



# Parent-Infant

— FOUNDATION —

Dr Karen Bateson  
with Dr Beckie Lang, Sally Hogg  
and Alanna Clear

## Development and Implementation Toolkit

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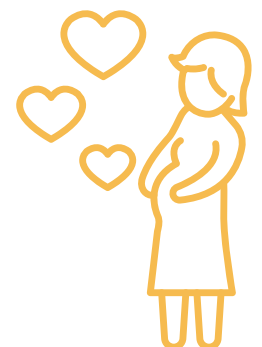
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## Disclaimer

This toolkit, comprising eight chapters and additional resources, provides information of a general nature for anyone setting up a specialised parent-infant relationship team. It has been prepared to promote and facilitate good practice in the United Kingdom in commissioning, implementation and clinical practice. This toolkit includes published evidence and expert opinion which is current at the time of publication.

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This toolkit is due for review by January 2021.



## Chapter 1

# Introduction and Key Concepts

### This chapter covers:

- What is included in this toolkit
- Our definition of specialised parent-infant relationship teams and why they are so important
- Advice about agreeing a shared language

There is also a description about the ways the Parent-Infant Foundation can support new and existing providers, commissioners, those setting up an entirely new service and those seeking to develop existing parent-infant provision into a specialised parent-infant relationship team.

## What is this toolkit and who is it for?

Welcome to this toolkit which shares learning, information, resources and advice for commissioners and providers who want to set up, improve or expand parent-infant relationship teams in the UK.

Since 2012, the Parent-Infant Foundation (formerly Parent Infant Partnership UK) has set up and supported seven Parent Infant Partnership (PIP) teams around the UK and built close relationships with other parent-infant relationship teams in the public and voluntary sectors. We have accumulated a great deal of learning about how to establish strong and effective teams.

This document brings together our learning for the first time in one place as well as insights from teams around the UK to help those who wish to set up these important services. We hope it will make it easier for anyone wanting to set up a new team,

reducing the risk and workload involved in establishing a new team, and increasing the chances of success.

This toolkit, comprising eight chapters and an additional resources section, includes:

- The compelling case for specialised parent-infant relationship teams
- Best evidence, and insights from experts, about setting up and delivering specialised parent-infant relationship teams that are strong, sustainable and cost-effective, and, most importantly, that deliver a service that is attractive and effective for families
- Information about funding and commissioning, clinical interventions and measuring outcomes

Specialised parent-infant relationship teams are not yet part of mainstream family services across the UK. One reason for this is that there has previously been no clear 'blueprint' for how to establish, resource, implement, and evaluate them.

This toolkit provides that blueprint, one that does not advocate or require adoption of a specific model, but is based on evidence and learning, to promote best practice and to support the development and expansion of services that meet local need.

**The Toolkit sets out what we and others have learned is best in order to:**

- **Establish/maintain strong and sustainable teams that meet the needs of the local community**
- **Deliver interventions in a way that is attractive and engaging for families and delivers results**
- **Deliver evidence-based interventions for families in a cost-effective way**
- **Collect data and measure outcomes**

We are committed to improving and updating the toolkit to reflect the latest evidence and learning from the parent-infant relationships sector. During 2019-2020 we will be using the toolkit in a newly developing team, to gain further learning and to review content. We would also be delighted to receive your feedback, insights and ideas for the toolkit.

Please send these to [karen@parentinfantfoundation.org.uk](mailto:karen@parentinfantfoundation.org.uk). New resources will also be uploaded onto the website periodically, so do check back from time to time at [www.parentinfantfoundation.org.uk](http://www.parentinfantfoundation.org.uk).



## Navigating the Toolkit

The chapters and resources that make up this toolkit create a practical guide about how to set up specialised parent-infant relationship teams and share our collective learning about implementation. This is the first edition and the toolkit will be reviewed annually so that it is relevant and responsive to local and national policy changes and reflective of new evidence and learning.

### Chapter 1 Navigating the toolkit

This introductory chapter includes information about what all the following chapters cover, the definition of specialised parent-infant relationship teams and why we need them, important notes about agreeing a shared language, and other sources of help, support and further reading, including evidence hubs. There is also a description about the ways the Parent-Infant Foundation can support new and existing providers, commissioners and start-ups.

### Chapter 2 The Case for Change

Chapter 2 will help you understand and communicate the reasons why every area in the UK needs a specialised parent-infant relationship team. It condenses the compelling case for parent-infant teams, and their associated systems-level work into ten easily-communicated key messages. We summarise the scientific, moral and economic arguments with reference to research and policy.

### Chapter 3 Funding and Commissioning A Specialised Parent-Infant Relationship Team

Chapter 3 is a guide to where specialised parent-infant relationship teams fit strategically, what outcomes they can deliver, and an introduction to various commissioning arrangements including joint commissioning, fundraising and grants. You will find our system-level Theory of Change here and this will help you think about commissioning for outcomes.



## Chapter 4 Clinical Interventions and Evidence-Informed Practice

This chapter of the Parent-Infant Foundation toolkit will help you think about which therapeutic approaches your specialised parent-infant relationship team might offer. It introduces some of the clinical guidance, such as NICE quality standards relevant to parent-infant relationship work, and an example of a clinical Theory of Change. There are brief descriptions of some of the most popular and effective evidence-based practices in parental engagement, assessment and intervention in parent-infant relationship work, so that families can receive effective interventions tailored to their needs. This chapter also includes information about approaches to workforce training and consultation.

## Chapter 5 Setting up a Specialised Parent-Infant Relationship Team and Preparing for Operational Delivery

There are three phases of setting up a specialised parent-infant team: preparing for operational delivery, starting the parent-infant work and steady-state management. This chapter covers the first of these, including information about things to do before you start accepting referrals such as creating referral pathways, clarifying step up, step down and step out relationships, establishing strategic and operational relationships across the system, and marketing and promotion.

## Chapter 6 From Set-up to Sustainability

Chapter 6 will help you on your development journey from opening the doors to families to becoming a sustainable service. The information is sourced from the collective expertise of many practitioners, clinical and operational leads and implementation specialists across the field of parent-infant relationships, including many of the existing teams.

Topics covered include how to manage referrals and waiting lists, initial contact and engagement, screening and assessment, managing beginnings and endings with families, and follow-up. It is not intended as a guide in how to be a parent-infant practitioner, but as a collection of learning and prompts to guide you in how you organise the work with families.

## Chapter 7 Recruitment, Management and Supervision of a Specialised Parent-Infant Relationship Team

This chapter provides information about the professionals who make up a specialised parent-infant relationship team and the roles they fulfil, so that you can plan the constituents of your team.

We have included some information about recruitment and there are helpful insights from existing teams about getting the management and supervision arrangements right.

## Chapter 8 Managing Data and Measuring Outcomes

In the final chapter, you will find guidance about how to set clinical goals, team outputs and outcomes and how to go about measuring them. There is a helpful table describing various clinical assessment and outcome measurement tools, guidance about how to capture and review data, and some guidance on information sharing.

## Bibliography

This is a useful list of academic papers, text books, policy documents and relevant websites.

## Network Area of the Parent-Infant Foundation Website

The Network area of our website contains various free-to-download templates and examples of policies, processes, parent-facing and professional-facing leaflets,





terms of reference, job descriptions, person specifications and service agreements, shared by parent-infant relationship teams around the UK. These will help you see what other services have already developed so that you can use them as a blueprint if necessary.

The Network area is free of charge but access requires registration. Please visit our website at [www.parentinfantfoundation.org.uk](http://www.parentinfantfoundation.org.uk) to register.

## What are specialised parent-infant relationship teams?

Specialised parent-infant relationship teams are multi-disciplinary teams with expertise in supporting and strengthening the important relationships between babies and their

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

Parent-infant relationship teams 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.

There is local variation in how teams are constituted and commissioned, which interventions they offer, and whether they work with particular needs or populations. All teams include at least one and often several highly-experienced psychologist or psychotherapist with specific expertise in parent-infant relationships.



## 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<sup>7</sup>.



**They assess families and offer individualised programmes 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 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 training, consultation and/or supervision to other professionals. This level of work also includes strategic influencing to promote the sustainability and local political support for the team by engaging with commissioners, funders, local elected members and other local decision makers.

- 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.

## Specialised teams are part of the parent-infant relationships ecosystem

Anyone who works with families during the first 1001 days can help to protect and promote babies' emotional wellbeing, and to support early relationships. Many professionals in the public, private and voluntary sector have developed a specialist expertise in babies' emotional wellbeing and offer interventions, including evidence-based programmes, to support parent-infant relationships. For example, health visitors can play a particularly important role as they work with every family during this important period.

Some health visiting services have specialists in infant mental health who offer interventions to support families who need additional help. Some Child and Adolescent Mental Health Services (CAMHS) have time dedicated to working with children under two, although not all focus on the parent-infant relationship.

Some perinatal adult mental health teams and Adult IAPT (Improving Access to Psychological Therapies) teams are increasingly thinking about and in some cases beginning to support the parent-infant relationship.

Other services may have professionals who have the expertise but not the time or mandate to offer families' therapeutic support. These are all important parts of the ecosystem that supports babies' emotional wellbeing.

Whilst these parts of the system are unlikely to offer the same therapeutic intensity of specialised, multi-disciplinary parent-infant relationship teams, it is important that all relevant teams and services work together in as integrated a way as is possible.

Work with babies is very different from work with older children. Babies are developing more quickly, they are completely dependent on adults, and they cannot talk to us; they communicate their distress in different ways. Babies are also more vulnerable to abuse.

In work with parents and infants, the 'client' is their two-way relationship and it takes specialised training and interventions to hold both parties therapeutically and work in the interaction between them. Parent-infant teams can offer a range of relationship-focussed therapies in a way which is tailored to the needs of each family.

**Forty-five per cent of serious case reviews in England relate to babies under the age of one year and in England and Wales, babies are eight times more likely to be killed than older children<sup>1</sup>.**



## Why do we need specialised parent-infant relationship teams?

The first 1001 days of life, from conception to age two, 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, even in the womb. 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 completely dependent on adults to survive. The parent-foetal relationship develops according to the idea's parents formed from their own past experiences, without much input from the child.

After birth, babies continue to be unable to talk about their feelings and needs, although they do communicate these in different ways. Therefore, work with babies in the first 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 the skills to read babies' pre-verbal cues.

They need the ability to work with adults about to become parents, parents, babies and their relationships. This is skilled work that requires specialist expertise. It is also truly preventative work: acting from conception onwards 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.

1. Cuthbert C, Rayns G & Stanley K (2011). All Babies Count, Prevention and protection for vulnerable babies. NSPCC. <https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/search2?searchTerm0=C3380>



# 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.**



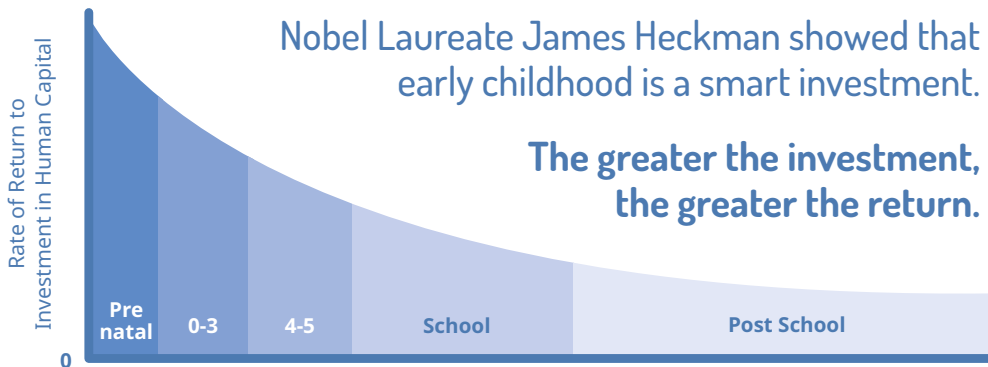
**Children's development in the early years sets them on a positive trajectory**, although what happens next also matters. Children's development at just 22 months has been shown to predict their qualifications at 26 years.



**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.

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.

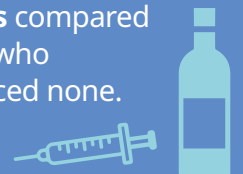


When parents experience problems in the first 1001 days it can have long term impacts on their children.

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**





## The importance of a shared language from the start

We encourage local systems to discuss use of terms and language from the outset, to avoid confusion and improve mutual understanding and communication. The emotional wellbeing of babies, sometimes called infant mental health<sup>2,3</sup> refers to how well babies experience, regulate and express emotions, and is dependent upon the quality of the relationship between infant and carers.

Our own research has shown that the term 'infant mental health' can sometimes give the wrong impression: either that the problem is located only in the child or that this work is only about mental health. Practitioners told us that 'mental health' is often (mis) understood as 'mental illness' which is difficult to understand when thinking about babies.

At the Parent-Infant Foundation, we talk about the 'parent-infant relationship' and its impact on the 'emotional wellbeing of babies'. Some areas find the term attachment or early attachment helpful as this focuses on the relationship between parents and infants, although we have found that attachment can have different definitions in lay and professional circles. There are also some criticisms about the overuse and misinterpretation of attachment as a concept.<sup>4</sup>

There can also be confusion about the term 'perinatal'. Adult perinatal mental health services focus on the emotional wellbeing of the primary carer, often the mother. Their work tends to start and end according to the mental health needs of the adult and the relationship with the baby is not the core focus of the work.

Some perinatal mental health teams do offer specialised parent-infant relationship work as a supplement and the NHS 10-year plan encourages this. However, many do not so this should not be assumed. Specialised parent-infant relationship teams focus on improving the quality of relationship between the parent(s) and baby, and the emotional wellbeing of the baby. Therefore, perinatal adult mental health services and specialised parent-infant relationship teams are ideal complementary services and should work closely together where both exist.

It is important to consider the specialised work of a parent-infant relationship team with regard to local definitions of early help and early intervention. Direct therapeutic parent-infant work occurs in the first two years of life (hence, it is 'early in the life course') but is often complex and involves very high levels of need just like CAMHS work for older children (hence also 'specialised'). Clarification about this point locally promotes a shared understanding between strategic partners about how the teams' work fits with early help/intervention policy documents and commissioning. Without this clarity, misunderstandings may arise about the potential commissioning routes of teams.

Finally, at the Parent-Infant Foundation we use the term 'specialised parent-infant relationship teams' to distinguish multi-disciplinary teams with a dedicated remit and referral pathway. For shorthand, we use parent-infant teams. This is distinct from individual practitioners who offer parent-infant relationship work as part of their broader work in another service, such as specialist infant mental health visitors. These are not hard and fast definitions but offer some helpful clarity in language and thinking.

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2. Osofsky JD & Fitzgerald HE (2000). *WAIMH Handbook of Infant Mental Health*. p. 30. New York: John Wiley & Sons.

3. Zero to Three. (2001) Definition of infant mental health. Washington, DC: Zero to Three Infant Mental Health Steering Committee.

4. Meins, E (2017) Overrated: The predictive power of attachment. *The Psychologist*.

<https://thepsychologist.bps.org.uk/volume-30/january-2017/overrated-predictive-power-attachment>



## How can the Parent-Infant Foundation help?

The Parent-Infant Foundation is a national charity which believes that all babies should have a sensitive, nurturing relationship to lay the foundation for lifelong emotional wellbeing, mental and physical health. We are the only national charity proactively supporting the growth and quality of specialised parent-infant relationship teams across the UK, and campaigning for policy change. We bring together and support the sector, providing a collaborative leadership and a much-needed national voice.

In addition to this toolkit, the Parent-Infant Foundation can offer you support in the following ways:

### 1. Bespoke development, implementation and strategic consultation, advice and mentoring

Through our work directly setting up and supporting seven services over the last six years, and our close relationships with other specialised parent-infant relationship teams around the country, we have accumulated a great deal of learning about how to establish strong and effective services in different community settings.

Our existing knowledge and ongoing learning are accessible throughout the UK on our website, through individual conversations and through working with us in partnership.

### 2. Access to the Parent-Infant Network

Every practitioner in a specialised parent-infant relationship team around the UK is invited to join the national Parent-Infant Network: a free, multi-disciplinary collective which provides a space for shared learning and information, continued professional development, peer

discussions and mutual support. The Network's aim is to facilitate sharing of resources, good practice and help with common challenges and to foster a shared drive to improve the reach, quality and impact of teams.

The Network offers two free face-to-face events each year and we plan to deliver several webinars on topics of shared interest by the end of 2019/20. Networking and collaboration are further facilitated through the Network newsletter.

### 3. Quality Standards

Via the Parent-Infant Network, we are developing a set of service standards for teams which will complement the Association of Infant Mental Health UK (AIMH UK)'s competencies for individual practitioners. Over the coming year we will co-create these standards with teams, with a view to the establishment of an accreditation process through peer review.

### 4. Data Management

The Parent-Infant Foundation provides a free software offer to any specialised parent-infant relationship team in the UK. The Foundation's data portal can be used to track bespoke output and outcome data often missed from statutory or off-the-shelf data management systems.

This helps local teams to communicate more easily with stakeholders, funders and commissioners, to benchmark their performance against an anonymised national data set, and to support their quality improvement work.

### 5. Policy and Campaigns

Part of our mission is to convince national and local decision makers across the UK about the importance of policies and services to support parent-infant relationships, and specifically about the importance of specialised parent-infant relationship teams.



We provide a national voice for the sector and campaign tirelessly for change. We coordinate the Conception to Age Two All-Party Parliamentary Group and the 1001 Critical Days Movement. Our most recent report *Rare Jewels: Specialised Parent-Infant Relationship Teams in the UK* makes the case for national promotion of specialised parent-infant teams.

## 6. Contributing to the Evidence Base

In addition to disseminating academic research findings and signposting to good sources of evidence, the Parent-Infant Foundation supports the creation of new evidence through its own research and evidence activities.

### Further sources of help, support, evidence, useful reports and websites

Each of the chapters in the toolkit signposts to topic-specific sources of help, evidence, resources and guidance.

In the Bibliography, you will find helpful information of general interest in the arena of parent-infant relationships and babies' emotional wellbeing.



## Chapter 2

# The Case for Change: Why do we need specialised parent-infant relationship teams?

This chapter will help you understand and communicate the reasons why every area in the UK needs a specialised parent-infant relationship team. It condenses the compelling case for parent-infant teams and their associated systems-level work into ten easily-communicated key messages. We summarise the scientific, moral and economic arguments with reference to research and policy.

## Introduction

The first 1001 days of life, from conception to age two, 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, early interactions and relationships between babies and their parents are incredibly important for healthy brain development. Persistent and severe difficulties in early relationships can have pervasive effects on many aspects of child development, with long term costs to individuals, families, communities and society. This is recognised in numerous national and international policy documents and reports, with increasing calls for investment.

We have a unique window of opportunity to intervene, at the start of a babies' life from conception onwards, when parents are often receptive to help and in contact with universal services. Yet, specialised interventions which focus on the parent-infant relationship are commonly not available in universal services, Child and Adolescent Mental Health Services (CAMHS) or perinatal mental health teams.

Therapeutic work with babies is different from work with older children and requires a specific set of competencies. It is skilled work that requires specialist expertise in child development and the unconscious communications between parents and their babies and between both of them and the therapist.

The opportunities and risks 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.





**This chapter explains ten different elements of this case for action in more detail.**

1. The first 1001 days are a crucial time and what happens in this period influences lifelong health and wellbeing
2. Relationships, especially the parent-infant relationship, are at the heart of healthy development
3. Early adversity brings costs to individuals, society and the public purse: investments in early life pay the greatest dividends
4. There is increasing international and national recognition of this important work
5. We have a unique opportunity to intervene when parents are generally receptive to help and in touch with services
6. Specialised parent-infant relationship interventions are commonly not available in existing provision
7. Early social and emotional development lays the foundation for a range of important life outcomes which feature in policy priorities
8. A significant number of babies are at risk in the UK
9. Babies are currently largely ignored in policy, commissioning and practice
10. Specialised parent-infant relationship teams can drive systems change



# 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







## 1. The first 1001 days are a crucial time and what happens in this period influences lifelong health and wellbeing

It is now widely recognised that what happens in the first 1001 days of a child's life, from conception to their third birthday, is key to enabling that child to survive and thrive<sup>1</sup>. Children's brains develop fastest and are at their most 'plastic' or adaptable in the womb and early years of life. This is when the foundations are laid for later development. Many millions of neural connections are made and then pruned as the infant adapts to his or her unique family setting, and the initial architecture of the brain is developed<sup>2</sup>.

Children's development is shaped by their environment, especially the relational environment. By supporting early development, we have the opportunity to put children on a positive developmental trajectory, better able to take advantage of other opportunities that lie ahead. Conversely, if babies have a difficult start it can have pervasive effects on multiple domains of child development<sup>3</sup>.

**"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."**

UNICEF, World Bank and World Health Organisation Nurturing Care Framework

## 2. Relationships, especially the parent-infant relationship, are at the heart of healthy development

Babies' development is strongly influenced by their experiences of the world and these are shaped by their primary caregivers (usually their parents). Parent-infant relationships are vitally important, especially for building the brain architecture upon which other forms of development will rest. Yet, specialised interventions are commonly not available in local areas. In parent-infant teams, the "client" is the relationship that is developing between the baby and his or her parents.

**"Young children experience their world as an environment of relationships, and these relationships affect virtually all aspects of their development"<sup>4</sup>**

Nurturing relationships begin before birth. How parents feel about their unborn baby influences their antenatal care. The foetal brain is developing rapidly during pregnancy, changing in response to the biochemical experience of the mother's mental<sup>5,6,7</sup> and physical health<sup>8,9</sup> and to substances she may ingest, such as alcohol<sup>10</sup>. This process, known as foetal programming<sup>11</sup>, ensures the baby is highly adapted to the world into which it will be born.

1. Center on the Developing Child (2010). The Foundations of Lifelong Health (InBrief). Retrieved from <https://developingchild.harvard.edu/resources/inbrief-the-foundations-of-lifelong-health/>
2. Center on the Developing Child (2007). The Science of Early Childhood Development (InBrief). Retrieved from <https://developingchild.harvard.edu/resources/inbrief-science-of-ecd/>
3. National Scientific Council on the Developing Child (2005/2014). Excessive Stress Disrupts the Architecture of the Developing Brain: Working Paper No. 3. [https://developingchild.harvard.edu/wp-content/uploads/2005/05/Stress\\_Disrupts\\_Architecture\\_Developing\\_Brain-1.pdf](https://developingchild.harvard.edu/wp-content/uploads/2005/05/Stress_Disrupts_Architecture_Developing_Brain-1.pdf)
4. National Scientific Council on the Developing Child (2004). Young Children Develop in an Environment of Relationships: Working Paper No. 1. Retrieved from <https://developingchild.harvard.edu/resources/wp1/>.
5. Goodman, JH (2019) Perinatal depression and infant mental health. Archives of Psychiatric Nursing, 33(3): 217-224. <https://www.sciencedirect.com/science/article/pii/S0883941718303984>
6. Coburn, S.S., Luecken, L.J., Rystad, I.A. et al. Matern Child Health J (2018) 22: 786. <https://doi.org/10.1007/s10995-018-2448-7> <https://link.springer.com/article/10.1007/s10995-018-2448-7>





Babies' brains are sensitive to both the physical health environment of the mothers' womb and the relational environment beyond it. Babies recognise their mother's and father's voice in the womb<sup>12</sup> probably as part of an innate drive to seek out those voices after birth. Babies can even experience adversity in the womb. For example, where domestic abuse is occurring, babies' stress regulation systems can adapt accordingly, leaving them more responsive to threat but consequently more irritable and difficult to settle once they are born<sup>13</sup>.

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, 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<sup>14</sup>.

- When babies receive appropriate comfort and care, they can feel safe and begin to explore the world around them, to play and learn<sup>15</sup>.
- 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<sup>16,17</sup>

Babies and toddlers have no choice but to adapt to their family's emotional habitat. When the infant finds consistent stress rather than comfort within the family then survival takes precedence over emotional connection.

If a child's emotional environment causes them to feel unsafe or fearful, or if they experience toxic stress in the absence of relationship which can help them regulate or buffer their stress<sup>18</sup>, this will be reflected in their psychological and neurological development and will influence how their brain develops to deal with stress in later life.

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7. Adamson, B., Letourneau, N. & Lebel, C. (2019). Corrigendum to prenatal maternal anxiety and children's brain structure and function: A systematic review of neuroimaging studies. *Journal of Affective Disorders*, 253: 456. <https://www.sciencedirect.com/science/article/abs/pii/S0165032718311340>
  8. Ou, X., Thakali, K. M., Shankar, K., Andres, A., & Badger, T. M. (2015). Maternal adiposity negatively influences infant brain white matter development. *Obesity (Silver Spring, Md.)*, 23(5), 1047–1054. doi:10.1002/oby.21055 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4414042/>
  9. Dismukes, A. R., Shirtcliff, E. A. & Drury, S. C. (2019) Genetic and epigenetic processes in infant mental health. pp. 63-80 in: Zeanah, C. H. (Ed.) (2019) *Handbook of Infant Mental Health (4th Edition)*. New York: The Guilford Press.
  10. Fitzgerald, H. E., Puttler, L. I., Mun, E. Y., & Zucker, R. A. (2000) Prenatal and postnatal exposure to parental alcohol use and abuse. pp. 123-159 in: Osofsky, J. D. & Fitzgerald, H. E. (Eds). *WAIMH Handbook of Infant Mental Health. Vol. 4. Infant Mental Health in Groups at High Risk*. New York: John Wiley & Sons
  11. See Faa et al (2016) <https://onlinelibrary.wiley.com/doi/abs/10.1002/bdrc.21139> for an example
  12. Lee & Kisilevsky (2014) in Chapter 9 of Fruholz & Belin (2019). *The Oxford Handbook of Voice Perception*. Oxford University Press, Oxford. <https://books.google.co.uk/books?hl=en&lr=&id=-Yx8DwAAQBAJ&oi=fnd&pg=PA191&dq=fetal+voice+preference+mother+father&ots=iZLo19ddqX&sig=kCghI7tGL9HCVCtWWp31qw1R7Y0#v=onepage&q=fetal%20voice%20preference%20mother%20father&f=false> p194
  13. Parade, S., Newland, RP., Bublitz, MH., & Stroud, LR. (2019) Maternal witness to intimate partner violence during childhood and prenatal family functioning alter newborn cortisol reactivity. *Stress*, 22:2, 190-199, DOI: 10.1080/10253890.2018.1501019
  14. See Tronick, E. (1989). Emotions and Emotional Communication in Infants. *American Psychologist*, 44(2):112-9. DOI:10.1037//0003-066X.44.2.112
  15. See Bowlby, J. (2005). *A secure base*. Routledge, London. ISBN: 9780203440841
  16. Department for Education (2018). *Improving the home learning environment*. <https://www.gov.uk/government/publications/improving-the-home-learning-environment>
  17. Cabrera, N. J., Karberg, E., Malin, J. L., & Aldoney, D. (2017). The magic of play: low-income mothers'and fathers'playfulness and children's emotion regulation and vocabulary skills. *Infant mental health journal*, 38(6), 757-771.
  18. Center on the Developing Child. *Toxic Stress*. <https://developingchild.harvard.edu/science/key-concepts/toxic-stress/>



A 2019 study by the Child Trauma Academy in Houston<sup>19</sup> found that a severe lack of positive relational experiences in the first two months of life changes the child's self-regulation and sensory integration systems and may be particularly influential for neurodevelopmental or brain-related outcomes. The study also found that early-life stress in one developmental period was likely, in the absence of intervention, to carry on into the next developmental period.

The large Adverse Childhood Experiences<sup>20</sup> studies have demonstrated a clear association between childhood trauma and a range of poorer outcomes across the life course, including obesity, substance misuse including alcoholism, smoking, mental health problems such as depression, physical health problems including cancer<sup>21</sup> and age-related diseases such as dementia and diabetes<sup>22</sup>.

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19. Hambrick, EP., Crawler, TW. & Perry, BD. (2019). Timing of Early-Life Stress and the Development of Brain-Related Capacities. *Front. Behav. Neurosci.*, 13:183. doi: 10.3389/fnbeh.2019.00183. <https://www.frontiersin.org/articles/10.3389/fnbeh.2019.00183/full>
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21. Holman, DM., Ports, KA., Buchanan, ND., et al (2016). The Association Between Adverse Childhood Experiences and Risk of Cancer in Adulthood: A Systematic Review of the Literature. *Pediatrics*, 138 (1). doi: [10.1542/peds.2015-4268L](https://doi.org/10.1542/peds.2015-4268L)
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Attachment theory is a framework that is commonly used to describe and understand patterns of emotionally-significant relationships in both children and adults. Its importance lies in its explanation that early parent-child relationships lay the blueprint for future relationships. This “template” for relationships is always open to change but reflects the child’s adaptation to the emotional availability of the parent(s).

The longer this interaction goes unchallenged, the greater the influence over how the child will anticipate the behaviour of others, conduct relationships and manage ruptured relationships. What happens between an infant and her caregiver is therefore vitally important. It is important not only for the way the infant will come to relate to herself and to other people, but also for her developing capacity to think<sup>23</sup>.

There are four commonly-used ways to describe children’s patterns of attachment: secure, avoidant, ambivalent (or resistant) and disorganised. Children who have received sensitive, responsive care generally display secure attachment (estimated prevalence 60-65% of the general population<sup>24,25</sup>).

Secure attachment is a broadly protective factor, conferring confidence, resilience and adaptability, although it does not provide a total guarantee of future mental health. Disorganised attachment is the category posing the most serious risks to future development<sup>26</sup>. This form of attachment is frequently, although not always, associated with maltreatment within the family.

Disorganised attachment is always a reason to offer specialised help and for very young children that specialised help is commonly not available in existing provision. At least 15% of children in the general population experience a disorganised attachment and this figure is higher for children facing adversity<sup>27</sup>.

We recommend the NICE final scope document<sup>28</sup> as a concise source of further information about attachment styles including disorganised attachment and Levy and Orlans (2014)<sup>29</sup> for a more comprehensive introductory text.

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23. Hobson, P. (2002) *The Cradle of Thought: Exploring the Origin of Thinking*. p180. London: Macmillan.
24. Barlow, J., Schrader-McMillan, A., Axford, N., et al. (2016). Review: Attachment and attachment-related outcomes in preschool children – a review of recent evidence. *Child and Adolescent Mental Health*, 21 (1): 11-20  
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28. Pp3-5, <https://www.nice.org.uk/guidance/NG26/documents/childrens-attachment-final-scope2>
29. Levy, T.M. and Orlans, M. (2014) *Attachment, Trauma, and Healing: Understanding and Treating Attachment Disorder in Children, Families and Adults*. <https://www.jkp.com/uk/attachment-trauma-and-healing-2.html>

### 3. Early adversity brings costs to individuals, society and the public purse: investments in early life pay the greatest dividends

**“It is easier to build strong children than to repair broken men”<sup>30</sup>**

Children experiencing extremely difficult family relationships are more likely to struggle in a number of domains of development<sup>31</sup>. From therapeutic experience, these are children who often feel frustrated and unhappy for reasons they cannot put into words. Without specialised help, such as is offered by a specialised parent-infant relationship team, a child might go through life responding to even minor problems as if they were a dangerous life-threatening situation<sup>32</sup>. This hyper-reactivity can underpin later problems in self-control<sup>33</sup> which affect behaviour, education, employment and adult relationships. This brings costs not only to the individual, but also to the community, public services and the wider economy.

Toxic stress is the prolonged activation of the stress response systems in the absence of protective relationships. Early traumatic experiences and toxic stress are associated

with an increased risk of a wide range of poor physical and mental health outcomes<sup>34</sup>, including major public health issues such as depression, cancer and dementia, with costs to individuals, families, communities and the public purse<sup>35</sup>. The impacts of early adversity can be overcome, but it is harder and often more costly to improve children’s lives later rather than getting things right from the start<sup>36</sup>.

Improving early relationships could prevent and/or mitigate the impact of adverse childhood experiences (ACEs). If babies do not have sensitive and responsive early relationships, this relational trauma can have pervasive effects on multiple domains of child development. Secure relationships confer resilience, which buffer children against the negative impacts of adversity<sup>37</sup>. Conversely, a challenging home environment is itself an adversity and can increase the impact of other challenges that affect a child’s wellbeing and development.<sup>38</sup>

#### Return on investment

A number of publications have estimated the costs of ‘late intervention’ in children’s lives. For example, mental health problems in children and young people are associated with excess costs estimated at between £11,030 and £59,130 annually per child. These costs fall to a variety of agencies (e.g. education, social services and mental health and include the direct costs to the family of the child’s illness)<sup>39</sup>.

30. Quote widely attributed to Frederick Douglass but original source unknown.

31. Green, J. & Goldwyn, R. (2002). Annotation: Attachment disorganisation and psychopathology: new findings in attachment research and their potential implications for developmental psychopathology in childhood. *Journal of Child Psychology and Psychiatry*, 43(7): 835-436.

32. Coan, JA. (2008). Towards a Neuroscience Attachment. From *The Handbook Of Attachment: Theory, Research, And Clinical Implications*. Jude Cassidy And Philip R. Shaver, Eds. 2nd Edition Pages 241 - 265 The Guilford Press, NY. [https://www.researchgate.net/profile/James\\_Coan/publication/230669685\\_Toward\\_a\\_Neuroscience\\_of\\_Attachment/links/Ofcfd502d39a581d8e000000.pdf](https://www.researchgate.net/profile/James_Coan/publication/230669685_Toward_a_Neuroscience_of_Attachment/links/Ofcfd502d39a581d8e000000.pdf)

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34. Hambrick, EP., Crawler, TW. & Perry, BD. (2019). Timing of Early-Life Stress and the Development of Brain-Related Capacities. *Front. Behav. Neurosci.*, 13:183. doi: 10.3389/fnbeh.2019.00183

35. **National Scientific Council on the Developing Child** (2005/2014). Excessive Stress Disrupts the Architecture of the Developing Brain: Working Paper No. 3. Updated Edition. From [www.developingchild.harvard.edu](http://www.developingchild.harvard.edu).

36. Chowdry, H. & Fitzsimons, P. (2016). The Cost of Late Intervention. Early Intervention Foundation . <https://www.eif.org.uk/files/pdf/cost-of-late-intervention-2016.pdf>

37. Moullin, S., Waldfogel, J., & Washbrook, E. (2014). *Baby Bonds: Parenting, Attachment and a Secure Base for Children*. Sutton Trust.

38. **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](http://www.developingchild.harvard.edu).

39. NHSE (2014). Model Child and Adolescent Mental Health Specification for Targeted and Specialist Services (Tiers 2 and 3). <https://www.england.nhs.uk/wp-content/uploads/2018/04/mod-camhs-tier-2-3-spec.pdf>



James Heckman has shown that money spent on interventions at this stage of the life course brings the greatest dividends<sup>40</sup>. This is because:

- It is relatively easier and more effective to act early (prevention is better than cure)
- The families with the greatest need for specialist early intervention tend to make the greatest gains from it
- Early action leads to accumulated savings by preventing other services being required later in the child's life
- Effective early intervention improves the child and family's participation in the economy

**"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

## 4. There is increasing international and national recognition of this important work

There is now global recognition of the need to prioritise early childhood development. The World Health Organisation, UNICEF and the World Bank, in collaboration with the Partnership for Maternal, Newborn & Child Health, the Early Childhood Development Action Network and many other partners, have developed the Nurturing Care Framework.

### The framework outlines:

- Why efforts to improve health and wellbeing must begin in the earliest years, from pregnancy to age 3
- The major threats to early childhood development
- How nurturing care protects young children from the worst effects of adversity and promotes physical, emotional and cognitive development
- What families and caregivers need to provide nurturing care for young children

**"Investing in early childhood development is one of the best investments a country can make to boost economic growth, promote peaceful and sustainable societies, and eliminate extreme poverty and inequality. Equally important, investing in early childhood development is necessary to uphold the right of every child to survive and thrive."**

World Health Organisation<sup>41</sup>

40. Heckman, J. The economics of human potential. <https://heckmanequation.org/>

41. WHO, UNICEF and the World Bank (2018). Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential. [https://www.who.int/maternal\\_child\\_adolescent/child/nurturing-care-framework/en/](https://www.who.int/maternal_child_adolescent/child/nurturing-care-framework/en/)



## England

The recent **Prevention Green Paper** recognises the importance of the first 1001 days:

**"We start building our health asset as a baby in the womb. The first 1,000 days of life are a critical time for brain development, and parents and carers have a fundamental role to play in supporting their child's early development..."**

**We know that a wide range of long-term outcomes are improved through the positive relationships established between parents and carers and their baby from pregnancy onwards."**

Advancing our health: prevention in the 2020s – consultation document<sup>42</sup>

In recent months, the Government has been criticised for not having a strategic approach to giving children the best start in life. There is a lack of leadership and accountability nationally and locally for work to support the first 1001 days, as recently recognised by three separate recent Select Committees.



**"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<sup>43</sup>

An inter-ministerial group, chaired by Andrea Leadsom MP, was established to look at how Government might improve the coordination of its work for families in the early years of life. However due to recent developments in Westminster, the future of this work is not clear.

**The NHS Long Term Plan** for England states that "Over the coming decade the goal is to ensure that 100% of children and young people who need specialist care can access it"<sup>44</sup>. Delivering this goal would require the NHS to ensure that 100% of children under two who need specialist care could access it which would mean providing specialised parent-infant relationship teams.

Funding to deliver on the NHS Long Term Plan will shortly enter Clinical Commissioning Group (CCG) baselines. All CCGs (or equivalent structures) must create a strategic plan for how they will spend their money before Christmas 2019.

42. Cabinet Office/DHSC (2019) Advancing our health: prevention in the 2020s – consultation document <https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s/advancing-our-health-prevention-in-the-2020s-consultation-document>

43. House of Commons Science and Technology Committee (2019). Evidence-based early years intervention. <https://publications.parliament.uk/pa/cm201719/cmselect/cmsctech/506/506.pdf>

44. NHS England (2019). Long Term Plan. Page 50. <https://www.england.nhs.uk/long-term-plan/>





## Wales

There is increasing recognition of the importance of infant mental health in Wales. The Welsh Government's programme for Government 2016-2021, Prosperity for All<sup>45</sup> includes a cross-cutting priority for all children to have the best start in life, recognising the importance of the first 1000 days. Public Health Wales are leading work with a group of stakeholders to make infant mental health a central part of the First 1000 Days framework which will be published later this year.

## Scotland

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.

Getting it Right for Every Child (GIRFEC)<sup>46</sup> is the national approach to improving children's wellbeing. GIRFEC aims to provide a common framework and language for all those working with children. The Early Years Framework<sup>47</sup> 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.

The Scottish Government's Programme for Government, published in September 2019, announced £3m to support the creation of integrated infant mental health hubs,

described as a multi-agency model of infant mental health provision to meet the needs of families experiencing significant adversity, "including infant development difficulties, parental substance misuse, domestic abuse and trauma"<sup>48</sup> This delivers on commitments made in 2018, in the Mental Health: Programme for Government Delivery Plan and the recommendations of the national managed clinical network in February 2019<sup>49</sup>. Additional investment has also been announced to enhance infant mental health provision within Scotland's two specialist inpatient Mother and Baby Units, and to improve community-based support delivered by the third sector.

There were no specialised parent-infant relationship teams reported in Scotland during the Freedom of Information for the Rare Jewels (2019) report, although some CAMHS services do offer some types of parent-infant work and the NSPCC has a specialised team in Glasgow which provides a service solely to young children in foster care.

## Northern Ireland

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 was 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 antenatal period through to children aged three years old"<sup>50</sup>.

45. Welsh Government (2017). Prosperity for All: The National Strategy.

<https://gov.wales/sites/default/files/publications/2017-10/prosperity-for-all-the-national-strategy.pdf>

46. Scottish Government, Getting It Right For Every Child. <https://www.gov.scot/policies/girfec/>

47. Scottish Government (2009). Early Years Framework. <https://www.gov.scot/publications/early-years-framework/>

48. Scottish Government Programme for Government 2019-20.

<https://www.gov.scot/publications/protecting-scotlands-future-governments-programme-scotland-2019-20/pages/7/>

49. <https://www.pmhn.scot.nhs.uk/wp-content/uploads/2019/03/PMHN-Needs-Assessment-Report.pdf>

50. Public Health Agency (2016). Infant Mental Health Framework for Northern Ireland.

<https://www.publichealth.hscni.net/publications/infant-mental-health-framework-northern-ireland>



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."

Two new parent-infant relationships services have been developed in Northern Ireland,

the ICAMHS service, which is hosted within CAMHS in the Southern Health Trust, and the ABCPiP team in South Eastern Health Trust.

### **5. We have a unique opportunity to intervene when parents are generally receptive to help and in touch with services**

The first 1001 days of a baby's life are an important period of transition for parents too and one that can bring challenges. This is a time of huge social, psychological, physical and relationship change. Most parents will have some contact with maternity services during this period which provides an opportunity for engagement and referrals or signposting to other services.



Parents are preparing to relate to their baby during pregnancy. There is 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 child outcomes<sup>51,52</sup>.

Practically all parents want to do their best, to enjoy their relationship with their baby and to give their baby the best start in life. Therefore parents, even those who have had difficult relationships with professional services in the past are often most receptive to help during the final months of pregnancy and the first months in their baby's life<sup>53</sup>.

Parents who are going to struggle to establish a healthy relationship with their child are often identifiable during pregnancy and the early months of parenthood, sometimes because they are not receptive to care as usual. Indeed, serious case reviews of adolescents often highlight warning signs from this early time: parents who didn't attend antenatal appointments, baby weighing clinics, or immunisations.

Specialised teams can offer timely, effective early interventions to see off the risks and get the parent-infant relationship back on track. This takes time, patience and skill to engage the most vulnerable or suspicious parents.

If we can capture and build on parents' motivations during pregnancy and the early days and offer them a service which is engaging and feels helpful to them, we can make a huge difference to the whole family and set a template of positive engagement with services that can continue through the child's life.

## 6. Specialised parent-infant relationship interventions are commonly not available in existing provision

At least 15% of babies in the general population need specialised parent-infant relationship interventions which are beyond the scope of universal services and are commonly not available elsewhere, including from CAMHS. In England, 42% percent of CCGs report that their CAMHS service does not accept referrals for children under 2 years, and even in areas where CAMHS might on paper take referrals for younger children, children aged 2 and under are rarely seen<sup>55</sup>.

Some perinatal mental health services offer parent-infant work, and this is welcome, but this is only available where mothers have significant mental health problems that meet the thresholds for these services. So, despite the importance of early relationships, most babies live in an area where they cannot access the specialised help they need.

Therapeutic work with babies is different from work with older children and requires a specific set of competencies: practitioners need the ability to work with parents, babies and crucially their relationships. This is skilled work that requires specialist expertise in child development and the unconscious communications between parents and their babies and between both of them and the therapist.

51. 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.

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53. Department of Health (2012) Preparation for Birth and Beyond: A resource pack for leaders of community groups and activities. <https://www.gov.uk/government/publications/preparation-for-birth-and-beyond-a-resource-pack-for-leaders-of-community-groups-and-activities>

55. Hogg, S. (2019). Rare Jewels Specialised Parent-Infant Relationship Teams. Parent Infant Partnership UK. <https://parentinfantfoundation.org.uk/our-work/campaigning/rare-jewels/>

## 7. Early social and emotional development lays the foundation for a range of important life outcomes which feature in policy priorities

Early relationships, and the social and emotional development that results from them, play an important role in how well a child will go on to achieve many of the key outcomes that public, professionals and policy makers care about.

### Education

Babies who have had good early relationships start school best equipped to be able to make friends and learn<sup>56,57,58</sup>. This 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 their perceptions of themselves and others and teach them how to regulate their emotions and control their impulses. Children who can control their emotions and behaviours are better able to settle into the classroom and learn. They have a template for positive relationships, which builds self-confidence and self-esteem, and can strengthen their relationships with peers and teachers.

Research suggests that emotional development in childhood has a greater impact than academic skills such as literacy and numeracy on adult outcomes such as mental wellbeing, physical health (such as obesity, smoking and drinking), and a similar impact on outcomes such as income and employment<sup>59</sup>.

### Emotional and physical health and wellbeing

Emotional regulation, one aspect of emotional development shaped by early attachment relationships, is at the heart of many of the challenges currently concerning policy makers. Better self-regulation is strongly associated with mental wellbeing, good physical health and health behaviours and socio-economic and labour market outcomes<sup>60</sup>. Emotional regulation is at the heart of the specialised interventions offered by parent-infant teams.

Young people who can regulate their emotions and behaviours and develop positive relationships are more likely to have good mental health from the early weeks of life and to avoid risky, harmful or antisocial behaviour such as self-harm<sup>61</sup> and youth violence<sup>62</sup>.

Poor emotional regulation in the early years is a proven risk factor for later adolescent violent crime<sup>63</sup>. Healthy and loving relationships enable children to develop the capacities they need to participate in society and to lead happy and fulfilling lives.

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56. Geddes, H. (2006) *Attachment in the Classroom: the links between children's early experience, emotional wellbeing and performance in school*. London: Worth Publishing.

57. Bergin, C. and Bergin, D. (2009) *Attachment in the Classroom*. *Educational Psychology Review*, 21, 141-170.

58. Siegel, D. (2012) *The Developing Mind: How relationships and the brain interact to shape who we are*. New York: Guilford Press.

59. Feinstein, L. (2015) *Social and Emotional learning: skills for life and work*. Early Intervention Foundation

60. Feinstein, L. (2015) *Social and Emotional learning: skills for life and work*. Early Intervention Foundation

61. Gratz, KL. (2006) Risk Factors for and Functions of Deliberate Self-Harm: An Empirical and Conceptual Review. *Clinical Psychology Science and Practice*, 10(12): 192-205.

62. Kliewer, W., Cunningham, JN., Diehl, R. et al (2004) Violence Exposure and Adjustment in Inner-City Youth: Child and Caregiver Emotion Regulation Skill, Caregiver-Child Relationship Quality, and Neighborhood Cohesion as Protective Factor. *Journal of Clinical Child & Adolescent Psychology*, 33:3, 477-487, DOI: [10.1207/s15374424jccp3303\\_5](https://doi.org/10.1207/s15374424jccp3303_5)

63. Sitnick, SL., Galán, CA., & Shaw, DS (2018). Early childhood predictors of boys' antisocial and violent behavior in early adulthood. *Infant Mental Health Journal*, 40(1): 67-83. <https://onlinelibrary.wiley.com/doi/full/10.1002/imhj.21754>





## Language and literacy

Healthy parent-infant interactions help children's early language development, which is facilitated when parents talk, sing and read books with their children<sup>64</sup>.

## Parenting capacity

A child's experience of being parented also influences how they go on to parent their own children; supporting babies' brain development pays dividends for generations to come<sup>65</sup>.

## Social mobility

Growing up in a low-income family is associated with poorer emotional health and development<sup>66</sup>. This is likely to be a contributing factor to worse outcomes that children and young people from lower income families experience across a wide range of domains. Any strategy to support social mobility must therefore include acting early to support emotional development, to close gaps between disadvantaged children and young people and their peers<sup>67</sup>.

Healthy social and emotional development can also help to protect children against the impact of poverty and adversity. One study found that boys who lived in poverty but had secure attachment relationships were 2.5 times less likely to have social and behavioural problems later in childhood<sup>68</sup>.

## 8. A significant number of babies are at risk in the UK

Urgent action is required to support parent-infant relationships now, given the number of babies who are vulnerable or experiencing harm and the lack of availability of specialised teams to support them.

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 are living in circumstances that might put their emotional wellbeing and development at risk.

Around 15% of children in the general population 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: children of mothers experiencing domestic violence at 57%<sup>69</sup>, of mothers using drugs and alcohol estimated at 43%, of mothers with depression estimated at 21%<sup>70</sup>. Disorganised attachment is beyond the scope of what typical universal or early help services can offer as it requires specialised interventions delivered by specialist practitioners

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<sup>71</sup>.

64. Department for Education (2018) Improving the home learning environment.

<https://www.gov.uk/government/publications/improving-the-home-learning-environment>

65. Fraiberg, S., Adelson, E., & Shapiro, V. (2003). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. *Parent-infant psychodynamics: Wild things, mirrors and ghosts*, 87, 117.

66. Yoshikawa, H., Aber, J.L. & Beardslee, W. (2012). [https://www.researchgate.net/publication/224956205\\_The\\_Effects\\_of\\_Poverty\\_on\\_the\\_Mental\\_Emotional\\_and\\_Behavioral\\_Health\\_of\\_Children\\_and\\_Youth\\_Implications\\_for\\_Prevention](https://www.researchgate.net/publication/224956205_The_Effects_of_Poverty_on_the_Mental_Emotional_and_Behavioral_Health_of_Children_and_Youth_Implications_for_Prevention)

67. Feinstein, L (2015) *Social and Emotional learning: skills for life and work*. Early Intervention Foundation

68. Moullin, S., Waldfogel, J., & Washbrook, E. (2014). *Baby Bonds: Parenting, Attachment and a Secure Base for Children*. Sutton Trust.

69. Zeanah, CH., Danis, B., Hirschberg, L. et al (1999). Disorganized attachment associated with partner violence: A research note. *Infant Mental Health Journal*, 20(1): 77-86.

70. 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

71. Miles, A (2018). *A Crying Shame*. A report by the Office of the Children's Commissioner into vulnerable babies in England.

<https://www.childrenscommissioner.gov.uk/wp-content/uploads/2018/10/A-Crying-Shame.pdf>

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<sup>72</sup>

An epidemiological study in Denmark found mental health problems in 18% of 1½ year-old children from the general population<sup>73</sup>

We are seeing the costs of poor mental health and emotional wellbeing in older children:

- Nearly 18,000 children in England accessed children and young people's mental health services last year, a number that is rising steadily
- 1,032,898 children in England self-reported emotional and mental health issues in 2017, a 50% increase from 2004<sup>74</sup>

Mental health problems are a risk factor for youth violence and school exclusion. Youth violence is rising, with increasing concerns about knife crime.

School exclusions are also rapidly increasing. The total number of permanent exclusions in England increased by 60% between 2013/14 and 2017/18, with on average 42 pupils expelled every school day<sup>75</sup>

**Babies in crisis are easily overlooked.**

## 9. Babies are currently largely ignored in policy, commissioning and practice

Despite the incredible importance of the first 1001 days, babies are often forgotten about and easily ignored in policy, commissioning and practice. Whilst 0-2 year olds should receive an equal, or even a greater share of attention, spending and service provision, they often miss out.

Research by the Parent-Infant Foundation found that despite CAMHS nominally being a service for 0-18 year olds, in 42% of Clinical Commissioning Group (CCG) areas in England CAMHS services do not accept referrals for children aged two and under.

Even where services might accept referrals, many do not actually see many children in this age range<sup>76</sup>.

### There are a number of reasons for this, including:

- Very 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 (such as being thought of as placid or "good" when in fact their normal responses have been dampened by distress). 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 ongoing distress from difficult

72. Miles, A (2018). A Crying Shame. A report by the Office of the Children's Commissioner into vulnerable babies in England. <https://www.childrenscommissioner.gov.uk/wp-content/uploads/2018/10/A-Crying-Shame.pdf>

73. Skovgaard, A. M. (2010). Mental health problems and psychopathology in infancy and early childhood. Dan Med Bull, 57(10), B4193.

74. Children's Commissioner (2019) Childhood vulnerability in England 2019. <https://www.childrenscommissioner.gov.uk/publication/childhood-vulnerability-in-england-2019/>

75. Department for Education (2019) Statistics on pupils who are excluded from school. <https://www.gov.uk/government/collections/statistics-exclusions>

76. Hogg, S. (2019). Rare Jewels: Specialised Parent-Infant Relationship Teams. Parent Infant Partnership UK. <https://parentinfantfoundation.org.uk/our-work/campaigning/rare-jewels/>



**In 42% of Clinical Commissioning Group (CCG) areas in England CAMHS services do not accept referrals for children aged two and under.**



relationships. It is not uncommon for adults only to take note of a child's behaviour once they enter nursery or even school, by which time early maladaptive patterns of relating may be becoming prominent and important opportunities for early intervention have been missed

- Increasingly-stretched services may 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, often through understanding the parent-infant relationship
- When services are very stretched, there can be pressure to prioritise cases which are perceived to be more urgent, such as older children who are exhibiting disruptive or harmful behaviour.

**Babies in crisis are easily overlooked. 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 problems can contribute to the mental health problems of children who present to CAMHS at a later stage.**

## 10. Specialised parent-infant relationship teams can drive systems change

Work with babies requires a whole-system approach, with practitioners equipped in specific skills and leaders equipped with relevant knowledge. Parent-infant relationship teams can help to create effective systems and lead workforce training. These teams work at clinical and systems-change levels.

As well as offering high-quality therapeutic support for families experiencing severe, complex and/or enduring difficulties in their

early relationships, they are also expert advisors and champions for all parent-infant relationships, driving change across their local systems and empowering professionals to turn families' lives around.

Families' needs and situations are varied and complex and a whole range of services and policies are required to support parent-infant relationships.

Work to protect and promote parent-infant relations is different to work with older children. It is skilled work that requires specialist expertise rarely developed through core training in health and social care. Parent-infant teams have this expertise and can help others in their local system to develop it.

Specialised parent-infant work 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.

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 specialised parent-infant relationship teams who can address problems early to prevent more pervasive or longer-term harm being caused. Specialised parent-infant relationship teams can catalyse this systemic change.





## Chapter 3

# Funding and Commissioning a Specialised Parent-Infant Relationship Team

This chapter of the Parent-Infant Foundation toolkit provides a guide to where specialised parent-infant relationship teams fit strategically and what outcomes they can deliver. There is a description of the various commissioning arrangements currently supporting teams around the UK, including joint commissioning, fundraising and grants.

You will find our system-level Theory of Change here and this will help you think about commissioning for outcomes. In addition to this chapter, you can find template commissioning contracts in the Network section of the Parent-Infant Foundation website.

## The range of work that parent-infant teams do and the impact they create

Specialised parent-infant relationship teams work at multiple levels: as experts and champions across the system, and providers of specialised therapeutic interventions. They enable local systems to offer effective, high-quality prevention and early intervention to give every baby the best start from conception onwards.

Alongside their direct work with families, teams offer specialised parent-infant relationship training, consultation and/or supervision to build capacity in the local workforce. They are 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.

Chapter 2 The Case for Change explains the wide range of impacts their work can have on later outcomes, including reducing the demands on other public services such as child protection, speech and language and mental health. Many parts of the local system reap the dividends of a well-functioning specialised parent-infant relationship team.

Visit the Parent-Infant Foundation website [www.parentinfantfoundation.org.uk](http://www.parentinfantfoundation.org.uk) for more examples of the work that teams do within their local systems and tips for others on how to do this effectively.



## An example of a system-level Theory of Change: the impacts of specialised parent-infant relationship teams on a local system

### The problem

- At least 15% of new babies experience complex or persistent relationship difficulties with their parent/carer(s). Without specialised help these unresolved problems can undermine a range of life outcomes and families may require future specialist interventions including, in the most severe cases, a child being taken into care
- Unresolved parent-infant relationship difficulties can be passed on to future generations of parents leading to inter-generational distress and additional high costs to the public purse
- The complex and persistent nature of some parent-infant relationship difficulties are beyond the scope of universal or typical early help support, and need specialised, multi-disciplinary intervention

### Contributing Factors

- Frontline practitioners may lack confidence or awareness to identify early relationship problems and provide or refer families to appropriate support
- The right kind of specialised help may not be available locally
- Local leaders, including commissioners, may be unaware of the importance of parent-infant relationships or face a lack of local strategic co-ordination in supporting the work

### What P-I teams do

- A variety of direct therapeutic work to address and improve the difficulties in the parent-infant relationship
- Training, consultancy and campaigning to raise public and professional awareness and improve workforce capacity to protect and promote the parent-infant relationship
- Act as "systems champions" by facilitating local networks and working with local leaders and organisations to improve awareness, co-ordination and decision-making

### Short-term outcomes

- Improved parent-child attunement and interaction (a direct outcome of work with families and an indirect outcome of work with other professionals)
- Improved capacity for the public and professionals to identify and support babies and their parents
- Improvements in how organisations work separately and together, so that babies can receive timely and appropriate support

### Medium-term outcomes

- More children benefit from a sufficiently secure and nurturing relationship with at least one parent/carer
- Local cost savings as fewer children need to be referred to speech therapy, early help, children's services, CAMHS, paediatrics, or special educational needs services for problems rooted in parent-infant relationships

### Long-term outcomes

- More children experience better social, economic, physical and mental health outcomes across the lifecourse
- Fewer children move into the Looked After system
- Fewer children need mental health support as older children or adults for attachment-related difficulties
- Fewer families experience the transmission of parent-infant relationship difficulties into the next generation



## Commissioning for outcomes

The system-level Theory of Change shows the short, medium- and long-term outcomes\* that a parent-infant team can generate.

An example of a clinical-level Theory of Change about the impacts on individual families can be found in Chapter 4 Clinical Interventions and Evidence-Informed Practice.

the nature and scope of the services. These services will be seeing adults who are parents, and commissioners may be thinking about additional support for them in this role

- NHS England funds GP services and Mother and Baby Units (MBUs)

### Clinical Commissioning Groups (CCGs)

are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area. These are led by GPs and other clinicians and commission for a population of, on average, 250,000 people.

## Commissioning arrangements

### England

Commissioning of services for young children in England is currently complex and fragmented, and varies locally:

- Clinical Commissioning Groups (CCGs) commission maternity, mental health (where there might be different funding streams for adults, children's and perinatal mental health services) and some other areas of NHS children's health services
- Within local authority children's services, there can be different funding streams for the early years (which might include children's centres) and child protection services (which might include both early help and children's social services)
- Health visiting is funded from the local authority public health budget, which should also be used to fund the wider Healthy Child Programme and other aspects of children's population health
- Adult services, such as those for alcohol, substance misuse, mental health and domestic violence can be funded by local authorities and/or CCGs depending on

Since 2015, many CCGs have worked together in **Sustainability and Transformation Plan (STP)** partnership areas, together with local authorities, to develop 'place-based plans' for the future of health and care services in their area. STPs are five-year plans covering all aspects of NHS spending in England.

Forty-four partnership areas have been identified as the geographical 'footprints' on which the plans are based, with an average population size of 1.2 million each.

CCGs are currently undergoing significant changes in structures and arrangements, with mergers and the development of **Integrated Care Systems (ICS)** across larger footprints, typically larger than upper tier and unitary local authorities. ICSs are a new type of even closer collaboration which has evolved from an STP partnership.

NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve. Some areas already have an ICS, and the NHS has committed to there being ICSs across the whole of England by April 2021.

\* In our example Theories of Change, we use "short-term outcomes" to describe the outcomes that come about during the intervention or work, such that they can be seen or measured by the end. We use "medium term" to mean after the intervention/work is finished (exactly how long depends on a number of factors including the nature of the intervention and what follow-up is planned). "Long-term outcomes" are much longer term and may relate to impact at a community or population level.

## Specialised parent-infant relationship teams support outcomes which align to strategic priorities

### Local Authority Public Health

Child development at 2/2.5 years, including language development  
School readiness  
Child wellbeing  
Emotional wellbeing of looked after children

### Local Authority Early Years Services

Child development at 2/2.5 years, including language development  
School readiness  
Child wellbeing

### Local Authority Children's Social Services

Number of children entering care  
Informed and timely decisions about permanency  
Breakdowns in fostering and adoption  
Emotional wellbeing of looked after children

### CCG Children and Young People's Mental Health

Provision of MH services for all 0-18 year olds who need them  
Reduced mental health problems in older children

### Local authority and CCG Adult Services Commissioners (eg. maternity, adult mental health, domestic abuse)

Wellbeing of parents and their children





The NHS Long Term Plan states:

**“ICSs will have a key role in working with Local Authorities at ‘place’ level and through ICSs, commissioners will make shared decisions with providers on how to use resources, design services and improve population health (other than for a limited number of decisions that commissioners will need to continue to make independently, for example in relation to procurement and contract award). Every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level. This will typically involve a single CCG for each ICS area. CCGs will become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and Long-Term Plan implementation”.**

ICSs will agree system-wide objectives with the relevant NHS England/NHS Improvement regional director and be accountable for their performance against these objectives. This will be a combination of national and local priorities for care quality and health outcomes, reductions in inequalities, implementation of integrated care models and improvements in financial and operational performance”<sup>1</sup>.

Alongside this, **Primary Care Networks**<sup>2</sup> (PCNs) are being developed. Each PCN will have a medical director (a GP). NHS England (March 2019) describes PCNs as:

**“Groups of general practices working together with a range of local providers, including across primary care, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care to their local populations. Networks would normally be based around natural local communities typically serving populations of at least 30,000 and not tending to exceed 50,000. They should be small enough to maintain the traditional strengths of general**

**practice but at the same time large enough to provide resilience and support the development of integrated teams.”**

**Health and Wellbeing Boards (HWBs)** are established by local authorities to bring together representatives from health, social services and the local community to understand and meet the public health needs of the local population in an integrated and holistic way. HWBs bring together the directors of adult social services, children’s services and health from the local authority, together with CCG representatives. HWBs have statutory responsibility for producing Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, which assess the health and social care needs of the local population and lay out strategies for how these will be addressed.

HWBs give local government a key role in coordinating local health and care services. The future role of HWBs is somewhat uncertain, given the growth of STPs and ICSs. HWB’s have the same footprint as upper tier and unitary local authority.

Many CCGs, HWBs, ICSs will have small sub-groups with a focus on issues such as maternity, mental health and children. The emphasis on these areas and the priorities for action vary greatly by area. In some places, the First 1001 days might be a local priority, making it easier to make the case for investment in parent-infant relationship teams.

In addition to the structures set out above, some areas still have children’s trusts in place. The Children’s Act 2004 required local authorities to set up children’s trusts, which brought together a range of local agencies (many of whom had a statutory duty to cooperate). The statutory duties underpinning children’s trusts were removed in 2010, but some areas still have similar structures in place, often reporting to the HWB.

1. NHSE (2019) Long Term Plan, page 29 <https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/>

2. NHSE (2019) Primary Care Networks: Frequently Asked Questions <https://www.england.nhs.uk/wp-content/uploads/2019/04/pcn-faqs-000429.pdf>



### Other organisations and structures to be aware of include:

- **NHS England** The national body responsible for overseeing the commissioning of health services by CCGs. Also commissions certain services directly
- **Public Health England** Executive agency providing expertise and information to public health teams in local authorities and the NHS
- **Regional commissioning support** units Providers of commissioning support services to NHS commissioners
- **Healthwatch** Responsible for engaging with users of health and social care services and ensuring their views are heard
- **Strategic clinical networks** Region-based networks of commissioners, patients and providers which ensure a strategic approach to improving quality of care in priority clinical areas
- **Clinical senates** Comprised of a steering group and broader forum of experts to provide strategic advice to commissioners in their local area<sup>3</sup>

Public Health England have added localised reports about the mental health of women during pregnancy and of infants to their Fingertips database. These reports provide data that has been designed to support local needs assessment and commissioning to improve health and wellbeing.

You may like to have a look at how your area is doing by searching at: <https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/13/gid/1938133228/pat/6/par/E12000005/ati/102/are/E10000031>

## Northern Ireland

Northern Ireland has a Health and Social Care Board, and five local Health and Social Care Trusts which are responsible for both health and social services, including children's services.

In Northern Ireland, work to promote infant mental health is being led by the Public Health Agency who developed the Infant Mental Health Strategic Framework in 2016<sup>4</sup> referred to in Chapter 2 The Case for Change.

## Wales

In Wales, there are seven local Health Boards and twenty-two local authorities. Health Boards play a similar role to CCGs in England, with responsibility for commissioning most health services for the local population.

Children's services sit within local authorities. Public Health Wales are leading work with a group of stakeholders to make the case for the emotional wellbeing of babies, which they plan to make a central part of the First 1000 Days framework which will be published later this year.

## Scotland

In Scotland, fourteen regional Health Boards have responsibility for planning and delivering health services for their local area, and Health Board and Local Authorities have a joint duty under the Children and Young People (Scotland) Act 2014 to integrate planning of children's services.

Recent legislation has encouraged and enabled increased integration of services in Scotland, and thirty-one Integration Joint Boards (IJBs) have been established across the country to integrate plans and budgets<sup>5</sup>. The specific areas of children's services that have been devolved to integration authorities varies between areas, but all hold strategic responsibility for some aspect of children's

3. NCVO website. Health and wellbeing boards - roles and responsibilities <https://knowhow.ncvo.org.uk/funding/commissioning/commissioning-1/influencing-commissioning-1/health-and-wellbeing-boards-1/roles-and-responsibilities>

4. Public Health Agency (2016). 'Supporting the best start in life' Infant Mental Health Framework for Northern Ireland. [https://www.publichealth.hscni.net/sites/default/files/IMH%20Plan%20April%202016\\_0.pdf](https://www.publichealth.hscni.net/sites/default/files/IMH%20Plan%20April%202016_0.pdf)



health and children's social work services. It may vary from area to area whether NHS Boards, Local Authorities or Integration Joint Boards take the lead for the first 1001 days and infant mental health.<sup>6</sup>

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.

**Chapter 2 The Case for Change includes information about national policies relevant to commissioning services which ensure the emotional wellbeing of babies.**



## Commissioning specialised parent-infant relationship teams: the ideal

Ideally, specialised parent-infant relationship teams should not be commissioned in isolation, but as part of a wider strategy that secures a pathway of support for babies and their families in the local area. This ensures support for families with differing levels of need, so that parent-infant teams can focus on the most appropriate families for their service and are able to refer families who do not need such intensive support to other services.

The range of work undertaken by specialised parent-infant relationship teams, together with the complex commissioning arrangements currently in place, means that parent-infant teams can legitimately be funded from a range of sources.

**Ideally parent-infant teams should be jointly funded by CCG Children and Young People's Mental Health commissioners (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 authority public health budgets (recognising their role in child health and mental health promotion), perhaps also with contributions from maternity and adult services and other public services such as the Police and Crime Commissioner.**

**Such pooling of resources enables the development of a strong, sustainable team that can work with professionals across the system to ensure babies at risk are safe, healthy and developing well.**

5. [http://www.parliament.scot/ResearchBriefingsAndFactsheets/S5/SB\\_16-70\\_Integration\\_of\\_Health\\_and\\_Social\\_Care.pdf](http://www.parliament.scot/ResearchBriefingsAndFactsheets/S5/SB_16-70_Integration_of_Health_and_Social_Care.pdf)

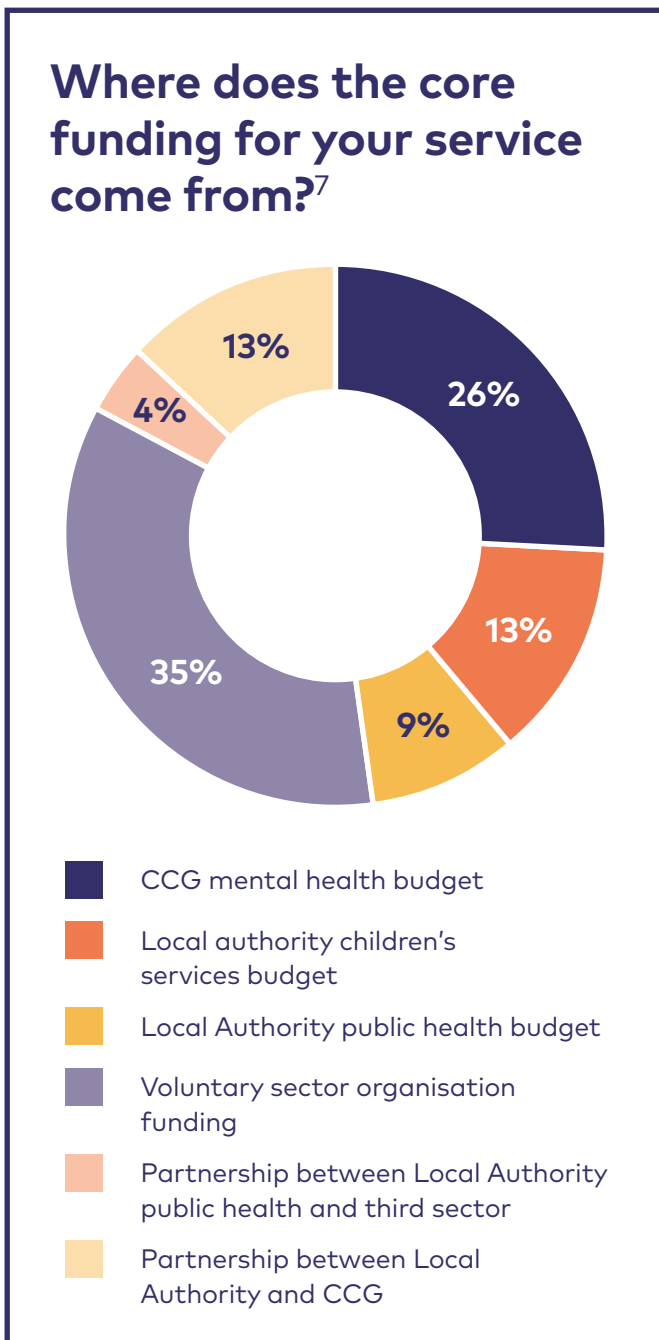
6. All aspects of children's services are included in 9 Integration Joint Boards (IJBs), in 1 IJB children's services are located with children's primary health services and education within the council; and 21 where children's services remain with the local authority. <https://childreninscotland.org.uk/integration-of-health-and-social-care/>

Partnership working and joint commissioning arrangements need clear accountability. Our Rare Jewels report (2019) identified that there is confusion about where responsibility for commissioning parent-infant relationship services should sit.

We have argued that there should be a lead accountable commissioning body for all children’s mental health services (including those for infants).

## Commissioning specialised parent-infant relationship teams: the reality

Some of the parent-infant teams in the UK, such as the Anna Freud Centre team and OXPIP, have been around for over 20 years. New teams are being commissioned around the country and we are pleased to see the number of services growing.



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 a survey of parent-infant teams, 21 services told us where they got their core funding from.

Interviews with commissioners in Leeds, Tameside and Glossop and Croydon illustrate the importance of the following themes in setting up and sustaining a specialised parent-infant relationship team:

- Local leaders having a good understanding of the First 1001 days, 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

7. Hogg, S (2019). Rare Jewels: Specialised Parent-Infant Relationship Teams in the UK. Parent Infant Partnership UK. <https://parentinfantfoundation.org.uk/our-work/campaigning/rare-jewels/>





## Examples of existing commissioning arrangements

### LEEDS

The Infant Mental Health Service started from an intervention offered by health visitors in children's centres. Seeing the value of this work, commissioners made infant mental health part of the CAMHS service specification to ensure a clear, consistent offer across the system. The service is funded by the Local authority public health budget and the CCG Children and Young People's mental health budget.

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.

### CROYDON

The Best Start PIP team is commissioned by the local authority. The team is part of Croydon Best Start, a local initiative to combine fully health and local authority 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 PIP team is seen as part of the local offer to address adverse childhood experiences and to support nurturing relationships in order to give all children the Best Start.

### TAMESIDE AND GLOSSOP

The Early Attachment Service is funded by public health and the CCG Tameside and Glossop as part of the Greater Manchester Combined Authority, which has prioritised perinatal and infant mental health and all children starting school "ready to learn". To deliver this, the authority is working to integrate 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 setting up new parent-infant services, perinatal mental health services and IAPT services for parents of babies in each borough.

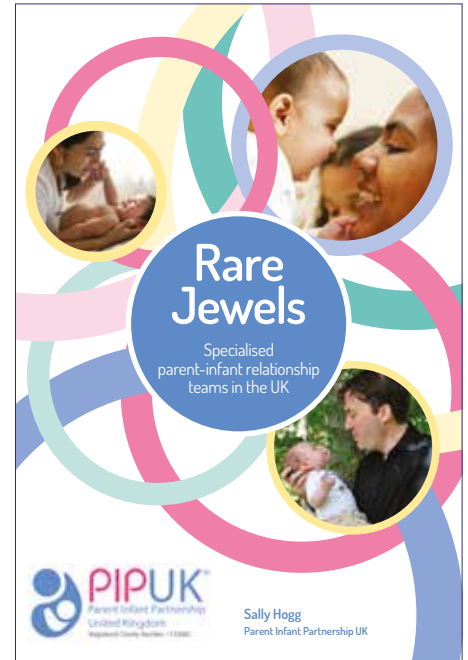
These services work closely together and integrate with existing universal and specialist services that work with families. Manchester has prioritised both perinatal and infant mental health, using new funding from NHS England and investing additional funds in each of the 10 boroughs.

This has provided an opportunity to roll out the Early Attachment Service to other boroughs, which the Tameside and Glossop team are supporting.

## Rare Jewels: Specialised Parent-Infant Relationship Teams in the UK

In 2019, PIP UK completed the first comprehensive survey of parent-infant relationship team provision across the UK<sup>8</sup>. This report found that there is very little mental health provision for children aged two and under. Most babies in the UK live in an area where there is no parent-infant relationship team; our research found only twenty-seven multi-disciplinary, free at the point of delivery parent-infant relationship teams in the UK.

Despite child and adolescent mental health services (CAMHS) nominally being a service for 0-18 year olds, data collected through Freedom of Information requests suggested that in some areas, commissioners do not commission any mental health services at all for young children. Forty-two percent of CCG areas in England CAMHS services do not accept referrals for children aged two or under. Provision is also limited in Wales, Scotland and Northern Ireland. Rare Jewels discusses why this might be the case.



8. Hogg, S (2019). Rare Jewels: Specialised Parent-Infant Relationship Teams in the UK. Parent Infant Partnership UK. <https://parentinfantfoundation.org.uk/our-work/campaigning/rare-jewels/>



## Current opportunities for commissioning in England

All areas in England have had to produce a Children and Young People's Transformation plan to indicate their ambitions to achieve the aims of the Future in Minds strategy document. This has now moved on to the NHS Long Term Plan<sup>9</sup> (LTP, January 2019) which continues the focus on children's mental health. The LTP states:

**"Over the coming decade the goal is to ensure that 100% of children and young people who need specialist care can access it".**

Sustainability and Transformation Partnerships (STPs) or Integrated Care Systems (ICSs) are required to develop and agree strategic five-year plans by mid-November 2019 which set out how they will deliver the commitments made in the Long-Term Plan. The plans should include information about what local systems are doing to improve prevention and how they are expanding children and young people's mental health services in line with the LTP commitments.

As set out in the Rare Jewels report (2019), we believe that achieving the LTP commitments for the youngest children requires adequately resourced specialised parent-infant relationship teams in all localities. A traditional CAMHS model and interventions may not meet the needs of 0-2 year olds.

Clinical Commissioning Groups (CCGs) will be receiving additional funding to deliver NHS Long Term Plan commitments, including

expansion of children and young people's mental health services which could be used to fund parent-infant relationship services.

Therefore, a useful point for conversations with CCGs is the requirement for them to commission a service for 0-25 year olds.

The NHS Long Term Plan also has a clear focus on perinatal (adult) mental health and includes a comment on providing support for women with relationship/attachment concerns. Again, CCGs have increased funding in their baseline budgets for a range of mental health services including perinatal and most areas have a commissioner responsible for perinatal mental health.

Another potential funding route may be through Local Maternity Systems (LMS) which are responsible for delivering the Better Births<sup>10</sup> ambition, a five-year forward view for maternity and related services. There is usually a local programme lead working on behalf of the local CCGs across a larger footprint.

In some areas, the Chair of the local Community and Voluntary Sector (CVS) infrastructure organisation may meet regularly with CCG and Local Authority leaders and may be willing to raise suggestions and identify opportunities.

Finally, the prevention green paper<sup>11</sup> currently out for consultation includes emphasis on early intervention and 1001 days therefore, there may be future opportunities through public health commissioning within local government.

9. NHS (2019) NHS Long Term Plan <https://www.longtermplan.nhs.uk/>

10. NHS England (2015) The National Maternity Review <https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf>

11. Cabinet Office and DHSC (2019) Open consultation. Advancing our health: prevention in the 2020s – consultation document <https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s/advancing-our-health-prevention-in-the-2020s-consultation-document>

## Sources of information which commissioners and others may find helpful:

### The costs of perinatal mental health problems

<https://www.centreformentalhealth.org.uk/costs-of-perinatal-mh-problems>

### Child health profiles

<http://fingertips.phe.org.uk/profile-group/mental-health/profile/perinatal-mental-health>

### Child health profiles, including mental health in pregnancy and infancy

<https://fingertips.phe.org.uk/profile/child-health-profiles>

**Maternity data set interactive report** <https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set>

### Children's and Young People's Mental Health and Wellbeing

<http://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh/data>

### Early Years Child Health Profiles

<https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/1/gid/1938133223/pat/6/par/E12000007/ati/102/are/E09000024>

## What should be commissioned?

Specialised parent-infant relationships teams are ideally commissioned as an essential and fully-integrated part of the broader ecosystem that supports the emotional wellbeing of babies. This includes universal and specialist services such as health visiting, maternity, adult and perinatal mental health and the voluntary sector. The team's system-level work should be commissioned to build skills and knowledge across the workforce so that parent-infant relationships are at the heart of the system and community.

Commissioners may decide to commission teams to cover specific CCG or local authority areas or to pool resources to create a proportionately larger team to work across a larger geographical area (which might enable some economies of scale).

What works best will depend on local factors such as geography, transport links, population need and the level of resourcing in other services in the region.

Specialised parent-infant relationship teams tend to be provided by NHS CAMHS teams, multi-disciplinary teams in public health services or children's services, or third sector organisations. In recent years, some perinatal mental health teams have recruited workers with specialised parent-infant relationship competencies.

Teams look different across the UK but they are all multi-disciplinary with specialised expertise in supporting and strengthening the important relationships between babies and their parents or carers. Together they provide a toolbox of interventions and support for early relationships at risk or experiencing severe difficulties.





The majority have at least one clinical psychologist and one parent-infant or child psychotherapist. Other roles on the team often include:

- Family support workers or key workers
- Infant mental health practitioners/parent-infant therapists
- Specialist health visitors
- Operational 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.

**Chapter 5 Setting Up a Team and Chapter 7 Recruitment, Management and Supervision contain lots of information about different professionals and the roles within teams. The section below focusses on commissioning according to local need and size of population.**

## Commissioning for local need

Teams should be designed so that they can support the needs of the local population. One way to understand the level of local need for specialised parent-infant provision is to take the accepted incidence of disorganised attachment in the general population of infants and then adjust to account for local indices of need. Robust research estimates that disorganised attachment, the parent-infant relationship style most closely associated with

the poorest outcomes for children, is about 15% in middle-class non-clinical groups and 34% in low-income samples<sup>12</sup>. This figure is greater in families where there has been, or there is a risk for, maltreatment (up to 48%), children of mothers misusing substances/ alcohol (estimated at 43%), children of depressed parents (estimated at 21%) and for families coping with multiple risks<sup>13</sup>. The need will be even higher in communities affected by other forms of trauma, such as in Northern Ireland, refugees and asylum-seeking families or other communities particularly affected by racism or harassment, poverty, mass unemployment or traumatic incidents.

Where it exists, local survey data regarding the prevalence of Adverse Childhood Experiences (ACEs) in parents may help commissioners to adjust their estimates for how many families could benefit from parent-infant work. This can only be done at a whole population or community level, not as an individual screening mechanism. For example, where previous work has established that a community has a high average ACE score, one might argue that the pressures on the parent-infant relationships in that community will be higher.

Some places are applying the ACEs research to service thresholds or to screen individual families. Their hypothesis is that a person's number of ACEs indicates their level of need. Unfortunately, this is not supported by the latest evidence<sup>14</sup>: the ACEs research is based on large population-level studies, with estimates of risk only being applicable to groups not individuals. There is currently insufficient evidence to support the use of ACEs in screening or referral criteria<sup>14,15,16</sup>.

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12. 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
13. Cyr, C., Euser, E. M., Bakermans-Kranenburg, M. & Van IJzendoorn, M. (2010) Attachment security and disorganization in maltreating and high-risk families: A series of meta-analyses. *Development and Psychopathology*. 22 (1), 87-108
14. Ford, K., Hughes, K. Hardcastle, K. et al (2019). The evidence base for routine enquiry into adverse childhood experiences: A scoping review. *Child Abuse and Neglect*, 91: 131-146. <https://www.sciencedirect.com/science/article/pii/S014521341930095X>
15. Murphey, D & Dym Bartlett J (2019). Childhood adversity screenings are just one part of an effective policy response to childhood trauma. *Child Trends*. <https://www.childtrends.org/publications/childhood-adversity-screenings-are-just-one-part-of-an-effective-policy-response-to-childhood-trauma>
16. Bateson, K., McManus, M. & Johnson, G (2019). Understanding the use, and misuse, of Adverse Childhood Experiences (ACEs) in trauma-informed policing. *The Police Journal: Theory, Practice and Principles* April 23. Doi: <https://doi.org/10.1177/0032258X19841409>
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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. The table below shows the suggested staffing in their service specification.

## Incremental development

There is a myriad of ways to commission, fund and set up a specialised parent-infant relationship team. Many teams grow from humble beginnings. For example, the Early Attachment Service in Tameside and Glossop, a team of now 7.3WTE staff, started 13 years ago with 0.5 WTE and has grown through small, yearly increments. Chapters 5 and 6 are all about getting started, delivering services to families and becoming sustainable, but we describe briefly below some of the different ways that existing teams began to gather support and momentum locally:

### 1. Creating clinical leadership capacity

With agreement from strategic leads, identifying a clinical lead (typically in community services) to help think about and map local resources and identify gaps. Sometimes this starts as a ring-fenced part of an existing post and grows into something more substantive over time.

### 2. Creating an infant/perinatal mental health forum

These can take different forms but typically involves bringing together people from different parts of the community, professional services, commissioning and strategic development to provide a space to think about the needs of local babies and their families, to co-develop professional development activities and explore opportunities for partnership working. Ideally, the forum is an integrated perinatal and infant mental health forum which facilitates "whole system" thinking and working.

Staff	Band	WTE	Notes
Cluster Lead: clinical psychologist or psychotherapist	8c	0.33	1.0 WTE could work across more than one locality
Locality Lead: clinical psychologist or psychotherapist	8b	1	
Early Attachment Specialists (HV, parent-infant infant psychotherapist, midwife, clinical psychologist)	7	2	
Embedded Mental Health practitioner	7	1	Reaching in from AMH with a service development role in AMH
Social Worker		1	
Administrator	4	1	
Embedded Home Start PIMH worker & volunteers		1	
	<b>Total WTE</b>	<b>7.33</b>	



### 3. Writing an infant mental health strategy

Bringing together commissioners and service leads, potentially with local service providers, the voluntary sector and community or service user reps to write a 2-3 years strategy (either an Infant Mental Health strategy or ideally an integrated Perinatal and Infant Mental Health strategy) to build on local strengths and identify key drivers and opportunities for growth.

This group may also form an infant mental health forum, or at least relate to it as its strategic body, feeding into existing governance structures.

**“Once we’d got a shared infant mental health strategy that everyone could sign up to, it allowed us to create a really well co-ordinated parenting strategy.**

**This meant that all the parenting groups offered to families in our locality then built on the importance of parent-child relationships and sensitive attunement”.**

Parent-infant team clinical lead

### 4. Maximising impact by enhancing existing services' offers in the first 1001 days

There are likely to be commissioned and provided services locally which already have contact with parents and their babies. These existing services might be able to improve their offer of specialised parent-infant relationship work further through enhanced or joint commissioning and funding arrangements.

For example, a pre-birth assessment service may be able to recruit parent-infant relationship specialists to begin offering work to families about to have a baby.

In Birmingham, Ruth Butterworth, an academic psychologist from the local clinical psychology training course, saw that babies were missing from the attentions of clinicians and commissioners and so began running a twice-yearly Infant Mental Health forum.

The meetings were two-hours long and had an invited speaker on clinical topics. It grew rapidly to attract a wealth of participants and provided crucial support for isolated practitioners trying to do parent-infant work in various agencies across the city.

Whilst led from a university, the forum provided a useful quality-improvement and partnership-development role.

Invitees to an IMH forum can include midwifery, health visiting, perinatal adult mental health teams, adult mental health, child mental health, social care, voluntary and third sector providers, domestic abuse organisations, substance misuse services, public health, local councillors, Family Nurse Partnerships, police, safeguarding teams/boards, infant feeding colleagues, children’s centres and various senior service leads and commissioners.

The learning from the Birmingham example was that it was helpful that the lead was “strategically neutral” and not from one of the provider trusts as this may have led to a different dynamic.

Forums like this take a lot of time, effort and commitment which busy clinicians are generally not afforded, although having this type of clinical leadership/ quality improvement activity written into local strategies can help legitimise it and develop momentum.

## Developing a service within CAMHS

CAMHS may be able to develop their offer to under-twos through specialised direct work, consultation to other colleagues or training, in small ways at first but which can demonstrate 'demand' and impact. This supports CAMHS staff to develop some of the specialist skills required to work with the parent-infant relationship and could lead to dedicated referral pathways for children under two.

This specialised part of CAMHS should be clearly defined as a parent-infant relationship service so as not to inadvertently locate the difficulties in the infant. The focus is on the relationship and the infant's presentation is understood as an adaptation in the context of that relationship.

In a Freedom of Information request for the Rare Jewels report (2019), 42% of CCGs reported that their mental health services do not accept referrals for under-twos.

## Other sources of funding

### Charitable funding

Some specialised parent-infant relationship teams operate as charities or charitable organisations, i.e. OXPIP and NorPIP, or as a programme of work within a larger third sector organisation i.e. NEWPIP within Children North East and Croydon Best Start PIP within Croydon Drop In.

Third sector organisations may be set up in a variety of formats. Detailed information about the different structures and governance options can be found at:

<https://www.gov.uk/set-up-a-charity> (England or Wales)

<https://www.oscr.org.uk> (Scotland)

<https://www.charitycommissionni.org.uk> (Northern Ireland)

There is also usually information available through your local Community and Voluntary Services infrastructure organisation. A list of these are available at:

<https://navca.org.uk/find-a-member-1>

Local charitable organisations can also find advice and support on governance, fundraising, marketing, etc. through the following national bodies:

**NCVO** <https://www.ncvo.org.uk/>

**Small Charities Coalition**

<http://www.smallcharities.org.uk/>

Charitable organisations rely on finding their own funding so usually need an in-house fundraiser or budget to pay an external fundraiser with the time, effort and expertise to source the right type of funding for the organisation and its activities.

**Income typically comes from a range of sources:**

#### 1. Local commissioning

Third sector organisations are often able to apply for local NHS and local authority commissioning tenders to deliver a service. The tender opportunity will stipulate the budget, the key performance indicators and the scope of the service expected to deliver these.

#### 2. Fundraising from trusts and foundations

There are a range of trusts and foundations that offer funding for charities providing local services. Applications for funding may be accepted on a rolling basis, during certain windows throughout the year or related to specific funding calls on themed topics. Each trust and foundation operate differently and applicants will need to familiarise themselves with each funders' specific priorities.

**Things to consider include (but are not restricted to):**

- a. Whether the funding body has stipulations around demographics of beneficiaries such as the age, gender, specific communities





- b. The amounts available and the typical size of grants distributed
- c. The time period over which grants are available i.e. one year, three years
- d. Whether they fund a charity of your size and income (within a specified annual turnover)
- e. Whether they fund core (running) costs or only certain activities

## Major donors

These are typically philanthropists or companies who seek to invest in local and national charities in areas of work which align to their interests. Access to these funders often requires a warm relationship which might be generated through staff, trustees, patrons.

## Community fundraising

This is income generated through fundraising activities such as sponsored activities, street collections and so on. Fundraisers typically have a personal reason for supporting your charity and this might be a consideration in your fundraising strategy.

**The Parent-Infant Foundation may know other people in your area looking into setting up a parent-infant relationship team, so do contact us as we may be able to put you in touch with them. We do not fundraise on behalf of local parent-infant relationship teams but can assist with discussions and thinking around fundraising and income generation.**

## Evidence of impact

Funders need robust data collection and demonstration of the benefits of your work to reassure them that your work is worth investing in. There is more information in Chapter 8 Managing Data and Measuring Outcomes. The Parent-Infant Foundation can assist with this in various ways and has a bespoke data software system to support local teams in collecting data for service improvement and impact reporting.

## Income generation

When charities are considering their income streams, some also include activities to generate income beyond applying for funds from elsewhere. Examples from some of the existing teams include:

- The provision of therapeutic services on a private basis (charging some clients based on a variety of criteria) or invoicing public sector services on an individual case basis
- The provision of training days or courses for other professionals, either charged for on an individual/organisational basis or commissioned at scale
- Commissioned or contractually-funded supervision or consultations

NHS and local authority teams can also establish income generation activities and these are most easily set up at the commissioning contract stage where the legal and commercial aspects can be discussed.



In Newcastle, NEWPIP offer an Infant Mental Health Course that is an intensive multi-agency 10-week course for professionals working to promote infant mental health and development. It helps professionals address difficulties in the parent-infant relationship and to enhance their skills in early intervention.

The course is a practical and theoretical introduction to some essential themes concerning the foundations of emotional, cognitive and personality development in babies and young children in the context of their primary relationships and experiences.

It considers infant development from the perspectives of psychoanalysis, attachment theory, infant developmental research and social policy.

There is a focus on the development of participants' observation skills to make the connection between feelings, needs and behaviour. Weekly seminars explore pioneering studies and clinical approaches and involve in-depth discussion of participants' own case work and clinical experiences.

The course is three hours per week with a requirement to read and prepare for seminars and to carry out a one-hour infant observation outside of the course hours. The course is accredited with 35 CPD hours through the CPD Standards Office. There is also a 'Train the Trainer' franchise model for areas outside of Newcastle. The fee includes initial tutor fees, the licence to deliver the course and participants' course packs.

**Please contact [newpip.info@children-ne.org.uk](mailto:newpip.info@children-ne.org.uk) for further details.**



## Chapter 4

# Clinical Interventions and Evidence-Informed Practice

This chapter of the Parent-Infant Foundation UK toolkit will help you think about which therapeutic approaches a specialised parent-infant relationship team might offer. This might influence the types of professionals you recruit. It introduces the clinical guidance relevant to parent-infant relationship work and an example of a clinical-level Theory of Change. There are brief descriptions of some of the most popular and effective evidence-based practices in parental engagement, assessment and intervention in parent-infant relationship work. For information about mental health professions and their training, skills and qualifications see Chapter 7 Recruitment, Management and Supervision.

## National clinical guidance

There are not yet any national guidance or quality standards which direct the work of specialised parent-infant relationship teams. There are recommendations relevant to the parent-infant relationship in several NICE guidance documents including **Children's Attachment (QS133)**, **Postnatal Care (QS37, quality statement 9)**, **Social and Emotional Wellbeing: Early Years (PH40)** and **Early years: promoting health and wellbeing in under 5s (QS 128)**.

The National Institute for Health and Clinical Excellence (NICE.org.uk) states that securely attached children have better outcomes than non-securely attached children in social and emotional development, educational achievement and mental health. Early attachment relations are thought to be crucial for later social relationships and for the development of capacities for emotional and stress regulation, and self-control.

Children and young people who have had insecure attachments are more likely to struggle in these areas and to have emotional and behavioural difficulties

(NICE, QS133). Parents and carers of children under 5 should be offered a discussion during each of the five key health visitor contacts about factors that may pose a risk to their child's social and emotional wellbeing (NICE, QS128).

Women should have their emotional wellbeing, including their emotional attachment to their baby, assessed at each postnatal contact (NICE, QS37).

Parents or main carers who have infant attachment problems should receive services designed to improve their relationship with their baby (NICE, QS37).



Therapies offered by parent-infant teams are based on sound psychological theory, excellent scientific research and increasingly promising outcomes evidence. However, the body of 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<sup>1</sup>.

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. Some of the parent-infant interventions described below feature in the **Early Intervention Foundation's Guidebook**<sup>2</sup> which provides information about early intervention programmes that have been evaluated. Some programmes widely used in the UK are yet to be rated<sup>3</sup>.

The EIF Guidebook reports two types of evidence: one about a programme's effectiveness and the other about its cost-benefit. The Guidebook uses high-quality, often academic research such as Randomised Controlled Trials (RCTs) but does not yet account for the variability created by implementation factors. These are critical aspects of delivery which determine whether

an intervention will actually deliver outcomes in real-world settings. For example, the world's best-evidenced intervention will not help families if parental engagement is poor, staff are not properly trained and supervised, and the intervention is delivered in an inaccessible venue and manner. Where available, we provide a link to the relevant section of the EIF Guidebook with this caveat in mind.

There is additional analysis of infant-related interventions at the **California Evidence-Based Clearing House for Child Welfare**<sup>4</sup>.

## Theories of Change

**"A theory of change lays out what specific changes the group wants to see in the world, and how and why a group expects its actions to lead to these changes."**<sup>5</sup>

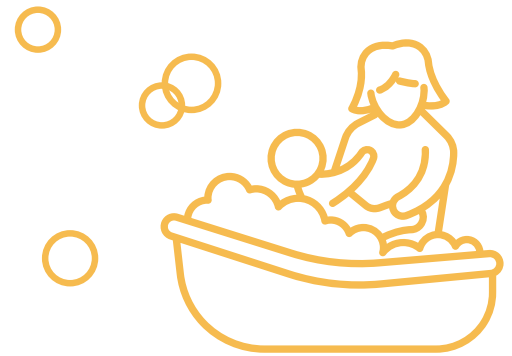
Which clinical approaches and interventions to select is influenced by the outcomes you wish to achieve. A Theory of Change helps clarify those outcomes and which activities should achieve them. Figure 1 presents an example of a clinical-level Theory of Change which explains the therapeutic mechanism of change and intended outcomes between individual families and practitioners. In Chapter 3 Funding and Commissioning, there is an example of a system-level Theory of Change for the work of specialised parent-infant relationship teams which explains the impact teams can have at a population and system level.

Many teams develop, and ideally co-create with stakeholders, their own clinical Theory of Change to ensure that they select the

1. 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.
2. The Early Intervention Guidebook website <https://guidebook.eif.org.uk/>
3. <https://guidebook.eif.org.uk/about-the-guidebook/other-programmes>
4. The California Evidence-Based Clearinghouse for Child Welfare: Information and Resources for Child Welfare Professionals. <https://www.cebc4cw.org/search/results/?keyword=infant>
5. Guthrie K., Louie J., David T. & Foster C. (2005) The Challenge of Assessing Policy and Advocacy Activities: Strategies for a Prospective Evaluation Approach. The California Endowment: Los Angeles.



most appropriate clinical approaches for their intended local outcomes. It shows what kinds of activities and essential therapeutic ingredients an intervention should contain in order to effect change for children and their parents. It should ideally be based on the research that shows trauma and adversity within the early parent-infant relationship have the potential to compromise the child's long-term emotional, mental and physical health.



**Co-creating a local Theory of Change can be a very helpful process to work through with a range of local stakeholders because it helps everyone think together about exactly what the team will and won't be doing, how and for what exact purpose.**

There is helpful guidance about co-creating a Theory of Change at **NCVO Knowhow<sup>6</sup>** and information about how Theories of Change underpin evaluation in the Early Intervention Foundation's **"10 Steps for Evaluation Success"<sup>7</sup>**.

In our example Theories of Change, we use "short-term outcomes" to describe the outcomes that come about during the intervention, such that they can be seen or measured by the end of the intervention. We use "medium-term" to mean after the intervention is finished (exactly how long depends on a number of factors including the nature of the intervention and what follow-up is planned).

"Long-term outcomes" tend to be at a population, community or societal level.



6. How to Build a Theory of Change <https://knowhow.ncvo.org.uk/how-to/how-to-build-a-theory-of-change>
7. Asmussen, K., Brims, L. & McBride, T. (2019). 10 Steps for Evaluation Success. The Early Intervention Foundation, London. <https://www.eif.org.uk/resource/10-steps-for-evaluation-success>



## An example of a clinical-level Theory of Change

### The problem

- Not every child has access to a sufficiently secure relationship with at least one permanent adult carer

### How the problem develops

- Unresolved parental traumas from the past ("ghosts in the nursery") or present can be translated into parental states of mind that get played out in maladaptive ways and these damage the interactions with the baby
- Aspects of the parent's behaviour can lack sensitivity or capacity for appropriate responsiveness leading to distress in the baby
- Aspects of the baby's behaviour can trigger unresolved traumas in the parent, leading to stress or lack of pleasure from parenting

### How we can change this

- Address the states of mind and interactional behaviour of the parent that negatively impact the baby. Give meaning to why these occur and how they can be changed
- Improve reflective functioning and parental capacity to provide emotional regulation for their infant
- Improve infants' capacity to engage confidently and feel secure with parent

### Activities

- Offer families a variety of direct therapeutic approaches (with the parent-infant dyad but sometimes also with the family triad, the parental couple without the baby and/or with parents individually) which:
  - Address parental unresolved traumas, current stressors, anxieties and risk factors
  - Support parents' strengths to improve parental sensitivity, mentalisation and reflective functioning
- Signpost and facilitate contact with a range of other services which can address current stressors (such as housing, financial stress, substance misuse, parental conflict/relationship strain)

### Short-term outcomes

- Decreased traumatising behaviour by the parent towards the baby, reduced sense of stress with the baby, improved parental empathy, consistency and motivation
- Parent and infant feel safe with each other, improved warmth in the interaction, improved attunement and more developmentally appropriate interactions
- Improved infant invitation and initiation of interaction with adults including parents
- Improved assessment and support of the family's needs, child protection issues and the parent's capacity to change

### Medium-term outcomes

- Improvements in parent's capacity to sustain emotional and behavioural self-regulation
- Quality of parent-child relationships for indicated child and siblings is improved
- Child is more relaxed, with improved social and emotional development
- Improvements in parents' openness to trusting relationships with helping professionals and in the effectiveness of professional assessment and support

### Long-term outcomes

- Improved likelihood of child securing better physical and mental health, social, emotional, cognitive and language development
- Reduced risk of child needing referral to speech therapy, early help, children's services, CAMHS, paediatrics, or special educational needs services for problems rooted in parent-infant relationships
- Reduced risk of transmission of parent-infant relationship difficulties into the next generation



**A system-level Theory of Change explains the impact teams can have at a population and system level. A clinical-level Theory of Change explains the therapeutic mechanism of change and intended outcomes between individual families and their parent-infant practitioner.**

## Engagement prior to and during assessment

Your referrers are critical to parental engagement: the quality of engagement they have with the family and with you as a team influences the motivation of the family. Therefore, time spent with your referrers, building mutual understanding, offering consultations and joint visits and ensuring smooth referral paths pays dividends in terms of family engagement later down the line. Joint visits can be particularly effective in scaffolding a families' transfer from referrer to team.

Give referrers guidance and support about how best to describe the work of the team including language to describe the work to families. Language should be strengths-based, not focussed on deficits or "fixing the problem" and small tweaks can be important. For example, after describing what the parent-infant team can offer, referrers could say to families "Is that something you'd be willing to try?"

Dialogic research shows that use of the word willing (as opposed to want, will, should etc) increases motivation to engage in services perceived to involve difficult conversations<sup>8</sup>.

Parents who are struggling to form a relationship with their baby commonly experience relationship difficulties in other areas of their life, including with professionals and services. **Trust is at the heart of attachment. The reason that a family have been recommended to a parent-infant relationship team might be the very thing that makes it so hard for them to engage.**

Engaging families referred to a specialised parent-infant relationship team frequently takes skill and tenacity from sensitive practitioners but the investment in time is essential if the later work is to be effective. Home visits, texting families and joint visits may help.

Motivational interviewing may offer a promising approach to enhance families' motivation to engage<sup>10</sup>. The Health Foundation produced a useful evidence scan in 2011 about how best to train professionals<sup>11</sup>.

**Despite good evidence that the engagement of fathers is highly beneficial for children, mothers and the whole family even where parents are separated, fathers are more likely to be overlooked or inadvertently excluded by services supporting children<sup>9</sup>. We recommend the Dads Matter and Fatherhood Institute websites for practical advice and information about training.**



8. Elizabeth Stokoe (2018) Talk: The Science of Conversation. London: Robinson
9. Bateson, K., Darwin, Z., Galdas, P. and Rosan, C. (2017) Engaging fathers: Acknowledging the barriers. Journal of Health Visiting, 5 (3). pp. 126-132. ISSN 2050-8719 <http://eprints.whiterose.ac.uk/111579/>
10. Ingoldsby, E.M. Review of Interventions to Improve Family Engagement and Retention in Parent and Child Mental Health Programs. J Child Fam Stud (2010) 19:629. <https://doi.org/10.1007/s10826-009-9350-2>
11. The Health Foundation (2011). Training professionals in motivational interviewing. <https://www.health.org.uk/publications/training-professionals-in-motivational-interviewing>

## Infant Massage

Some parent-infant relationships teams either include or work closely with infant massage practitioners. Those teams tell us that infant massage can be a useful vehicle through which parents can be identified and supported to engage with a specialised parent-infant relationship team, or as a useful step down or step out offer. Infant massage is typically viewed by parents as a non-threatening, enjoyable experience, which can be a time to build trust with helping professionals and spend quality time learning how to interact sensitively with their very small baby.

Infant massage comes in different forms and quality varies. Good quality infant massage focusses on the infant's needs for sensitivity and attunement<sup>12</sup> to ensure it does not create an opportunity of relational harm for the baby. Where a parent or carer is coached in how to massage their infant's skin gently and calmly, this is reported to help babies to feel secure and improve emotional regulation such that crying and emotional distress are reduced, and relaxation and sleep are improved<sup>13</sup>. For parents, infant massage is reported to improve feelings of closeness to the baby and improve attunement through a deeper understanding of the baby's cues and responses, possibly aided by both the baby and parent experience an increase in oxytocin<sup>14</sup>.

The intervention outcomes evidence about infant massage is mixed. The EIF Guidebook reports that the outcomes evidence does "not currently support the use of infant massage

with low-risk groups of parents and infants". Additional evidence suggests that infant massage could potentially make things worse for mothers and infants whose relationship was observed to be 'at risk'. However, EIF go on to say "if the activity is safe, relatively inexpensive and commissioned primarily because local families want and enjoy it — then there is likely no harm in making it available to parents and children, or for communities to commission it for themselves. However, if the activity is being offered to improve outcomes that it has little evidence of achieving then commissioners should think twice about why and for whom they are commissioning it, particularly when resources are very tight."

There may be more promising effects on the interaction where mothers are moderately depressed. A meta-analysis of approaches to enhance depressed mothers' sensitivity revealed that 'the most effective and robust technique to improve maternal sensitivity... was the use of baby massage'<sup>15</sup> and this study, which had strict inclusion criteria, in fact found no evidence that individual interpersonal therapy for depressed mothers had any effect on sensitivity. However, the evidence suggests that baby massage has the most effect when applied to medium-risk mothers with little or no positive results for low- or high-risk families<sup>16</sup>. Baby massage with depressed mothers has been shown to increase their capacity to recognise emotional expressions, including negative ones, and be more accurate in affective language communication<sup>17</sup>.

12. Underdown, A. and Barlow, J. (2011). Interventions to support early relationships: Mechanisms identified within infant massage programmes. January 2011. *Community Practitioner: the journal of the Community Practitioners' & Health Visitors' Association* 84(4). [https://www.researchgate.net/publication/263749630\\_Interventions\\_to\\_support\\_early\\_relationships\\_Mechanisms\\_identified\\_within\\_infant\\_massage\\_programmes](https://www.researchgate.net/publication/263749630_Interventions_to_support_early_relationships_Mechanisms_identified_within_infant_massage_programmes)

13. International Association for Infant Massage, 2019. <http://www.iaim.org.uk/about-baby-massage.htm>

14. Glover, V. (2002). Benefits of infant massage for mothers with postnatal depression. *Seminars in Neonatology*, 7(6), 495-500. <https://www.sciencedirect.com/science/article/pii/S1084275602901545>

15. Kerstan-Alvarez, L. E., Hosman, C. M. H., Riksen-Walraven, J. M. et al. (2011). Which preventative interventions effectively enhance depressed mothers' sensitivity? A meta-analysis. *Infant Mental Health Journal*, 32, (3), 362-376 (p372).

16. Underdown, A., Norwood, R. & Barlow, J. (2013) A realist evaluation of the processes and outcomes of infant massage programs. *Infant Mental Health Journal*, 34, (6), 483-495.

17. Free, F., Alechina, I., & Zahn-Waxler, C. (1996) Affective language between depressed mothers and their children: The potential impact of psychotherapy. *Journal of the American Academy of Child & Adolescent Psychiatry*, 35, (6), 783-790



## Practitioners Perspective on Infant Massage

"I have been part of the Parent Infant Mental Health Service programme delivered by Surrey NHS for more than 12 years, providing infant massage teacher training to health visitors, nursery nurses and local children's centre staff.

The specialist health visitors tell me that it has proved to be one of the most helpful and positive parts of the programme and they do not want to lose it.

Infant massage is always part of a 'whole child' viewpoint, whether as an enhancement to everyone's parenting or as a help for those parents identified as struggling.

For those parents who have not received close care in their own infancy and childhood and who may never have formed a close bond with their own mothers and fathers, infant massage can be a simple and enjoyable way to help them discover a new relationship with their baby.

Infant massage can be "a welcoming first step across the threshold" and is relatively inexpensive. Once inside the children's centre, the other resources and support on offer become accessible. This is especially true of families who may face a host of barriers, including poverty and ongoing mental health issues.

I believe that the training process is primarily about enabling the parent to tune in to their own sensitivity so that they can carry out this simple skill with confidence and enjoyment."

Sally Cranfield, **Massage for Babies**

## Assessment

All qualified children's health and social care professionals are trained to conduct a thorough assessment of a family's needs. Differences in emphasis and approach bring an advantageous multi-disciplinary aspect to team working. It is useful for team colleagues to acknowledge and articulate what helpful differences exist between them, as well as what is core to their unified approach.

Like treatment approaches, assessments should be tailored to the family's particular needs and presentation. Parent-infant assessments typically include:

- Information provided by a referrer or other professional
- A semi-structured conversation with the family to hear about their concerns
- A direct observation of the parent-infant interaction by the practitioner
- Questionnaires, interview or assessment methods which enhance understanding of particular aspects of the infant's experience, such as reflective functioning, adult mental health questionnaires, parental emotional regulation and infant social and emotional development.

Ideally, an initial assessment of a families' needs provides both critical clinical information and important baseline data for future outcomes monitoring. If the team is required to report against certain standard outcomes or they are part of a research trial, what is collected for clinical purposes is then enhanced through additional baseline measures.

Detailed information about how to measure outcomes and a comprehensive table of assessment tools is found in Chapter 8 Managing Data and Measuring Outcomes. The section below focusses on the composite elements of a robust clinical assessment.



## Tools to support clinical assessment

Chapter 8 Managing Data and Measuring Outcomes includes comprehensive tables of assessment questionnaires and measurement tools, including the age range with which they can be used. There is further information about assessment tools in Appendix 2 of Conception to 2: Age of Opportunity (2013). We highlight below a few selected tools which have been used by the nine PIP<sup>18</sup> teams.

### The Ages and Stages Questionnaire Social and Emotional – 2nd edition (2015)

The ASQ:SE2 ([www.agesandstages.com](http://www.agesandstages.com)) is a parent-completed questionnaire about their baby that covers communication, gross and fine motor skills, problem solving and personal-social skills. It identifies social and emotional issues for the baby including self-regulation, communication, autonomy, compliance, adaptive functioning, affect and interaction with people.

The ASQ:SE2 can be used to demonstrate that the infant has attained, or remained on, an acceptable pathway of social and emotional development in a situation when this might be jeopardized. Optional training is available from [www.brookespublishing.com](http://www.brookespublishing.com). In 2019, prices are: starter kit US\$295, user guide \$55, DVD \$50.

### Keys to Interactive Parenting Scale (KIPS)

The KIPS assesses a caregiver interacting with a child during a 20-minute (maximum) video observation which is later coded against 12 key facets of parenting such as Sensitivity to Responses, Supporting Emotions and Promoting Exploration and Curiosity. It adopts a strengths-based approach promoting parental learning and building confidence.

The KIPS can be used as a baseline clinical assessment and to track progress over time and is therefore suitable for pre- and post-outcome measurement. Training to use the KIPS is available as e-learning from [www.comfortconsults.com](http://www.comfortconsults.com).

In 2019, prices were \$155USD with additional charges for the e-learning workbook, annual reaccreditation and scoring forms.

### The DC: 0-5 assessment (Levels of Adaptive Functioning; LOAF)

The DC: 0-5™ assessment manual and training (sometimes referred to as the Levels of Adaptive Functioning or LOAF scale) has been devised by Zero to Three<sup>19</sup> as the first developmentally-based system for practitioners assessing mental health and developmental disorders in infants and toddlers. It replaces the previous Parent-Infant Relationship Global Assessment Scale (PIR-GAS) from Zero to Three. The 'LOAF' can be used by practitioners from various disciplines to plan treatment and evaluate progress in their parent-infant relationship work. Information about training can be accessed via the Zero to Three Learning Centre <https://learningcenter.zerotothree.org/Default.aspx>

18. ABC PiP in Ballygowan, Bright PiP, Croydon Best Start PiP, DorPIP, EPIP, LivPIP, NEWPIP, NorPIP and OXPIP

19. Zero to Three. DC:0-5™ Manual and Training <https://www.zerotothree.org/resources/2221-dc-0-5-manual-and-training>





## Identification of risks and stresses on the parent-infant relationship

The Gloucestershire Infant Mental Health Team has developed a checklist<sup>20</sup> for acknowledging the stressors and potential risks that might be negatively impacting the parent-baby relationship. Many of the PIP teams find it helpful for guiding referrers to think about potentially hidden stressors and risks in addition to the current quality of parent-infant interaction. We have provided the list in the Network Area of the Parent-Infant Foundation website. See the **Zero to Three website**<sup>21</sup> for a more extensive example.

Stresses are cumulative: on the whole, more stress factors make it harder for parents to hold their child in mind and increase the possibility of maltreatment. The emotional headspace that parents need for sensitive attunement with their baby can easily be hijacked by multiple competing demands. Parents may need help to overcome these multiple challenges in order to gain a fuller understanding of their babies and then interact with them in an appropriate way.

Although it might not be possible to change the existence of many of these (such as family poverty or trauma in the parents' childhood) it is still important to appreciate the amount of pressure that might be affecting the relationship.

## Formal assessment of attachment

**NICE guidance** (NG26, Nov 2015) which relates to children who are adopted from care, in care or at high risk of going into care recommends that health and social care professionals should offer a child who may have attachment difficulties, and their parents/carers, a comprehensive assessment before any intervention, which includes:

- Personal factors, including the child's attachment pattern and relationships
- Factors associated with the child's placement(s), such as history of placement changes, access to respite and trusted relationships within the care system
- The child's developmental status
- Parental sensitivity
- Parental factors, including conflict between parents (such as domestic violence and abuse), parental drug and alcohol misuse or mental health problems, and parents' and carers' experiences of maltreatment and trauma in their own childhood
- The child's experience of maltreatment or trauma
- The child's physical health
- Co-existing mental health problems and neurodevelopmental conditions commonly associated with attachment difficulties, including emotional dysregulation and other signs of mental health distress, and autism.

Only two assessments tools are recommended: the Infant Strange Situation Procedure (for children aged 11-17 months) and the Attachment Q-sort (for children 12-48 months). The Infant Strange Situation is based on the work of Mary Ainsworth, Mary Main and Judith Solomon, and Pat Crittenden.

Intensive training (12 days in the UK<sup>22</sup>) is offered by various private providers. Unlike the Strange Situation procedure, the Attachment Q-sort does not require a separation scenario but does require an observer to rate an infant's behaviour after detailed observation.

20. The Wave Trust (2013). Conception to 2: Age of Opportunity. Appendix 2C p.89.

<https://www.wavetrust.org/conception-to-age-2-the-age-of-opportunity>

21. Zero to Three. The Psychosocial and environmental stressors checklist.

<https://www.zerotothree.org/resources/preview/425bc4ce-5d05-49b5-9893-b279bf155243>

22. <https://iswmatters.co.uk/training/the-infant-strange-situation/>





**The well-known Infant Care Index ([www.patcrittenden.com](http://www.patcrittenden.com)) is a qualitative screening tool of the risk and patterns of interaction between infants 0-15 months and their carers. It is best used as part of a comprehensive risk assessment.**

**The procedure requires a 3-5 minute video of an infant and parent playing to be coded according to three subscales for parents and four for infants. Training to become a reliable coder takes nine days, in three-day blocks, followed by a reliability test of submitted video clips.**

**Training is available in the UK for professionals who work with infants and their carers. In 2019, the 9-day training costs in the region of £720 (excluding travel and accommodation) from <http://www.iswmatters.co.uk/>. Ongoing accreditation is required.**

## Choosing which interventions to offer

The ideal scenario is for a multi-disciplinary team to offer a range of evidence-informed interventions so that every family can receive a tailored package of care. The team's therapeutic toolbox should include individual and group interventions which can cater for a range of presenting difficulties and levels of complexity. It will blend expert clinical practice with structured or manualised programmes.

Several existing teams have keyworker or similar posts which link families into other services such as housing, substance misuse or social isolation. This reduces families' stress, facilitating their engagement in therapy and maximising its effectiveness.

Louison and Metz (2018) at the University of North Carolina at Chapel Hill have developed the "Hexagon Tool" to help scrutinise interventions, ensure strategic fit and plan for operational requirements. It is reproduced overleaf with the permission of the authors. More information on how to use the tool can be found on the National Implementation Research Network website<sup>23</sup>. The Hexagon Tool can be used to develop a rigorous implementation plan to ensure chosen interventions are appropriately deployed and delivered for maximum impact.

## Interventions for parents and their child together

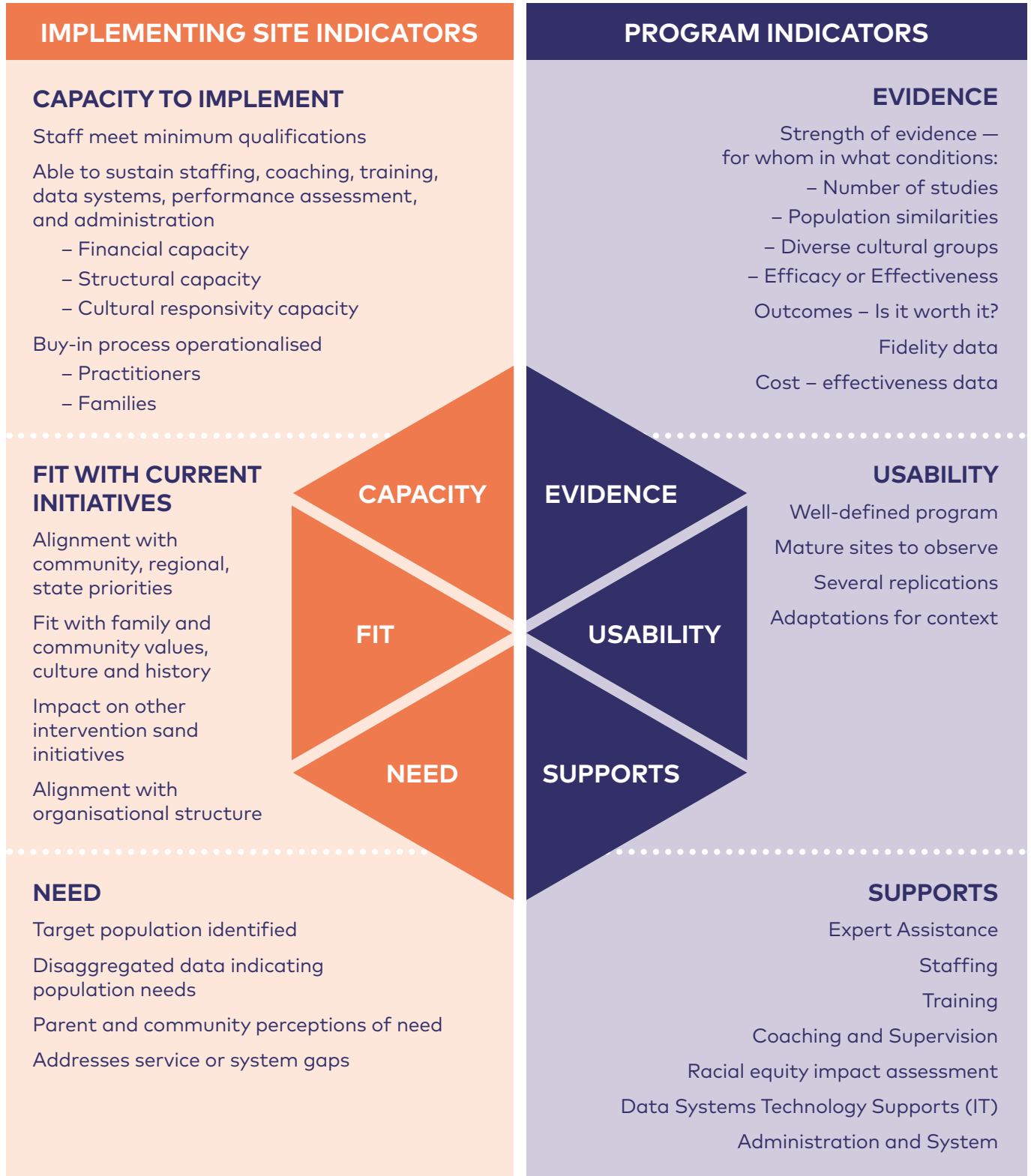
Parent-infant teams are multi-disciplinary and work with a 'toolbox' approach that can be flexible in response to the family's situation rather than being forced into the limitations of a manualised method of working. For example, individual work (parent(s) and baby seen together) and group work are not mutually exclusive and may be mutually beneficial when offered in parallel or consecutively. Below we provide information about some of the relevant, evidence-informed interventions and we will continue to add to the list as this toolkit develops.



23. National Implementation Research Network (2018). The Hexagon: an exploration tool. <https://nirn.fpg.unc.edu/resources/hexagon-exploration-tool>

# The Hexagon: An Exploration Tool

The Hexagon can be used as a planning tool to guide selection and evaluate potential programs and practices for use.



Metz, A. & Louison, L. (2019). The Hexagon Tool: Exploring Context. Chapel Hill, NC: National Implementation Research Network, Frank Porter Graham Child Development Institute, University of North Carolina at Chapel Hill. Based on Kiser, Zabel, Zachik, & Smith (2007) and Blase, Kiser & Van Dyke (2013). © 2019 NIRN – University of North Carolina at Chapel Hill.





## Parent-infant psychotherapy

Parent-infant psychotherapy is historically the clinical foundation of the PIP teams and it remains the predominant therapeutic approach across those teams.

Psychotherapy is a distinctive though broad paradigm and arena of scholarship, thinking, literature and clinical practice, rooted in psychoanalysis, which gave rise to the interest and practice of infant mental health.

Parent-infant psychotherapy is a psychoanalytical and attachment-based intervention which aims to help the parent(s) reflect on past and/or present experiences which may be influencing their view of their infant and their relationship with them. The psychotherapist models sensitive responding and helps the parent to interpret their baby's behaviour appropriately. Psychotherapy pays particular attention to the unconscious and non-verbal aspects of communication between parent(s) and their baby. Parent-infant psychotherapists are trained to work with the parent and infant (dyad), and parents and infant (triad), the couple relationship and systemically (including wider family members) as required.

Parent-infant psychotherapists complete a specific and intense professional qualification and training route which confers a depth of expertise in parent-infant relationships. They vary the exact therapeutic approach, duration, content and focus of therapy based on their professional assessment of the clinical presentation. Hence, parent-infant psychotherapy is not a singular or standardised type of intervention so it is less amenable to the kinds of evaluation typically used for a standardised or manualised intervention, such as an RCT.

The breadth of approaches within parent-infant psychotherapy raises substantial challenges for evaluation. 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<sup>24</sup>. The review found that problems in the current evidence base were due to significant variation in the type of intervention evaluated, little consistency in the outcomes measured and low quality of evidence.

One particularly intensive form of parent-infant psychotherapy, Infant-Parent Psychotherapy (IPP), also known as the Lieberman model, has been demonstrated to improve infant attachment security in two Randomised Controlled Trials (RCTs). IPP has an evidence rating of 3+ in the Early Intervention Foundation Guidebook<sup>25</sup>. IPP is not currently delivered in the UK, probably due to the significant resources required to deliver this level of intervention. In Infant-Parent Psychology practitioners must have 92 hours of programme training and delivery involves at least weekly hour-long sessions for around a year. However, there are similarities with the 1:1 psychotherapy offered by parent-infant psychotherapists who also undergo extensive training and can offer long term therapy.

For parents who have maltreated, or are at risk of maltreating, their pre-school child (including children under 2) NICE guidance NG26 (Pre-school children in care or at risk of going into care) recommends parent-child psychotherapy based on the Cicchetti and Toth model<sup>26</sup>.

24. 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).

25. The Early Intervention Guidebook website <https://guidebook.eif.org.uk/>

26. Cicchetti, D., Toth, S. and Rogosh, F. (1999). Attachment & Human Development Vol. 1 No. 1 April 1999 34-66 The efficacy of toddler-parent psychotherapy to increase attachment security in off- spring of depressed mothers <http://childparentpsychotherapy.com/wp-content/uploads/2016/11/cicchetti-toth-rogosh-1999-efficacy-of-tpp-depressedmoms-j-h-dev.pdf>





## Video Feedback Approaches

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

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<sup>25</sup>.

In a large meta-analysis of studies which examined the effectiveness of video-feedback, Fukkink (2008)<sup>27</sup> found a positive, statistically significant effect on parenting behaviours. Brief video-feedback interventions with parents in high-risk groups were the most effective. The authors concluded that family

programmes that include video feedback achieve a dual level effect: parents improve their interaction skills, which in turn help in the development of their children. Parents become more skilled in interacting with their young child and experience fewer problems and gain more pleasure from their role as parent.

Video feedback is also recommended in two NICE Guidelines<sup>28</sup>. For pre-school children (including under 2s) on the edge of care, NICE guidance NG26 provides clear guidance about the use of video feedback approaches. There are different types of video feedback interventions. The two types most commonly used in the UK are Video Interaction Guidance (VIG) and Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline (VIPP-SD).

In VIG, practitioners are trained to use video feedback through a series of filming and review sessions in order to encourage parents to see and build on what they are doing to help things go well and thus become aware of the positive aspects of the caregiver-infant interaction. The intervention is based on principles for attuned interactions and guidance. 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 in the UK although a Cochrane review is due in late 2019<sup>29</sup>. The AVIG website reviews some of the research on effectiveness.

Further information, including about training, can be found at

<https://videointeractionguidance.net/>.

27. Fukkink, R.G. (2008). Video feedback in widescreen: A meta-analysis of family programs. *Clinical Psychology Review*, 28(6), 904-16. from [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/429740/150520RapidReviewHealthyChildProg\\_UPDATE\\_poisons\\_final.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/429740/150520RapidReviewHealthyChildProg_UPDATE_poisons_final.pdf)

28. NICE guideline (NG26, 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. Public health guideline (PH40, 2012) Social and emotional wellbeing: early years.

29. O'Hara, L., Smith, E.R., Barlow, J., Livingstone, N., Herath, N.I.N.S., Wei, Y., Spreckelsen T.F., Macdonald, G. (forthcoming). Video feedback for parental sensitivity and attachment security in children under five years: A systematic review and meta-analysis. *Cochrane Library*.



VIPP-SD is a more manualised, structured approach for parents of children aged 1-6 years. It typically consists of seven 2-hour sessions, working with one or both parents 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. More information, including training, can be found at <http://vippleiden.com/en>.

The effectiveness of the original VIPP-SD programme on enhancing parental sensitive behaviour has been demonstrated through 12 RCTs in different countries and among different target groups<sup>30</sup>.

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<sup>31</sup> with the highest evidence rating "demonstrably effective".

## Watch, Wait and Wonder

Watch, Wait and Wonder (WWW) is an infant-led psychotherapeutic approach developed initially by child psychiatrists Frank Johnson, Jerome Dowling, and David Wesner in Wisconsin, USA<sup>32</sup>. It was further developed by Elizabeth Muir and Nancy Cohen and colleagues in Toronto in the early 1990s. It can be conducted one-to-one or in groups by any suitably qualified practitioner who has attended a Watch, Wait and Wonder training and is receiving appropriate, ongoing supervision. This might be someone who works with children and families and who has some experience of therapeutic approaches.

The Watch, Wait and Wonder intervention involves 18 weekly sessions during which 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 as there is evidence that it improves children's attachment security, emotion regulation and cognitive development.

Watch, Wait and Wonder can also be used flexibly with fewer sessions. Dr Michael Zibilowitz, Developmental & Behavioural Paediatrician in Sydney, has developed a modified Watch, Wait and Wonder intervention which he describes as 'a highly effective and simple way for all parents to be with their children, that has the potential to help them: enjoy their child more, stimulate their child's creativity and imagination, help their child play more by themselves, settle difficult behaviours, and foster a surge in development'.

OXPIP offers an Introduction to Watch, Wait and Wonder (visit <https://www.oxpip.org.uk/events-1/watch-wait-and-wonder-an-introduction-4>) and more intensive courses and supervision are available from <https://watchwaitandwonder.com/>

30. VIPP-SD website <http://vippleiden.com/en/professionals/scientific-research>

31. Nederlands Jeugd Instituut [https://www.nji.nl/nl/Video-feedback-Intervention-to-Promote-Positive-Parenting-and-Sensitive-Discipline-\(VIPP-SD\)](https://www.nji.nl/nl/Video-feedback-Intervention-to-Promote-Positive-Parenting-and-Sensitive-Discipline-(VIPP-SD))

32. Johnson, F.K., Dowling, J., & Wesner, D. (1980). Notes on infant psychotherapy. *Infant Mental Health Journal*, 1, 19–33





## Mellow Groups

Mellow Parenting interventions are evidence-informed manualised parenting programmes. There is a family of Mellow Programmes, including Mellow Bumps for expectant parents, Mellow Mums, Mellow Dads and a group tailored for mothers with learning difficulties called Mellow Futures. 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 Mums 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 Guidebook, but Mellow Bumps and Mellow Babies are not. There is also a review of evidence on the What Works For Children's Social Care? Evidence Store<sup>33</sup>.

Information about all the training for Mellow parenting and relationship programmes is at <https://www.mellowparenting.org/>.

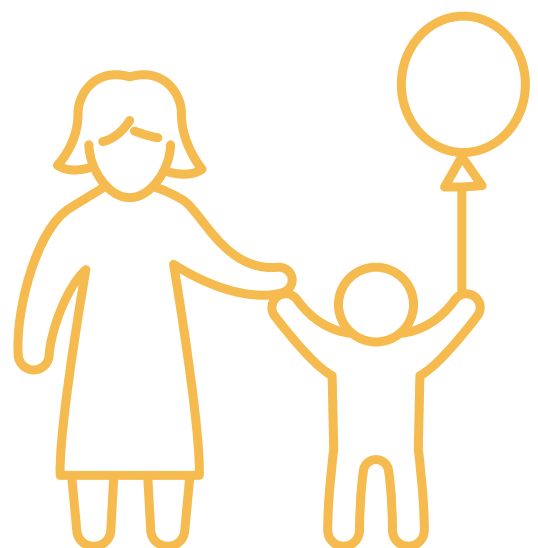
## Circle of Security

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 for socially disadvantaged children from 1-5 years and a less intensive but targeted 8-10 session programme for children from four months old called Circle of Security Parenting.

Both programmes involve weekly sessions and 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 an evidence rating of 2+ in the Early Intervention Foundation Guidebook.

The four-day Circle of Security training costs approximately US\$900. Details of occasional courses in the UK can be found at <https://www.circleofsecurityinternational.com/find-a-training#>.



33. What Works for Children's Social Care website. Mellow Parenting. <https://whatworks-csc.org.uk/evidence/evidence-store/intervention/mellow-parenting/>





## Attachment and Bio-behavioral Catch-up (ABC)

This manualised approach “helps caregivers nurture and respond sensitively to their infants and toddlers to foster their development and form strong healthy minds<sup>34</sup>”. ABC makes extensive use of video (for showing topic illustration as well as feedback) and focuses on specific parenting behaviours: nurturance, following the child’s lead and reducing frightening caregiving behaviour.

The emphasis is on a skilled reinforcement of strengths. It has been particularly effective in helping foster parents. ABC has been shown to be effective in the US with birth parents as part of an ‘edge of care’ programme and foster parents.

Research findings about child outcomes include a greater proportion of children with secure attachments and fewer with disorganised attachments compared to controls<sup>35</sup>, better cortisol regulation details, including links to books and references, are available at 3-year follow-up<sup>36</sup>, less anger at 1-2 year follow-up, and higher vocabulary scores which were fully mediated by improvements in parental sensitivity<sup>37</sup>.

Initial training in ABC takes 2 days although it is not widely available outside of the US and can be costly due to the requirement for ongoing supervision. More at <http://www.abcintervention.org/>.

## Incredible Years Parents and Babies

The Incredible Years (IY) is a comprehensive suite of parenting and classroom management groups with a well-established portfolio of evidence across its interventions. The group-based Parents and Babies programme aims to promote a positive attachment between parents and their babies aged 0-12 months<sup>38</sup>. Content includes becoming a new parent, developmental milestones, temperament differences, safety and building a positive parent-infant relationship. A follow-on Parent and Toddler programme is also available.

IY Parents and Babies group facilitators use video clips of simulated real-life scenarios to support learning, with group discussions, problem solving and practice skills with babies in the group.

This intervention is not yet rated by the EIF Guidebook although others from this developer are, for example, the Parent and Toddler programme has an EIF rating of 2+. Research is summarised on the [Incredible Years website](#). A service evaluation in Wales found significant short-term increases in parental mental health and parenting confidence but did not measure parent-baby interaction<sup>39</sup>.

The first randomised control trial in Denmark found the programme was not effective on outcome measures related to the parent-child relationship<sup>40</sup>. An RCT is ongoing in the UK.

34. Attachment and Biobehavioural Catchup website [Abcintervention.org](http://www.abcintervention.org)

35. Bernard, K., Dozier, M., Bick, J., Lewis-Morrarty, E., Lindhiem, O., & Carlson, E. (2012). Enhancing attachment organization among maltreated children: results of a randomized clinical trial. *Child development*, 83(2), 623–636. doi:10.1111/j.1467-8624.2011.01712.x <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3305815/>

36. Bernard, K., Hostinar, C. and Dozier, M. (2015) Intervention Effects on Diurnal Cortisol Rhythms of CPS-Referred Infants Persist into Early Childhood: Preschool Follow-up Results of a Randomized Clinical Trial. *JAMA Pediatr.* 2015 February ; 169(2): 112–119. doi:10.1001/jamapediatrics.2014.2369. <http://www.abcintervention.org/wp-content/uploads/2017/11/2015-Bernard-Hostinar-Dozier.pdf>

37. Lind, T., Bernard, K., Ross, E. and Dozier M. (2014). Intervention effects on negative affect of CPS-referred children: Results of a randomized clinical trial. *Child Abuse & Neglect*, 38, 1459–1467. <http://www.abcintervention.org/wp-content/uploads/2017/11/2014-Lind-et-al.pdf>

38. White, C. and Webster-Stratton, C. (2014) The Incredible Years Baby and Toddler Programmes: Promoting attachment and infants’ brain development. *Parent Education Programme*. <http://www.incredibleyears.com/wp-content/uploads/Incredible-Years-baby-toddler-programmes-promoting-attachment-2014.pdf>

39. Evans, S., Davies, S., Williams, M. and Hutchings, J. (2015). Short-term benefits from the incredible years parents and babies programme in Powys. *Community Practitioner*, vol. 88, no. 9, 2015, p. 46+. Gale Academic Onefile. <https://go.galegroup.com/ps/anonymous?id=GALE%7CA436440017&sid=googleScholar&v=2.1&it=r&linkaccess=abs&issn=14622815&p=AONE&sw=w>.

40. Pontoppidan M, Klest SK, Sandoy TM (2016) The Incredible Years Parents and Babies Program: A Pilot Randomized Controlled Trial. *PLoS ONE* 11(12). doi:10.1371/journal.pone.0167592 <https://pure.vive.dk/ws/files/670324/file.pdf>





## Empowering Parents Empowering Communities (EPEC): My Baby and Us

EPEC<sup>41</sup> is an approach developed by Centre for Parent and Child Support, South London and Maudsley NHS Foundation Trust and the CAMHS Research Unit, King's College, London.

It is an internationally recognised evidence-based peer-led parenting programme. It provides a system for training and supervising parent-led parenting groups that help parents to learn practical parenting skills for everyday family life and develop their abilities to bring up confident, happy and co-operative children. Free crèches are provided alongside each group and parents attending the course can choose to gain accreditation for their work through the Open College Network.

The EPEC Team have received funding from NESTA and the Department of Digital, Culture, Media and Sport to support the setting up and running of 16 new EPEC hubs in the England.

There are three core EPEC courses: one for parents of teenagers, one for parents of children aged 2-11 years and the My Baby

and Us course which is for parents of babies aged up to one year. EPEC courses consist of eight 2-hour sessions, supported by on-site crèche facilities, co-facilitated by two EPEC-accredited parent group leaders for between 8-12 parents.

Courses focus on improving parent-child communication, interaction and play; parental bonding, attachment and reflective function to improve parental sensitivity and warmth; positive parenting skills to regulate and promote pro-social child behaviour and parent self-care and stress reduction.

Courses use highly interactive methods involving information sharing, group discussion, demonstration, role play and reflection. Practice and parents' use of skills in everyday life are a key feature, with participants working on specific goals throughout their course.

EPEC has an effectiveness rating of 3 and cost rating of 1 in the **EIF Guidebook**.



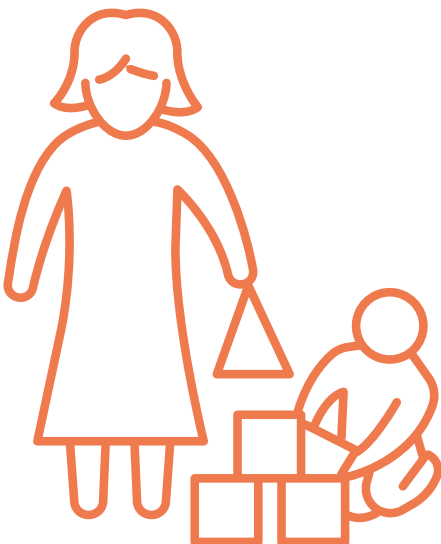
41. Centre for Parent and Child Support website.  
<http://www.cpcs.org.uk/index.php?page=empowering-parents-empowering-communities>

## Short-term interventions for parents with additional mental health needs

Working effectively with the parent-infant relationship means that both the parent's and the infant's needs are being attended to. Specialised parent-infant relationships teams often find that the parent needs some help in their own right to move past psychological barriers. This does not replace formalised adult mental health input but some focussed, short-term work on their own may help to support the parent to make progress in their parent-infant work. Similarly, some perinatal (adult) mental health therapies include thinking about the infant and the parent-infant relationship, on the basis that it cannot and should not be separated off.

### Cognitive Analytical Therapy (CAT)

Cognitive Analytical Therapy is a therapeutic approach to working with adults and is used by a range of qualified professionals. The ethos and underpinning theories align well with parent-infant work as CAT explores the events and relationships, often from childhood or earlier in life, that underpin an adult's way of thinking and feeling. Object relations theory features in the genesis of both CAT and parent-infant psychotherapy.



**"Sometimes parent-infant interventions uncover issues from the parent's own childhoods which need addressing for the infant work to continue. A short course of CAT for a parent can unstick psychological barriers which have been impeding progress in the parent-infant work.**

**CAT is a really helpful model to use in this area of work because its basis is in the importance of relationships. If we always had to refer on to Adult Mental Health colleagues, the infant work might need to pause and that would mean we might lose some families."**

Sue Ranger, Consultant Clinical Psychologist and Manager of Leeds Infant Mental Health Service

CAT is a time-limited therapy (usually 16 weeks) although there is some flexibility. CAT Training courses of differing lengths and levels, from introductory to supervisory, are available from multiple providers including the Association for Cognitive Analytical Therapy (ACAT) [www.acat.me.uk](http://www.acat.me.uk). The website also has further information about CAT with FAQs for commissioners and practitioners.

### Eye Movement Desensitisation and Reprocessing (EMDR)

EMDR can be particularly helpful for addressing parental trauma which is impeding progress in the parent-infant work, including trauma resulting from the birth, previous sexual assault/abuse or other traumatic incidents.

A range of professionals can train to become an accredited EMDR therapist, with multiple levels of training on offer. The EMDR Association of UK and Ireland is a good starting point <https://emdrassociation.org.uk/>.



## Cognitive Behaviour Therapy (CBT)

CBT is a talking therapy which addresses the links between thoughts, feelings and behaviours. Typically, CBT focusses on the present rather than the past and looks for practical ways to improve a person's state of mind in manageable steps. It might be used as an adjunct to parent-infant work where the parent is experiencing mental health difficulties or thought patterns which are interfering with the progress of parent-infant therapy.

Like CAT, some professionals will already have a basic training in CBT and multiple providers offer training of various levels across the UK. The **British Association of Behavioural and Cognitive Psychotherapies** has a useful website.

## Related early years interventions

Other relationship-focussed approaches employed by specialised parent-infant relationships teams or relevant to the wider workforce might include:

### Peep

The Peep Learning Together Programme is based on good evidence that simple things which families can do (by providing warm, responsive relationships, a rich language environment with conversation, stories, songs, rhymes and books, and lots of play) make a difference to children's outcomes and help children from poor backgrounds do well in education and later life.

The Programme covers five strands of development (Personal, Social and Emotional; Communication and Language; Early Literacy; Early Maths; Health and Physical Development) and can be used with babies from birth.

It is delivered to parents and children together in Peep groups, home visits and in drop-in settings. The Learning Together Programme also includes opportunities for parents to gain accredited units based on meaningful learning in context of family life which can provide a first step into further learning, volunteering or employment. Practitioners can undertake a two-day training course in order to deliver this programme.

Learning Together has a sister programme The Peep Antenatal Programme: Getting to Know Your Baby which aims to support parents (mums and dads) to:

- Think about their baby, tune in to their baby's feelings and respond sensitively (also known as reflective function)
- Understand the importance of sensitive parenting to developing a loving, consistent and secure attachment
- Become more aware of the social and emotional aspects of the transition to parenthood
- Manage their own (sometimes difficult) feelings that are aroused by a new baby
- Meet other expectant or new parents and develop a supportive network group
- Reduce the risk to the early parent-infant relationship (by helping to prevent, for example, isolation, anxiety and low-level depression)
- Engage with other local services

The Peep Antenatal Programme can be used during pregnancy (from 28+ weeks is recommended) to the early weeks following birth. It can be used in a range of contexts and settings including one-to-one work with parent and baby, in the home or in other settings, and small group work. Practitioners can undertake one-day antenatal training which includes skills, knowledge and comprehensive resources.

The Learning Together Programme evidence includes the Birth to School Study, a longitudinal evaluation Programme, with a sample of 600 families.



The study was carried out by the University of Oxford (2005) and found outcomes for parents on the quality of the care-giving environment, and for children in skills related to future literacy success: vocabulary; phonological awareness of rhyme & alliteration; letter identification; understanding of books and print and writing. Peep children had significantly higher self-esteem. A Randomised Controlled Trial (RCT) of the programme is currently being carried out by Queen's University Belfast. It is one of the largest studies to be carried out on a parenting programme and findings will be published in late 2019.

Further details about the Learning Together Programme, Peep Antenatal Training and other programmes can be found [www.peeple.org.uk](http://www.peeple.org.uk)

### Watch Me Play

Watch Me Play<sup>42</sup> was developed in Haringey First Step, part of the Tavistock and Portman NHS Foundation Trust. It is an intervention to promote child-led play in order to enhance relationships and inform child-centred care planning. The programme manuals are freely available on the [Watch Me Play website](http://www.watchmeplay.org.uk).

## Increasing capacity in the local system

Specialised parent-infant relationship teams have an important role in increasing the capacity of the local system to support families during the first 1001 days. This can be achieved through workforce training at all levels, consultation and outreach or joint working with relevant parts of the system. In our experience,

these activities only succeed where good relationships are built upon credibility, trust and mutual understanding between services.

Asking for help and advice from another, such as through consultation or joint working, is a step of faith which needs to be received respectfully and this is true for both families and practitioners.

## Workforce training

Most specialised parent-infant training teams offer some form of training about the emotional wellbeing of babies and the parent-infant relationship. Some have developed a training offer tailored to their local context. For example, [Leeds Infant Mental Health Service](http://www.leedsinfantmentalhealthservice.org.uk)<sup>43</sup> has trained over 2500 local practitioners in their Babies' Brains and Bonding course. This training integrates neuroscientific research about how babies develop with attachment theory and evidence-based practice on how to support emotional and social development in the early years of life. Importantly, this training is also offered free to the third sector.

[OXPIP](http://www.oxpip.org.uk)<sup>44</sup> offers a wide range of courses including extended courses on infant observation and a parent-infant therapist diploma, short courses such as ghosts in the nursery, emotional regulation and group work, and public lectures.

ABCPIP in Northern Ireland have found Five to Thrive to be a popular and useful element of their workforce training offer. It has also helped them create engaging resources for parents. Five to Thrive is a suite of resources, tools and training content built around five building blocks for a healthy brain: respond, cuddle, relax, play, talk. These themes are drawn from research into the key processes of attachment

42. Tavistock and Portman NHS Trust website. Watch me play: supporting babies and young children in care. <https://tavistockandportman.nhs.uk/care-and-treatment/our-clinical-services/first-step/watch-me-play-supporting-babies-and-young-children-care/>

43. Leeds Community Healthcare NHS Trust website. Infant Mental Health. <https://www.leedscommunityhealthcare.nhs.uk/our-services-a-z/infant-mental-health/>

44. OXPIP website <https://www.oxpip.org.uk/training>









and attunement that forge bonds between young children and their carers. Practitioner training is either face-to-face or online via <https://fivetothrive.org.uk/>.

The Greater Manchester Perinatal Infant Mental Health Training Matrix (Feb 2019) is a comprehensive description of their local workforce training approach, and is free to download from the Network area of the Parent-Infant Foundation website.

We advise you to offer training to all levels of leadership, management and frontline practice so that awareness is raised and a shared language is adopted across the system. In time, we hope all relevant courses will map their training content against the Association of Infant Mental Health UK (AIMH-UK) competencies framework<sup>45</sup>.

Below, we describe some national training courses which have been subjected to independent evaluation.

## Solihull Approach

The Solihull Approach is an evidence-based approach to improving emotional health and wellbeing through relationships starting from the antenatal period through childhood into adulthood. It integrates psychodynamic ideas of containment and parallel process with reciprocity and managing behaviour and is therefore highly relevant to practitioners working with the parent-infant relationship.

The Solihull Approach was developed in the mid-1990s by a multi-disciplinary team of NHS child psychotherapists, psychologists, health visitors and school nurses. It now offers a suite of relationship-based practitioner trainings which can be used across the lifespan, in universal and targeted settings, in frontline practice and management relationships.

Use of the Solihull Approach is widespread across the UK, often delivered initially as workforce training for individual practice but then developed into groups for parents at various stages of their journey through parenthood. Its focus on the quality of interaction between child and parent(s) raises frontline practitioners' confidence in supporting families with infants<sup>46</sup> and provides a good basis for consultations between specialised teams and universal services.

The training offer includes: two-day foundation training for antenatal teams, perinatal teams and early years teams; training for facilitators to deliver the antenatal group, postnatal group, postnatal plus group and parenting group (1-19 years); training for facilitators to deliver the peer breastfeeding supporter training; three online courses for parents: antenatal, postnatal and 'Understanding your child' 1-19 years (this course also available in Urdu, Arabic, Bulgarian, Chinese and Polish); advanced training days and online training on 'Understanding trauma', 'Understanding attachment' and 'Understanding brain development'.

'Understanding Your Child', the Solihull Approach manualised parenting group for 0-18 years, is reviewed in the EIF Guidebook with an evidence rating of 2 and a cost rating of 1. Other published evidence appears at [www.solihullapproachparenting.com](http://www.solihullapproachparenting.com).



45. The Association of Infant Mental Health (UK) website. The Infant Mental Health Competencies Framework (Pregnancy - 2 years). <https://aimh.org.uk/infant-mental-health-competencies-framework/>

46. Douglas, H. and Ginty, M. (2001) The Solihull Approach: changes in health visiting practice. *Community Practitioner* 2001, 74 (6): 222-224. <http://s571809705.websitehome.co.uk/Images2/changes-in-health-visiting-practice.pdf>



## The Family Partnership Model and the Antenatal/Postnatal Promotional Guides System

The Family Partnership Model (previously known as the Parent Advisor Model) is an evidence-based approach to working with children and families that demonstrates how specific helper qualities and skills, when used in partnership, enable parents and families to overcome their difficulties, build strengths and resilience and fulfil their goals more effectively<sup>47</sup>.

It is used in practice for prevention and early intervention with childhood and family difficulties and in the management of complex longer-term psychosocial difficulties. The model has been widely adopted by community health and early help services, where it has been used to improve prevention and early intervention for families experiencing a range of health and psychosocial needs during pregnancy, infancy and early childhood.

A review of research<sup>48</sup> showed some positive impacts including improving parent-child interaction.

The Antenatal/Postnatal Promotional Guide System is an additional component of the Family Partnership Model that has been developed specifically for health visitors to facilitate screening and support to families during pregnancy and infancy. It can be used to assess and enhance parent-infant relationships, parental bonding, reflective function and sensitivity, family transition and support risk analysis and decision-making. The guides enable sensitive and attuned exploration of key areas of early development and parenting including foetal and infant growth, health and wellbeing of mother, father/partner and baby; couple relationship; parent-infant care, nurture and interaction;

developmental tasks of early parenthood and infancy. Barlow and Coe (2013) found that the Antenatal/Postnatal Promotional Guide System provides a significant opportunity to identify and strengthen aspects of parental functioning and parent-infant interaction. The Centre for Parent and Child Support provides a range of training packages including in the programmes described above, as well as through a licensed cascade system of trained trainers. More information is available at [www.cpcs.org.uk](http://www.cpcs.org.uk).

## Consultation, outreach and joint working

The Parent-Infant Foundation defines consultation as a conversation between a parent-infant team practitioner (consultant) and another worker outside of that team (consultee) for the purpose of discussing the consultee's work with families and providing access to the consultant's expertise in parent-infant relationships. This might be on a one-to-one basis or in small groups. For example, BrightPIP offers regular health visitor reflective practice meetings which are open to all health visitors who want to participate in case discussion with a parent-infant therapist in a safe and supportive environment.

Understanding good practice in consultation about what should be recorded, where notes should be kept and how accountability and risk are managed is dealt with in Chapter 6 From Set-up to Sustainability. Consultation, like supervision, is a welcome activity with many benefits for families and workers because it:

- Allows practitioners to seek the expert advice of others without families needing a formal referral (thereby preventing unnecessary referrals) or whilst families are on a waiting list for specialised services

47. Day, C. and Harris, L. (2013) The Family Partnership Model: Evidence-based effective partnerships. *Journal of Health Visiting*, Vol 1(1). <https://www.magonlinelibrary.com/doi/abs/10.12968/johv.2013.1.1.54>

48. Schrader-McMillan, A., Barnes, J. and Barlow, J. (2012). Primary study evidence on effectiveness of interventions (home, early education, child care) in promoting social and emotional wellbeing of vulnerable children under 5. Page 4 <https://www.nice.org.uk/guidance/ph40/documents/social-and-emotional-wellbeing-early-years-expert-report-12>



- Can be an excellent form of professional learning
- Can provide an additional quality assurance function
- Raises awareness of the parent-infant team and the benefits of the work they offer
- Improves inter-professional communication and mutual understanding of roles
- Encourages a shared language and understanding of babies' emotional wellbeing across the system

Outreach and joint working can build further professional awareness of babies' emotional wellbeing and offer families specialised parent-infant relationship interventions as part of their wider care. For example, the Anna Freud National Centre for Children and Families runs therapeutic weighing clinics<sup>49</sup>, a parent-toddler group at a 136-bed homeless hostel for families<sup>50</sup> and has run specialist parent-infant group work with mothers in prisons which was demonstrated to have a positive impact in an

RCT study<sup>51</sup>. In Bradford, where the community is very diverse and over 120 languages are spoken, the Little Minds Matter team in Bradford has trained interpreters to enable them to work more effectively with the service. At LivPIP, one of the senior therapists has built relationships at the Neonatal Intensive Care Unit (NICU) and offers regular consultation and joint working there. In Croydon, families referred by children's social care are frequently offered a joint visit with the allocated social worker to maximise co-ordination and understanding across agencies, and to help the family feel held through the engagement process.

Given how immensely busy practitioners are across the system, it can take quite a while, sometimes months or even years, and sustained effort, to build the credibility and trust upon which sound professional relationships are built. Existing parent-infant teams tell us that the offer of free workforce training was often an important precursor in forging new relationships with services that then led to further consultation and joint working.

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49. 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.

50. 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.

51. 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.



## Chapter 5

# Setting Up a Specialised Parent-Infant Relationship Team and Preparing for Operational Delivery

There are three phases of setting up a specialised parent-infant relationship team: preparing for operational delivery, starting the parent-infant work and steady-state management.

This chapter covers the first phase, including information about things to do before you start accepting referrals such as:

- Creating referral pathways
- Clarifying step up, step down and step out relationships
- Establishing strategic and operational relationships across the system
- Marketing and promotion

Chapter 6 covers the second and third phases including operational information such as how to manage referrals and waiting lists, recording clinical notes, data management, establishing beginnings and endings with families, managing risks and safeguarding.

## Developing a service within the local context

Specialised parent-infant relationship teams are found in the public sector, private sector and voluntary and community sectors. Invariably, they emerged from the passion and tenacity of a small group of committed individuals who had a vision and set out to achieve it. Hence, there is no one way to set up a team but in listening to their stories we have heard four repeated themes:

### 1. Start where you are with what you've got

The largest and best-sustained parent-infant relationship teams often started as one

practitioner or commissioner carving out a small bit of time or money to do something differently. This might have been a psychologist offering consultation to multi-agency colleagues, a commissioner squeezing money out of their baseline to appoint a specialist health visitor, a committed community member pulling interested parties together or a child psychotherapist offering to do their sessions jointly with a children's centre worker.

This was the start that exposed others to the evidence and impact of parent-infant work, upon which word of mouth and collective local campaigning was built. The exact details are varied and inspiring, but they frequently share these humble beginnings. (See the end of Chapter 3 Funding and Commissioning for more examples).



Leeds Infant Mental Health Service grew from a part-time psychology post in Sure Start in 2002. It is now a thriving team of clinical psychologists, health visitors and infant mental health practitioners. They have trained over 2500 local practitioners and offer training, consultation and supervision across the city.

## 2. Build a network: you can't do this alone

Building a personal and professional supportive network, and raising awareness across agencies and sectors, can help strengthen your resolve, unify the system around a common agenda and create a collective voice. Finding ways to have conversations, communicate evidence, and offer training to all stakeholders, including local families, MPs, councillors, commissioners and the families' workforce are often important mechanisms.

A commissioner we know to be particularly passionate about parent-infant teams started her journey knowing nothing about the importance of babies' emotional wellbeing. When she arrived in post, every service in her portfolio from CAMHS to health visiting to paediatrics, referenced the importance of the first 1001 days. A community of commitment had emerged from various local and national campaigns and awareness raising and had converged on the same point. It spurred the commissioner into wanting to find out more. Her motivation at first was based on the economics of prevention but when she read the science and research in greater depth, she was fully persuaded of the case for change. She pulled together the committed band of practitioners who had been working ardently for years to raise awareness, and a broad group of stakeholders, and together they launched a specialised parent-infant relationship team.

## 3. Create clear and concise but varied arguments

The case for specialised parent-infant teams is compelling but funders and commissioners hear compelling stories multiple times a day. Passion is not enough: decisions to commission services are based on well-written arguments which cater to the needs of multiple diverse audiences.

What appeals to a public health commissioner responsible for the 0-2s strategy might be different from what appeals to a grant giving foundation, the Police and Crime Commissioner, Director of Children's Services or the Clinical Commissioning Group responsible for CAMHS. Your arguments can sit alongside a pitch which puts the experience of babies in crisis at the heart of the message and describes how their distress is communicated. See Chapter 2 The Case for Change for information about communicating evidence to commissioners.

## 4. Tenacity, taking chances and patience

Repeatedly, we hear about the tenacity of those early local pioneers and their patience in building a network, raising awareness and local campaigning. Many fledgling parent-infant teams face moments of jeopardy during their journey to becoming high-quality, sustainable services.

Taking risks and seizing opportunities are often a feature: going out on a limb to contact others, offer training or have conversations, recruit new staff or influence new strategies.





**"There is no other period in life which touches so many different services and professional groups and including them all in the development of a specialised parent-infant relationship service is helpful."**

Pauline Lee, Clinical Lead, Tameside and Glossop Early Attachment Service

## Different operating contexts

In Chapter 3, we described the various options for commissioning and funding. The information below about setting up a team is applicable to all commissioning and funding contexts although language, structural arrangements and exact operational details will vary across public, voluntary and private sectors. These differences are not to be underestimated so, where practical, we have described some of the variations and how to approach them.

## Preparing for operational delivery

Setting up a new team requires lots of different activities to proceed in parallel. We advise teams to appoint an operational lead early, with dedicated time to drive forward the project plan.

This person ideally has experience of business development or project management so that they can initiate recruitment processes, secure appropriate clinical venues, and ensure business critical procedures and policies are in place in time.

We estimate that setting up a new team requires a 0.5-0.7 WTE project manager or operational lead for a minimum of nine months prior to accepting referrals, and this is borne out in recent experience of setting up a team in south east England.

Learning from existing teams shows that agreeing a 'piloting' period with stakeholders can be useful. This provides time to embed new working practices and establish good referral pathways before the service starts to be formally evaluated. Without this, early data can be skewed by common implementation challenges.

## The overall aims of the team

Clarifying your overall aims and your Theories of Change will guide you in how to prepare for operational delivery. Co-creating a system-level (see Chapter 3 Funding and Commissioning) and a clinical-level (see Chapter 4 Clinical Interventions and Evidence-informed Practice) Theory of Change is a crucial starting point; if you don't know where you're going it's much harder to get there.

Specialised parent-infant relationship teams have several inter-related objectives, which can be used to create a project plan.



Objective	Project planning	Resources which may be available from the Parent-Infant Foundation to help you
<p>Work with others (ideally including parents) to develop a joint strategic vision for infant mental health across the local health, social care and early years ecosystem</p> <p>In addition to direct therapeutic services to families, this should include the provision of training and consultancy to the local workforce, which might start with early years but needs to extend to all services including Adult Mental Health</p> <p>Co-create Theories of Change</p> <p>Establish a co-ordinated approach to funding and fundraising across relevant local strategic partners</p>	<p>Establish a strategic board to oversee development across the system and to ensure the inclusion of the parent-infant relationship in all strategic plans and documentation</p> <p>Clarify the forum for strategic fundraising co-ordination</p> <p>Agree a training, consultancy and direct delivery plan across all partners and aligned to local workforce development initiatives (eg safeguarding partnership training plans)</p> <p>Agree free at the point of delivery vs paid for arrangements</p> <p>Consider the need for an operational steering group with clear and robust reporting lines to senior managers and commissioners</p>	<p>Terms of reference for strategic and operational boards</p> <p>Examples of strategic plans which have included parent-infant relationships</p> <p>See 'Agreeing a training, consultation and delivery plan' below</p> <p>Examples of risk management policy</p>
<p>Establish a clinical base for the team</p>	<p>Agree funding and maintenance responsibilities</p> <p>Ensure accessibility measures are in place for parents facing additional barriers</p>	
<p>Agree:</p> <p>How client data will be captured and linked (where numerous funders/partners involved)</p> <p>How data about drop-ins, supervision, trainings will be captured</p>	<p>Agree data sharing protocols and reporting lines, including the management of risk where there is more than one delivery partner</p> <p>Work with in-house IT colleagues to ensure required data fields are embedded in local system</p> <p>Note: video feedback interventions seem universally to face difficulties with information governance and this particular point is likely to take time to resolve locally (please contact us for example policies)</p>	<p>Example of data handling and sharing protocol</p>



Objective	Project planning	Resources which may be available from the Parent-Infant Foundation to help you
<p>Ensure appropriate targeting and accessibility of services to support the parent-infant relationship by creating integrated pathways of care. Embed services within local facilities such as Children's Centres, midwifery or GP clinics, community hubs, etc., wherever possible, to provide access routes which have high acceptability to families</p>	<p>Establish eligibility criteria, referral and discharge processes as part of broader Standard Operating Procedures</p> <p>Establish operational relationships with a range of referrers, community support organisations and relevant services</p>	<p>Stakeholder engagement plan</p> <p>Referral guidance for Perinatal Mental Health colleagues</p> <p>Examples of referral guidance and standard operating procedures</p> <p>Service specifications</p>
<p>Use evidence-based tools to assess the parent-infant relationship, the infant's social and emotional development, and the parent's state levels of anxiety and depression, and use this information to guide any necessary intervention</p> <p>Deliver evidence- and practice-informed therapeutic interventions designed to strengthen the relationship between the parent(s) and their baby</p>	<p>Plan clinical interventions, including selection of engagement and assessment tools, therapeutic approaches and training/consultancy offer</p> <p>Dependent upon which interventions are going to be delivered, consider the intervention-specific training and supervision needs of particular tools and therapies, and plan to embed practice</p> <p>Purchase equipment (may include video cameras or tablets with video recording functions, baby change mats etc)</p>	<p>You will find information in Chapter 4 Clinical Interventions and Evidence-informed Practice</p>
<p>Encourage and facilitate continuous professional development for all parent-infant therapists, by ensuring access to regular reflective specialist infant mental health supervision and training. (See Chapter 7 for recruitment, supervision and training information)</p>	<p>Plan for the supervision, continuing professional development and continuing professional registration needs of qualified staff</p> <p>Create a supervision policy</p>	<p>Chapter 7 Recruiting, Managing and Supervision contains information about the needs of qualified staff</p> <p>Example of supervision policy</p>
<p>Support referred families to access relevant statutory and voluntary services, which could help to reduce any stress or adversity and/or provide practical and social support</p>	<p>Establish step up, step down and step out pathways to ensure families are safe and supported. Include the voluntary sector and the local infrastructure organisation (eg CVS)</p>	



Objective	Project planning	Resources which may be available from the Parent-Infant Foundation to help you
Use recognised clinical outcome measures as a core part of service delivery – both to use clinically to support improvements in the relationship and to provide evidence of impact for service funders	Agree outcome measurement and information reporting requirements/schedule with commissioners and managers	See Chapter 8 Managing Data and Measuring Outcomes for further information about measuring outcomes
Create safe and sustainable working practices which enable the team to deliver highly-skilled and emotionally demanding work	Collate/write policies and procedures including consent processes	Examples of: consent to service, consent to outcome measures, consent to share information with others, home working and lone worker policies, safeguarding management, adult mental health risk management, vulnerable adults' policies, whistleblowing
Promoting the work of the team at a local political, policy, stakeholder and commissioning level as a crucial part of the early years offer in each locality	Create a communication, marketing and influencing plan  Liaise with partner communications teams	
Engage with commissioners to ensure a two-way flow of communication, including data, which can help support the sustainability and reach of the service	Establish data management systems to support required reporting	Chapter 8 Managing Data and Measuring Outcomes contains more information about managing data
Work as part of the Parent-Infant Network co-ordinated and supported by the Parent-Infant Foundation, to contribute to a national collective voice which lobbies for the needs of babies and their families	Make links with the Parent-Infant Foundation to seek support and advice and join the Parent-Infant Network	Parent-Infant Foundation website



## Establishing a strategic board

Parent-infant relationship teams benefit from strategic connectedness and oversight. The function of a strategic board is to:

- Provide leadership in developing a joint strategic vision for babies' emotional wellbeing across the local health, social care and early years ecosystem
- Ensure co-ordination and strategic fit of the team's plans for training and consultancy to the local early years' workforce
- Remove inter-agency barriers to the effective functioning of the team
- Ensure a shared vision across commissioning and delivery
- Set aspirational goals for the development of the team

Example terms of reference are available in the Parent-Infant Foundation website's Network area.



Where parent-infant teams are smaller charities or Community Interest Companies (CICs), trustees can fulfil some of these functions and the local voluntary sector infrastructure organisation (eg CVS) can often support and guide you regarding the local strategic fora. Where teams are located within larger local charities or voluntary sector consortia, the host organisation is often already invited to be part of local strategic relationships. In the public sector, teams report to senior managers through their usual lines of accountability and that will often link them in to a multi-agency strategic forum.

All of these arrangements provide some opportunity to communicate with decision makers but their ability to service the strategic needs of parent-infant teams varies. Babies and their parents are frequently overlooked so we advocate for parent-infant relationship teams to report into either a dedicated board of their own or an existing one which is very closely connected to the first 1001 days agenda.

The **Rare Jewels report** identified a lack of co-ordination at a national level, and this can be replicated at a local level with stakeholders spread across safeguarding, public health, the voluntary and community sector, health, policing, education, social care, communities and the private sector. Ideally, all relevant partners are represented at the strategic board, but as a minimum it should include health visiting, midwifery, early help/children's centres, children's social care, perinatal mental health specialist teams and CAMHS.

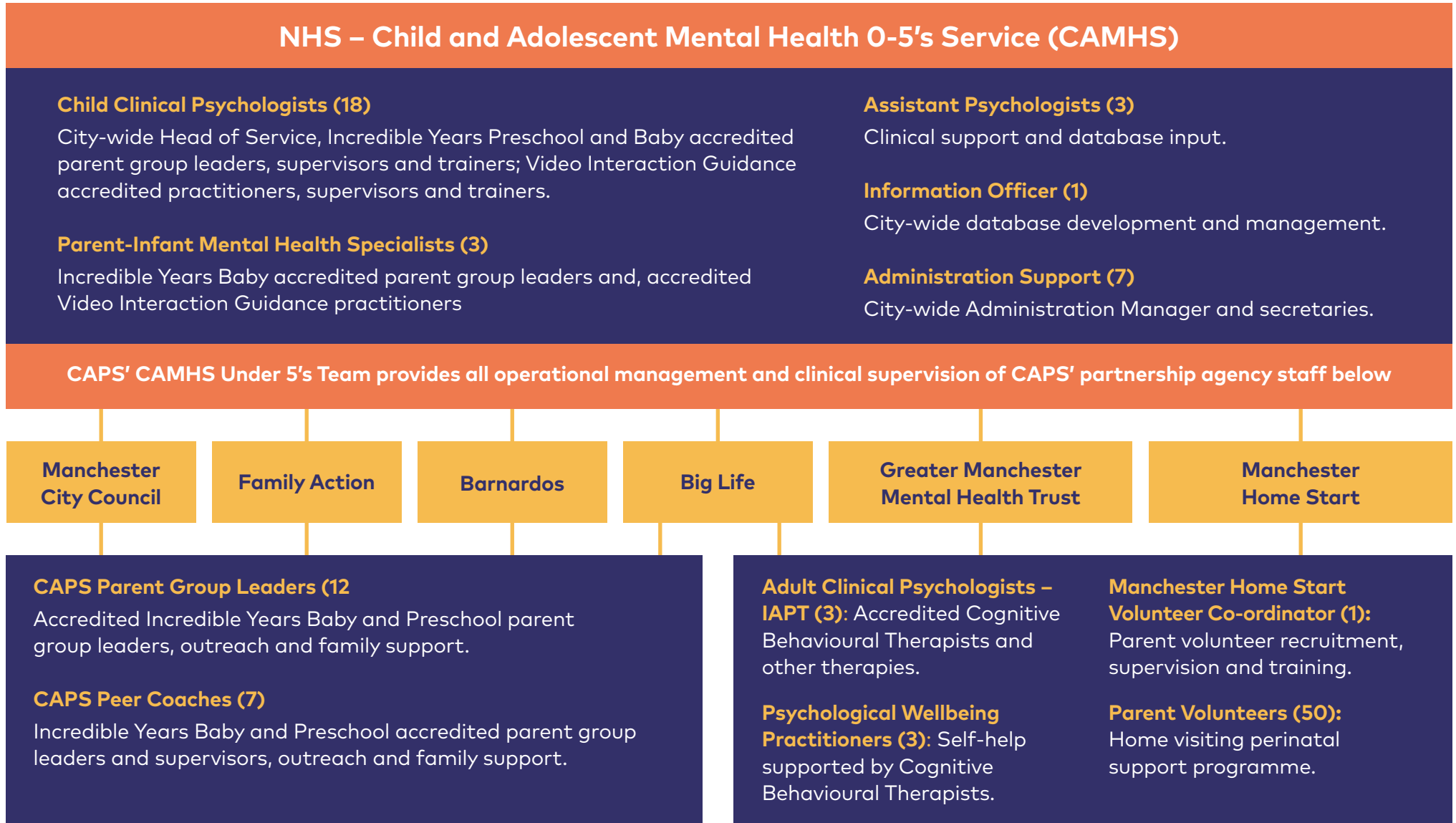
Depending on the exact nature of the strategic board, they may also decide to appoint an operational steering group who will accept delegated responsibility for operational oversight and performance management of the development process. This is typical where the strategic board oversees more than one project, service or priority.

Figure 1 shows how statutory and third sector partners work together in relation to the Child and Parent Service (CAPS) in Manchester.





# Figure 1: Children and Parents' Service (CAPS Early Intervention): Manchester





## Agreeing a training, consultation and direct delivery plan across all partners

Specialised parent-infant relationship teams sit at the heart of the ecosystem around babies' emotional wellbeing. Their role is to be 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.

Workforce training should be planned at a strategic level, including voluntary sector partners, to maximise opportunities for partnership working, reduce duplication and ensure staff are released to attend. Training can be offered at different levels, for example light touch awareness raising (which may be part of other existing training), more detailed understanding for frontline helping professionals, and then in-depth skills training for those practitioners working with families in need of longer term or additional help.

This training activity may need to be funded separately from the contracted direct work of the team as it can be a substantial endeavour. Some areas make training about the emotional wellbeing of babies mandatory, in which case a whole workforce plan is required, to include an ongoing diary of dates to capture new starters. This often requires dedicated time from a training co-ordinator and/or administrator.

**ABCPiP in Ballygowan, Northern Ireland are clear about their dual role to effect system-wide change and to deliver direct interventions to families. To that end, they have facilitated workforce training for over 350 local staff in various approaches such as Five to Thrive, Baby Massage and Baby Yoga and the Community Resilience Model.**

**All the trainings were delivered by expert external trainers and ABCPiP employed an Infant Mental Health (IMH) Keyworker to support practice embedding in all the approaches, to ensure the learning wasn't lost.**

**The IMH Keyworker also continues to build relationships and support colleagues across the workforce to ensure parent-infant relationships are at the heart of local services and to maintain the profile of the ABCPiP team.**

Information about some approaches to training and consultation are in Chapter 4 Clinical interventions and Evidence-informed Practice.





## Free at the point of delivery and paid for arrangements

Most public sector specialised parent-infant relationship teams do not charge families for any of their services, but some charge for training or supervision. It is possible for NHS teams to charge families but this requires substantial development and administration and is likely to require Executive Board sign-off.

Some charities or CICs do charge families and this may be on a flat-rate or means-tested basis. Charities may charge for services (therapy, consultation or training) or use of their facilities but it is a legal requirement that they are not run in a manner which excludes families living in poverty.

For more information on this see Annex C Charging for Services in **Public Benefit: rules for charities**<sup>1</sup>.

## Agreeing data sharing and protocols

Where more than one organisation is involved in commissioning or delivery a specialised parent-infant relationship team, data often needs to be passed across organisational boundaries. This might be evaluation data, outputs data or demographic indicators.

We advise specialised parent-infant relationship teams to seek out existing data sharing protocols which exist locally between the same or similar partners and use these as a template or to inform their own. There will often be local intelligence and learning about how to make the process of data sharing easier.

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1. HM Government The Charity Commission (Feb 2014). **Public Benefit: rules for charities** <https://www.gov.uk/guidance/public-benefit-rules-for-charities>



Where personally-identifiable data is being shared, partners may need a legal contract to be drawn up, so ample time is needed in the project plan. This might occur for example where a parent-infant team requests a child's developmental assessment from local health visitors to support outcome evaluation.

## Agreeing how risk will be managed

As with any complex project, the setting up of a parent-infant relationship team involves different kinds of risk.

Clinical risks, such as safeguarding or adult mental health risks, should be managed according to existing local protocols, and parent-infant teams could request training from their local safeguarding, perinatal mental health and/or adult mental health colleagues to ensure they understand local procedures.

Where staff from different agencies will work together, for example a parent-infant therapist and a children's centre worker running a Mellow Parenting group together, there should be a written policy about how safeguarding concerns will be responded to, handled, recorded and supervised, to clarify individual responsibilities and what will happen if colleagues have different views on the risk.

Project risks, such as not being able to recruit key staff or secure appropriate clinical venues, would normally be collated on a risk register so that the operational lead can discuss with the strategic board what needs to be done.

**"Unlike other mental health services, in parent-infant relationship teams there does not need to be a clinical diagnosis in the adult or child, and the client may be conceptualised as 'the relationship!'"**

## Eligibility or referral criteria

Eligibility criteria should reflect what the team has been commissioned to deliver, ensuring that the most appropriate families receive the service. Some teams adopt relatively broad eligibility criteria, accepting referrals from any source so long as the focus of referral is the parent-infant relationship.

Other teams are commissioned for families experiencing particular challenges, such as young parents in the looked after system, and some teams have a mix of these arrangements.

**In 2019, a consistent message from parent-infant teams of all arrangements is that referrals have been getting more complex and concerning. If there are no robust internal mechanisms to manage different levels of need, practitioners get rapidly pulled into responding to the needs of the most complex family situations.**

**For example, where teams are commissioned to support families with a range of difficulties, clinicians spend most of their time helping the families with the most complex needs and far less time proportionally helping those with moderate needs. This may reflect what is required by commissioning contracts but can lead to misunderstanding with commissioners who have different expectations for preventative work.**

**Some families need an alternative type of support to "stabilise" their situation and resolve current crises before they are able to make use of a therapeutic offer, or for family support to work alongside the parent-infant therapist so that ongoing support needs do not undermine the family's ability to focus on the parent-infant relationship.**



Unlike other mental health services, in parent-infant relationship teams there does not need to be a clinical diagnosis in the adult or child, and the client may be conceptualised as 'the relationship'. A request for service may be based on multiple risks to the parent-infant relationship which create a cumulative negative concern, and not necessarily on a single presenting problem or symptom in either parent or child. This allows a team to operate as a preventative and trauma-informed intervention, providing treatment where an infant has been exposed to potentially traumatising events and working to prevent any trauma in the future.

There are several risk factor tools available which provide the starting point for a referral to a parent-infant relationship team. The infant mental health team in Gloucestershire has developed a list of risk factors and stresses on the relationship which we have included in Chapter 4 Clinical Interventions and Evidence-Informed Practice. Many of the specialised teams find it helpful in guiding referrers. See the Psychosocial and Environmental Stressor Checklist<sup>2</sup> for a more extensive example recommended by Zero to Three in the USA. These tools, which provide an initial method for acknowledging both the stressors that might be negatively impacting the parent-baby relationship as well as some potential risks, can help guide both referral criteria and referrers.

Perinatal mental health difficulties are commonly not considered to be an automatic reason for referral unless there is some evidence that the parent-infant relationship is under strain. Many mothers and fathers with perinatal mental health difficulties maintain good attunement with their baby, although it is a potential risk factor. Where a parent is experiencing mental health problems, parent-infant teams will usually want further information about the parent-infant relationship before accepting a referral.

It may be a clinical judgement as to whether a parental mental health problem needs to be addressed by adult mental health services before a referral with the baby will be considered. Some teams ask that a parent's mental health is stabilised before referral for parent-infant work, so that the adult mental health issues and any associated risks do not hinder the relationship-focussed work.

A specialised parent-infant relationship team may not be suitable for the following situations:

- a) If a parent referred to a parent-infant relationship team is identified to have a new or unsupported episode of severe mental illness, they should be referred for a mental health assessment preferably (where available) from a specialist perinatal mental health service. This includes parents who are experiencing an active episode of a psychotic illness or those who are acutely suicidal and require active risk management.
- b) Parents with a substance dependence (including alcohol) where the situation is not being managed by the area's specialist service. In such instances, liaison and joint working might first be set up to ensure the family's lifestyle and capacity to place their baby's needs before their own improves and then continues to be separately supported.
- c) A family where care proceedings, and any associated parenting assessments, are either imminent or ongoing. If these have been completed and the decision is that the baby remains in the family then it might be appropriate for a parent-infant relationship team to offer intervention.

Teams vary about accepting referrals with current safeguarding risks. Some teams accept referrals irrespective of whether the child is on a Child Protection Plan (CPP), some do but ask children's services not to close the case until the parent-infant work is complete, some don't accept referrals whilst the child is on a CPP.

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2. Zero to Three. The Psychosocial and Environmental Stressor Checklist, DC:05 Resources, <https://www.zerotothree.org/resources/preview/425bc4ce-5d05-49b5-9893-b279bf155243>





It is helpful to co-produce draft referral guidance with commissioners and referring organisations, with the caveat that it may change, before you begin to promote your team to referrers and local services. Referral guidance is often adjusted within the first year of operational delivery in light of early learning about the needs and referral patterns of the local area.

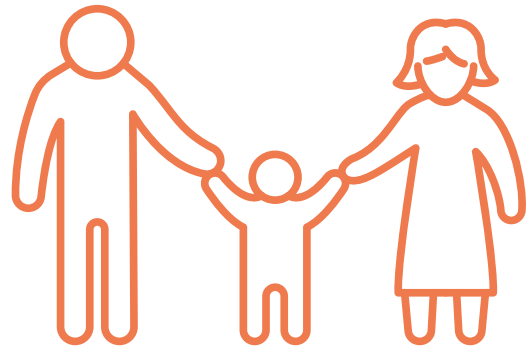
There are examples of referral criteria in the Network area of the Parent-Infant Foundation's website. If you have capacity to do so, offering some dialogue, introductory training or awareness raising sessions to referrers can help improve the appropriateness and rate of referrals.

## Setting up referral pathways

Referral or recommendation to a specialised parent-infant relationship team should not be seen in isolation but as part of a pathway of care, agreed with partners across the whole system, which describes how all families can get the right help at the right time.

Referrals or recommendations typically come through a maternity, health or early years' service provider from either statutory or voluntary sectors i.e. midwife, health visitor, children's centre, GP, social worker, substance misuse or domestic abuse service, perinatal mental health.

In the early days of setting up a team, it can be helpful to prioritise communication with these more likely referrers. In all cases, the clinical focus for a specialised team is the parent-baby relationship and so all requests for service need to describe clearly how this may be in danger of being compromised currently or in the future.



Building relationships is important here: staff might request training from the specialised team to build confidence in identifying families to recommend, but equally parent-infant teams should take the time to understand the context and needs of the referring agencies. It is worth spending time with your referrers so that you can design a process which fits well with their systems, ways of working and paperwork. This supports strong partnership working and effective pathways.

In some parent-infant relationship teams, self-referral is encouraged and in such instances the health visitor and GP as a minimum should be informed (following the usual consent to share information procedures).

**The language of "referral" comes from health and social care and some families can find it stigmatising. An alternative is to describe the process as the "registration" or "recommendation" process. Both imply more ownership of the process by the family and may connote the offer of parent-infant work in a more strengths-based way.**

Referrals are usually preferred in writing (email, letter, a template referral form – see the Network area of the Parent-Infant Foundation website for examples) but the process should strike a balance between collecting the necessary information and being quick and easy for referrers. Low referral rates can sometimes be traced back to lengthy or complicated referral processes.



## Mapping the system

The ideal scenario is for agencies to work together to create an integrated perinatal and infant mental health pathway which clearly responds to the needs of both the child and parent(s). Working together in this way can establish good relationships between services and a better understanding of how each service works.

As a minimum, local services and their referral pathways should be clarified in relation to the new parent-infant team. For example, if there is a local Family Nurse Partnership, specialist infant mental health visitor(s), domestic abuse antenatal pathway, perinatal adult mental health team or pre-birth children's services team, it is important to understand how these services are different, how families are referred to the most appropriate service, or transferred between services if necessary, and what an appropriate package of care might look like.

A specialised parent-infant relationship team can offer highly complementary input to all these services. Good care co-ordination starts with clarity in eligibility criteria and referral processes. Reaching across sectors, from voluntary to public and private and vice versa, is usually fruitful.

### Establishing relationships with referrers and local services

There are several reasons to visit, communicate with and build relationships with referrers and other local services, including:

- To raise awareness about the importance of parent-infant relationship work
- To promote the team and their direct therapy, training and consultancy offers
- To discuss the referral criteria and what is an appropriate referral
- To support the shift in mindset towards the relationships being the client, not the baby or parent

- To begin to understand potential step up, step down and step out options and to think about opportunities for joint-working

'Step up' refers to the transfer of families from a lower intensity intervention, such as a universal parenting group or infant massage, into parent-infant work. 'Step down' refers to transfer in the opposite direction. 'Step out' refers to the transfer of families out of parent-infant work where the intervention has proven to be unsuccessful, inappropriate or the family have decided not to attend any more sessions but still want help of another kind. It is important to establish pathways into community-based services for all families as a way of creating or strengthening their social connectedness.

Setting up smooth transitions and referral pathways helps families feel held, maintains momentum in the progress they are making and can prevent repeat referral to crisis services. Planning these pathways in advance helps staff be clear about mutual expectations and facilitates relationships across teams. Recording these transfers can be helpful in reporting outputs and outcomes, which may also be useful for colleagues in maternity, health visiting and perinatal adult mental health teams who have a remit to support parent-infant relationships.

You may need to visit your referring colleagues regularly to stay up to date with changes in their services, discuss any issues in the referral pathway, to raise awareness of your service, engage with new staff, encourage appropriate referrals and communicate service changes.





## Specialised parent-infant relationship teams are part of an ecosystem which promotes and protects the parent-infant relationship





## Ensuring accessibility measures are in place for parents facing additional barriers to access

The Equality Act (2010) requires you to ensure your service is accessible to everyone who needs it. The government page "Making your service accessible: An introduction"<sup>3</sup> is a useful place to start. Accessibility considerations should include culturally diverse groups, parents with learning difficulties, autistic spectrum disorders or sensory needs and LGBTQI+ families. Part of your search for clinical venues needs to consider how all families will access them. Beyond the requirements of the law, there are other ways to be helpful – for example, thinking about the need for interpreters, stairs for families with buggies, or being close to bus routes.

**The Network area of the Parent-Infant Foundation website has several examples of leaflets for families and professionals to help you create your own.**

## Location

Ideally, a specialised parent-infant relationship team has one base which accommodates therapeutic and administration activities. Some teams are co-located with other services and this tends to enhance inter-professional relationships.

The therapeutic work of a parent-infant relationship team can be delivered in a range of locations and typically include: the family home, within the team's base (if it has appropriate clinical spaces), children's centres or other venues in the community as appropriate and convenient for families with young children.

Home visits may often be best for the family, especially at the beginning of work. It is anticipated that as their work progresses, families will become more confident to access other facilities in their community e.g. children's centre, support from voluntary agencies such as Home Start, additional educational opportunities.

Therapy locations should feel physically and psychologically safe (for family and therapist) and this includes rooms which will not be interrupted. Home visits should balance the needs of the client with the safety of the therapist and no team can see all families at home all of the time. Some families will not attend venues which have past negative associations for them, and this may include schools, social care venues, churches or hospitals.

Community venues need to be accessible for pushchairs and disability needs, have accessible toilets including baby change facilities, offer baby feeding facilities and be clean enough to allow floor play. Rooms for group therapy sessions need to be comfortable (seating, room temperature, space to move about, adequate lighting).

Appropriate health and safety checks will be determined by local procedures. Staff inductions need to include fire evacuation, security access to the building, safeguarding reporting and accident reporting. Where home working is expected then adequate lone working and home visiting policies should be in place. The Parent-Infant Foundation website has examples of these in its Network area.



3. HM Government Accessibility Community (July 2019)  
<https://www.gov.uk/service-manual/helping-people-to-use-your-service/making-your-service-accessible-an-introduction>



## Recruitment, training, supervision and licences

All recruitment and supervision issues, including planning for the needs of professionally-registered staff, are in Chapter 7 Recruitment, Management and Supervision.

Some therapeutic tools and approaches, for example the Key to Interactive Parenting Scale, stipulate licensing, re-licensing or supervision criteria and these may need to be built into the project plan and budget.

New multi-disciplinary teams may find it helpful to complete a core set of training together, for example VIG or one of the OXPIP or Anna Freud Centre ITSIEY courses (see Chapter 4 Clinical Interventions and Evidence-informed Practice). This facilitates team development, contributing to a better understanding of one another's work and a shared focus on the parent-infant relationship. The AIMH-UK core competencies<sup>4</sup> also provide a framework to structure conversations between team colleagues about key skills and plans for continued professional development.



4. Association for Infant Mental Health UK (2019). Infant Mental Health Competencies Framework <https://aimh.org.uk/infant-mental-health-competencies-framework/>





## Purchasing equipment

Before you buy any video recording, editing or other IT equipment, make sure you understand your organisation's position on the recording, storage and deletion of video material. For example, if your employer will not allow you to transfer video footage of families onto your work laptop, then this may have a significant bearing on whether you buy a video camera or a tablet with its own editing function. (Note: this needs to be addressed in your record keeping and archiving policy as well).

### Other equipment you may need includes:

- Floor rugs and bean bags to ensure parents and therapists can sit on the floor next to babies\*
- Baby changing mats
- Age-appropriate toys, dolls\*
- Software to support data management (see Chapter 8)
- The manuals and record forms for licensed assessment tools
- Materials connected to specific approaches such as Five to Thrive (see Chapter 4)

## Writing policies and procedures including consent processes

Where teams are made up of staff from different agencies they may be expected to work to different agencies' policies and procedures, in which case it can be helpful to identify a partnership board to iron out any inconsistencies.

Many parent-infant teams are located in sectors and organisations that already have a full suite of policies, such as home working, lone working,

whistleblowing, consent to service, consent to share information, consent to record outcome measures, safeguarding and vulnerable adult policies. If not, local colleagues will likely have similar ones that can be adapted. The Parent-Infant Foundation can support teams with this so if you cannot find an example of what you are looking for in our website's Network area, please contact us directly.

## Creating a communication, marketing and influencing plan

This is often an overlooked aspect of setting up a new team but can prove important in terms of later influencing and sustainability. Creating a communication, marketing and influencing plan means asking "who do you want to know what about the specialised parent-infant relationship team?". Families can be involved from the start in helping to develop the service, the team name, etc. but also as a future audience for communications from the team.

Other typical audiences include commissioners and senior leaders (who might welcome quarterly, light touch updates with key outputs and outcomes), the early years workforce (who might welcome clinical updates, service updates and information about training opportunities), referrers (who will want feedback about referrals they've made but also might need reminding every now and again that the team is still there) and national audiences with whom you wish to network (e.g. the Parent-Infant Network).

Your plan might include a launch event, media and press outputs, leaflets and newsletters. The Parent-Infant Foundation may be able to share examples with you from other teams.

Creating a repository of case study material can be extremely useful for a range of purposes, so now is the time to think through your consent and retention policy.

\* Consider health and safety requirements here such as whether items are fit for use with infants, cleaning/laundry etc



## A note about Implementation Science

There is increasing interest from practitioners, researchers and policy makers about the potential of “implementation science” to help improve how we deliver (or implement) services in ways which improve family engagement, retention and outcomes.

Implementation science is described by the **Global Alliance for Chronic Disease**<sup>5</sup> as “the study of methods and strategies to promote the uptake of interventions that have proven effective into routine practice, with the aim of improving population health. Implementation science therefore examines what works, for whom and under what circumstances, and how interventions can be adapted and scaled up in ways that are accessible and equitable.”

The **House of Commons Science and Technology Committee Report**<sup>6</sup> into Evidence-Based Early Years Intervention includes reference to the importance of implementation factors (pp 63-65) such as the importance of collecting data, accrediting training and supervision and model fidelity. Good review texts are available by Fixsen<sup>7,8</sup> and Blase<sup>9</sup>. Implementation science also takes into its scope the capacities, motivations and opportunities for people to adopt new ways of working. For this aspect, we like the book *Switch*<sup>10</sup> by Chip and Dan Heath which provides an introduction to some key change concepts for non-specialists.



## Making links with the Parent-Infant Foundation

If you are setting up a new team and have not yet contacted us, please do so. We are delighted to be able to share the information and resources we have, broker relationships with similar teams, learn about and promote your work, and hear about your challenges and successes. All specialised parent-infant relationship teams in the UK are invited to join the Parent-Infant Network, a collective space for peer support and learning.

We also have a newsletter specifically for parent-infant teams and a variety of other opportunities for teams to make use of. There is more information in Chapter 1.

5. Global Alliance for Chronic Disease. Implementation Science <https://www.gacd.org/research/implementation-science>
6. House of Commons Science and Technology Committee (November 2018). Evidence-based early years intervention <https://publications.parliament.uk/pa/cm201719/cmselect/cmsctech/506/506.pdf>
7. Fixsen et al (2007) Implementation: The Missing Link Between Research and Practice <https://files.eric.ed.gov/fulltext/ED507422.pdf>
8. Fixsen et al (2005) Implementation Research: A Synthesis of the Literature <https://nirn.fpg.unc.edu/sites/nirn.fpg.unc.edu/files/resources/NIRN-MonographFull-01-2005.pdf>
9. Blase et al (2012) Bridging the Gap from Good Ideas to Great Services: The Role of Implementation <http://www.cevi.org.uk/docs/Colebrooke%20Centre%20&%20CIB%20workshop%20March%207th%202012%20%20Karen%20Blase%20Keynote%201%20slides.pdf>
10. Heath, C & Heath D (2011). *Switch*. Random House Business.



## Chapter 6

# Operational Delivery: Moving from Set-Up to Sustainability

Chapter 5 dealt with how to prepare for operational delivery. Chapter 6 will help you on your development journey from opening the doors to families to becoming a sustainable service. The information is sourced from the collective expertise of many practitioners, clinical and operational leads and implementation specialists across the field of parent-infant relationships, including many of the existing teams.

Topics covered include how to manage referrals and waiting lists, initial contact and engagement, screening and assessment, managing beginnings and endings with families, and follow-up. It is not intended as a guide in how to be a parent-infant practitioner, but as a collection of learning and prompts to guide you in how you organise the work with families.

## Finding families to work with

Reaching the families who will benefit most from working with a specialised parent-infant relationship team can be initiated in several ways:

- Accepting families through consultation activity with other services. Some new parent-infant teams start out initially not by accepting referrals but by offering consultation and joint visits with colleagues in other services. This helps manage the inflow of families and creates a mutual exchange of learning between organisations
- Accepting families referred directly from practitioners e.g. midwives, GPs, health visitors, social workers, children's centres, etc.
- Accepting self-referrals\*. Many teams worry that self-referrals will inundate them, but self-referrals can be a helpful mechanism to stimulate numbers of referrals, for example

in smaller charities who are just setting up, or where the team wants to break down accessibility barriers (such as having to get a professional referral)

As described in Chapter 5, building relationships with referrers is key. Meaningful dialogue about their contexts and ways of working helps referral pathways be easy to use. Workforce training from specialised teams supports referrers to make appropriate and timely referrals and to help them have conversations with families which de-stigmatise referral.

## Screening for suitability

Not all referrals will be suitable for the team: some will not meet the eligibility/referral criteria, some will not have enough information for you to make a decision, some referrals will be unclear about whether the family is aware of and has agreed to the referral in the first place.

\* "referrals" and "referrers" is language typically used in health settings. Teams may prefer to use the alternative language of "registrations".



Parent-infant teams tend to be more likely to accept referrals that clearly identify recognised risk factors or current stressors that may be putting the caregiving relationship at risk. The team can then complete an observational and interview-based assessment to establish the extent, intensity and urgency of the difficulties in the parent-infant relationship.

There are different ways to prioritise referrals:

- Chronologically. Some teams see families in the order they have been referred
- By risks and stressors. Some teams prioritise those parent-infant relationships exhibiting many/certain types of risks and stressors
- Triage. Some teams triage all families equally quickly and then prioritise from there

PIP teams such as Croydon Best Start PIP have been using the list of risk factors<sup>1</sup> developed by Gloucestershire Infant Mental Health team to support referrers and their own practitioners when thinking about the stresses and risks individual parent-infant relationships are under.

Those considered to be the most significant risk factors are underlined. One significant risk factor is considered sufficient reason for referral, but as risks are cumulative, four or more 'minor' risks also qualify for referral.

'Studies show that early intervention works best when it is made available to children experiencing particular risks'<sup>2</sup>

Typically, the team's Clinical Lead sifts through new referrals for ones that are obviously unsuitable and then explains the reasons to the referrer and suggests an alternative service for the family, if appropriate. In some instances, the whole team reviews referrals together. Ideally, this is done within a working week of receiving the referral but you may need to gather more information on the situation in the family and their context before being able to make a decision.

Once the team accepts a referral, the family are placed on the waiting list or allocated to a practitioner within the team and the family and referrer are informed. If you accept self-referrals, you should inform the Health Visitor and GP of the referral and outcome (according to your consent to share information policy).

## Managing a waiting list

If you reach the point where you need to manage a waiting list, you should work cooperatively with all the referring agencies to make sure that being on the waiting list does not lead the referrer or other services to withdraw or lower their level of support for that family.

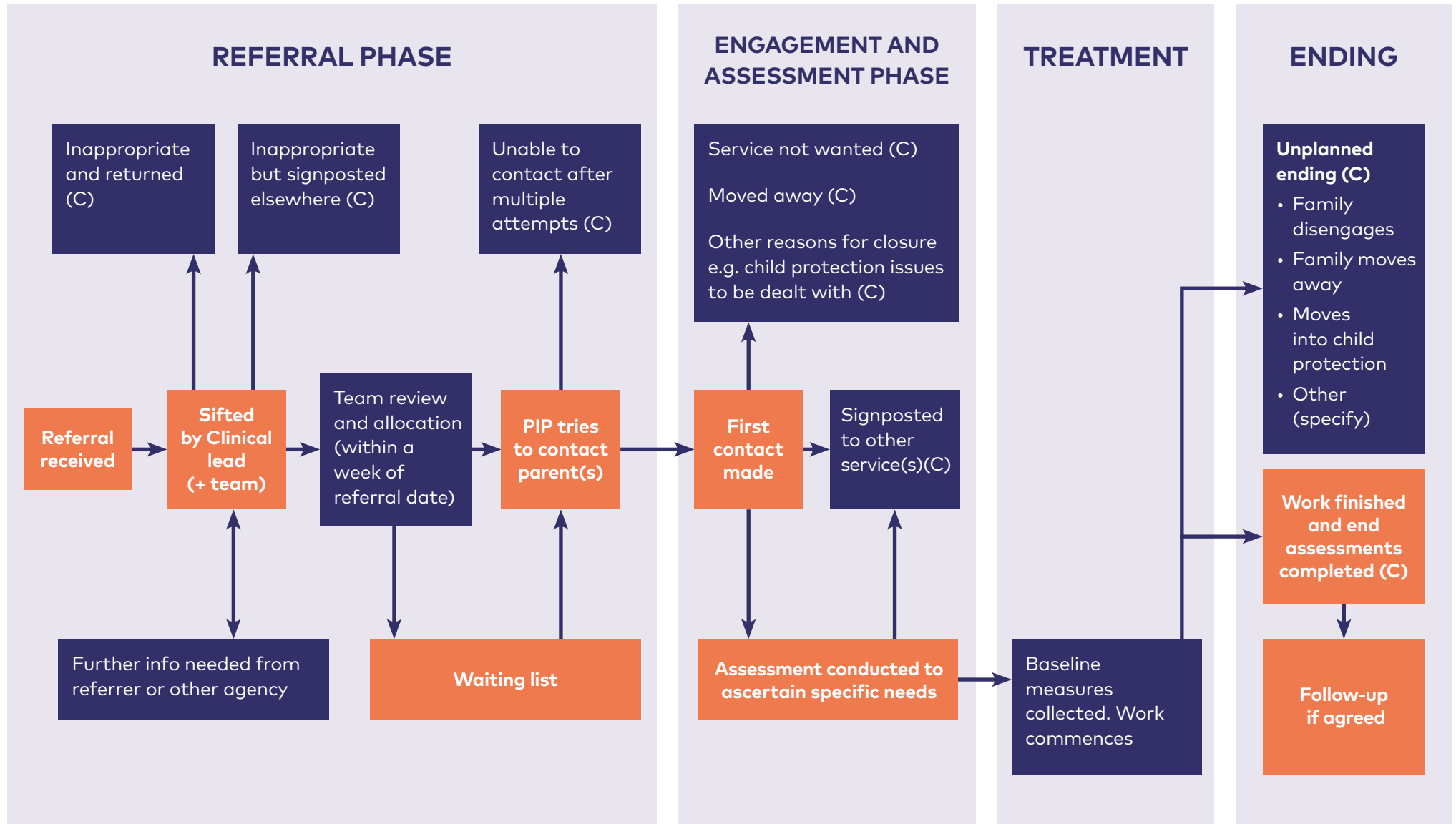
If referring services withdraw ongoing support, the family may feel abandoned or resentful of the referral, reducing the likelihood of them engaging with the new service and potentially raising a safeguarding risk.



1. The Wave Trust. Conception to 2: Age of Opportunity (2013), page 89  
<https://www.wavetrust.org/Handlers/Download.ashx?IDMF=474485e9-c019-475e-ad32-cf2d5ca085b0>  
 2. Early Intervention Foundation (2018). Realising the Potential of Early Intervention p.6.  
<https://www.eif.org.uk/report/realising-the-potential-of-early-intervention>



## Typical referral management process



(C) = case closed





## Allocation within the team

Typically, teams discuss appropriate referrals at a weekly team meeting. Families are allocated to the practitioner with the professional skills most suited to the families' needs although some teams might operate on a locality or assessment clinic basis. The assigned practitioner will make any final enquiries to the referrer and make the first contact with the family. This can take time and persistence if families are unsure about engaging or their contact is erratic.

Some teams have keyworker roles to help both with this first engagement and with later aspects of supporting the family. Some parent-infant teams put a time limit on how long to attempt engagement before the family are referred back to the original referrer. Trust might be difficult for families experiencing relationship problems so sensitive, well-timed and respectful approaches are crucial.

## Trauma informed approaches

Many parents referred to a specialised parent-infant relationship team will have experienced at least one, if not multiple, forms of trauma during their lifetimes. This may not be detailed in the referral and may not be obvious at first contact but may be impacting on the parent-infant relationship and making it hard for parents to engage. Being trauma-informed means approaching everyone in a respectful, transparent and empowering way such that contact is not re-traumatising and does create the conditions of safety needed for that person to trust and engage.

Some of the elements of trauma-informed practice are described in this [Research in Practice Blog](#)<sup>3</sup>, this [Centers for Disease Control and Prevention Infographic](#)<sup>4</sup> and in this [review article by Sweeney et al \(2016\)](#)<sup>5</sup>.

## Making first contact

First contact is the moment when the allocated practitioner contacts the family to say hello, welcome them to the service and arrange the first appointment, and there are various considerations.

- Text:** we have heard from teams across the network that texting is a popular way to make the first contact as it is less personal than a phone call but more personal than a letter. Many parents find this a comfortable first contact and a helpful way to be reminded of appointments. Teams need a policy in place for contact by text, to include how to respond to information shared out of hours and how to manage risk.
- Contact with both parents:** where a couple have been referred with their baby, the first contact should be to both parents.
- Tailored to needs:** sensitive approaches to literacy and learning difficulties may favour text or phone as the first contact, but with a follow-up letter to confirm the date and time of any appointments.
- Additional information:** some parent-infant teams include leaflets or baseline assessment questionnaires in the letter confirming the first appointment, as well as any outstanding consent forms, although others prefer to wait until they've met the family.

3. Danny Taggart (June 2018). Trauma-informed responses in relationship-based practice. Research in Practice. <https://www.rip.org.uk/news-and-views/blog/trauma-informed-responses-in-relationship-based-practice/>

4. Centers for Disease Control and Prevention. Infographic: 6 Guiding Principles To A Trauma-Informed Approach [https://www.cdc.gov/cpr/infographics/6\\_principles\\_trauma\\_info.htm](https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm)

5. Sweeney A, Clement S, Filson B & Kennedy A (2016). Trauma-informed mental healthcare in the UK: what is it and how can we further its development? Mental Health Review Journal 21(3): 174-192. <https://www.emerald.com/insight/content/doi/10.1108/MHRJ-01-2015-0006/full/html>





## The first appointment

Though there may be times when a phone consultation is offered first, most specialised parent-infant relationship teams offer a face-to-face first appointment. Unless there is an issue of safety, the first appointment might be a home visit.

It is worth considering, with the parents' permission, inviting the referrer to the first appointment. This improves the families' experience of transition, improves communication between professionals and with the family, and can offer mutual learning between parent-infant teams and referrers.

When it comes to scheduling appointments, families with older children can find it hard to attend during periods of the day which clash with school drop-off and pick-up times. We have heard from teams that sending text reminders a day or two before the appointment can increase attendance rates.

## Agreeing further work

At the end of the first appointment, the practitioner will typically check that the family fully understands that their relationship with their baby is the focus of the work and discusses an offer of further work.

This is likely to involve further assessment in the first instance, with a view to finding the most appropriate intervention approach to follow. Information management systems may need to be able to accommodate these different types of sessions.



## Letters

You may wish to consider addressing any follow-up letters to the parents who attended and copy these to other professionals and absent parents, rather than write to professionals with copies to parents.

## Interventions

**Assessments and interventions are described in detail in Chapter 4 Clinical Interventions and Evidence-Informed Practice.**

## Managing endings

Whilst this toolkit is not a clinical guide, clinical guide, how best to manage endings is a perennial topic of discussion that is raised at our network events. Sustainable teams need families to flow into and out of the service, otherwise the backlog can lead to lengthy waiting lists and practitioners feeling swamped.

Some specialised parent-infant relationship teams limit sessions in parts of their service, typically to 5 or 6 sessions, but allow flexibility for those families who clearly need additional work. Certain manualised interventions offer a fixed number of sessions.

How relationships begin and end is significant, and ending a therapeutic relationship is typically an extended phase rather than one ending session. The ending should be negotiated with the family at an appropriate time in advance, leaving enough sessions to work this through. A review session mid-way through the work can establish what more work the parent thinks remains to be done. It is not uncommon for families to discover another issue they want support with when the work starts coming to a close.



Some families appreciate transition to step down services such as Infant Massage or universal parenting groups such as Solihull Approach, or into community-based services which can support their social connectedness. DorPIP runs Keep In Touch group sessions once families have completed therapy.

There is a **helpful report<sup>6</sup> on the Anna Freud Centre website about ending treatment in challenging circumstances.**

## Follow up

There may be advantages to following up families after six months or so, for example if you are keen to collect follow-up outcome measures or monitor the success of intervention. Many teams do not have the capacity to do this. It is worth remembering that some clinical recording systems would require the case-notes to be re-opened if there was a successful follow-up.

## Sharing information with others

At any point in the work with families, information may come to light that the practitioner believes could be beneficially shared with another. All parent-infant relationship teams are required to follow data protection legislation and the guidance set out in Government guidance<sup>7</sup>. This states: 'Information sharing is essential for effective safeguarding and promoting the welfare of children and young people. It is a key factor identified in many serious case reviews (SCRs), where poor information sharing has resulted in

missed opportunities to take action that keeps children and young people safe.'

Information sharing is also good practice when there are no safeguarding issues. However, since a parent-infant relationship team is providing a therapeutic service, patient confidentiality applies and (unless there is an immediate observed safeguarding concern) no personal information derived from the work should ever be shared without formal permission. The ethical guidelines from professional associations should be followed at all times, as should the guidance set out in the NHS England Confidentiality Policy<sup>8</sup>.

'All employees working in the NHS are bound by a legal duty of confidence to protect personal information they may come into contact with during the course of their work. This is not just a requirement of their contractual responsibilities but also a requirement within the common law duty of confidence and the Data Protection Act 2018. It is also a requirement within the NHS Care Record Guarantee, produced to assure patients regarding the use of their information'

## Recording clinical notes

All public sector organisations and registered professionals will have their own record keeping policies and guidance from professional bodies. Details of professional bodies can be found in Chapter 6 Recruitment, Management and Supervision.

For anyone who needs to develop their own, there is a Clinical Record Keeping policy template in the resources section and you are advised to have your policy ratified by your Executive Team or Board of Trustees. You may need to reference record keeping procedures in your home worker and lone worker policies.

6. Dalzell, K. Garland, L. Bear, H. Wolpert, M. (2018). In search of an ending: Managing treatment closure in challenging circumstances in child mental health services. London: CAMHS Press. <https://www.annafreud.org/media/6593/in-search-of-an-ending-report.pdf>
7. HM Government (2018). Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers. [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/721581/Information\\_sharing\\_advice\\_practitioners\\_safeguarding\\_services.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf)
8. NHS England (2018). Confidentiality Policy <https://www.england.nhs.uk/wp-content/uploads/2016/12/confidentiality-policy-v4.pdf>





**The Parent-Infant Foundation can support you in developing record keeping policies and procedures, please contact us through our website.**

Whether notes are kept in the parents or child's name is often determined by where the team is located in the system. Parent-infant teams that are managed within CAMHS, health visiting or children's social care keep records in the child's name. This has the benefit of the records staying with the child if their carers change e.g. if the child goes into care. The child can access the notes when s/he is older, as can every adult with parental responsibility (which may be problematic if the parents are separated), although information about any adult may need to be redacted, including any opinions expressed about one parent by the other or information about their past or present experiences.

**The Leeds Infant Mental Health Service is managed through CAMHS so the record management system has been adapted to accommodate antenatal referrals. The child is referred to as 'Baby of [Mother's name]' with the Expected Due Date as date of birth, which is then updated once the baby is born.**

If the parent-infant team is managed through perinatal (adult) mental health or a charity, the records are typically kept in one of the parent's names. This prevents the child, and an abusive or separated other parent, from accessing the notes. It can also make it easier to link safeguarding information where one parent may have several children with different surnames.

The Parent-Infant Foundation advocates for the meaningful engagement of male parents and carers in all work, where this is safe for the mother and child. We ask that all teams gather, share and record information in a way that

supports a father's and/or partner's important role in the infant's life. This includes recording their contact details, understanding their relationship with the baby and actively bringing them into the work as much as possible where clinically appropriate.

## Accountability, risk management and note-keeping in consultation

The Parent-Infant Foundation defines consultation as a conversation between a parent-infant team practitioner (consultant) and another worker outside of that team (consultee) for the purpose of discussing the consultee's work with families and providing access to the consultant's expertise in parent-infant relationships.

Understanding good practice in consultation, including what should be recorded, where notes should be kept, how accountability and risk are managed, can be a grey area. Consultation, like supervision, is a welcome activity with many benefits for families and workers because it:

- Allows practitioners to seek the expert advice of others without families needing a formal referral, thereby preventing unnecessary referrals
- Can be an excellent form of professional learning
- Can provide a useful quality assurance function
- Gets the right advice to those already working with the family without the need for a waiting list or face to face appointment
- Raises awareness of the parent-infant team and the benefits of the work they offer
- Improves inter-professional communication and mutual understanding of roles
- Encourages a shared language and understanding of babies' emotional wellbeing across the system





We advise all specialised parent-infant teams to follow the consultation policy of their host organisation, and to provide a clear statement about consultation note-keeping, issues of accountability and risk management to all consultees. In the absence of a specific local policy on consultation there may be an organisational policy on supervision and note-keeping which can be used to inform practice. Teams should consider the following questions if writing their own consultation policies.

### a. Note-keeping

Should there be one shared record of the consultation which both the consultant and consultee keep, or should each record the consultation separately?

Most consultations occur anonymously, without the families' knowledge, because like supervision it is provided as a support mechanism to the person already working with the family. As such, the anonymised notes are likely treated the same as supervision notes. If consultation occurs with the family's consent, might notes of the consultation be kept in the families' notes? And how should the consultation time be recorded in the consultees diary system (as a clinical contact against the families' name or as generic consultation time)?

Who has access to consultation notes? For example, does the consultees' manager have access to consultation notes in the event of a concern or later enquiry?

### b. Accountability and risk management

Whilst consultation is very similar to supervision, it usually crosses organisational boundaries so the accountability arrangements are likely to differ. Is there a need for a written agreement between consultants and consultees stating that advice given during consultation is based on information provided by the consultee, and that the consultee and his/her employer remain accountable for the consultee's decisions and actions?



There are rare occasions when the consultant has significant concerns during consultation, for example about safeguarding issues or the capability of the consultee. How will consultants respond and manage their concerns?

## Team meetings and case discussion

Specialised parent-infant relationship teams around the UK tend to have two types of team meeting as a minimum: a team business meeting where non-clinical matters such as future developments, capacity challenges, building maintenance, mandatory training and other operational necessities are discussed and then a clinically-focussed meeting which may encompass referral allocation, caseload reviews and case discussions. These might be supplemented by formal peer or external supervision meetings, journal or book clubs, and topic- or profession-specific supervision groups (e.g. safeguarding supervision).





## Caseload management

Caseloads should be determined locally but as a rule of thumb, for individual work four families are seen in a normal 7.5 hour working day. This figure is based on the assumptions that the case load will be mixed (including some very complex families requiring liaison with multiple external and internal colleagues and potentially multiple modalities of therapy, alongside more straightforward work) and that the practitioner will be given dedicated time for team meetings, training etc.

A two-hour group session is likely to require at least one hour's preparation and one hour's follow-up for experienced group facilitators and considerably more for practitioners new to that intervention.

## Recording non-clinical work

We advise all specialised parent-infant relationship teams to record their non-clinical activity, such as consultation, delivery of training, strategy development, conferences and presentations in a manner which allows them to be easily reported to commissioners and managers. This type of data usually proves helpful for service review and improvement, commissioning conversations and funding oversight.

Many teams devise their own spreadsheets, but the Parent-Infant Foundation also offers a free data portal system to record anonymised family descriptors (age at referral, ethnicity, etc.), clinical outcomes and non-clinical outputs. It is helpful to have a very clear protocol for who collects, enters and analyses each kind of data so that everyone's clear about who's job it is.

**We may be able to provide you with aggregated anonymised data from other parts of the country to help you benchmark your own activities and support your quality improvement work. Please see Chapter 8 Managing Data and Measuring Outcomes or contact us for further details.**

## Steady-state management and expansion

Listening to the experienced team developers we have spoken to, it can take a specialised, multi-disciplinary team around three years to get into their full stride and start to embed their work across the system. Throughout this forming and storming stage, it is important to manage expectations of funders. Outcomes and outputs will be building but will likely not be fully representative of the maximum capability of the team.

Once a new team is stable in its core delivery, expansion into specialised areas such as the neonatal unit or parents in prison might act as a spring board for new work to be commissioned. Teams might look to take on additional roles, such as keyworkers, adult therapists or social workers.

Rapid expansion, for example rolling out a localised service across a much broader area, can put pressure on the infrastructure that supports a team, and therefore should be planned carefully.

If possible, it can be helpful if someone in the team or commissioning network can be scanning for funding opportunities, for example, charitable grants, and commissioning deadlines. Where teams have operational leads, this would usually fall to them. Public sector budgets are often being developed from September/October for the following year, so teams might need to be developing proposals over the summer.



## Chapter 7

# Recruitment, Management and Supervision of a Specialised Parent-Infant Relationship Team

This chapter has three sections. The first provides information about the professionals who make up a specialised parent-infant relationship team, their qualifications and registration. This will help you recruit appropriately qualified and experienced people. The second section deals with the roles in specialised parent-infant relationship teams, so that you can plan the team structure.

The third section includes information about recruitment and there are helpful insights from existing teams about getting the management and supervision arrangements right. You will find sample job descriptions/role definitions and person specifications in the Network area of the Parent-Infant Foundation website.

A parent-infant relationship team is a multi-disciplinary team of professionals who fulfil a range of roles such as 'clinical lead' and 'parent-infant therapist'. Everyone in the team is bound together by a working knowledge of early child development, attachment theory, neurological development and an awareness of the importance of the unconscious dynamics of parenting.

The team offers a range of evidence-informed interventions so that every family can receive a tailored package of care. The team's collective therapeutic toolbox should include individual and group interventions which can cater for a range of presenting difficulties and levels of complexity. Several existing teams employ a keyworker or similar family support colleagues who link families into other services such as housing, substance misuse or social isolation. This reduces families' stress, facilitating their engagement in therapy and maximising its effectiveness.

## Professions

Specialised parent-infant relationships teams tend to be made up of three complementary groups of practitioners:

### 1. Mental health professionals

These are practitioners who have a mental health-specific qualification, such as a psychotherapist, clinical psychologist, mental health nurse, counsellor or psychiatrist. Every parent-infant psychotherapist, and most clinical psychologists and child psychotherapists, are specifically trained in the theory and practice of early years work and so every parent-infant team should have at least one of these, ideally one psychotherapist and one clinical psychologist.

The Parent-Infant Foundation defines a specialised parent-infant teams as multi-disciplinary which includes at least one





clinical psychologist or child/parent-infant psychotherapist with excellent parent-infant knowledge, skills and experience.

Mental health professions are trained in a range of treatments and therapies although the depth and breadth of their training, and hence gradings, differ. Within each profession, individuals specialise in a particular life stage and we recommend recruiters seek out relevant parent-infant specialism.

Psychotherapy is the profession most closely aligned, philosophically and therapeutically, with attachment theory and the unconscious communication of parent-infant relationships. In the teams PIP UK supported to develop, parent-infant psychotherapy is an essential, but not exclusive, clinical component which provides psychodynamic thinking to the team.

Other child mental health practitioners may have good early years' experience and a deep understanding of psychotherapeutic approaches, but this will need to be checked at recruitment.

Mental health professionals might work as a Clinical Lead or Parent-Infant Therapist in specialised parent-infant teams. Alternatively, some teams recruit people into profession-specific job roles, such as "Clinical Psychologist" or "Specialist Health Visitor". This might be to enhance job appeal or to align with the employing organisation's existing job profiles.

## 2. Health, education, social care or other related professionals

These are practitioners who have come into parent-infant work from a non-mental health background (e.g. health visiting, social work, early years, occupational therapy or family support work) and have specialist parent-infant skills by virtue of additional training, qualifications and experience.

## 3. Therapy-specific professionals

These are practitioners who are trained in one specific therapy, such as play therapists, cognitive-behaviour therapists or EMDR practitioners. They are from a wide variety of backgrounds, all having pursued a course of study and qualification in one chosen approach.

They may or may not have broader therapeutic training but, as stated above, everyone taking up a role in a specialised parent-infant relationship team must have a working knowledge of early child development, attachment theory, neurological development and an awareness of the importance of the unconscious dynamics of parenting. In some teams, therapy-specific professionals are employed in the 'parent-infant therapist' role, in others they have a job title specific to their training, such as play therapist.





There are NHS National Job Profiles available on the [nhsemployers.org](https://www.nhsemployers.org) website for:

- **Psychologists, psychotherapists and counsellors**<sup>1</sup>
- **Occupational Therapists**<sup>2</sup>
- **Play Therapists**<sup>3</sup>
- **Art Therapy Staff**<sup>4</sup>
- **Health Visitors**<sup>5</sup>
- **NHS salary ranges (current as of 1 August 2019) can be found at [healthcareers.nhs.uk](https://www.healthcareers.nhs.uk)**<sup>6</sup>

## Competencies, skills and qualities

The Association of Infant Mental Health in the UK (AIMH UK) has recently published a set of competencies for infant mental health work which brings welcome clarity to the competencies, skills and qualities needed to work at different intensities in parent-infant relationship work. We strongly recommend the AIMH Competency Framework which can be found at <https://aimh.org.uk/infant-mental-health-competencies-framework/>

All parent-infant relationship practitioners should be at level three of the AIMH Competencies. Some teams require their practitioners to complete an infant observation

course for the depth of understanding it brings regarding the world of infants.

All members of a team need to be non-judgemental, compassionate, solutions-focused and trauma-informed in their approach, and values-based interviewing can assist in identifying these qualities at recruitment.

## Qualifications, Registration and Regulation

Neither "Parent-infant Therapist" nor "parent-infant psychotherapist" are protected titles. The former is a generic job title, the latter a speciality within the profession of psychotherapy.

A Parent-infant Therapist (or Parent-infant Practitioner) could be a person from any non-psychotherapy background (so a psychologist, social worker, health visitor, occupational therapist etc) who is employed in a role entitled Parent-infant Therapist. For example, a Parent-infant Therapist might be a specialist health visitor who has completed the ITSIEY modules at the Anna Freud National Centre for Children and Families, or could be a psychologist who completed a specialist placement in a parent-infant team. Parent-infant Therapists are registered with the professional body responsible for their core professional qualification.

Psychotherapy is a distinct mental health profession with its own clinical training, qualifications and registration requirements. There are multiple different training routes to becoming a psychotherapist. Some are

1. NHS. National profiles for clinical psychologists, counsellors & psychotherapists. [https://www.nhsemployers.org/-/media/Employers/Documents/Pay-and-reward/Clinical\\_Psychologists-Counsellors.pdf?la=en&hash=02CA64816455E0A3B5B8DE22CFB30489F2A654DF](https://www.nhsemployers.org/-/media/Employers/Documents/Pay-and-reward/Clinical_Psychologists-Counsellors.pdf?la=en&hash=02CA64816455E0A3B5B8DE22CFB30489F2A654DF)
2. NHS. National profiles for occupational therapy. [https://www.nhsemployers.org/-/media/Employers/Documents/Pay-and-reward/Occupational\\_Therapy.pdf?la=en&hash=DB121FCC1F78FAACFBB61F7A2823EF944E5433E7](https://www.nhsemployers.org/-/media/Employers/Documents/Pay-and-reward/Occupational_Therapy.pdf?la=en&hash=DB121FCC1F78FAACFBB61F7A2823EF944E5433E7)
3. NHS. National profiles for play specialists. [https://www.nhsemployers.org/-/media/Employers/Documents/Pay-and-reward/Play\\_Specialists.pdf?la=en&hash=B731A847EF87CF06F3A40E7D810C0AEB24FCC6FC](https://www.nhsemployers.org/-/media/Employers/Documents/Pay-and-reward/Play_Specialists.pdf?la=en&hash=B731A847EF87CF06F3A40E7D810C0AEB24FCC6FC)
4. NHS. National profiles for art therapists. [https://www.nhsemployers.org/-/media/Employers/Documents/Pay-and-reward/Art\\_Therapy.pdf?la=en&hash=FA276BE3C252B42A0EB3F80EDB674BF1AD652899](https://www.nhsemployers.org/-/media/Employers/Documents/Pay-and-reward/Art_Therapy.pdf?la=en&hash=FA276BE3C252B42A0EB3F80EDB674BF1AD652899)
5. NHS. National profiles for health visiting. <https://www.nhsemployers.org/-/media/Employers/Documents/Pay-and-reward/Health-Visitors-current-version-291118.pdf?la=en&hash=44073CFF26552097BA35E68929891F59390D4E73>
6. NHS Health Education England. Agenda for Change pay rates (April 2019). <https://www.healthcareers.nhs.uk/working-health/working-nhs/nhs-pay-and-benefits/agenda-change-pay-rates>



child and adolescent psychotherapists whose training has covered the theory and practice of working with infants. Some are parent-infant psychotherapists who have completed qualifications specific to parent-infant work, such as a Diploma in Parent-Infant Psychoanalytic Psychotherapy. Psychotherapists are registered and regulated by whomever regulates the training course they completed to qualify as a psychotherapist.

**Details of relevant Professional Bodies are listed at the end of this chapter and in the Bibliography.**

## Roles and team structure

There are various team structures and models around the UK but all comprise a range of roles with varying levels of skill and expertise. We describe below the roles of clinical lead, operational manager, parent-infant therapist, keyworker and administrator, and you will find example job descriptions and person specifications in the Network area of the Parent-Infant Foundation's website. Some teams additionally employ adult therapists. As a minimum, a sustainable team requires a clinical lead, operations manager, two therapists and an administrator. The time commitment of each will depend on local population and birth rate per annum (see Chapter 3 Funding and Commissioning for more information).

### i. Clinical Lead

The Clinical Lead acts as the guardian of clinical standards, providing clinical leadership across the team and supervising and supporting other staff. It is expected that this key member of the team has at least four years' post-qualification experience and is working at NHS AFC Grade 8b and above. They will be trained as a clinical psychologist or a child/parent-infant psychotherapist and be registered with one of the relevant professional bodies (see Person Specification in

the Resources Section). The Clinical Lead needs to be appreciative of the variety of approaches available for parent-infant relationships and highly skilled in at least one. They will be trained to supervise others and ideally have experience of leading a team and managing a service.

#### The role might include:

- a) Clinical management, recruitment, development and support of the clinical team, providing regular clinical supervision and supporting the therapists in their continued professional development
- b) Ensuring that the parent-infant team meets the needs of the local community and is embedded in established referral pathways
- c) Overseeing and managing systems for clinical audit which includes ensuring the completion and recording of outcome measures
- d) Working with the operations manager to promote the team locally including to secure ongoing funding
- e) Holding an appropriate caseload, this will depend on hours worked
- f) Leading the wider local workforce training on infant mental health, and the consultation offer

### ii. Operational Lead/Manager

Depending on the structure and siting of the service within local structures, a local operations manager will work with the clinical lead to ensure an efficient and cost-effective service that is embedded within local systems. This team member may have a wider service remit i.e. CAMHS. This person is not normally a clinician and typically does not do clinical work.

#### The role might include:

- a) The business management, development and support of the service including identifying local need, working with the clinical lead on the development of the clinical team, referral pathways, linking up with local services and exploring innovative ways of working which reflect local needs





- b) Working with the clinical lead to understand the service data and how effectiveness can be improved, especially in relation to any impact reporting required by funders
- c) A responsibility to identify and apply for funding opportunities, or local commissioning, to ensure sustainability
- d) Developing and promoting the profile of their team locally with key early years services and organisations also working in the field of infant mental health
- e) With the Clinical Lead, provide a link between the local parent-infant relationships team and PIP UK
- f) Representing the team at a strategic level jointly with the clinical lead
- e) Presenting on topics related to infant mental health at local conferences and events

#### iv. Keyworker (grades vary locally)

Key/family workers within a team are key connectors and engagers of families to the service, and to other local services that might be identified as being able to offer the family additional assistance. These team members are trained in early child development and typically work within maternity or early years. Keyworkers may be seconded from or working in local services already embedded within the local community i.e. children centre workers, family support workers, Homestart. They are usually supervised by a Parent-infant Therapist or more senior member of staff.

A major part of the Keyworker role is to support engagement through proactive outreach and casework for those parents who need extra help in order to access a parent-infant therapist. In addition, they may support families as the main worker where the help from other agencies (e.g. housing, financial advice) needs to be put in place before the family is able to engage with therapy. The Keyworker will contribute to the outcome measures and may be in the best position to set up and run therapeutic groups. Many Keyworkers will be able to use their existing specialist skills, such as VIG or Mellow Parenting.

#### iii. Parent-Infant Therapist

Parent-infant Therapist is a generic title for any practitioner in the team whose work focusses on the parent-infant relationship. They typically work at the equivalent of NHS AFC high Grade 7 or low Grade 8 and will hold a recognised professional qualification, such as psychologist, social worker, health visitor, early years worker. They will be trained in the delivery of at least one parent-infant intervention i.e. parent-infant psychotherapy; Watch, Wait and Wonder; Circle of Security; Video Interaction Guidance (or similar); Mellow Parenting; Attachment and Biobehavioural Catch-up (ABC), etc. and ideally will also be trained in parent-infant observation.

##### The role might include:

- a) Providing a range of treatments for families, focussing on the infant-caregiver relationship
- b) Applying all assessment and outcome measures as appropriate and ensuring that these are recorded on the data system
- c) Working and liaising with the local network of early years and adult mental health / perinatal services
- d) Offering consultation to other early years practitioners in the locality

#### v. Adult Therapists

Some teams include (or buy in/second) practitioners who can deliver adult-specific interventions such as EMDR or CBT (see Chapter 4 Clinical Interventions and Evidence-Informed Practice). Their grades and skills depend upon the needs of the team.

#### vi. Administration and Data Manager

Each team requires a competent administrator to support the whole team and manage the data. This person typically works at





the equivalent of NHS AFC Grade 4 and is managed by the Operational Lead.

#### The role might include:

- a) Providing the day-to-day administrative support for the clinical team
- b) General secretarial duties
- c) Ensuring all outcomes data is uploaded in a timely manner
- d) Being a central point of contact for general enquiries and unscheduled communication from families (e.g. sudden cancellations)

Other roles employed by specialised parent-infant teams include 'Specialist Health Visitor' or 'Social Worker', filled by practitioners from the relevant professions with additional training or experience in parent-infant relationships work.

## Recruitment and interviewing

We recommend a minimum of a competencies-based interview and a values-based interview (if you have someone trained in VBI available) to secure appropriately qualified staff with the ideal mix of qualities. Values-based interviewing is a specific model of interviewing which translates the values of an organisation into exploratory questions. It is widely used by the NSPCC and various NHS organisations and Local Authorities. The values-based interview can help recruiters assess a candidates' suitability to work with the emotional states of infancy.

Because the training and qualification routes into parent-infant work are varied, recruiters should ask candidates about their parent-infant knowledge, skills, experience and any specific training, as well as which professional body they are regulated by.

Some areas of the UK are experiencing recruitment shortages in certain professions, leading to compromise in the job description

or grading. Creating generic posts (e.g. Parent-infant Therapist) may broaden the scope of who can apply but may be less appealing to those looking for the career benefits of a profession-specific post (e.g. specialist health visitor).

Recruitment offers an opportunity to involve service users/beneficiaries, for example in the way the job description and person specification are written and/or in the interview panel.

## Supervision

This section covers three types of supervision:

- Clinical and model-specific (talking about the direct work with families with a more experienced therapist)
- Professional (talking with a more senior member of the same profession about the role and its responsibilities)
- Safeguarding (talking with a safeguarding specialist about families)

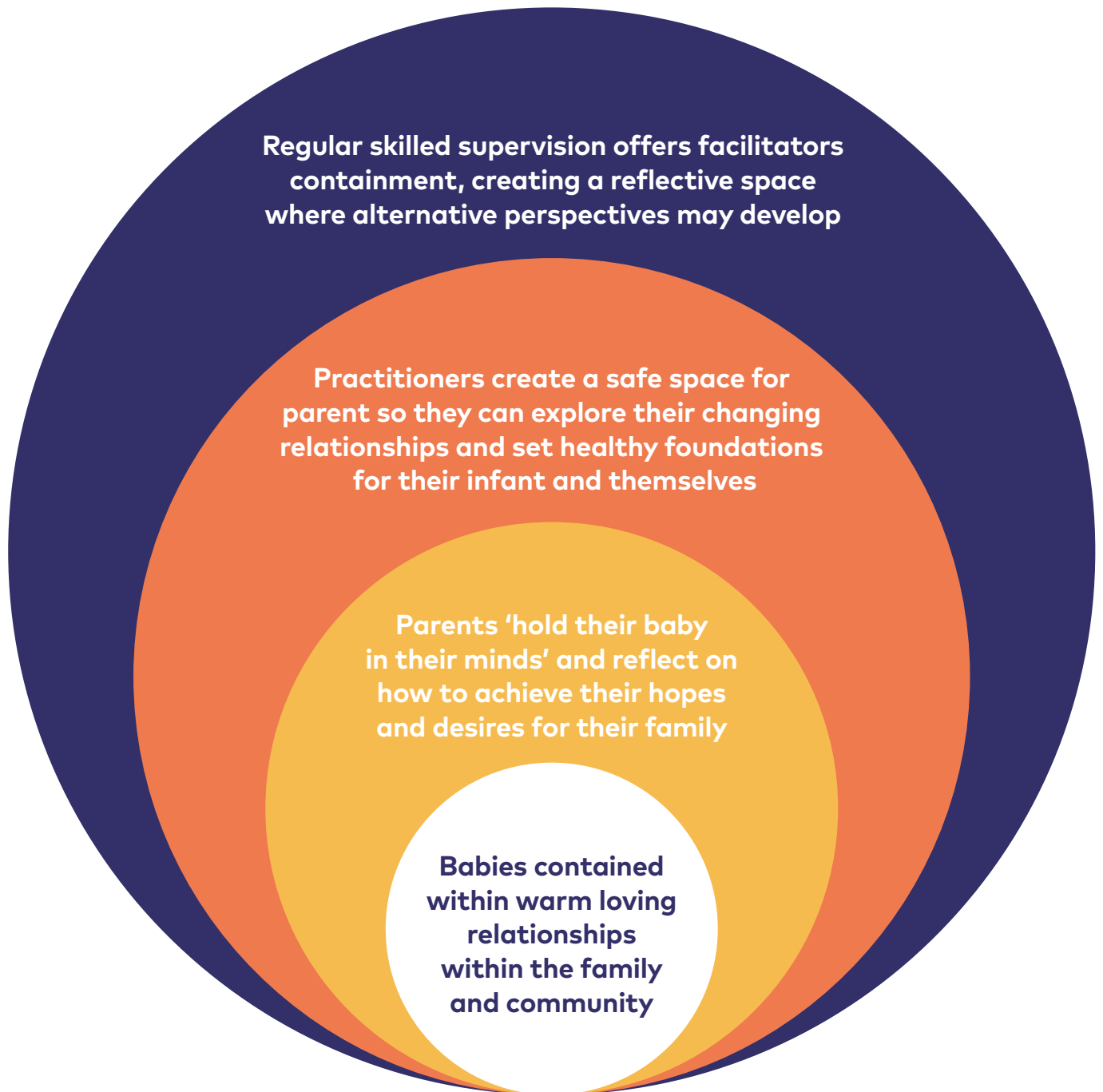
These are all distinct from line management which is the operational leadership of an individual to include performance management, welfare and practicalities such as details of employment, contracts, annual leave, etc. It is not uncommon for your line manager also to be your clinical or professional supervisor, although there are benefits in separating out these roles, namely decoupling reflective learning and restorative functions from performance management functions, and being able to access different kinds of expertise.

Professional body requirements differ and we recommend that recruiters familiarise themselves with the guidance from the relevant organisation.

**Contact details of the main professional bodies are listed at the end of this chapter.**



## Supervision supports the reflective functioning between therapist and family and between parent and infant<sup>7</sup>



7. Underdown, A. (2017) Baby Steps. A relationship-based perinatal group programme. Ch 12, p159: In: Celebi, M. (Ed) Weaving the Cradle. London: Singing Dragon Jessica Kingsley.



## Clinical and model-specific supervision

All team members (not just those from certain professions) should receive regular clinical supervision from an appropriately-qualified supervisor. This may be the clinical lead, a senior therapist in the team or an appropriate external supervisor. The supervision should be a reflective, restorative and formative experience for the supervisee. The Parent-Infant Foundation suggests that the minimum should be one hour every two weeks, more for less-experienced practitioners or those with particularly complex caseloads.

The minimum clinical supervision time set by the Association of Child Psychotherapists is two hours a month for a newly-qualified child psychotherapist and, after two or more years' full time experience, this may be one hour a month from a consultant child psychotherapist.

Some interventions, such as VIG, require practitioners to access regular model-specific supervision from an appropriately qualified supervisor, on top of their regular clinical supervision.

The clinical supervision arrangements for clinical leads can be harder to address as there may be no one in their locality more experienced than them. Most clinical leads find a bespoke solution: peer supervision with other clinical leads, supervision from senior clinicians in other specialties, or buying in supervision from private consultants.

## Professional supervision

Where clinical supervision is provided by someone from a different profession, it is usually a professional requirement for staff also to receive profession-specific supervision every now and again, although professional bodies differ in their guidance about this. Profession-specific supervision reflects on how the person is executing their role and responsibilities according to the expectations of their profession, and is being supported by the organisation to do so.

## Safeguarding supervision

This supervision provides a reflective space to concentrate on how to keep all children safe. It is not a professional requirement for mental health professions but may be an organisational or departmental requirement. Safeguarding is emotionally draining work and good safeguarding supervision should be restorative as well as formative. Specialised parent-infant relationships teams located in the NHS or local authorities will have access to safeguarding specialists, but it may be harder for charities or CICs. The NSPCC has safeguarding information for voluntary and community organisations on its website [www.nspcc.org.uk/vcs](http://www.nspcc.org.uk/vcs) including information about safer recruitment.

## A note about personal therapy

Working with infants and their parents is very likely to stir up strong emotions in therapists as it is intense work. Parents and babies require different responses from the therapist, who has to hold both positions in mind without identifying with one more than the other. The parent-infant relationship resonates with every individual, both from their own childhood and possibly parenthood, so this work can trigger unexpected feelings. Without reflection on these issues, therapists may risk re-enacting their own unresolved traumas which could be psychologically harmful to the families they work with.

Good quality supervision helps therapists become more conscious of their own responses to the work but may not necessarily help change them. Personal therapy provides insights into what they might be feeling and why, leading to a greater awareness of where their blind-spots are, and potential for change. Everyone has patterns of interaction that can be unhelpful to the work with families, so many therapists access personal therapy either regularly or intermittently to support their professional practice.



In today's financial climate, it is hard to imagine employers being in a position to fund this type of support for therapists, although occasionally personal short-term psychotherapy is available through Employee Assistance Programmes. However, employers may be able to support therapists with finding a suitable therapist and allowing time to attend personal therapy sessions.

## Management and leadership

The Parent-Infant Foundation promotes the ethos that any programme aiming to improve the relationship between parent and baby can only succeed if it is embedded within a 'relationship-based organisation'<sup>8</sup>. This is sometimes referred to as the parallel process, where the quality of relationships within the team match the quality of the relationships they aim to form with, and so foster within, and so foster within families. This takes skilled and committed leadership. Non-clinical managers may find restorative leadership training helpful.

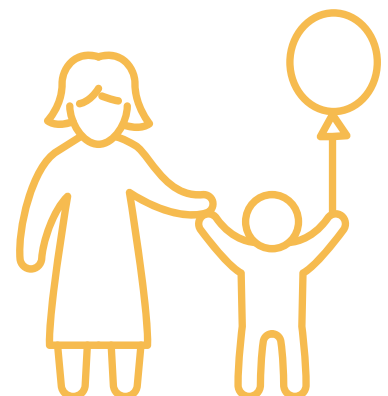
**The Parent-Infant Network, which the Parent-Infant Foundation facilitates, can be an invaluable place to access other team managers to discuss common challenges and shared solutions. Bringing together a new multi-disciplinary, sometimes multi-agency or multi-sector team, can raise interesting questions about professional identities, cultures, roles and language. Colleagues in similar roles are an invaluable source of support and information and the Parent-Infant Foundation is happy to broker peer support relationships where we can.**

## Training and Continuous Professional Development (CPD)

As a minimum, all practitioners are expected to remain up-to-date in evidence and practice and to fulfil the Continuous Professional Development (CPD) needs to remain registered with their professional body. This is likely to affect social workers, health visitors and midwives the most, as they may need to return to traditional practice after a period of time in another post or maintain their practice via a split post.

However, teams should aspire to do more than the minimum in terms of regular training. In particular, teams tell us there is significant value in the whole team training together in core theory, assessment and interventions. The selection of these trainings will differ in each team, although Chapter 4 Clinical Interventions and Evidence-Informed Practice introduces some of the options. Teams who share some core training have a shared language and increased mutual understanding of the theoretical principles underpinning their collective work and this enables improved communication.

The accreditation and supervision requirements for some interventions need to be managed and built into budgets. In some cases, practitioners can train to be supervisors/trainers for those interventions which require it, which builds internal capacity and reduces costs for colleagues.



8. Bertacchi, J. (1996) Relationship-based organizations. Washington, DC: Zero to Three, 17, (2), 1-7



## Professional bodies

All health, psychological and social work professionals should be registered with The **Health and Care Professional Councils (HCPC)** who regulate these professions via their Code of Conduct <https://www.hcpc-uk.org/>. As of 2 December 2019, the HCPC will transfer their social worker regulation responsibilities over to **Social Work England** (<https://socialworkengland.org.uk/>).

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Psychologists may also optionally be members of **The British Psychological Society** ([www.bps.org.uk](http://www.bps.org.uk)).

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The **British Association of Social Workers** (<https://www.basw.co.uk/>) acts as both a professional membership body and union for social workers.

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Health visitors must maintain their registration as a nurse or midwife with the **Nursing and Midwifery Council** (<https://www.nmc.org.uk/>). The **Institute of Health Visiting** ([www.ihv.org.uk](http://www.ihv.org.uk)) is a professional membership body for those working in Health Visiting.

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The **Royal College of Midwives** is a professional membership body and trade union specifically for midwives ([www.rcm.org.uk](http://www.rcm.org.uk))

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Psychotherapists are registered and regulated by whomever regulates the training course they completed. For example, the **Association of Child Psychotherapists** (<https://childpsychotherapy.org.uk/>) registers child and adolescent psychoanalytic psychotherapists who have qualified via one of the following training schools:

- Birmingham Trust for Psychoanalytic Psychotherapy, Birmingham
- British Psychotherapy Foundation, London
- Human Development Scotland, Glasgow
- Northern School of Child and Adolescent Psychotherapy, Leeds
- Tavistock and Portman NHS Foundation Trust, London

and completed the NHS funded 4-year clinical training. These training schools provide ACP child psychotherapists with competencies aligned to or exceeding Level 3 of the AIMH-UK competencies.

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The **UK Council for Psychotherapy** ([www.psychotherapy.org.uk](http://www.psychotherapy.org.uk)) accredits the Diploma in Parent-Infant Psychoanalytic Psychotherapy run by the School of Infant Mental Health in London.







## Chapter 8

# Chapter 8 Managing Data and Measuring Outcomes

This chapter will help you understand outputs, outcomes and impact, how to measure them and how to manage the data. We include some insights and examples from existing parent-infant relationship teams. At the end of the chapter there is a table of measurement tools describing their properties and utility for clinical assessment and outcome measurement.

**"Good feedback is the key to improvement."**<sup>1</sup>

## The purpose of measuring outcomes

There are several good reasons to invest in measuring outcomes:

### 1. Being sure the intervention is safe and works

Many sensible ideas to improve the world turn out to be unexpectedly harmful when their outcomes are measured. The most notable example is the Scared Straight programme, an American programme to deter at-risk young people from committing crime, but which led to increased recidivism<sup>2</sup>.

There is increasing attention being paid to the "dark logic" of interventions<sup>3</sup>, whereby well-intentioned programmes have unintended negative consequences.

Outcome measurement is therefore essential to ensuring safe, effective practice.

### 2. To assure funders that the work delivers the desired outcomes

In most circumstances, the clear reporting of outcome measures is crucial to the maintenance of funding. Some interventions do not achieve all their expected outcomes but may achieve some unexpected ones. Funders are usually keen to understand what outcomes their money is achieving and so may want clear explanations/training on what the measures tell them.

### 3. Quality improvement

Collecting, reviewing and understanding outcomes is an essential part of the quality improvement cycle.

### 4. Understanding what works for whom

Outcome measures help teams to better understand which interventions work for which groups of families.

1. Bill Gates

2. National Institute of Justice. Practice profile: Juvenile Awareness Programs (Scared Straight). <https://www.crimesolutions.gov/PracticeDetails.aspx?ID=4>

3. Bonell C, Jamal F, Melendez-Torres GJ, et al. 'Dark logic': theorising the harmful consequences of public health interventions. *J Epidemiol Community Health* 2015;69:95-98.



The Early Intervention Foundation has produced "10 steps to Evaluation Success"<sup>4</sup> which helpfully covers a range of evaluation topics including Theories of Change, logic models and testing for effectiveness.

## Defining outputs, outcomes and impact

There are lots of different definitions of outputs, outcomes, impacts and the relationships between them. These terms are unhelpfully used interchangeably. The following information is not presented as a definitive text, but as a helpful guide with references to further sources of useful information.

**Outputs** are what your service produces<sup>5</sup> as a result of your activities. Activities are the things you do (e.g. individual work or groups) and outputs are what those activities generate. They are usually easy to measure because they are described in volume terms, e.g. 6 families attending a group; 1 family attended 4 individual sessions; 2 training courses, etc. You might say "We ran four Mellow Babies groups (activities) which were attended by thirty parents in total (outputs)".

**Outcomes** are the effect, value or achievements that result from of your work. They are usually described in change terms, e.g. 30% improvement in parental sensitivity; 15 people have now qualified; 5 points reduction in anxiety, etc. Outcomes should not just be "a sandwich of good intentions"<sup>6</sup>; they should be what your work is focussed on. Some commissioners adopt the Outcomes-Based

Accountability (OBA) framework to ensure providers are focussed on delivering outcomes. If this is the case with your commissioners, we would recommend the **National Children's Bureau report on OBA**<sup>7</sup> as a starting point and that you enquire about whether there is local OBA training available.

## Short-, medium- and long-term outcomes

In our example Theories of Change, we use "short-term outcomes" to describe the outcomes that come about during the intervention, such that they can be seen or measured by the end of the intervention.

We use "medium-term" to mean after the intervention is finished (exactly how long depends on a number of factors including the nature of the intervention and what length of follow-up is planned). "Long-term outcomes" are different in that they are outcomes for a population, community or society and so this is the same as "impact". Hence, impact (long-term outcomes) tends to be the cumulative result of your short- and medium-term outcomes having been sustained over the long term.

Long-term outcomes ("impact") are the hardest to measure since they are what we hope our efforts will accomplish but are often uncertain, unpredictable or too long-term to measure.

**Outcomes and impact should be presented with your audience's priorities in mind.**

4. Asmussen, K., Brims, L., & McBride, T (2019). 10 steps for evaluation success. The Early Intervention Foundation, London. <https://www.eif.org.uk/resource/10-steps-for-evaluation-success>
5. Fritz, J. (2019). How to Talk About Non-profit Impact from Inputs to Outcomes. Inputs, Outputs, Outcomes, Impact - How are they Different? <https://www.thebalancesmb.com/inputs-outputs-outcomes-impact-what-s-the-difference-2502227>
6. Drucker, P (2011). Chapter 1 – The Commitment. The World According to Cheever Blog. <https://theworldaccordingtocheever.blogspot.com/2011/03/peter-drucker-chapter-1-commitment.html>
7. National Children's Bureau. Outcomes Based Accountability (OBA): Guidance. What is OBA and how can NCB help you with it? <https://www.ncb.org.uk/resources-publications/outcomes-based-accountability-oba-guidance>



Long-term outcomes are affected by multiple factors so it is rarely possible to say your intervention definitely, and solely, caused the long-term impact, more that the work contributed to it. For example, a crime prevention initiative in 2019 may have contributed to, but not been the sole cause of, a reduction in offences in 2020: the appalling bad weather was another contributory factor (persistent rain is a known factor in reducing offence rates).

Medium- or long-term outcomes might be used as Key Performance Indicators (KPIs) by your funder/commissioner. Theories of Change lay out your evidence-based theoretical arguments as to why your short- and medium-term outcomes can feasibly be thought to contribute to KPIs, so ensure you think about local strategic priorities when creating your Theories of Change.

**Distinguishing between short and medium outcomes helps practitioners and evaluators better understand when they should measure outcomes appropriately.**

**Failure to think carefully about when outcomes are likely to come about runs the risk of measuring outcomes too early or too late which can lead to ill-informed conclusions about the effectiveness of a service.**





### Activities, reach, outputs, outcomes and impact might be described like this:

**Activity:** We have delivered 286 individual sessions for referred families.

**Reach:** These sessions were delivered to 28 different families living in the CV34 and CV35 postcodes.

**Outputs:** 68% of the sessions were 'attended as planned', 20% of sessions were 'cancelled in advance', 12% of sessions were 'not attended and no prior cancellation'.

#### Short-term outcomes

20 (71%) families were assessed as having an improved parent-infant interaction between their first and last session, using the KIPS scale; 22 (79%) parents reported a clinically-significant improvement in mental health as measured by the HADS.

#### Medium-term outcomes

At six-month follow-up, 24 (86%) infants were assessed as demonstrating improved initiation of interaction with their parent; of 8 infants who had been on a Child Protection Plan at time of referral, 6 had come off their plan with no further social care involvement.

#### Long-term outcomes/impact

All 28 families seen have benefitted in some way; 86% of parent-infant dyads show improved interaction, an early precursor of improved emotional regulation which is proven to contribute towards school readiness; 6 infants (75% of those on a Child Protection Plan at time of referral) came off plan within six months of their last session. This contributes towards the local priority of reducing the number of children requiring long term social care input.

## Sourcing evidence about outcomes and impact

Research in Practice ([rip.org.uk](http://rip.org.uk)) is a charity which helps organisations and individuals in England and Wales to access, understand and apply evidence in their work with children, young people and families. They bring together findings from academic research, the expertise and insights of practitioners, and the expertise and experiences of children and families.

RiP have created a model of Evidence-Informed Practice<sup>8</sup> to represent these three sources of evidence. Their members can **access learning resources and opportunities** via RiP's national **Partnership network**.

The Research in Practice model of Evidence-Informed Practice relates to individual practice but we also recommend it as a useful blueprint for the collation of outcomes evidence: one third of the information should come from research and academic evidence, one third information from practice expertise (i.e. practitioners' views of the work) and one third information from service users/beneficiaries and other stakeholders.

These three components can be translated into relevant questions, such as:

**1. Is the team delivering work that is based on the latest research and evidence?**

Chapter 2 The Case for Change and Chapter 4 Clinical Interventions and Evidence-Informed Practice can help you answer this.

**2. Do expert practitioners consider this to be valid and effective work?**

The responsibility to ensure clinically valid and effective work falls to the team's clinical lead. The Parent-Infant Foundation is currently developing a set of Quality Standards for teams which will be co-created with practitioners.

8. Research in Practice (2011). Evidenced informed Practice updated 2018.

**3. Does the data from a range of stakeholders including service users/beneficiaries show the work to be effective?**

The information below focusses on collecting and analysing data from a range of sources.

**Evidence relating to clinical-level vs system-level outcomes**

Outputs, outcomes and impact can be measured at different levels to provide insights into different aspects of the team’s work.

Clinical-level refers to changes in individual families, system-level refers to changes in the wider system around the team, including at a community or local population-level. This is not a rigid distinction, simply a suggested way for you to approach evidence gathering and reporting methodically.

Clinical-level evidence includes the number and types of sessions delivered to individual families and changes in pre- and post- intervention clinical scores e.g. the percentage increase of parental sensitivity over time. System-level evidence includes the number of local workers trained or offered consultations and how that work has been rated or created change locally in the system, for example by increasing professional skills in identifying children at risk.

Your clinical-level and system-level Theories of Change should map onto the same long-term impact. Theories of Change help clarify the team’s purpose and clinical objectives and how they lead to the desired impact. They can also help with decisions such as which interventions to use and which training to invest in. We strongly recommend parent-infant relationship teams develop their own Theories of Change, ideally with local stakeholders, or use our templates (system-level in Chapter 3, clinical-level in Chapter 4).



Research in Practice (2011, updated 2018). Reproduced with permission.





## An example of a system-level Theory of Change: the impacts of specialised parent-infant relationship teams on a local system

### The problem

- At least 15% of new babies experience complex or persistent relationship difficulties with their parent/carer(s). Without specialised help these unresolved problems can undermine a range of life outcomes and families may require future specialist interventions including in the most severe cases, a child being taken into care
- Unresolved parent-infant relationship difficulties can be passed on to future generations of parents leading to inter-generational distress and additional high costs to the public purse
- The complex and persistent nature of some parent-infant relationship difficulties are beyond the scope of universal or typical early help support, and need specialised, multi-disciplinary intervention

### Contributing Factors

- Frontline practitioners may lack confidence or awareness to identify early relationship problems and provide or refer families to appropriate support
- The right kind of specialised help may not be available locally
- Local leaders, including commissioners, may be unaware of the importance of parent-infant relationships or face a lack of local strategic co-ordination in supporting the work

### What P-I teams do

- A variety of direct therapeutic work to address and improve the difficulties in the parent-infant relationship
- Training, consultancy and campaigning to raise public and professional awareness and improve workforce capacity to protect and promote the parent-infant relationship
- Act as "systems champions" by facilitating local networks and working with local leaders and organisations to improve awareness, co-ordination and decision-making

### Short term outcomes

- Improved parent-child attunement and interaction (a direct outcome of work with families and an indirect outcome of work with other professionals)
- Improved capacity for the public and professionals to identify and support babies and their parents
- Improvements in how organisations work separately and together, so that babies can receive timely and appropriate support

### Medium term outcomes

- More children benefit from a sufficiently secure and nurturing relationship with at least one parent/carer
- Local cost savings as fewer children need to be referred to speech therapy, early help, children's services, CAMHS, paediatrics, or special educational needs services for problems rooted in parent-infant relationships

### Long term outcomes

- More children experience better social, economic, physical and mental health outcomes across the lifecourse
- Fewer children move into the Looked After system
- Fewer children need mental health support as older children or adults for attachment-related difficulties
- Fewer families experience the transmission of parent-infant relationship difficulties into the next generation



## An example of a clinical-level Theory of Change

### The problem

- Not every child has access to a sufficiently secure relationship with at least one permanent adult carer

### How the problem develops

- Unresolved parental traumas from the past ("ghosts in the nursery") or present can be translated into parental states of mind that get played out in maladaptive ways and these damage the interactions with the baby
- Aspects of the parent's behaviour can lack sensitivity or capacity for appropriate responsiveness leading to distress in the baby
- Aspects of the baby's behaviour can trigger unresolved traumas in the parent, leading to stress or lack of pleasure from parenting

### How we can change this

- Address the states of mind and interactional behaviour of the parent that negatively impact the baby. Give meaning to why these occur and how they can be changed
- Improve reflective functioning and parental capacity to provide emotional regulation for their infant
- Improve infants' capacity to engage confidently and feel secure with parent

### Activities

- Offer families a variety of direct therapeutic approaches (with the parent-infant dyad but sometimes also with the family triad, the parental couple without the baby and/or with parents individually) which:
  - Address parental unresolved traumas, current stressors, anxieties and risk factors
  - Support parents' strengths to improve parental sensitivity, mentalisation and reflective functioning
- Signpost and facilitate contact with a range of other services which can address current stressors (such as housing, financial stress, substance misuse, parental conflict/relationship strain)

### Short-term outcomes

- Decreased traumatising behaviour by the parent towards the baby, reduced sense of stress with the baby, improved parental empathy, consistency and motivation
- Parent and infant feel safe with each other, improved warmth in the interaction, improved attunement and more developmentally appropriate interactions
- Improved infant invitation and initiation of interaction with adults including parents
- Improved assessment and support of the family's needs, child protection issues and the parent's capacity to change

### Medium-term outcomes

- Improvements in parent's capacity to sustain emotional and behavioural self-regulation
- Quality of parent-child relationships for indicated child and siblings is improved
- Child is more relaxed, with improved social and emotional development
- Improvements in parents' openness to trusting relationships with helping professionals and in the effectiveness of professional assessment and support

### Long-term outcomes

- Improved likelihood of child securing better physical and mental health, social, emotional, cognitive and language development
- Reduced risk of child needing referral to speech therapy, early help, children's services, CAMHS, paediatrics, or special educational needs services for problems rooted in parent-infant relationships
- Reduced risk of transmission of parent-infant relationship difficulties into the next generation

## Gathering local data and evidence

There is a range of ways to gather objective local evidence about outcomes, including:

- Setting clinical goals and reviewing progress against them, e.g. **Parent and Baby Outcomes Star**<sup>TM9</sup> or the Goals-Based Outcomes (GBO) from Children and Young People's IAPT dataset
- Using self-report or observational measurement tools and tracking progress over time, e.g. HADS or ASQ:SE2
- Gathering quantitative participant feedback e.g. training evaluation feedback forms

## Setting and monitoring clinical goals

Many practitioners set goals with the families they work with as a way of mutually agreeing the terms and focus of the work. How well the goals have been achieved by the end can be measured as an outcome. This can be done effectively in an informal way but there are some helpful tools and information available if required from sources such as **Child Outcomes Research Consortium (CORC)**<sup>10</sup>.



The current CORC advice around setting and monitoring clinical goals is:

### 1. Set the goals over the first three sessions of the intervention/assessment

Some clients come with very clear ideas of the goals they want to achieve, others take a little longer to decide. It may not take three sessions to agree goals with clients but all goals, if they are going to be used as measures for outcomes, should be fixed in the first three sessions.

### 2. Record up to three goals

Three is probably a good number of goals to be getting on with but it's not a limit. Record how close the family feels they are to reaching the goal at the outset of the work on a scale from zero to ten where 'zero' means the goal is not met in any way, 'ten' means the goal is met completely and a rating of 'five' means they are half way to reaching the goal.

### 3. Review regularly and reflect

Reviewing the goals in order to discuss progress can be done at every session, or frequently throughout the work. At the end of the work, record how close the family now feels they are to their goal, on a scale 0-10. The difference in scores between the start and end of the work provides a numerical measure of progress.

Whilst not specific to parent-infant work, **the goal setting worksheet by Choices in Recovery**<sup>11</sup> demonstrates how a simple goal setting sheet can be user-friendly.

9. Triangle Consulting Social Enterprise Ltd. Parent and baby Outcome Star<sup>TM</sup> The Outcomes Star for perinatal mental health and well-being. <http://www.outcomesstar.org.uk/using-the-star/see-the-stars/parent-and-baby-star/>

10. Child Outcome Research Consortium. <https://www.corc.uk.net/>

11. Janssen Pharmaceuticals, Inc. (2015). Choosing your Goals. Choices in Recovery. [http://www.choicesinrecovery.com/sites/default/files/Worksheet\\_1\\_ChoosingYourGoals.pdf](http://www.choicesinrecovery.com/sites/default/files/Worksheet_1_ChoosingYourGoals.pdf)



The ABCPiP practitioners in Ballygowan, Northern Ireland are trained in the Parent and Baby Outcomes Star™, a licensed tool to support early conversations with families about what their hopes are for the work, the issues they want to work on and to track progress against these issues over time.

Roberta Marshall and Janine Dougan, clinical co-managers of the team, told us “we do find the Parent and Baby Outcomes Star a useful tool, not just for measuring progress but also for having a helpful conversation about what the family want from our work together”.

More details can be found at:  
<http://www.outcomesstar.org.uk/using-the-star/see-the-stars/parent-and-baby-star/>

It is worth noting that the Early Intervention Foundation views outcome stars as useful tools for engaging parents and discussing progress, but not as a validated way of assessing outcomes<sup>12</sup>.

## Using self-report or observational measurement tools to track progress over time

Some measurement tools are suitable for both clinical assessment and pre- and post-outcomes measurement, and this can save time and effort on the part of practitioners. Some clinical assessment tools are not statistically validated for test-retest situations and therefore, strictly speaking, should not be used for outcomes measurement. However, the parent-infant relationship field is not replete with validated, low-cost measures which are quick and easy to administer and score, so some of the most clinically-useful tools are put to use locally as outcome measures. The alternative would be practitioners using additional academic outcome measures on top of their clinical assessment tools which would be burdensome and impractical, but one should bear in mind these statistical limitations.

At the end of this chapter, you will find tables of information about self-report, interview and observational measurement tools relevant to the work of specialised parent-infant relationship teams. Where available, we have included weblinks for further information about evidence, how to acquire the tool and where to receive training.

12. Personal correspondence, 4 Sep 2019.

## The PIP teams' approach to assessment and outcome measures

The description below may help you to think about how to construct your own suite of assessment and outcome measures. The information here is not intended as a prescriptive approach to outcome measurement: the parent-infant relationships sector does not have one standard set of recommended tools.

Where available, the gold standard outcome measure for parent-infant work is formal assessment of attachment security. This provides a reliable and clear indication that change has occurred in the parent-infant relationship. However, this is often impractical for routine clinical use, as it can be time-consuming and require special training which is often expensive.

The vast majority of specialised parent-infant relationship teams use quicker, cheaper methods such as video observation, questionnaires and information-gathering from other sources.

The nine Parent Infant Partnership teams (PIPs) used a collection of measures chosen both for their clinical application and for the way they 'triangulate' the infant and the caregiving relationship. These demonstrated to potential partners and commissioners that there were good, evidenced, measures in place for service evaluation.

All scores are collected on the Parent-Infant Foundation Data Portal in a way that removes "personally-identifying details".

### 1. Changes to the family's levels of risk and stress

The Risks and Stresses checklist developed by Gloucestershire Infant Mental Health Team<sup>13</sup> is used by those referring into a PIP team, and is later updated by clinicians, to profile the details of those families who are engaged with the service. These are factors in parents' lives that can have a negative impact on the caregiving relationship.

### 2. The quality of the caregiving relationship

This is assessed using the 'Levels of Adaptive Functioning' (LOAF) section from Zero to Three's DC:0-5. This assesses the prime caregiving relationship as well as the wider caregiving environment. It also provides detailed guidance for diagnosing a relationship-specific disorder in infancy.

### 3. Child's social and emotional development

The Ages and Stages Questionnaire (Social and Emotional; 0-2) produces a score which can be compared to the benchmark cut-off for each age; above this indicates a serious difficulty.

The ASQ:SE2 can be used to demonstrate that the infant has attained, or remained on, an acceptable pathway of social and emotional development in a situation when this might be jeopardized. A reduction in the mean score, whether below or above the cut-off, indicates an improvement in social and emotional functioning.

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13. The Wave Trust (2013). Conception to 2: Age of Opportunity. Appendix 2C p.89.  
<https://www.wavetrust.org/conception-to-age-2-the-age-of-opportunity>





#### 4. Parental Mental Health

The Hospital Anxiety and Depression Scale (HADS) has seven questions each for anxiety and depression and takes about 5 minutes to complete. It enables early identification of both, each of which can leave less space in the caregiver's mind for the baby.

#### 5. Parenting Interactivity

The Keys to Interactive Parenting Scale (KIPS) is a coded video observation and gives a way of assessing twelve different aspects of parenting behavior from about 10 -15 minutes of interaction. KIPS produces clinically-useful information that may be fed back to caregiver using interaction guidance since it can pinpoint

clearly defined strengths. Here too the mean score is significant, with any increase showing an observable improvement in the interaction between caregiver and child.

#### 6. Parent satisfaction questionnaire

A final parent-completed satisfaction questionnaire covers the parent's experience and observations. They can also be used with a change of tense from 'was' to 'is' to monitor the therapeutic contract while treatment is in progress. Graded answers on a Likert rating scale means that responses can be recorded quickly and easily and there should also be space for free text.



## Gathering quantitative participant feedback

Traditional participant feedback/parent satisfaction questionnaires tend to lean towards factors that affect 'acceptability' rather than measuring outcomes, although outcome questions can also be included. For example, training feedback forms tend to ask about the venue, the agenda or the speaker (satisfaction/acceptability) rather than whether the delegate has learned anything new (short-term outcome).

Without outcomes questions, these forms tell us little about the effectiveness of a service in bringing about identified outcomes/changes but can be valuable in gauging the temperature of a person's experience or getting feedback about specific aspects of service provision.

'Participants' might include families who have participated in therapy, colleagues who have participated in consultation or delegates that have participated in training. There are lots of examples on the internet of participant feedback/parent satisfaction questionnaires which generate numerical data, we have provided some examples of parent evaluation feedback forms and training evaluation forms in the Network area of the Parent-Infant Foundation website. Evaluators may also find the Kirkpatrick Model<sup>14</sup> helpful.

There are more examples at <https://www.sampleforms.com/parent-feedback-form.html>.

## A note about electronic administration

**Survey Monkey, MS Forms and other free, specialised software can make the administration, scoring and analysis of simple forms quicker and easier via computer or tablet.**

**A word of caution: some published questionnaires are only free to use in paper format and require a licence to be acquired from the author before electronic administration can be used.**

**Electronic administration may assist you to better support parents who experience language, literacy, or sensory barriers.**

## Gathering the expertise and insights of stakeholders

The remaining two-thirds of the Research in Practice model of Evidence-Informed Practice relate to gathering the expertise and insights of two important groups of stakeholders: practitioners and families. Obviously, teams might also like to extend their evaluation reach to other stakeholders such as the local children's workforce, commissioners and other teams such as CAMHS.

This type of evidence can be collected through quantitative methods such as questionnaires or surveys, but this can miss the richness and nuance of qualitative feedback.

**Using the same training evaluation feedback form for every training course, irrespective of the topic, makes data collection and comparison easier.**

14. Kirkpatrick Partners (2019) <https://www.kirkpatrickpartners.com/Our-Philosophy/The-Kirkpatrick-Model>



In all data collection activity, it is crucial that the method and tools are sensitively designed to be appropriate to the audience and to the questions you are asking. There are numerous ways to collect information from practitioners and service users/beneficiaries, here are just a few:

- Ask practitioners to agree a closing statement with families which reflects the important aspects of their work together, the critical ingredients of the work that led to progress or the reasons for lack of progress, how the family and practitioner will remember the work and what it has meant to each of them. These vignettes can be anonymised and collated
- Ask families to draw or write on sticky-notes their experiences of the work. In groups, this can be a collective activity to include photographs and messages to one another, to form an album or poster
- Invite families to provide written or photographic accounts of their experience of working with the parent-infant relationship team
- Invite families to an informal and carefully-facilitated participation forum, where they can feedback to leaders about their experience of the service
- Invite families to participate in telephone feedback sessions
- Ask practitioners to identify key areas of focus and mechanisms of change in a particular piece of therapeutic work. Map these against the Theories of Change to see if they align<sup>15</sup>
- Collate anonymised parent letters and notes, of both thanks and of complaints
- Ask stakeholders to complete a timeline of their recent experiences of the parent-infant team. This can easily be done with lining paper and felt tips. It is a useful activity

to understand the temporal links between what has been delivered and the outcomes it has led to

- Ask stakeholders collectively to create an image of the system as it exists now (or before the parent-infant team existed) and how they would like it to look (or how it does look, now that the parent-infant team has been working for some time). This works well with small groups, such as a strategic board or local health visiting team
- Families sometimes agree to be filmed talking about the service they received
- Families can be invited to coffee mornings at the team's base or places where they work, such as the Neonatal Intensive Care Unit (NICU) to talk about service
- Some families could be invited to attend professionals' planning meetings to share their experience of the service



**We acknowledge that this toolkit does not cover service user participation in any detail. The Parent-Infant Foundation is keen to gather experiences from across the Network and is engaging with other partners to support the development of resources on this topic.**

**We hope to have more detailed content for the review in a years' time.**

15. With sincere thanks to Anna Freud Centre PIP for their insights into this exercise.

## Statistical analysis of quantitative data

Local reporting requirements do not usually extend beyond having to show pre- and post-intervention changes in questionnaire scores. The clinicians in the parent-infant team are usually able to provide commentary about the clinical significance of such changes. However, for more formal purposes, such as planning to publish data in a journal or present it at an academic conference, some teams seek the reassurance of statistical analysis.

Psychologists are typically trained in statistical analysis although do not always have easy access to statistical analysis software. The Royal Statistical Society may be able to advise teams and, for those located in charities, may be able to offer some support from one of their pro-bono statisticians ([www.rss.org.uk](http://www.rss.org.uk))

## Data management

### Outputs data

Output data is relatively straightforward to collect as it is simply counting activities and numbers. Most specialised parent-infant relationship teams use either data management software, such as the Parent-Infant Foundation's data portal, or spreadsheets that keep track of outputs as they occur. This is typically data provided by practitioners to the administrator for input, simple analysis and periodic reporting.

In our experience, teams often want to analyse their data by certain categories, for example how many referrals were antenatal vs postnatal, how many referrals related to children on a child protection plan, etc. This helps teams answer questions such as "are





we doing enough to raise awareness with our midwifery colleagues?” and “should we start a dialogue with children’s services commissioners about the increasing demand for work with babies?”. There is a balance to be struck between the burden of recording and analysing many data fields versus the utility of the data. We recommend that every field of data you collect is ‘actionable’ i.e. that it can be and is used to inform improvements during regular review.

## Outcomes data

Some data management systems integrate clinical record keeping functions with the ability to collate and report clinical scores. System 1 is an example of a widely-used, large data management system (in the NHS) which can be adapted locally to collect pre- and post-intervention scores. Essex Partnership University NHS Foundation Trust have done this for their new Together with Baby parent-infant relationship team to assist outcome measure data collection. Where data management systems can’t do this, teams may be left to create their own spreadsheets which link families’ clinical records to separate databases of scores through the use of a unique identifying code number.

The Parent-Infant Foundation’s data portal is a free software offer being developed for early 2020. It will not offer a clinical record-keeping function but will allow teams to upload and draw reports on outcome measure scores easily, and to compare their own data to an anonymised, aggregated data set from other teams. This will save time in that teams will not have to design their own spreadsheets, and it will help teams to benchmark their own data against that of others.

For more information about how you can access this free software, please contact us directly through our website

[www.parentinfantfoundation.org.uk](http://www.parentinfantfoundation.org.uk).

**Working with disadvantaged and vulnerable parents may alter engagement and attendance data.**

**We recommend the [Early Intervention Foundation’s 2019 Engaging Disadvantaged and Vulnerable Families](#)<sup>16</sup> for an evidence review of this area.**

## Data-linkages to systems outcomes and long-term outcomes

Some specialised parent-infant relationship teams can access data from other local services and organisations which can be tracked back to the families they have worked with. For example, in some areas of Scotland there is comprehensive collection of SDQ scores for all 3-year-olds and this could facilitate interesting follow-up analyses of parent-infant relationship work.

Other examples might include the linking of a child’s parent-infant work with the team to their school readiness scores (EYFS or the new standardised reception assessments from September 2020), parental mental health screening scores as collected by health visitors, or standardised child development scores during mandated child health surveillance visits.

This kind of data sharing normally requires a formal information sharing agreement between all relevant partners which covers consent issues and GDPR responsibilities.

A word of caution about long-term or distal outcome measures: these are influenced by a range of factors such as the quality of childcare during pre-school years, or the socio-economic

16. Pote, I., Doubell, L., Brims, L., Larbie, J., Stock, L. & Lewing, B. (2019). Engaging disadvantaged and vulnerable parents An evidence review. The Early Intervention Foundation, London.

<https://www.eif.org.uk/reports/engaging-disadvantaged-and-vulnerable-parents-an-evidence-review>



experiences of the family and are therefore not generally used by clinical teams to evidence outcomes of one specific early-life intervention, unless already linked through their local authority. This echoes the points made above that Theories of Change are necessary to show how your interventions are believed to be linked to the intended long-term outcomes but you may not be able to prove causality through outcome measurement.

## Cost-benefits data

At a local level, generating valid and reliable cost-benefits data about a team or intervention is cost-prohibitive for funders and we have yet to find a team which has been funded to complete such an analysis.

Globally, the parent-infant relationship research base is not sophisticated enough to generate meaningful calculations about the cost-benefits of how specific interventions map onto outcomes which would be relevant to UK commissioners. This does not mean that we cannot describe potential cost-savings or the general principle that prevention saves money, but it does make it difficult to attribute exact figures.

Even well-established universal measures, such as the Early Years Foundation Stage assessment cannot yet be confidently used to assess the cost-benefits of interventions in the first 1001 days. The Parent-Infant Foundation is currently working with economists to think about how to strengthen the research and data in order to begin to address this area.

The Nobel Prize-winning work of James Heckman embeds the principle that effective interventions pay the greatest returns on investment the earlier in the life course they are applied. There is ample neuroscientific evidence linking the quality of parenting and parent-child interaction to child development outcomes, and the Adverse Childhood Experiences studies demonstrate a clear life-long impact of childhood adversity. See

Chapter 2 The Case for Change for further information.

At a local team level, qualitative information about individual families, referral patterns and working practices which demonstrates positive change will support the principle if not the detail of cost-savings. For example: where social workers have been able to remove a child from a Child Protection Plan following the family's work with the team; where, following training, health visitors feel more confident to work with parent-infant dyads without referral to CAMHS; where a parent who has had a previous child removed into care is able to keep a subsequent child following work with the team; where specialised consultation has helped a social worker craft a more effective family support offer.

## Reporting outcomes

**Commissioners give us some consistent messages about how they prefer impact to be reported.**

### 1. Co-creation

The format of how you report your outputs, outcomes and impacts is best co-created with the audience, in this case your commissioners or funders (some have standardised templates and reporting schedules).

Commissioners and funders want to understand how your work contributes to their local strategic priorities so this point needs to be very clear in your reports.

For example, Leeds wants all children to be in safe, supportive families and to reduce the need for children to be taken into care. These are key impact areas that the Infant Mental Health Services' outputs and outcomes fit within, alongside a range of other services and programmes.

If a local priority is 'preventing children going into care' or 'improving school readiness' you should explain in your report how the team's work contributes to this.



Commissioners and funders usually want reporting requirements to be proportionate and not a huge burden on clinical resource, whilst answering key questions on impact. They are often willing to negotiate how reporting best achieves that balance.



## 2. Style and content

Funders and commissioners welcome concise, clearly-presented quantitative and qualitative data with clear, brief explanations of what the data means and what the measures can tell us. Visual devices and infographics may be helpful.

We would recommend the **LivPIP/Parent Support Service Social Impact report**<sup>17</sup> as an excellent example of a periodic impact statement. We have other examples of more regular reporting formats in the Network area of our website.

### Remembering the importance of the work to families

This excerpt is from a mother who was first seen while pregnant and at the end of the work with the parent-infant team many months later, she was asked to comment on what aspects of the intervention she had found helpful. (All identifying details have been changed.)

Specifically, this mother felt she had been helped by considering her own childhood, having a time to think about her baby and their burgeoning relationship, being given information on development and simply the sense of being listened to and understood. At a six month follow up things were still going well. In her own words:

'Before meeting K, 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. K was able to talk me through those worries and give reassurance when I started to lose my confidence and give into the anxiety.

Once Annie was born, meeting with her helped to set aside worries and assure me of Annie's normal development. She also gave insight into how Annie might be experiencing the situation and how to help her cope with the newness of being in the outside world. K's kind and patient manner and ability to convey practical and clinically-based rationale 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. It was a huge transition going back to work with its own challenges.

If I hadn't been given the chance to get a sound foundation I'm not sure I would have been able to handle the increased pressure of being a full-time working mum. If only you could give me more sleep!

17. Person Shaped Support (2017). Social Impact Report: Parent and Baby Wellness. PND (Postnatal Depression) and LivPIP (Liverpool Parent-Infant Partnership)  
<http://www.psspeople.com/wp-content/uploads/2017/04/Parent-and-Baby-Wellness-Impact-Report-v2-27032017.pdf>





The following tables begin to collate information about a range of assessment tools relevant to specialised parent-infant relationship work. This is not an exhaustive nor even fully completed list, but a start and a work in progress. We will continue to improve and extend this table on our website over the coming months and welcome your feedback, contributions and insights.

We received a great deal of information about some of the measures from the Anna Freud National Centre for Children and Families and the Lambeth PAIRS service to whom we are very grateful.

We also extend our thanks to the clinicians from teams and services around the UK who have shared with us their clinical insights about some of the measures.

**Measures Table A** Reflective functioning and mentalisation abilities of parents

**Measures Table B** Postnatal parent-infant interaction, parental sensitivity/emotional availability and attachment

**Measures Table C** Antenatal parent-infant interaction and attachment

**Measures Table D** Adult mental health, parental confidence, self-esteem/self-efficacy/confidence, parental stress; parent's perception of self, parenting satisfaction

**Measures Table E** Parental emotional regulation

**Measures Table F** Infant's social and emotional development





## Measures Table A: reflective functioning and mentalisation abilities of parents

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
Parent Development Interview (PDI)	Mentalisation (Caregivers ability to mentalize about their child)	Parent	Interview	60 minutes	<p>Semi-structured interview for the parent with clinician about experience and feelings about being a parent</p> <p>Codes the capacity of the parent to mentalize about his child</p> <p><b>Clinicians' insights:</b>                      Gives a lot of useful information which is relevant clinically</p> <p>Not designed to be used as a pre- post-intervention measure</p> <p>Long to administer and code</p>	Contact trainers	<p>Training and reliability coding. Duration of training varies (1-3 days)</p> <p>Contact training providers for costs</p> <p><a href="http://pditraininginstitute.com/parent-development-interview/">http://pditraininginstitute.com/parent-development-interview/</a></p> <p><a href="https://www.annafreud.org/training/training-and-conferences-overview/training-at-the-anna-freud-national-centre-for-children-and-families/reflective-functioning-training-on-the-parent-development-interview/">https://www.annafreud.org/training/training-and-conferences-overview/training-at-the-anna-freud-national-centre-for-children-and-families/reflective-functioning-training-on-the-parent-development-interview/</a></p>	No

**Psychometric Properties and References:**

High inter-rater reliability, internal consistency, and criterion validity. Modest associations with some sociodemographic variables and PDI-RF were found, but together these only accounted for a small amount of variance in the measure, suggesting adequate discriminant validity.

1. Slade, A., Aber, J. L., Bresgi, I., Berger, B., & Kaplan, M. (2004). The parent development interview–revised. Unpublished protocol.
2. Slade, A., Sadler, L., De Dios-Kenn, C., Webb, D., Currier-Ezepchick, J., & Mayes, L. (2005). Minding the baby: A reflective parenting program. *The Psychoanalytic study of the child*, 60(1), 74-100.
3. Slade, A. (2005). Parental reflective functioning: An introduction. *Attachment & human development*, 7(3), 269-281.
4. Slade, A. (2008). Working with Parents in Child Psychotherapy. *Mentalization: Theoretical considerations, research findings, and clinical implications*, 207.





## Measures Table A: reflective functioning and mentalisation abilities of parents

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
Parental Embodied Mentalizing Assessment (PEMA)	Embodied Mentalisation (Caregivers ability to comprehend a child's mental states via their body movements)	Parents and their infant (0-2yrs)	Observational (video)	7-10 minutes	<p>The Parental Embodied Mentalizing Assessment (PEMA™) is a 12-point tool used to assess non-verbal risk and protective factors in parent-infant (0-2) dyads. The aim is to focus on participant's bodies. Videos are observed on mute mode. Four stages to coding: identifying embodied circles of communication (ECC), delineating movement qualities (tempo, space, pathways, pacing, directionality, and tension flow), rating the quality of ECC events on from "very low" (1) to "very high" (9), and finally rating a global PEM score (1-9) which represents the parent's overall, typical, mentalizing capacity, considering all the individually rated ECC events of the dyadic interaction</p> <p><b>Clinicians' insights:</b> Valid and reliable measure which considers dimension beyond verbal expression</p>	Contact trainers	<p>4-day training course and reliability process led by Dana Shai</p> <p>£700 without or £800 with reliability coding for research purposes</p> <p><a href="https://www.annafreud.org/training/training-and-conferences-overview/training-at-the-anna-freud-national-centre-for-children-and-families/mentalizing-the-body-in-research-and-clinical-practice-parental-embodied-mentalizing-assessment-pema/">https://www.annafreud.org/training/training-and-conferences-overview/training-at-the-anna-freud-national-centre-for-children-and-families/mentalizing-the-body-in-research-and-clinical-practice-parental-embodied-mentalizing-assessment-pema/</a></p>	

### Psychometric Properties and References:

Inter-rater reliability for the global PEM rating ranged from ICC= .84 to .92. Parent's embodied mentalizing, measured at six months during free play, predicted infant attachment security at 15 months as well as internalising and externalising problems, social skills and competence, and academic performance (54months: Shai & Belsky, 2016)

1. Shai, D., & Belsky, J. (2011). When words just won't do: Introducing parental embodied mentalizing. *Child Development Perspectives*, 5(3), 173-180.
2. Shai, D., & Belsky, J. (2017). Parental embodied mentalizing: How the nonverbal dance between parents and infants predicts children's socio-emotional functioning. *Attachment & human development*, 19(2), 191-219.
3. Shai, D., & Belsky, J. (2011). Parental embodied mentalizing: Let's be explicit about what we mean by implicit. *Child Development Perspectives*, 5(3), 187-188.



## Measures Table A: reflective functioning and mentalisation abilities of parents

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
Parental Reflective Functioning Questionnaire (PRFQ)	Reflective Functioning  Looks at pre-mentalizing modes, certainty about the mental states of the infant, and interest and curiosity in the mental states of the infant	Parent of 0-5 years old child (further age ranges being piloted by UCL)	Self-report	18-item self-report measure	Developed as a research tool not for clinical practice, to provide a brief, multidimensional assessment of parental reflective functioning that is easy to administer to parents with a wide range of socioeconomic and educational backgrounds  For further information see <a href="https://www.ucl.ac.uk/psychoanalysis/research/parental-reflective-functioning-questionnaire-prfq">https://www.ucl.ac.uk/psychoanalysis/research/parental-reflective-functioning-questionnaire-prfq</a>	<a href="https://www.ucl.ac.uk/psychoanalysis/research/parental-reflective-functioning-questionnaire-prfq">https://www.ucl.ac.uk/psychoanalysis/research/parental-reflective-functioning-questionnaire-prfq</a>	n/a	

**Psychometric Properties and References:**

Further research is required to establish the reliability and validity of the measure.

1. Luyten, P., Mayes, L. C., Nijssens, L., & Fonagy, P. (2017). The parental reflective functioning questionnaire: Development and preliminary validation. *PLoS one*, 12(5), e0176218.
2. Pazzagli, C., Delvecchio, E., Raspa, V., Mazzeschi, C., & Luyten, P. (2018). The parental reflective functioning questionnaire in mothers and fathers of school-aged children. *Journal of Child and Family Studies*, 27(1), 80-90.



## Measures Table A: reflective functioning and mentalisation abilities of parents

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
Working Model of the Child Interview (WMCI)	Parent's working model of their relationship with child	Adult parent of child of any age (antenatal to no upper age limit)	Videod observation and interview	30-75 minute interview plus lengthy coding	<p>The WMCI was developed to assess parents/caregivers internal representations (also known as working models) of their experiences with a child. The WMCI produces clinically salient information and involves structured interview that is videoed and assessed. Can produce a clinical opinion on the caregiver's initial representation of the infant. Responses provide data that indicate the likelihood of attachment security or not in the child (there is a pre-natal version as well)</p> <p>For use by experienced child psychologists, child psychotherapists, child psychiatrists, IMH-specialists and other clinicians</p>	<a href="https://sundpsykologerna.se/files/C.H-Zeanah-et-al-Working-Model-of-the-Child-Interview.1986-1993.pdf">https://sundpsykologerna.se/files/C.H-Zeanah-et-al-Working-Model-of-the-Child-Interview.1986-1993.pdf</a>	<p>€750 in Amsterdam (3 days) led by Diane Benoit</p> <p><a href="https://www.rino.nl/cursus/working-model-child-interview">https://www.rino.nl/cursus/working-model-child-interview</a></p>	

### Psychometric Properties and References:

The WMCI has validity and can be used in clinical research when exploring the relationship between parental representations and the development of an infant.

1. S1. Benoit, D., Zeanah, C. H., Parker, K. C., Nicholson, E., & Coolbear, J. (1997). "Working model of the child interview": Infant clinical status related to maternal perceptions. *Infant Mental Health Journal: Official Publication of The World Association for Infant Mental Health*, 18(1), 107-121.
2. Zeanah, C. H., Benoit, D., & Barton, M. (1986). Working model of the child interview. Unpublished manuscript, 1986-1993.
3. Vreeswijk, C. M., Maas, A. J. B., & van Bakel, H. J. (2012). Parental representations: A systematic review of the working model of the child interview. *Infant Mental Health Journal*, 33(3), 314-328
4. Zeanah, C.H., & Benoit, D. (1995). Clinical applications of a parent perception interview in infant mental health. *Child and Adolescent Psychiatric Clinics of North America*, 4, 539-554.

For full reference list see [https://www.researchgate.net/publication/268053260\\_Working\\_Model\\_of\\_the\\_Child\\_Interview\\_Coding\\_Manual](https://www.researchgate.net/publication/268053260_Working_Model_of_the_Child_Interview_Coding_Manual)



## Measures Table A: reflective functioning and mentalisation abilities of parents

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
Meaning of the Child Interview (MOTCI)	Parent's meaning of the child	Parent (suitable for mothers and fathers) and child from birth	Interview	Approx. 1 hr to administer, 3-4 hours to code plus time for transcribing	<p>Used in child protection arena, predominantly by social workers, to evaluate the way parents think about their child</p> <p>It makes use of a semi-structured interview in which parents talk about their child, their relationship with their child, and their parenting, which is then carefully analysed using a manualised system</p> <p>Does not require a professional qualification to learn, training is aimed at social workers, family centre workers, therapists, psychologists, occupational therapists, and psychiatrists</p> <p>Suitable for clinical practice and research</p>	Contact trainers	<a href="http://www.meaningofthechild.org/">http://www.meaningofthechild.org/</a>	Yes

**Psychometric Properties and References:**

See <http://www.meaningofthechild.org/>



## Measures Table A: reflective functioning and mentalisation abilities of parents

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
Assessment of mind-mindedness	Mind-mindedness (a parent's/ care-givers ability to view an infant as an individual with their own mind rather than just a being that has needs to be satisfied)	Parent and child	Observational for infants up to age 2; interview or self-report for older children	A short, filmed play session (5-10 minutes) for the observation measure. A short (5 minute) interview or self-report questionnaire  Additional time is required for coding using the manual provided	MM focuses on the caregiver's willingness or ability to read the child's behaviour with reference to the likely internal states that might be governing it. MM with infants up to age 12 months is operationalised in terms of the caregiver's tendency to comment appropriately or in a non-attuned manner on the infant's putative internal states during interactions. It is therefore heavily focussed on the verbal aspects of interaction and does not code for non-verbal aspects. For very young infants, child sits in a baby seat on a table and a mirror placed on the table so that the mother's face can be clearly seen. For children aged 6 months and above, free play sessions where a range of age-appropriate toys is provided. Training is suitable for midwives, health visitors, clinical psychologists, childcare professionals, social workers, and any other professionals working with children	Contact trainer  Coding manual freely available at <a href="https://www.york.ac.uk/media/psychology/mind-mindedness/MM%20manual%20version%202.2-2.pdf">https://www.york.ac.uk/media/psychology/mind-mindedness/MM%20manual%20version%202.2-2.pdf</a>	Training is not formally required to use the measure, but occasional training courses are offered.  The training is provided free of charge, but a small payment is required to cover the cost of materials and refreshments  Information is available at <a href="https://www.york.ac.uk/psychology/research/groups/mind-mindednessinresearchandpractice/professional-training-courses/">https://www.york.ac.uk/psychology/research/groups/mind-mindednessinresearchandpractice/professional-training-courses/</a>	Yes

### Psychometric Properties and References:

Established as a predictor of numerous positive aspects of children's development. Validated as an outcome measure in intervention studies.

1. Meins, E., Fernyhough, C., Wainwright, R., Das Gupta, M., Fradley, E., & Tuckey, M. (2002). Maternal mind-mindedness and attachment security as predictors of theory of mind understanding. *Child development*, 73(6), 1715-1726.
2. Meins, E., Fernyhough, C., Johnson, F., & Lidstone, J. (2006). Mind-mindedness in children: Individual differences in internal-state talk in middle childhood. *British Journal of Developmental Psychology*, 24(1), 181-196.
3. Meins, E., Fernyhough, C., Wainwright, R., Clark-Carter, D., Das Gupta, M., Fradley, E., & Tuckey, M. (2003). Pathways to understanding mind: Construct validity and predictive validity of maternal mind-mindedness. *Child development*, 74(4), 1194-1211





## Measures Table B: postnatal parent-infant interaction, parental sensitivity/ emotional availability and attachment

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
Parent-Infant Relational Assessment Tool – Global Scales (PIRAT)	Parent-infant and infant-parent interaction	Baby 0-25 months old and their parent	Observational (video)	30 minutes of play to generate 10 minutes of video, plus time for coding	<p>Observational measure designed to assess the dyadic quality of parent-infant interactions. PIRAT is grounded in clinical practice, psychoanalytical thinking on the parent-infant relationship and infancy research</p> <p>It aims to reflect the needs of health care professionals working with parents and infants in their workplace settings</p> <p>PIRAT was designed to systematize their observations and thinking of the parent-infant relationship, and to pin-point areas of concern and identify risk (ref Hommel, Broughton and Target 2018, PDF in Network area of Parent-Infant Foundation website)</p>	Contact trainers	<p>3-4 days training plus an additional reliability training day and completion of the first reliability test which includes coding of 10 videotaped parent-baby interactions. Feedback on the first reliability test is provided before participants complete the second reliability set comprising 20 more parent-baby interactions</p> <p>Training is aimed at professionals working with parents and infants, including GPs, social workers, health visitors, midwives, infant mental health workers, psychiatrists, clinical psychologists, child psychotherapists and researchers in the field</p> <p>Contact trainer for prices:  <a href="https://www.annafreud.org/training/training-and-conferences-overview/training-at-the-anna-freud-national-centre-for-children-and-families/parent-infant-relational-assessment-tool-pirat-global-scales-training/">https://www.annafreud.org/training/training-and-conferences-overview/training-at-the-anna-freud-national-centre-for-children-and-families/parent-infant-relational-assessment-tool-pirat-global-scales-training/</a></p>	Not yet

### Psychometric Properties and References:

Excellent reliability and internal consistency. For comprehensive information see PIRAT Global Scales Reliability and Validity PDF in the network area at [www.parentinfantfoundation.org.uk](http://www.parentinfantfoundation.org.uk)



## Measures Table B: postnatal parent-infant interaction, parental sensitivity/emotional availability and attachment

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO)	Parenting behaviour (affection, responsiveness, encouragement and teaching)	Child from 10-47 months old (although some aspects can be applied earlier) and parent.	Observational (can be administered live but best if videoed)	Requires 10 minutes of interaction plus time for coding	<ul style="list-style-type: none"> <li>Assesses 29 observable parenting behaviour across the four domains</li> <li>Assesses positive parenting behaviours that predict good child outcomes</li> <li>guides individualized positive parenting interventions with families</li> <li>tracks positive parenting outcomes of a parenting support program</li> </ul> <p><b>Clinicians' insights:</b> Produces clinically salient information The grid summarizes scores indicative of high risk, moderate risk, and strength (e.g., low/no risk) for each domain such that risk corresponds to suboptimal toddler development. The scoring grid is helpful for identifying families' strengths and areas that need improvement (see Tribal Early Childhood hyperlink below)</p>	<a href="https://brookespublishing.com/product/piccolo/">https://brookespublishing.com/product/piccolo/</a>	Minimal staff training required. Staff need to practice asking the questions as an interview  Training DVD \$155 Administration Starter Kit \$60  <a href="https://brookespublishing.com/product/piccolo/">https://brookespublishing.com/product/piccolo/</a>	Yes

### Psychometric Properties and References:

May not be norm-referenced – users should check with the publisher. Cronbach's  $\alpha$  averaged .78 across the four domain items (.78 for the affection domain, .75 for the responsiveness domain, .77 for the encouragement domain, and .80 for the teaching domain);  $\alpha = .91$  for the total PICCOLO score at each age. Roggman et al. 2013 reported that internal consistency reliability was similar among European American, African American, and Latino American low-income families. Interrater reliability correlations between pairs of observers averaged  $r = .77$  for all items and ranged from  $r = .74$  for the responsiveness domain to  $r = .80$  for the affection domain. Interrater reliability correlations between observers of different ethnicities averaged  $r = .80$  for PICCOLO total scores,  $r = .78$  for the affection domain,  $r = .68$  for the responsiveness domain,  $r = .66$  for the encouragement domain, and  $r = .75$  for the teaching domain. Construct Validity: Domains and total scale scores were significantly correlated with established measures of the same parenting interactions in the total sample and within the subgroups of European American, African American, and Latino American low-income families. Predictive Validity: PICCOLO total scores and domain scores were significantly correlated with later child cognitive, language, and socioemotional outcomes at ages 2, 3, and 5. PICCOLO total and domain scores predicted: cognitive outcomes as measured by the MDI at age 3 years and the WJ-AP subscale at age 5; language and literacy outcomes as measured by the PPVT-II at ages 3 and 5 and the WJ-LW subscale at prekindergarten; socioemotional outcomes as measured by the BRS-ER at age 3 and the CBCL-A at ages 3 and 5; and an index of school-readiness. Predictive validity was similar among European American, African American, and Latino American families (ref <https://tribalearlychildhoodmeasures.com/the-parenting-interactions-with-children-checklist-of-observations-linked-to-outcomes-piccolo/>)

Roggman, L. A., Cook, G. A., Innocenti, M.S., Jump Norman, V. K., & Christiansen, K. (2009). PICCOLO (Parenting Interactions With Children: Checklist of Observations Linked to Outcomes) user's guide. Logan, UT: Utah State University.

## Measures Table B: postnatal parent-infant interaction, parental sensitivity/emotional availability and attachment

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
Parent-Infant Relationship Global Assessment Scale (PIRGAS)	Parent-infant relationship (strengths of a relationship and the severity of any disorder)	Parent with child aged 0-3 years (0-5 version available)	Interview and observation	Coding a 'live' observation requires at least 45 minutes Manual states a full evaluation of all five axes "requires a minimum of three to five sessions of 45 or more minutes each"	Research-based rating instrument consisting of a clinical interview with the parent coupled with observed behavioural patterns. Provides a continuously distributed rating of p-i relationship quality ranging from well adapted to grossly impaired. Three aspects of parent/infant relationship are evaluated: the behaviours indicating quality of interaction, affective tone and psychological involvement  <b>Clinicians' insights:</b> In the nine PIP teams, the PIRGAS was phased out in favour of the DC05 LOAF, as the PIRGAS was found to be a bit subjective so best when combined with other tools  There's risk that caregivers act out positive behaviours while being observed but the ratings can be changed in light of new information.	Contact trainers  The scoring guide is available here <a href="https://cypiapt.files.wordpress.com/2016/07/0-3r-pirgas1.pdf">https://cypiapt.files.wordpress.com/2016/07/0-3r-pirgas1.pdf</a>	A two-day training provided by Zero to Three internationally is required. Costs include the DC:0-3R Manual of \$75 and a training fee of \$50-100  Contact Zero to Three Learning Center for details <a href="https://learningcenter.zerotothree.org/Default.aspx">https://learningcenter.zerotothree.org/Default.aspx</a>	Yes

### Psychometric Properties and References:

IRR found 92% agreement and an ICC= .83-.86.

1. Parent-infant relationship global assessment scale: a study of its predictive validity. Aoki et al (2002) [https://www.gla.ac.uk/media/Media\\_510987\\_smxx.pdf](https://www.gla.ac.uk/media/Media_510987_smxx.pdf)
2. Inter-rater reliability and aspects of validity of the parent-infant relationship global assessment scale (PIR-GAS). Muller et al (2013) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3679830/>
3. Using the Parent-Infant Relationship Global Assessment Scale (PIR-GAS) to identify caregiver – infant/toddler dyads with abusive relationship patterns in six European countries: Identify Abusive Relationships With the PIR-GAS [https://pure.roehampton.ac.uk/portal/en/publications/using-the-parentinfant-relationship-global-assessment-scale-pirgas-to-identify-caregiver--infanttoddler-dyads-with-abusive-relationship-patterns-in-six-european-countries\(233fbb33-88ca-4651-8e83-ff41fac7dac\)/export.html](https://pure.roehampton.ac.uk/portal/en/publications/using-the-parentinfant-relationship-global-assessment-scale-pirgas-to-identify-caregiver--infanttoddler-dyads-with-abusive-relationship-patterns-in-six-european-countries(233fbb33-88ca-4651-8e83-ff41fac7dac)/export.html)



## Measures Table B: postnatal parent-infant interaction, parental sensitivity/emotional availability and attachment

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
The DC: 0-5 assessment (Levels of Adaptive Functioning; LOAF)	A rating of Caregiving Dimensions (refers to primary caregiver) and Caregiving Environment (embraces other caregivers in the child's emotional world regardless of whether they live with the child)	Parent and Child up to 5 years of age	Observation		<p>A developmentally-based system for practitioners assessing mental health and developmental disorders in infants and toddlers.</p> <p>It can be used by practitioners from various disciplines to plan treatment and evaluate progress in their parent-infant relationship work</p> <p>Caregiving Dimension and Caregiving Environment each rated as one of four levels of concern</p>	<a href="https://www.zerotothree.org/resources/2221-dc-0-5-manual-and-training">https://www.zerotothree.org/resources/2221-dc-0-5-manual-and-training</a>	International training offered by Zero to Three <a href="https://www.zerotothree.org/resources/2221-dc-0-5-manual-and-training">https://www.zerotothree.org/resources/2221-dc-0-5-manual-and-training</a>	

### Psychometric Properties and References:

Contact <https://www.zerotothree.org/>



## Measures Table B: postnatal parent-infant interaction, parental sensitivity/emotional availability and attachment

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
CARE- Index	Patterns of attachment and risk (dynamic maturational model)	Babies of 0-15 months and their parent or carer	Observational	3-5 min video of parents playing and talking with their baby, + 15-20 min coding	Coding system made of 7 scales: three parent descriptors (sensitive, controlling, unresponsive) and four infant descriptors (cooperative, difficult, compulsive and passive). Seven aspects of parental interactive behaviour are evaluated including facial and vocal expression, positions and body contact, expressions of affection, pacing of turns, control and choice of activity. Used for initial assessment, outcome evaluation and used to guide risk assessment in child protection  <b>Clinicians' insights:</b> People have reported difficulties becoming reliable on this measure Expense/length of training	Contact trainers	Training to become a reliable coder takes nine days, in three 3-day blocks, followed by a reliability test of submitted video clips. Training is available in the UK for a wide range of professionals who work with infants and their carers, including midwives, health visitors, social workers, psychologists and psychotherapists. In 2019, the 9-day training costs in the region of £720 (excluding travel and accommodation) from <a href="http://www.iswmatters.co.uk/">http://www.iswmatters.co.uk/</a>  International training can be found via <a href="https://www.patcrittenden.com/">https://www.patcrittenden.com/</a>	Yes

### Psychometric Properties and References:

It is highly correlated with the Infant Strange Situation. No information found on internal consistency. Inter-rater reliability was tested at 85% agreement. Criterion validity established for different groups of mothers: middle-class, low income, deaf, with learning difficulties, abusive and neglectful as well as for prospective longitudinal studies. Construct validity established with the infant's patterns of attachment and assessed with the SSP, along with prospective longitudinal studies.

1. [https://www.patcrittenden.com/include/care\\_index.htm](https://www.patcrittenden.com/include/care_index.htm)
2. Hautamaki (2014) Chapter in **The Routledge Handbook of Attachment Assessment**
3. Kunster (2010) Assessing parent—child interaction in the preschool years: A pilot study on the psychometric properties of the toddler CARE-Index. <https://journals.sagepub.com/doi/abs/10.1177/1359104510367585>





## Measures Table B: postnatal parent-infant interaction, parental sensitivity/emotional availability and attachment

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
Keys to Interactive Parenting (KIPS)	Dimensions of interactive parenting behaviour	Child 2-71 months old and their parent	Observational	20 minutes observation plus 15 minutes scoring	<p>12 key facets of parenting such as Sensitivity to Responses, Supporting Emotions and Promoting Exploration and Curiosity. It adopts a strengths-based approach promoting parental learning and building confidence. The KIPS can be used as a baseline clinical assessment and to track progress over time and is therefore suitable for pre and post outcome measurement</p> <p>Can be used by family services practitioners in health, education or social services</p> <p><b>Clinicians' insights</b></p> <p>Does not specifically look for markers for problems or disorganized attachment in the child</p> <p>Can be difficult to gain accreditation but programme developers very helpful</p> <p>Slow motion can assist scoring</p>	<a href="http://www.comfortconsults.com/">http://www.comfortconsults.com/</a>	<p>Training to use the KIPS is available as e-learning from <a href="http://www.comfortconsults.com/">http://www.comfortconsults.com/</a>. Annual re-certification is required for valid use</p> <p>In 2019, prices for the e-learning workbook, annual reaccreditation and scoring forms were \$155USD</p>	Yes

### Psychometric Properties and References:

Has received the Measurement Tools Rating of "A – Psychometrics Well-Demonstrated" based on the published, peer-reviewed research available ref <https://www.cebc4cw.org/assessment-tool/keys-to-interactive-parenting-scale/>

- Comfort, M., & Gordon, P. R. (2006). The Keys to Interactive Parenting Scale (KIPS): A practical observational assessment of parenting behavior. *NHSA Dialog: A Research-to-Practice Journal for the Early Intervention Field*, 9(1), 22-48.
- Comfort, M., Gordon, P. R., & Naples, D. (2011). KIPS: An evidence-based tool for assessing parenting strengths and needs in diverse families, *Infants & Young Children*, 24(1), 56-74.



## Measures Table B: postnatal parent-infant interaction, parental sensitivity/emotional availability and attachment

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
Parent-Infant Interaction Observation Screen (PIIOS)	Parental sensitive responsiveness/ attunement	Baby of 2-7 months and parent	Observational	3-4 minutes video clip + 30 minutes for coding	Short screening tool for 'high risk' dyads specifically developed for frontline practitioners. It is a validated, simple, easy-to-learn screening tool to assess the parent-infant relationship. It was developed and validated by Dr P.O. Svanberg in collaboration with colleagues at Warwick Infant Family Wellbeing Unit (WIFWU) and has been shown to be reliable and also 'teachable' with significantly improved ability to recognise 'risky' interaction following the training. It contains items derived from Ainsworth's Sensitivity Scale and Crittenden's CARE-Index, as well as additional constructs based on research on 'mid-range interactions' when the infant is neither very active, nor passive, nor vigilant. Assesses any dysregulated interactions that have been shown to be predictive of an infant's attachment security. It comprises of a total of 13 scales: 8 parent, 1 infant, 4 dyadic, scored on a 14-point Likert Scale indicating Sensitivity (1=low, 14=high)	Contact trainers	<p>Training via the University of Warwick is available to individuals or commissioned groups</p> <p>The training is 3 days and costs £450</p> <p><a href="https://warwick.ac.uk/fac/sci/med/study/cpd/cpd/piios">https://warwick.ac.uk/fac/sci/med/study/cpd/cpd/piios</a></p>	

### Psychometric Properties and References:

Internal consistency showed good levels of positive correlation between each item score and the total score. Inter-rater reliability was excellent (94%). It has been validated against the CARE-Index maternal 'Sensitivity' scores.

1. The Parent-Infant Interaction Observation Scale: reliability and validity of a screening tool (Svanberg et al, 2013) <https://www.tandfonline.com/doi/abs/10.1080/02646838.2012.751586>
2. Using an observation tool (PIIOS) to assess parent-infant interaction in the first two weeks of life: a feasibility study (Naughton et al., 2019) [https://www.safetylit.org/citations/index.php?fuseaction=citations.viewdetails&citationIds\[\]=citjournalarticle\\_600617\\_23](https://www.safetylit.org/citations/index.php?fuseaction=citations.viewdetails&citationIds[]=citjournalarticle_600617_23)
3. The effectiveness of training in the Parent-Infant Interaction Observation Scale for health visitors (Svanberg & Barlow, 2014) <https://www.magonlinelibrary.com/doi/abs/10.12968/johv.2013.1.3.162>

## Measures Table B: postnatal parent-infant interaction, parental sensitivity/emotional availability and attachment

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
Parent-Child Early Relational Assessment (PCERA)	Quality of parent-child interaction	Child of 2-60 months and parent	Observational	1 hour observation + coding	<p>A semi-structured observation assessing the affective and behavioural quality of interactions between the parent and child, for both research and clinical purposes, in families at risk of, or evidencing, early relational disturbances. The PCERA can be conducted and videotaped in a clinic or home setting. Segments are rated on 65 (29 parent, 28 child and 8 dyadic) behavioural and affective variables on a 5-point Likert scales with behavioural anchors. The instrument is designed to pick up on both positive and negative behaviours and affective states</p> <p><b>Clinicians' insights:</b></p> <p>Developed to be used in research but widely used in clinical work as well, to inform intervention strategies</p>		No information found	

### Psychometric Properties and References:

Internal consistency was tested in several studies with good results. The inter-rater reliability was reported at as 83%-97%. Concurrent construct validity subscales have been also been demonstrated with significant relationships to a number of constructs such as infant attachment and IWM.

1. For a clinician's experience of the PCERA see [http://www.infanthearing.org/meeting/archive/ehdi2015/ehdimeeting.org/archive/2015/System/Uploads/pdfs/Monday\\_Combs%20Chandler\\_230\\_RebeccaMartin\\_1625.pdf](http://www.infanthearing.org/meeting/archive/ehdi2015/ehdimeeting.org/archive/2015/System/Uploads/pdfs/Monday_Combs%20Chandler_230_RebeccaMartin_1625.pdf)
2. The Parent-Child Early Relational Assessment: A Factorial Validity Study Clark (1999) <https://journals.sagepub.com/doi/abs/10.1177/00131649921970161>



## Measures Table B: postnatal parent-infant interaction, parental sensitivity/emotional availability and attachment

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
NCAST Parent-Child Interaction Feeding and Teaching Scales (PCI)	Parent-child interaction	Parent with child 0-12 months for feeding scale, 0-36 months for teaching scale	Observation (videoed)		Widely used by frontline professionals in USA. Suitable for clinical and research purposes.	Contact trainers <a href="https://www.pcrprograms.org/">https://www.pcrprograms.org/</a>	Training may be available in the UK, check <a href="https://www.pcrprograms.org/training/">https://www.pcrprograms.org/training/</a> for updates.  Training in America \$1500	Yes

### Psychometric Properties and References:

1. Farel et al (1991) Interaction between high-risk infants and their mothers: The NCAST as an assessment tool <https://onlinelibrary.wiley.com/doi/abs/10.1002/nur.4770140205>
2. Glatigny Dallay E., Guedeney A. (2016) Parent-Infant Interaction Assessment. In: Sutter-Dallay AL., Glangeaud-Freudenthal NC., Guedeney A., Riecher-Rössler A. (eds) Joint Care of Parents and Infants in Perinatal Psychiatry. Springer, Cham [https://link.springer.com/chapter/10.1007%2F978-3-319-21557-0\\_6#citeas](https://link.springer.com/chapter/10.1007%2F978-3-319-21557-0_6#citeas)



## Measures Table B: postnatal parent-infant interaction, parental sensitivity/emotional availability and attachment

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
The Atypical Maternal Behaviours Instrument for Assessment and Classification (AMBIENCE)	Anomalous parental behaviours associated with disorganized attachment in infancy	Mothers and their 12-24 months baby (also adapted for 4+ months)	Observational	Uses pre-recorded videos. Coding 1 hour	<p>AMBIENCE coding of pre-recorded videos looks for disrupted maternal behaviours on five dimensions: affective communication errors, role/boundary confusion, disorganised/disoriented behaviours, negative/intrusive behaviour, and withdrawal. Behaviours on each of the dimensions are coded and an overall score of the level of disruption on a 7-point scale is given. A binary code of disrupted or not disrupted is also given</p> <p>Work is underway to validate a shortened version as the original is found to be lengthy and complex, with reliability training taking about a year, making it impractical for most clinical purposes</p>		Training may not be available in the UK	

### Psychometric Properties and References:

Concurrent validity with maternal RF has been established.

1. Lyons-Ruth K., Bronfman E. & Parsons E. (1999). Maternal frightened, frightening, or atypical behaviour and disorganised infant attachment patterns. *Monographs of the Society for the Research in Child Development*, 64, 67-9
2. Goldberg et al (2003) Atypical maternal behavior, maternal representations, and infant disorganized attachment <https://pdfs.semanticscholar.org/f9a7/e250bba06fee94c67d6e1a5882f9a7f063fa.pdf>
3. Haltigan et al (2017) Refining the assessment of disrupted maternal communication: Using item response models to identify central indicators of disrupted behaviour [https://www.researchgate.net/publication/321881692\\_Refining\\_the\\_assessment\\_of\\_disrupted\\_maternal\\_communication\\_Using\\_item\\_response\\_models\\_to\\_identify\\_central\\_indicators\\_of\\_disrupted\\_behavior](https://www.researchgate.net/publication/321881692_Refining_the_assessment_of_disrupted_maternal_communication_Using_item_response_models_to_identify_central_indicators_of_disrupted_behavior)





## Measures Table B: postnatal parent-infant interaction, parental sensitivity/emotional availability and attachment

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
Emotional Availability Scales (EAS)	Emotional availability (the parent's receptive presence to the child's emotional signals)	Child of 0-48 months and parent	Observational	20 minutes interaction+ time for coding	<p>Assessment of dyadic interaction for emotional availability of parent to child and vice versa. Consists in six dimensions for each party: parental dimensions are sensitivity, structuring, non-intrusiveness, and non-hostility, and the child dimensions are the child's responsiveness to the parent and the child's involvement of the parent</p> <p><b>Clinicians' insights:</b> Recommended to code with video and analyse later</p> <p>Can be used with fathers and other adults Suitable for clinical and research use</p>	Biringen, Z. (2008). The Emotional Availability (EA) Scales and the Emotional Attachment & Emotional Availability (EA2) Clinical Screener (4th edition): Infancy/ Early Childhood Version		

### Psychometric Properties and References:

Internal consistency was reported as acceptable to good. The criterion validity has been demonstrate within the context of postpartum depression, substance abuse and economic disadvantage.

1. Tribal Early Childhood Measures Database <http://tribalearlychildhoodmeasures.com/emotional-availability-ea/>
2. Biringen, Derscheid, Vliegen, Closson, & Easterbrooks, 2014. Emotional Availability (EA): Theoretical background, empirical research using the EA Scales, and clinical applications. *Developmental Review*, 34, 114-167.
3. Biringen, Zeynep, and M. Ann Easterbrooks. 2012. "Emotional Availability: Concept, Research, and Window on Developmental Psychopathology." *Development and Psychopathology* 24 (01): 1-8. <https://doi.org/10.1017/S0954579411000617>.

For further references see the Annenberg Brown University website <https://www.annenberginstitute.org/instruments/emotional-availability-scales>



## Measures Table B: postnatal parent-infant interaction, parental sensitivity/emotional availability and attachment

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
Global Rating Scales for Mother-Infant Interaction (GRS)	Mother-infant interaction of depressed vs non-depressed mothers	Mother and infant of 2-4 months	Observational	5 minute, videoed interaction without toys, using mirrors to ensure both faces are recorded. 30 minutes for coding	Initially developed for research purposes by Lynne Murray, to distinguish between the mother-infant interaction of both depressed and non-depressed mothers, 2-4 months after birth  25 subscales: 7 infant, 13 maternal, and 5 joint interactive behaviours  Maternal dimensions describe mother's overall sensitivity, intrusiveness, remoteness and affect, in particular signs of depression. Infant dimensions observe the level of communication, interactive behaviours, whether inert or distressed. The interactive dimension describes mutual engagement, such as smooth and easy/difficult, fun/serious, satisfying/unsatisfying, much engagement/no engagement and exciting engagement/quiet engagement	Contact author via <a href="https://www.researchgate.net/publication/227696334_The_Impact_of_Postnatal_Depression_and_Associated_Adversity_on_Early_Mother-Infant_Interactions_and_Later_Infant_Outcome">https://www.researchgate.net/publication/227696334_The_Impact_of_Postnatal_Depression_and_Associated_Adversity_on_Early_Mother-Infant_Interactions_and_Later_Infant_Outcome</a>	No information available	

### Psychometric Properties and References:

Good criterion validity for a number of clinical groups such as depression and schizophrenia, social adversity, and low risk/high risk groups. It has also been validated cross-culturally and has been used to investigate associations between infant psychological profiles, temperament and quality of mother-infant interaction. Predictive validity was shown for the quality of the interaction assessed and child cognitive outcome at 18 months and 5 years of age.

1. Gunning, Murray et al (2002). Global Rating Scheme. A paper presented at the 8th Congress of WAIMH, Amsterdam – not available on the internet
2. Murray et al (1996a) The impact of postnatal depression and associated adversity on early mother-infant interactions and later infant outcomes <https://www.ncbi.nlm.nih.gov/pubmed/9022253>



## Measures Table B: postnatal parent-infant interaction, parental sensitivity/emotional availability and attachment

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
Postpartum Bonding Questionnaire (PBQ) later called the Parental Bonding Questionnaire	Screening for bonding disorders	Mother	Self-report questionnaire	5-10 minutes	25 item self-report questionnaire recommended for midwives and health visitors for the early identification of dyads at risk of mother-infant bonding disorders  Four subscales: impaired bonding, rejection and pathological anger, infant-focused anxiety and incipient abuse. A review of parental bonding questionnaires (Mason, 2015) was positive about their use. Literature suggests simultaneous use of EPDS if postnatal depression is also suspected	<a href="https://sundpsykologerna.se/files/Brockington-et-al-2001-PBQ-Archives-of-women_s-meantal-health.pdf">https://sundpsykologerna.se/files/Brockington-et-al-2001-PBQ-Archives-of-women_s-meantal-health.pdf</a>	No training required although we suggest users read the original papers (2001, 2004) and related papers	

**Psychometric Properties and References:**

1. Brockington et al (2001) A screening questionnaire for mother-infant bonding disorders. [https://sundpsykologerna.se/files/Brockington-et-al-2001-PBQ-Archives-of-women\\_s-meantal-health.pdf](https://sundpsykologerna.se/files/Brockington-et-al-2001-PBQ-Archives-of-women_s-meantal-health.pdf)
2. Klier (2006) Mother-infant bonding disorders in patients with postnatal depression: The Postpartum Bonding Questionnaire in clinical practice <https://sundpsykologerna.se/files/Klier-2006-Mother-infant-bonding-disorders-in-patients-with-postnatal-depression-PBQ.pdf>
3. Mason (2015) Impact of bonding questionnaires in an assessment of maternal-infant bonding: A review of the literature <https://www.magonlinelibrary.com/doi/abs/10.12968/johv.2015.3.8.432>



## Measures Table C: antenatal reflective functioning and attachment

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
The Pregnancy Interview	Predicts adult attachment classification	Pregnant women	Interview		39 questions and probes to assess the quality of a mother's representation of her relationship with her unborn child  Administered during the third trimester	Contact trainers <a href="http://pditraininginstitute.com/#pi">http://pditraininginstitute.com/#pi</a>	Not currently found in UK – check <a href="http://pditraininginstitute.com/#pi">http://pditraininginstitute.com/#pi</a> for updated information  3 days training in America \$1100	

### Psychometric Properties and References:

Slade, A., Grunebaum, L., Haganir, L. and Reeves, M., 2007. The pregnancy interview-revised. New York: City College of New York.

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
The Prenatal Parental Reflective Functioning Qu'naire (P-PRFQ)	Reflective Functioning	Pregnant women	Self-report		14 item questionnaire	See journal reference below	n/a	Not yet

### Psychometric Properties and References:

Pajulo et al (2015) THE PRENATAL PARENTAL REFLECTIVE FUNCTIONING QUESTIONNAIRE: EXPLORING FACTOR STRUCTURE AND CONSTRUCT VALIDITY OF A NEW MEASURE IN THE FINN BRAIN BIRTH COHORT PILOT STUDY <https://onlinelibrary.wiley.com/doi/abs/10.1002/imhj.21523>



## Measures Table C: antenatal reflective functioning and attachment

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
Prenatal Attachment Inventory (PAI)	Maternal attachment to foetus	Mother	Self-report questionnaire	5-10 minutes	<p>21-item self-report questionnaire asking respondents to endorse items like "I feel love for the baby" and "I wonder what the baby looks like now" on a four-point Likert scale</p> <p><b>Clinician's insights:</b> No father's version</p> <p>Studies published using versions for Hungarian, French, Italian, Swedish, Polish and Persian mothers and mothers expecting twins</p>	<p>Contact author</p> <p><a href="https://journals.sagepub.com/action/doSearch?target=default&amp;ContribAuthorStored=Muller%2C+Mary+E">https://journals.sagepub.com/action/doSearch?target=default&amp;ContribAuthorStored=Muller%2C+Mary+E</a></p> <p>The Egyptian version can be viewed at <a href="http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.389.6878&amp;rep=rep1&amp;type=pdf">http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.389.6878&amp;rep=rep1&amp;type=pdf</a></p>	No training required	No

### Psychometric Properties and References:

Best validated of the three antenatal attachment scales available (Perelli et al., 2014, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4227350/>)

1. Busonera et al. (2017) Prenatal Attachment Inventory: expanding the reliability and validity evidence using a sample of Italian women  
[https://www.researchgate.net/publication/318562559\\_Prenatal\\_Attachment\\_Inventory\\_expanding\\_the\\_reliability\\_and\\_validity\\_evidence\\_using\\_a\\_sample\\_of\\_Italian\\_women](https://www.researchgate.net/publication/318562559_Prenatal_Attachment_Inventory_expanding_the_reliability_and_validity_evidence_using_a_sample_of_Italian_women)
2. Pallant et al. (2014) Psychometric evaluation and refinement of the Prenatal Attachment Inventory  
[https://www.researchgate.net/publication/259932406\\_Psychometric\\_evaluation\\_and\\_refinement\\_of\\_the\\_Prenatal\\_Attachment\\_Inventory](https://www.researchgate.net/publication/259932406_Psychometric_evaluation_and_refinement_of_the_Prenatal_Attachment_Inventory)
3. Gau & Lee (2013) Construct Validity of the Prenatal Attachment Inventory: A Confirmatory Factor Analysis Approach  
[https://www.researchgate.net/publication/9040039\\_Construct\\_Validity\\_of\\_the\\_Prenatal\\_Attachment\\_Inventory\\_A\\_Confirmatory\\_Factor\\_Analysis\\_Approach](https://www.researchgate.net/publication/9040039_Construct_Validity_of_the_Prenatal_Attachment_Inventory_A_Confirmatory_Factor_Analysis_Approach)



## Measures Table C: antenatal reflective functioning and attachment

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
Maternal Antenatal Attachment Scale (MAAS) and Paternal Antenatal Scale (PAAS)	Parental attachment to foetus	Mother or father of foetus	Self-report questionnaire	5-10 minutes	<p>Maternal (19 items) and paternal (16 items) self-report questionnaire. Items rated on basis of last two weeks. 5-point Likert scale.</p> <p><b>Clinicians' insights:</b> Very helpful to have a comparable father's version</p> <p>Use with caution with non-clinical/universal population due to item about miscarriage</p> <p>Published papers using versions in Spanish, Dutch, Turkish, Italian</p>	<p>Maternal version <b>SMG_change_projectMaternal_antenatal_attachment_scale%20(1)</b></p> <p>Paternal version <b>SMG_change_projectPaternal_antenatal_attachment_scale%20(1)</b></p> <p>Scoring Guidance <b>SMG_change_projectMaternal_paternal_antenatal_attachment_scale-scoring_guidance%20(1)</b></p>	No training required	No but UK test-retest paper in preparation

**Psychometric Properties and References:**

1. Van Den Burgh & Simons (2007) A review of scales to measure the mother–foetus relationship <https://www.tandfonline.com/doi/abs/10.1080/02646830802007480#>
2. Condon JT: The assessment of antenatal emotional attachment: Development of a questionnaire instrument. Br J Med Psychol. 1993, 66 (2): 167-183. 10.1111/j.2044-8341.1993.tb01739.x <https://onlinelibrary.wiley.com/doi/abs/10.1111/j.2044-8341.1993.tb01739.x>



## Measures Table C: antenatal reflective functioning and attachment

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
Maternal Fetal Attachment Scale (MFAS) 20-item version from Busonera et al (2016)	Prenatal maternal attachment	Mother	Self-report questionnaire	5-10 minutes	<p>The original 24 item scale consisted of five subscales to represent theorized dimensions of prenatal attachment (although the 1993 factor analysis and other papers found this version problematic)</p> <p>However, a 20-item version, validated on Italian women in 2016, is found to be valid and reliable</p> <p>This has three factors: future parental role-taking, present interaction with the baby, giving of self and responsibility to the unborn child</p>	<a href="https://www.midwiferyjournal.com/article/S0266-6138(16)00004-8/pdf">https://www.midwiferyjournal.com/article/S0266-6138(16)00004-8/pdf</a>	No training required	

**Psychometric Properties and References:**

1. Muller (1993) Factor Analysis of the Maternal Fetal Attachment Scale [https://www.researchgate.net/publication/14693481\\_Factor\\_Analysis\\_of\\_the\\_Maternal\\_Fetal\\_Attachment\\_Scale](https://www.researchgate.net/publication/14693481_Factor_Analysis_of_the_Maternal_Fetal_Attachment_Scale)
2. Busonera et al (2016) Psychometric Properties of a 20-item version of the Maternal-Fetal Attachment Scale in a sample of Italian expectant women [https://www.midwiferyjournal.com/article/S0266-6138\(16\)00004-8/pdf](https://www.midwiferyjournal.com/article/S0266-6138(16)00004-8/pdf)



## Measures Table D: adult mental health; parental confidence/self esteem/self-efficacy/confidence; parental stress; parent's perception of self/parenting satisfaction

		Antenatal	Child 0-12 months	Child 12-24 months
<b>Adult Mental Health: Questionnaires for use with adults to assess various aspects of their own mental health</b>				
Hospital Anxiety and Depression Scale (HADS)	Gives an early identification of anxiety and depression in the caregiver	✓	✓	✓
Beck Depression Inventory		✓	✓	✓
Beck Anxiety Inventory		✓	✓	✓
GHQ-12		✓	✓	✓
GAD 7		✓	✓	✓
PH9		✓	✓	✓
Adult Wellbeing Scale		✓	✓	✓
Impact of Event Scale- Revised	A 22-item scale primarily used for the provisional diagnosis of PTSD	✓	✓	✓
Primary Care PTSD Screen		✓	✓	✓
Warwick – Edinburgh Mental Wellbeing Scale	14 item scale covering feelings and functioning aspects of mental wellbeing. (S)WEMWBS is the shorter 7-item version	✓	✓	✓
Kessler Psychological Distress Scale	10 item self-report questionnaire. Global measure of distress based on previous four weeks		✓	✓
Standardised Assessment of Personality – Abbreviated Scale (SAPAS)	8-item screening interview for likelihood of personality disorder		✓	✓



## Measures Table D: adult mental health; parental confidence/self esteem/self-efficacy/confidence; parental stress; parent's perception of self/parenting satisfaction

		Antenatal	Child 0-12 months	Child 12-24 months
<b>Parental Confidence/Self Esteem/Self-Efficacy/Confidence</b>				
Rosenberg Self Esteem Scale		✓	✓	✓
Karitane Parenting Sense of Confidence (0-12mths)			✓	
Brief Parenting Self Efficacy Scale			✓	✓
Parenting Sense of Competence, (Gibaud-Wallston, 1978)			✓	
Parenting Sense of Competence (Johnston & Mash, 1989)			✓	✓
Maternal Self-Efficacy Scale	Examines maternal depression, infant difficulty and maternal competence as reported/perceived by the parent		✓	✓

## Measures Table D: adult mental health; parental confidence/self esteem/self-efficacy/confidence; parental stress; parent’s perception of self/parenting satisfaction

		Antenatal	Child 0-12 months	Child 12-24 months
<b>Parental Stress</b>				
Parenting Stress Index			✓	✓
Parenting Daily Hassles Scale			✓	✓

		Antenatal	Child 0-12 months	Child 12-24 months
<b>Parent’s perception of self/parenting satisfaction</b>				
Mothers Object Relations Scale	Child must be 2-4 years old Not validated for under 2s			
Kansas Parental Satisfaction Scale	3 questions on satisfaction with children’s behaviour, satisfaction with oneself as a parent and one’s relationship with children		Valid age range not specified	





## Measures table E: parental emotional regulation

		Antenatal	Child 0-12 months	Child 12-24 months
<b>Parental Confidence/Self Esteem/Self-Efficacy/Confidence</b>				
Parent Emotion Regulation Scale (PERS)	35 items covering four dimensions of parental emotion regulation: orientation to child's emotion, acceptance of emotions, avoidance of child's emotion and emotional control	For parents of children aged 3-15 years		
Coping with Children's Negative Emotions Scale (C-CNES) for parents of toddlers	Self-report scale, adapted for parents of toddlers. Freely available on the internet at <a href="https://ccnes.org/">https://ccnes.org/</a>			✓ For parents of children aged 18 months old and older
Difficulties in Emotional Regulation Scale (DERS and DERS-SF)	A self-report scales for adults (not specific to parents) to assess in emotion regulation relevant to clinical difficulties. 36 and 18 item scales	✓	✓	✓
Emotion Regulation Questionnaire (ERQ)	A 10-item scale designed to measure respondents' tendency to regulate their emotions in two ways: cognitive reappraisal and Expressive Suppression. Not specific to parenting	✓	✓	✓
Revised Parental Emotion Regulation Inventory (PERI-2)	A self-report measure of reappraisal, capitulation, suppression and escape strategies used by parents during discipline encounters with their child	For parents of children aged 2 years and older		



## Measures Table F: infant's social, emotional and behavioural development

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
Ages & Stages Questionnaire Social-Emotional 2nd edition (ASQ:SE-2, 2015)	Child's social emotional development (child's ability to experience, express, and manage emotions, develop positive relationships with caregivers and others, and explore their environment with curiosity and confidence)	Parental self-report of infants from 1 month of age (up to 72 months)	Self-report questionnaire	Approx. 20 minutes plus 5 minutes to score	<p>The ASQ is a parent completed questionnaire that covers communication, gross and fine motor skills, problem solving and personal-social skills. The ASQ:SE-2 (2015) complements ASQ and identifies social and emotional issues for the baby including self-regulation, communication, autonomy, compliance, adaptive functioning, affect and interaction with people. Can help identify young children at risk of social or emotional difficulties. Different questionnaires for different age ranges: 2-, 6-, 12-, 18-, 24-months old</p> <p>Development guides for parents are available at <a href="http://archive.brookespublishing.com/content/ASQSE2-Social-Emotional-Development-Guides.pdf">http://archive.brookespublishing.com/content/ASQSE2-Social-Emotional-Development-Guides.pdf</a></p> <p><b>Clinicians' insights</b></p> <p>Helpful that it's photocopyable</p> <p>It can be tricky to measure change over time if the child crosses one of the age categories during the course of intervention</p>	<p><a href="http://www.agesandstages.com">www.agesandstages.com</a></p>	<p>No formal training required but training is available from <a href="http://www.brookespublishing.com">www.brookespublishing.com</a></p> <p>Starter kit \$295 User guide \$55 DVD \$50</p>	Yes

### Psychometric Properties and References:

Test-retest reliability, internal consistency, validity, sensitivity and specificity all excellent (data set over 14000 children). Published study suggests validity for use by pre-school teachers (Pooch et al., 2018)

1. Ages & Stages website. An introduction to the ASQ:SE-2 <https://agesandstages.com/resource/intro-asqse-2-presentation/>
2. Pooch et al. (2018) Ages and Stages Questionnaire: Social-Emotional as a Teacher-Report Measure [https://www.researchgate.net/publication/327587962\\_Ages\\_and\\_Stages\\_Questionnaire\\_Social-Emotional\\_as\\_a\\_Teacher-Report\\_Measure](https://www.researchgate.net/publication/327587962_Ages_and_Stages_Questionnaire_Social-Emotional_as_a_Teacher-Report_Measure)



## Measures Table F: infant's social, emotional and behavioural development

Name of Measure	Construct or domain	Participant	Self-report, interview or observational	Completion Time	Brief Description	Source of Measure	Costs and UK Training (2019)	Validated as outcome measure (pre- post-)?
Neonatal Behavioural Assessment Scale	Infant's responses to their new environment, contribution to the parent-infant relationship and newborn's individuality	Infant 0-2 months	Direct assessment and observation		<p>A strengths-based, practitioner-administered assessment of a newborn's individuality and skills</p> <p>53 scorable items which are either administered by the practitioner or observed, including habituation, social interactive responses and capabilities, motor system, state organisation and regulation, autonomic system and reflexes</p> <p>Clinical and research applicability</p> <p><b>Clinicians' insights</b></p> <p>Lovely that it is strengths based – sets a positive tone to the early parent-practitioner relationship</p> <p>Can really help parents understand their unique new baby</p>	<a href="https://www.brazelton.co.uk/courses/neonatal-behavioural-assessment-scale-nbas/">https://www.brazelton.co.uk/courses/neonatal-behavioural-assessment-scale-nbas/</a>	<p>Provided by the Brazelton UK centre. £745.00 (or £373 if have previously completed NBO training)</p> <ol style="list-style-type: none"> <li>1. Pre Course Preparation – a manual and video</li> <li>2. 2-day face-to-face training course</li> <li>3. Practice phase and support</li> <li>4. Certification</li> </ol> <p>Re-certification is required every 3 years</p> <p>For more details contact <a href="https://www.brazelton.co.uk/courses/neonatal-behavioural-assessment-scale-nbas/">https://www.brazelton.co.uk/courses/neonatal-behavioural-assessment-scale-nbas/</a></p>	No – can only be used in first 2 months of life

### Psychometric Properties and References:

Not designed as a predictive assessment (e.g. of child's later intelligence) or as a comparator of norms (e.g. against other children) but as an exploration of the uniqueness of the child. Cronbach's alpha found to be 0.974 in Turkish validation study (Basdas et al., 2018). A 2018 Cochrane review found that the NBAS has only low-quality evidence of being able to support improvement in the parent-infant interaction.

1. Brazelton, T. Berry; Nugent, J. Kevin (2011). Neonatal behavioral assessment scale (4th ed.). London: Mac Keith Press. ISBN 978-1-907655-03-6.
2. Cochrane website. The effectiveness of the Neonatal Behavioural Assessment Scale (NBAS) and Neonatal Behavioural Observation (NBO) system for parents and babies [https://www.cochrane.org/CD011754/BEHAV\\_effectiveness-neonatal-behavioural-assessment-scale-nbas-and-neonatal-behavioural-observation-nbo](https://www.cochrane.org/CD011754/BEHAV_effectiveness-neonatal-behavioural-assessment-scale-nbas-and-neonatal-behavioural-observation-nbo)
3. Basdas et al. (2018) The Brazelton Neonatal Behavioral Assessment Scale: A validity and reliability study in a Turkish sample. [https://www.researchgate.net/publication/324897368\\_The\\_Brazelton\\_Neonatal\\_Behavioral\\_Assessment\\_Scale\\_A\\_validity\\_and\\_reliability\\_study\\_in\\_a\\_Turkish\\_sample](https://www.researchgate.net/publication/324897368_The_Brazelton_Neonatal_Behavioral_Assessment_Scale_A_validity_and_reliability_study_in_a_Turkish_sample)



## Measures Table F: infant's social, emotional and behavioural development

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
Infant and Toddler Social and Emotional Assessment Revised (ITSEA-R) and brief form (BITSEA)	Child's social and emotional development	Parent of child aged 12-35 months	Self-report	10-20 minutes	<p>36-item parent-completed form used when the infant has reached 12 months. Screens for social, emotional and behavioural problems and delays in overall competence</p> <p>There is also ITSEA which is the longer version</p> <p><b>Clinicians' insights</b> Easy to administer and analyse, Copyrighted and could be seen as expensive</p>	<p>Previously provided by Pearson Assessments but now thought to be provided by <a href="https://eprovide.mapi-trust.org/instruments/brief-infant-toddler-social-emotional-assessment">https://eprovide.mapi-trust.org/instruments/brief-infant-toddler-social-emotional-assessment</a></p>	<p>No specific training for this measure is required but it should be administered by a professionally qualified person</p> <p>Cost is thought to be in the region of \$230 for starter set plus \$2 per form</p>	

### Psychometric Properties and References:

1. Briggs-Gowan MJ, Carter AS. Preliminary acceptability and psychometrics of the infant-toddler social and emotional assessment (ITSEA): A new adult-report questionnaire. *Infant Mental Health J.* 1998 Winter ; 19 (4):422-445
2. Carter AS, Briggs-Gowan MJ, Jones SM, Little TD. The Infant-Toddler Social and Emotional Assessment (ITSEA): factor structure, reliability, and validity. *J Abnorm Child Psychol.* 2003 Oct;31(5):495-514
3. Briggs-Gowan MJ, Carter AS, Irwin JR, Wachtel K, Cicchetti DV. The Brief Infant-Toddler Social and Emotional Assessment: screening for social-emotional problems and delays in competence. *J Pediatr Psychol.* 2004 Mar;29(2):143-55 (Pubmed abstract).
4. Briggs-Gowan MJ, Carter AS, McCarthy K, Augustyn M, Caronna E, Clark R. Clinical validity of a brief measure of early childhood social-emotional/behavioral problems. *J Pediatr Psychol.* 2013 Jun;38(5):577-87 (Full-text article)



## Measures Table F: infant's social, emotional and behavioural development

Name of measure	Construct or domain	Participant	Self-report, interview or observational	Completion time	Brief description	Source of measure	Costs and UK training (2019)	Validated as outcome measure (pre- post-)?
Alarm Distress Baby Scale (ADBB)		Infant of 0-3 years	Practitioner interacts directly with baby	?	Recent video-based screening procedure. Assesses the infant's withdrawal behaviour on eight items that correspond with the interpersonal and non-interpersonal dimensions of withdrawal behaviour: facial expression, eye contact, general activity, self-stimulating gestures, vocalisations, response to stimulation, relationship to the observer, ability to attract attention, reaction to cuddling, and reaction to separation. It can be coded 'live' or via video coded assessments  Available in multiple different languages	Free from <a href="http://www.adbb.net/gb-conditions.html">www.adbb.net/gb-conditions.html</a>  Manual is free to download	Training videos are sent for the cost of postage, terms and conditions on the website	Not yet

**Psychometric Properties and References:**

Reliability and validity established by Lopes et al (2008). Construct validity was established regarding the age of the mothers, parity, age of the father, age of the infant, birth order, and duration of the consultation.

See <http://www.adbb.net/gb-echelle.html#> for further information

**NB:** The Bayley Scales of Infant Development – 3rd edition – known as the Bayley-III has a newly introduced social-emotional subscale which assesses the attainment of important age-related milestones, including the capacity to engage and use a range of emotions, experiences, and expressions, as well as to comprehend various emotional signals and to elaborate upon a range of feelings through the use of words and other symbols. The Bayley Scales are typically used to assess a child's full developmental range and can only be used by professionals registered with Pearson Assessment. For more information see the **Pearson Assessment website**.





## Chapter 9

# Bibliography

## Clinical Guidance

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1. NICE guideline [NG26] **Children's Attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care** November 2015
2. NICE Quality standard [QS128] **Early years promoting health and wellbeing** August 2016
3. NICE Quality standard [QS133] **Children's Attachment** October 2016
4. NICE Clinical guideline [CG192] **Antenatal and Postnatal Mental Health** April 2018
5. SIGN Clinical Guidance [SIGN 127] **Management of perinatal mood disorders** March 2012
6. SIGN Clinical Guidance [SIGN 156] **Children and young people exposed prenatally to alcohol** January 2019

## Policy Reports and Documents

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**Evidence Based Early Years Intervention. The Eleventh Report of the Session 2017-2019, House of Commons Science and Technology Committee (2019).** A review of evidence provided to the Science and Technology Committee. The government's response can also be found at <https://www.parliament.uk/business/committees/committees-a-z/commons-select/science-and-technology-committee/inquiries/parliament-2017/evidence-based-early-years-intervention-17-19/>

**First 1000 Days of Life. The Thirteenth Report of the Session 2017-2019, House of Commons Health and Social Care Select Committee (2019).** A review of evidence provided to the Health and Social Care Select Committee. The government's response can also be found at <https://www.parliament.uk/business/committees/committees-a-z/commons-select/health-and-social-care-committee/inquiries/parliament-2017/first-1000-days-life-inquiry-17-19/>

**Realising the Potential of Early Intervention, October 2018.** A Report from the Early Intervention Foundation. This report sets out a bold plan of action to ensure effective early intervention is available to the children, young people and families who need it most.

**Building Great Britons. Conception to Age 2: First 1001 Days All Party Parliamentary Group, February 2015.** A report and recommendations from the Perinatal Inquiry – Evidence Sessions on First 1001 Days.

**1001 Critical Days Manifesto. Conception to Age 2: First 1001 Days All Party Parliamentary Group, 2013.** A cross-party political manifesto highlighting the importance of acting early to enhance the outcomes for children.



**The Age of Opportunity – Conception to Age Two, March 2013.** A report from The Wave Trust containing recommendations to guide both national and local decision makers and commissioners in reducing the causes of disadvantage at the earliest and most effective point in life.

**Conception to Age Two – the economics of early years' investment, March 2013.** This report lays out the economic case for investment by looking at both international and UK-based studies on return on investment for early years' interventions.

**Early Intervention: Smart Investment, Massive Savings. The Second Independent Report to Her Majesty's Government. Graham Allen MP, July 2011.** A report outlining the evidence for investing in early intervention.

## Referenced text books

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**Research and Practice in Infant and Early Childhood Mental Health (2016).** Cory Shulman. Springer International Publishing.

**Transforming Infant Wellbeing: Research, Policy and Practice for the First 1001 Critical Days, 1st Edition (2018).** Penelope Leach. Routledge, London.

## Review Papers and Texts on Clinical Interventions

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**Foundations for Life: What works to support parent-child interaction in the early years? July 2016.** A report from the Early Intervention Foundation. An assessment of 75 early intervention programmes aimed at improving child outcomes through positive parent-child interactions in the early years.

**The Best Start at Home: What works to improve the quality of parent-child interactions from conception to age 5 years? A rapid review of interventions, March 2015.** A report from the Early Intervention Foundation presenting the results of a comprehensive investigation into the range of early intervention programmes in the UK for 0 to 5 year olds and their families.

## Training organisations

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**The Anna Freud National Centre for Children and Families** <https://www.annafreud.org/>  
International Training School for Infancy and Early Years (ITSIEY) provides mental health and early years professionals with expert-agreed standards of knowledge and skills to work confidently with infants (0-3) and their families.

**The Brazelton Centre** <https://www.brazelton.co.uk/>  
A network of training centres across the world making a difference to the lives of families through teaching the Newborn Assessment Scale (NBAS) and Newborn Observation (NBO).



**OXPIP** <https://www.oxpip.org.uk/>

Provision of a range of shorter- and longer-term courses and training in various parent-infant relationship interventions.

**NewPIP** <https://www.children-ne.org.uk/newpip-newcastle-infant-mental-health-course>

Provision of the Infant Mental Health and Early Intervention with Babies and Parents 10-week course for professionals.

**NHS Education Scotland**

[https://www.nes.scot.nhs.uk/media/3552795/final\\_imh\\_interactive\\_pdf\\_\\_3\\_.pdf](https://www.nes.scot.nhs.uk/media/3552795/final_imh_interactive_pdf__3_.pdf)

**The School of Infant Mental Health** <http://www.infantmentalhealth.com/school>

The School of Infant Mental Health delivers a range of training for professionals who work with infants and young children.

**The Tavistock and Portman NHS Foundation Trust**

<https://tavistockandportman.nhs.uk/training/cpd/working-children-young-people-and-families/>

**Warwick University – Warwick Infant and Family Wellbeing Unit**

<https://warwick.ac.uk/fac/sci/med/about/centres/wifwu/training/>

The **Infant Mental Health On Line (IMHOL)** course is delivered through the University of Warwick.

## Professional bodies

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### Regulatory bodies

**Health and Care Professions Council (HCPC)** <https://www.hcpc-uk.org/>

The HCPC regulate health, psychological and, until 2 December 2019, social work professions.

**Social Work England (SWE)** <https://socialworkengland.org.uk/>

Social Work England will regulate social workers from 2 December 2019.

**Association of Child Psychotherapists (ACP)** <https://childpsychotherapy.org.uk/>

The professional body and regulator for Psychoanalytic Child and Adolescent Psychotherapists in the UK.

**UK Council for Psychotherapy (UKCP)** <https://www.psychotherapy.org.uk/>

An organisation for the education, training, accreditation and regulation of psychotherapists and psychotherapeutic counsellors in the UK.

### Membership organisations

**The UK Association of Infant Mental Health (AIMH UK)** <http://www.aimh.org.uk>

A membership organisation for any professional working in or interested in the field of infant mental health.

**British Association of Social Workers (BASW)** <https://www.basw.co.uk/>

Acts as both a professional membership association and union for social workers.

**The Institute of Health Visiting (IHV) <https://ihv.org.uk/>**

Membership of the IHV is open to anyone working in the area of health visiting.

**British Association of Counselling and Psychotherapy (BACP) <https://www.bacp.co.uk/>**

Professional association for members of the counselling professions in the UK.

**British Psychological Society (BPS) <https://www.bps.org.uk/>**

The representative body for psychology and psychologists in the UK responsible for the promotion of excellence and ethical practice in the science, education, and application of the discipline.

**Royal College of Psychiatrists (RCPsych) <https://www.rcpsych.ac.uk/>**

The professional and educational body for psychiatrists throughout their careers.

**Royal College of Occupational Therapists <https://www.rcot.co.uk/>**

The professional association for occupational therapists.

## UK charitable/Not-for-profit organisations

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**The Parent-Infant Foundation <https://parentinfantfoundation.org.uk>**

The UK charity supporting the development, growth and quality of specialised parent-infant relationship teams.

## Overseas/International organisations

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**Brazelton Touch Points Center, Boston University. <https://www.brazeltontouchpoints.org/>**

The Center develops and applies knowledge of early childhood development to practice and policy through professional and organizational development, evaluation, advocacy and awareness and serving as a resource for proven practices.

**Center on the Developing Child, Harvard University. <https://developingchild.harvard.edu>**

A highly-regarded international centre of excellence committed to driving science-based innovation in policy and practice, which produces high quality summary reports of relevant early years research.

**Heckman. The Economics of Human Potential. <https://heckmanequation.org>**

A website relating to the research by Nobel laureate economist Professor James Heckman demonstrating return on investment of early years programmes.

**Infant Mental Health Promotion <http://www.imhpromotion.ca>**

The Canadian membership organisation for infant mental health professionals.

**World Association of Infant Mental Health (WAIMH) <https://www.waimh.org>**

The worldwide membership organisation for professionals working and studying in the field of infant mental health.

**Zero to Three <https://www.zerotothree.org>**

An American membership organisation working to ensure that babies and toddlers benefit from the early connections that are critical to their wellbeing and development.





**Parent-Infant**  
FOUNDATION

[www.parentinfantfoundation.org.uk](http://www.parentinfantfoundation.org.uk)



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