution of actions and operations among a community of workers (Hashim & Jones, 2007). The main themes surrounding the division of labour node can be found in Figure 20.

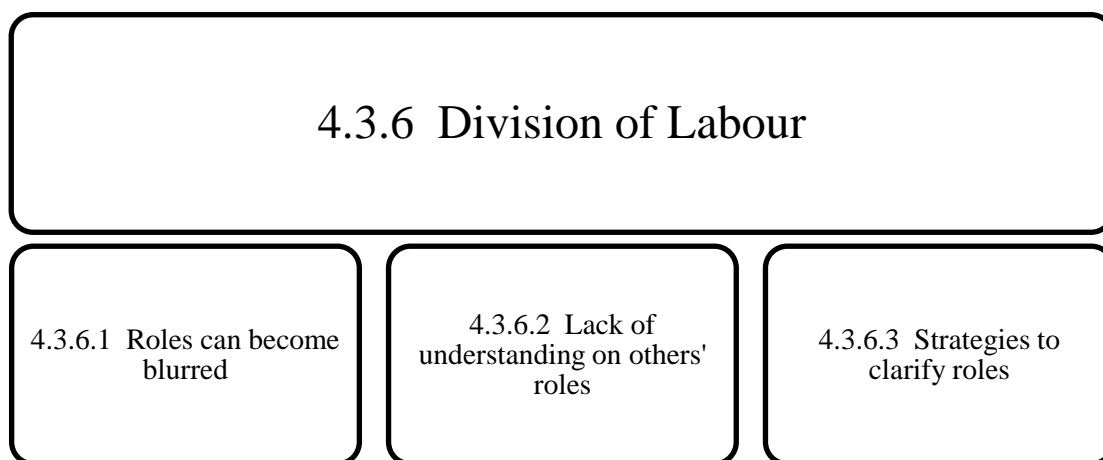


Figure 20: Diagram of division of labour node

4.3.6.1 Roles can become blurred. In light of IMH ideally being provided from a multidisciplinary context, it was hypothesised in the literature that there is potential for professional boundaries to become blurred. Participants interviewed confirmed this hypothesis, noting that roles can frequently become blurred amongst different professionals as the expectations of each professional are not clearly outlined, “I would say yes I think that it is quite blurred as to who the key players should be. There’s probably a role for everyone to play but they’re just not clearly defined” (SLT1). Additionally, a traditional medical model approach to mental health may cause confusion regarding what disciplines should be involved in IMH services.

With other professionals having the skills to work in an IMH framework, another potential area for role blurring emerges. An IMH framework or approach consists of evidence informed strategies and approaches for working with a young baby and their family, including counselling skills, building a therapeutic relationship, and

meeting the family where they are at. With this overlap in skill set, the differentiation between professionals can lack clarity and potentially create confusion among service users.

It can be a little bit blurry particularly if they're working with me and then they're also working with a counsellor or psychologist because we might be dealing with similar topics like post-traumatic stress or whatever so they're working there and then working with me and sometimes with the clients it's a little bit confusing because a lot of them would see me as a counsellor you know. (N1)

4.3.6.2 Lack of understanding on the role of others. From the data gathered a subtheme emerged regarding the uncertainty some participants expressed regarding the roles and activities of other professionals. Some interviewees explicitly stated that they weren't exactly sure of what their team members did with the 0-3 age group, "I think there has to be a space there where [the Occupational Therapist] can do some work, play or exercise, or whatever work they do with babies I'm not quite sure" (P3). Other participants noted that the lack of understanding of other professionals' roles in IMH contexts resulted in feelings of confusion regarding why a particular professional was operating within a particular capacity.

I know they used to employ nurses on their staff and I always kind of felt the role the nurses played... was very much an educational role and more like I suppose like a preschool teacher's role with the children and not as hugely medical role that they played ... I wasn't always sure why it had to be a nurse. (SLT1)

4.3.6.3 Strategies to clarify roles. While there can be an overlap in roles at times, participants referred to methods and approaches that can unpick and clarify role boundaries when working in IMH contexts. Firstly, participants acknowledged that, while different professionals may be working from a similar approach (that being, an IMH approach), each professional will possess discipline-specific skills, "there's an awful lot of overlap between some of us who've been around a long time and who have

been experienced in the area. And yet, each discipline, have the things that only they can do” (P4). Thus, participants noted that so long as the relational context is the “common thread” (P4) among professionals, each discipline has something different to offer to an IMH case.

Another means of unravelling role boundaries is through clear communication with colleagues. Having an open dialogue with colleagues one is working closely with can ensure that overlaps in roles are acknowledged and dealt with appropriately. This will ensure that there are limited gaps in the service offered among a team, or there is not repetition in services offered, “I suppose it’s just a matter of me being clear with a client and being clear with my colleague you know where the crossover is and there’s always gonna be crossovers”(N1). Clear communication can ensure that professionals are accountable in their work and have acknowledged their level of responsibility in a case.

Finally, ongoing reflective supervision/practice was considered another means to untangle these blurred lines between professionals. Reflective supervision may provide professionals with the space to consider their level of involvement with a particular case and support them if they feel they are working beyond their professional capacity, “It’s about providing the awareness and the training and the ongoing reflective practice around knowing where your own professional boundaries starts and finishes and what to do if you’re outside your remit” (P5). This reinforces the importance of reflective supervision in IMH, and is a service that should be provided or sought by all professionals working with young babies and their families, not solely psychologists.

4.3.7 Tools/Artefacts. This node refers to the tools used in the mediation between the subject and object in order to receive an outcome. Leadbetter (2008, p. 199) notes that these tools/artefacts “might be concrete (such as an object, machine or instrument) or may be abstract (the most common being language, but also including processes or frameworks).” A diagram of this node can be found in Figure 21.

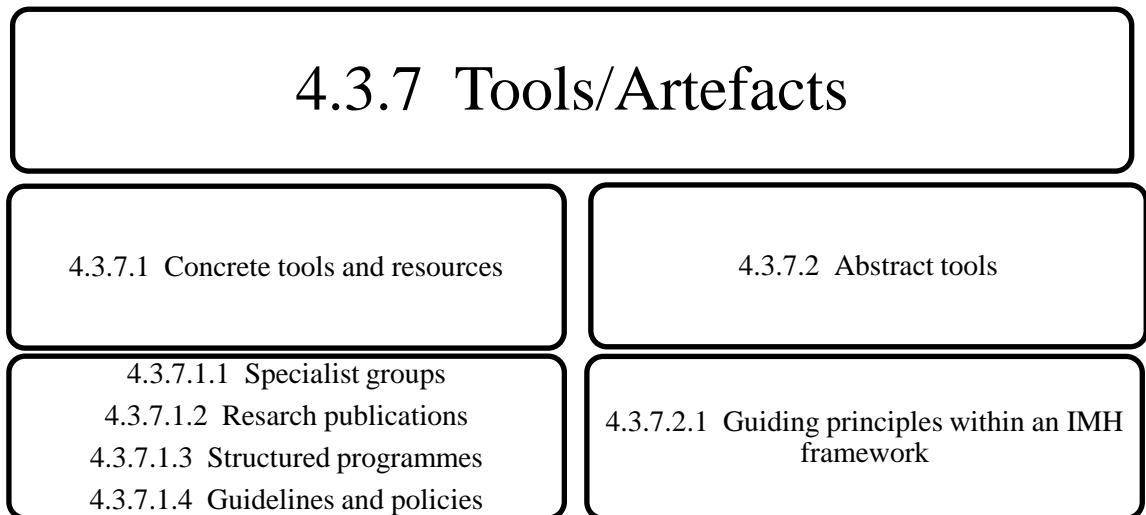


Figure 21: Diagram of tools/artefacts node

4.3.7.1 Concrete tools and resources.

4.3.7.1.1 Specialist groups. Some interviewees valued the professional interactions with special groups, such as the PSI's Special Interest Group in Perinatal and Infant Mental Health or else the Irish Association for Infant Mental Health. Through these groups, participants could access resources or trainings, share information, and connect with other professionals, "The Irish Association of Infant Mental Health have a lot of workshops - I have gone to a couple of those which have been brilliant and I think it's brilliant that you can contact them afterwards" (P1).

4.3.7.1.2 Research publications. Certain researchers or publications were also highly valued by participants, including the work of Dan Siegel, Kevin Nugent, the "PACE" model by Dan Hughes, or the work of Esther Bick.

4.3.7.1.3 Structured programme. Participants also referred to numerous evidence based programmes that they incorporate into their work in IMH contexts. Structured programmes alluded to as being helpful included Circle of Security, Theraplay or the use of VIG.

4.3.7.1.4 Guidelines and policies. As well as tools or resources, many interviewees mentioned particular guidelines or policies that supported them when working in an IMH framework. These included national guidelines such as the PSI

Code of Ethics or the Children's First guidelines. Many psychologists alluded to a set of competency guidelines that were designed by the Irish Association for Infant Mental Health. These guidelines were launched in April 2018, yet have not been published at the time this research was being conducted. These guidelines were based on the Michigan Association of Infant Mental Health's Competency Guidelines, yet were developed for an Irish audience.

4.3.7.2 Abstract tools.

4.3.7.2.1 Guiding principles of an IMH framework. The most prominent abstract tool that emerged from the data involved the incorporation of certain guiding principles that grounded their work with young infants and their families. The first principle regarded the preventative nature of IMH. Participants advocated how investment in IMH can mitigate or reduce the chances of future emotional or behavioural difficulties. The preventative nature of IMH can often be a short spell of intervention to prevent the onset of a larger problem and "nip it in the bud" (P3). Some highlighted how difficulties that aren't supported in the early infancy stage can ignite a downward spiral of difficulties and can result in more drastic treatment needs, such as a child being referred to CAMHS or being put on medication.

A second key tenet of an IMH framework that emerged from the data is the consideration of the ecological nature of IMH. Psychologists emphasised the need to explore the family constellation and the wider environment and community in order to best meet the needs of the infant. This may include supporting the parent(s) in exploring their own childhood experiences and how they may be impacting on their current relationship with their child. The notion that IMH is an intergenerational concept was highlighted on many occasions as an important feature of the work, as many parents may be "at risk of re-enacting her own history in the current relationship with her baby" (P6). Many psychologists interviewed advocated for the inclusion of perinatal mental health as a core component of IMH practice, as "everyone comes to a pregnancy with their own story and their own unresolved issues" (P4). Additionally, it may be pertinent to look at the social and physical environment the child is growing up in, and how this can be affecting the relationship.

If you have a mother living in adversity of course there's going to be problems around attention deficit, hyperactivity there's going to be all of that because the family environment isn't able to contain the child and meet its needs you know. (P3)

An essential guiding principle when working in an IMH framework that emerged from the data was IMH as a relational practice. This relational component is vital for both the client-professional relationship, as well as the relationship between the caregiver and infant. A positive therapeutic relationship between the family and psychologist was noted as a “key ingredient” (P6) when working on an IMH case. Having this relationship can develop trust and security for a family, which can be a gateway to ensuring accurate assessments of the nature of the difficulties as well as ensuring success of interventions. Moreover, the relationship between the infant and caregiver was mentioned frequently as the cornerstone for IMH. Many psychologists interviewed defined IMH “as best understood under the context of the attachment or the baby's relationship with their primary caregivers” (P1). This caregiving relationship was also considered a key protective feature in the life of a child and the “most essential ingredient for a child's optimal development” (P6). Enhancing the quality of this relationship was noted as a goal or outcome of a psychologist's involvement in IMH casework, as aforementioned.

4.3.8 Key contradictions. Through the analysis, primary and secondary contradictions were highlighted. Primary contradictions occur within a component of the activity system (e.g. within the rules node) and secondary contradictions occur between the components of the activity system (e.g. between the rules and outcomes node). The most relevant contradictions are highlighted in Tables 9 and 10.

Table 9

Primary Contradictions

| No. | Location | Contradiction | Extract from interview |
|------------|--------------------|--|---|
| 1. | Rules | Psychologists value the support of line managers when working in IMH contexts, yet there is a general lack of understanding about IMH among managers | <p><i>“having support of your line manager and basically confirming through them that this was good use of your time was useful” (P1)</i></p> <p><i>Vs “if management had a better understanding of this area of work and so that you I guess didn’t feel under pressure to justify why you’re working that way” (P4)</i></p> |
| 2. | Community | IMH is perceived as ‘everybody’s business’ yet there exists a need for upskilling | <p><i>“I think everybody working in across services not just with mothers and babies but mothers or parents in any context have a role” (P6)</i></p> <p><i>Vs “my training going years back didn’t feature any IMH” (SW1)</i></p> |
| 3. | Division of labour | Roles can become blurred when working in IMH contexts yet there is a lack of understanding on roles to begin with | <p><i>“I can see it ourselves on our CAMHS teams, there’s an awful lot of overlap between some of us” (P4)</i></p> <p><i>Vs “I think that it is quite blurred as to who the key players should be. There’s probably a role for everyone to play but they’re just not clearly defined” (SLT1)</i></p> |
| 4. | Rules | Reflective supervision is a key facilitator in IMH work yet there is a lack of resources that may impact on this coming to fruition | <p><i>“Reflective supervision as well, I don’t think it would be possible to do the work without it” (P5)</i></p> <p><i>Vs “the funding shifted from one to the other so there wasn’t really a commitment to the investment” (P6)</i></p> |

Table 10

Secondary Contradictions

| No. | Location | Contradiction | Extract from interviews |
|-----|-------------------------------|---|--|
| 1. | Subject vs Division of Labour | Perceived lack of clarity on role of psychologist vs lack of knowledge on other's roles in in IMH contexts also | <p><i>"unfortunately a lot of parents who have no understanding of what a psychologist does"</i> (P6)</p> <p>Vs <i>"I think sometimes you're seen as someone doing arts and crafts"</i> (N1)</p> |
| 2. | Outcomes vs Rules | Desired outcomes of IMH casework vs difficulties documenting outcomes | <p><i>"The quality of attunement between the parent and the caregiver and for me that comes first"</i> (P2)</p> <p>Vs <i>"It's the parent's realisation like ahhh okay now I understand why he's doing that so yeah I would more value those kind of outcomes but just unfortunately you can't document those as well in your stats"</i> (P6)</p> |
| 3. | Subject vs Tools | Psychologists referred to in crisis situations vs psychologists trying to work in preventative framework | <p><i>"So if there is a crisis, you will get referred a kid younger. But in the main, you are not referred kids to work on attachment or engagement"</i> (P2)</p> <p>Vs <i>"if we enhance or focus on that relationship at an earlier stage then we can mitigate or at least reduce the chances of further emotional behaviour difficulties as a child grows older"</i> (P1)</p> |
| 4. | Object vs Rules | Psychologists engaging in some IMH work vs psychologists being restricted in capacity for IMH work by service requirements | <p><i>"Like on any given day you could be doing parent psychotherapy but you could be also offering you know supportive counselling, you could be doing concrete assistance, etc."</i> (P5)</p> <p>Vs <i>"I work in CAMHS so I don't take many small babies or toddlers"</i> (P4)</p> |
| 5. | Subject vs Community | Psychologists perceived by others as not being 'on the ground' vs psychologists valuing collaborative work with other professionals | <p><i>"Yes sometimes psychologists are quite surprised, there was a reflective practice meeting there a little while ago and it's amazing that they are often surprised at what goes on for a family on the ground."</i> (CM1)</p> <p>Vs <i>"Your working relationships with colleagues really are key. You might, like we would have a good relationship with community mothers programme that's a peer volunteer programme"</i> (P5)</p> |
| 6. | Subject vs community | Psychologists viewing themselves working in leadership capacities vs IMH being everybody's business | <p><i>"Well I would say psychologists are in an ideal place to provide the leadership on a team"</i> (P5)</p> <p>Vs <i>"I think when people hear infant mental health they think of psychology and they don't see their role in it. But there are roles for everyone"</i> (P2)</p> |

4.4 Summary

This chapter aimed to discuss the main findings of this research, from an AT perspective. Quantitative data were gathered via an online questionnaire from 19 psychologists. Semi-structured interviews were used to gather data from six psychologists, and five other relevant professionals. Quantitative data were analysed using descriptive statistics. Thematic analysis was utilised as the primary data analysis technique, using Braun and Clarke's (2006) six step approach. Data were coded inductively into various codes and themes. Following this, themes were mapped onto the nodes of this study's guiding framework providing a further deductive approach to analysis. Quantitative and qualitative data were merged using the AT framework. An activity system of the role of the psychologist in IMH contexts was consequently produced. Key contradictions that arose among the tenets of the AT framework were highlighted, and will be used to inform the implications of this study, which will be discussed in the following chapter.

Chapter Five: Discussion

5.1 Introduction

The previous chapter provided a detailed report of the empirical findings of the current research. In light of the quantity of the data and themes presented in the previous chapter, the current chapter will focus on superordinate themes that are considered relevant in addressing the research questions of this study. The findings of this study will be analysed, contextualised, and interpreted through the use of three key overarching themes. These subordinate themes include: “psychologists working in an IMH framework”; “psychologists’ role in collaborative work”; and “the distinctive contribution of psychologists in IMH contexts”. Potential explanations for findings will be considered in light of previous literature and alternative viewpoints will be explored. The implications of these findings will subsequently be discussed from a research, policy, and practice perspective. As research can be a flawed process (Meltzoff & Cooper, 2018) limitations of the current study will then be recognised and acknowledged. This will lead to the development of recommendations for future research, to expand and advance the current study.

5.2 Interpretation of Findings

5.2.1 Psychologists working in an IMH framework. A key aim of this research was to gain an insight into how Irish psychologists use an IMH framework in their practice. Findings of this study suggest that psychologists assimilate an IMH framework into the pre-existing model of service their multidisciplinary team (e.g. CAMHS, Primary Care) currently operate within. Integrating IMH frameworks into existing service models has been advocated for in the literature also (Klawetter & Frankel, 2018; McNeil, Patterson, Manetto-Spratt, and Patsch, 2016). This approach enables psychologists to remain within the remits of their own service, yet provides a lens through which they can effectively work the case (Klawetter & Frankel, 2018). In order to adequately evaluate how psychologists are using an IMH framework, it may be helpful to explore the data through the lens of a particular framework. As alluded to in the literature review, Ahlers et al. (2006) present a comprehensive IMH framework

which adopts a layered approach to the provision of services to infants and their families. The tiers within this framework will subsequently be discussed in relation to this study's findings.

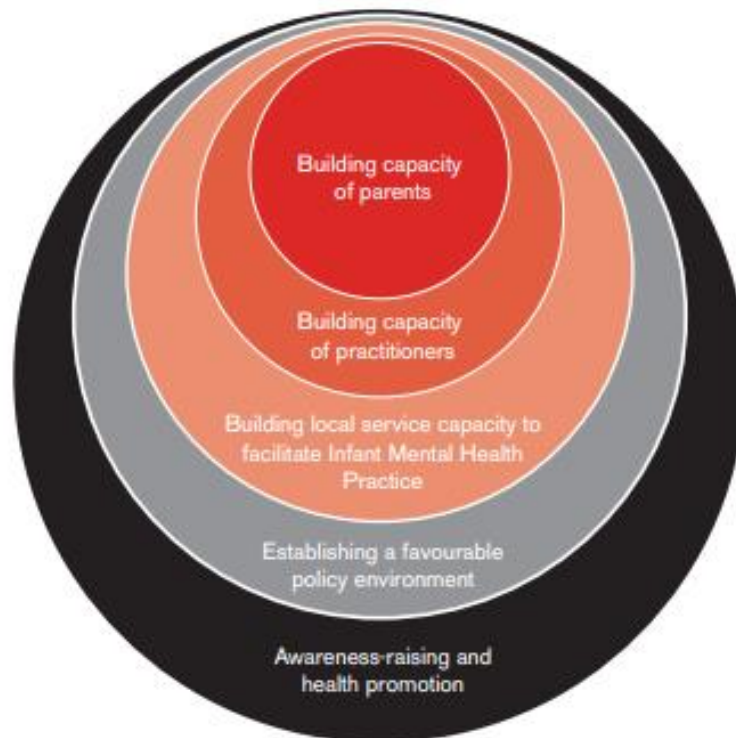


Figure 3: Ahlers et al.'s (2006) IMH Framework (as taken from Chapter Two)

In considering Ahlers et al.'s (2006) IMH framework, results of this study suggest that Irish Psychologists are primarily working within the three inner tiers of the model. With regards to the core tier, "building capacities of parents", findings of this study noted how psychologists engaged in activities such as parent training programmes (e.g. Circle of Security), individual parent consultations, or providing parent-infant interventions (e.g. Theraplay, VIG), with the aim of ensuring parents are supported in meeting the child's needs. In the second tier, "building capacity of practitioners", findings demonstrated how psychologists were noted to develop the competencies of other practitioners through engaging in peer consultations with other professionals about a client, or else by providing supervision to other practitioners. Finally, with regards the third tier, "building local service capacity to facilitate IMH practice", this study noted how psychologists are engaged in capacity building for the community

through activities such as the IMH Network Group master classes, or else providing workshops to professionals within the community.

The final two tiers are areas of an IMH framework that were not well represented in the findings of this study. In terms of “establishing a favourable policy environment”, Ahlers et al. (2006) highlight how policy makers at various levels need to become more aware of the importance of IMH through the provision of practice evidence or ground-up research. However, this study notes how few participants engaged in the conducting of research projects regarding IMH work. Keith (2000) noted how psychologists working in research capacities fall into three categories: “consumers” of research, “distributors” of research, and “conductors” of research. Psychologists in the current study did not appear to be significant conductors of research, yet did participate as consumers and distributors of research. Psychologists acknowledged how they used or “consumed” theoretical principles of IMH as abstract tools when working in IMH contexts. Furthermore, psychologists also distributed the research on IMH to colleagues through IMH network groups or workshops, as previously mentioned. While this use of evidence based practice is of value, the void in the conducting of research is not conducive to a favourable IMH policy environment

The final tier of “awareness raising and health promotion” was also a feature of an IMH framework that was not reflected in the current study. Osofsky (2016) notes how there is a need to develop the understanding of IMH and infant wellbeing at a more global level, including to areas outside of healthcare such as early years education services, family resource centres, or other community service providers. Stellenberg (2012, p. 16) suggests that this tier may be operationalised through the “development and distribution of information, advice and guidance to parents in a variety of accessible and practical ways and could include information campaigns aimed at practitioners as well as parents”. Nonetheless, no findings within this study highlighted psychologists explicitly engaging in this type of promotional work. However, psychologists did acknowledge the need for universal awareness-raising campaigning, as it emerged how lack of understanding of IMH can be a notable barrier to their work in IMH contexts.

5.2.1.1 Irish waiting list agendas. The challenges of lengthy waitlists and staff shortages for psychology have gained national attention in recent years (Cullen, 2019).

Barnardo's children's charity engaged in a national study exploring wait list figures, highlighting how 6,584 children were waiting for an appointment with primary care psychology, with 1,684 of these waiting more than a year (Barnardos, 2018). Herein suggests a potential rationale as to why certain elements of an IMH framework are not evident in Irish psychologists' practice. This crisis of waiting lists and professional resources severely infringe on psychologists' ability to truly engage in the preventative and early-intervention work characterised by an infant mental health and wellbeing approach. This dearth of time and resources was mentioned as a constraining factor within this study's findings, with one psychologist highlighting how she felt she couldn't prioritise IMH casework due to the amount of older children on her caseload experiencing significant mental health conditions that could potentially be cases of life or death. Moreover, many CAMHS psychologists who were invited to interview for this study declined the invitation as they felt the content of the interview would not be directly relevant to them. Despite their formal service description indicating that they provide services to children aged 0-18, many respondents highlighted how they rarely work with children under the age of five. Therefore, how can we expect psychologists to engage in the promotional and research-based IMH work that is currently missing from Irish practice, when their services are already vastly stretched?

The immense resource challenge Irish psychology is facing exemplifies a reasoning as to why psychologists perceive themselves as a crisis service, as found in the current study. From the data gathered, psychologists acknowledged how they felt they were "firefighting" these demanding waitlists, and thus were restricted in their ability to engage in preventative and promotional IMH work. In addition to not having the capacity to engage in desired preventative activities, working against an ever-growing caseload can cause practitioners to experience significant stress and could potentially lead to burnout. A recent meta-analysis highlighted how workload and perceived time pressure were a "strong and consistent" demand contributing to psychologist burnout (McCormack, Macintyre, O'Shea, Herring & Campbell, 2018, p. 12). Sim et al. (2016) also emphasise how crisis work and non-clinical tasks induce the likelihood of professional burnout and also query how this type of work affects the professional's identity of their role. This study points to how workload does affect the psychologist's perception of their role, and is something that ought to be supported and rectified in order to prevent stress and burnout.

This national waiting list and resourcing crisis may also provide an explanation as to why other professionals working in IMH contexts perceived the psychologist as not being “on the ground”. That being, the perception that the psychologist is not involved in the hands-on or practical activities with families of young infants. This view may reflect the psychologist’s restricted capacity to engage in long-term intervention work due to time or assessment pressures (e.g. Assessment of Need⁴). It may also be reflective of the aforementioned perception that a psychologist ought to only become active with a case when the problems reach crisis point. Moreover, the Heads of Psychology Services in Ireland (HPSI, 2015) highlighted how Primary Care psychology ought to capitalise on the skills of the Assistant Psychologist (AP) within the service in order to alleviate some of the pressure of the extensive waiting list. APs are recommended to provide low-intensity interventions such as group therapies or training programmes (HPSI, 2015). By doing so, qualified psychologists are freed up, “allowing them to better utilise their specialist skills for dealing with complex referrals, organising services and ensuring high standards of governance” (HPSI, 2015, p.20). Thus, this perception of the psychologist as not being on the ground, may be reflective of this model of working; using assistant psychologists as the mediums through which the “ground work” is completed. While this may be an effective method of service delivery in theory, the reality poses many questions: do APs have the necessary skillset for this type of work? What characterises a low intensity level of support? Does this method of working reinforce the psychologist as a professional who is not on the ground and deals only with complex or crisis cases? It is important to note that governing bodies have flagged that this method is “not a substitute for a fully qualified psychologist” and future research on the efficacy of this approach will be needed in order to justify organising psychological services in this manner (Mental Health Commission, 2006, p. 31).

It is suggested that this resource crisis ranks the conducting of empirical research in IMH contexts as a low-priority on a psychologists work load. While understandable, given the service demands, this will have implications for Irish policy. National bodies have advocated for psychologists working in IMH contexts to engage in

⁴ An Assessment of Need is provided for children below the age of five, under the Disability Act 2005. It entitles parents of young children to receive an assessment of their child’s health and education needs, within a specified time frame (Department of Education and Skills, 2011).

practice-based evidence in order to contribute “to the knowledge base that informs policy decisions” (PSI PIMHSIG, 2015, p.12). In addition to facilitating a favourable policy environment, this dearth in research from an Irish perspective can have implications for clinical settings also. A recent study carried out by Farrell & Grey (2018) noted that while Irish psychologists valued incorporating evidence from the literature into their practice, they often found that evidence from clinical trials did not translate easily into psychology practice. Thus, this finding dovetails with a larger argument in the field of psychology regarding “evidence-based practice” versus “practice based evidence” (Barkham & Mellor-Clarke, 2003). From the results of this study, it can be argued that psychologists are using evidence based practice in their work in IMH contexts, yet their contribution to practice based evidence remains an area for development.

5.2.2 The role of psychologists in collaborative work

A key theme that emerged from the data was how psychologists and other professionals interviewed, felt IMH services were best met from a multidisciplinary perspective. This is in line with how IMH services were initially visualised by Selma Fraiberg when IMH was first coined, in that IMH is everybody’s business (Fraiberg, 1980). It is interesting how professionals noted that they valued a multidisciplinary or interdisciplinary approach to IMH, yet none advocated for a transdisciplinary approach, which is the model of working offered by other Irish mental health agencies (Duffy, 2018). Multidisciplinary health care teams provide treatments independently within their discipline, yet share information with one another (Choi & Anita, 2008). On the other hand, a transdisciplinary team comprises the “sharing of roles across disciplinary boundaries” in providing services (King, Tucker, Desserud, Shillington, 2009, p.211). Therefore, even though a transdisciplinary approach is considered the most relevant for early intervention services within the literature (e.g. Hanson & Bruder, 2001), the findings of the current study suggests that professionals value the discipline-specific skills brought by each profession.

As discussed in the findings chapter, collaborative work with different professionals was noted to be helpful in IMH context by enabling them to consult with one another, share tools or resources, and seek support from one another also. This

finding is mirrored in that of MacDonald et al.'s (2005) study whereby service providers felt the need for collaboration was a high priority. However, this collaborative practice may not be as beneficial from the perspective of service users. Myor's et al. (2014) noted how service users felt bombarded with information from different professionals and felt they were repeating themselves continuously. This take on collaboration was not noted in the current study, as this study did not gather data from service users; something which may be interesting for future researchers to explore. The co-operative support provided through interactions with other colleagues may be an example of a "community of practice" (Wegner, 2011). A community of practice is a term used to describe "groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly" (Wegner, 2011, p. 1). This theoretical perspective conceptualises learning as a shared process involving others, whereby the individual learns through "doing, becoming, and belonging" (Lawthom, 2011, p. 153). Whilst this theory has its critics (e.g. Roberts, 2006), this study's findings indicate that communities of practice exist in IMH contexts and are helpful in stimulating new learning and knowledge.

Another prominent finding of this study is how professionals felt that role boundaries could become blurred when working in IMH contexts (Hinshaw-Fuselier et al., 2009). "Role blurring" in the literature is defined as a stressor involving poor role definition with an additional pressure to work generically so as to minimise the number of team members involved with individual service users (Byrne & Onyett, 2010). Blurring of professional boundaries has been a finding of other studies including Robinson & Cottrell (2005) whereby health professionals from multi-disciplinary teams noted that some of their roles become blurred in the attempt to treat the child as a whole. While role blurring was noted as a strength within Robinson & Cottrell's (2005) study, it can also cause significant tension and can present resistance to collaborative working. The findings of Suter et al.'s (2009) study noted how if other colleagues are perceived to take over one's roles, participants became protective of their own scope of practice and could be reluctant to engage in collaboration with others.

A potential reason for this role blurring is due to the lack of designated IMH services in Ireland. As aforementioned, IMH services have only reached community level in Ireland, with other professionals operating within IMH frameworks within their

own work settings (e.g. disability teams, CAMHS teams). Therefore, in adopting this IMH approach, professionals may feel that they have to “dip” into the roles of other professionals as a means of supporting the parent-child dyad, as there exists no formal structure or pathways for working with IMH cases as of yet in Irish healthcare teams (PSI PIMHSIG, 2015). A potential solution for this ambiguity in IMH services concerns Engeström’s concept of “knotworking” (Engeström, 2008). Knotworking is a novel way of working whereby professionals from different organisations come together to work on a specific task, that being, a shared object (Engeström, 2008). This collaboration forms a temporary “knot”, which is not fixed or stable. If the specific task changes or finishes, the knot is untied, and new knots with different professionals can be subsequently formed (Engeström, 2008). In contextualising this in IMH services, this may be best operationalised on a case-to-case basis. For example, a psychologist may have one particular case where the knot involves a social worker, parent, and infant, with the overarching goal of developing parental capacity in a parent with an intellectual disability. On a separate case, the psychologist may have a different knot with a paediatrician, public health nurse, and parent-child dyad, with the shared object being to support the parent come to terms with a traumatic birthing experience and facilitate her attachment bond. These knots transcend traditional work boundaries, thus could eliminate certain barriers to effective IMH work including “belonging” to certain services, lack of communication between organisations, or overlaps in services between different professionals. Thus, while specific IMH services are an idealistic long-term goal, a knotworking conceptualisation of working may be of particular benefit to professionals in the current state of IMH services in Ireland.

Nonetheless, the findings of this research did suggest certain strategies for professionals to utilise in order to clarify role boundaries and facilitate greater collaborative working. Firstly, clear communication was a theme that was noted as helpful in clarifying any grey areas where roles overlapped. This finding was mirrored in Suter et al.’s (2009) study whereby participants felt there was a need to clearly articulate how each professional contributes to the work, in order to delegate and direct team work more efficiently. However, it was also noted that some participants did not feel they would be comfortable in speaking up to clarify their role if such an instance arose. This was also echoed in Myers et al.’s (2015) study, included in the literature review, which suggested the use of multidisciplinary review meetings, case conferences,

and use of technology, as some strategies that can facilitate more effective communication. A finding of Robinson and Cottrell's (2005) that was not mentioned in the current study, regards communication of personal client information between services (e.g. between child and adult mental health services). Issues such as confidentiality and data protection can compromise how much collaboration can actually occur between services, and could be a potential barrier to IMH service going forward. This may be particularly important for all psychologists to consider in light of the recent implementation of EU General Data Protection Regulation (GDPR) principles (PSI, 2018).

Another approach that emerged as a theme to facilitate collaborative work in IMH contexts was use of reflective supervision. This supervision time can offer professionals a safe space to reflect on their involvement in a particular case, and problem solve as to whether they feel they are working effectively within the remits of their role, or whether they may need to seek further support from a colleague. However, in order for this process to be effective, professionals ought to have an understanding of their colleague's roles in IMH contexts. Recognition of the value of other professionals has been argued as a key prerequisite for effective collaboration (Orchard, Curran, & Kabene, 2005). This study noted however, that there was a lack of understanding on other professionals roles. This finding has been reiterated among other research (e.g. Suter et al., 2009) and can result in professionals underutilising colleague experience. If professionals are unsure of the contribution of another discipline to a case, one can end up attempting to work in a generic capacity and thus enter into the viscous cycle of role blurring, as aforementioned.

In addition to professionals becoming aware of the roles of other professionals in IMH, a theme also emerged regarding the need for training or upskilling among all professionals working with young babies and their families. As found in the current study, very few professionals noted having obtained any input on IMH in their original training. Many participants valued the use of the IMH Network Groups (2015) as a way to upskill in this area. This finding is similar to international research, highlighting how many undergraduate and postgraduate programs do not include principles and practice of IMH as part of their formal taught curriculum, (Wajda –Johnston, Smyke A.T., Nagle & Larrieu 2005, Weatherston, 2005). This may explain why psychologists viewed

themselves working in a leadership capacity, despite acknowledging the philosophy that IMH is everybody's business. As psychologists have some training at either undergraduate or postgraduate level on IMH, it may be natural for them to assume a leadership capacity when working on IMH cases, despite this role not necessarily being formally appointed or negotiated. Whilst upskilling and training will help to provide a balance in terms of training and skillsets among professionals, it is also important to have an overarching set of standards competencies for professionals working in this area. The Irish Association of Infant Mental Health (IAMH) has acknowledged the need for a comprehensive framework pertaining to IMH and wellbeing in an Irish context. Thus, the IAMH have created a series of competency guidelines for Irish professionals, based on the internationally recognised competency guidelines from the Michigan Association for Infant Mental Health. These guidelines will provide a professional framework for all practitioners working with babies/young infants and their families, including those in education settings as well as health care settings. As the term wellbeing has been an educational focus of recent years, professionals working in this sector may see their role in the promotion of wellbeing, yet may view IMH as a health-care delivered service. These guidelines will hopefully demonstrate that all professionals working with young infants have a role to play in both IMH and infant wellbeing, through advancing IMH knowledge as well as promoting the development of reflective practice in work settings.

5.2.3 The distinctive contribution of psychologists in IMH contexts

The final research question addressed within the current study regarded what attributes of the psychologists practice made their contribution to IMH service unique or distinctive. Four primary themes emerged relating to this question. The first theme concerned how the level and nature of psychologist's training was a valued asset that they bring to an IMH case. This study highlighted how all psychologists who took part had qualifications to a Masters or Doctoral level, in line with standards for the profession of psychology in Ireland. University programmes offering professional training in psychology were initially established between 1997 and 2004 (Carr, 2015). These originally began as Masters programmes, yet have recently moved to Doctorate programmes in both areas of clinical and educational and child psychology. Within these programmes, trainees are required to complete a research project, engage in

structured academic modules, as well as complete placements in a variety of health and education settings (Carr, 2015). This professional training is in addition to undergraduate degrees psychologists are required to complete prior to engaging in professional training courses. While other relevant professionals (e.g. social work, occupational therapy) are fully qualified to practice following their basic training, psychology is the only discipline that formally requires this additional professional training in order to be a practitioner in the field. Farrell et al. (2006) also reported how psychologists' academic background and training were factors that enabled them to offer a distinctive contribution to multi-agency work. Thus, the lengthy period of training could be considered a positive trait of psychologists in IMH contexts, with other professionals valuing and respecting this dedication to the profession.

A second notable attribute of a psychologist's practice that facilitates their distinctive contribution to IMH work is their knowledge of child development. Findings of this study noted how psychologists are well placed to work with young infants and their families due to their extensive and thorough knowledge of both typical and atypical child development. The BPS (2014) published a document outlining how psychologists in training who completed their child psychology placements wished they had previously understood how important their knowledge of child development stages and theories would have been to them, before they embarked upon their placement. Other researchers have reiterated how this knowledge of child development is an "essential" skill of psychologists as a means of "aiding our understanding of the diversity of paths that children can develop along and also for understanding their individual needs" (Davies, Banyard, Norman, & Winder, 2010, p.297). Moreover, Cameron (2006, p. 293) argues that another factor of a psychologist's practice that offers a distinct contribution concerns their ability to adapt a psychological perspective, and "approach human problems with specific and well-established psychological perspectives in mind". This theory dovetails with the findings of the current study, with psychologists using their psychological knowledge of typical and atypical development when working with specific IMH cases.

The use of and experience in "reflective practice" was a noteworthy theme that enabled psychologists to make a unique contribution to IMH casework. Although the definition of reflective practice has historically been difficult to pin down, Schon (1983)

uses this term in a general sense to explain the process by which professionals make difficult decisions based on more than just technical knowledge. Schon (1983) argued that while professionals may be familiar with a range of theory and research (e.g. cognitive behavioural theory), this knowledge is not sufficient in supporting them to make sound decisions in complex situations. Thus, reflective practice focuses more on the process rather than the methods of practice, requiring professionals to take a helicopter view of their work, and reflect on what is happening for them and the client (Youngson, 2009). The relationship between psychology and reflective practice is surprising, yet successful. Psychologists have a longstanding history embedded in behavioural science, and working heavily in a scientist-practitioner paradigm; therefore was slow as a profession to adopt reflective practice as a concept (Bennett-Levy, 2003). However, currently reflective practice is becoming more rooted in psychology practice, with the PSI promoting its use in formal training courses as well as in professional supervision contexts (PSI, 2017).

Reflective practice in the field of IMH is considered a space for professionals to explore their responses to their work with young infants and their families. By engaging in this explorative practice, professionals may gain insight and perspective that help clarify and shape their work with a family (Gatti, Watson, & Siegel, 2011). This process is recommended as a shared and collaborative approach in IMH contexts, with a particular focus on the professionals own feelings and emotional reactions to their work with clients (Gatti et al., 2011). This study highlighted how psychologists valued the reflective practice process and felt it would be difficult to engage in IMH casework without it. While psychologists value engaging in this process with their own supervisor, this study noted how they also use reflective practice skills to foster reflective thinking in other team members also. This finding is in line with research mentioned in the literature review, with psychologists engaging in reflective consultations with others (Harrison, 2016). Incorporation of reflective practice into multidisciplinary models in mental health is something that has been advocated for in an Irish context. The Mental Health Commission (2006) note how professionals' competencies in their job role ought to extend to consider how to apply these competencies effectively to casework, with reflective practice in action being recommended as the vehicle to achieve this. Moreover, the demands of a professional's busy working day can often result in practitioners missing opportunities to change or

alter their practice. Cameron (2006, p.300) suggests that a psychologist can aid in facilitating positive change through the “promotion of big ideas”. Through engaging in reflective practice with others, psychologists may enable other professionals to see avenues for change in their work, and opportunities to incorporate contemporary approaches; which can “rekindle the sometimes submerged enthusiasm” of professionals working with young children and their families (Cameron, 2006, p. 300).

A final aspect of a psychologist’s practice that this research suggested which contributes to their distinctive contribution in IMH contexts is their ability to formulate. Formulation has been defined as “a hypothesis about a person’s difficulties, which draws from psychological theory” (Johnstone & Dallos, 2006, p. 4), and is a fundamental skill for psychologists in practice. This process provides an understanding of each individual client’s presenting problem, and outlines a bespoke and personalised approach to intervention. Cameron’s (2006) model considers this a practice where “the objective is to provide a ‘best fit’ which encapsulates the main features of the situation” (Cameron, 2006, p. 296). Findings from this study indicate how psychologists noted how they integrated data from a variety of sources in order to obtain a holistic picture of the presenting problem. Professionals from other disciplines interviewed also reiterated the psychologist’s skills in formulation and valued their ability to provide a big picture. Other research has also acknowledged the psychologists role in formulation as a useful framework for practice within a multidisciplinary context (Gaskell & Leadbetter, 2009). Onyett (2007) suggests that the tangible presence of a psychologist within multidisciplinary forums (e.g. care planning meetings) helps to promote a holistic and ecological approach to the client’s needs and offer an alternative perspective to the medical model typically seen in mental health. Moreover, a study carried out by Christofides, Johnstone and Musa (2012, p.433) of psychologists in adult mental health teams, noted how the sharing of a case formulation or indeed jointly producing a formulation with their colleagues was considered a “significant part of their role and workload in multidisciplinary teams” and was considered of value by both team members and clients of the service. This study also noted how sharing the psychological thinking behind a case formulation sharpened the role of the psychologist for others, and reduced the mystery regarding what psychologists actually do (Christofides et al., 2012).

5.2.3.1 Valued but not unique?

Ascertaining the unique contribution of psychologists has been well documented in the literature (e.g. Ashton & Roberts, 2006; Cameron, 2006). The ability to clearly outline the distinctiveness of one's professional discipline has been theoretically linked to enhanced professional identity and lower levels of anxiety (Kerry, 2003). In fact, the British Psychological Society (2015b, p.22) indicates that contributing "a distinct psychological perspective within multidisciplinary teams" is a core competency for psychologists. While this study elucidated some qualities of the psychologist's role that participants considered valuable from psychologists, whether this research can confirm that these qualities are unique to the discipline of psychology is questionable. Many of the aforementioned "unique" qualities may also be within the remit of other professional disciplines too. For example, although this study noted that psychologists' relationship with reflective practice was a distinct quality, reflective practice has also been demonstrated among social workers (Knott & Scragg, 2016), nurses (Bulman & Schutz, 2013), as well as occupational therapy (Kinsella, 2001). This study also outlined how psychologists' level of training and knowledge of child development are qualities that may be evident in the roles of other professionals working with children. This begs the question as to whether the findings of the distinctive attributes of psychologists are necessarily unique to the profession.

Previous research in the unique contribution of psychology has also raised questions about the unique contribution of psychology. For example, in Farrell et al.'s (2006) study, many respondents including education professionals and psychologists indicated that an alternate professional may have been able to carry out the same work as the psychologist. A similar study was carried out by Ashton and Roberts (2006), who investigated what Special Educational Needs Coordinators considered valuable and unique about the psychologist. Their findings also pointed to how other professionals felt some services offered by the psychologist were not unique to that discipline. For example, they noted that the consultation services offered by psychologists could potentially be provided by a specialist advisory teacher (Ashton & Roberts, 2006). Furthermore, Cameron (2006, p. 299) postulates how, when problem solving "real-life" difficulties, the psychological aspect of the problem can be obvious. This can result in

stakeholders holding the opinion that the psychologist is not offering anything new to the understanding of the problem.

The findings of this research point to several potential reasons why the unique contribution of psychologists is difficult to pin down. Woods (2012) argues that ascertaining what is distinctive about psychologists should be a question for service users to answer, instead of something psychologists themselves have to address. While this study did not include the voice of service users, psychologists noted how they felt their role was not clearly understood by either parents/caregivers or other professionals. This lack of clarity from the perspective of others may be reflective of psychologists own lack of clarity of their own role in IMH contexts. Secondly, the difficulties in assessing outcomes of IMH cases, as alluded to in this study's findings, may also obscure the psychologists ability to articulate their distinctive contribution in this context. Finally, previous literature has also highlighted how "giving away psychology" to other professionals dilutes the role of the psychologist (Woods, 2012, p.262). Therefore, it could be argued how building capacities of other professionals through IMH network groups or consultations may be affecting the psychologist's unique contribution.

This challenge in ascertaining uniqueness may not be solely a challenge for the discipline of psychology. Woods (2012) argues how this challenge in ascertaining uniqueness could be applied to any professional. For example, Woods (2012 , p.322) argues that the contribution of teachers to education, social workers to child protection, or doctors to health care could be replaced "by some degree by a worker not qualified in the particular applied discipline". However, while each individual quality may not be unique to psychology, it could be argued that it is the collective combination of these qualities that justifies the psychologist's role in IMH contexts. Alternatively, perhaps the term "unique" may not best reflect the qualities found by this study. It may be more pertinent to refer to the themes addressed within this research question as characteristics of psychologists that are considered "valuable" to IMH contexts.

5.2.2.2. A discipline divided? Interestingly, there was no major finding with regards to the difference between clinical psychologists and educational psychologists working in IMH contexts. Forty percent of participants who engaged in the online

questionnaire were from an educational psychology background, and one educational psychologist was interviewed. As mentioned in the literature review, educational psychologists working in healthcare settings is a relatively new progression in Ireland (HSE, 2017a), therefore a subsidiary hypothesis within this research was to explore whether any differences in practice existed between the roles of the clinical versus the educational psychologist. However, no clear theme emerged regarding differing aspects of practice between the two branches of psychology. In fact, one psychologist noted how “there shouldn’t be any difference between psychologists, for me a psychologist is a psychologist”. Yet, this school of thought was not mentioned repeatedly or was not evident across data sets therefore did not become a significant theme of the research. This finding was also noted in Farrell et al.’s (2006) study, who suggested that psychological contributions to multi-agency work are valued by others regardless of the branch of psychology one is trained in. This study suggests that clinical and educational psychologists are working in similar remits within IMH contexts, and thus should not be segregated or appraised as a result of the branch of the psychology one is trained in.

5.3 Implications

Following on from the previous discussion of this study’s research findings in the context of previous literature and empirical research, it is now pertinent to consider what repercussions these findings may have going forward. Put more simply, this section aims to consider the “now what?” phase of research (Rolfe, Freshwater, & Jasper, 2001). The implications of this research will subsequently be discussed from a research, policy, and practice perspective.

5.3.1 Research. This study’s findings contribute to the knowledge base on professional roles in IMH service provision. Specifically, this research addresses a gap in the literature, by providing empirical data on the role of the psychologist in IMH. No previous research to date had explored the role of the psychologist in an empirical manner, thus this research hopes to have filled this gap. Additionally, this study adds to the global research base on IMH, offering insights into multidisciplinary working, components of an IMH framework, as well as highlighting some challenges to working in an IMH context.

5.3.2 Policy. The findings of this study may also support potential future policies in the area of IMH. Firstly, this study provides evidence in support of the role of psychologists in IMH and highlights their contribution to an IMH team. This may be of interest to policy makers and service managers during recruitment and deployment of personnel within these IMH contexts. Secondly, this research again provides food for thought regarding content required for an IMH policy. For example, an IMH framework will need to be reflected in any broader policy, therefore the findings of this research may flag potential avenues for exploration. Finally, this study addresses the need for more research in an Irish context on the importance of IMH practice, to advocate for and inform future policy. This study noted how very few psychologists are engaging in research activities, potentially due to time and resource demands. Thus, it is suggested for policy makers to provide supports such as funding or secondments, which will enable psychologists to engage in necessary research activities to provide the empirical data in an Irish context needed to support such policies and programmes.

5.3.3 Practice. Through the use of AT as a psychological framework for this study, contradictions or areas of tension between components of the activity system were explored in the results section of this research. The purpose of exploring said contradictions is to highlight potential areas of change, growth, or development within a system (Leadbetter, 2008). Through the process of exploring contradictions, the findings point to the following implications for practice:

- There is a need for the **development of clear role definitions** for professionals involved in IMH across all health settings. This may be in the form of a flow chart or information booklet, with relevant contact details provided for ease of access. The IMH network groups may be a useful local medium through which this activity could be realised. A monthly meeting could be dedicated to a reflective and collaborative focus group discussion on professional role definitions and role boundaries. The information derived within this meeting would be of benefit to attendees in their own local area, yet could also be formally recorded and disseminated to a relevant national body (e.g. Irish Association of Infant Mental Health). This national body could subsequently collate data provided by IMH network groups across the country and present the findings in a formal publication.

- This research highlighted the lack of awareness of IMH among the general public as well as other professionals. Of particular importance, the data identified the need for managerial support when engaged in IMH casework. Thus, there appears to be a discrete need for **targeted awareness activities** to promote the importance of IMH and infant wellbeing among service managers, as well as other professionals and the public. Whilst highlighting the importance of IMH and wellbeing to one's manager at a local level may be of some benefit, it is envisaged that this activity would be of most influence if delivered by an overarching HSE body. Thus, it is recommended that the professionals involved in the HSE Nurture programme consider running a professional development training day for service managers on the importance of promoting infant wellbeing and working in an IMH framework, and offer recommendations as to how this may be operationalised within their teams.
- Reflective supervision and reflective practice were strongly advocated for in the findings of this study. This supervision is above and beyond the line management supervision that professionals working in team settings may attend. Thus, in order to work effectively in IMH contexts, **practitioners ought to consider their level of reflective supervision and seek further support** if necessary. The use of "self-study" may be a valuable strategy to fulfil this recommendation. Self-study is an approach traditionally used in teacher education, yet has also been advocated for use by practising psychologists (Belar et al., 2003). Self-study involves reflecting and analysing one's own lived professional practice in order to identify gaps in areas of knowledge, skills, or beliefs (Samaras, 2010). Part of the self-study process is working with a critical friend, that being, a colleague who will act as a "reflective sounding board" to support the learning and self-examination process (Tidwell & Fitzgerald, 2004, p. 70). Psychologists who engage in self-study and who make use of critical friends may be enabled to adequately reflect on aspects of their work that require further support, such as their level of reflective supervision.
- Certain tension was highlighted in the findings of this study regarding the funding for reflective supervision. Therefore, it is recommended that discussions take place on a local level between **professionals and team managers as to how best to meet this need for reflective supervision** on a practical level. This may be in the form of allocating funding for professionals, organising group

supervision for the team, or else training up an individual team member who could then facilitate reflective supervision with other team members.

- A noteworthy finding of this study regards how there is a role in IMH for all professionals who engage with young children and their families. However, the level of training in IMH held by said professionals can vary. This may be addressed by an increase in awareness-raising activities among the public and relevant professionals, as aforementioned, yet also through a **competency framework that will assist professionals identify their individual training and upskilling needs**. The IAMH have developed a set of competency guidelines for Irish practitioners that were not publically available during the timeframe for this project. However, professionals are urged to be alert for this publication in the coming year.
- The findings of this study highlighted the difficulties in assessing and/or reporting the outcomes of IMH casework. Therefore, there is a need for managers to have an awareness of this type of work, as outlined above, yet also to be aware that a professional's involvement in an IMH case may not have clear outcomes or may not be well reflected within their monthly statistics. Furthermore, policy makers and government bodies may need to **generate a creative and novel means of reporting these types of social-emotional outcomes**, in order for the work being done in IMH to be reflected in the statistics for that profession or team.
- A prominent theme within this data highlighted how psychologists valued IMH work due to its preventative nature, yet often did not get the chance to work in this way due to the demands of time and resources. Psychologists being seen as a crisis service resulted in many psychologists noting that they do not have the capacity for effective IMH work. Thus, it is argued that there is an intense **need for an increase in psychologists within Irish multidisciplinary teams**, in order to reduce waitlists and facilitate psychologists to work in more preventative and early-intervention frameworks.

5.4 Limitations of Current Study

A primary limitation in the current study is regarding the initial scope of the literature review. The systematic review component of the literature review occurred in two waves; the first reviewing effective service provision in IMH services and the second reviewing the role of the psychologist in IMH services. Each review question was explored using specific search terms in a variety of databases. However, as McDonald, Taylor, and Adams (1999) suggest, the choice of databases utilised can vary in terms of the coverage of papers produced. Only two databases per review question were searched in this study, therefore some journal articles may have been omitted or not be indexed by said databases. With reference to the first review question, a notable limitation is that the researcher self-coded the findings of the studies into the facilitators and barriers to effective service IMH provision. In the aim of being transparent and unbiased, future studies may wish to analyse findings through the use of a meta-thematic analysis, in order to present findings in a systematic manner. Moreover, the second review question regarding the roles of psychologists in IMH contexts may have been restricted by the search terms employed, as the terms used may have been too broad or narrow, or may not have been the correct terms to use for the review question. Finally, it is acknowledged that the small selection of studies included may also be a limitation of the systematic review (Møller & Myles, 2016). Therefore, findings of the systematic review presented in Chapter Two ought to be considered in light of the relative limitations.

The study's sample may also be a relative weakness in this research. Firstly, the data for this study is gathered from a relatively small sample size. While sample size in qualitative research is a controversial topic in general (Boddy, 2016), quantitative research requires a robust sample size in order to ensure validity and generalisability. Nineteen psychologists took part in online interviews; therefore, the generalisability of the findings from this cohort may be limited. While the data gathered was useful in providing a picture of the nature of IMH work being carried out in Ireland, it is proposed that this cannot be considered a representative sample of psychologists in Ireland. Ideally, a nationwide survey would be needed to establish a clearer picture of the nature of IMH work being undertaken by Irish psychologists.

The use of purposive sampling may also be considered a limitation of this study. This study utilised a criterion sampling procedure, whereby the participants were

recruited based on a set number of specific criteria (e.g. had to provide services to children aged 0-3, experience working in multidisciplinary capacity). While this method of sampling was considered appropriate in identifying and accessing the appropriate participants to answer the research questions, it also results in an increased potential for bias within the findings (Palinkas et al., 2015). It could be suggested that participants who met this criteria and agreed to participate in the research did so out of a personal interest in the area of IMH and thus had additional motivations to take part. Although this concern could be an arguable flaw of many research methodologies, it does question how well these data reflect all relevant professionals working in IMH capacities Ireland. Thus, the representativeness of the sample is an overall limitation of this research.

Another limitation to the current study is regarding researcher subjectivity. As the researcher designed, conducted, and analysed findings themselves, there is an increased risk of researcher bias within the findings. Attempts have been made to ensure transparency in methodology and analysis, by providing coding trails (Appendix S) as well as following Braun and Clarke's (2006) step- by- step approach to thematic analysis. Secondary coding was carried out on two separate occasions throughout the analysis process by peer trainee psychologists. The aim of this was to ensure transparency and reduce bias within the findings (Nowell, Norris, White, & Moules, 2017). Ongoing supervision was provided which helped to highlight and identify areas of researcher bias and how they can be addressed.

The use of AT as the principal theoretical and conceptual framework enabled the researcher to gather rich and informative data in a structured manner, accounting for a range of complex social and cultural factors encountered in IMH contexts. Yet, the use of this theory poses limitations to the research implications also. Firstly, some researchers argue that using a collective group of participants in order to create a singular activity 'system' dismisses the role of the individual within the system (Leadbetter, 2008). Moreover, some researchers argue that AT does not have one unified definition and therefore could be interpreted in multiple perspectives, putting the integrity and fidelity of the core theory at risk (Holzman, 2006). This research has attempted to address this critique by using the definitions provided by Engeström, one of the key writers in AT, and through explicit clarification of the components of the

theory. Additionally, one of the notable strengths and interesting aspects of AT is the consideration of historicity (Daniels, 2001). This tenet of AT concerns how an activity system develops over a period of time, and needs to be understood within the context of its history (Leadbetter, 2008). This thesis did not explicitly examine past influences on how the current activity system came to be, or expectancies of future practices. The inability of the current research to address this component of the theory may be considered a theoretical and conceptual flaw, and is something future researchers may wish to develop.

5.5 Potential Directions for Future Study

This research investigated the understandings and perceptions of the psychologists from both psychologists themselves, as well as other relevant professional disciplines that may work alongside psychologists in IMH casework. However, other studies that have utilised this multi-perspective sampling approach have also included the voice of service users within their participant base (e.g. Myors et al., 2015; Ashton & Roberts, 2006). Exploring the views and thoughts of IMH clients, that being the primary caregivers of young infants, may add an interesting dimension to the research aims of this study. Through asking these parents/caregivers how they perceive differing professional roles could provide highly useful and person-centred understanding of the experience of IMH service provision.

Another potential avenue for future research is to explore the roles of professional groups using a solely deductive and theory driven approach. This study used both an inductive and deductive approach to analysis, whereby data-driven codes and themes were initially gathered, and subsequently mapped onto the study's psychological theory. Other studies that have used AT as their guiding framework have taken one or more distinct participant cohorts and created an activity system for each cohort using solely a deductive approach to data analysis (e.g. Gaskell & Leadbetter, 2007). That being, the interview protocols for these studies involved participants and the researcher actively creating the activity system together as the method of data collection. Due to the exploratory nature of this research, a solely deductive approach was not considered appropriate as potentially important themes may have been overlooked as a result. However, future researchers interested in the utility of AT as a

framework to explore professional roles in IMH may wish to employ a “top-down” or deductive approach to data collection and analysis. Moreover, whilst other professionals were interviewed, it was not within the scope of this study to produce an activity system for each distinct professional discipline from which data was gathered. Future research may wish to explore multidisciplinary working using different cohorts to create two or more distinct Activity Systems (e.g. Activity System of psychologists vs. Activity System of Primary Care team members).

Replicating this study through a different methodological means may also provide additional insight into roles in IMH contexts. For example, a case study approach could offer an insightful exploration of differing activities, roles, and perceptions of professionals working on a singular IMH case. Similarly, a focus group consisting of different professionals involved in an IMH case may also offer stimulating insight into their working identities. A focus group was initially considered for this research yet was dismissed amid ethical and logistical concerns. Said ethical concerns included the risk of professionals feeling under pressure to defend their work in IMH contexts, as well as logistical concerns regarding how to manage recording the multiple voices of different professionals. Additionally, an alternative method of data analysis may provide another means of understanding professional roles with IMH. For example, the use of a Grounded Theory approach could be incorporated to generate a specific theory regarding professional roles in IMH service provision.

Moreover, future research may wish to expand on the current work, through further engagement with the work of Engeström, in particular the Cycle of Expansive Learning as aforementioned. This research has journeyed through the first two stages of the model, that being “questioning” current practice and “analysing” contradictions within the psychologist’s role in IMH (Engeström, 1999). The next step in the cycle involves the production of a new model and new solutions to existing contradictions: a process referred to as developmental work research (DWR; Engeström, 1999). DWR considers the application of AT through interventionist research to progress the Cycle of Expansive Learning within the workplace. This process may involve using the current findings to model to participants what is happening in the activity system through a series of workshops in order to stimulate discussion, reflection, and contribution to the model presented. The aim may be for professionals from the various disciplines

interviewed, to come together and develop a shared understanding of multidisciplinary work in IMH contexts. DWR has been previously applied to a variety of contexts including Local Authorities (Leadbetter et al., 2007), occupational therapy services (Villeneuve & Shulha, 2012), and hospital settings (Kajamaa, 2011). While the current research timeline did not have the scope to complete DWR and complete the Cycle of Expansive Learning, it is a concept future researchers should consider. Overall this research has suggested some implications for professional work in IMH contexts, however future research needs to consider more generally how IMH can be operationalised positively within our health care system.

5.6 Summary

This chapter has discussed the study's findings in light of relevant literature and the study's overarching research questions. The implications of said findings were considered from a research, policy, and practice perspective. Finally, limitations of the study were acknowledged, and potential directions for future research were explored. The final chapter of this research will aim to discuss overall conclusions to the study, and summarise the key findings and recommendations.

Chapter Six: Conclusion

6.1 Summary of Research Rationale

IMH has been defined in the current study as “the developing capacity from birth to three to experience, regulate, and express emotions; to form close relationships; and to explore the environment and learn, all in the context of family, community, and cultural expectations for young children” (Zero to Three, 2002, p.1). The importance of positive IMH as a blueprint for optimal development has been demonstrated across an array of research fields, from neuroscience (e.g. Schore, 2001) to public policy research (e.g. QMHC, 2014). In practice, the IMH needs of young children and their families is best met from a “multidisciplinary professional field of inquiry, practice, and policy concerned with alleviating suffering and enhancing the social and emotional competence of young children” (Zeanah & Zeanah, 2009, p. 6). Said multidisciplinary professionals include the psychologist. Although there are no specifications as to the branch of psychology required to practice in IMH contexts, researchers have noted that the field is dominated by psychologists from a clinical training background (Osofsky, 2016). Yet, Osofsky (2016, p.43) also highlights how working in IMH fields is “strongly represented by clinical psychologists but not only by them”. This research has suggested that Educational and Child psychologists in Ireland are well placed to meet the mental health needs of young children, in light of recent policy changes (HSE, 2017a) and training changes (MIC, 2018). Herein presents the rationale for the current research interest as undertaken within an Educational and Child psychology programme.

The two-wave systematic review undertaken for the current project set the scene for the current research by pointing to significant gaps in the evidence base. The first wave of the systematic review explored facilitators and barriers to IMH services. One of the key findings of this literature search highlighted how lack of role clarity was considered a barrier to effective IMH services (e.g. Myors et al., 2015). This finding propelled the second wave of the systematic review which explored the role of the psychologist in IMH contexts. From here, it was noted that there was no apparent empirical research undertaken to date that reviewed and explored the psychologist’s

work in IMH. Thus, this wave instead had to review empirical studies produced that included psychologists within their sample, as a means of unearthing what psychologists do in IMH contexts. Findings noted how psychologists can be involved in a variety of different tasks and role functions, including assessment of parent-child relationships, specific intervention work with parent-infant dyads, and consultation work, particularly in the form of reflective supervision. Overall, the systematic review highlighted how role clarity is an important feature of IMH service provision, yet there is limited empirical data on the role of the psychologist in these contexts. Thus, this formed the foundation for the current research.

Although this gap exists in the literature, it is also important to query its relevance to psychology practice. Researchers have previously acknowledged that role clarity with IMH practice can cause confusion, and role boundaries of professionals may not be very clear (Hinshaw-Fuselier et al., 2009). Role clarity is considered important from both a service and a practitioner perspective. Firstly, it ensures services have a certain level of accountability for their team members and a justification for their presence on a multidisciplinary team (MacKay, 2002). Secondly, role clarity supports a more fluid and holistic multidisciplinary service, by ensuring there are limited gaps or overlaps in service provision. From a practitioner perspective, having role clarity maintains a level of professional identity (Greenhouse, 2013) and also reduces tensions or anxieties regarding work performance (Kerry, 2003). Therefore, exploring the role of the psychologist was considered a valuable task from both a research and practice perspective.

Finally, it was important to explore the relevance of this research to an Irish context. Currently, Ireland has no dedicated IMH services or overarching IMH policy. Specialist IMH services are being offered a community level (e.g. YoungBallymun, 2012). However, there has been an increased drive to move towards specialised IMH services on a national level (PSI PIMHSIG, 2015). If specialist services are to come to fruition, it will be highly necessary to have some clarity and insight into the role of the psychologist in IMH contexts in order to justify and validate the psychologists place within these teams. Whilst recent progress has been made with the introduction of the Perinatal Mental Health Strategy (HSE, 2017b) into maternity hospitals, it is hoped that this early intervention movement will ripple into community settings also. As reported

in the United Nations Convention on the Rights of the Child, children have the right to appropriate services so it is hoped that Ireland will continue to progress to ensure the social and emotional needs of young infants are adequately met (United Nations, 1989).

6.2 Review of Findings

This study aimed to explore professional roles within IMH contexts, with a particular focus on that of the psychologist. Data were gathered via online questionnaire and semi-structured interviews. Information was collected from a range of professionals, including a speech and language therapist, nurse, paediatrician, as well as a number of psychologists. Findings were underpinned by an AT framework, and analysed using Thematic Analysis. The discussion section of this thesis aimed to interpret the findings, with respect to the relevant research questions, while also comparing and contrasting the findings to existing literature within the field. Results also drew attention to potential areas for development and change, which recommendations were made around. A summary of the findings will be provided presently.

It may be first pertinent to explore what we now know about the activities and roles of the psychologist in IMH, as a result of this study's findings. The initial research question posed queried how Irish psychologists are implementing an IMH framework in their practice. Data gathered indicated how psychologists use an IMH framework across the functions of assessment, intervention, consultation, and training. Few psychologists were engaged in research activities, yet actively used research within the field of IMH to inform their practice. It was suggested that psychologists use an IMH framework as a lens to work a particular case, whilst remaining with the remit of the overarching model of service provided by their organisation (e.g. CAMHS, disability teams, etc.). It was proposed that the national crisis of lengthy waiting lists and limited psychology resources presents as one of the most significant barriers to working in IMH frameworks. The pressures surrounding waiting lists provide some insight as to why certain elements of an IMH framework were not reflected in this data. Specifically, it may explain why psychologists are not engaging in promotional or policy-directed initiatives within IMH contexts. This crisis may also clarify why psychologists perceive

themselves as being a crisis service and why other professionals view psychologists as not being on the ground.

The unique contribution of psychology has been an area of discussion and research for several years. This study aimed to ascertain what elements of psychologists practice were considered of greatest value and made the psychologists work distinct within IMH contexts. Four key themes emerged to address this research question. Firstly, participants appreciated and respected the extent of training psychologists have to complete in order to practice. Secondly, other professionals valued the psychologist's ability to formulate a particular case and get a bigger picture of the situation. Additionally, a psychologist's intense knowledge of child development was a noteworthy attribute of their practice, particularly a psychologist's capacity to differentiate typical and atypical child development. Finally, the psychologist's relationship with reflective practice was an aspect of practice that contributed positively when working with others. This may be in the form of enhancing others' reflective capacities informally (e.g. in team meetings), or through direct reflective supervision with colleagues. However, these findings were critically discussed in relation to whether they are unique to psychologists or should be better conceptualised as valuable characteristics of psychologists instead.

It has been reiterated within the field that IMH is not the preserve of any one discipline. The study's final research aim was to explore multidisciplinary working in IMH. While the scope of this study did not allow for individual exploration of each professional's role in IMH, interesting findings were gathered on multidisciplinary work and the psychologist's role. From the data gathered, it was evident that psychologists valued a multi-disciplinary approach to IMH work, and highlighted that IMH should be "everybody's business". That being said, findings did highlight how other professionals may not have the necessary training to effectively engage in this type of work, with many alternative professionals noting that they had not received any IMH training as part of their core professional training, yet engaged in CPD activities to bridge this gap. Moreover, when working in IMH contexts, it was hypothesised that roles could become blurry between the various professional disciplines involved. This finding was confirmed in the current study, with participants noting that roles can become ill-

defined due to the novel nature of IMH practice, as well as a lack of clarity of various professionals' roles.

6.3 Summary of Recommendations

The findings of this study have identified a series of recommendations from a research, policy, and practice viewpoint. The majority of these recommendations are data and theory driven, with suggestions being generated from the various 'contradictions' within the tenets of the AT system. A summary of said recommendations can be found in Table 11.

Table 11

Summary of Key Recommendations

| Number | Recommendation |
|---------------|--|
| 1. | Increased research from Irish practitioners to contribute to a knowledge base that can inform policy makers on current IMH needs in Ireland. |
| 2. | For services, at both local and national level, to develop clear role expectations for working in multidisciplinary IMH contexts. |
| 3. | For practitioners to increase engagement in targeted awareness raising activities, to highlight the importance of IMH services to other professionals, managers, policy makers, as well as the general public. |
| 4. | For professionals working with young infants and their families to reflect on their use and experience in reflective supervision and seek further support if they feel necessary. |
| 5. | For services to consider their capacity and budget for funding for reflective supervision and to seek funding opportunities for same if required. |
| 6. | Development and integration of an IMH competency framework for all professionals involved in the care of young infants and their families within Irish healthcare. |
| 7. | Consideration of effective and creative means of reporting outcomes for IMH casework to reflect progress and successes in an appropriate manner. |
| 8. | To increase the number of psychologists in multidisciplinary teams across Ireland to ease the burden of waitlists and facilitate a more preventative and responsive psychological service. |

6.4 Original Contribution to Knowledge

The current study has contributed to the research and knowledge base in IMH in the following ways. Firstly, this study has used empirical data to provide an original insight into the role of psychologists when working in IMH contexts. As demonstrated in the systematic review at the beginning of this thesis, there appears to be little to no empirical studies having explored the work of the psychologist in supporting the social and emotional development of infants. Thus, this study hopes to have filled this research gap. Secondly, this project has illustrated an application of AT to the practice of IMH. AT has been widely used to explore many aspects of psychology practice, including multi-agency working (Gaskell & Leadbetter, 2009), interprofessional learning (Meyer & Lees, 2013), and change management (Greenhouse, 2013). This research has hoped to expand on the utility of AT as a methodological framework within psychology practice with a particular focus on its use in elucidating professional roles within multidisciplinary contexts. Thirdly, this research has attempted to advance current knowledge on the role of the psychologist through the triangulation of data. As other professionals as well as psychologists were interviewed regarding their perception of the psychologist's role, findings represent a collated and multidimensional perspective. Finally, areas of tension within the activity system were highlighted through the use of contradictions. These dilemmas paved the way for concrete data-informed recommendations to be made. The findings of this research are most applicable to psychologists working in multidisciplinary healthcare teams across Ireland, who incorporate an IMH framework into their practice. However, it is hoped that the findings may provide some inspiration and insight for professionals in other contexts or multidisciplinary teams.

6.5 Dissemination of Research

On the basis of this study's findings, recommendations were made regarding the need for psychologists to engage in research in IMH to provide evidence and data for policy makers to facilitate change within the IMH world in Ireland. Therefore, to "practice as you preach", it is hoped that the results of this study will be disseminated in

a variety of contexts and through a range of media. In fact, it is considered a core competency of psychologists to broadcast the research they complete, through appropriate channels in order to “contribute to the professional knowledge base” (BPS, 2015b, p.23). Moreover, many professionals gave up their free professional time and energy to participate in this research. Thus, it could be classed as an ethical duty to represent their efforts through distribution of findings, to ensure their voices and stories do not lay uncultivated and are actively used to enforce and encourage change. Efforts will be made to disseminate and distribute research findings in a variety of contexts and through a range of media. An empirical paper has been drafted for the purpose of dissemination through relevant national and international journals. In particular, it is envisaged that the “Infant Mental Health Journal”, “Irish Journal of Psychology” and the “Journal of Child and Adolescent Mental Health” may be pertinent choices for initial dissemination. This empirical paper can be found in Appendix T. It is anticipated that the audience for this publication will consist primarily of psychologists, yet also respective service managers and relevant policy makers. This study’s findings may also be disseminated through various conferences and presentations, with the aim of reaching a wider and more diverse population. Finally, it is hoped that the published material from this research will be sent to policy makers in the hope of ensuring that the finding and recommendations are actively put into practice.

6.6 Final Reflections

Having reflected on the research process, there are certain key learning points that have become evident for me as a researcher. Firstly, the utility of AT as a methodological and conceptual framework has been demonstrated to me throughout this project. As Lewin (1952, p.161) famously exclaimed, “there is nothing as practical as a good theory”. Until I came across AT, I was unsure of the validity of this statement. However, using AT as my methodological framework has demonstrated how psychological theory can be applied to real world contexts in a practical, helpful, and realistic manner. This theory provided me with content to design my interview schedule around, deductive codes to use in my data analysis, and a logical structure to which I could pin my findings to. While the initial phases of reading around the theory were taxing due to the complex concepts and language, the benefits of using AT far

outweighed the challenges. I feel my knowledge of this theory and its use in practice will stand to me in my future career as an educational and child psychologist.

A second reflection concerns the inevitable trials of engaging in a doctorate level research project. Whilst the prospect of engaging in an exploratory study in an area of interest was exciting, there were notable challenges along the research journey. In particular, I recall the difficulties in recruiting suitable participants to partake in the study. As Irish psychologists are all under the intense pressures of sizable waiting lists, finding the time to complete research tasks is an understandably low priority. Many psychologists who were invited to partake declined due to work pressures or for the fact that they do not work in IMH frameworks. Thus, data collection took a longer time to complete than I originally envisaged, in order to collect a suitable number and profile of participants. Furthermore, being a sole researcher undertaking a doctorate level thesis also brought certain challenges. In light of the time frame for the production of this thesis within the current programme of study, a strict timeline had to be adhered to in order to meet college deadlines. This may have impacted on the scope of this research as well as curtailing the researcher's autonomy in expanding on the research through the addition of alternative data sources (some of which were discussed as recommendations for future practice in section 5.5).

A final reflection coming to the end of this thesis concerns the multidisciplinary and collaborative nature of working with infants and young children. I frequently revert to the following quote from Winnocott (1947, p.47), "there is no such thing as a baby ... if you set out to describe a baby, you will find you are describing a baby and someone." Whilst Winnocott was referring to the centrality of a primary caregiver, I also feel this quote describes collaborative working in IMH contexts, in that, a baby and "someone" could include the public health nurse, paediatrician, social worker, or psychologist. Having gained an insight into the work of different professionals in the health and wellbeing of an infant, I have come to realise that (to reference a colloquial proverb) it truly does take a village to raise a child. At the beginning of this research journey, I had considered the practice of IMH to rest heavily within the caseload of psychologists. However, having engaged in the research, I was informed of the variety of interesting and inspirational work activities being undertaken by other professionals in IMH and wellbeing, of which I was previously unaware. My newfound view on the topic may be

best described using the metaphor of a cog in a machine. Whilst this metaphor may traditionally be viewed in a negative light, I consider this a positive conceptualisation of professional working. Each member is a different yet necessary “cog”, working in parallel with others in order to ensure the success of the overarching “machine” of infant mental health and wellbeing. In my future practice as a psychologist, I hope to always remember this conceptualisation. I hope to transcend any ego or politics involved in professional working, and instead strive to promote, enhance, and engage in effective collaborative practice when working with infants and young children.

6.7 Concluding Remarks

In an address to the Oireachtas Joint Committee on Health and Children, Professor Kevin Nugent, an expert in early childhood development, highlighted how “the earliest years of life present the greatest opportunity for preventing and mitigating harm from trauma and setting the course for optimal development” (Nugent, 2015, para.11). It is argued that this “greatest opportunity” within the early years needs to be capitalised on by psychologists. Although psychology in Ireland has made strides in the development of school age mental health programmes, Heckmann and Masterov (2007, p.487) argue that school “comes too late”. This research has illustrated the role psychology plays in IMH contexts, and has highlighted the substantial economic and political challenges that are hindering psychologists from engaging in this type of work. As mentioned in the opening paragraph of this thesis, psychologists have the capacity to be a force for positive change (Zimbardo, 2012). Therefore, it is of utmost importance that psychologists continue to strive for positive changes to occur even within the earliest days of a child’s life.

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Appendices

Appendix A: Description of Multidisciplinary Children's Teams in Ireland

1. Primary Care Teams.

Primary Care children's teams consist of a multidisciplinary group of health and social care professionals. They work in collaboration with each other to deliver local services for children's 'primary' or first point of contact with the health service. Psychologists in these teams provide services for children with mild to moderate psychological issues

2. Child and Adolescent Mental Health Teams.

Child and Adolescent Mental Health teams provide assessment and treatment for young people aged 0-18, and their families, who are experiencing moderate to severe mental health difficulties. The team may consist of psychiatrists, psychologists, nurses, social workers, occupational therapists and speech & language therapists. Referral is made through the General Practitioner (GP) or another senior clinician.

3. Early Intervention Disability Teams.

Early Intervention Disability Teams work with children, aged 0-6 years, and their families who have complex developmental needs. This team may consist of Occupational Therapists, Psychologists, Social Workers, Physiotherapists and Speech and Language Therapists.

Appendix B: Justification of Inclusion and Exclusion Criteria

Search Strategy 1: What do we know about effective IMH services?

| | Inclusion criteria | Exclusion criteria | Justification |
|---------------------|--|---|--|
| Type of research | Research must have included empirical data | Research that consists of secondary data e.g. meta-analyses, literature reviews | Empirical data is necessary to evaluate effectiveness of service provision |
| Type of publication | Must be included in a peer reviewed journal | Not included in a peer reviewed journal | Peer reviewed journals involve intense inspection and analysis of studies prior to publication |
| Participants | Must have included at least one healthcare professional or parent who have experienced IMH provision | Included no participants who have experienced mental health provision, or professionals outside health care service e.g. teachers | Most appropriate service users/providers in evaluating IMH services |
| Dependent Variable | Must have reviewed effectiveness of IMH service provision/models as a dependent variable | Examined alternative dependent variables, with no focus on service provision e.g. child attachment relationship | To accurately address research question, the study will need to have examined service provision as its main dependent variable |
| Type of service | Must have considered both perinatal and infant mental health, or solely infant mental health | Solely focused on perinatal infant mental health | Research question is concerned about infant mental health provision |
| Language of study | Must be published in English | Studies not published in English | Translation services unavailable for review |

Search Strategy 2: What do we know about the roles and activities of the psychologist when working in IMH contexts?

| | Inclusion criteria | Exclusion criteria | Justification |
|---------------------|---|---|--|
| Type of research | Study included empirical data | Study did not consist of original data e.g. book reviews, meta-analyses, etc. | Empirical data necessary to ascertain roles and activities of psychologists in IMH contexts |
| Type of publication | Study was published in a peer-reviewed journal | Study was not published in a peer-reviewed journal | Peer reviewed journals involve intense inspection and analysis of studies prior to publication |
| Study sample | Study's sample included a minimum of one psychologist providing service targeting the social and emotional development of children aged 0-3 | Study's sample did not consist of any psychologists OR study did not clearly indicate the professional discipline providing service | Sample needed to include psychology in order to answer search strategy question |
| Study outcomes | Study outcomes must have focused on a specific component of IMH service e.g. training, intervention etc. | Study's outcomes did not focus on the social and emotional development of children aged 0-3 e.g. focused on post-partum depression with no assessment of infant wellbeing | This study's focus is on the social and emotional development of children aged 0-3 |
| Language of study | Study must have been written in English | Study was not available in English | Translation services not available for the current study |

Appendix C: Weight of Evidence Framework

The use of a quality criteria framework ensures an objective and rational review of the methodological quality used for each study. An adapted version of Letts et al. (2007) was utilised in order to evaluate the methodological quality of studies that were qualitative in nature. Ratings of high, medium, or low were prescribed by the researcher to the various indicators. See Appendix D and Appendix E for full details of quality criteria and descriptors.

WoE A: Methodological Quality

| Weighting | Descriptor |
|------------------|---|
| High (3) | Study consisted of all quality indicators across all study areas (Appendix D) |
| Medium (2) | Study consisted of at least one quality indicator in each of the areas |
| Low (1) | Study consisted of no quality indicators in at least one area |
| Zero (0) | Study consisted of no quality indicators in any area |

For studies that were mixed-method in nature, a version of Pluye et al., (2011) was used, and ratings of ‘high’, ‘medium’, and ‘low’, were prescribed by the researcher. See Appendix E for full details of the quality criteria for mixed-methods studies.

| Weighting | Descriptor |
|------------------|--|
| High (3) | Study consisted of all quality indicators across all relevant areas (Appendix E) |
| Medium (2) | Study consisted of at least one quality indicator in each of the relevant areas |
| Low (1) | Study consisted of no quality indicators in at least one relevant area |
| Zero (0) | Study consisted of no quality indicators in any area |

WoE B: Methodological Relevance

WoE B is concerned with evaluating whether the design of the study was efficient and effective in answering the review question. As this systematic review contained studies with varying research designs, a hierarchy of evidence (e.g. Guyatt et al., 1995) was applied to the studies included in this review. Within these hierarchies of evidence, research designs such as randomised control trials (RCT's) are deemed of high quality due to their validity and reliability and are thus given higher weighting, whereas study designs such as single cases may receive a lower weighting. The criteria for methodological relevance most applicable to the studies of this review included:

| Weighting | Descriptor |
|------------------|---|
| High (3) | <p>Study includes <u>all</u> of the following:</p> <p>Outcome measures were of relevance to review question</p> <p>Analytic procedures made clear</p> <p>Study used appropriate design to answer research question e.g. interviews, survey, meta-analysis</p> <p>Study had sufficient sample size to draw robust conclusions from data/data saturation reached</p> |
| Medium (2) | <p>Study includes <u>at least three</u> of the following:</p> <p>Outcome measures were of relevance to review question</p> <p>Analytic procedures made clear</p> <p>Study used appropriate design to answer research question e.g. interviews, survey, meta-analysis</p> <p>Study had sufficient sample size to draw robust conclusions from data/data saturation reached</p> |
| Low (1) | <p>Study includes <u>at least two</u> of the following:</p> <p>Outcome measures were relevant to review question</p> <p>Analytic procedures made clear</p> <p>Study used appropriate design to answer research question e.g. interviews, survey, meta-analysis</p> <p>Study had sufficient sample size to draw robust conclusions from data/Data saturation achieved</p> |
| Zero (0) | <p>Study includes one or none of the above criteria</p> |

WoE C: Relevance of Evidence to the Review Question

WoE C involves analysis of the relevance of the findings of the study in answering the review question. The following criteria were deemed important in determining the relevance of evidence for the purpose of this study's review.

| Weighting | Descriptor |
|------------------|---|
| High (3) | <p>Study includes <u>all</u> of the following:</p> <p>Study analysed IMH services as a whole system</p> <p>Study consisted of data from both service users and service providers</p> <p>Study provided sufficient information on the nature of services provided</p> |
| Medium (2) | <p>Study includes at <u>least two</u> of the following:</p> <p>Study analysed IMH services as a whole system</p> <p>Study consisted of data from both service users and service providers</p> <p>Study provided sufficient information on the nature of services provided</p> |
| Low (1) | <p>Study includes <u>at least one</u> of the following:</p> <p>Study analysed IMH services as a whole system</p> <p>Study consisted of data from both service users and service providers</p> <p>Study provided sufficient information on the nature of services provided</p> |
| Zero (0) | Study includes none of the above criteria |

WoE D: Overall Weight of Evidence

In order to determine the overall weight of evidence for the study, the scores from WoE A, WoE B and Woe C were added together and averaged. Each score was awarded a weighting of “high”, “medium” or “low”.

| Weighting | Numerical Rating |
|------------------|-------------------------|
| High | 2.6 - 3 |
| Medium | 1.5 – 2.5 |
| Low | 0 – 1.5 |

**Appendix D: Quality Indicators for Qualitative Research Designs (adapted from
Letts et al., 2007)**

| Area | Quality Indicator |
|---------------------------------|---|
| Study Purpose | Purpose of the research stated clearly |
| Literature Review | Relevant background literature reviewed Suitable gap identified Relevant to practice |
| Appropriateness of study design | Use of qualitative methods was appropriate for research question Theoretical perspective outlined |
| Sampling | Process of purposeful selection was identified and described Sampling was done until redundancy in the data was reached Informed consent was obtained |
| Data Collection | Clear and complete descriptions of data collection procedures given Role of the researcher and relationship with participants clarified Assumptions and biases of researcher addressed Procedural rigour in data collection procedures |
| Data Analysis | Data analyses were inductive Findings were consistent and reflective of data Process of analysing data was described adequately Meaningful 'picture' of data emerged |
| Overall Rigor | Evidence of credibility Evidence of transferability Evidence of dependability Evidence of confirmability |
| Conclusions and Implications | Conclusions were appropriate given the study's findings The findings contributed to theory development and future practice |

Appendix E: Quality Criteria for Mixed-Methods Designs (Adapted from Pluye et al., 2011)

| Area | Quality Indicators |
|---|--|
| Screening Questions | <ul style="list-style-type: none"> ○ Are there clear qualitative and quantitative research questions, or a clear mixed-method question? ○ Does the data allow address the research question? |
| Qualitative | <ul style="list-style-type: none"> ○ Are the sources of qualitative data relevant to address the research question? ○ Is the process for analysing qualitative data relevant to address the research question (objective)? ○ Is appropriate consideration given to how findings relate to the context, e.g., the setting, in which the data were collected? ○ Is appropriate consideration given to how findings relate to researchers' influence, e.g., through their interactions with participants? |
| *Quantitative Randomised Control Trials | <ul style="list-style-type: none"> ○ Is there a clear description of the randomization (or an appropriate sequence generation)? ○ Is there a clear description of the allocation concealment (or blinding when applicable)? ○ Are there complete outcome data (80% or above)? ○ Is there low withdrawal/drop-out (below 20%)? |
| *Quantitative Non-randomised Control Trials | <ul style="list-style-type: none"> ○ Are participants (organizations) recruited in a way that minimizes selection bias? ○ Are measurements appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes? ○ In the groups being compared (exposed vs. non-exposed; with intervention vs. without; cases vs. controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups? ○ Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable |

| | |
|---------------------------|---|
| *Quantitative Descriptive | <p>follow-up rate for cohort studies (depending on the duration of follow-up)?</p> <ul style="list-style-type: none"> ○ Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed methods question)? ○ Is the sample representative of the population under study? ○ Are measurements appropriate (clear origin, or validity known, or standard instrument)? ○ Is there an acceptable response rate (60% or above)? |
| Mixed Methods | <ul style="list-style-type: none"> ○ Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)? ○ Is the integration of qualitative and quantitative data (or results*) relevant to address the research question (objective)? ○ Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data in a triangulation design? |

* Chosen as appropriate for study type

Appendix F: Summary of Included Studies

Studies Included for Review Question 1: What do we know about effective IMH services?

| Myors et al. (2015) | | | | |
|---|----------------------------|--|---|--|
| Participants | Service Location | Type of service | Methodology | Outcome |
| 13 professionals (six PIMH clinicians, two PIMH service managers, and five key stakeholders) and 11 women service-users | New South Wales, Australia | Two services: one rural and one city-based. Consisted of multi-disciplinary team of psychologists, social workers, nurses, and psychiatrists | Mixed methods design using semi-structured interviews and review of medical records | Three key themes drawn: 1. 'We don't sit in silos.. but they do' 2. 'We need to enhance communication' 3. 'Collaboration is hard work'. |

McDonald et al. (2005)

| Participants | Service Location | Type of service | Methodology | Outcome |
|---|------------------------|--|--|--|
| Professionals from 18 different services | Brisbane, Australia | Hospital based PIMH services, community based services, Residential services and home visiting services | Qualitative using semi- structured interviews | Main findings included that (1) services were fragmented with very little communication between them and lack of continuity in services (2) very few services worked jointly with the infant and the mother (3) it is difficult to provide services for some at-risk populations |

Coates et al. (2017)

| Participants | Service Location | Type of service | Methodology | Outcome |
|---|-----------------------|--------------------|--|--|
| 40 women service users who had been discharged within the past three years | Gosford, Australia | PIMH service | Qualitative data collection using semi structured interviews data analysed using grounded theory | One subordinate theme of service being a 'lifesaver'. Four subordinate themes highlighted how the service met the needs of women: 'supportive counselling, trauma counselling, specialist interventions and assertive outreach.' |

| Myors et al. (2014) | | | | |
|---|----------------------------------|--|--|---|
| Participants | Service Location | Type of service | Methodology | Outcome |
| 11 women discharged from the service | New South Wales, Australia | Specialist PIMH service consisting of multidisciplinary team | Qualitative methods using face-to-face or telephone interviews | One overarching theme: 'my special time'. Three subordinate themes 'there is someone out there for me', 'it wasn't just a job' and 'swimming or stranded: feelings about leaving the service'. |

Studies Included for Review Question 2: What do we know about the role and activities of the psychologist working in IMH contexts?

Broughton (2014)

| Study aim | Participants | Methodology | Outcome |
|--|---|---------------|--|
| To measure the reliability of the PIRAT (Parent Infant Relational Assessment Tool) | Two health visitors, one two midwives, one clinical psychologist, one clinical psychologist in training, one speech and language therapist, one child protection social worker, one child and family worker | Mixed methods | Good inter-rater reliability demonstrated for PIRAT tool |

Ben-Sasson et al., (2007)

| Study aim | Participants | Methodology | Outcome |
|--|--|--|--|
| To clarify the distinction between sensory over-responsivity and anxiety disorders in toddlers | Twenty-four occupational therapists and 25 psychologists | Quantitative methods using survey questionnaire data | Psychologists and Occupational Therapists had differing perspectives on how to distinguish sensory over-responsivity and anxiety |

Ostler (2010)

| Study aim | Participants | Methodology | Outcome |
|--|--|--|---|
| Examining the reliability and validity of the Child and Adult Relational Experimental Index (CARE-Index) | 44 mothers assessed by a team of psychologists | Quantitative – using data gathered from the CARE-Index | The measure can provide reliable, valid, and independent information on parenting behaviour |

Smith et al. (2010)

| Study aim | Participants | Methodology | Outcome |
|--|-------------------------|--|--|
| To examine the processes in the detection of early developmental delays of high-risk infants | 451 mothers and infants | Mixed methods – quantitative data gathered from standardised assessments and qualitative data gathered from interviews | Mothers reported that very few eligible children were identified by medical professionals as having any problems that could interfere with development |

Harrison (2016)

| Study aim | Participants | Methodology | Outcome |
|---|---|---|---|
| To explore the experiences of early intervention practitioners in a reflective consultation program | Fifteen participants including early childhood special education teachers, speech and language therapists, occupational therapists, physio therapists and psychologists | Qualitative – use of semi structured interviews | Main themes created a change process model defined as release, reframe, refocus, and respond. Efficacy of reflective supervision and consultation also reflected. |

Watson, Bailey, & Storm (2016)

| Study aim | Participants | Methodology | Outcome |
|---|--|---|--|
| To explore an initiative to further develop capacity in reflective practice among public health home visitors and their supervisors | 2 mentors, 11 IMH consultants, 30 supervisors, and 120 home visitors | Mixed research methods - use of a survey, standardized measures, and interviews | Home visitors reported a sense of accomplishment in their reflective work and that they value “releasing” emotions in a safe environment during reflective supervision |

Bain (2014)

| Study aim | Participants | Methodology | Outcome |
|---|--------------------------|--|---|
| To explore the use of a manualized parent–infant psychotherapy group model entitled ‘New Beginnings’. | 22 mother – infant dyads | Quantitative – data gathered using standardised measures | The program enabled mothers to become more sensitized to their infants’ needs in interaction and that communication between mother and infant increased |

Aspoas & Amod (2014)

| Study aim | Participants | Methodology | Outcome |
|---|------------------------|--|---|
| To investigate the efficacy of a parent–infant intervention entitled the ‘Baby Mat’ project | 11 mother-infant dyads | Qualitative data gathered from a focus group | Participants were receptive to the intervention, yet their socio-economic stance hindered them from fully benefitting from intervention |

Appendix G: Reflection of Malterud et al.'s (2016) model of Information Power as applied to current study

| Items having an impact on information power | Description | Application to current study |
|---|--|--|
| Study aim | <i>“A broad study aim requires a larger sample than a narrow aim to offer sufficient information power, because the phenomenon under study is more comprehensive.” (p.1754)</i> | Study aim is neither broad nor narrow. Research aims to explore professional roles (broad) in IMH in Ireland (narrow). |
| Sample specificity | <i>“Information power is also related to the specificity of experiences, knowledge, or properties among the participants included in the sample.” (p. 1755)</i> | A purposive sampling strategy was used to recruit participants for the current study, based on set of specific criteria. |
| Use of established theory | <i>“A study supported by limited theoretical perspectives would usually require a larger sample to offer sufficient information power than a study that applies specific theories for planning and analysis.” (p. 1755)</i> | Study was devised, organised, and analysed using Second Generation Activity Theory (Engeström, 1999). |
| Quality of the dialogue | <i>“A study with strong and clear communication between researcher and participants requires fewer participants to offer sufficient information power than a study with ambiguous or unfocused dialogues” (p. 1756)</i> | Rapport between interviewer and interviewee considered strong and use of semi-structured interview style facilitated the gathering of focused yet rich information. Participants of the research had significant interest and experience in the area of study, again leading to high-quality dialogue. |
| Analysis strategy | <i>“An exploratory cross-case analysis requires more participants to offer sufficient information power compared with a project heading for in-depth analysis of narratives or discourse details from a few, selected participants.”</i> | Study adopted an exploratory approach as opposed to an in-depth narrative analysis. |

Appendix H: Consent Forms

Informed Consent Form for Interviews



“An Exploration into the Activities, Perceptions, and Understandings of the Role of the Psychologist in Infant Mental Health Service Provision”

Informed Consent Form

Dear Sir/Madam,

As outlined in the participant information sheet, the current study will investigate the roles of multidisciplinary team members in the provision of Infant Mental Health (IMH) services. A primary focus will be on the role of the psychologist, and the components of their practice that make their contribution to IMH service provision distinct.

The participant information sheet outlines what will be involved in this project. This should be read fully and carefully before consenting to take part in the study.

Your anonymity is assured and you are free to withdraw from the study at any time. All information gathered will remain confidential and will not be released to any third party. In accordance with the MIC Record Retention Schedule, all participant data will be stored for the duration of the project plus three years, at which time it will be destroyed.

Please read the following statements before signing the consent form:

- I am over 18 years of age
- I have read and understood the participant information sheet
- I understand what the project is about, and what the results will be used for.

- I am fully aware of all of the procedures involving myself, and of any risks and benefits associated with the study.
- I know that my participation is voluntary and that I can withdraw from the project at any stage without giving reason.
- I am aware that my results will be kept confidential.
- I understand that I can contact the researcher if I have any queries. I can also contact the researcher for a summary of the findings arising from this study.

Name (printed): _____

Name (Signature): _____

Date: _____

Kayleigh Sheerin - Researcher
Supervisor

Kayleighsheerinresearch@outlook.com

Suzanne.Parkinson@mic.ul.ie

Dr. Suzanne Parkinson – Research

Dr. Therese Brophy – Research Coordinator

Therese.brophy@mic.ul.ie

Informed Consent Form for Online Questionnaire



“An Exploration into the Activities, Perceptions, and Understandings of the Role of the Psychologist in Infant Mental Health Service Provision”

Informed Consent Form

Dear Sir/Madam,

As outlined in the participant information sheet, the current study will investigate the roles of multidisciplinary team members in the provision of Infant Mental Health (IMH) services. A primary focus will be on the role of the psychologist, and the components of their practice that make their contribution to IMH service provision distinct.

The participant information sheet outlines what will be involved in this project. This should be read fully and carefully before consenting to take part in the study.

Your anonymity is assured and you are free to withdraw from the study at any time. All information gathered will remain confidential and will not be released to any third party. In accordance with the MIC Record Retention Schedule, all participant data will be stored for the duration of the project plus three years.

Please read the following statements and tick the appropriate option:

- I am over 18 years of age

Yes
No

- I have read and understood the participant information sheet

Yes
No

- I understand what the project is about, and what the results will be used for.

Yes

No

- I am fully aware of all of the procedures involving myself, and of any risks and benefits associated with the study.

Yes

No

- I know that my participation is voluntary and that I can withdraw from the project at any stage without giving reason.

Yes

No

- I am aware that my results will be kept confidential.

Yes

No

- I understand that I can contact the researcher if I have any queries. I can also contact the researcher for a summary of the findings arising from this study.

Yes

No

- I have read the above statements carefully and I consent to partake in this study

Yes

No

Date: _____

Kayleigh Sheerin - Researcher

Kayleighsheerinresearch@outlook.com

Dr. Suzanne Parkinson – Research Supervisor

Suzanne.Parkinson@mic.ul.ie

Dr. Therese Brophy – Research Coordinator

Therese.brophy@mic.ul.ie.

Appendix I: Participant Information Letters

Participant Information Sheet for Online Questionnaire



“An Exploration into the Activities, Perceptions and Understandings of the Role of the Psychologist in Infant Mental Health Service Provision”

Participant Information Sheet

What is the project about?

There is a recent impetus in Ireland to move towards more specialised and discrete Infant Mental Health (IMH) services. As IMH is a new field of practice, role clarity and professional boundaries remain an under-researched area. The aim of this project is to gain an understanding of the roles and activities of professionals working with cases pertaining to IMH. The purpose of the current questionnaire is to explore the current activities and experiences of psychologists in IMH service provision in Ireland.

Who is undertaking it?

My name is Kayleigh Sheerin. I am a doctorate student attending Mary Immaculate College. I am presently completed a degree in Educational and Child Psychology under the supervision of Dr. Suzanne Parkinson. The current study will form part of my final doctorate research project.

Are there any risks involved in participating in this study?

There are no known risks to partaking in this study. All information is anonymous and no identifying details are required (e.g. name, service location, etc.).

Exactly what is involved for the participant (time, location, etc.?)

I invite you to complete an online questionnaire .This questionnaire consists of mainly multiple choice questions. It is estimated that this questionnaire should take no longer than 10-15 minutes to complete.

Right to withdraw

You are free to withdraw from completing the questionnaire at any time without giving a reason and without consequence, by simply closing the tab on your browser.

However, if you have submitted the questionnaire once completed, your data cannot be deleted. Due to the anonymous nature of this questionnaire, there will be no way to match the data to the individual.

How will the information be used/disseminated?

As aforementioned, the information will be used to provide contextual information regarding current IMH provision among psychologists in Ireland. Descriptive statistics will be used primarily.

How will confidentiality be kept?

All information gathered will remain confidential and will not be released to any third party. The persons who have access to the data include me and my research supervisor. Anonymity will be maintained throughout the data collection process, with no identifiable details being used at any stage in the study (e.g. names, regional locations, etc.).

What will happen to the data after the research has been completed?

All research data will be stored for the duration of the project, plus three years if publication occurs.

Contact details:

If, at any time, you have any queries or issues with regard to this study, my contact details are as follows:

- Name: Kayleigh Sheerin
- Email address: Kayleighsheerinresearch@outlook.com

If you have concerns about this study, please contact my research supervisor or research coordinator using the details below:

- Name: Dr. Suzanne Parkinson (Research supervisor)
- Email address: Suzanne.parkinson@mic.ul.ie
- Name: Dr. Therese Brophy (Research Coordinator)
- Email address: therese.brophy@mic.ul.ie

Thank you for taking the time to read this information letter.

References

- Psychological Society of Ireland Perinatal and Infant Mental Health Special Interest Group
(2015). *Perinatal and Infant Mental Health: Draft Position Paper & Recommendations*.
Accessed from
<https://www.psychologicalsociety.ie/files/UserFiles/file/Draft%20Position%20Paper%20PIMHSIG.pdf>.
- Stobie, I. (2002). Processes of Change and Continuity in Educational Psychology – Part 1.
Educational Psychology in Practice, 18(3), 203-212.

Participant Information Sheet for Interviews



“An Exploration into the Activities, Perceptions and Understandings of the Role of the Psychologist in Infant Mental Health Service Provision”

Participant Information Sheet

What is the project about?

Currently, in Ireland, there is an impetus to provide more specialised and discrete Infant Mental Health services ((Psychological Society of Ireland, Perinatal and Infant Mental Health Special Interest Group [PSI PIMHSIG], 2015). In order to provide effective multidisciplinary services, role clarity is essential (Stobie, 2002). However, the professional roles within IMH service, including that of the psychologist, remain unclear. The current project aims to explore the different roles of the psychologist in IMH service provision, in order to de-mystify and provide clarity on the involvement of the psychologist when working in IMH contexts/frameworks.

Who is undertaking it?

My name is Kayleigh Sheerin. I am a doctorate student attending Mary Immaculate College. I am presently completing a degree in Educational and Child Psychology under the supervision of Dr. Suzanne Parkinson. The current study will form part of my final doctorate research project.

What are the risks and benefits of this research?

The risks associated with this research are minimal. However, discussing aspects of your practice may cause some distress if you have experienced, or are currently experiencing, interpersonal difficulties in the workplace. If you do not wish to answer a question or wish to stop the interview at any point, you are welcome to do so. Should you become distressed at any point during the interview process, the interview will be

paused. At this point, the researcher will check in with you to ascertain whether you feel comfortable finishing the interview or not. Information regarding employee support can be provided, if required.

It is hoped that the benefits of your engagement will include (a) an enhanced understanding of the roles of discrete multidisciplinary professionals in IMH service provision; (b) a proposed working model for effective multidisciplinary IMH service provision; (c) recognition of potential barriers to effective working due to lack of role clarity; (d) an awareness of professional accountability in service provision.

Exactly what is involved for the participant (time, location, etc.?)

I would like to invite you to participate in a semi-structured interview which should take no longer than 30 minutes. The content of this interview will consist of a case vignette regarding Infant Mental Health. The questions asked will pertain to what your involvement in this case would look like. These case studies will be provided to you before the interview for your perusal. The interview will be situated in a location that suits you or via telephone. If you so wish, the researcher will organise an independent space for the interview to be conducted.

Right to withdraw

You are free to withdraw from the research at any time without giving a reason and without consequence.

How will the information be used/disseminated?

All data from the interview will be coded and anonymised so that any individual participants will not be identifiable. Anonymised quotations from individual participants may be used in the thesis or publications arising from the research.

How will confidentiality be kept?

All information gathered will remain confidential and will not be released to any third party. The persons who have access to the data include me and my research supervisor. Data analysis support staff within Mary Immaculate College may have access to the data, adhering to their specific data protection guidelines and protocols.

Anonymity will be maintained throughout the data collection process, with no identifiable details being used at any stage in the study (e.g. names, regional locations, etc.). All participants are welcome to read over the transcripts to ensure your anonymity is maintained.

Paper data (e.g. consent forms) will be stored in a locked filing cabinet. Audio data, and anonymised transcripts, will also be kept on an encrypted external hard drive.

What will happen to the data after the research has been completed?

All research data will be stored for the duration of the project, plus three years if publication occurs.

Contact details:

If, at any time, you have any queries or issues with regard to this study, my contact details are as follows:

- Name: Kayleigh Sheerin
- Email address: Kayleighsheerinresearch@outlook.com

If you have concerns about this study, please contact my research supervisor or research coordinator using the details below:

- Name: Dr. Suzanne Parkinson (Research supervisor)
- Email address: Suzanne.parkinson@mic.ul.ie
- Name: Dr. Therese Brophy (Research Coordinator)
- Email address: therese.brophy@mic.ul.ie

Thank you for taking the time to read this information letter.

References

Psychological Society of Ireland Perinatal and Infant Mental Health Special Interest Group
(2015). *Perinatal and Infant Mental Health: Draft Position Paper & Recommendations*.
Accessed from

<https://www.psychologicalsociety.ie/files/UserFiles/file/Draft%20Position%20Paper%20PIMHSIG.pdf>.

Stobie, I. (2002). Processes of Change and Continuity in Educational Psychology – Part 1.
Educational Psychology in Practice, 18(3), 203-212.

Appendix J: Online Questionnaire



Questionnaire on the Role of the Psychologist in Infant Mental Health Services

Thank you for taking the time to complete this questionnaire. The purpose of this questionnaire is to explore the activities of psychologists in Infant Mental Health service provision.

For the purpose of this questionnaire, the term 'Infant Mental Health' will refer to the social and emotional development of young children aged 0-3.

Please respect the privacy and anonymity of your colleagues and clients. Do not provide detailed information on specific children, parents, teachers/schools, or colleagues throughout this questionnaire.

Please read each of the following questions carefully, and answer all of the questions.

Part I: Demographic Information

1) What is your gender

- a. Female
- b. Male

2) What is your age

- a. 18 -29 Years Old
- b. 30-49 Years old

c. 50-64 Years old

d. 65 + Years old

3) What is your country of practice?

a. Ireland

b. The United Kingdom

c. Other

4) What is the highest level of education you have completed?

a. Diploma

b. Bachelor's degree

c. Master's Degree

d. Professional Doctorate/PHD

5) What branch of psychology are you trained in?

a. Clinical Psychology

b. Educational Psychology

c. Counselling Psychology

d. Other (Please indicate) _____

6) What service are you currently employed in?

a. Child and Adolescent Mental Health

b. Primary Care

c. Child and Family

d. Disability

e. Other: _____

7) What is the age range that you provide psychological services to, as per formal job description? _____

8) What is the age range of children you most frequently provide psychological services to? You may select more than one answer.

- a. 0-3
- b. 3-6
- c. 6-12
- d. 12-18

Part 2: Professional Competence and Confidence in IMH

1) Please rate your knowledge of Infant Mental Health theory

- a. Very good
- b. Good
- c. Average
- d. Below average
- e. Poor

2) Please rate your knowledge of Infant Mental Health research

- a. Very good
- b. Good
- c. Average
- d. Below average
- e. Poor

3) Have you completed any post-graduate or CPD training in Infant Mental Health? If so, please provide details of said training.

- a. Yes _____
- b. No

4) Where does the majority of your IMH knowledge come from? You may select more than one option.

- a. College material
- b. Post-graduate training/CPD

- c. Personal research
- d. Other (Please specify):

Part 3: Work with individual IMH cases

This section will require you to explore your work with individual children aged 0-3, who have been referred to you for difficulties with social and emotional development. This individual case work may include, consultations with parents/caregivers, intervention work, or assessment work. Please tick the most suitable option and provide example of work activity if relevant.

| | Never | Weekly | Monthly | Termly | Rarely | Example of work activity |
|---|-------|--------|---------|--------|--------|--------------------------|
| How often do you engage in ASSESSMENT work related to an individual child or their parent(s)/caregiver(s) | | | | | | |
| How often do you engage in INTERVENTION work related to an individual child or their parent(s)/caregiver(s) | | | | | | |
| How often do you engage in CONSULTATION work related to an individual child or their parent(s)/caregiver(s) | | | | | | |
| How often do you engage in TRAINING work related to an individual child or their parent(s)/caregiver(s) | | | | | | |
| How often do you engage in RESEARCH work related to an individual child or their parent(s)/caregiver(s) | | | | | | |

Part 4: Work with group IMH cases

This section will require you to explore your work with children aged 0-3 in a group context or their parents, who have been referred to you for difficulties with social and emotional development. This group work may consist of group interventions for children or parent training groups. Please tick the most suitable option and provide example of work activity if relevant.

| | Never | Weekly | Monthly | Termly | Rarely | Example of work activity |
|---|-------|--------|---------|--------|--------|--------------------------|
| How often do you engage in ASSESSMENT work related to a group of children or their parent(s)/caregiver(s) | | | | | | |
| How often do you engage in INTERVENTION work related to a group of children or their parent(s)/caregiver(s) | | | | | | |
| How often do you engage in CONSULTATION work related to a group of children or their parent(s)/caregiver(s) | | | | | | |
| How often do you engage in TRAINING work related to a group of children or their parent(s)/caregiver(s) | | | | | | |
| How often do you engage in RESEARCH work related to a group of children or their parent(s)/caregiver(s) | | | | | | |

Part 5: Collaboration with other professionals in work pertaining to Infant Mental Health

This section will require you to explore your collaboration with other professionals in work pertaining to Infant Mental Health, that is, the social emotional development of children aged 0-3. This work may consist of research activities, providing

training to other professionals, attendance at trainings with other disciplines etc.

Please tick the box that is most appropriate and provide an example of a work activity, if relevant.

| | Never | Weekly | Monthly | Termly | Rarely | Example of work activity |
|---|-------|--------|---------|--------|--------|--------------------------|
| How often do you engage in ASSESSMENT work with other professionals in cases regarding Infant Mental Health | | | | | | |
| How often do you engage in INTERVENTION work with other professionals in cases regarding Infant Mental Health | | | | | | |
| How often do you engage in CONSULTATION work with other professionals in cases regarding Infant Mental Health | | | | | | |
| How often do you engage in TRAINING work with other professionals in cases regarding Infant Mental Health | | | | | | |
| How often do you engage in RESEARCH work with other professionals in cases regarding Infant Mental Health | | | | | | |

1. Please list the professionals you frequently collaborate with when engaged in work pertaining to IMH. These may include other psychologists, social workers, public health nurses, etc. (Refer to role titles only, and not names of professionals).

2. Please highlight any facilitators and barriers that exist to working collaboratively with other professionals on cases concerning Infant Mental Health

-Facilitators:

-Barriers:

Appendix K: Interview Questions

Sample interview questions using Activity Theory (adapted from Leadbetter, 2008).

1. Object
 - a. What is your understanding of IMH?
2. Subject
 - a. Do you feel you have a role to play in IMH?
 - b. What would your role in an IMH case look like?
3. Outcome
 - a. What would you like to see as the desired outcome from your involvement in an IMH case?
 - b. What would you perceive to be the main barriers to working in an IMH framework?
 - c. What facilitates your work when working in an IMH framework?
4. Tools and Artefacts
 - a. Are there any particular resources or tools that support you in working within an IMH framework?
 - b. Is there any legislation that guides/professional guidelines that guides your work with IMH?
5. Community
 - a. What other professions do you feel should be part of IMH teams/casework?
6. Division of labour
 - a. How would the work be shared amongst other professionals?
 - b. If you had no psychologist working on your team, what would you miss them doing?
 - c. Is there any other team member who could do the work of a psychologist if one was absent from the team?
 - d. Do you feel there is a clear distinction between different professional roles working in IMH?
7. Rules
 - a. What person governs the work for this case?
 - b. Who would you see as holding the 'power' in IMH casework?

Appendix L: Case Vignette

Amy, an 18-month-old girl, was referred to the team by her GP, Dr. Murphy. Amy was referred for assessment due to considerable dysregulation, rapid mood changes, aggression toward herself and others (head banging, poking her own and others' eyes, pulling hair, slapping, and kicking), crying in public places, and significant sleep disturbance. Her parents reported extreme sensory sensitivities, including refusing to have certain clothing textures touch her body, difficulty dealing with loud noises, and having a hard time when others tried to touch her. These symptoms were causing tremendous stress for Amy and her family. The GP's referral requested multidisciplinary assistance for the family in coping with their past and current traumas while helping Amy gain age-appropriate independence and experience that would foster developmental and socioemotional growth. Furthermore, Dr. Murphy requested support in reconciling the strengths and potential she saw in Amy with the family's fears that something was "terribly wrong" with their baby. Amy's parents are from an Irish Traveller background. Their daily lives are complicated by their struggles with poverty, history of intergenerational trauma, discrimination, and mistrust of those in authority, including police and medical professionals. Amy, her 8-year-old sister, and her mother and father live in a small caravan. She and her mother share a bed, her sister and brother sleep in an adjacent bedroom and her father sleeps on the couch. Their living space has only about a 4 × 4 foot area of furniture-free space. In addition, the children do not play outside due to the location of the caravan, that being, adjacent to a busy road with limited open space. Amy's mother is unemployed, and her father was recently let go from his recent job. When the family agreed to complete this interdisciplinary assessment, they were desperate to understand what was "wrong" with their youngest daughter. They wanted to be listened to, respected, and taken seriously by a team of professionals. They reported being frustrated by paediatricians with whom they had consulted who had told them to "wait and see" or that Amy was too young to benefit from intervention.

Appendix M: Example of Interview Transcript

Interviewer: So my first question is what is your understanding on IMH?

P2: Ok. Well it is the social emotional development of infants (0-3years of age). I think it has moved up to even 6 from the last I have heard from when I went to the launch of the IMH Irish competency framework, where they were talking about it from 3-6, there's some competencies for 3-6, and that's the first I have heard of it moved up. You know it is about working with families, parents and that engagement with their children attunement and that engagement with babies and toddlers initiatives. I think it's a multi-disciplinary role because they're all working around babies in EI and all learning happens through engagement with the parent and I think there's not enough at the primary care level in terms of campaigns or whatever to parents about the importance of IMH and about attachments, and what insecure attachment looks like and what a secure attachment looks like. I don't think there's enough out there. Parents don't know about it, crèches don't know about it

Interviewer: Yeah, there's a space for promotion at a universal level?

P2: Yeah at the universal level definitely. And if there was, it would make our job a lot easier I think.

Interviewer: Absolutely! So, my next question then is in terms of you as a psychologist, do you think you would have a role to play in working with IMH cases and if so, what might that role look like?

P2: Absolutely! We are a disability team and I think with cases, historically people look at it with a medical lens, looking at the disability, whereas I am looking at it through a biopsychosocial lens and looking at the interaction, the quality of attunement between the parent and the caregiver and for me that comes first. For me that the gateway to interventions around the disability rather than kind of the disability itself, say autism or whatever. The child is still going to learn the same way and the quality of the relationship, the attachment between the parent and the child is the gateway to strategies

and interventions. Because the intervention happens through the relationship. The client really is the relationship.

Interviewer: So would your desired outcome be to enhance that relationship as a means of intervention?

P2: Absolutely! I struggled to do that because of working in a system that hasn't historically looked at cases that way in a disability sector. It is hard, you feel like you're beating that drum alone. Social work actually beats that drum as well. But you do feel like you are beating that drum alone in the disability sector. It is different in services like child and family where IMH is kind of their bread and butter and they are set up for that. But, you know children who have disabilities have insecure attachments too and it's almost like the family and the relationships are not seen as important in disabilities, just speech problems and 'let's fix that and the sensory and the social and 'let's fix that', the behaviour problems, 'let's fix that' but you can't divorce the child's needs from the family, the relationships within the family and the quality attachments. So, it is hard to change that culture in disability I think. I do not think we are resourced well enough. I would love to be doing much more of it. I don't think we do enough of it. It is always in the back of my head you know. There needs to be systemic change

Interviewer: I see, very interesting, thank you. My next question, we have kind of touched on it, you mentioned being a lone practitioner in it, as well as the model of service but are there any other barriers you would find to working in IMH frameworks?

P2:

I think, people don't know about IMH. The word is not widely used, certainly in the sector I am working in. Or the understanding of what it is. It is a very new concept. So awareness is probably a barrier. Perceptions of what a psychologist's role was traditionally, is another barrier I think. Traditionally, psychologists weren't referred to until they went to preschool is my experience of working in EI in Ireland, they refer the kids at age 3 but that's gone. So really, kids are only referred when below aged 3 if there an ASD diagnosis or if there is a particular problem. For example, the child suddenly stops feeding or if there is a lot of behavioural issues around feeding. So if there is a crisis, you will get referred a kid younger. But in the main, you are not

referred kids to work on attachment or engagement because I don't think people notice these things. They are working on language or sensory because of their awareness of what the red flags are such as; insecure attachment or parental stress or parental anxiety or depression. Their awareness is low, so it is just not being noticed. I think there has to be a shift of psychology being used in crisis, to being more preventative.

Interviewer: Okay so when you do get a case, and you do have the time and resources to work on that relationship, is there anything that facilitates your work?

P2: The VIG is one and I would love to be doing it all of the time because when I used to use it, it did work. It is short term & powerful. The theraplay as well. That's another one. I do kind of use the theraplay. I don't use theraplay from beginning to end but I do use elements of it such as looking at how the parent nurtures the child, challenge, engagement, are they setting tasks at the right developmental level. I do look at those things and use that model. Also, the PACE model the Daniel Hughes model I kind of hold that in my head when I am looking at the quality of the relationship.

Interviewer: At the start you mentioned those, was it a framework or?

P2: With the theraplay, its dimensions. So you are looking at nurture. So it's the marschark interactive assessment which you are trained in when you do the theraplay. What you do is you video the parent and child interacting. I have only done it once in west limerick. You video the parent and child interacting and then you analyse the video and you give them certain tasks to do. Standardised tasks. So if you do it with several parents, you are given them the same tasks to do. One task might be; brushing hair or playing with hats, playing with blocks. You might say to the parent play an interactive game with your child, such as peek a boo. Then you analyse the video looking at the nurture, engagement, how they structure the task and the level of challenge. So I hold those dimensions in my head, I am not doing the marschark formally, but I am using those dimensions when I am looking. I would like to be doing more structure, more formal stuff doing things properly but... What I have noticed as cases come in, and I am using the term IMH at meetings, new referrals saying I think there is IMH difficulties here and I think there is a primary need before we get to the ASD diagnosis, we need to address this because attachment presentations and ASD presentations can overlap and I

think I am the alone voice in that because people don't really understand what I am talking about. It ends up with kind of ; Oh well we will hold on to them to do the ASD piece and we will refer to child and family Which is fine, but I actually think you know in one of the cases, as it has come to fruition, there are serious attachment problems. Ages ago when I first mooted it, what I was saying wasn't trusted enough but it has come to full fruition that there are huge IMH problems. There were 9 aces. At least 9, in the child's upbringing. But again, people don't understand about aces. There is just a whole load of awareness raising to be done.

Interviewer: In your job, do you think, if you said in a meeting there is some attachment difficulties here, do you have the scope to do anything? Or would you be saying we need to refer him/her on.

P2: Capacity wise I probably don't have the scope. I could do bits of VIG because VIG is evidence based I mean it's in the NICE guidelines, but it's finding time. I wouldn't have the time to do theraplay because it is a much longer intervention. If you refer them onto child and family there is a 2 year waiting list if you are a Tulsa case, more than that if you are not a Tulsa case. So actually services for kids with attachment difficulties are really poor. So we should be doing it because what we know is if the intervention doesn't happen there is going to be huge problems later on so we should be doing it.

Interviewer: So you mentioned the NICE guidelines, is there any other guidelines or legislation that guides your work with IMH cases?

P2: I suppose the Special Interest groups. The PSI's Special Interest Group group. I am a member of that. I don't know in relation to legislation but the Irish Association of Infant Mental Health have framework for competency coming out being published at the moment and when that comes out, that will be very important guiding everybody's work on a multidiscipline team. I will be grasping that and running with it. We are the first country outside of Australia and America to have a framework for IMH.

Interviewer: Brilliant. I must keep an eye out for that. So my last questions are; if you did have an IMH case that you were given the scope and free reign on working on, what professionals do you feel would be absolutely necessary on a team?

P2: I think it is wide open. I think everybody who is working with children 0-3 should have some level of awareness depending on what capacity they are working; family support worker, community mother, speech therapist, occupational therapist, and that's what this framework of competency aims to do, so it goes from level of competency from just the family support worker right up to maybe a specialist psychologist. So I think anybody working with children 0-3 you should have some level of awareness and a capacity to intervene. So I think the whole team should be involved.

Interviewer: So, if you weren't on a team, or you had taken leave, do you think there is any other team member that could do your work as a psychologist in an IMH case?

P2: Speech could do a bit of the engagement stuff, social work-the family relationship piece but the big formulation piece, no. Nobody else could do that.

Interviewer: Do you think in terms of governing the case, what sort of professional could do it?

P2: It would have to be psychology I think.

Interviewer: My last question is, as I was saying to you before. Do you think there is a clear distinction between different roles in working in IMH cases

P2: No, I don't think there is. I think when people hear mental health they think of psychology and they don't see their role in it. But they're roles for everyone and I think that this framework that is coming out will make that very clear. Everyone has a responsibility at whatever level. But, ultimately the psychologist is the specialist.

Interviewer: Perfect, is there anything else you wanted to mention in relationship to IMH and psychology?

P2: I don't think so. I think you have covered everything. I just think it is that awareness raising needs to happen and you know if parents have anxiety or depression in the first 6 weeks, following birth that that is a major red flag for IMH difficulties. But there is a perinatal-IMH specialist working in XXX, so that is a really huge step. XXXX are doing a great job at raising awareness and I am a part of that group, so that is really good. So, that should raise some awareness. Also if there's Circle of Security or something going on in child and family. I think services should be more fluid - disability should be able to access that I think services should be more fluid instead of being taught of as individual entities

Interviewer: Brilliant, thank you so much. I have reached the end of my questions so I will just stop the recording here.

Appendix N: Sample of Interview Notes**Interview Notes**

Time: 17:00

Date: 23/10/16.

Participant Code: PA.

Notes/reflections/comments:

- capacity building of others mentioned a lot in this interview
- Works in CAMHS - said she doesn't get to see a lot of infants due to demands of service - interesting point. - stressed v.e. same?
- feelings that she has to justify working in IMH
- Emphasised reflective supervision vs case management as important in IMH.

Appendix O: Ethical Issues and Researcher Actions

| Ethical Issue | Researcher Action |
|-------------------------------|--|
| Informed Consent | <p>Informed consent was obtained for all participants. Within the online questionnaire, a discrete information page was attached explaining the nature of the research so that participants had a thorough understanding of what was expected of them before providing consent. This information page also contained contact details of the researcher, and researcher's supervisor, should any</p> <p>of the participants have required further information or clarification. Participants would then be required to indicate their consent, on another discrete page of the online questionnaire. With regards the interview process, participant information sheets and informed consent sheets were sent via email to all participants prior to engaging in the interview.</p> |
| Confidentiality and anonymity | <p>No personal information was gathered at any point during the research. Managerial consent was sought for initial</p> <p>correspondence with all professionals and only professional email addresses and/or phone numbers were required. The details held by the researcher (i.e. names and work email addresses) were deleted following data collection. All quantitative</p> |

data gathered via online questionnaire did not contain any identifying information (e.g. location of service). All qualitative data was anonymized by giving each participant a unique code to which only the researcher is privy. Voice recordings of interviews were held on a password encrypted hard drive for transcription. Following this, voice recordings were deleted from the device. Thus, only the anonymous transcription of the interview was retained, ensuring that it was not possible to trace data back to individual participants.

Right to withdraw

Within the consent form for the interviews participants were informed how they have the right to withdraw from the study at any point, and their data will subsequently be destroyed and removed from the research. For the online questionnaire, participants were informed how they have the right to withdraw *during* the , yet their data cannot be removed if they have completed the questionnaire, as there is no way of linking individual participants back to their data once it has been submitted.

| | |
|----------------------------------|---|
| Straightforwardness and openness | At all times, the researcher was clear and open about the purpose of the research, and will not use any methods to attempt to dupe or deceive participants into partaking in the research. |
| Continuity of care | A protocol was in place by the researcher if a situation arose where it is evidence that a subject requires additional assistance to support their care and development. Such situations may include a professional making a negative personal disclosure about an aspect of their professional practice. If this were the case, the professional would be directed to the Employee Assistance and Counselling Service, which is available to health care professionals working in Ireland and where appropriate support can be obtained. |
| Avoidance of harm | If the researcher was concerned with the impact the research is having on the participant's mental or physical integrity (e.g. if participant becomes upset or distressed), the researcher would pause the interview and check in with client to see if they wish to continue or cease the interview process. Support information will subsequently be provided after the interview, or at the point at which they choose to discontinue. |

Appendix P: Letter of Ethical Approval



Decision of the DECPsy Research Ethics Committee

| | |
|---|---|
| 1 Applicant | |
| Name: | Kayleigh Sheerin |
| Programme: | Doctorate in Educational and Child Psychology |
| Year: | 2 |
| 2 Ethical Considerations Relating to this Project | |
| The DECPsy Research Ethics Committee has considered the application and the following ethical considerations were raised in relation to the proposed research: n/a | |
| 3 Decision and Conditions on Award of DECPsy REC Ethical Clearance | |
| <i>Tick as appropriate</i> | |
| Application approved | <input checked="" type="checkbox"/> |
| Application approved subject to minor clarifications or changes without the need for formal re-submission | <input type="checkbox"/> |
| Application referred back for revision in specified areas and resubmission within two weeks to the Chair of the DECPsy Research Ethics Committee | <input type="checkbox"/> |
| Application not approved | <input type="checkbox"/> |
| Application referred to MIREC for resolution | <input type="checkbox"/> |
| Signed DECPsy REC CHAIR | |
| Therese Brophy | |

Appendix Q: Feedback on Measures Provided by IMH Practitioner

Are all questions answerable?

Rather than asking for a definition of IMH, I would suggest broadening the question to ask what the clinician's understanding of IMH is. Many clinicians will not have experience of IMH in a clinical setting in terms of working within that framework and can feel under pressure to provide a definition. By keeping the question more general, you're more likely to put people at ease and generate more feedback from them. You could also provide a definition if you felt it would generate more discussion with the clinician in terms of answering subsequent questions.

Under 'subject' questions, it might be interesting to know what the barriers are for clinicians in an IMH case (e.g. one barrier in an Irish setting being that other colleagues may not recognise the case as an IMH case and may push for an ASD diagnosis).

Are all questions relevant to Irish practice?

The questions are certainly relevant for those clinicians working with an IMH framework and who have an interest in IMH and perinatal psychology. However, given that there are no specific perinatal psychology posts in the country (e.g. in the maternity hospitals), most clinicians with an interest in the area work within an IMH framework as part of the role in an EIT service/community psychology service/CAMS/adult mental health service. Again, it might be an idea to ask more questions about the barriers to working within an IMH framework- particularly in an Irish context.

Is the case vignette relevant to the type of referrals a multidisciplinary team may get?

Your vignette is excellent and covers many difficulties that can present in an early intervention service (EIT)/community psychology service.

Are there any other questions/topics I should include?

Other than asking more about barriers to working within an IMH approach and probing clinicians' understanding of IMH and what it looks like in a clinical setting, your interview schedule and vignette are both excellent; a really timely and important piece of research Kayleigh- I look forward to reading your results!

Appendix R: Stages of Thematic Analysis (Braun & Clark, 2012)

Phase 1: Familiarisation with the data

Interviews had been conducted and transcribed by the researcher, which enabled the researcher become increasingly familiar with the content of the data prior to the analysis stage. Transcriptions were checked against the original audio recordings to ensure accuracy and begin the search for initial meanings, patterns, or interesting aspects of the data. An accompanying notebook was used to document initial ideas for codes.

Phase 2: Generating initial codes

This phase involved generating initial codes from the interview data, and collating the data extracts for each code. Software NVivo was utilised to facilitate the coding process. As aforementioned, the creation of codes was derived both inductively, and deductively.

Data-driven or inductive coding was initially undertaken, in order to effectively capture the meaning of the data. These inductive codes included items such as ‘IMH is evocative for practitioners’, ‘IMH is an ecological concept’, and ‘psychologist as champion for the child’. The inductive codes were subsequently mapped onto the deductive codes derived from this study’s theoretical framework, Activity Theory. These codes included items such as ‘outcomes’, ‘division of labour’ and ‘tools and resources’. Secondary coding was undertaken by a peer trainee psychologist. A sample of the coding framework utilised, as well as an anonymised transcript, was provided. The secondary coding was then compared to the original coding to review overlap or areas of dissonance. Overall, the inter-rater agreement reached 83%. Miles and Huberman (1994) propose that an inter-rater reliability of over 80% is considered sufficient in qualitative research. An example of initial coding is presented below.

| Data | Initial Codes |
|---|--|
| <p>Interviewer (I)</p> <p>I suppose what would be one of the main barriers with you working with IMH frameworks and contexts?</p> <p>Participant (P)</p> <p>Yeah.. am, I suppose there's a number of different barriers. At a systems level I suppose there's just not really the support for the IMH work because I don't think there's enough of an awareness out there yet and because of that I suppose most of our resources go into intervention in the older age group, that's what's hitting our desks in terms of referrals. Because we have empty waiting lists at times, the getting to the early years when you know difficulties aren't at crisis point, there's not as much of an emphasis on that. you know a lot of our services is on fire fighting. I think that makes it difficult as I was saying we just have capacity for two cases each but if we were to go out and do more promotion activities our referral rates would definitely increase, you know?</p> <p>I: I can imagine</p> <p>P: And we don't really have the capacity to be able to respond. So that's a real barrier. And then very practical things like getting travel expenses for people to go out and do home visits. A key perineal of the model is that it's a</p> | <p><i>Lack of systemic support for IMH</i></p> <p><i>Lack of awareness of IMH</i></p> <p><i>Capacity for IMH work</i></p> <p><i>Psychologists working in crisis situations</i></p> <p><i>Capacity for IMH work</i></p> <p><i>Lack of awareness of IMH</i></p> <p><i>Promotion and prevention work</i></p> <p><i>Lack of resources</i></p> <p><i>Challenges to IMH work</i></p> <p><i>Home visiting is important in IMH</i></p> |

| | |
|--|--|
| <p>home visiting model that we would use. Now it's not to say that parents can't bring their children into the clinic, they do and sometimes they prefer that but you know really yeah practical it's about getting travel expenses to go out to homes. Amm. What else I suppose because a psychologist can't do it all, it's very much an interdisciplinary field. Your working relationships with colleagues really are key. You might, like we would have a good relationship with community mothers programme that's a peer volunteer programme</p> | <p><i>Challenges to home visiting</i></p> <p><i>IMH as multidisciplinary field</i></p> <p><i>Colleague support is helpful</i></p> |
| <p>I: Yes I think I've heard of it</p> | |
| <p>P: Yeah, so we would have relationships built up with those so if the family need concrete assistance we would ask the community mothers would they help out with the family and meet them and see if they want practical supports. Amm.. like in the case that you had given like obviously the living conditions and the poverty. They would be areas that we would be picking up on and trying to get other people involved in that you know? So very much relationships with colleagues and other departments in the community are key and you know if you don't have those relationships that would be a real barrier in being able to</p> | <p><i>Collaborative relationships</i></p> <p><i>Working through other professionals</i></p> <p><i>Collaborative working is helpful</i></p> |

| | |
|--|--|
| <p>further the work</p> <p>I: Ah very good, and I suppose on the flip side of that what facilitates your work when working in an IMH framework</p> <p>P: I suppose very good coordination and very good working relationships with people. Am.. capacity to do home visits. Reflective supervision as well, I don't think it would be possible to do the work without it. I just think it's so key because we bring so much of ourselves to the work</p> | <p><i>Collaborative working is helpful</i></p> <p><i>Home visiting is important in IMH</i></p> <p><i>Reflective supervision is helpful in IMH</i></p> <p><i>IMH is evocative for practitioners</i></p> |
|--|--|

Phase 3: Searching for themes

Phase three of the analysis process involved sorting the codes into potential themes and collating the relevant coded data extracts within the identified theme. Using NVivo, the codes were grouped into categories. Codes that did not 'fit' into any category were placed into a 'miscellaneous' category. Following this, the codes within each category were collapsed or clustered to reflect a meaningful pattern in the data. For example, the codes 'getting a big picture' and 'formulating skills' were combined to produce the theme 'psychologist's ability to formulate'. Additionally, the codes of 'attending trainings' and 'delivering trainings' were combined to create the overall code of 'training and development work'. Some codes were expanded to describe the data in more detail. For example, the code 'division of labour' was broken up into 'roles can be blurred', 'lack of clarity on other professional's roles', and 'strategies to clarify roles'. This phase ended with a table of potential themes and subthemes.

Phase 4: Reviewing themes

This phase of analysis was concerned with the refinement of themes and subthemes, as gathered during phase three. Firstly, the themes and subthemes were checked against the collated data extracts to explore whether the theme works in relation to the data. If the data and theme did not adequately correlate, the theme was either changed or else the data extract was moved to another theme. For example, the subtheme 'relationship with reflective practice' was originally 'experience with reflective practice'. However, when this was reviewed, the theme didn't adequately capture the story of psychologists having both an experience of reflective practice, yet also a professional dedication to the importance of reflective practice. Therefore the theme name was changed to accurately reflect the data set.

Secondly, the above mentioned 'quality checking' procedure was repeated in relation to the entire data set to ensure that the thematic map accurately reflected the meanings evident in the data set as a whole. As such, all interviews were re-read both to review existing codes and themes and to code any additional data within themes that had been missed in earlier coding stages. Braun and Clarke (2006) note that re-coding from the data set is to be expected reflecting the organic nature of the coding process. Moreover, some subthemes that were identified during phase three were eliminated during phase four due to their lack of relevance and evidence. For example, themes that may have been repeated in one interview, yet were not present across more than one data set, were excluded. Braun and Clarke (2012) emphasise the need for themes to be 'thick'; meaning that the theme had enough meaningful data across the dataset to create a meaningful theme. For example the subtheme 'psychologist's therapeutic skills' was eliminated as the theme only emerged in one data set. As a final quality check, the data was re-read in light of the research questions in order to find any data that disproves or disconfirms the emerging themes. If data were found, they were incorporated into the existing theme as an exception to that particular pattern of meaning found.

Phase 5: Defining and naming themes

The final phase of analysis involved defining and naming themes in more detail. To support this process, and to ensure the validity of themes and subthemes, a second peer trainee psychologist double coded the data to date. Themes and subthemes were written

out on individual flashcards and given to the peer trainee. They were then asked to spend some time matching the various subthemes with the overarching themes. Following this, discrepancies were analysed and a discussion took place as to why the discrepancies were occurring. These discussions indicated the need for refinement of some subthemes and themes; particularly with the use of language in defining the theme. Finally, the themes and subthemes were organised to tell the 'story' of the data, and a thematic map was created to represent the findings visually.

Appendix S: Example of Coding Trail

| <i>Direct Quote from Participant</i> | <i>Initial Coding</i> | <i>Subthemes</i> | <i>Final Themes</i> |
|---|--|--|---|
| P6: “unfortunately a lot of parents who have no understanding of what a psychologist does” | Parents don’t understand psychologists role | lack of understanding about the psychologists role | Perceptions of the role of the psychologist in IMH contexts |
| P1: “there’s a huge role for psychologists to play in sort of championing the importance of IMH and then also on a community basis” | Psychologists championing importance of IMH in community | Psychologist as champion for the infant | Perceptions of the role of the psychologist in IMH contexts |
| P2: “What I have noticed as cases come in, and I am using the term IMH at meetings, new referrals saying I think there is IMH difficulties here and I think there is a primary need before we get to the ASD diagnosis” | Differential diagnosis Psychologist is advocate for IMH on team | Psychologist as champion for the infant | Perceptions of the role of the psychologist in IMH contexts |
| SW1: “we are very often working with the lower level kind of stuff and I suppose it would get routed up | Psychologist not involved in ‘lower level’ activities. | Psychologist is not ‘on the ground’ | Perceptions of the role of the psychologist in IMH contexts |

higher as needs be but certainly we would refer in if we felt there was an identified need from social work or whatever and the next layer was needed we would use that pathway.”

| | | | |
|---|--|---|--|
| <p>P5: “Yeah well, that’s it I suppose, you know you’re kinda de-mystifying the whole psychology piece, and like showing that you’re really just there to help”</p> | <p>Need to clarify mystery of role of psychologist for others</p> | <p>lack of understanding about the psychologists role</p> | <p>Perceptions of the role of the psychologist in IMH contexts</p> |
| <p>P5: “Yeah, yeah.. and why would you prioritise that over a suicidal teenager.. which is life and death sort of a thing. Though there’s incredible value in the work it takes longer for it to be noticed.. it’s very hard to prove what you prevented”</p> | <p>Difficulty assessing outcomes in IMH Different services enable different levels of IMH work Psychologist working in crisis situations</p> | <p>Psychologist is referred to in crisis situations</p> | <p>Perceptions of the role of the psychologist in IMH contexts</p> |
| <p>P6: “And I think that’s probably now that I’m thinking about it where that</p> | <p>Psychologist keeping the relationship in mind within interagency work</p> | <p>Psychologist as champion for the infant</p> | <p>Perceptions of the role of the psychologist in IMH contexts</p> |

role of let's say a
 psychologist or
 psychotherapist or
 someone in that kind
 of holding space is
 kind of holding and
 yeah something about
 even the hands on the
 circle in the circle of
 security it's almost
 that person that's
 holding the
 relationship within the
 network of agencies
 and just ensuring that
 that is actually that we
 are working within a
 relational context"

CM1: "Yes
 sometimes
 psychologists are
 quite surprised, there
 was a reflective
 practice meeting there
 a little while ago and
 it's amazing that they
 are surprised at what
 goes on for a family
 on the ground"

Other professionals
 feel psychologists do
 not know what goes
 on for families on the
 ground

Psychologist is not 'on
 the ground'

Perceptions of the
 role of the
 psychologist in IMH
 contexts

P1: "So social work
 And/or family support
 workers are pivotal
 because it's that real

Helpful colleagues in
 IMH casework
 Psychologist working
 in collaboration with

Psychologist is not 'on
 the ground'

Perceptions of the
 role of the
 psychologist in IMH
 contexts

on the ground sort of others
 support and I suppose Psychologist
 they can really I can delegating the
 often work through practical jobs
 them so I would often
 work with the family
 support worker so like
 okay we are going to
 support this mom to
 even spend more time
 with this baby or
 reduce her financial
 burden by doing this
 and they would
 actually go and make
 sure that happened.”

| | | | |
|--|--|---|---|
| <p>P6: “Am, I think am the way it has happened for me has been much more ad- hoc in the sense that I’ve been working with families and then had to get other people involved so I’ve maybe naturally led a team of people who have been put together simply with the specific purpose of meeting the needs of this particular family”</p> | <p>Psychologists operating in leadership roles</p> | <p>Psychologists viewing themselves working in leadership capacity in IMH work</p> | <p>Perceptions of the role of the psychologist in IMH contexts</p> |
|--|--|---|---|

| | | | |
|---------------------------|---------------------------|---------------------------|---------------------------|
| <p>P2: Traditionally,</p> | <p>History of role of</p> | <p>Psychologists feel</p> | <p>Perceptions of the</p> |
|---------------------------|---------------------------|---------------------------|---------------------------|

| | | | |
|--|--|---|--|
| <p>psychologists weren't referred to until they went to preschool is my experience of working in EI in Ireland, they refer the kids at age 3 but that's gone. So really, kids are only referred when below aged 3 if there an ASD diagnosis or if there is a particular problem. For example, the child suddenly stops feeding or if there is a lot of behavioural issues around feeding. So if there is a crisis, you will get referred a kid younger</p> | <p>psychologist Psychology referred to in crisis situation Medical model</p> | <p>they are referred to only in crisis situations</p> | <p>role of the psychologist in IMH contexts</p> |
| <p>SLT1: "I suppose I just find there doesn't seem to be they don't seem to be on the ground."</p> | <p>Lack of psychologists on the ground</p> | <p>Psychologist is not 'on the ground'</p> | <p>Perceptions of the role of the psychologist in IMH contexts</p> |

Appendix T: Empirical Paper



Empirical Paper

Doctorate in Educational and Child Psychology

Student Name: Kayleigh Sheerin

Supervisor: Dr. Suzanne Parkinson

Title: Working in an Infant Mental Health Framework: Activities, Supports, and Challenges Faced by Irish Psychologists

Abstract

Aim: The aim of this study was to explore how Irish psychologists are incorporating an IMH framework in their practice. This study also aimed to highlight supports and challenges that psychologists encounter when working in this model.

Method: This study adopted a convergent parallel mixed methods approach to data collection, with Activity Theory being utilised as a guiding psychological framework. Quantitative data was gathered from psychologists working in multidisciplinary teams across Ireland using an online questionnaire. Semi-structured interviews were utilised to gather qualitative data from psychologists working with young infants and their families. Findings were analysed using descriptive statistics and thematic analysis.

Results: Results explore how psychologists adopt an IMH framework in their practice through the functions of assessment, intervention, consultation and training. Supportive factors when using an IMH framework include having managerial support, colleague support, and the capacity to engage in reflective practice. Challenges faced include difficulty justifying outcomes of IMH cases, lack of resources hindering IMH work, stigma associated with IMH difficulties, and a lack of public and professional understanding on IMH.

Conclusion: This small-scale exploratory study provides insight into how psychologists use an IMH framework in Irish health care settings to meet the social and emotional needs of the 0-3 cohort. Implications for psychology practice in IMH are further considered, as well as study limitations and potential directions for future research.

Introduction

Infant mental health has been described in the literature as the capacity of children to “experience, regulate, and express emotions; form close, secure interpersonal relationships; and explore the environment and learn” (Zero to Three, 2002, p.1). As originally defined by Selma Fraiberg in her notorious article “Ghosts in the Nursery” (Fraiberg, Adelson, & Shapiro, 1975), “infant” refers to children aged between birth and three years of age, “mental” relates to social emotional functioning, and “health” equates to wellness in this area (Fraiberg, et al., 1975). Infant mental health (IMH) has become synonymous with healthy social and emotional functioning, and is a cornerstone for successful psychological development (Osofsky, 2016). IMH also incorporates the field of practice and research involving the child, their family and the wider community. This growing field of research and practice is dedicated to the promotion, prevention, and treatment of IMH difficulties (Weatherston, 2012).

The significance of positive early parent-child relationships has been demonstrated repeatedly in research from a variety of fields of study including psychology (Schoore, 2001), psychiatry (Keren, Feldman, & Tyano, 2001), occupational therapy (Olson & Baltman, 1994), and nursing (Horowitz et al., 2001). Predictable, reliable, and secure relationships with caregivers positively mould the neural connections within an infant’s brain (Schoore, 2001). This relationship creates a neural blueprint and establishes a solid social and emotional mental state, which acts as a springboard to success in other areas of development (Clinton, Feller, & Williams, 2016). A disturbance to the caregiver-infant relationship can have grave consequence, with potential knock-on effects to variety of domains of development, including delays in cognition and learning, school problems, and difficulty expressing emotions (Osofsky et al., 2007). It has been proposed that unfavourable childhood experiences occurring in the first five years of life can account for more than 30% of psychosis in adulthood, can predict the onset of drug use in adolescence, and is related to risk of involvement in the criminal justice system (Queenstown Mental Health Commission, 2014). Research also suggests that mental health difficulties affect one in seven children, and when left untreated can have detrimental impacts on family functioning, wellbeing, and academic attainment (Lyman, Holt, & Dougherty, 2010). While there is some opposing evidence

to suggest that children can demonstrate “resilience” despite adverse childhood experiences (Luthar, Cicchetti, & Becker, 2000), the salience of the attachment relationship as a key protective factor in the life of a child cannot be denied.

IMH Frameworks for Practice

In order to operationalise IMH theory and research into psychologist’s casework, frameworks for practice are recommended as an essential professional resource in IMH (MacKay et al., 2016). As IMH is an emerging concept in psychology practice, frameworks to guide psychologists practice are also in the emergent stages. The original framework envisaged by Fraiberg (1980) is still relevant to practice today, and has been used as a blueprint for other contemporary IMH frameworks (e.g. Weatherson, 2012; Ahlers, Gilkerson, & Onunaku, 2006). Most IMH frameworks are not overwhelmingly different from one another, but rather expand certain concepts over others or use different language to define similar terms. For the purpose of this research, Ahlers, Gilkerson and Onunaku’s (2006) Framework was chosen as a lens to view the data gathered.

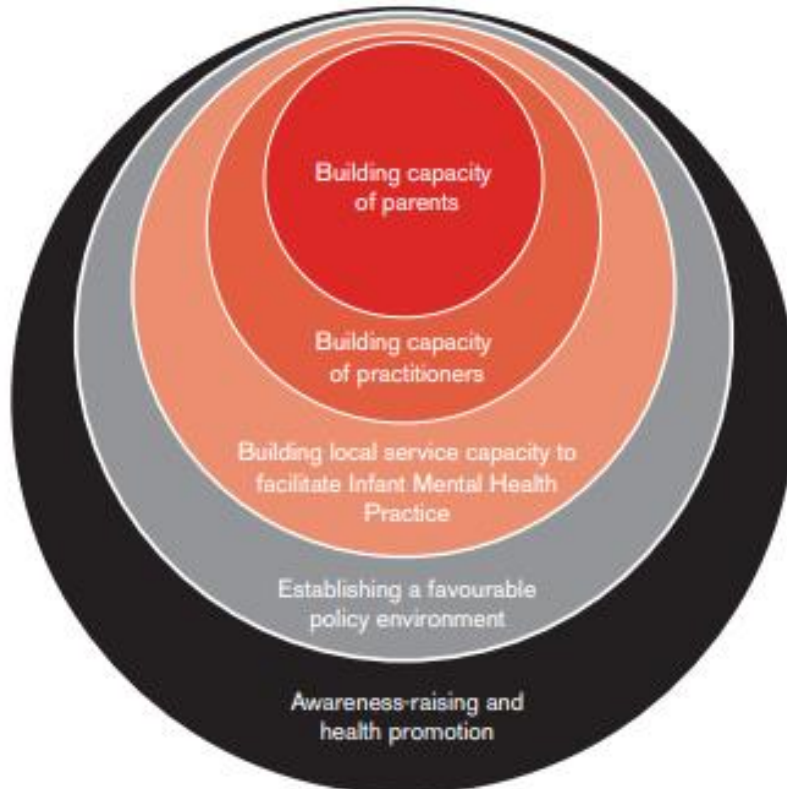


Figure 1: Ahlers, Gilkerson and Onunaku’s (2006) IMH framework

Ahlers et al.'s framework can be found in Figure 1, and consists of the following five areas of support.

- *Building capacities of parents:* Central to the framework is the need to build parents skills and confidence in their abilities to care for the social and emotional development of their children. Suggested activities at this level include information sessions for parents on topics such as post-natal depression, structured parenting programmes, or the establishment of baby development clinics that can offer consultations to parents if they have concerns regarding their infant.
- *Building capacities of practitioners:* This aspect of the framework concerns upskilling other practitioners within the service, to develop their competence in incorporating IMH principles into their work. This may be achieved through study groups, in-service trainings, or through reflective supervision.
- *Building local service capacity to facilitate IMH practice:* Developing on the previous point regarding building capacities of other team members, Ahlers et al. (2006) also emphasise that an effective IMH approach builds capacity among professionals in other relevant local services (e.g. Family Resource Centres, local crèches).
- *Establishing a favourable policy environment:* This aspect of Ahler's et al. (2006) framework concerns activities and efforts to integrate IMH principles into local, regional, and national policy change. These activities may include creation of position papers or engaging in small-scale research to inform policy makers.
- *Awareness-raising and health promotion:* The final layer to Ahler's et al. (2006) framework regards the promotion of the importance of IMH across statutory, education, judicial, and community services. Efforts at this level to promote IMH principles may direct campaigns at relevant policy makers, or specific government bodies.

An Irish Perspective

Ireland has the second highest birth-rate in Europe and the population of the number of children aged between 0-6 has steadily increased over the past number of

years (Early Years Strategy [EYS], 2013). Considering this stark statistic, it may be inferred that Perinatal and Infant Mental Health (PIMH) would be a leading health concern for an Irish context, yet in fact, the area has only recently gained traction and attention. Whilst currently Ireland does not have specific IMH policies or dedicated IMH services (Psychological Society of Ireland Perinatal and Infant Mental Health Special Interest Group [PSI PIMHSIG], 2015), there are several progressive movements taking place. Such movements include a model of care for Perinatal Mental Health being introduced to select Irish hospitals in 2016 (Health Service Executive [HSE], 2016a); a national programme entitled “Nurture – Infant Health and Wellbeing” being launched into existing child health services in 2018 (HSE, 2018), and the inclusion of mental health for young children as a key goal for development in the most recent policy strategy (Department of Children and Youth Affairs, 2018). However, while these are very positive actions, they have only been a recent introduction to the health care system, suggesting that IMH remains in its infancy in Irish practice.

Irish children are by no means immune to the consequences of poor infant mental health. The Growing up in Ireland study noted that difficulties in infant temperament at nine months were associated with problematic behaviours at three years of age (Quail, Williams, McCrory, Murray, & Thornton, 2011), mirroring the findings of international research (e.g. Shah, 2010). Although research advocates for interventions to occur at the earliest possible period, current Irish mental health policies, funding, and research have focused on providing treatment and intervention for children of school age, or older (e.g. Malla et al., 2016; O’Keeffe, O’Reilly, O’Brien, Buckley, & Illback, 2015). Currently, IMH services are only being offered at community level (e.g. YoungBallymn, 2012), only providing services to local parent and infant dyads despite impressive uptake and outcomes of said programmes (PSI PIMHSIG, 2015).

It is recognised that the provision of IMH services is best met from a multidisciplinary perspective and is not the preserve of any one professional group (Osofsky, 2016). However, in the absence of specialised IMH services, Irish psychologists are in a prime position to meet the needs of this cohort through adopting an IMH framework within their practice. Psychologists hold specialised skills and knowledge in the areas of child development and disability, and work individually with

children or at a systemic level in supporting parents, teachers, social workers or other professionals (Feehan & Hutton, 2003). They are regularly employed in a wide range of settings including community settings, schools, and specialist services such as those provided for youth at risk and children in care (Health Service Executive [HSE], 2017). They also play a key role as part of multi-disciplinary teams such as Early Intervention Teams and School Age Disability Teams (HSE, 2017). However, the practice of psychology and IMH in Ireland remains a grey and under-researched area. Various national bodies have highlighted specific gaps in psychology services provided to young children and their families; including the absence of psychologists in maternity hospitals, lack of psychologists working in primary care, no specific care pathways for IMH cases, and absence of specialised IMH services (Mental Health Reform, 2015; PSI PIMHSIG, 2015). Thus, whilst on paper psychologists have a range of services to contribute to IMH care in Ireland, significant ambiguity exists regarding psychology practice within IMH contexts.

Research Focus

Whilst the field of psychology has made renowned contributions to the theoretical base of IMH (e.g. Coo, Somerville, Matacz, & Byrne, 2018; Schore, 2001; Facchini, Martin, & Downing, 2016), it is suggested that there is limited ground-up research on what the practical involvement of a psychologist with IMH cases entails. Current Irish practice has seen a change in the role of the psychologist over the past number of years. Previously, psychologists were operating under a medical model, concerned with the assessment in the identification and placement of children with additional needs. More recently, this model has evolved to working in a systemic and collaborative model, whereby the psychologist engages in “a collaborative process with the people in the individual’s bio-psycho-social system” (Feehan & Hutton, 2003, p.1). Due to this new diversity in practice and policy, the role of the psychologist has changed, however a decrease in role clarity may be a logical consequence of this role expansion (Ashton & Roberts, 2006). While working in IMH-informed framework is advocated (PSI PIMHSIG, 2015), no empirical research has been conducted to date on how an IMH framework may be implemented or what challenges this method of service delivery may pose.

Research Questions

The aim of this article is to address the following research questions:

1. How are Irish psychologists adopting an IMH framework in their practice?
2. What are the supports and challenges Irish psychologists experience when working in an IMH framework?

Methodology

In order to address the aforementioned research question, the following methodologies were informed both by social constructivist paradigm and by methodologies employed in previously reviewed research on the role of the psychologist (Gaskell & Leadbetter, 2009; Leadbetter, 2008). This data was gathered as part of a larger research project exploring professional roles in IMH service provision.

Design

The research incorporated a parallel mixed-methods design. This type of design is the most common approach to mixing methods (Creswell, 1999), as the design lends itself to a “valid and well-substantiated conclusions about a single phenomenon” (Creswell & Clark, 2007, p. 65). This design consists of two distinct phases of data collection, both occurring simultaneously. The data is analysed separately and merged during the interpretation phase. The purpose of this design is to “to obtain different but complementary data on the same topic” (Morse, 1991, p. 122). This design was considered appropriate for this study as a means of validating and corroborates qualitative findings with quantitative results and vice versa.

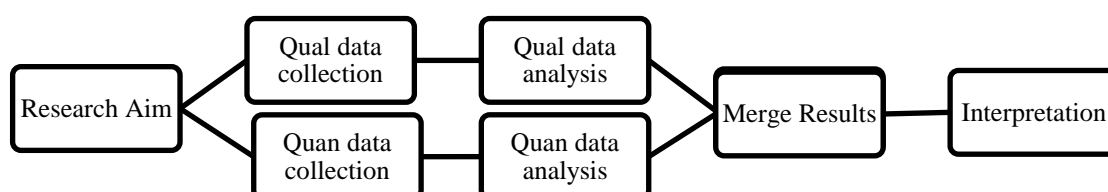


Figure 2: Convergent parallel mixed methods design

Data Collection

Quantitative data was gathered using an online questionnaire. The purpose of this questionnaire was to provide quantitative data on how psychologists are implementing an IMH framework in their practice. This data aimed to explore casework, training, as well as levels of confidence and competence in working with IMH cases. Use of surveys has been previously used as a means of reflecting on models of service delivery in healthcare (e.g. Pirkis et al., 2006), therefore was considered appropriate to address this research question, as well as provide demographic and contextual data regarding current IMH provision in Ireland. The questionnaire was based on that of a previous study (Farrell, Woods, Lewis, Rooney, Squires, & O'Connor, 2008) and adapted for an Irish context. This questionnaire was reviewed by a practicing psychologist working in the early years setting, in order to ensure the questionnaire was valid and relevant.

Regarding the qualitative component of this research, semi-structured interviews were considered the most appropriate technique to gather qualitative data on psychologists use of IMH approaches, in light of the purpose and paradigm of the current study, as well as practices from previous empirical studies (Novoa & de Valderrama, 2006; Philibin et al., 2010; Sheldon, 2000). Interview questions were drawn from the psychological framework of this research, that being Second Generation Activity Theory (see Engstrom, 2001 for overview). An overview of Activity Theory (AT) can be found in Figure 3. Questions were derived from the discrete themes or elements within the activity system, and were modelled on those found in Leadbetter's (2008) research. A case vignette was also used to provide a platform for discussion and permit a less personal and/or threatening way to explore the topic (Barter & Reynold, 1999). The case vignette used was an adapted version of one found in Gart, Zamora & Williams (2016) and was adapted to relate to the Irish cultural and health care setting. Again, this vignette was reviewed by an independent IMH practitioner, in order to ensure that this case reflected a typical case referral.

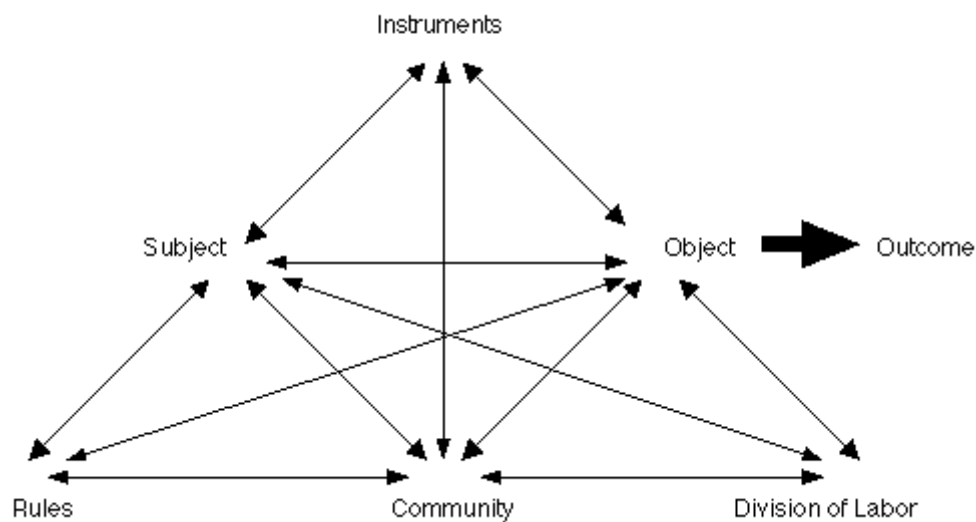


Figure 3: Second Generation Activity Theory Model

Participants

A purposive sampling procedure was utilised within the current study. Purposeful sampling has a long withstanding history in qualitative research as a means of obtaining rich information from participants relevant to the topic of study (Patton, 2002). Specifically, criterion sampling was employed to identify and select participants that met pre-determined criteria of importance to effectively and validly address the research aims (Palinkas, et al., 2015).

With regards the quantitative phase of this research, it was envisaged that the sample would provide a representative sample of psychologists working in multidisciplinary teams in Ireland, providing services to children aged 0-18 years old. These included Early Intervention disability teams, Primary Care teams, or Child and Adolescent Mental Health teams in the Republic of Ireland. Emails were distributed to relevant managers, psychologists, or through specialist groups (e.g. Psychological Society of Ireland's Special Interest Group in Perinatal and Infant Mental Health).

For the qualitative component of this research, participants were recruited using various national IMH interest groups (e.g. members of the Irish Association of IMH) or specialist IMH community services (e.g. ABC Start Right programmes). The purpose of using these platforms was to identify psychologists who have an interest in IMH and who may have experience implementing an IMH framework in their practice.

Results

Data Analysis

A total of 25 psychologists were involved in this study; 19 psychologists completed an online questionnaire and six psychologists took part in semi-structured interviews. Descriptive statistics were used to analyse quantitative data. Thematic analysis was utilised as the data analysis technique for the qualitative component. This approach was chosen as it is an “accessible and theoretically flexible approach to analysing qualitative data” (Braun & Clarke, 2006, p.77). Thus, this approach was considered appropriate to answer the research questions as well as incorporating the study’s psychological framework.

The data analysis for this research involved a two-stage sequential analysis. Firstly, an inductive or “bottom up” approach was taken, whereby themes were derived from the raw content of the data. Once this process was complete, the second stage of the data analysis ensued, incorporating the psychological theory guiding the research; AT. The data that was obtained deductively was subsequently matched to the corresponding nodes of AT. Due to the exploratory nature of this study, it was deemed important to incorporate an inductive approach to data analysis, in order to acknowledge all meaningful data and ensure that potentially important themes were not overlooked as a result of a solely deductive approach. At the end of the data analysis stage, an “activity system” diagram depicting the role of the psychologist was produced.

With regards the psychologists who completed the online questionnaire, 78.9% were female and 21.1% were male. All psychologists who completed this questionnaire

were practicing in Ireland. With regard to branch of psychology, 44.4% were clinical psychologists, 38.9% were educational psychologists, and 16.7% were counselling psychologists. In terms of level of training, 47.4% of this sample had obtained a PHD/Professional Doctorate, with the remaining sample having obtained a Master's Degree. Participants were all currently working in multidisciplinary contexts, with 36.8% working in disability services, 36.8% working in primary care, 15.8% working in CAMHS, and 10.6% working in child and family services.

The psychologists who engaged in semi-structured interviews came from a variety of different work experiences. Two psychologists worked in Primary Care Services, two psychologists worked in Child and Adolescent Mental Health Services, one psychologist worked in Early Intervention Disability Services, and the final psychologist worked in private practice. As aforementioned, these professionals were drawn from IMH networks around Ireland, therefore had substantial knowledge, training, and experience in using an IMH framework in practice.

Findings

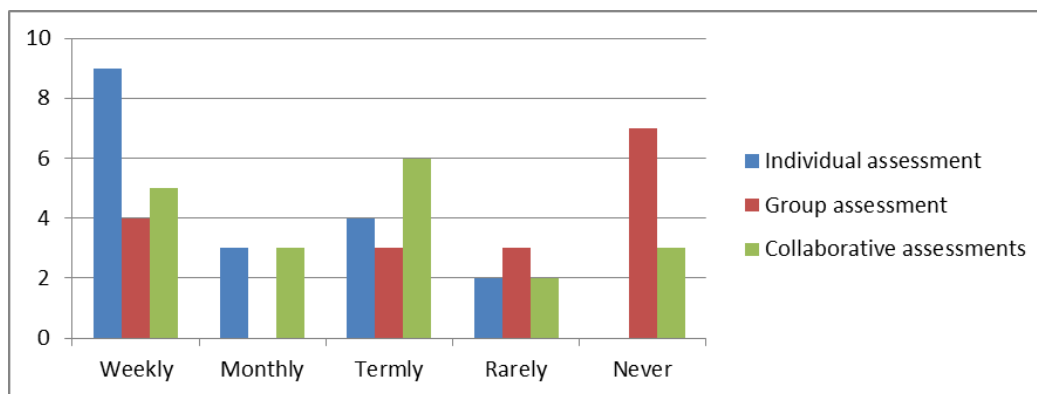
The data gathered was used to create an activity system of the role of the psychologist in IMH contexts. This data was gathered as part of a larger research project, therefore for the purpose of this empirical paper, only the themes comprising the AT nodes of “object”, and “rules” will be explored as a means of addressing the research questions outlined above. The primary themes of these nodes can be found in the Table 1 and will be subsequently discussed in detail.

Table 1
Key Findings

| Activity Theory Node | Theme | Subthemes | |
|----------------------|---|---|---|
| Object | Activities of psychologists in IMH contexts | <ul style="list-style-type: none"> - Assessment work - Intervention work - Consultation work - Training and development work - Research work | |
| Rules | Supportive factors | <ul style="list-style-type: none"> - Managerial support - Reflective supervision - Colleague support | |
| Rules | Constraining factors | <ul style="list-style-type: none"> - Service restrictions to IMH work - Difficulty justifying outcomes - Lack of resources can hinder IMH work - Lack of understanding on IMH work - Stigma around IMH difficulties - IMH work is evocative for practitioners - Working with parents | <p>A</p> <p>activities of the psychologist in IMH contexts.</p> <p>Data encompassing this</p> |

theme was drawn from both the quantitative and qualitative components of the research. The information gathered aimed to clarify how psychologists engaged in IMH work across the five core functions of the psychologists role, that being, assessment, intervention, consultation, training, and research (Farrell et al.,2006).

Assessment.



The information gleaned from the online questionnaire and presented in the above graph, highlights how the most common form of assessment work was assessment with individual IMH cases. Examples of this individual assessment work, as provided within the questionnaire, included “observation of parent-child relationship”, “developmental assessments”, and “screening for disability/ASD”. Assessment with groups of IMH cases was most frequently reported as “never” occurring. Collaborative assessment activities were reported most frequently on a termly basis. These activities included joint observations, ASD assessments where there is a differential of query attachment difficulties.

The psychologist in their assessment role also occurred frequently in the qualitative interviews by both psychologists. Such assessment work mentioned included developmental assessments, in order to provide the parent with an understanding of their child’s level of functioning and how they can adapt their expectations and interactions to suit the needs of the child. Other professionals reinforced the assessment function of the psychologists for children who they are working with for the purpose of a diagnosis, “I would refer some children for assessment maybe that I think there might be something additional going on like autism or whatever so I would refer in for a diagnosis really” (N1).

The importance of assessment for the purpose of differential diagnosis was also highlighted frequently. Participants emphasised that there can be a significant overlap between the presentations of certain complex developmental needs (e.g. ASD, Attention Deficit Hyperactivity Disorder [ADHD]) and attachment difficulties. Due to the general lack of understanding about IMH, psychologists noted that children were often referred

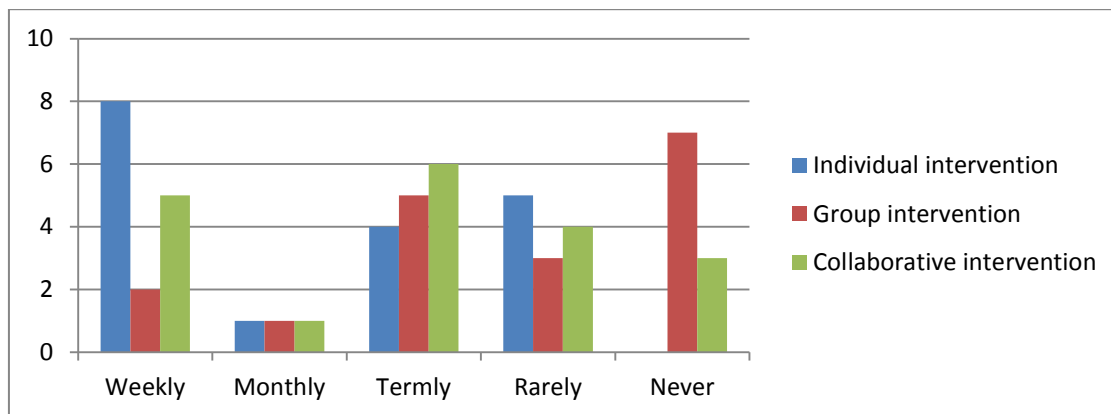
to them to ascertain what was “wrong” with them, “sometimes that’s all the referral information would be ADHD question mark” (P6). The psychologist’s role in the assessment process can be to ascertain the root of the client’s difficulties, and provide an accurate differential diagnosis for the case.

You would often be referred children where there are emotional behavioural difficulties, they don’t necessarily meet the criteria for ASD or ADHD, but when you speak to the parents on their own you might find out about maybe post-natal depression or just a very traumatic birth experience and the difficulties that the child is presenting with would seem to be sort of stemming from that area of relationship and maintained by that relationship. (P1)

Nonetheless, this differential piece can create a sense of isolation for psychologists due to a limited understanding of IMH among team members. Psychologists felt that they can be “banging the drum alone” (P2) when they flag potential attachment difficulties.

What I have noticed as cases come in, and I am using the term IMH at meetings, new referrals saying I think there is IMH difficulties here and I think there is a primary need before we get to the ASD diagnosis, we need to address this because attachment presentations and ASD presentations can overlap and I think I am the alone voice in that because people don’t really understand what I am talking about. (P2)

Intervention.

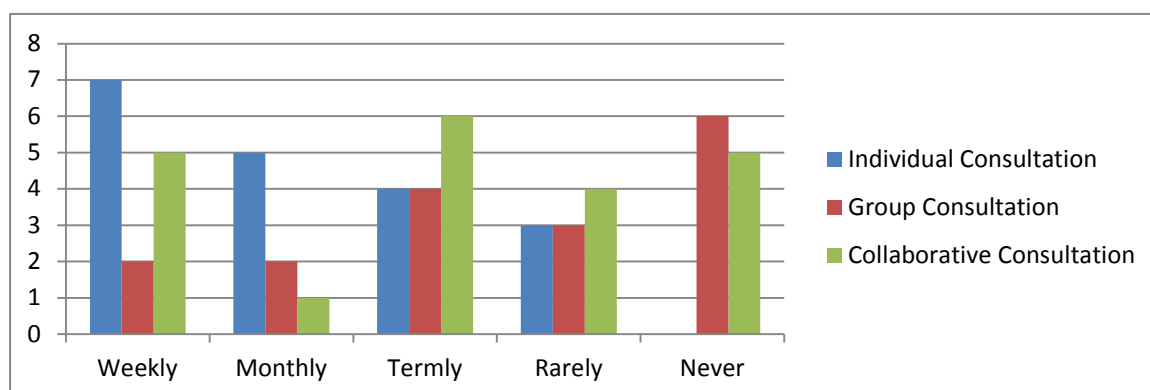


Participant's questionnaire responses regarding their intervention work highlighted how individual intervention occurred most frequently on a weekly basis, with participants referring to individual Theraplay sessions, use of Video Interactive Guidance (VIG) with parent and child, and infant-parent psychotherapy. Group intervention was most frequently reported as "never" occurring. Collaborate intervention was reported most frequently on a termly basis. Psychologists who completed the online questionnaire reported that they would engage in joint work to deliver a parent training programme such as Circle of Security, or jointly creating an intervention plan for a particular infant and family.

These intervention activities were also alluded to in the qualitative data. Psychologists viewed their role in providing one to one therapeutic intervention to parents, using evidence based strategies and approaches including attunement strategies, or parent-infant psychotherapy. Many interventions mentioned by psychologists involved joint working with another discipline, such as social work or speech and language therapy, to provide group or individual intervention work. Other professionals also valued the intervention work of the psychologist for young infants, and would refer them for intervention regarding behaviour or emotional development. However, one psychologist noted that the time to provide significant intervention work is limited due to the other demands of the role.

Capacity wise I probably don't have the scope [to do intervention work]. I could do bits ... but it's finding time..we should be doing it because what we know is if the intervention doesn't happen there is going to be huge problems later on so we should be doing it. (P2)

Consultation.



Data from the online questionnaire highlights how psychologists engage in individual consultation most frequently on a weekly basis. Participants referred to their individual consultations with parents of an infant, or else consulting with other professionals regarding a specific case. Consultation with other professionals occurs most frequently on a termly basis. Examples of this type of work included drop in clinics with another professional, joint consultations with social work or speech and language therapy, consulting with others as part of the “Meitheal”⁵ process, and providing supervision to other professionals or to assistant psychologists.

A psychologist’s role as consultant was also reflected in the data, with other professionals appearing to value the collaboration with the psychologist, “I think that I have probably been drawn into it a lot by other professionals who have asked for my input with cases that are now looking at them were IMH cases” (P1). However, other professionals reported that it can at times be difficult to obtain formal consultation, thus relying on more informal and ad-hoc means.

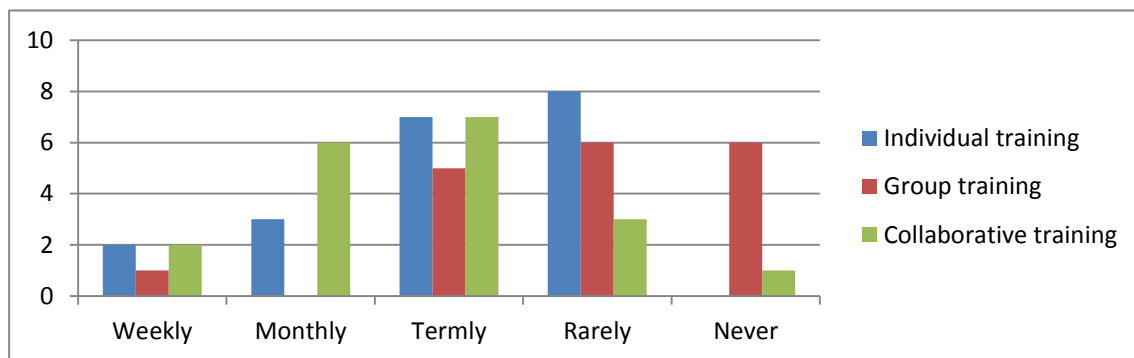
I would love to have more of an input or relationship with a psychologist, even just to discuss clients with a psychologist.. It makes it so much easier when you’re having a cup of coffee and someone is sitting beside them and you can

⁵ Meitheal is a “case co-ordination process for families with additional needs who require multi-agency intervention but who do not meet the threshold for referral to the Social Work Department” (TUSLA, 2019, para.1).

say look I had this child before lunch what do you think I should do you know five minutes over coffee can help a lot .(SLT 1)

Providing consultation in the form of reflective supervision and facilitating reflective practices was also mentioned as an activity that psychology can provide, “I think staff need to be supported with that [reflective supervision] and I think psychology is in a good position for that”(P4).

Training and development.



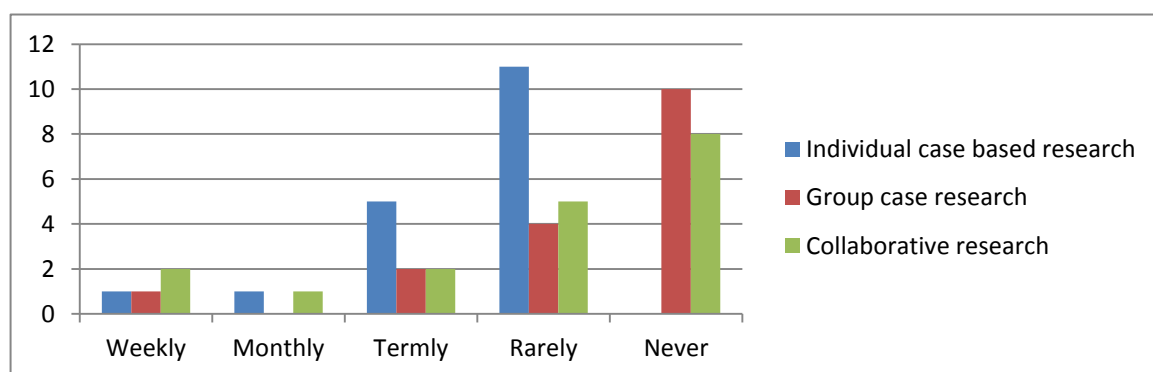
With regard to individual casework, training falls most frequently in the “rarely” category, suggesting individual training is not a frequent activity of psychologists in IMH. With regards to group training, psychologists reported that this mostly occurs “rarely” or “never”. However, collaborative training was reported on a termly basis. This training referred to both attendance at workshops with other professionals (e.g. attending IMH network meetings) or else providing training to parents.

The psychologist’s activities in training also constitute continuing professional development related activities. Within this questionnaire, over 68% of respondents noted that the majority of their IMH knowledge came from post graduate training opportunities such as Circle of Security training, Video Interactive Guidance training, or various online IMH courses. Only 26% of respondents reported obtaining IMH knowledge from their college material, suggesting that the topic is not covered in sufficient detail in professional training courses. Upskilling in IMH was also reflected in

qualitative findings, with many participants seeking additional training opportunities including “Solihull” training⁶, the “Michigan Association of Infant Mental Health Endorsement Programme”⁷ or shadowing a practising psychologist.

Qualitative data also highlighted the psychologists work in providing training to other professionals or parents. The model of the IMG-NG (2015) were frequently referred to training activity facilitated by psychologists. These masterclasses are attended by a range of professionals in order to support them to use an IMH approach in their work. Moreover, the psychologist’s involvement in training at a universal or promotional level was referred to frequently in the data. The aim of this type of work is to enhance the awareness and importance of IMH in the community, as well as among workforces who engage with young children on a daily basis. This type of training work occurred both on a uni-discipline basis, or else in collaboration with another professional group, “The psychology team have gone and done some universal stuff with us they are developing universal services in XXXX they have assistant psychologists running workshops and early intervention type services for parents” (SW1).

Research.



⁶ Solihull is an evidence-based and early intervention approach to working with families, which combines three theoretical concepts: “containment (psychoanalytic theory), reciprocity (child development) and behaviour management (behaviourism)” (Lancashire Children and Young People’s Trust, 2019, para.4).

⁷ The Michigan Association of Infant Mental Health Endorsement is a training programme designed to recognise “an individual’s efforts to specialize in the promotion/practice of IMH within his/her own chosen discipline” (Washington Association of Infant Mental Health, 2019, para. 1).

Survey data highlighted how psychologists “rarely” or “never” engage in research activities. It is postulated that lack of time and heavy caseloads limit their ability to engage in this type of work, something which has been alluded to frequently in the literature (Keith, 2008). Nonetheless, qualitative information demonstrated how, although psychologists may not have time to engage in specific research and evaluation type exercises, their research skills are something that they use frequently. Participants referred to their research skills in synthesising, evaluating, and communicating psychological research in an appropriate manner as a skill that is valuable. For example, one psychologist referred to her research skills in synthesising, evaluating, and communicating psychological research in an appropriate manner as a skill that she values.

If you show the Strange Situation ..that you know being able to communicate the results of that in a way that is sensitive and useful and also being aware of the limitations of that. (P1)

Supportive Factors. Supportive factors relate to the aspects of the psychologist’s practice that enhance or facilitate their work in IMH contexts.

Managerial support. A key facilitator to IMH work was having managerial support. Due to the preventative nature of IMH, the outcomes of each case can be difficult to assess. Psychologists highlighted how having managers who understood and valued IMH made their working easier and that one “didn’t feel under pressure to justify why you’re working that way” (P4). This managerial support was referred to across line managers, psychology department managers, as well as government managers. One psychologist emphasised the importance of programmes and policies being endorsed and supported by government bodies as a means to validate a psychologist’s work in IMH, “It’s great that the HSE have acknowledged that this is importance and this is in line with policy so it adds strength to what you’re saying” (P1).

Reflective supervision. From a professional view, participants emphasised the importance of reflective supervision as a noteworthy facilitator to their work in IMH,

“To really make sense of the work you need ongoing reflective supervision” (P6). The importance of reflective practice in IMH contexts is a concept that has reoccurred throughout this results section. Participants considered this important, as the nature of the work in IMH can often be distressing for a practitioner to manage. This level of stress could potentially negatively impact the practitioner’s ability to effectively engage with a case, “There’s a very understandable tendency to turn away from that and say god I can’t sit with this it’s too painful so I’ll just refer you on to someone ” (P6). As the nature of the work can be evocative for psychologists, having the capacity and service support to engage in reflective supervision was considered helpful in order to process one’s own feelings and experiences on the work, “Reflective supervision as well, I don’t think it would be possible to do the work without it. I just think it’s so key because we bring so much of ourselves to the work” (P5).

Colleague support. Additionally, the support from colleagues was considered of great help in their IMH casework. Participants noted that IMH is not “something you should do on your own” (P3). In particular, psychologists valued sharing of resources and tools, or attending trainings provided by colleagues, “Everybody who is kind of interested in the area tend to share resources so that is really helpful” (P1).

Constraining factors.

Service restrictions to IMH work. Psychologists interviewed noted how their capacity to engage in IMH work varied among services. Psychologists from CAMHS teams who were interviewed noted how they “don’t take many small babies or toddlers” (P4) due to their lengthy waiting lists and service demands for older children or adolescents. Similarly, psychologists working in disability services noted how these services may not recognise that children within their service may also have attachment or IMH difficulties also, “Children who have disabilities have insecure attachments too and it’s almost like the family and the relationships are not seen as important in disability services” (P2).

Over 70% of the participants who completed the online questionnaire highlighted that they work most frequently with the 6-12 year old cohort, despite their official age range of services being children aged 0-18. Moreover, as there is no discrete IMH

service, psychologists noted how IMH cases can fall between two stools, as by the time they reach an appropriate service, the opportunity for early intervention has passed, “if you refer them onto child and family there is a 2 year waiting list ... So actually services for kids with attachment difficulties are really poor” (P2).

Difficulty justifying outcomes. Another systemic challenge when working in IMH, is the difficulties in assessing outcomes. Due to the preventative nature of IMH it can be “very hard to prove what you prevented” (P4). This has implications for government policies, as it is difficult to document the nature of the work effectively in monthly or annual statistics. One psychologist noted how her desired outcome would be increased reflective functioning of the parent yet putting this on paper can be a challenge, “The parents realisation like ahhh okay now I understand why he’s doing that so yeah I would more value those kind of outcomes but just unfortunately you can’t document those as well in your stats” (P6). This can have knock on effects in terms of government funding for future investment in the area, as one psychologist noted.

This is why IMH is not getting a lot of funding because it’s not like working with the spectrum where you get funding to do a certain amount of tests and then a certain amount of ABA intervention it’s so much more concrete this is difficult to conceptualise because you can’t write the blue print up because it’s written as they grow up. It’s ever evolving. (P3)

Lack of resources can hinder IMH work. In addition to service capacity, lack of resources can hinder the efficacy of IMH work being undertaken. Fifty three percent of psychologists who engaged in the online questionnaire noted lack of resources as being the most prominent barrier to IMH service provision. Psychologists noted how they would love to do more IMH work but they feel they do not have the resources to support them in doing so, “I do not think we are resourced well enough. I would love to be doing much more of it” (P2).

In particular, psychologists noted how the primary resource they are lacking for IMH casework is time, “we need more time and time is a precious commodity.. and we are so busy” (P4). One psychologist noted how the lack of time allocated to IMH

casework is due to the lengthy waitlists, which resulted in the service allocating a certain capacity for IMH casework per year, “We have a capacity here..each of the three specialists would have a max of two families at any one time. And that’s just the pressure of resources and the waiting lists for children 3-18” (P5).

Lack of understanding on IMH work. From a societal perspective, participants noted how a perceived lack of understanding on IMH can adversely impact providing an effective IMH service. It was noted how other professionals, as well as parents, may not have the knowledge of IMH to accurately detect any difficulties at an early stage, “I don’t think there’s enough out there. Parents don’t know about it, crèches don’t know about it” (P2).

Stigma around IMH difficulties. Another subtheme suggests that there may be a stigma around IMH difficulties, which may also present an additional challenge in providing IMH services. In particular, parents may be fearful of their child being taken away from them if they admit to having difficulties in their early days, “There is still a sense among woman that if they admit to having any difficulties, a social worker is going to take their baby. That’s a very real fear” (P1). Participants noted how it’s important to operate a strengths-based model to attempt to remove this perception, as well as reassure parents “..that these feelings are all absolutely normal, you know to have them de-stigmatised and taken out of the shadows” (P3).

IMH work is evocative for practitioners. As aforementioned, the nature of the work can be extremely evocative for practitioners and can stir up difficult emotions that may have an adverse impact on the psychologist’s ability to manage their own reactions to the case, “it’s so evocative to observe and bear witness to an infant in distress and being neglected or being emotionally abused or whatever it might be ... I suppose all our defences are evoked” (P6).

Working with parents. Finally, participants noted that the nature of the work can be a challenge in itself, that being, working with parents when there is a difficulty or trauma. One psychologist noted how parents can find it difficult to cope with the realisation that their child is presenting with difficulties, “It’s very difficult for them to deal with the fact that they may already have a challenge” (P3). This can result in the

parents embarking on “a journey that might be painful” (P6) and which they will need additional support in dealing with.

Discussion

In considering Ahlers (2006) IMH framework, results of this study highlight how Irish Psychologists are incorporating the framework into their practice through the first three tiers (Figure 1). With regards to the core tier, “building capacities of parents”, findings of this study noted how psychologists engaged in activities such as parent training programmes (e.g. Circle of Security), individual parent consultations, or providing parent-infant interventions (e.g. Theraplay, VIG), with the aim of ensuring parents are supported in meeting the child’s needs. In the second tier, results demonstrated how psychologists were noted to build capacities of practitioners through engaging in consultations with other professionals about a client, or else by providing supervision to other practitioners. Finally, with regards the third tier, building local service capacity to facilitate IMH practice, this study noted how psychologists are engaged in capacity building for the community through activities such as the IMH Network Group master classes, or else providing workshops to professionals within the community.

The final two tiers are areas of an IMH framework that were not represented in the findings of this study. In terms of “establishing a favourable policy environment”, Ahler’s et al. (2006) highlight how policy makers at various levels need to become more aware of the importance of IMH through the provision of practice evidence or ‘ground-up’ research. However, this study notes how few participants engaged in the conducting of research projects regarding IMH work. Keith (2000) noted how psychologists working in research capacities fall into three categories: “consumers” of research, “distributors” of research, and “conductors” of research. Psychologists in the current study did not appear to be significant conductors of research, yet did participate as consumers and distributors of research. Yet, the absence of local data is not favourable for a policy making perspective. The current findings may suggest some rationale for

same, including difficulties assessing and reporting outcomes of IMH casework, as well as lack of practitioner time and resources.

This dearth of time/resources may also be a confounding factor as to why the final tier of “awareness raising and health promotion” was also a feature of an IMH framework that was not reflected in the current study. Osofsky (2016) notes how there is a need to develop the understanding of IMH at a more global level, including to areas outside of healthcare such as early years education services, family resource centres, or other community service providers. Stellenberg (2012, p. 16) suggests that this tier may be operationalised through the “development and distribution of information, advice and guidance to parents in a variety of accessible and practical ways and could include information campaigns aimed at practitioners as well as parents”. Nonetheless, no findings within this study highlighted psychologists explicitly engaging in this type of work. However, psychologists did acknowledge the need for universal awareness-raising campaigning, as it emerged how lack of understanding of IMH can be a notable barrier to the psychologist’s work in IMH contexts.

5.2.1.1. Irish waiting list agendas. The challenges of lengthy waitlists and staff shortages for psychology have gained national attention with recent years (Cullen, 2019). Barnardo’s children’s charity engaged in a national study exploring wait list figures, highlighting how 6,584 children were waiting for an appointment with primary care psychology, with 1,684 of these waiting more than a year (Barnardos, 2018). Herein suggests a potential rationale as to why certain elements of an IMH framework are not evident in Irish psychologists practice. This crisis of waiting lists and professional resources severely infringe on psychologists ability to truly engage in the preventative and early intervention work characterised by an IMH approach. This dearth of time and resources was mentioned as a constraining factor within this study’s findings, with one psychologist highlighting how she felt she couldn’t prioritise IMH casework due to the amount of older children on her caseload experiencing significant mental health conditions that could potentially be cases of life or death. Moreover, many CAMHS psychologists who were invited to interview for this study declined the invitation as they felt the content of the interview would not be directly relevant to them. Despite their formal service description indicating that they provide services to children aged 0-18, many respondents highlighted how they rarely work with children

under the age of five. Therefore, how can we expect psychologists to engage in the promotional and research-based IMH work that is currently missing from Irish practice, when their services are already vastly stretched?

The immense resource challenge Irish psychology is facing exemplifies a reasoning as to why psychologists perceive themselves as a crisis service, as found in the current study. From the data gathered, psychologists acknowledged how they felt they were “firefighting” these demanding waitlists, and thus were restricted in their ability to engage in preventative and promotional IMH work. In addition to not having the capacity to engage in desired preventative activities, working against an ever-growing caseload can cause practitioners to experience significant stress and could potentially lead to burnout. A recent meta-analysis highlighted how workload and perceived time pressure were a “strong and consistent” demand contributing to psychologist burnout (McCormack, Macintyre, O’Shea, Herring & Campbell, 2018, p. 12). Sim et al. (2016) also emphasise how crisis work and non-clinical tasks induce the likelihood of professional burnout and also query how this type of work affects the professional’s identity of their role. This study points to how workload does affect the psychologist’s perception of their role, and is something that ought to be supported and rectified in order to prevent stress and burnout.

It is suggested that this resource crisis ranks the conducting of empirical research in IMH contexts as a low-priority on a psychologists work load. While understandable, given the service demands, this will have implications for Irish policy. National bodies have advocated for psychologists working in IMH contexts to engage in practice-based evidence in order to contribute “to the knowledge base that informs policy decisions” (PSI PIMHSIG, 2015, p.12). In addition to facilitating a favourable policy environment, this dearth in research from an Irish perspective can have implications for clinical settings also. A recent study carried out by Farrell & Grey (2018) noted that while Irish psychologists valued incorporating evidence from the literature into their practice, they often found that evidence from clinical trials did not translate easily into psychology practice. Thus, this finding dovetails with a larger argument in the field of psychology regarding “evidence-based practice” versus “practice based evidence” (Barkham & Mellor-Clarke, 2003). From the results of this study, it can be argued that psychologists are using evidence based practice in their

work in IMH contexts, yet their contribution to practice based evidence remains an area for development.

Interestingly, there was no major finding with regards to the difference between clinical psychologists and educational psychologists working in IMH contexts. Forty percent of participants who engaged in the online questionnaire were from an educational psychology background, and one educational psychologist was interviewed. Educational psychologists' working in healthcare settings is a relatively new progression in Ireland (HSE, 2016b), therefore a subsidiary hypothesis within this research was to explore whether any differences in practice existed between the roles of the clinical versus the educational psychologist. However, no clear theme emerged regarding differing aspects of practice between the two branches of psychology. In fact, one psychologist noted how "there shouldn't be any difference between psychologists, for me a psychologist is a psychologist" (P3). Yet, this school of thought was not mentioned repeatedly or was not evident across data sets therefore did not become a significant theme of the research. This finding was also noted in Farrell et al.'s (2006) study, who suggested that psychological contributions to multi-agency work are valued by others regardless of the branch of psychology one is trained in. This study suggests that clinical and educational psychologists are working in similar remits within IMH contexts, and thus should not be segregated or appraised as a result of the branch of the psychology one is trained in.

Implications of research

Following on from the previous discussion of this study's research findings in the context of previous literature and empirical research, it may be now pertinent to consider what repercussions these findings may have going forward. Put more simply, this section aims to consider the "now what?" phase of research (Rolfe, Freshwater, & Jasper, 2001). The implications of this research will subsequently be discussed from a research, policy, and practice perspective.

Research. This study's findings contribute to the knowledge base on IMH frameworks in psychology practice. Specifically, this research addresses a gap in the literature, by providing empirical data on how psychologists implement an IMH

framework within their role. No previous research to date had explored the role of the psychologist in IMH contexts in Ireland using an experimental approach, thus this research hopes to have filled this gap. Additionally, this study adds additional to the global research base on IMH, offering insights into working in an IMH framework, as well as highlighting some challenges to working in an IMH context.

Policy. The findings of this study may also support potential future policies in the area of IMH. Firstly, this study provides evidence in support of the role of psychologists in IMH and highlights their contribution in providing IMH services. This may be of interest to policy makers and service managers during recruitment and deployment of personnel within these IMH contexts. Secondly, this research again provides food for thought regarding content required for an IMH policy. For example, an IMH framework will need to be reflected in any broader policy; therefore the findings of this research may flag potential avenues for exploration through addressing some of the challenges alluded to in the data. Finally, this study addresses the need for more research from an Irish context on the importance of IMH practice, to advocate for and inform future policy. This study noted how very few psychologists are engaging in research activities, potentially due to time and resource demands. Thus, it is suggested for policy makers to provide supports such as funding or secondments, which will enable psychologists to engage in necessary research activities to provide the empirical data in an Irish context needed to support such policies and programmes.

Practice. Through the use of AT as a psychological framework for this study, “contradictions” or areas of tension between components of the activity system were explored in the results section of this research. The purpose of exploring said contradictions is to highlight potential areas of change, growth, or development within a system (Leadbetter, 2008). Through the process of exploring contradictions, the findings point to the following implications for practice:

- This research highlighted the lack of awareness of IMH among general public as well as other professionals. Of particular importance, the data identified the need for managerial support when engaged in IMH casework. Thus, there appears to

be a discrete need for targeted awareness activities to promote the importance of IMH among service managers, as well as other professionals and the public.

- Reflective supervision and reflective practice were strongly advocated for in the findings of this study. This supervision is above and beyond the line management supervision that professionals working in team settings may attend. Thus, in order to work effectively in IMH contexts, **practitioners ought to consider their level of reflective supervision and seek further support** if necessary.
- Moreover, certain tension was highlighted in the findings regarding the funding for reflective supervision. Therefore, it is recommended that discussions take place on a local level between **professionals and team managers as to how best to meet this need for reflective supervision** on a practical level. This may be in the form of allocating funding for professionals, organising group supervision for the team, or else training up an individual team member who could then facilitate reflective supervision with other team members.
- Regarding the outcomes of IMH casework, findings of this study highlighted the difficulties in assessing and/or reporting these outcomes. Therefore, there is a need for managers to have an awareness of this type of work, as outlined above, yet also to be aware that a psychologist's involvement in an IMH case may not have clear outcomes or may not be well reflected within their monthly statistics. Furthermore, policy makers and government bodies may need to **generate a creative and novel means of reporting these types of social-emotional outcomes**, in order for the work being done in IMH to be reflected in the psychologist's statistics.
- Data from this study highlights how psychologists valued IMH work due to its preventative nature, yet often did not get the chance to work in this way due to the demands of time and resources. Psychologists being seen as a crisis service resulted in many psychologists noting that they do not have the capacity for effective IMH work. Thus, it is argued that there is an intense **need for an**

increase in psychologists within Irish multidisciplinary teams, in order to reduce waitlists and facilitate psychologists to work in more preventative and early-intervention.

Limitations

A primary limitation of the current research is the study's sample. Firstly, the data for this study is gathered from a relatively small sample size. While sample size in qualitative research is a controversial topic in general (Boddy, 2016), qualitative research requires a robust sample size in order to ensure validity and generalisability. Nineteen psychologists took part in online interviews; therefore, the generalisability of the findings from this cohort may be limited. While the data gathered was useful in providing a picture of the nature of IMH work being carried out in Ireland, it is proposed that this cannot be considered a representative sample of psychologists in Ireland. Ideally, a nationwide survey would be needed to establish a clearer picture of the nature of IMH work being undertaken by Irish psychologists.

A second limitation the sample stems from the use of purposive sampling. This study utilised a criterion sampling procedure, whereby the participants were recruited based on a set number of specific criteria (e.g. had to provide services to children aged 0-3, experience working in IMH framework). While this method of sampling was considered appropriate in identifying and accessing the appropriate participants to answer the research questions, it also results in an increased potential for bias within the findings (Palinkas et al., 2015). It could be suggested that participants who met this criteria and agreed to participate in the research did so out of a personal interest in the area of IMH and thus had additional motivations to take part. Although this concern could be an arguable flaw of many research methodologies, it does question how well this data reflects all relevant psychologists working in IMH capacities Ireland. Thus, the representativeness of the sample is an overall limitation of this research.

Another limitation to the current study is regarding researcher subjectivity. As the researcher designed, conducted, and analysed findings themselves, there is an increased risk of researcher bias within the findings. Attempts have been made to ensure transparency in methodology and analysis, through the use of Braun and Clarke's

(2006) step- by- step approach to thematic analysis. Secondary coding was carried out on two separate occasions throughout the analysis process by peer trainee psychologists. The aim of this was to ensure transparency and reduce bias within the findings (Nowell, Norris, White, & Moules, 2017). Ongoing supervision was provided which helped to highlight and identify areas of researcher bias and how they can be addressed.

The use of AT as the principal theoretical and conceptual framework enabled the researcher to gather rich and informative data in a structured manner, accounting for a range of complex social and cultural factors encountered in IMH contexts. Yet, the use of this theory poses limitations to the research implications also. Firstly, some researchers argue that using a collective group of participants in order to create a singular activity system dismisses the role of the individual within the system (Leadbetter, 2008). Additionally, one of the notable strengths and interesting aspects of AT is the consideration of historicity (Daniels, 2001), this thesis did not explicitly examine past influences on how the work of the psychologists in IMH contexts came to be, or expectancies of future practices. The inability of the current research to address this component of the theory may be considered a theoretical and conceptual flaw, and is something future researchers may wish to develop.

Directions for future research

This research investigated the activities, supports, and challenges faced by Irish psychologists when working in an IMH framework. However, other studies that have explored a particular framework for service delivery also included the voice of service users within their participant base (e.g. Myors et al., 2015; Ashton & Roberts, 2006). Exploring the views and thoughts of IMH clients, that being the primary caregivers of young infants, may add an interesting dimension to the research aims of this study. Through asking these parents/caregivers how they perceived the use of an IMH framework could provide highly useful and person-centred understanding of the experience.

Another potential avenue for future research is to explore the roles of professional groups using a solely deductive and theory driven approach. This study used both an inductive and deductive approach to analysis, whereby data-driven codes and themes

were initially gathered, and subsequently mapped onto the study's psychological theory. Other studies that have used AT as their guiding framework have taken two or more distinct participant cohorts (e.g. psychologists and Special Education Co-ordinators) and created an activity system for each cohort using solely a deductive approach to data analysis. That being, the 'interview' protocols for these studies involved participants and the researcher actively creating the activity system together as the method of data collection. Due to the exploratory nature of this research, a solely deductive approach was not considered appropriate as potentially important themes may have been overlooked as a result. However, future researchers interested in the utility of AT as a framework to explore the psychologist's role in IMH may wish to explore future research in the field in this manner.

Replicating this study through a different methodological means may also provide additional insight into psychologist's views and experiences of working in an IMH framework. For example, a case study approach could offer an insightful exploration of what an IMH framework looks like in practice with a service user. Similarly, a focus group consisting of psychologists may provide intriguing and collaborative discussion on the practices and challenges of working in an IMH framework. A focus group was initially considered for this research yet was dismissed amid ethical and logistic concerns. Additionally, an alternative method of data analysis may provide another means of understanding IMH frameworks in psychology practice. For example, the use of a Grounded Theory approach could be incorporated to generate a specific theory regarding how psychologists adopt an IMH approach (Strauss & Corbin, 1994). Alternatively, the use of Interpretive Phenomenological Analysis may provide unique insight into the psychologists lived experiences of working an IMH framework (Smith & Osborn, 2004).

Conclusion

Irish psychologists working in health care settings have a pivotal role to play in supporting the social and emotional development of infants. This study has highlighted specific practices Irish psychologists are engaging in, in an attempt to adopt an IMH informed framework to their practice. It is hoped that the interest and energy surrounding IMH in Ireland will continue to surge and that the findings and implications of this research will be considered and implemented in policy and practice. Irish

psychologists have a duty of care to meet the needs of all children (HSE, 2017), therefore it is vital that psychologists are supported and prepared in meeting the needs of children within their earliest years of life.

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