



Rare Jewels

Specialised
parent-infant relationship
teams in the UK



PIPUK[®]
Parent Infant Partnership
United Kingdom
Registered Charity Number: 1152082

Sally Hogg
Parent Infant Partnership UK

Contents

Executive Summary	2
Summary of Recommendations	5
1. Rare Jewels: An introduction to this report	8
2. The Case for Action: Why supporting parent-infant relationships can transform life chances	11
3. Babies: A special time requiring a special response	17
4. Defining Specialised Parent-Infant Relationship Teams: Multidisciplinary teams of experts, working at different levels of the system to promote and protect parent-infant relationships	20
5. Creating System Change: parent-infant teams as experts and champions	24
6. Providing Direct Support: Delivering therapeutic interventions to families experiencing the most serious difficulties	27
7. The Rare Jewels: Parent-infant teams that currently exist in the UK	35
8. Mind the Gap: Gaps in provision across the UK	38
9. Closing the Gaps: Commissioning parent-infant teams	45
10. Central Leadership: How government policy supports action	52
11. Conclusion	55
References and notes	56

Acknowledgements

We are very grateful for everyone who contributed towards the production of this report.

We would like to thank the families who agreed that we could tell their stories.

This document includes insights from new research with commissioners of services conducted by Olha Homonchuk and Jane Barlow at the University of Oxford, who also provided helpful steers on the drafting of this report.

We were also supported by students from Bournemouth University, Shannon Lumley, Kathryn Burroughs and Charlie Collins who helped to process information gathered from Freedom of Information Requests.

Beckie Lang, Alanna Clear, Karen Bateson, Peter Clarke and Alex Ford at Parent Infant Partnership all contributed to the report, and we received very helpful input from our Trustee Camilla Rosan.

This report was peer reviewed by members of the Parent Infant Partnership UK Expert Reference Group: Robin Balbernie, Tessa Baradon, Joanna Chapman, Clare Law, Penelope Leach, Pauline Lee, Yvonne Osafo and Peter Toolan. We are very grateful for their time, expertise and support.

We would also like to thank who shared information with us, including all the professionals who spoke to us or completed our surveys and the Specialised Parent-Infant Relationship Teams who shared detailed information and insight. We are grateful to the Nick Waggett and Silvina Diaz-Bonino at the Association of Child Psychologists, Anne McFadyen from the Scottish Perinatal Mental Health Managed Clinical Network, Lucy Thorpe at the Mental Health Foundation and Caroline Cunningham, Sarah Witcombe-Hayes and Susan Galloway at the NSPCC for generously sharing insights and expertise with us.

Mark Teagles at White Halo worked very hard to design and produce this report to short deadlines and we appreciate all his efforts.

About the author

Sally Hogg is Head of Policy and Campaigning at Parent Infant Partnership UK.

Parent Infant Partnership UK is a national charity that believes that all babies should have a sensitive, nurturing relationship to lay the foundation for lifelong mental and physical health. We support the growth and quality of specialised parent-infant relationship teams across the UK by bringing together and supporting the sector, providing clinical leadership and campaigning for policy change.

Executive Summary

This Report

This ground-breaking report explains for the first time what specialised parent-infant relationship teams are, and why they matter. It contains the most up-to-date analysis of provision across the four nations of the UK. It explains that:

- Specialised parent-infant teams work at multiple levels, as experts, champions and providers of specialised care. They enable local systems to offer effective, high-quality prevention and early intervention to give every baby the best start in life.
- Our research could find only 27 of these teams in the whole of the UK. But their value is being realised, and an increasing number of commissioners are funding new services - despite the difficult economic climate.
- Most babies in the UK live in an area where there is no parent-infant team. And there is very little mental health provision at all for children aged 2 and under. Despite children and young people's mental health services (CAMHS) nominally being a service for 0-18 year olds, data collected through Freedom of Information suggested that in 42% of Clinical Commissioning Group (CCG) areas in England CAMHS services will not accept referrals for children aged 2 and under.

In the next 10 years - by 2030 - we would like to see specialised parent-infant relationship teams available across the UK, able to support all families who need them. This will require concerted action from national and local decision makers. We hope this report can inform the conversations and actions required to achieve this goal.

Why do we need specialised parent-infant relationship teams?

The first 1001 days of life, from conception to age 2, is a time of unique opportunity and vulnerability. It is a period of particularly rapid growth, when the foundations for later development are laid. During this time, babies' brains are shaped by the interactions they have with their parents. The evidence is clear: At least one secure, responsive relationship with a consistent adult is a vital ingredient in babies' healthy brain development. Persistent difficulties in early relationships can have pervasive effects on many aspects of child development, with long term costs to individuals, families, communities and society.

During this period, babies are unable to talk about their feelings and needs, but communicate these in different ways. They are completely dependent on adults to survive. Therefore, work with babies is in the 1001 days is different from work with older children and requires a specific set of competencies: Practitioners must have a deep understanding of child development and have the ability to read babies' pre-verbal cues. They need the ability to work with parents, babies and their relationships. This is skilled work that requires specialist expertise. It is also true preventative work: acting early to prevent potential harm to babies' emotional wellbeing and later mental health.

The unique opportunities and challenges during the first 1001 days, and the need for practitioners to have specific expertise to work effectively with families during this period, create a strong case for the existence of specialised parent-infant relationship teams.

What are specialised parent-infant relationship teams?

Specialised parent-infant relationship teams are multidisciplinary teams with expertise in supporting and strengthening the important relationships between babies and their parents. These teams work at multiple levels; They are expert advisors and champions for all parent-infant relationships, driving change across their local systems and empowering professionals to turn families' lives around.

They also offer high-quality therapeutic support for families experiencing severe, complex and/or enduring difficulties in their early relationships, putting babies on a positive developmental trajectory and better able to take advantage of the opportunities that lie ahead.

Specialised parent-infant relationship teams are like rare jewels in the UK: scarce, small, and, where they do exist, extremely valuable and highly valued.

How many teams exist?

This report contains the most up-to-date snapshot of provision across the four nations of the UK. We have found only 27 specialised parent-infant relationship teams currently in operation. Yet there are nearly 200 CCGs in England, 7 health boards in Wales, 15 in Scotland and 6 health trusts in Northern Ireland. parent-infant teams can transform the life chances of babies, yet the majority of babies live in an area where these services do not exist.

Actually, there is very little mental health provision at all for children aged 2 and under. Even though CAMHS services should be for 0-18 year olds, our research showed that NHS Children and Young People's Mental Health Commissioners are overlooking the needs of the youngest children in their own right. In some areas, commissioners do not commission any mental health services for young children: Our Freedom of Information exercise suggested that in 42% of CCG areas in England CAMHS services do not accept referrals for children aged 2 or under. Provision is also lacking in the devolved nations of the UK.

Even when particular CAMHS services told us that they accept referrals for younger children, we found that young children are often not accessing the service in reality. The data we collected showed that in 36% of CCG areas in England where CAMHS said they would accept referrals for young children and could provide data broken down by age, NO children aged 2 or under were accessing the service. Our mental health system is focussed on older children, and often fails to recognise or respond to the needs of babies – despite the importance of early emotional wellbeing for virtually all aspects of later development.

The statistics uncovered for this report are shocking, and should be a source of disgrace, just as it would be if services excluded children because of other characteristics, such as disability, race or sex, or if commissioners were failing to fund other services, such as cancer services, for young children.

Things have to change.

Why are there gaps in provision?

The case for investing in parent-infant teams is clear, and more decision makers around the UK are now recognising this and committing to their development. We are excited to see that new services have been, or are in the process of being, established in a number of places despite the difficult economic climate. But there is still work to do.

Whilst we applaud the growing number of commissioners investing in parent-infant teams, there are still only 27 such teams in the whole of the UK. This report highlights some of the challenges to commissioning in this area, such as:

- It is not clear who is accountable for commissioning parent-infant relationship support.
- Resources are limited, and often directed to late intervention to deal with the issues such as the mental health needs of older children.
- Despite compelling evidence about the importance of the first 1001 days, babies' needs are not identified, understood or prioritised.

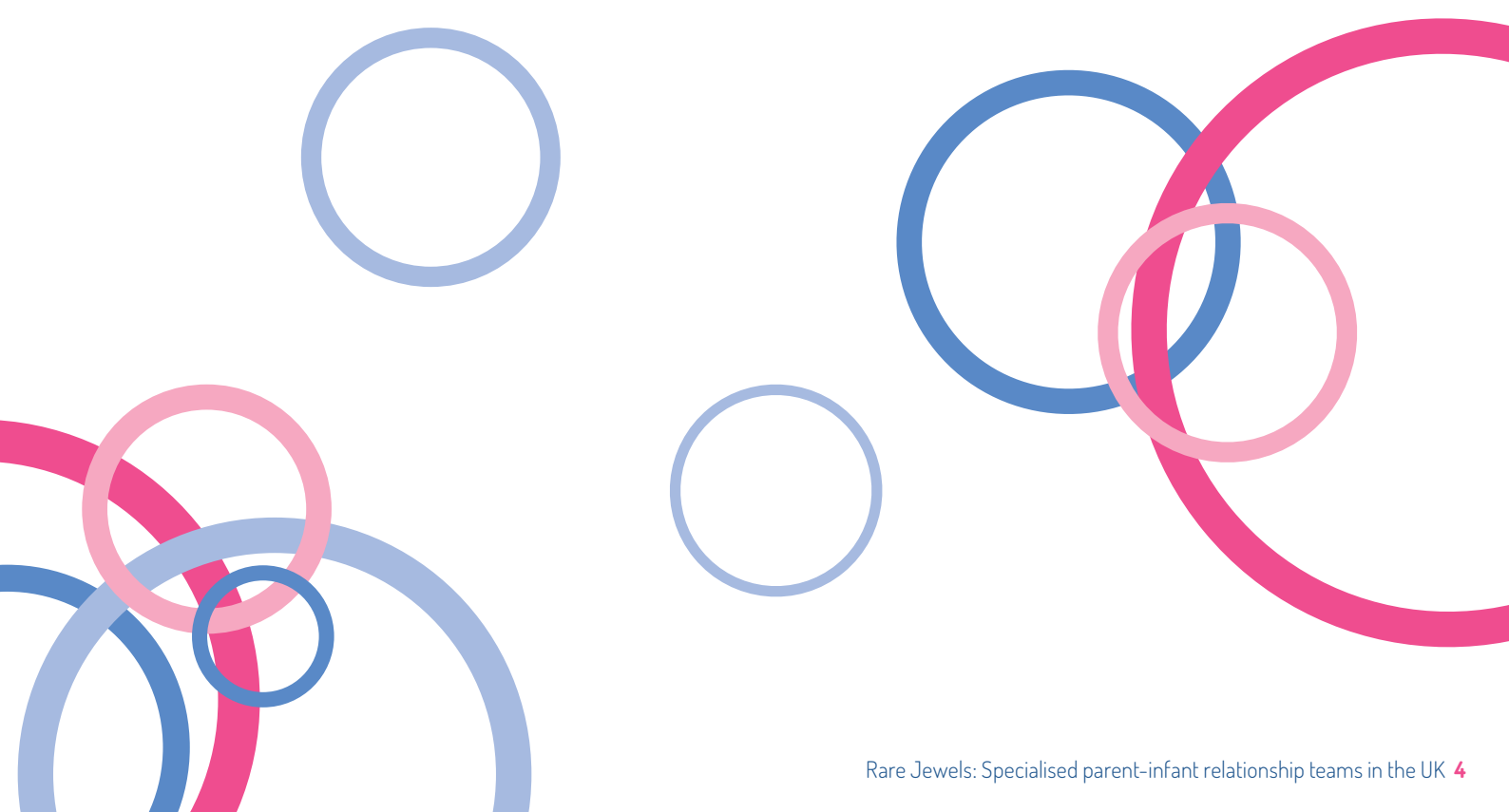
What is needed to close the gaps?

This report makes a number of recommendations for local and national decision makers about how they could support the development of specialised provision across the UK.

Governments across the UK have made commitments to increase early intervention, to improve children's mental health and to close inequalities in outcomes. In England, the Government has committed that, in the next decade, all children from 0-25 who need specialist mental health provision should be able to access it. And in Scotland, Government has actually promised that all infants and parents who need such support should have access to specialist infant mental health services.

Governments now need to provide the focused and determined leadership, the clarity, the action and the investment required to translate their commitments into a reality and to give every baby the best start in life.

In the next 10 years – by 2030 – we would like to see specialised parent-infant relationship teams available across the UK, able to support all families who need them. We hope this report can inform the conversations and actions required to achieve this goal, and we look forward to working with the sector to make this happen.



Summary of Recommendations

1

Commissioning bodies (i.e. Clinical Commissioning Groups in England or alternative commissioning bodies, such as Integrated Care Systems and funders of services in the devolved nations) should commission mental health services that are appropriate for and accessible to ALL children who need them.

Commissioning bodies should be aware of what mental health services they are commissioning, and should collect and monitor data on the ages of children accessing services to ensure that the services they commission are appropriate for, and accessible to, all.

2

Local Commissioning bodies should be held to account by national governments for commissioning services that meet the needs of all children in their area, including the youngest children.

National governments and arms lengths bodies (e.g. NHS England) should ensure that their data reporting systems and processes enable and encourage local commissioners to report data disaggregated by age.

3

Commissioning bodies in all areas of the UK should fund specialised parent-infant relationship teams in order to:

- Improve professionals' understanding of relationships and child development, so that they can identify and intervene when babies' emotional wellbeing is at risk.
- Provide a mental health service that is able to meet the needs of the youngest children, and can act early when problems are identified, providing interventions to address parent-infant relationship problems.
- Be the 'champions' of babies, in a system where their voices are seldom heard.
- Provide a protected space where babies will be prioritised, and do not have to compete for a service with children whose needs may be perceived as more urgent.

4

Every government in the UK should have a clear and ambitious cross-government strategy to give every child the best start in life, setting out clear outcomes for children and a plan to improve services for children, parents and families during the first 1001 days of life. Protecting and promoting parent-infant relationships should be a core part of this strategy.

National governments should encourage and incentivise local partners across health, children's services and the voluntary and community sector to work together to develop and deliver local strategies to give all babies in their area the best start in life and to deliver local goals.

5

National governments must ensure that accountability for parent-infant relationship service provision is clear at a national and local level. At local level there must be a lead accountable commissioning body for all children's mental health services. This should include commissioning specialised parent-infant relationship teams for children from conception to age 2.

It may be helpful for governments and others in the sector to stop talking about Children and Adolescent or Children and Young People's Mental Health Services, and instead to talk about Infant, Children and Young People's Mental Health services, to emphasise that these services should meet the differing needs of children of all ages.

6

Whilst we recognise the challenges associated with ringfenced budgets, without some protection funding for early intervention is always vulnerable to being drawn to other challenges that are perceived to be more urgent. Therefore, **national governments** should provide a ringfenced transformation budget to support local investment in the first 1001 days (just as the Westminster Government did to address disparities in provision of perinatal mental health services in England). This funding should be sufficient to fund the establishment of local specialised parent-infant relationship teams to meet the needs of the population in each area.

7

National governments should provide increased funding for bodies such as the National Institute for Health Research to fund primary research and build the evidence-base in parent-infant relationship intervention.

National governments should also provide increased funding for What Works Centres like the Early Intervention Foundation and NICE to synthesise the evidence base for the first 1001 days and to support commissioners to make decisions using the existing evidence and research base (including commissioning interventions which are based in research but yet to establish robust evidence of their impact). This should include providing guidance for commissioners about what outcomes measures they might require from services working with families in the first 1001 days.

National governments and local commissioning bodies must not use gaps in the evidence base as an excuse of inaction.

8

All relevant government departments and public bodies, in partnership with other organisations in the sector, must do more to raise awareness of the importance of parent-infant relationships for healthy brain development.

9

In England, the Department of Health and Social Care and NHS England should clarify how they will deliver on the goal of ensuring 100% of children – including children under 2 - being able to access specialist mental health care in the coming decade. This must include setting out who is accountable at a national and local level for delivering this goal, how it will be funded and implemented, and how progress will be measured.

NHS England should set out service specifications to enable local commissioners to understand what is required to provide specialist mental health care for children aged 2 and under. We believe that these service specifications should be developed in partnership with Parent Infant Network.¹

10

The **Welsh Government and Public Health Wales** should commit to learning from the trial of the new parent-infant team, and using this to inform roll out of specialised parent-infant relationship teams across Wales.

11

The **Scottish Government** should set out how it will deliver on its goal of ensuring access to specialist infant mental health service services, including specifying who is accountable at a national and local level for progress towards this goal, and how it will be funded and delivered.

12

The **Public Health Agency in Northern Ireland** should work with Health Boards to share learning from the ABCPIP service and encourage and support the development of more parent-infant teams in Northern Ireland. The Northern Ireland Assembly should support this work when it is restored to power.

1. The network of existing specialised parent-infant relationship teams coordinated by Parent Infant Partnership UK.

Specialised parent-infant relationship teams are multidisciplinary teams with expertise in supporting and strengthening the important relationships between babies and their parents.

Specialised parent-infant relationship teams are expert advisors and champions, driving change across local systems.

Specialised parent-infant relationship teams can help all the services around a family to do more to support early relationships.

Secure, responsive relationships between babies and their parents are a vital ingredient in healthy brain development.



Teams also work directly with those families who need specialised support.

Specialised parent-infant relationship teams help to create local systems that provide effective prevention and early intervention to give every baby the best start in life.

Parent Infant Partnership UK's research only found 27 of these teams in the whole of the UK at the moment. Although some new teams are being set up.



Most babies in the UK live in an area where there is no specialised parent-infant relationship team.



And there is very little mental health provision at all for children aged 2 and under.

Despite CAMHS nominally being a service for 0-18 year olds, in 42% of CCG areas in England CAMHS does not offer a service to children aged 2 and under.



In the next 10 years – by 2030 – we would like to see specialised parent-infant relationship teams available across the UK, able to support all families who need them.



We hope this report can inform the conversations and actions required to achieve this goal.



Rare Jewels:

An introduction to this report

The first 1001 days of a baby's life, from conception to age 2, are a period of rapid growth, when the foundations for later development are laid. During this time, babies' brains are shaped by the world around them, and in particular the interactions they have with their caregivers (usually their parents). Early relationships play an extremely important role in cognitive, emotional and social development. There is now compelling research to show that when these relationships are compromised, it can have pervasive long term effects on physical and mental health.¹

Ensuring all children have sensitive, nurturing relationships is vital. Achieving this for requires a whole system of services and support to be available, ranging from universal support for all families, to targeted and specialist services for those who need extra help. These services must be working together as part of care pathways, which ensure that families receive the right support at the right time.² To be effective, services must all be delivered by a workforce with an educated understanding of child development and the skills required to support early relationships and promote positive interactions, notice when families are struggling and signpost to or provide appropriate additional support. We believe that specialised parent-infant relationship teams are key to delivering this vision.

Specialised parent-infant relationship teams are multidisciplinary teams with expertise in supporting and strengthening the important relationships between babies and their parents or carers³. They can help parents to overcome difficulties, build on existing strengths and develop new capacities to provide the sensitive, responsive and appropriate care that their babies need to thrive.

In this report, we refer to specialised parent-infant relationship teams, or parent-infant teams in short. The teams are often known locally by different names such as a PIP, an Infant Mental Health Team, parent-infant mental health service, early CAMHS or an early attachment team.

Parent-infant teams generally work at two levels:

- They are expert advisors and champions for parent-infant relationships. They use their expertise to help the local workforce to understand and support parent-infant relationships, to identify issues where they occur and take the appropriate action. This happens through offering training, consultation and/or supervision to other professionals and advice to system leaders and commissioners.
- They offer direct support to families. This includes targeted work with families experiencing early difficulties, and specialist therapeutic work with families experiencing severe, complex and/or enduring difficulties in their early relationships, where babies' emotional wellbeing and development is particularly at risk.

These two tiers of activity mean that, when specialised parent-infant relationship teams are functioning effectively, and embedded within their local system, they can help to promote healthy relationships for all babies in their locality through working with other services, and offer early and effective intervention to those most at risk.

2. Ideally services should operate using a 'stepped care model' which matches families' needs with the least intensive intervention that has the best chance of achieving positive outcomes.
3. Services work with primary caregivers, including parents, foster carers, grandparents or others who may be playing this role. In this report, when we refer to parents, it is shorthand for this wider group.

“It’s definitely one of the jewels in the crown.”

CCG Commissioner in Leeds describing their parent-infant team

This report explains more about parent-infant teams, what they do and why they matter. It also describes some of the gaps in services supporting babies’ relationships and emotional development, and what might be done to fill these gaps. It makes recommendations for local and national decision makers about how they could support the development of specialised provision across the UK.

The report draws on insights collected from:

- Parent Infant Partnership UK’s experiences of supporting the development of new parent-infant teams (PIPs) around England since 2013.
- A detailed survey of specialised parent-infant relationship teams, which was answered by 25 services around the UK, including the PIPs and other services.
- A short online survey of professionals, asking about local parent-infant and CAMHS provision, which was answered by 194 respondents.
- Further desk-based research and conversations with stakeholders.
- Freedom of Information requests to all Clinical Commissioning Groups (CCGs) in England, and to many mental health trusts, to understand what mental health services they offered for children under 2.
- Interviews with commissioners of parent-infant teams in 4 areas of the UK (quotes from these interviews are included throughout the report).
- Given the importance of understanding families’ experiences, we have included stories of families who used parent-infant teams at regular intervals throughout this report.

Parent-infant teams provide training and support to unlock the potential of all professionals so that they can all support early relationships. They unlock the potential of parents to provide the nurturing care their babies need. By doing this they unlock the potential of babies to develop into healthy, happy members of our communities. Like rare jewels, they may be small but their value can be immense.

We strongly believe that parent-infant teams are a core part of a system that is able to offer effective, high-quality prevention and early intervention to give every baby the best start in life.

Some commissioners understand this and are taking action, and we are seeing growth in parent-infant teams, despite the difficult economic context. But many families still cannot benefit from these services.

In the next 10 years – by 2030 – we would like to see these teams available across the UK, embedded into local systems and able to support all families who need them. We hope this report can inform the conversations and actions required to achieve this goal.

A FAMILY'S STORY

The legacy of childhood abuse

BrightPIP is a small service in Brighton, led by Dr Kerry Taylor, a Clinical Psychologist.

The BrightPIP team also includes a psychotherapist, baby massage therapist and specialist health visitor all with expertise in parent-infant relationship work.

Baby Joe was Claire's fourth child. His elder siblings had been taken into care due to physical and emotional neglect linked to drug and alcohol misuse, domestic abuse and poor mental health. Claire's new partner, Joe's father Jason, had a history of domestic abuse.

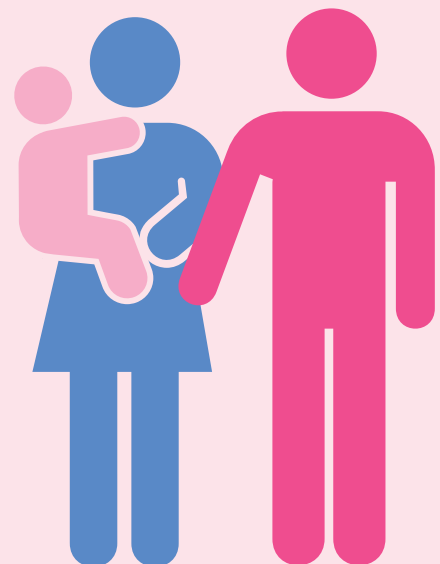
Claire was referred to the BrightPIP service when she was 3 months pregnant with Joe.

The BrightPIP team worked in close partnership with a network of other professionals to support Claire, Jason and Joe.

Claire felt very anxious and fearful of going out alone, but could attend appointments at BrightPIP with Jason's support. The team offered Claire trauma-focussed therapy to work with her own mental health issues, trauma and loss. They worked to help her understand her background of sexual abuse and being in care, and the impact these might have had on her parenting in the past, and how it could potentially impact on her parenting of baby Joe.

BrightPIP gave Claire space to grieve for her older children, and to prepare for her new baby. The service helped Claire to bond with Joe during her pregnancy, and to care for him when he arrived. The family did very well, and Joe remained with his parents. Claire's depression and anxiety scores reduced and her relationship with her baby was excellent. Jason described the impact that the service had had on him:

“ I now understand my partner and her needs in terms of mental health and this has helped me recognise what I can do to help. Kerry is so supportive and has gotten to know us as a family. BrightPIP is the service that recognises when we are overwhelmed and steps in to support us. I would recommend it to any family. ”



The Case for Action:

Why supporting parent-infant relationships can transform life chances

What happens in the first 1001 days lays the foundations for later development

It is now widely recognised that what happens in the first 1001 days of a child's life is key to enabling that child to survive and thrive. During this period babies' brains are shaped by their environment. This environment – babies' experiences of the world – are shaped by their primary caregivers (usually their parents), which is why parent-infant relationships are vitally important. Healthy brain development depends upon babies having a secure, responsive relationship with their parents or caregivers.

“ Young children experience their world as an environment of relationships, and these relationships affect virtually all aspects of their development.” ”

“ What is one of the best ways a country can boost shared prosperity, promote inclusive economic growth, expand equitable opportunity, and end extreme poverty? The answer is simple: Invest in early childhood development. Investing in early childhood development is good for everyone – governments, businesses, communities, parents and caregivers, and most of all, babies and young children. It is also the right thing to do, helping every child realize the right to survive and thrive. And investing in ECD is cost effective: For every \$1 spent on early childhood development interventions, the return on investment can be as high as \$13. ” ”

Unicef, World Bank and World Health Organisation
Nurturing Care Framework

Babies are reliant on parents to respond to their needs. Parents who are tuned-in and able to respond to babies' needs sensitively in an appropriate and timely way, support their early development in profound ways:

- Parents' responses shape how babies experience their emotions and how they learn to regulate and express these emotions. If someone responds sensitively to a baby when they cry, for example, the baby learns that they matter, that they can rely on their parents to help them when they are upset, and how difficult emotions can be brought under control.
- When babies receive appropriate comfort and care, they can feel safe and begin to explore the world around them, to play and learn.
- When parents provide positive, playful interactions, and when they engage in play and activities such as singing and reading to their baby, this provides stimulation that helps a child to learn and develop.

Nurturing relationships begin before birth: There is some evidence to suggest that parents' perceptions of their foetus are associated with the quality of their relationships after birth, and that maternal-foetal attachment is associated with later outcomes.^{iii,iv}

Infant mental health describes the emotional well-being of children in the earliest years of life. It reflects whether children have the secure, responsive relationships that they need to thrive.

Attachment theory is a framework that is commonly used to describe and understand patterns of relationships. It can be simply understood as a way to describe an emotional bond with at least one other significant human being that provides a sense of security. Attachment relationships between young children and their parents help us to understand about a child's important early relationships, their perceptions of themselves and others, and their expectations of other relationships.

Children's brains develop fastest, and are at their most 'plastic' or adaptable in the womb and early years of life when many millions of neural connections are made and then pruned, and the architecture of the brain is developed. During this period, we have the opportunity to put children on a positive developmental trajectory, better able to take advantage of other opportunities that lie ahead. Babies who have had good early relationships start school best equipped to be able to make friends and learn, which then increases the chances that they will achieve their potential in later life and contribute to society and the economy. A child's early relationships shape how their perceptions of themselves and others and teach them how to regulate their emotions and control their impulses. Healthy relationships enable children to develop the capacities they need to participate in society and to lead happy and fulfilling lives. A child's experience of being parented also influences how they go on to parent their own children, so supporting babies' brain development pays dividends for generations to come.

There is a moral, social and economic case for supporting parent-infant relationships. James Heckman has shown that money spent on interventions at this stage of the life course brings the greatest dividends.^v

Conversely, if babies do not have sensitive and responsive early relationships, it can have pervasive effects on multiple domains of child development. Strong, secure relationships are very protective and can help children to cope with other adversities in their lives. If a child's emotional environment causes them to feel unsafe or fearful, or if they experience

stress in the absence of a buffering relationship, this will be reflected in their psychological and neurological development and will determine how their brain develops to deal with stress in later life. Early traumatic experiences and toxic stress⁴ are associated with a wider range of poor physical and mental health outcomes, with costs to individuals, families, communities and the public purse^{vi}. The impacts of early adversity can often be overcome, but it is harder and often more costly to improve children's lives later.

“ It is easier to build strong children than to repair broken men.”^{vii}

“ The period from pregnancy to age 3 is when children are most susceptible to environmental influences. Investing in this period is one of the most efficient and effective ways to help eliminate extreme poverty and inequality, boost shared prosperity, and create the human capital needed for economies to diversify and grow.”^{viii}

Unicef, World Bank and World Health Organisation Nurturing Care Framework

A significant number of babies are at risk

There is no robust data on the number of babies experiencing poor relationships with their primary caregivers in the UK. But a range of research suggests that a significant number of babies are living in circumstances that might put their emotional wellbeing and development at risk:

- It is estimated that around 10-25% of children have a disorganised attachment with their primary caregiver, although prevalence depends on the social profile of the community and is much higher in vulnerable groups such as children in care.^{viii}
- The latest comprehensive data available for England found that there were 19,640 babies under a year old identified by Local Authorities as being 'in need', largely due to risk factors in the family home.^{ix}

4. Toxic stress is stress that is extreme and long-lasting, and occurs in the absence of a buffering relationships.

- Babies are at particular risk when they live in households where parental mental ill-health, domestic violence and/or substance misuse are present. NHS Digital's 2014 Adult Psychiatric Morbidity Survey (APMS) suggests that 25,000 babies under one in England live in a household where two of these three risk factors are present and 8,300 live in a household where all three are present.^x

An epidemiological study in Denmark found mental health problems in 18% of 1½ year-old children from the general population.^{xi}

A whole system response is required to protect and promote healthy early relationships

Promoting healthy emotional development in the first 1001 days requires collective action to tackle adversities and to support early relationships. Families' needs and situations are varied and complex, and a whole range of services and policies are required to support healthy development.

A well-functioning whole system approach to supporting parent-infant relationships, might be similar to one to prevent the harm caused by cancer. Public policies and universal services must address risk factors, such as social determinants of health and wellbeing. Universal services, such as health visiting and midwifery, can promote healthy behaviours for everyone, prevent and detect problems. And when problems emerge, families need timely access to parent-infant teams who can address problems early to prevent more pervasive or longer-term harm being caused.

Nurturing care is about children, their families and other caregivers, and the places where they interact. We know what strengthens families and caregivers' capacity to support young children's development. An enabling environment is needed: policies, programmes and services that give families, parents and caregivers the knowledge and resources to provide nurturing care for young children.

Unicef, World Bank and World Health Organisation Nurturing Care Framework



Investing in the emotional wellbeing of our babies is a wonderful way to invest in the future.


Giving children the best start in life.

Improving the mental and physical health of the next generation.

Reducing risky and antisocial behaviour and the costs they bring.

Building a skilled workforce to support a thriving economy.


Creating a compassionate society.



The **first 1001 days**, from conception to age two, is a period of rapid growth. During this time **babies' growing brains** are **shaped by their experiences**, particularly the **interactions** they have with their parents and other caregivers. What happens during this time lays the **foundations for future development**.



Early relationships between babies and their parents are incredibly important for building healthy brains.



I need a **secure relationship** with at least one sensitive, nurturing caregiver who can respond to my needs.



Supporting my parents and other important people in my life to develop this relationship will give me the best start in life.



Stress factors such as domestic abuse and relationship conflict, mental illness, substance misuse, unresolved trauma and poverty can make it harder for my parents to provide me with the care I need. The more adversities that my family experiences, the harder it can be to meet my needs.



Healthy social and emotional development during the first 1001 days:

- Lays the foundations for lifelong mental and physical health.
- Means I feel safe and secure, ready to play, explore and learn.
- Leaves me ready to enjoy and achieve at school, and progress in the workforce.
- Enables me to understand and manage my emotions and behaviours; which means that I can make a positive contribution to my community.
- Gives me skills to form trusting relationships and to be a nurturing parent myself; sowing the seeds for the next generation.



Tackling adversity + supporting early relationships
→ healthier brains + better futures



Baby Brain Facts

Babies:

- hear at around 24 weeks of pregnancy,
- recognise familiar voice at birth, and
- prefer faces to other shapes.



We are hardwired for relationships!

In the first years of life, more than 1 million new connections are formed every second in a baby's growing brain.

The way babies' brains develop is shaped by their interactions with others.



A range of research shows that **the way parents interact** with their babies **predicts children's later development.**



Family income and education is strongly related to children's development. Babies in higher income families are more likely to have frequent caregiver-child conversations. By age 3, babies with university educated parents have been found to have vocabularies 2-3 times larger than those whose parents had not completed school.

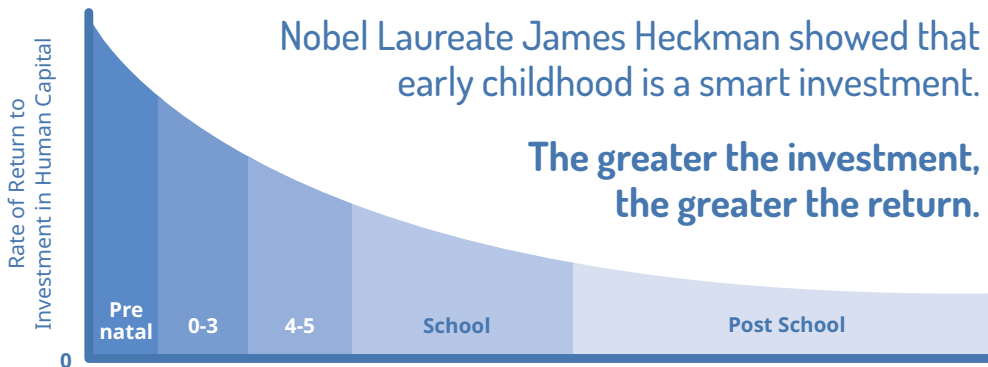


Children's development in the early years sets them on a positive trajectory, although what happens next also matters. Children's development at just 22 months has been shown to predict their qualifications at 26 years.



Nobel Laureate James Heckman showed that early childhood is a smart investment.

The greater the investment, the greater the return.



8,300 babies under one in England currently live in households where domestic violence, alcohol or drug dependency and severe mental illness are ALL present.

Rigorous long term studies found a range of returns between £4 and £9 for every pound invested in early intervention for low income families.

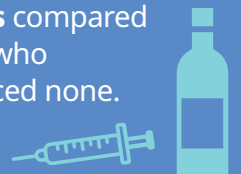


When parents experience problems in the first 1001 days it can have long term impacts on their children.

One study showed that children whose mothers were stressed in pregnancy were twice as likely to have mental health problems as teenagers.



Adults who reported four or more adverse childhood experiences had 4- to 12-fold increase in **alcoholism, drug abuse, depression, and suicide attempts** compared to those who experienced none.



**Tackling adversity + supporting early relationships
→ healthier brains + better futures**

A FAMILY'S STORY

Difficult beginnings

Lily (aged 5 months) and her mum Emma were referred to the Infant Mental Health Service in Leeds by their health visitor who was concerned about their relationship. Emma had experienced a traumatic birth followed by a large post-partum haemorrhage. Emma was feeling frustrated with Lily and felt that Lily was deliberately annoying her. Emma reported leaving Lily to cry at times.

Emma was feeling exhausted, anxious and low in mood. She felt distant from Lily and found it hard to think about Lily's experience. Emma was keeping herself busy and trying to do the things she normally did to prove that she was coping; but she was feeling increasingly worse. Emma described not enjoying motherhood. Significantly, Emma also had a difficult relationship with her own mother who she described as distant and selfish. Emma's mother had not been available or involved so far as a grandmother.

The Leeds Infant Mental Health Service is a multidisciplinary team, including a clinical psychologist, health visitors and infant mental health practitioners. The team began their work with the family by supporting Emma to recognise and respond to Lily's cues (the non-verbal ways Lily expressed her needs and feelings such as facial expression and body movements) and to become aware of the positive moments of interaction she had with Lily. In addition, four sessions of EMDR (Eye Movement Desensitization and Reprocessing) helped Emma to process her traumatic delivery.

It was powerful for Emma to re-experience Lily's birth during the EMDR and some new memories emerged including Emma remembering holding Lily for skin-to-skin contact immediately after birth. She could connect with the physical sensations and remember her emotional connection with Lily, which she had forgotten. By the end of these sessions Emma described how the birth memories were no longer traumatic and she felt at peace with this.

Emma and Lily's relationship improved significantly and the way Emma felt about Lily changed completely. The warmth, empathy and love Emma felt for Lily was very evident in their interactions. These positive changes were reflected in the routine outcome measures which showed that Emma's invasive behaviours towards Lily reduced significantly and she showed much more warmth towards her baby. Emma's low mood and anxiety were significantly improved.



Babies:

A special time requiring a special response

Work with babies is very different from work with older children

The first 1001 days is a time like no other. As explained, it is particularly important time in a babies' development. It is also a time when children are still developing, unable to speak fully but communicating their struggles and needs in different ways. Children of this age are completely dependent on adults to survive, as Paediatrician and Psychoanalyst Donald Winnicott famously wrote "a baby alone doesn't exist" what exists is always a "nursing couple": a baby plus someone who takes care of him/her.^{xii}

The first 1001 days is an important transition for parents too and one that can bring a number of challenges. This is a time of huge social, psychological, physical and relationship change. Most parents want to do their best and to enjoy their relationship with their baby. Parents are often most receptive to help

during the final months of pregnancy and the first months in their baby's life.

Work to protect and promote babies' mental health therefore requires an understanding of very early child development (including brain development and attachment theory), the ability to read babies' pre-verbal cues and to understand when they are showing distress or the signs of early emotional difficulties. It also requires being able to understand and work with early relationships, helping parents to overcome difficulties, identifying and promoting existing strengths and building parents' capacities to provide the sensitive, responsive and appropriate care that their babies need to thrive. This is skilled work that requires specialist expertise.

Very few professionals are routinely trained in parent-infant relationship work as part of their core training. In many professions, such as midwifery, health visiting and clinical psychology, these skills are developed through

Babies are different from older children:

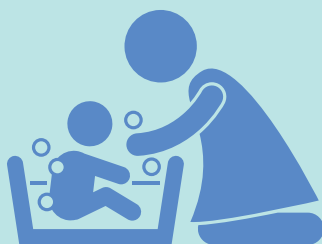


Babies are developing more quickly.



Babies cannot speak but communicate their needs in different ways.

Babies are completely dependent on adults.



Babies are more vulnerable: more likely to be abused and more fragile.



practitioners taking a special interest in this area and accessing additional training.⁵ An exception to this is child psychotherapy, where the core training covers perinatal and early infancy work, including undertaking supervised weekly observation of infants and their caregivers from birth until their second birthday. The Association of Child Psychotherapists is currently developing a supported clinical network for child psychotherapists who are specialising in parent-infant relationships work, to enable this group to support one another and further develop their practice.

The Association for Infant Mental Health in the UK (AIMH UK) together with the International Training School for Infancy and Early Years (ITSIEY) have developed a framework of infant mental health competencies; the skills, knowledge and behaviours that enable practitioners to deliver high-quality care to babies and their families. This competency framework has been developed for all staff working with infants and their parent/s/caregivers from pregnancy to the second year of life. It has three levels to distinguish between (1) general knowledge and skills, (2) advanced knowledge and skills, and (3) the knowledge and skills required to supervise and manage. Practitioners working in parent-infant teams would be expected to have skills at the higher levels, but also play a role in upskilling the wider workforce.

The core infant mental health competency required by practitioners is an ability to hold an “infant mental health frame of mind.” This includes the capacity of staff “to be able to maintain the perspective not only of the parent but also that of the baby, to be able to use observations in order to imagine the experience of the non-verbal infant... maintain a focus on the parent-infant relationship... and to be able to apply interventions flexibly in-line with the strengths, vulnerabilities and wider social context of each infant, parent and family.” The Competency Framework has a number of domains including: Relationship-based practice, Normal and atypical development, Factors that influence caregiving, Assessment of caregiving, Supporting caregiving and Reflective practice and supervision.^{xiii}

Supporting parent-infant relationships involves helping parents to provide their babies with nurturing care

Parent-infant interactions are shaped by a complex interaction of many factors relating to the parent, the child, their relationship and their environment. It is now recognised that parents’ ability to provide their babies with sensitive, responsive and appropriate care has both cognitive and behavioural elements.^{xiv, xv, xvi, xvii} At a cognitive or representational level, parents need ‘reflective function’ - the capacity to think about their child’s point of view, their mental states such as thoughts, feelings and desires, and how these influence behaviours⁶. At a behavioural level, sensitivity involves being consistently available and making appropriate responses to babies’ cues.

There are a number of reasons why parents may not be able to provide their baby with the care that they need. Some of these reasons include:

- A parent may be experiencing high levels of stress and not have the capacity to notice their baby, think about the world from their point of view or reflect on how the baby may be feeling.
- In some cases, a parent’s thoughts and attributions about their baby may be distorted because of emotional issues that the parent is feeling or unresolved emotional issues from the past (sometimes referred to as ‘ghosts in the nursery’).^{xviii}
- Parents’ expectations about how to parent are often shaped by how they were parented themselves, and this is problematic if their own early experiences were traumatic or difficult.
- A parents’ behaviour towards their baby may be inappropriate, frightening or intrusive. Perhaps because the parent struggles to regulate their own emotions and behaviours, or because they struggle to understand their babies’ needs.

Particular factors in a parents’ own life, such as a history of childhood abuse, domestic violence, mental health problems, substance misuse and poverty can increase the likelihood that will struggle to provide their baby with the care that they need to thrive.

5. It is not difficult or costly to access this additional training, particularly in a locality with a parent-infant team.

6. A parent’s ability to consider their child’s own mind, mental states and experiences can also be called mentalisation or mind-mindedness.

Parent-infant teams work with parents to understand and work through the factors that might make parenting difficult; to develop the skills, capacities and behaviours they need to provide their baby with the care they need; to develop a realistic and appropriate understanding of their baby's development and the role they play in this, and to access further help for themselves and their child if this is needed to deal with other challenges that the family might be facing.

Parent-infant relationship work is early intervention

Protecting and promoting babies' mental health requires practitioners to focus not only on the baby or their parents, but on the relationship between them. This is true preventative work: parent-infant teams do not wait for a clinical diagnosis of mental illness in the child, but act when a baby's emotional wellbeing and later mental health is at risk because of adversities and difficulties in early relationships.

This report is not advocating that work with children under 2 negates the need for later intervention, nor that it should happen in a silo. However, it is arguing that work to promote and protect infant mental health is crucial because:

- The first 1001 days provide an important foundation for later development and is a time when the brain is particularly plastic and experiences have a significant impact on development.
- Work to protect and promote infant mental health requires specialist expertise, and is different to work with older children.

A FAMILY'S STORY

The ghosts in the nursery

B, a four-month-old baby, and his mother, S, a young mum, were referred to the PIP service in Croydon.

S suffered from severe depression, and had disclosed to her perinatal psychiatrist that she did not love her baby. She had been ill throughout her pregnancy and since the baby's birth was expressing suicidal thoughts and described herself as 'a very bad mother'. She found B's crying very hard to bear.

The Croydon Best Start PIP service is a team of psychotherapists and key workers.

The team saw S and B for weekly sessions, and sometimes B's father, D, also attended. During the sessions S, was able to explore her experience of feeling unloved and abused by her own mother, which has coloured her own parenting. She was helped to observe her baby and think about what she might be communicating. S and her partner had time to reflect on the changes in their relationship since B came along.

Gradually S grew in confidence and found that she was able to respond more readily to her baby. B in turn became less fretful and began sleeping better at night. After only six sessions S said:

"I love looking after him now. I never thought I'd feel like this. I want to have the kind of relationship with him that I never had with my own mum."



Defining specialised parent-infant relationship teams:

Multidisciplinary teams of experts, working at different levels of the system to promote and protect parent-infant relationships



We have identified the common characteristics of parent-infant teams

Specialised parent-infant relationship teams bring together professionals with specialist expertise in multidisciplinary teams that both offer direct therapeutic work, and use their expertise to drive change in the wider system.

The specialised parent-infant relationship teams that currently exist in the UK have different names and work in different ways. Parent Infant Partnership UK is working with the sector to define what specialised provision looks like and to create quality standards for the sector, but at the moment there is no agreed definition of a parent-infant team.

However, there are clear commonalities, which we believe are the essence of a specialised parent-infant relationship team:

Characteristics of specialised parent-infant relationship teams



They are ideally **multidisciplinary teams**, which include highly skilled mental health professionals such as clinical psychologists and child psychotherapists, with expertise in infant and parent mental health and in supporting and strengthening the important relationships between babies and their parents or carers.⁷



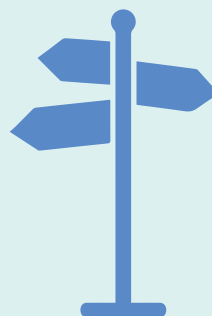
They assess families, and offer them an **individualised programme of support** to meet their needs drawing on a toolkit of both professional practice and evidence-based programmes.



Their **focus is on the parent-infant relationship**. They do not work only with an individual child or parent(s) but with the dyad or triad (although there may be particular sessions in which parents see a therapist on their own).



They are **experts and champions**. They use their expertise to help the local workforce to understand and support all parent-infant relationships, to identify issues where they occur and take the appropriate action. This happens through offering training, consultation and/or supervision to other professionals and advice to system leaders and commissioners.



There is a clear referral pathway to enable families who need support to access the service. Families are referred because of concerns about **difficulties in their early relationships**, which is putting or could put babies' emotional wellbeing and development at risk. Unlike other mental health services there does not need to be a clinical diagnosis in the adult or child for families to be eligible for the service.



They offer **direct support for families who need specialised help**. This includes targeted work with families experiencing early difficulties whose needs cannot be met by universal services alone, and specialist therapeutic work with families experiencing severe, complex and/or enduring difficulties in their early relationships, where babies' emotional wellbeing and development is particularly at risk.



They accept referrals for **children aged 2 and under and their parent(s)**. Some work from conception, others from birth. (Some services see older children too, and some are currently expanding to reach other preschool children, up to the age of 4.)

7. Services work with primary caregivers, including parents, foster carers, grandparents or others who may be playing this role. In this report, when we refer to parents, it is shorthand for this wider group.

Parent-infant teams make a unique and different contribution

Parent-infant teams are different from, but complementary to, other services that should exist in their local area.

Health Visiting

Health visitors can play an important role in promoting parent-infant relationships as they have the opportunity to work with every family during this important period. Nice Guidance for postnatal care states that assessment for emotional attachment should be carried out at each postnatal contact and home visits should be used as an opportunity to promote parent- or mother-to-baby emotional attachment.^{xix}

In some places, health visiting services have specialist infant mental health visitors who offer interventions to support families who need additional help. When systems are working effectively, specialist health visitors may be part of parent-infant teams, or may be a separate part of the infant mental health pathway, working closely with parent-infant teams and offering a service to families with a lower level of need. Parent-infant teams offer training, consultation and, in some cases, supervision, to health visitors in their locality.

Unfortunately, many health visiting services are unable to offer additional parent-infant relationship support to families. In some places, there are health visitors who have the expertise but without the time or mandate to offer families additional support. And sadly, many health visiting services are can barely deliver the core health visiting services to families, let alone specialist work to support parent-infant relationships, despite the clear value of this work. The number of health visitors employed by the NHS has fallen since 2015 from just over 10,000 to just under 8000 as of April 2018, and 65% of families do not see a health visitor at all after their baby is aged six to eight weeks old.^{xx}

Family Nurse Partnership

Family Nurse Partnership (FNP) works with parents aged 24 and under, partnering them with a specially trained family nurse who visits them regularly, from early pregnancy until their child is two. Family nurses work with families on a wide range of topics. Family nurses' training includes attachment

theory, and their visits include work to strengthen early relationships between parents and their babies. This is important targeted work, and, where it exists in a locality, should be part of the infant mental health pathway. Family nurses may refer families to parent-infant teams when they need specialist additional relationship support. Part of the FNP service requirements are that nurses receive reflective supervision from a psychologist, and a number of parent-infant teams (such as Haringey, Trafford and Plymouth) provide this support to the team.

Specialist Perinatal Mental Health Services

Specialised parent-infant relationship teams are different to perinatal mental health services. Perinatal mental health services provide maternal mental health support to mothers who have serious perinatal mental health problems, whereas specialised parent-infant relationship teams provide relationship support to families who need specialised help with their early relationships.

However, whilst perinatal mental health services focus on treating the mothers' mental illness, many are supporting the mother's relationship with her baby if there are difficulties in the early relationship. NICE guidance on maternal antenatal and postnatal mental health states that services should assess the mother-infant relationship, discuss any concerns with the mother and "Consider further intervention to improve the mother-baby relationship if any problems in the relationship have not resolved."^{xxi} The NHS Long term plan for England committed to expanding access to evidence-based psychological therapies within specialist perinatal mental health services in England so that they also include parent-infant, couple, co-parenting and family interventions.^{xxii} Some specialist perinatal mental health services may still refer families to parent-infant teams if they need additional or ongoing parent-infant relationship support.

Whilst some families who access specialised parent-infant relationship teams are also eligible for perinatal mental health services, there are many families who are experiencing early relationship problems where the mother does not have a mental health problem (or the mother's mental health problem does not meet the threshold for specialist perinatal mental health services), and equally there may be mothers held by perinatal mental health services who do not need support with their early relationship. Perinatal mental health services in the UK (at the moment at least) focus their work with biological mothers, whereas

specialised parent-infant relationship teams are designed to work with the babies' primary caregivers, whether that be mum, dad, adoptive parents, foster carers, grandparents or someone else.

“ I work in the community perinatal team as a parent infant psychologist and offer parent interventions to women accessing the team, however as I am only 0.5 WTE and cannot see all the women and babies who need support within the team. There are also many families with babies who cannot access this service because the mother does not have moderate to severe mental health problems... ”

Quote from our survey of professionals

“ The specialist service that is in the area for perinatal mental health is for more severe presentations. This leaves those who are experiencing less severe difficulties to worsen when left unsupported. This is a crucial time in babies' development but also the development of the relationship between parent and infant. With many of the cases seen in CAMHS when they do reach an older age, the concerns have become much more chronic and difficult to shift. ”

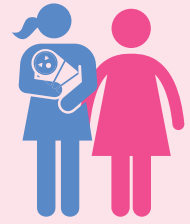
Quote from our survey of professionals

Parent-infant teams work as part of a system to offer joined-up support for families

Parent-infant teams play a hugely valuable role, but they can't exist in isolation. They have to be integrated into a wider system, where professionals in universal and targeted services can support families with lower levels of need, and identify and refer families who need additional help at the earliest opportunity. Where they are embedded in a local system, parent-infant teams work in partnership with a range of other professionals to meet the needs of families who might be experiencing multiple disadvantage and need help with a range of issues. They can also signpost or refer families to other services during and at the end of their care.

A FAMILY'S STORY

Recovery from trauma



Baby Hannah's mother, Jenny, was referred to the Infant Mental Health Service in Leeds when she was 31 weeks into her pregnancy. Jenny had become pregnant as a result of rape, she was feeling detached from her unborn baby, had presented to services late in her pregnancy, and had made no plans for Hannah's arrival. Jenn was experiencing low mood and anxiety. She had no history of mental health problems prior to the attack, and had been planning to go to university. Jenny lived with her parents and family, with whom she had a good relationship.

Jenny described how the baby would 'ruin' her life. She concealed her pregnancy, and when attending antenatal appointments, couldn't look at the scan or listen to her baby's heartbeat. Jenny was considering adoption as she felt unable to think about becoming a mother. The Infant Mental Health service initially focused on connecting Jenny to the 'here and now' and helping her to think through her labour, delivery and first moments with her baby. After Hannah was born, Jenny shared feelings of wanting to harm her baby and so social care became involved in the family. The IMH team helped Jenny to consider her options, and she decided that Hannah would remain in her family and be cared for primarily by her Jenny's mother. Therapeutic work from this point focused on psychoeducation, using the 'Understanding you Baby' resources to help Jenny to understand and respond sensitively to baby Hannah.

Hannah remained in the family, primarily cared for by her Grandmother, and her development was healthy and positive. When the family were discharged from the specialised team, Jenny showed improved responsiveness to Hannah and was able to think about Hannah's experience of the world, her future and how she and Hannah's relationship would develop. Jenny accessed psychotherapy and began to make plans for her own future. Hannah was important to the whole family and Jenny was able to enjoy being with her daughter.

Creating System Change:

Parent-infant teams as experts and champions

Parent-infant teams help drive system-wide change in services and support for families, creating pathways of care, delivered by a workforce who understand child development, have the skills required to can support early relationships and notice when families are struggling and help those who need it to access appropriate additional support. They do this through offering training, consultation and/or supervision to build capacity in the local workforce. They can also be champions for early relationships and offer advice to system leaders and commissioners working at a strategic level to support the development and effective operation of local services and care pathways.

Effective pathways of care are critically important to ensure that every family gets the right support at the right time. Being embedded in a local system where such pathways exist is important to enable parent-infant teams to work effectively. It ensures that parent-infant teams receive timely and appropriate referrals and that they can signpost families who don't need specialist support to other services.



Parent-infant teams offer training to build capacity in the local workforce

The parent-infant teams that exist in the UK currently offer a wealth of training in their local areas to all professionals who can benefit from understanding about parent-infant relationships. Some of this is broad multidisciplinary infant mental health training, generally taken up by midwives, health visitors, social workers, adult mental health services and those working in the voluntary sector.

Some of it is bespoke training on particular interventions or particular audiences (such as training for family courts, interpreters, staff on the neonatal unit, specialist perinatal mental health teams). A number of teams take student placements or teach on university courses, for example NewPIP are shortly to begin teaching on the midwifery course at Newcastle University.

Thousands of professionals around the country are currently benefiting from training delivered by parent-infant teams. Over half of the parent-infant teams who responded to our survey told us they had trained between 100 and 300 practitioners in the last year. Some services deliver even more: OXPIP for example, runs a range of parent-infant training including short-courses; extended training programmes, commissioned training for teams, lectures, conference presentations and workshops. They estimate that in 2018-19 their training programme reached over 1000 individuals.



Parent-infant teams drive strategic change

Parent-infant teams can be the champions of infant mental health at all levels of their local system, including working with local leaders to develop a vision, strategies and pathways of care for families. Many of the parent-infant teams who completed our survey told us that they sit on local working groups and steering groups around infant and perinatal mental health, family and early years services.

Because of their role as catalysts for wider system change, these small teams can have a significant impact. Like rare jewels, they may be small but their value can be immense as these quotes from our research illustrate.

Parent-infant teams provide supervision and support

Training on its own is not sufficient to generate sustained change in local services. Professionals also need ongoing information and support. Therefore, parent-infant teams also offer ongoing consultation, support and supervision to other local practitioners. Examples of supervision and support offered by parent-infant teams include:

- Bradford Infant Mental Health Service (Little Minds Matter) offer telephone, face-to-face, individual and group supervision on a monthly basis to a range of key professionals including health visitors, midwives and other projects in Better Start Bradford.
- BrightPIP offer monthly case consultation for Health Visitors or Early Years Educators. Every month a group of professionals meet with the Clinical Psychologist for an hour. A practitioner chooses one of their cases to bring each time, and the Psychologist used a solution-focused approach to facilitate the group to support each other.
- Haringey PIPs offer regular consultation to health visiting and Family Nurse Partnership teams, and their team leads, as well as consultations to Social Workers, children's centres and nurseries.
- Surrey Parent Infant Mental Health Service provide regular supervision for all health visitors and nursery nurses delivering baby massage groups and consultation to the local Perinatal Mental Health team to help them to meet the needs of babies.

“... Community midwives, the health visitors, the children's centre workforce, and the third sector, the voluntary sector, who are working with families and parents...they were the first tranche of key people to get trained... And then it's been moving on since then to identify other key people, such as: mental health practitioners what work with adults so that they recognise the importance of attachment when they're looking after, for example, a woman with perinatal mental health difficulties; social workers, so that they understand the importance of attachment in their work, and they really love the training and really feedback positively; foster carers who are taking on infants who have been compromised because of attachment.

They've recently done targeted training to people who work in family courts and the judges across the region, which went down really, really well. So, we're trying to have a reach. They've done it in neonatal units because we don't want our [specialised] babies with complex needs to be compromised and missed out, so we've made sure that the workforce understand the importance of attachment that work in the neonatal units. So, we're really trying to stretch it everywhere and get the word out, the message out.

Commissioner in Leeds

“ We have a very small service (1.1 wte) to cover an entire county, with the aim of taking parent infant MH referrals from the specialist adult perinatal mental health team and from community health visitors, providing evidence-based interventions and support. The positive impact on families who are helped is considerable and the team also provide training and awareness raising for professionals in infant mental health. ”

Quote from professional survey

“ I think we've moved mountains there. I think our adult mental health services are far more aware of, not just safeguarding in terms of children and infants, but also the whole notion of the impact of parental mental health on the infant, and how we need to be mindful of it. We've had some great examples of our psychiatrist bringing in the Early Attachment service really early on and co-working together and supporting mums. ”

Commissioner in Tameside

LivPIP: An example of a service creating system-wide change for babies

LivPIP is a specialised parent-infant relationship team in Liverpool, made up of psychotherapists, clinical psychologists and family support workers. The team was established in 2014 and is part of a wider Parent Baby Wellness Service, alongside a service for mums with postnatal depression. Alongside direct work with families, the LivPIP team also:

- Educate and train professionals on infant mental health including topics such as baby brain development, intergenerational patterns of parenting and the impact of anxiety and obsessive patterns in the perinatal period (LivPIP trained 303 professionals in the last 12 months).
- Offer consultation to any professional who has concerns about a parent's relationship with their unborn baby or infant, relationships in the family or a parent's emotional state and beliefs.
- Work in partnership with all of the professionals who support families with babies; health visitors, GPs, children's centres, midwives, perinatal mental health teams and many others.
- Provide one-to-one support for parents at Liverpool Women's Hospital Neo Natal unit who are worried about the bonding and attachment process with their baby, and offer support and training to the staff.
- Offer placements to primary and social care students at the University of Central Lancashire, and to trainee Clinical Psychologists from the University of Liverpool.
- Take an active role in supporting the Liverpool Health and Wellbeing Board to develop the Liverpool Perinatal Mental Health Pathway, and sit on the North West Coast Strategic Clinical Network for perinatal mental health.
- Work closely with Liverpool City Council as part of their Parent Infant Wellbeing and Development group, which aims to reduce infant mortality and improve school readiness in the city.
- Sit on the CAMHS partnership Mental Health and Wellbeing Board, a collaboration to improve services for 0-18-year olds and to identify any risks within this collaboration
- Create resources that are shared through local services and over social media. For example, LivPIP worked with service users to produce a Parent & Baby Wellness DVD (funded by Public Health Liverpool): a collection of experiences of pregnancy, birth and early parenthood.

Providing Direct Support:

Delivering therapeutic interventions to families experiencing the most serious difficulties

Parent-infant teams work directly with families experiencing severe, complex and/or enduring difficulties in their early relationships, whose needs cannot be met by universal services alone, and where babies' quality of attachment, emotional wellbeing and development is particularly at risk. These families may be experiencing a range of challenges that compromise early relationships such as maternal mental health, previous baby loss, trauma, substance misuse, relationship conflict or domestic abuse, and their own negative or abusive parenting experiences.

In some cases, there may also be concerns about a baby's development, or behaviours such as sleep and feeding.

As multi-disciplinary teams with specialist expertise, parent-infant teams have a range of skills and a toolbox of professional practice and evidence-based interventions that they can use. Teams assess families' needs and then offer them an individualised programme of work, tailored to tackle the challenges the family are facing and to support the relationships

Data from parent-infant teams entered onto the Parent Infant Partnership Portal between 1 May 2018 and 30 April 2019 demonstrated that:

10% of referrals were for **parents aged 20 and younger**



66% of babies referred to the service were **white**, with others coming from a range of BAME groups



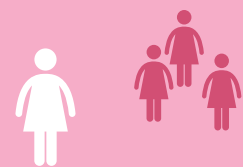
32% of referrals were from **single parent families.**



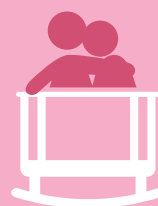
The top four risks included in referrals were:



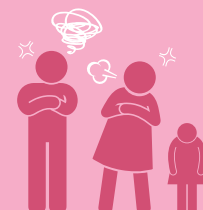
perinatal mental illness



isolation/ lack of support



recent life stress
i.e. bereavement/birth trauma/immigration,



history of parent being or witnessing **abuse in own childhood**

between parents and their baby. This might include individual or group work, at home or in community settings (services often try to work in setting such as children’s centres and GP clinics to provide an accessible and destigmatising service.).

Parent-infant teams are highly skilled multidisciplinary teams

Specialised parent-infant relationship teams are usually multidisciplinary teams with expertise in supporting and strengthening the important relationships between babies and their parents or carers. This multidisciplinary approach provides a rich mix of skills to support families.

Services are typically small (a few teams have fewer than 2WTE staff and larger teams currently have 5-9WTE staff per service). The make-up of current services varies. The majority have at least one clinical psychologist and at least one child psychotherapist, but some services do not have both professionals in place.

Other roles on the team vary, but often include:

- Family support workers or key workers

- Infant mental health practitioners (at band 6 or 7)
- Specialist Health visitors
- Service managers and administrators.

Some services also have practitioners such as a midwife, play therapist, family therapist, systemic therapist, occupational therapist, art therapist, baby massage teacher, social worker and/or community engagement coordinator.

The Infant Mental Health Competency Framework described in Section 4 of this report provides a core set of competencies for all professionals in a parent-infant team. Teams should be committed to continuous development, and all therapists must have access to regular, reflective supervision to support high-quality delivery. In addition, there is a common ethos within all teams: team members should be non-judgemental, compassionate, solutions focussed and trauma-informed in their approach.

Any service that aims to improve the relationship between parent and baby can only succeed if it is embedded within a ‘relationship-based organisation’^{xxiii} where the quality of relationships within the team match the quality of the relationships they aim to foster within families being supported.

The size of teams at the moment, often reflects the funding available to services, rather than the capacity required to support the local population. In Greater Manchester, some work has been done to understand the size of service required for population of 280,000 which equates to a birth rate of around 3300 and is roughly the size of an average local authority in England. This table shows the suggested staffing in their service specification.

Staff	WTE
Consultant Psychologist/Psychotherapist (Regional Service Lead)	0.33
Clinical Psychologist/Psychotherapist (Local Service Lead)	1
Parent-Infant Therapists/Practitioners (HV/Infant Psychotherapist/Midwife/Clinical psychologist)	2
Adult mental health practitioner.	1
Social Worker	1
Administrator	1
Community outreach/Peer support worker	1
	7.33

Parent-infant teams offer a range of interventions to meet families' needs

Parent-infant teams offer individualised packages of support to families, which can include a mix of both evidence-based programmes, and wider professional practice delivered by highly skilled and specialist therapists and key-worker support.

Parent Infant Psychotherapy

Parent Infant Psychotherapy⁸ involves a parent-infant psychotherapist working with the parent(s) and their baby, and their relationship. This is a psychoanalytical and attachment-based intervention, which aims to improve the parent-infant relationship through providing support to help the parent to reflect on past and/or present experiences that may be influencing their view of their infant and their relationship with them. The practitioner also models sensitive responding and helps the parent to appropriately interpret their baby's behaviour appropriately.

Parent Infant Psychotherapy is not a specific programme and can be delivered in many formats. A Cochrane review of parent-infant psychotherapy found that it is a promising model in terms of improving attachment security in high-risk families but there is currently no evidence of its impact^{xxiv}. The review found problems in the current evidence base for parent infant psychotherapy due to: significant variation in the type of intervention evaluated (including duration, content and focus), little consistency in the outcomes measured and low quality of evidence.

One particularly intensive form of Parent Infant Psychotherapy, Infant-Parent Psychology (IPIP)⁹ has been demonstrated to improve infant attachment security in two Randomised Controlled Trials (RCTs) and has an evidence rating of 3+ in the Early Intervention Foundation Guidebook¹⁰. IPIP is not delivered in the UK, probably largely due to the resources required to deliver this level of intervention¹¹. However, there are similarities with the 1:1 psychotherapy offered by parent-infant teams albeit far less intensive.

Watch, Wait and Wonder

Watch, Wait and Wonder is an infant-led psychotherapeutic approach. It can be conducted one-to-one or in groups. The programme is delivered by a specially-trained infant mental health specialists over a maximum of 18 weekly sessions. During the programme, parents are encouraged to play with their babies in a way that follows the baby's lead. The parent is then invited to explore the feelings and thoughts that were evoked by what he or she observed and experienced during the play. The intervention aims to enhance parental sensitivity, mentalisation and responsiveness, the child's sense of self and self-efficacy, emotion regulation, and the parent-infant relationship. This intervention has an evidence rating of 2+ in the Early Intervention Foundation Guidebook. There is evidence that it improves children's attachment security, emotion regulation and cognitive development.

Circle of Security

Circle of Security is an attachment-based parent reflection model. It uses video to help parents to reflect on how children communicate their needs through their behaviour, and to consider how best to meet these needs. There are two forms of Circle of Security: an original 20 session programme and a less intensive 8-10 session programme called Circle of Security Parenting. The programme involves weekly sessions and is designed for parents of children from conception to age 5. It can be used individually or in groups in a range of settings. Circle of Security Parenting has been shown through an RCT to improve children's inhibitory control and maternal response to child distress. It has evidence rating of 2+ in the Early Intervention Foundation Guidebook.

8. Parent Infant Psychotherapy can be shortened to PIP, but it's important to be aware that in the PIP in Parent Infant Partnership UK and many of the PIP services does not stand for parent infant psychotherapy (it generally stands for Parent Infant Partnership and in some cases for Parent Infant Psychology or Parent Infant Project).

Video feedback approaches

Video feedback approaches involve a practitioner filming the parent(s) interacting with their baby in normal moments, such as play time or meal times. The parent(s) is then supported to watch and reflect on the film. Throughout repeated filming and review sessions, parents are supported to become more sensitive to children's communicative attempts and to develop greater awareness of how they can respond in an attuned way.

There are many video feedback interventions. The two types most commonly used in the UK are Video Interaction Guidance (VIG) and Video Feedback for Positive Parenting (VIPP). In VIG, practitioners are trained to use video feedback through a series of filming and review sessions in order to encourage positive aspects of caregiver-infant interaction.

VIG methods, quality and standards are specified by the Association for Video Interaction Guidance UK, but the intervention allows some flexibility in delivery meaning that it can be used by different professionals in individual or group settings to offer tailored support to parents. VIG has not yet been subject to a robust quasi-experimental or controlled evaluation.

VIPP is a more manualised, structured approach. It typically consists of seven 2-hour sessions, working with one or both parent and one child in the home environment. It has different variants, which have been carefully tailored to work with different populations such as adopted infants, children with autism, babies of mothers with an eating disorder, fathers and couples with high levels of couple conflict. There is a range of evidence for video feedback approaches:

- A meta-analysis of studies using video feedback concluded that parents become more skilled in their interactions with their children, and have a more positive perception of parenting which helps the overall development of their children.^{xxv}
- The effectiveness of the VIPP-SD on enhancing parental sensitive behaviour has been demonstrated through 12 RCTs in different countries and among different target groups.

VIG and VIPP are not included in the Early Intervention Foundation Guidebook, but VIPP has been registered in the Effective Youth Interventions Database of the Dutch Youth Institute^{xxvi} with the highest evidence rating, "demonstrably effective". Video feedback is also recommended in two NICE Guidelines.^{xxvii, xxviii}

Mellow Groups

Mellow Parenting interventions are evidence-informed manualised parenting programmes. There are a family of Mellow Programmes, including Mellow Bumps for expectant parents, Mellow Mums, Mellow Dads, and others. These are attachment and relationship-based group interventions using a mixture of reflective and practical techniques to support parents. They involve weekly group sessions for high-risk families. For example, a typical Mellow Mum's

group will run for 14 weeks, one day a week. A typical group might run between 10am and 2:30pm including a group work session, followed by a shared lunch and play with the babies.

There is a growing body of research into the Mellow programmes, and two are currently undertaking an RCT. Mellow Toddlers is in the Early Intervention Foundation guide book, but Mellow Bumps and Mellow Babies are not.

9. Which is also known as the Lieberman model.
10. The Early Intervention Foundation (EIF) is an independent charity and one of the Government's 'what works' centres. It champions and supports the use of effective early intervention to improve the lives of children and young people at risk of experiencing poor outcomes. The EIF Guidebook provides information about early intervention programmes that have been evaluated and shown to improve outcomes for children and young people. Through a rigorous assessment process, EIF has rated the strength of evidence for a programme's impact on a scale of 1-4.
11. In Infant Parent Psychology practitioners have to have 92 hours of programme training and delivery involves at least weekly hour-long sessions for around a year.

Each service in the UK offers a slightly different selection of interventions depending on the skills and training of practitioners on the team. Other interventions offered in some of the services include:

- Brazelton interventions (Newborn Observation (NBO) and Neonatal Behavioural Assessment Scale (NBAS))
- Metalization-based therapy for parents
- Five to thrive
- Baby Massage
- Play therapy including Thera-play® informed approaches
- From Timid to Tiger parent group
- Parent Infant Feeding Clinic
- Solihull approach
- Couple and systemic family therapy
- Antenatal programmes, such as Baby Steps and PEEP
- Adult mental health interventions (including birth trauma therapies) including (but not limited to) CBT, EMDR and adult psychotherapy.

Many parent-infant teams offer particular outreach and tailored work for multiply disadvantaged and traditionally marginalised families. Some do work with specific at-risk families, for example the Anna Freud National Centre for Children and Families runs therapeutic weighing clinics^{xxix} and a parent-toddler groups at a 136-bed homeless hostel for families^{xxx} and has run specialist parent-infant group work with mothers in prisons, which was demonstrated through to have a positive impact in an RCT study.^{xxxi}

In Bradford, where the community is very diverse and over 120 languages are spoken, the Little Minds Matter team has a community engagement worker and has trained interpreters to enable them to work more effectively with the service. Some services also have peer support workers and volunteers to offer additional support to families.

DorPIP #Keepintouch Groups

The DorPIP service found that families would like to keep in touch with others that they met at groups, or reach out to those who have been through similar experiences. They have therefore set up a members-only online and community group for families who have completed parent-infant therapy or baby massage with the service.

We are developing the evidence base for parent-infant teams

Parent-infant teams collect a range of demographic and administrative data, and use clinical outcomes measures before, during and at the end of their work with families to inform practice and measure impact. These include measures of child wellbeing and development, of parental wellbeing and of the caregiving relationship. Services also collect service-user feedback (and in some cases, referrer feedback too) and many also regularly undertake case audits to review the work of the service.

Most of the individual therapies offered by parent-infant teams are based on excellent scientific research and an increasing number are well-evidenced. However, the evidence about the impact of different interventions on the parent-infant relationship is still developing, as is the evidence for many interventions for older children, young people and families. As the Early Intervention Foundation has explained, although the case for early intervention is very well made, the overall evidence base for the programmes available now in the UK needs further development.^{xxxii}

There has not yet been a robust evaluation of parent-infant teams themselves (as opposed to the interventions they offer). As services are very small it can be difficult for them to generate sufficient data for evaluation, which is why Parent Infant Partnership UK is bringing services together to pool data. Some services are also currently taking part in research, either to capture the impact of their service or of a particular intervention.

We recognise that the lack of robust data can also be a challenge for commissioners. Both because there is not always robust impact evaluation from services, but also because it can be hard for services to evidence the longer-term impact of their work and how they influence outcomes which are particularly relevant to commissioners (such as school readiness). However, it is important to note that this challenge is not unique to parent-infant relationship services – commissioners have to work without a robust evidence base for many of the early and late interventions they fund, and should not require higher standards of evidence for some services than others.

“ We’ve got some fantastic case examples... We’ve had, you know, examples of, really young parents finding...having that extra support really beneficial in connecting with their infant much more strongly. We also have examples where babies are [extracted] to safeguarding and adoption because the families are just not really able to make the changes necessary to be a safe, nurturing place for babies as well. So, difficult cases as well as good ones...So, lots of individual examples. It’s harder to collect some really strong evidence, in terms of the outcomes of children...”

Quote from commissioner, Tameside

“ ...we’ve had anecdotal evidence of... turning lives around, enabling also children to stay with their mother, but... I haven’t seen significant impact measures that... show us, actually, in the majority of cases, this is working... I think that’s where we need guidance in relation to the...in relation to the evidence and the specialism, so actually that commissioners need that guidance – this is what we should be seeing, you know.”

Quote from Commissioner, Croydon



EVIDENCE OF IMPACT: Work with families on the edge of care in Norfolk

Norfolk Parent Infant Mental Health Attachment Project (PIMHAP) is a parent-infant team with a specific focus on working with babies on the ‘edge of care’.

The service is a joint venture between Norfolk and Suffolk NHS Foundation Trust and Norfolk County Council. The project was commissioned in 2015, to work with families where there were significant safeguarding concerns, attachment problems in the parent-infant relationship and identified parental mental health problems.

PIMHAP assesses each family’s needs and designs a tailored multi-disciplinary intervention for the family which might also draw in other services, such as children’s centres, community mental health services or Family Nurse Partnership.

An evaluation of the service based on 55 families referred in the first year of operation found that 85.4% of the families were enabled to remain, or reunite with their child, compared with an estimated 50% ‘edge of care’ cases nationally.”^{xxxiii}



EVIDENCE OF IMPACT: Cost benefit analysis of services in Liverpool

In Liverpool, there was an economic impact evaluation of the Parent and Baby Wellness Services (this includes both the postnatal depression service and LivPIP). Using outcomes data on improvements in maternal mental health from the first three years of operation, and applying financial proxies, the service produced both a cost-benefit figure in terms of investment-to-save for the public sector, as well as a social value figure which comprises both the public savings as well as the human and emotional costs in the longer-term. This research found that :

- The cost benefit analysis shows that for every £1 invested in the Parent and Baby Wellness Service £13.18 will be saved by the Public Sector across Health, Social Care, Education and Criminal Justice.
- The social value analysis shows that for every £1 invested in the Parent and Baby Wellness Service £59.91 will be created in social value (a mixture of the cost-benefits but also including additional social, human and emotional benefits including quality of life and potential future earnings.).^{xxxiv}

EVIDENCE OF IMPACT: In families' own words

“ I can't thank my key worker and the [Croydon] Best Start team enough. My key worker has helped me to become a better parent, and the better me that I thought I'd lost. I have been fully supported with my feelings and building better relationships with my boys and myself. I feel more confident about myself, myself as a parent and the choices I make. We completed all our goals we set out to and many more. ”

“ Before meeting the therapist, I was extremely anxious about carrying a baby successfully and also worried about how my fears would impact on our relationship once she was born. The therapist was able to talk me through those worries and give reassurance when I started to lose my confidence and give into the anxiety. Once my daughter was born, meeting with her helped to set aside worries and assure me of my daughter's normal development. She also gave insight into how my daughter might be experiencing the situation and how to help her cope with the newness of being in the outside world. Her kind and patient manner ... helped me transition from a fearful to positive parent. The support I received was exceptional. I felt very lucky to be able to access the service. ”

Feedback from two parents using the Croydon PIP service

Parent Infant Partnership UK: Driving up reach and quality of parent-infant teams

Parent Infant Partnership UK is committed to supporting the growth and quality of specialised parent-infant relationship teams. We facilitate the Parent Infant Network, which brings together specialised parent-infant relationship teams from around the UK to share learnings and support each other to improve practice. Working with that network, we are defining what specialised parent-infant relationship provision looks like and creating quality standards for the sector. We will support services to work towards those standards. By the end of 2020, we will have established an accreditation for services to demonstrate that they meet the service, underpinned by a peer review process.

Parent Infant Partnership UK supports parent-infant teams to collect the most useful data. We also provides a portal where services who wish to can record information on the demographics of service users, risk factors affecting families, clinical outcome measures and parent feedback. The portal allows for the demographic, social and clinical data from across services to be pooled and analysed as a whole sample, which will in future enable more robust evaluation of parent-infant teams. We are keen to support new research into the impact of parent-infant teams, as well as enabling individual services to monitor their own data to inform and improve practice.

Parent Infant Partnership UK co-funded and supported the establishment of six services in the last five years in Brighton, Liverpool, Croydon, Dorset, Newcastle and Enfield. Our role has been evolving, from providing funding and expertise to support set up of services in the voluntary sector, to working with commissioners to support the development of services embedded within local system of health and children's services.

The ABCPiP (which opened in Northern Ireland in 2018) and the new service in Essex (which starts operation this year) have been developed through partnerships between local commissioners, providers and Parent Infant Partnership UK. These teams use the PIP UK approach to service delivery and outcomes measurements. We are now creating a toolkit of guidance and template resources to support commissioners and practitioners in other areas of the UK who wish to establish a service.

In addition to supporting parent-infant teams, we undertake policy and campaigning work to give babies and the services that work with them a clear and compelling voice that shapes the national and local agenda.

A FAMILY'S STORY



Overcoming the impact of depression

Jane developed severe postnatal depression following the birth of daughter and as a result suffered difficulty in bonding with her. Jane was referred to the LivPIP service, and the clinical psychologist from the service visited her and her baby weekly in her home.

According to Jane this was one of the best bits about the service, as she stated "when you suffer with depression it is difficult to find the motivation, energy and organisation to get to appointments. This is even more difficult with a small baby". Even more importantly the service also scheduled late sessions every other week to enable Jane's husband Tim to join in, emphasising that it was a problem facing the family together, and encouraging Tim to understand what Jane was going through and supported him to talk about things.

Using the Keys to Interactive Parenting (KIPS) approach and video feedback, the service videoed Jane playing with her daughter and then played it back to her to help her see the things she was doing well. Jane admitted "this was vital for me as I felt like I was failing and a bad mother because of my illness but LivPIP were able to give me confidence and help me to improve things further."

Jane has made huge advances since being with the service, and particularly appreciates that it is an open-ended longer-term service offering her an individual package of care that meets her needs. Having the time to review her own experiences, and do this together with her family has given her space to make the most of the service's input.

The Rare Jewels:

Parent-infant teams that currently exist in the UK

As part of this research we tried to identify all the parent-infant teams in the UK. Parent Infant Partnership UK already knew and worked with a number of teams, and we sent them an online survey to find out more about their work. We used our professional contacts to try and find more teams, including working with the Association of Child Psychotherapists to map the work their members were involved in. We also distributed an online survey to professionals via social media and through partner organisations, such as the Institute of Health Visiting and AIMH UK. In our Freedom of Information requests to CCGs in England, we asked if they commissioned parent-infant teams.

In our mapping exercise, we looked for teams that had the characteristics listed in section 4 of this report. To be defined as parent-infant teams, teams should ideally:

- Be multidisciplinary teams including clinical psychologists or child psychotherapists.
 - Offer direct parent-infant relationship support for families who need specialised help.
 - Offer families an individualised programme of support, based on an assessment of their needs.
 - Focus on the parent-infant relationship, rather than working with only the baby or parent.
 - Have a clear referral pathway for families based on concerns about the early relationship.
 - Accept referrals for families from conception or birth until (at least) the age of 2.
 - Work as experts and champions to support the local workforce.
8. We do not count specialist parent-infant practitioners within a perinatal mental health team as a Specialised Parent-Infant Relationship Team, as they only work with mums who have serious mental health problems.

It wasn't easy to map the provision that exists: As this report has described, the specialised parent-infant relationship teams that currently exist in the UK have different names and work in different ways. Furthermore, the services that do exist are also often very small and not often well known, so it can be difficult to understand what exists across the country.

Despite these challenges, this exercise represents the most exhaustive exploration of specialised parent-infant relationship teams in the UK to date and provides the most up to date snap shot of provision across the four nations.

We did find services doing valuable parent-infant work that were not parent-infant teams

Many professionals in the public, private and voluntary sector have developed a specialist expertise in infant mental health and offer interventions, including evidence-based programmes, to support parent-infant relationships. There were a number of services that came to our attention who were doing parent-infant work, which we did not classify as parent-infant teams. This was because they:

- Do not include qualified mental health professionals to offer more intensive specialist therapies (all parent-infant teams include a clinical psychologist and/or psychotherapist(s) alongside a number of other practitioners).
- Are not multidisciplinary teams, but are a small number of practitioners whose work might focus on parent-infant relationships and who are located

in a team with a wider remit such as within CAMHS or perinatal teams.

- Deliver a single intervention, rather than being able to offer families an individualised package of care based on an assessment of their needs.
- Were not set up and commissioned specifically to do parent-infant work (and perhaps therefore also do not collect data on parent-infant outcomes and/or do not have a referral pathway specifically for children under 2.)

And/or they

- Only work with a narrow group of families, perhaps defined by a characteristic such as perinatal mental health problems in the mother or being in the child protection system.¹²

Teams focussing on babies in the child protection system

Around the UK there are services that have been set up specifically and exclusively to promote and protect infant mental health in families involved in the care system, such as:

- Norfolk Parent Infant Mental Health Attachment Project (PIMHAP) a specialised parent-infant relationship teams with a specific focus on working with babies on the 'edge of care'.
- Anna Freud Early Years Parenting Unit, which offers assessment and therapy for parents with personality /complex early relational trauma with babies and children under the age of five who are subject to a Child in Need or Child Protection plan, or who are on the edge of care.
- The LIFT and GIFT teams in London and Glasgow (delivered by the NSPCC in collaboration with local NHS Trusts and Local Authorities) are offering the New Orleans Intervention Model for babies in foster care. This involves working with birth families and foster carers, in order to streamline decision-making about permanent placements for young children, minimising disruptions to attachment relationships and promoting infant mental health.

Our research identified a practitioner or practitioners within some CAMHS services, who had expertise in working with families with younger children and would offer consultation and/or pick up referrals for infant mental health work.

We found these services in the following areas:¹³

England

- Bath and North East Somerset
- Bedfordshire
- Bexley
- Birmingham
- Bristol and South Gloucestershire
- Buckinghamshire
- Coventry and Rugby
- Greenwich
- Kernow
- Southwark
- Walsall
- Wandsworth
- Wiltshire
- Worcestershire

Northern Ireland

- Southern Health and Care Trust

Scotland

- Dumfries and Galloway
- Greater Glasgow and Clyde
- Lothian
- Lanarkshire

When a clear definition of parent-infant teams and quality standards are agreed by the Parent Infant Network, Parent Infant Partnership UK are keen to work with these CAMHS services to support them to develop their local provision.

12. We do not count specialist parent-infant practitioners within a perinatal mental health team as a specialised parent-infant relationship team, as they only work with mums who have serious mental health problems.

13. This list contains all the CAMHS services we found out about that contained parent-infant specialists. There may, of course, be more.

We currently know about 27 Specialised Parent-Infant Relationship Teams around the UK:

1. ABCPiP, Ballygowan, Northern Ireland
2. Aneurin Bevan Health Board, Gwent, Wales
3. Anna Freud Centre PIP, Camden, London, England
4. BrightPIP, Brighton, England
5. Baby Infant Bonding Service, Halton and Warrington, England
6. Building Attachment and Bonds Service, Knowsley, England
7. CAMHS Infant Mental Health Team, Plymouth, England
8. Children and Parents Service, Manchester, Greater Manchester, England
9. Croydon Best Start PIP, London, England
10. DorPIP, Dorset, England
11. EPIP, Enfield, London, England
12. Gloucestershire Infant Mental Health Team England
13. Islington CAMHS Under 5s Team (incorporating Parent Baby Psychology), London, England
14. Lambeth Parent and Infant Relationship Service (PAIRS) London, England
15. Leeds Infant Mental Health Service, England
16. Little Minds Matter, Bradford, England
17. LivPIP, Liverpool, England
18. NewPIP, Newcastle, England
19. NorPIP, Northampton, England
20. OXPIP, Oxford, England



21. Perinatal Parent Infant Mental Health Service, Barking and Dagenham, Redbridge, Waltham Forest and Havering, London, England
22. Parent Infant Psychology Service (PIPs), Haringey, London, England
23. Stockport Infant Parent Service, Greater Manchester England
24. Surrey Parent Infant Mental Health Service, England
25. Tameside and Glossop Early Attachment Service, Greater Manchester, England

26. Tavistock Centre, Camden, London, England
27. Trafford Parent Infant Service, Greater Manchester, England

New services are starting this year in Bolton, Oldham, Rochdale, and Wigan (as a result of the expansion in Greater Manchester) and in Essex. Work has also begun on a service for Cumbria.

If there are parent-infant teams that are not on this list, we are keen to know about them so that we can invite them to join the Parent Infant Network.

Mind the Gap:

Gaps in provision across the UK

There are significant gaps in specialised parent-infant provision

Parent-infant teams bring important benefits to all babies in a local system and can radically transform the life chances of babies in families experiencing severe difficulties in their early relationships. Yet **the majority of babies in the UK live in an area where these teams do not exist.**

Section 7 of this report described a growing network of teams. There are currently 27 teams and even when the new teams come on line, there will be fewer than 35 parent-infant teams in the UK:

Yet there are nearly 200 CCGs in England,
15 in Scotland,
7 health boards in Wales,
and 6 health trusts
in Northern Ireland.



Furthermore, the services that do exist are often very small and don't have the capacity required to support all the vulnerable families in their locality, as these quotes from professionals suggest.

“ We have such limited capacity that we are not reaching the number and range of referrals... that you would expect. ”

“ With such limited staffing we are unable to provide an equitable service across the county. ”

“ Sometimes parents and their infants have to wait before they receive a service. ”

Quotes from professional survey

A recent report by the by Perinatal Mental Health Network in Scotland stated that “Outwith [perinatal mental health] teams, CAMHS rarely, if ever, had the capacity to manage children under one year. A small number of NHS boards had developed parent infant mental health services, often driven by enthusiastic and skilled individuals, but these services remain vulnerable and, in some cases, unsustainable.”^{xxxv}



NHS Commissioners are overlooking the needs of the youngest children

As part of the research for this project, we investigated whether CAMHS services are working with the youngest children. This was done through our online survey of professionals from across the UK and a Freedom of Information (FOI) request to Clinical Commissioning Groups (CCGs) in England. **The FOI research enabled us to look at whether the youngest children were able to access CAMHS and the number of children referred to and see by these services, but did not investigate the nature or quality of provision available to these children and their families (i.e. whether specialist parent-infant work was being offered by suitably trained staff).**

Methodology

We sent Freedom of Information Requests to all 195 CCGs in England, asking them:

- whether their CAMHS service takes referrals for children aged 0-12 months, 12-24 months and 24-26 months.
- how many children in each of these age groups had been referred to the service in 2017-18.
- how many children in each of these age groups had accessed the service in 2017-18.
- The overall numbers of children aged 0-18 who had been referred to and accessed their service.

160 CCGs responded to our request, although many of these did not provide a full and accurate response (we had some usable information for around 129 CCG areas, and full data for only 32). Many of the CCGs recommended that we contact their Mental Health Trust to get this information. Where we had accurate information for the Trust, and where there was still time available to make this request, we then sent an FOI to the Trust asking for the same information.

We sent FOI requests to 73 NHS Mental Health Trusts, of which 40 had replied at the time of analysis. The data below describes what we were told is available in CCG areas, based on compiling the total 200 responses we received from both CCGs and Mental Health Trusts.

We found that many CCGs do not know what mental health services they are commissioning for children under 2 or how many children are accessing services

Despite having the responsibility and funding to commission mental health services for all children from 0-18 (and beyond), many CCGs could not tell us if their mental health service took referrals for children under 2 or how many children were being seen by the service. For example, 75 CCGs told us that CAMHS in their area provided a service for children aged 2 and under, but only 20 of these CCGs had data disaggregated by age. A number gave us incorrect information, for example telling us that a service was on offer when the provider later clarified that younger children were not actually able to access their commissioned service.



Recommendation 1

Commissioning bodies (i.e. Clinical Commissioning Groups in England or alternative commissioning bodies, such as Integrated Care Systems and funders of services in the devolved nations) should commission mental health services that are appropriate for and accessible to ALL children who need them.

Commissioning bodies should be aware of what mental health services they are commissioning, and should collect and monitor data on the ages of children accessing services to ensure that the services they commission are appropriate for, and accessible to, all.

In nearly half of areas, CCGs do not commission any mental health services for young children.

Our research found that in 42% of CCG areas for which we have data, CCGs who are explicitly not commissioning CAMHS services for young children: CAMHS services in these areas are only offering a service for children over 3, or in some cases over 5.

CCGs are required and funded to provide mental health services to meet the needs of all children. (This is not the same as funding a single service to meet the needs of all children. A service for children under 5 should look different to that provided for school age children, as will a service for teenagers).

This is shocking, and should be a source of disgrace, just as it would be if CCGs were commissioning services that excluded children because of other characteristics, such as disability, race or sex.



Recommendation 2

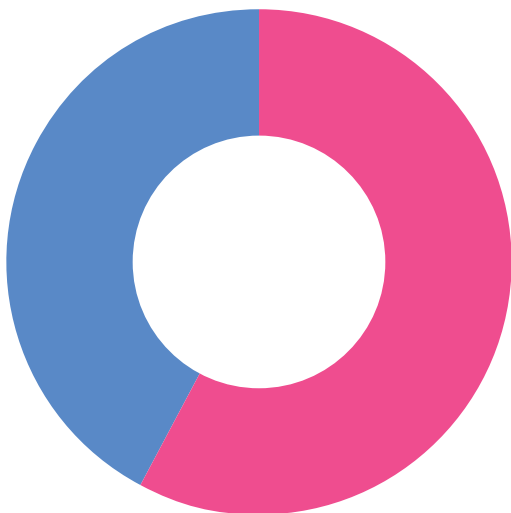
Local Commissioning bodies should be held to account by national governments for commissioning services that meet the needs of all children in their area, including the youngest children.

National governments and arms lengths bodies (e.g. NHS England) should ensure that their data reporting systems and processes enable and encourage local commissioners to report data disaggregated by age.

We received responses for 129 CCG areas about whether or not their CAMHS service would accept referrals for children aged 0-12 months, 12-24 months and 24-36 months. Of these:

58% said their CAMHS service **would** accept referrals for any children in these age groups.

42% said their CAMHS service **would not** accept referrals for any children in these age groups



Even when CAMHS services might on paper be open to younger children, these children are often not accessing the service

The data we collected, showed that in 36% of areas where CAMHS were reported to accept referrals for young children and could provide data broken down by age, NO children aged 2 or under were accessing the service.

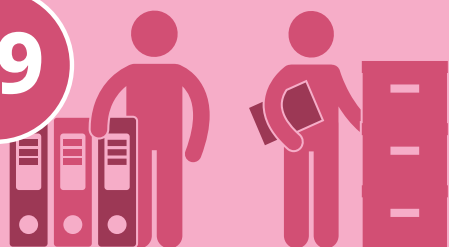


We found **75 CCG areas** where CAMHS said they accepted referrals for children aged 2 and under.

75



39



Of these, we could only get **referral and access data** disaggregated by age for **39 areas**.^{14,15}



Only 33 of these areas actually had any referrals for children aged 2 and under in the last year.

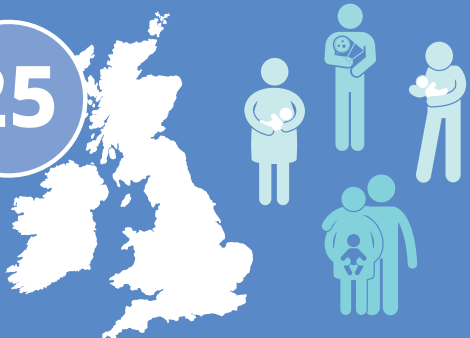
8 of this 33 only received referrals for between 1 and 5 children aged 2 and under (they received, on average over 2500 referrals for all children aged 0-18).

6 received no referrals for children aged 2 and under at all.

33



25



Only 25 of the 39 areas providing data actually had any children aged 2 and under accessing their services.

10 of this 25 only saw between 1 and 5 children aged 2 and under. In 14 areas, no children aged 2 and under accessed CAMHS.

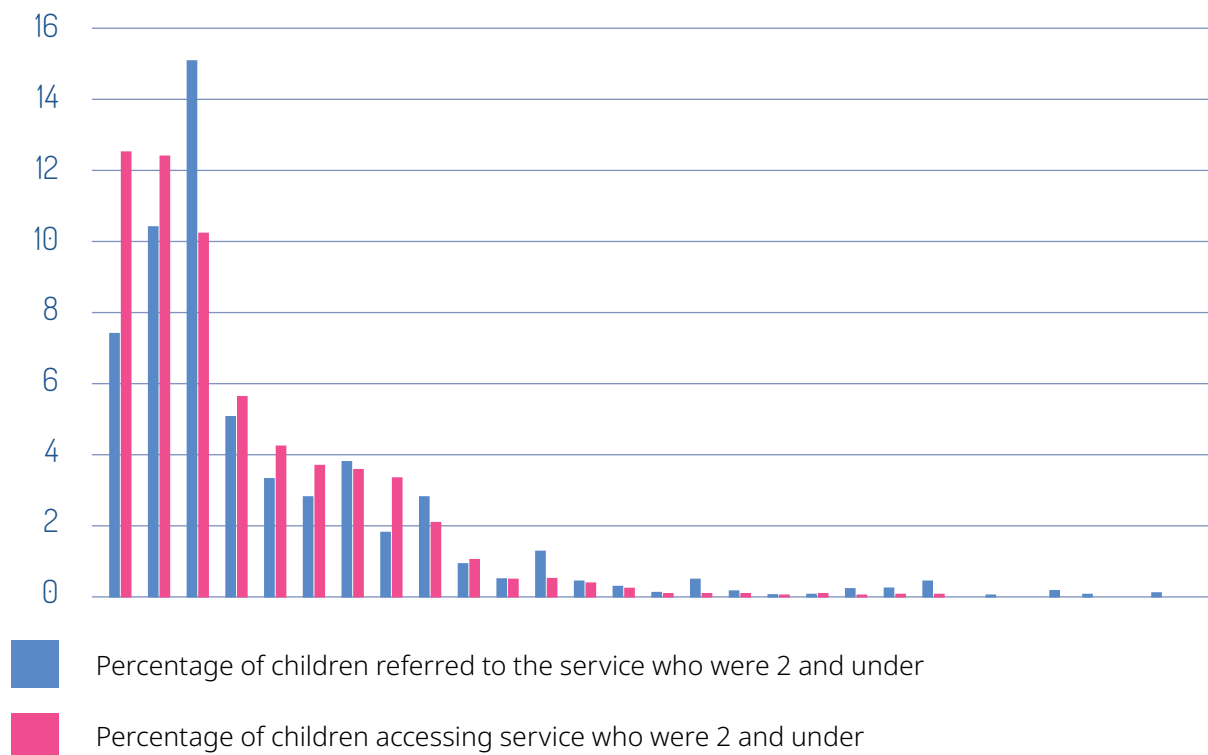
There were notable exceptions to this; in three areas (Islington, Manchester and City & Hackney), more than 100 children aged 2 and under accessed services in the last year.

14. This came from the CCG in 20 cases, and from the Mental Health Trust in a further 19. All of the CCGs replied to us, so only 20/75 actually had this data. Therefore 55/75 were not able to provide this information. Some of the Mental Health Trusts may not have been contacted, or may not have responded within our timescale. Therefore, the number of MHTs providing data is an indication of how many responded to our request rather than the number who had the data available.

15. We asked CCGs and MHTs to report on the number of children referred to CAMHS and the number of children who accessed the service. One flaw in our methodology was that we didn't define access.



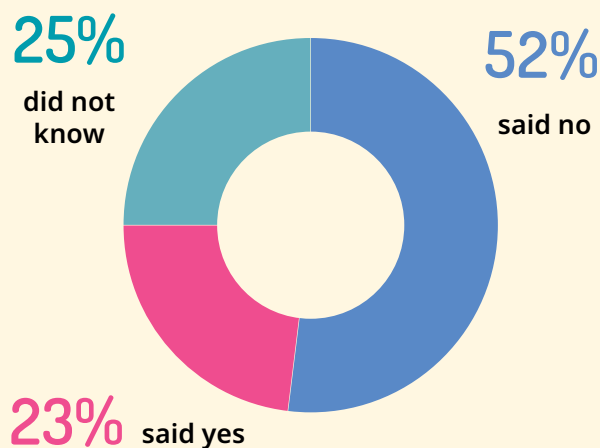
Proportion of children referred to and accessing CAMHS services who were aged 2 and under, by CCG area



This chart shows data for the 32 CCG areas where we received data on both referrals and access for children aged 2 and under, and for all children aged 0-18. It shows, for each CCG area, the children aged 2 and under who were referred to and accessing CAMHS services, as proportion of all children aged 0-18. Readers should be aware that children aged 2 and under make up around 16% of the population of under 18s.^{xxxvi}

The data we received fits with what little is known about access to mental health services nationally. The 2017-2018 Mental Health Bulletin Annual Report^{xxxvii} showed 4.4% of children who had a first contact, and 3.7% of those aged 0-18 who had a second contact with NHS funded secondary mental health and learning disability services were aged 0-5.¹⁶ 0-5-year olds make up 31.6% of the 0-18 population.

In our online survey for professionals, 191 professionals working with children across the UK answered the question "Does the CAMHS in your area take referrals for children aged 2 or under?"



16. NHS Digital do advise that "figures are potentially unreliable and should be used with caution."

Babies' needs are not understood and prioritised

There are many reasons why the youngest children may not be accessing services.



Babies' needs are not identified

Young children who are experiencing distress and poor emotional wellbeing may not be identified, perhaps because professionals do not

have the training to understand babies' cues and risks in the early relationship. Babies express their distress in a variety of ways, sometimes these are wrongly interpreted as 'just behaviour' or individual differences. There are reliable methods of noticing and assessing troubled relationships between parents and their babies which can be used by trained professionals. This training need not be expensive, especially where a local parent-infant team have the capacity to deliver training to local colleagues.

It can be hard for professionals without sufficient training to understand the subtle differences between a thriving infant and one whose behaviour and cues are showing us that they are experiencing difficult relationships and distress. It is not uncommon for adults to only take note of a child's behaviour once they enter nursery or even school, by which time damage may already have occurred and important opportunities for early intervention have been missed.

Specialised parent-infant relationship teams tell us that they see an increase in referrals after delivering training in infant mental health to local professionals. This training helps professionals to understand and articulate when they see babies who need help because of challenges to their early relationships.

“ Despite being advertised as a 0-19 service, CAMHS here don't really consider any under 5's referrals, saying that these are 'just behaviour'. ”

“ I don't think our team...have the specialist knowledge to be able to identify potential infant mental health red flags. ”

“ There's just no awareness, no conversation no services. ”

Quotes from professionals' survey



Babies' needs are not recognised

CAMHS services might require service users to meet certain thresholds, such as having a diagnosis or getting a particular score in a clinical measure to

access a service. This can exclude babies whose mental health needs must be understood in a different way (including through understanding the parent-infant relationship).

“ In theory we do accept referrals from 0 years. However, as you can see from the figures it is very rare, we get referrals from this age. If the child is such a young age, it is usually a consultation offer to the parents/carers. However, it is extremely uncommon that a very young child would present with mental health difficulties requiring a specialist mental health service. ”

Comment made on an FOI response

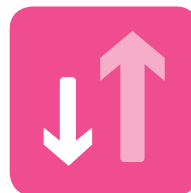
“ The local CAMHS requires a certain score on SDQ [Strengths and Difficulties Questionnaire] to access them... as the SDQ is age 2+ this automatically excludes children under 2 years. ”

Comment made in professional survey



Babies' needs are not supported

Some CAMHS services do not have adequate skills and expertise to meet the needs of babies and therefore referrals may be discouraged or refused.



Babies' needs are not prioritised

CAMHS Services, which we know are very stretched, may be under pressure to prioritise cases which are perceived to be more urgent, such as older children who are

exhibiting disruptive or harmful behaviour. However, missed opportunities to step in when there are problems in a babies' early relationships can have a pervasive impact on child development, which may manifest later as problems in language development, behaviour and mental health. These are the very problems that are causing CAMHS to be stretched.

“ I kind of get it, but I don't think...not everybody does, you know ...it's how do you persuade people... when you've got teenagers kicking off and the level of knife crime and all of those things that are competing, it's a difficult one to argue, you know, because those little babies aren't...they're not causing that problem. ”

Commissioner Croydon

The lack of provision for early relationships can have a huge impact on families and leads to increased demand for services as children get older, as the quote below illustrates:

“ There is a whole cohort of women who we come across who struggle with transition to motherhood and have come from poor parenting experiences themselves. They may also be experiencing some mental health problems, substance misuse and some safeguarding concerns and may fall between the gaps as they frequently don't meet criteria for what are considered to be a specialist service (either perinatal or CMHT's). Consequently, it may be years later when the children are identified as showing difficulties with their own mental health. This was a pattern I saw when I worked in the CAMHS team. Children were being referred in with difficulties in regulating their emotions, were unable to concentrate in school, were having difficulties in developing and sustaining relationships and in most cases when assessed, adverse childhood experiences were detected, including the mental health of the child's parents. Consequently, some of these families may bounce between services and their needs may escalate before they can access a service that meets their needs. It is also more cost effective financially and emotionally to offer a service at a much earlier stage. ”

Comment made in professional survey

Undoubtedly gaps in services are felt more intensely because of the significant cuts to other services for families in the early years, such as health visiting and children's centres – which means families have few other places to turn.

“ ...It can be so difficult having to tell parents there is no service that will support them, and as health visitors we are often the only service supporting but even that is becoming more difficult...” Quote from professional services. ”

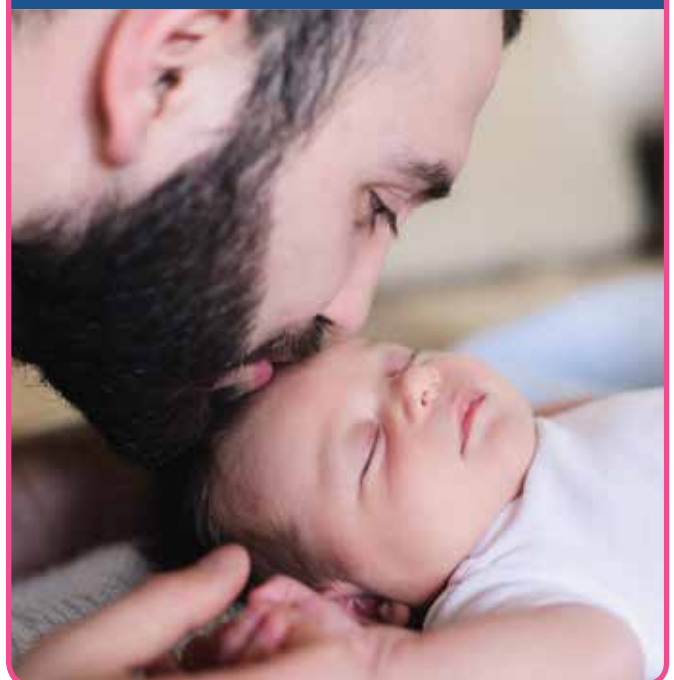
Comment made in professional survey



Recommendation 3

Commissioning bodies in all areas of the UK should fund specialised parent-infant relationship teams in order to:

- Improve professionals' understanding of relationships and child development, so that they can identify and intervene when babies' emotional wellbeing is at risk.
- Provide a mental health service that is able to meet the needs of the youngest children, and can act early when problems are identified, providing interventions to address parent-infant relationship problems.
- Be the 'champions' of babies, in a system where their voices are seldom heard.
- Provide a protected space where babies will be prioritised, and do not have to compete for a service with children whose needs may be perceived as more urgent.



Closing the Gaps:

Commissioning parent-infant teams

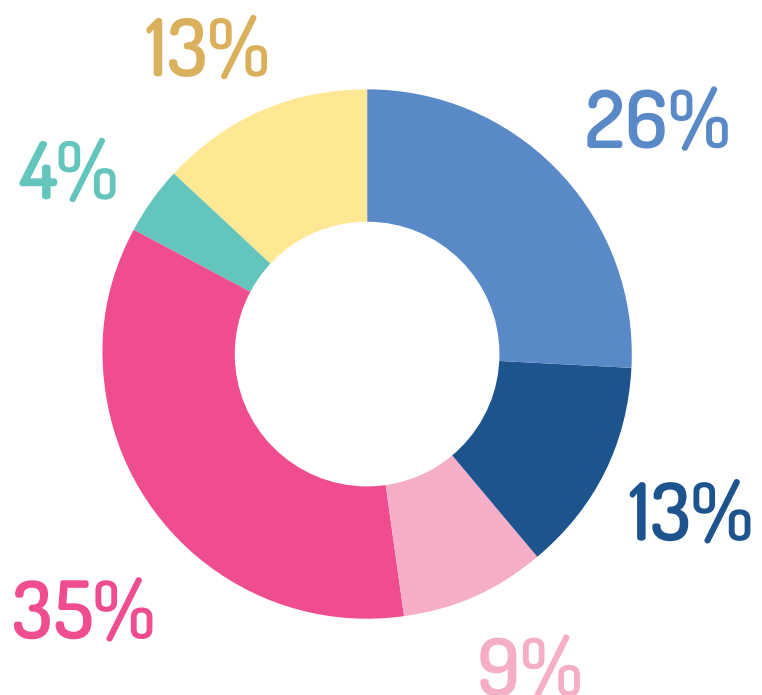
A growing number of commissioners are recognising the value of parent-infant teams

The case for investing in parent-infant teams is clear and more decision makers around the UK are now recognising this. Some of the parent-infant teams in the UK, such as the Anna Freud Centre and OXPIP have been around for over 20 years. We are excited to see that new services have been, or are in the process of being established in a number of places including Ballygowan, Essex, Gwent, Kernow, Halton, Wigan and Greater Manchester.

The funding and drive to establish the existing parent-infant teams has come from many different places – the voluntary sector, early years or child protection teams or public health within Local Authorities, and/or maternity, adult mental health and children and adolescent mental health budgets within CCGs (and their equivalents in the devolved nations). In our survey of parent-infant teams, 21 services told us where they got their core funding from. Their answers are shown below:

Where does the core funding for your service come from?

- CCG mental health budget
- Local authority children's services budget
- Local authority public health budget
- Voluntary sector organisation/fundraising
- Partnership between local authority public health and third sector
- Partnership between local authority and CCG



The three case studies below, developed through interviews with commissioners in England, illustrate different ways that parent-infant teams have developed. They illustrate common themes around the importance of:

- Local leaders having a good understanding of the first 1001 days and why early relationships matter, and driving change.
- Strategic commitment to giving children the best start in life, and a whole-system approach to achieving this goal.
- Partnership working between commissioners and between services.
- Flexibility, persistence and seizing opportunities to grow and develop services.

LEEDS: A story of Strategic Partnerships

The Leeds Infant Mental Health Service is a city-wide service made up of clinical psychologist, health visitors and infant mental health practitioners. They offer a range of interventions to support approximately around 130 local families each year, including parent infant psychotherapy, video feedback, Circle of Security, Watch Wait and Wonder, and the Brazelton Newborn Behavioural Observation. The service also trains a wide range of local professionals, including health visitors, midwives, the third sector, adult mental health professionals and those in the family justice system, and offers consultation and reflective supervision to teams and practitioners across the city.

The roots of the service came from work done in Sure Start and Health Visiting services to promote infant mental health. Seeing the value of this work, commissioners worked to make infant mental health part of CAMHS service specification to ensure a clear, consistent offer across the city. The Children and Maternity CCG Commissioner in Leeds (a health visitor by background), is clearly passionate and informed about infant mental health and has driven forward this agenda

The service is funded by Local Authority Public Health Budget and the CCG Children and Young People's Mental Health CAMHS budget. Originally, when health visitor numbers were growing under the Coalition Government, this provided an opportunity to create new health visiting positions in the team. As the commissioner explained,

“ So, that’s how we gradually grew it... and then... commissioning of certain universal services, like health-visiting, split off into, first, NHS England, and then over to Public Health in the Local Authorities, whereas the mental health service remained commissioned by the CCG... But we were determined to maintain our Infant Mental Health Service, so we do that through a joint commissioning arrangement now, so that’s kind of where we’re at now, because we had strong relationships anyway – despite the splitting of policy, we’ve kept it [together]. ”

Cuts to public health have made their funding of the service more difficult, but there is still buy-in to the service and CCG investment is growing and looking at increasing the reach of the service to support three and four-year-old children. The Health and Wellbeing Strategy in Leeds has giving children the best start in life as a key priority, and there is clear strategic leadership for the early years in the city, as well as good partnership working between organisations to deliver this.

“ So, yeah, it’s a combination of resource, yes, kind of strategic connections, partnership, and then seeing opportunities to join it up, and incrementally growing because you can’t get it all in one go – you have to just commit and keep going and expanding, and you won’t anticipate everything that can be delivered at the beginning. ”

TAMESIDE: The Power of Passionate Professionals

Tameside and Glossop Early Attachment Service is a multi-disciplinary team offering a wide range of interventions to parents, as well as training and supervision to other professionals. It was established in 2006. A whole system approach to parent and infant mental health has been implemented in Tameside and Glossop, including an infant mental health pathway based on the Thrive model^{xxxviii}.

The parent-infant team are key to this. The commissioner we spoke to described how Parent-infant mental health has been a priority in Tameside for many years now. This is a result of the work of particularly knowledgeable and passionate professionals who have championed the issue at all levels.

So, parent/infant mental health has been a high priority for us for many years now. ... It was very much driven by [name], who's a clinical psychologist, who was really keen to start thinking about infant mental health. We also had a nurse, who was a health visitor and also on our board at the time, and the two of them worked really hard together to develop a strategy. That's sort of the starting point.... It came from [name], her learning and knowledge and understanding, and her influencing the rest of us into recognising that it was a really important area and something that we should be focusing on...

The service is funded by Public Health and the CCG, with a social worker post funded by children's services. The commissioner told us a bit about this:

...The reason it comes from Public Health is that when the PCTs were disbanded and pots of funding were given over to Public Health, we'd identified the parent/infant service as a mental health promotion service and that's why the funding went across. It's not something that I would anticipate all Public Health services to be able to fund, although it sits very firmly in Public Health.

Tameside and Glossop is now part of the Greater Manchester Combined Authority, which has a priority that all children start school "ready to learn". To deliver this, the authority is working to integrated services for children and families from birth to when they start school. Greater Manchester Health and Social Care Partnership have identified parent and infant mental health as a key transformation priority and are looking at the work of the whole system including parent-infant teams, perinatal mental health services and IAPT services for parents of babies. Manchester have prioritised both perinatal and infant mental health, using new funding from NHS England and investing additional funds in each of the 10 boroughs. This has provided an opportunity to roll out the Early Attachment Service to other boroughs, which the Tameside and Glossop team are supporting.

CROYDON: A Whole System Approach to giving babies the Best Start

Croydon Best Start PIP team is commissioned by the Local Authority. It is managed by a voluntary sector organisation, Croydon Drop-In, and was supported by practical support and initial funding from Parent Infant Partnership UK. The service is made up of psychotherapists and key workers. Alongside individual parent-infant psychotherapy and key-working, they offer Mellow Parenting Groups to local parents.

The team is part of Croydon Best Start, a local initiative to fully combine health and Local Authorities services for children from pregnancy to five. Launched In 2016, Croydon Best Start brings together midwifery, health visiting, services for

children and families provided by Croydon Council and the voluntary sector.

The Best Start PIP service was created as part of a wider review of early services in Croydon "Because around... three and a half years ago, we were looking at developing, in Croydon, the Best Start integrated offer for children and their families, very young children and their families, so developing a whole integrated system to enable families to access services right the way through from universal all the way through to intensive support." The team is seen as part of the local offer to overcome adverse child experiencing and to support nurturing relationships in order to give all children the Best Start.

We believe there should be partnership working with clear accountability

The complexity of families' lives, and the services that work for them, requires an integrated approach to defining and meeting the needs of all families in a local area, with partnership working in both commissioning and service delivery.

As this report has already recognised, parent-infant teams play a hugely valuable role, but they can't exist in isolation. They have to be embedded into a wider system with clear care pathways, where professionals in universal and targeted services can support families with lower levels of need and identify and refer families who need additional help at the earliest opportunity.

NICE Guidance states, local partners should “ensure arrangements are in place for integrated commissioning of universal and targeted services for children aged under 5... The aim is to ensure... targeted, evidence based and structured interventions are available to help vulnerable children and their families... [and] children and families with multiple needs have access to Specialised Teams including child safeguarding and mental health services.”^{xxxix}

It is clear that many partners need to work together to give children the best start in life, both tackling adversity and supporting early relationships. The current fragmentation of policy, commissioning and service delivery makes this difficult, and we welcome any efforts by government to support and incentivise integration and a local level.



Recommendation 4

Every government in the UK should have a clear and ambitious cross-government strategy to give every child the best start in life, setting out clear outcomes for children and a plan to improve services for children, parents and families during the first 1001 days of life. Protecting and promoting parent-infant relationships should be a core part of this strategy.

National governments should encourage and incentivise local partners across health, children's services and the voluntary and community sector to work together to develop and deliver local strategies to give all babies in their area the best start in life and to deliver local goals.

Partnership working also enables the alignment or pooling of budgets, which is particularly relevant for specialised parent-infant relationship teams. Ideally these teams should be jointly funded by CAMHS (recognising their role in supporting the mental health of the youngest children), by Local Authority Children's Services (recognising their role in supporting development in the early years, and in tackling problems in parenting and family functioning that might otherwise lead families in the child protection system), and by Local Authorities Public Health budgets (recognising their role in child health and mental health promotion). Such pooling of resources enables the development of a strong, sustainable team that can work with professionals across the system to ensure babies are safe, healthy and developing well.

However, something that is everybody's business, can also end up being no-one's responsibility. So, alongside partnership working, there also needs to be clear accountability. At the moment, there is confusion about where responsibility for commissioning parent-infant relationship services should sit, as these quotes from commissioners illustrate.

“ The issue would be that there is a weakness in the designated responsibility for working preventatively. ”

Policy Maker, Northern Ireland

“ And there is a question about where... who the commissioners should be for this programme, and I know, in different places, it's different... So, is it local authority, is it CCG, what's the expectation? ”

Commissioner, Croydon

We agree with the recommendation in the Future in Mind report, that there should be a lead accountable commissioning body for all children's mental health services (including those for infants).^{xi}



Recommendation 5

National governments must ensure that accountability for parent-infant relationship service provision is clear at a national and local level. At local level there must be a lead accountable commissioning body for all children's mental health services. This should include commissioning specialised parent-infant relationship teams for children from conception to age 2.

It may be helpful for governments and others in the sector to stop talking about Children and Adolescent or Children and Young People's Mental Health Services, and instead to talk about Infant, Children and Young People's Mental Health services, to emphasise that these services should meet the differing needs of children of all ages.

There are a number of challenges that affect commissioning of parent-infant teams

Our interviews with commissioners highlighted four more reasons why it can be challenging to commission specialist provision (alongside the issues of accountability).

Resources are very limited and there is no clear funding for parent-infant services

“ So, it's all very well saying the funding is in the CCG baseline, but they say that about all sorts of things. If it's not identifiable, it's hard for CCGs to prioritise it against everything else. ”

CCG Commissioner, Thameside

“ So, there's lots of rhetoric in the policy about the importance of prevention and the importance of children ... but then it doesn't seem to materialise into actual practice because, if you think about what's happening with Local Authorities budgets and the Public Health budget, particularly, in terms of the prevention agenda, it's very hard to marry up the two things. ”

CCG Commissioner, Leeds

Late intervention gets priority.

Services prioritise the needs of older children who are experiencing problems that are easier to identify and seem more pressing, rather than investing in prevention and early intervention.

“ So, the... the issue would be it's about finite resource. Within the context of an already stretched child and adolescent mental health budget, we have... there are pressures, and of course, many of those pressures come from the... you know, we're seeing increased, autism assessment and diagnosed levels of ADHD [and] autism – I think it's doubled in the past 10 years in Northern Ireland. We are seeing a lot of self-harm among our adolescent population. We are seeing increasing demand for in-stay mental health care. So, there's a lot of crisis, people being seen at a crisis level, and of course the... the definition of receiving support for child and adolescent mental health services is... is that the child will have diagnosable... diagnosed mental illness. So, the challenge is that, while our CAMHS service describes itself as being a nought to 18 service, largely, the focus, understandably, will be

on children who begin to really begin to manifest very deep problems associated with their mental illness, particularly in adolescence. ””

Policy Maker, Northern Ireland

”” I suppose it’s just the challenge around actually...how do you meet the needs of all families...in today’s context, you know, with the pressures, for Local Authorities in relation to, their statutory duties, and this is a... fantastic, early-help intervention, and early on in [the life of] the child, which is absolutely the right thing, but it’s just... that pressure, that you just see all the time, you know. And we’re particularly, in London, have that, have the issue, which is very high up on everybody’s minds, around the knife crime and the youth violence that’s happening... So, I suppose, going back to what the Government could do, it’s that balance, isn’t it, and how do the two things come together? ””

Commissioner Croydon



Recommendation 6

Whilst we recognise the challenges associated with ringfenced budgets, without some protection funding for early intervention is always vulnerable to being drawn to other challenges that are perceived to be more urgent.

Therefore, **national governments** should provide a ringfenced transformation budget to support local investment in the first 1001 days (just as the Westminster Government did to address disparities in provision of perinatal mental health services in England).

This funding should be sufficient to fund the establishment of local specialised parent-infant relationship teams to meet the needs of the population in each area.

There are gaps in the evidence about what works

There is a lack of evidence about what works to improve early relationships and about the impact of parent-infant teams, and how this contributes to the outcomes that commissioners and policy makers are concerned about (such as school readiness, entry into care, or later mental health). However, it is important to note that this challenge is not unique to parent-infant relationship services.

”” We need more evidence, frankly. ””

Policy maker, Northern Ireland



Recommendation 7

National governments should provide increased funding for bodies such as the National Institute for Health Research to fund primary research and build the evidence-base in parent-infant relationship intervention.

National governments should also provide increased funding for What Works Centres like the Early Intervention Foundation and NICE to synthesise the evidence base for the first 1001 days and to support commissioners to make decisions using the existing evidence and research base (including commissioning interventions which are based in research but yet to establish robust evidence of their impact). This should include providing guidance for commissioners about what outcomes measures they might require from services working with families in the first 1001 days.

National governments and local commissioning bodies must not use gaps in the evidence base as an excuse of inaction.

Commissioners still do not realise the importance of early relationships and their impact on wider health and social outcomes

“I’ve had to battle really, really hard to get parent/infant mental health recognised... So, I think it’s a big education issue. I know, myself, I didn’t know anything about it, didn’t have a clue, and I’ve learnt over the years and, you know... So, I think, eh, it isn’t commissioned because there’s a lack of knowledge. I think the national profile has been quite high around perinatal mental health, with the rollout of the national programme, and now, in the long-term plan... but it’s very perinatal-focused and it isn’t broad enough...”

“I think we need a really good summary of the evidence. ... we need to be influencing a whole range of people that this is really important and these are the reasons why, and this is what the outcomes are going to be because of it. ... So, I think we need to be spoon-feeding, if that’s the right word, commissioners and clinical leads with the

evidence to make the case, [that it needs] to be this whole system change. We need to be influencing maternity services, Public Health, health-visiting circles, constantly still coming back to that. ... You kind of double the bang for your buck, if you like, by investing in this area, and there’s, I believe, a strong correlation between young people presenting with depression with teenage years and perinatal mental health, perinatal...post-natal depression. So, really, it’s an area we should all be focusing on. So, I think the case needs to be made for NHS investment but also Public Health investment.”

Commissioner Thameside



Recommendation 8

All relevant government departments and public bodies, in partnership with other organisations in the sector, must do more to raise awareness of the importance of parent-infant relationships for healthy brain development.



Central Leadership:

How government policy supports action

ENGLAND: Rhetoric without reality

Despite plenty of rhetoric about the importance of prevention and early intervention in recent years^{xli}, the current UK Government does not have a strategic approach to giving children the best start in life, as recently recognised by three select committees. Leadership, commissioning and service delivery for young children are fragmented at both a national and local level, with differences in how (and how much) services are funded and the outcomes they are working towards. There is no clear accountability for commissioning services for the first 1000 days, nor any effective oversight mechanisms for Government to monitor what is happening at a local level and take action if services are not being delivered.

Recently the Government has tended to focus on intervening later in childhood. The Government's approaches to children's mental health, obesity and even early childcare care focus more on intervening after age 2 than earlier in the crucial first 1000 days... Where Government and public services do intervene in the early years, we have found that it has done so in a fragmented way, without any overarching strategic framework and with little join-up...

Health Select Committee 1000 Days Inquiry

From April 2013, CCGs were expected to commission tier 1-3 CAMHS services in tandem with other agencies where appropriate, but as Future in Mind recognised, commissioning arrangements are complex and there is "a lack of clear leadership and accountability arrangement for children's mental health across agencies including CCG and Local Authorities, with the potential for children and young people to fall through the net."^{xliii}

Public health commissioning moved to Local Authorities in 2013, with commissioning of the Healthy Child Programme following from 2015. The goal of this transition was to enable better integration of public health with other local policies. However, the ability of Local Authorities to deliver on this has been significantly impeded by an enormous fall in public health budgets, which fell by £85million in this year alone^{xliii}. The NHS Long Term Plan^{xliv} suggested these commissioning arrangements might soon change again, as the Government and NHS are considering whether there should be a stronger role for the NHS in commissioning services like health visiting.

Whilst this Government has had a focus on mental health, and has invested significantly in some areas of mental health provision, there remains a gap in policy around the early years. The NHS Long Term Plan contained new ambitions for perinatal mental health services for women with the most severe mental illness (building on existing investment and including parent-infant work for these women and their babies), and contained new developments for school age children, building on the Children and Young People's Green Mental Health Green paper. But there was a clear gap around provision for pre-school age children, and for babies whose mothers do not meet thresholds for specialist perinatal mental health services. However the plan did contain the statement that **"Over the coming decade the goal is to ensure that 100% of children and young people who need specialist care can access it."**^{xlv}

Delivering on this goal would require the NHS to ensure that 100% of children under 2 who need specialist care could access it – which would mean providing specialised parent-infant relationship teams.

We expect more developments in policy for the first 1001 days in the coming months, in the form of the Prevention Green Paper from Department of Health and Social Care and the outputs of the Inter-Ministerial Group on Family Support from Conception to Age 2, both of which should influence Spending Review later this year.

The first parent-infant team in Wales recently started work in the Aneurin Bevan Health Board in South Wales, and has funding for one year in the first instance. The service includes child psychotherapists working within the Flying Start service, offering direct work with families, supervision, consultation and training to the wider workforce.

Recommendation 9



In England, the Department of Health and Social Care and NHS England should clarify how they will deliver on the goal of ensuring 100% of children – including children under 2 - being able to access specialist mental health care in the coming decade. This must include setting out who is accountable at a national and local level for delivering this goal, how it will be funded and implemented, and how progress will be measured.

NHS England should set out service specifications to enable local commissioners to understand what is required to provide specialist mental health care for children aged 2 and under. We believe that these service specifications should be developed in partnership with Parent Infant Network.¹⁷

Recommendation: 10



The Welsh Government and Public Health Wales should commit to learning from the trial of the new parent-infant team, and using this to inform roll out of specialised parent-infant relationship teams across Wales.

WALES: Green Shoots?

The Welsh Government's programme for Government 2016-2021, Prosperity for All^{xlvi}, includes a cross-cutting priority for all children to have the best start in life, recognising the importance of the first 1000 days. There is increasing recognition of the importance of infant mental health in Wales.

Public Health Wales are leading work with a group of stakeholders to make the case for infant mental health. They plan to make infant mental health a central part of the First 1000 Days framework which will be published later this year.

SCOTLAND: A Promise to Deliver

The Scottish Government has an aspiration to make Scotland the 'best place to grow up', and has a strong focus on reducing inequalities in outcomes. There is a strong and consistent focus on early years, prevention and early intervention in Scottish government policy.

The Scottish Getting it Right for Every Child policy (GIRFEC) is the national approach to improving children's wellbeing, it aims to provide a common framework and language for all those working with children, to ensure that a range of needs are met. The Early Years Framework^{xlvii}, developed in 2008, sets out the importance of early intervention, particularly in the early years and set out an ambition to give all young children in Scotland the best start in life. This has been followed by a range of policy developments to support the first 1001 days, such as national roll-out of Family Nurse Partnership and the introduction of the Best Start grant for low-income families.

In 2017, the Perinatal Mental Health Network for Scotland, a national managed clinical network was established. The network has undertaken a range of work including undertaking needs assessment, making service recommendations and launching a curricular framework for maternal and infant mental health. In 2018, a Children and Young People's Mental Health Taskforce in Scotland was set up in 2018 to improve mental health services for children and young people.

17. The network of existing specialised parent-infant relationship teams coordinated by Parent Infant Partnership UK.

The Scottish Government's Programme for Government, published in September 2018 set out commitments around increased investment for perinatal and infant mental health and the delivery of infant mental health services. This was followed by the Mental Health: Programme for Government Delivery Plan. Which stated that:

We will ensure there is sufficient investment in service provision for equitable access to perinatal counselling services, perinatal and infant mental health promotion, and preparation for parenthood for those who need it, including in the third sector. All mental health staff should have the knowledge and skills necessary to promote good maternal and infant mental health, and recognise and manage, to their level of competency, mental distress and disorder.

All infants, and their parents, who have significant disruption of the parent-infant relationship or impaired infant development, should have access to specialist infant mental health services, wherever they live in Scotland. From the start of next year onwards, the Children and Young People's Mental Health Taskforce's specialist and at risk workstreams will work closely with the Government, Local Authorities and other partners on the implementation of this commitment.^{xlviii}

As yet, there has been no detail on how this commitment on specialist infant mental health services will be delivered. In delivering this ambition, it will be important that the Children and Young People's Mental Health Taskforce works with both the Perinatal and Infant Mental Health Programme Board and the Perinatal Mental Health Network for Scotland.

Recommendation 11

The **Scottish Government** should set out how it will deliver on its goal of ensuring access to specialist infant mental health service services, including specifying who is accountable at a national and local level for progress towards this goal, and how it will be funded and delivered.

NORTHERN IRELAND: Baby Steps

In Northern Ireland, work to promote infant mental health is being led by the Public Health Agency. In 2016, the Public Health Agency developed an Infant Mental Health Strategic Framework.

The document was prompted by a desire to reduce health inequalities by giving children the best start in life, and informed by conversations with a range of international experts, it "represents a commitment by the Public Health Agency, Health and Social Care Board and Trusts, as well as academic, research, voluntary and community organisations across Northern Ireland, to improve interventions from the ante-natal period through to children aged three years old."^{xlix}

The Framework aims to ensure that commissioners and policy makers are fully informed of the latest evidence and interventions and are supported to make the most appropriate decisions based on this knowledge. It also aims to improve the skills of practitioners across a wide range of health, social care and education disciplines to support parents and children aged 0-3 in the development of positive infant mental health, and encourages service development "to ensure the optimum use of evidence based interventions with families with children aged 0-3 where there are significant developmental risks."

As a result of the framework there has been workforce development in Northern Ireland. Two new parent-infant relationships services have been developed, the icamhs service, which is expertise within CAMHS in the Southern Health Trust, and the ABC PIP team in Ballygowan. The Public Health Agency told us that they hope that more parent-infant teams will be introduced over time.

Recommendation 12

The **Public Health Agency in Northern Ireland** should work with Health Boards to share learning from the ABCPIP service and encourage and support the development of more parent-infant teams in Northern Ireland. The Northern Ireland Assembly should support this work when it is restored to power.

Conclusion

This report describes how parent-infant teams enable local systems to offer effective, high-quality early intervention. These teams empower professionals, turn families' lives around, and they put babies on a positive developmental trajectory, better able to take advantage of the opportunities that lie ahead.

The report also describes how currently many areas lack these parent-infant teams and a significant number provide no NHS mental health support for children aged 2 and under and their families. These gaps in provision are putting children's health, wellbeing and happiness at stake, not only during infancy but across their entire lives.

It is wonderful that an increasing number of policy makers and commissioners are recognising the value of parent-infant teams, and committing to their development. In the next 10 years – by 2030 – we would like to see these teams available across the UK, able to support all families who need them. We hope this report can inform the conversations and actions required to achieve this goal, and we hope that national and local governments across the UK join us in adopting this goal and taking action required to deliver it.

Governments across the UK have made commitments to improve early intervention, to improve children's mental health and to close inequalities in outcomes. Governments now need to provide the focused and determined leadership, the clarity and the action required to translate this into a reality and to give every baby the best start in life.



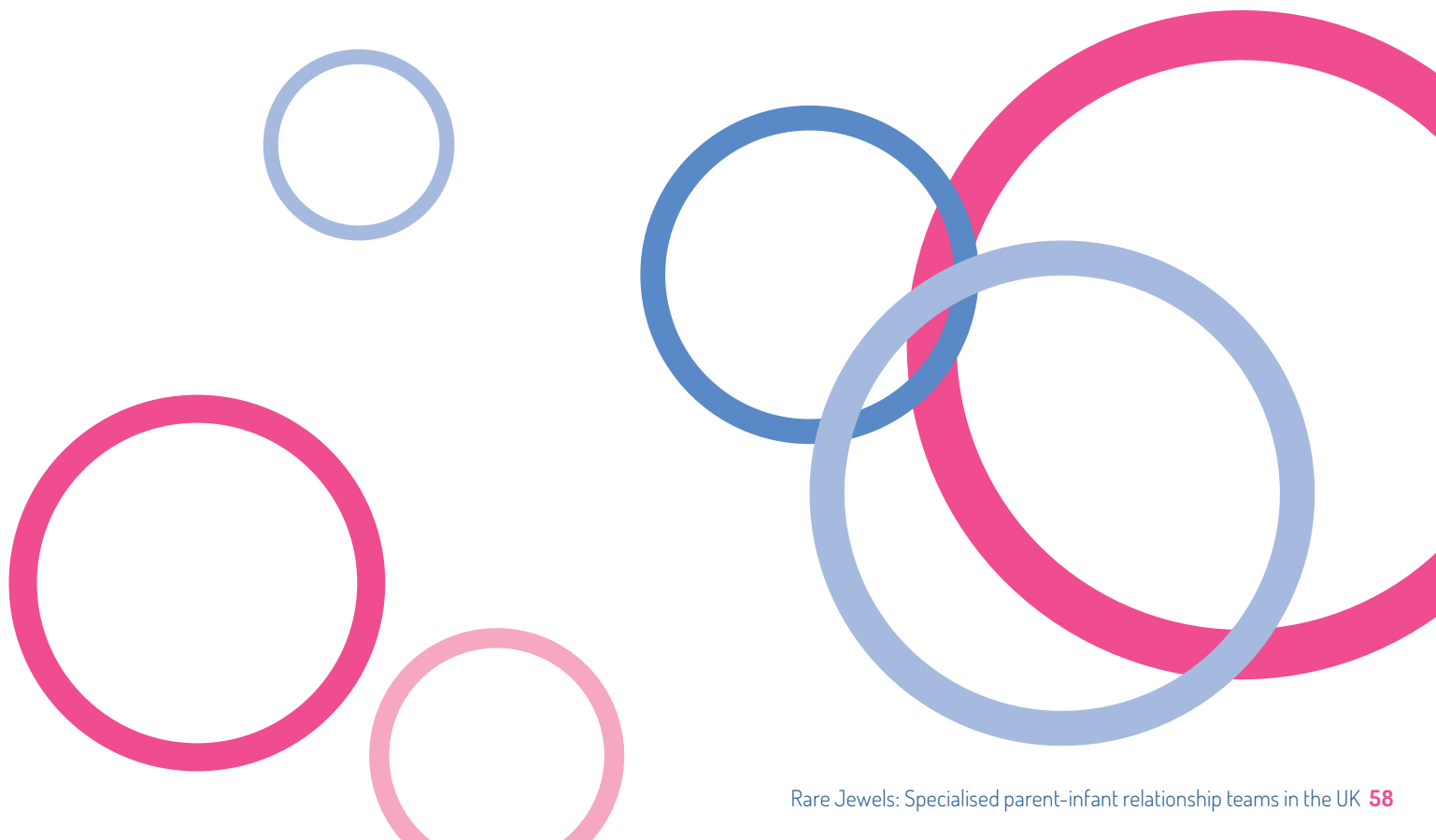
References and notes

- i. Center on the Developing Child (2010). *The Foundations of Lifelong Health Are Built in Early Childhood*. Retrieved from www.developingchild.harvard.edu.
- ii. National Scientific Council on the Developing Child. (2004). *Young children develop in an environment of relationships*. Working Paper No. 1. Retrieved from <http://www.developingchild.net>.
- iii. Benoit, D., Parker, K. C., & Zeanah, C. H. (1997). Mothers' representations of their infants assessed prenatally: Stability and association with infants' attachment classifications. *Journal of Child Psychology and Psychiatry*, 38(3), 307-313.
- iv. Branjerdporn, G., Meredith, P., Strong, J., & Garcia, J. (2017). Associations between maternal-foetal attachment and infant developmental outcomes: A systematic review. *Maternal and child health journal*, 21(3), 540-553.
- v. Heckman, J <https://heckmanequation.org/>
- vi. National Scientific Council on the Developing Child (2005/2014). *Excessive Stress Disrupts the Architecture of the Developing Brain: Working Paper No. 3. Updated Edition*. Retrieved from www.developingchild.harvard.edu.
- vii. Quote widely attributed to Frederick Douglas but original source unknown.
- viii. Van IJzendoorn, M., Schuengel, C. & Bakermans-Kranenburg, M. (1999) Disorganized attachment in early childhood: A meta-analysis of precursors, concomitants and sequelae. *Development and Psychopathology*, 11, 225-249.
- ix. Miles, A (2018). *A Crying Shame A report by the Office of the Children's Commissioner into vulnerable babies in England*.
- x. Miles, A (2018). *A Crying Shame A report by the Office of the Children's Commissioner into vulnerable babies in England*.
- xi. Skovgaard, A. M. (2010). Mental health problems and psychopathology in infancy and early childhood. *Dan Med Bull*, 57(10), B4193.
- xii. Winnicott, D. W. (1960). The theory of the parent-infant relationship. *International Journal of Psycho-Analysis*, 41, 585-595.
- xiii. AIMH, Infant Mental Health Competency Framework, found at <https://aimh.org.uk/infant-mental-health-competencies-framework/>
- xiv. De Wolff, M. S., & van IJzendoorn, M. H. (1997). *Sensitivity and attachment: A meta-analysis on parental antecedents of infant attachment*. *Child Development*, 68, 571-591.
- xv. Meins, E. (1999). Sensitivity, security and internal working models: Bridging the transmission gap. *Attachment & Human Development*, 1(3), 325-342.
- xvi. Slade, A., Belsky, J., Aber, J. L., & Phelps, J. L. (1999). Mothers' representations of their relationships with their toddlers: Links to adult attachment and observed mothering. *Developmental psychology*, 35(3), 611.
- xvii. Fonagy, P., Steele, M., Steele, H., Moran, G. S., & Higgitt, A. C. (1991). The capacity for understanding mental states: The reflective self in parent and child and its significance for security of attachment. *Infant mental health journal*, 12(3), 201-218.

- xviii. Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. *Journal of the American Academy of Child & Adolescent Psychiatry*, 14(3), 387-421.
- xix. Nice (2016) *Postnatal care up to 8 weeks after birth* NICE Clinical Guideline [CG37].
- xx. Information given to the Health Select Committee's Inquiry into the First 1001 Days, <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/1496/1496.pdf>
- xxi. Nice (2014) Antenatal and Postnatal mental health. Clinical Management and Service Guideline [CG197].
- xxii. NHS England (2019) *Long Term Plan*.
- xxiii. Bertacchi, J. (1996) Relationship-based organizations. Washington, DC: Zero to Three, 17, (2), 1-7
- xxiv. Barlow, J., Bennett, C., Midgley, N., Larkin, S. K., & Wei, Y. (2015). Parent-infant psychotherapy for improving parental and infant mental health. *Cochrane Database of Systematic Reviews*, (1).
- xxv. Fukkink, R. G. (2008). Video feedback in widescreen: A meta-analysis of family programs. *Clinical Psychology Review*, 28(6), 904-916.
- xxvi. Nederlands Jeugd Instituut <https://www.nji.nl/>
- xxvii. NICE (2016) *Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care*. NICE guideline [NG26].
- xxviii. NICE (2012) *Social and emotional wellbeing: early years Public health guideline* [PH40]
- xxix. Slead, M., James, J., Baradon, T., Newbery, J., & Fonagy, P. (2013). A psychotherapeutic baby clinic in a hostel for homeless families: Practice and evaluation. *Psychology and Psychotherapy: Theory, Research and Practice*, 86(1), 1-18.
- xxx. Zaphiriou Woods, M., & Pretorius, I. M. (2016). Observing, playing and supporting development: Anna Freud's toddler groups past and present. *Journal of Child Psychotherapy*, 42(2), 135-151.
- xxxi. Slead, M., Baradon, T., & Fonagy, P. (2013). New Beginnings for mothers and babies in prison: A cluster randomized controlled trial. *Attachment & Human Development*, 15(4), 349-367.
- xxxii. Asmussen, K., Feinstein, L., Martin, J., & Chowdry, H. (2016). Foundations for life: What works to support parent child interaction in the early years. *London Early Intervention Foundation*.
- xxxiii. McPherson, S., Andrews, L., Taggart, D., Cox, P., Pratt, R., Smith, V., & Thandi, J. (2018). Evaluating integrative services in edge-of-care work. *Journal of Social Welfare and Family Law*, 40(3), 299-320.
- xxxiv. Parent Shaped Support (2017) *Social Impact Report, Parent and Baby Wellness Service*.

NOTE: This analysis was conducted using the starting and ending HADS scores for a three-year cohort of women who had attended one of the parent and baby wellness services (LivPIP or the Postnatal Depression service) and completed the HADS questionnaire at the start and end of the intervention. Only those who completed the questionnaire at the end were included. Those women whose final scores were below 8/21 were included in the analysis. The general SROI principles were applied, using financial proxies contained in the PSSRU/ LSE publication - The costs of perinatal mental health problems. The service stress that it is important to note that: These are very conservative economic analyses for the service, focusing specifically on the impacts of reducing depression and anxiety in new mothers and the potential costs and cost-savings that can arise from these perinatal mental health problems. The work does not look at the wider benefits of the service to babies and their families. Since there were still outstanding cases to close originating in these years, and since some didn't complete the final HAD questionnaires, it is possible that the economic benefits could be even higher. The LivPIP service often uses other tools and techniques to assess outcomes and doesn't always use the HAD questionnaires, therefore these figures are based only a proportion of the client base, and therefore the economic benefits could be higher still. We have applied standard levels of attributability, displacement, deadweight and drop-offs to the figures to ensure that we do not overclaim.

- xxxv. PMH Network Scotland (2019) *Delivering Effective Services: Needs Assessment and Service Recommendations for Specialist and Universal Perinatal Mental Health Services*.
- xxxvi. Office for National Statistics (2018) Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland
- xxxviii. NHS digital (2018) *Mental Health Bulletin Annual Report 2017-2018*.
- xxxviii. Anna Freud Centre and The Tavistock and Portman NHS Foundation Trust (2014) *Thrive: A conceptual framework for CAMHS*.
- xxxix. NICE (2012) *Social and emotional wellbeing: early years* Public health guideline [PH40].
- xl. Department of Health and NHS England (2015) *Future in mind Promoting, protecting and improving our children and young people's mental health wellbeing* A report of the Children and Young People's Mental Health Taskforce.
- xli. NHS England (2019) Long Term Plan, Department of Health (2017) *Transforming Children and Young People's Mental Health*.
- xlii. Joint Commissioning Panel for Mental Health (2013) *Guidance for Commissioners of Child and Adolescent Mental Health Services*.
- xliii. 2019-20 Ring-fenced Public Health Grant to Local Authorities: Written statement - HCWS1221.
- xliv. NHS England (2019) *Long Term Plan*.
- xlv. NHS England (2019) *Long Term Plan* Page 50.
- xlvi. Welsh Government (2017) *Prosperity for All: The National Strategy*.
- xlvii. Scottish Government (2008) *Early Years Framework*.
- xlviii. Scottish Government (2018) *Mental Health: Programme for Government Delivery Plan*.
- xlix. Public Health Agency (2016) *Infant Mental Health Framework for Northern Ireland April 2016*.





www.pipuk.org.uk

 @earlypotential



PIP UK[®]
Parent Infant Partnership
United Kingdom
Registered Charity Number: 1152082

Sally Hogg
Parent Infant Partnership UK