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Final report

Evaluation of Together with Baby service

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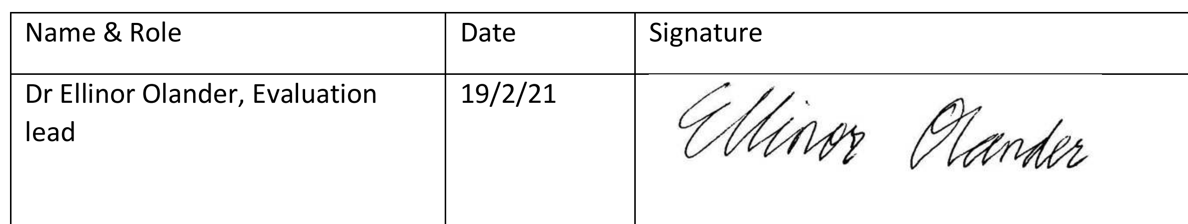

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Executive summary

The Together with Baby service started in May 2019 and is available in Essex, Southend and Thurrock. The service targets the parent-infant relationship and is as such a highly specialist service often supporting families with several risk factors. Targeting the relationship between baby and parent aims to enhance the mental and physical health of the baby as well as its future development. In addition to working with families, Together with Baby provides support and advice to other healthcare professionals working with families and provides training opportunities focused on the parent-infant relationship for the wider maternity and early years workforce.

Between September 2019 and December 2020, a process evaluation of the implementation of the Together with Baby service was conducted by researchers at City, University of London. Process evaluations focus on the barriers and facilitators influencing service implementation. This evaluation is based on 27 interviews with 20 individuals including the Together with Baby service team (interviewed twice), those referring to the service, service commissioners and Parent-Infant Foundation staff (interviewed twice). It is also based on the evaluation of the training the team has delivered to over 100 individuals and data on the referrals and families engaging with the service (172 adults and 144 children) to date. Many of these families enter the service with complex needs, and a relatively high proportion reported that their children were experiencing social and emotional developmental delay that needed monitoring or further intervention.

The overall finding of this process evaluation is that the **Together with Baby service has been implemented very successfully** alongside already existing perinatal mental health and maternity and early years services. There was a consensus among referrers that the service is highly valued, and succeeds in filling a gap in service provision. The two main contributing factors to its successful implementation have been the highly specialist team with their expertise and strong leadership and the effective partnership working between commissioners, service lead and Parent-Infant Foundation.

Early signs indicate that the **service is succeeding in raising awareness** of infant mental health among service providers and commissioners across Essex, as shown by the referrals received, training evaluation and the feedback on the impact of the team's consultations with practitioners. Commissioning on this geographic scale places many demands on a team, and its success is in no small part due to the enormous effort, commitment and skills of the team.

Additional findings have been summarised as factors supporting or hindering service implementation.

The main factors supporting the implementation of the service included

- A **high calibre, experienced team** with diverse set of skills and expertise who demonstrate a deep commitment to parent-infant work, supported by strong leadership.
- **Investment in team training** and good supervision is important, as is the team having opportunities to train together. This built up team skills and flexibility, alongside enabling a common therapeutic approach to the service offer.
- **Good collaboration, communication and support** between all key stakeholders including commissioning, clinical team and the Parent-Infant Foundation and support from other parent-infant teams.

- Team members **using existing networks to raise awareness of service** and develop knowledge of local services and professional networks.
- **Raising awareness through online training**.
- **Building referrals incrementally** helped avoid overstretching the service in its initial implementation phase.
- RAG-rating cases enabled **prioritisation of clients** that informed the timing and intensity of input to better meet families' needs, as well as enabling the management of cases within the team in order to avoid individual team members being overloaded with very complex cases.
- IT systems were developed to allow for **remote working following the pandemic outbreak**. This enabled easier access to families located more remotely using video calling, and to wide-spread professional networks, and the ability to offer online training to professionals, thereby reaching a larger audience.

The main factors hindering the implementation of the service

- The **large geographical spread** of the service meant that building awareness of and providing the service had to proceed gradually due to the large volume of services and professionals the team had to build relationships with.
- The **lack of dedicated clinical bases** to work from across the county meant that team members had to seek rooms within other services and agencies, and room availability could not be guaranteed.
- The large amount of travel time taken to reach families and professionals across widely dispersed localities can be an **inefficient use of team member's time**.
- **Organisational change in** closely related services such as health visiting can prevent effective referral.
- **Poor knowledge of team's remit** or professional composition potentially impacts referral rates, appropriateness of referrals, and quality of referral information provided.
- **COVID-19 pandemic** restricted providing service face-to-face and limited referrers' ability to identify families who might have benefited from contact with the service.
- **Identifying appropriate measures for capturing parent-infant work outcomes remains difficult,** delaying the generation of evidence of the impact of the service.

Regarding the **sustainability of the service**, it is important to consider increasing the capacity of the team. Whilst maintaining awareness with referrers is important, providing further workforce training is time-consuming and must be balanced with supporting families. Evidencing impact through using appropriate measures, service satisfaction surveys, records of consultations with other healthcare professionals also needs to be a priority going forward.

1. Introduction

A substantial evidence base clearly demonstrates the importance of a child feeling safe, secure and protected by their primary caregiver. This can be termed secure attachment, and is predictive of many social and emotional outcomes throughout the life course. Strong evidence suggests that children who do not experience an early secure attachment are more likely to experience poorer developmental outcomes. Depending on the type of suboptimal attachment (disorganized, avoidant, or ambivalent) such outcomes for children include vulnerability to stress, problems regulating emotions, internalizing and externalizing problems, poor peer interactions, and lower confidence and self-esteem which can in turn lead to lower academic attainment (Benoit, 2004). In adolescence, outcomes include higher levels of overall psychopathology, impaired social competence and academic skills (Benoit, 2004; Fraley, Roisman, & Haltigan, 2013). In addition, the long-term consequences of attachment difficulties and associated physical and mental health problems are thought to place a considerable economic burden on the public purse through increased costs to education, healthcare, social care, and the criminal justice system (Bachmann et al., 2019; National Collaborating Centre for Mental Health (UK), 2015).

The early interactions between the parent and the infant are essential to developing a secure attachment. The caregiver's understanding and responding, both appropriately and promptly, to the infant's cues (sensitive caregiving) is predictive of attachment security as well as other social, emotional, biological and cognitive outcomes (Bailey et al., 2017).

1.1 The Together with Baby service

The Together with Baby service started in May 2019 and is available in Essex, Southend and Thurrock. This area is served by 7 Clinical Commissioning Groups and local authority of Essex County Council and unitary authorities of Thurrock and Southend. The target population for the service are families where there are concerns about the parent-infant relationship from conception to age 2 years. It is a highly specialist service often supporting families with complex and/or a high level of need. Targeting the relationship between baby and parent will enhance the mental and physical health of the baby as well as its future development and can be done either antenatally or postnatally.

In addition to working with families, Together with Baby provides support and advice through consultations with other healthcare professionals working with families, and provides training opportunities focusing on the parent-infant relationship for the maternity and early years workforce.

1.2 Evaluation of the Together with Baby service

The Centre for Maternal and Child Health Research at City, University of London was awarded the evaluation of Together with Baby in August 2019. This work is led by Dr Ellinor Olander and was conducted together with Dr Patricia Moran, Dr Rose Coates and Professor Susan Ayers.

The primary evaluation question was *What factors helped and hindered the implementation of the Together with Baby service?* To answer this question, a process evaluation was conducted, guided by the Medical Research Council's process evaluation framework (Moore et al., 2015). The key questions the process evaluation sets out to answer are:

- What is implemented, and how?
- How does the delivered intervention produce change?
- How does context affect implementation and outcomes?

The evaluation's secondary aim was to identify service outcomes. This included analysing the data the service regularly collects and asking interviewees their views on the outcomes of the service.

A few small changes were made to the evaluation protocol due to COVID-19 and these were outlined in the interim report (March 2020). Separate to this report is a meta-review finalised in August 2020 identifying observational measures of the parent-child relationship and attachment. Families who have taken part in the service will be interviewed in January 2021 and this will be reported separately (February 2021).

2. Methods

2.1 Process evaluation

The process evaluation findings came from three strands of data;

1. Interviews with key stakeholders
2. Evaluation of the workforce training
3. Service referrals data

2.1.1 Interviews with stakeholder groups

In total, 27 interviews were conducted with 20 participants. The same participants (bar one) from the clinical team and Parent-Infant Foundation were interviewed twice to capture the service implementation journey. Table 1 summarises the interviews conducted. Interviews were either conducted face-to-face or over the phone/Microsoft Teams. The Parent-Infant Foundation team and clinical team were recruited directly by the evaluation team after being provided email addresses. Commissioners and service referrers were recruited via the Parent-Infant Foundation who sent out an initial email to ask for consent to share contact details with the evaluation team. Those who consented to this were then contacted by the evaluation team. The nine referrers who took part were based within different services and locations and had the following professional roles: health visitor (3), perinatal mental health nurse (1), adult mental health nurse (1), occupational therapist (1), social worker (1), Family Nurse Partnership worker (1), and CEO of a voluntary sector organisation (1). The three commissioners also worked in different parts across the Together with Baby service area.

Participant group	Number of participants	Date of interviews
Clinical team providing service	4 time 1 4 time 2	June 2020 (time 1) repeated Oct 2020 (time 2)
Referrers to service	9	July – Oct 2020
Service commissioners	3	July – Sept 2020
Parent-Infant Foundation team	4 time 1 3 time 2	Nov-Dec 2019 (time 1) repeated Oct-Nov 2020 (time 2)

Table 1. Description of participants interviewed and when.

Ahead of the interviews, participants provided verbal or written consent to take part in the evaluation. All interviews[1] were transcribed by a professional transcription service, and were analysed thematically using the steps outlined by Braun and Clarke (2006). Ethical approval was received from the Research Ethics Committee in the School of Health Sciences at City, University of London. Additional approval was received from the Essex Partnership University NHS Foundation Trust (EPUT) Research and Development department to interview the clinical team. Findings from these interviews can be found throughout section 3.

2.1.2 Evaluation of the workforce training

Two events were held to raise awareness of infant mental health and the Together with Baby service. First a stand-alone off webinar in June and then an eight-session training course from September to November 2020. Both events were evaluated by the Parent-Infant Foundation via surveys, and subsequently findings were anonymised and shared with the evaluation team. Questions focused on knowledge of infant mental health and Together with Baby service, referrals and training delivery. A summary of these findings can be found in section 3.4.2.

2.1.3 Data on service referrals

Anonymised service referral data for 172 adults and 144 children were provided by the Together with Baby service provider EPUT. Data were provided from 1st May 2019 to 31st October 2020. Data included the referral date, source of referral, reason for referral, current status of referral and registered CCG. A summary of referral data is reported in sections 3.1.3 and 3.4.2. Demographics of those entering the service were also provided (ethnicity, relationship status, gender and age of adults, ethnicity and age of children). No information was provided regarding service response times, so could not be compared to what is detailed in the service specification. A summary of the source and geographical spread of referrals is reported in section 3.3.1.

2.2 Outcome evaluation

Together with Baby collects data on parental mental health (Hospital Anxiety and Depression Scale), risk factors (Wave Trust, 2013), the mother-infant relationship (Mothers' Object Relations Scale), and child development (Ages and Stages Questionnaire) at entry to the service. Mental health and parent-infant relationship data are also collected at the end of treatment for some families. Two fathers completed this data, the remaining data comes from mothers.

Anonymised quantitative outcome measures data were provided by Together with Baby and by EPUT (all other data). As is usual in health services research, some outcome data were missing. Collaboration with EPUT allowed for some of the missing data to be provided. Frequency analysis is provided for all data. This data can be found in section 3.4.1.

[1] One interviewee did not want their interview recorded, so notes were taken instead and included in the analysis.

3. Findings

Findings from the interviews and quantitative data collection are presented below. Quotes are provided verbatim, with the role of the interviewee and their participant number provided, to retain anonymity.

3.1 What is the Together with Baby service and how has it been implemented?

3.1.1 The Together with Baby service

The Together with Baby service was set up to provide specialist therapeutic services focused on supporting the emotional and mental health needs of the baby and the relationship between the baby and parent(s) where there are concerns about attachment or bonding. The team carry out this work by providing:

- therapeutic interventions to families antenatally and postnatally up to the child's second birthday
- advice and consultation services for practitioners working with babies and their carers where concerns have been identified
- awareness raising of the parent-infant relationship for the wider children's workforce

The service is part of Essex Partnership University NHS Foundation Trust, and is a pan Essex service, with each member of the team assigned an area to work within. Currently there is one practitioner covering each of North East Essex, South Essex and Mid Essex respectively and two practitioners covering West Essex. The Trust has provided key support at various stages of implementation such as during procurement, and with provision of IT services. However, operating from an NHS context has not been without some challenges for the service:

> *… we have a lot of extraneous demands on us being within a Trust which can be time consuming and yeah maybe we're not as nimble on our feet perhaps because everything takes so long to clear.* (Team member 2)

An additional contextual challenge is that the service lacks a dedicated operational base within easy reach of all of the clinical locations it serves. This initially meant spending time developing co-location working with other services in centres such as family hubs, although the COVID-19 pandemic curtailed this. It has also involved considerable time spent traveling to family homes for provision of direct intervention work:

> *It might be a very long way to travel and take me a whole day. So it does sort of limit my capacity to do face-to-face work.* (Team member 4)

Team

The service is delivered by a multidisciplinary team comprised of a lead clinical psychologist and five parent-infant therapists whose professional backgrounds include psychoanalytic psychotherapy, art therapy, health visiting, and CAMHS mental health nursing. As such, each member brings their own expertise and professional network. Two practitioners work full-time, and the remainder work part-

time for the service, including the clinical lead who is also the psychology lead for the perinatal mental health service. The team is supported by an administrator, and for time-limited periods only, the team has had support from three trainee/assistant psychologists. For the duration of the evaluation, the team were also supported by a part-time Implementation Support Manager from the Parent-Infant Foundation.

The high calibre of the team and their specialist skillset were fully acknowledged by interviewees:

> *And what I've noticed in my interactions with the team is how much knowledge they have between them. They have got quite diverse backgrounds themselves.* (Parent-Infant Foundation 3)

> *I think it's a very specific, specialist set of skills they have, so that's a definite strength.* (Referrer 5)

The team's diversity of professional backgrounds was seen as a strength in terms of the wealth of experience and the flexibility of approach it offered. At the same time there was the potential for regional variation in the service depending on which practitioner was overseeing work in a particular region. This possibility was mitigated by the team undertaking training together to build a common skillset. The team highly valued the shared training they received as it allowed for development of team cohesion and a coherent service offer:

> *We all come to this work with our own kind of underpinning theoretical knowledge and understanding. […] We are trying to sort of build a shared language of intervention that we bring our own kind of understanding to that intervention. But, there is a sort of core set of principles that we are all striving towards having at the root of our practice.* (Team member 4)

The leadership of the team was assessed as strong and supportive by interviewees. Team members felt united by this support, and by their shared passion for parent-infant work and support of each other:

> *I think we are all incredibly passionate about the work, and I think we all want it to continue. And I think we are quite supportive of each other too, so I think that is really helpful in being about kind of have that backing of the team.[…] And I think (team leader) has been really helpful […] very supportive.* (Team member 1)

The team continues to develop its skillset by undertaking training in additional models such as the CARE Index and Compassion Focused Therapy, as well as reflective supervision. The result is a dynamic team, continually building skills and expertise, and able to offer an increasing range of interventions:

> *It just feels like it's ongoing, we're continuing to develop, and will continue to develop, we're on a kind of trajectory of development.* (Team member 4)

3.1.2 The need for the service

There was a consensus among interviewees that the service was both needed and valued. They affirmed that there was a '*definite role for this service'* (Referrer 2), and saw it as '*useful*' (Referrer 6)

and '*absolutely invaluable'* (Referrer 3). Prior to its introduction, interviewees agreed that there was 'a *huge gap'* (Referrer 1) in service provision, with little focus on the infant:

> *I don't think the infant, as a focus, would have been picked up, I think the parent, or the care-giver, probably would have come into adult services, with whatever struggles they were having, and their difficulties may have been addressed. But I'm sad to say, that probably that parent-child interaction and any of the problems that the baby is going to face due to that, has probably not been considered before now.* (Commissioner 2)

The gap in provision that the service fills was seen as critical for early prevention of longer-term difficulties for children:

> *They're trying to help families get back on a healthy development trajectory, and away from increased risk of a whole bunch of poor outcomes, education outcomes, mental health, physical health, all kinds of things. So, if this service didn't exist, what you'd end up with is children who need that specialist intervention not receiving it, and then they get to three, there isn't a service to pick them up there. So, they go to school, sometimes their mental health difficulties present as education or behavioural difficulties in school; very often those children still don't get picked up. Then be referred into social services, and eventually somebody will think, maybe this is to do with the relationship with the parents.* (Parent-Infant Foundation 4)

This gap in provision was seen to arise in part as a result of the perinatal service's age cut-off for working with children (at age 12 months), and CAMHS provision not adequately serving very young children with attachment and mental health needs:

> *Well, as I say, perinatal, there is a cut-off point anyhow, so the children that are above that age, they're, you know, it felt like there wasn't a great deal […]*(Referrer 5)
>
> *There's a whole cohort of children that just don't get serviced at all, if they don't get picked up when they're very little. I mean, that's a comment about the state of CAMHS as much as anything, and again it's not a criticism, but CAMHS don't provide the kind of service that these children need if they get missed before they're two.* (Parent-Infant Foundation 4)

Health visitors also recognised that while Together with Baby complimented some of their work, the service offered a more specialist, intensive focus:

> *It's what we do with MECSH (Maternal and Early Childhood Sustained Home Visiting Programme) but actually your [Together with Baby] service seems more detailed and ever since I've had the service, the service is far more valuable because they've far more time than we have.* (Referrer 9)

Similar reasons for valuing the service were echoed by referrers from the voluntary sector:

> *If we felt a bonding issue was becoming out of our depth, you know, we would then be phoning the Together with Baby service and saying, "We think this mum or dad might need additional support.* (Referrer 3)

In short, interviewees see the Together with Baby team as offering a distinctive and vital service that fills a gap in provision, and potentially impacting short-term and much longer-term outcomes for children. It complements the work of other professionals, while providing a specialist mental health service without which families' needs would not be adequately met.

3.1.3 Families using the Together with Baby service

Between 14th May 2019 and 31st October 2020, the service received referrals for 172 adults with 144 children. As of 31st October 2020, a total of 87 parents were either receiving care (n = 50) or had completed treatment (n = 37). The status of parents referred to the service can be seen in Figure 1.

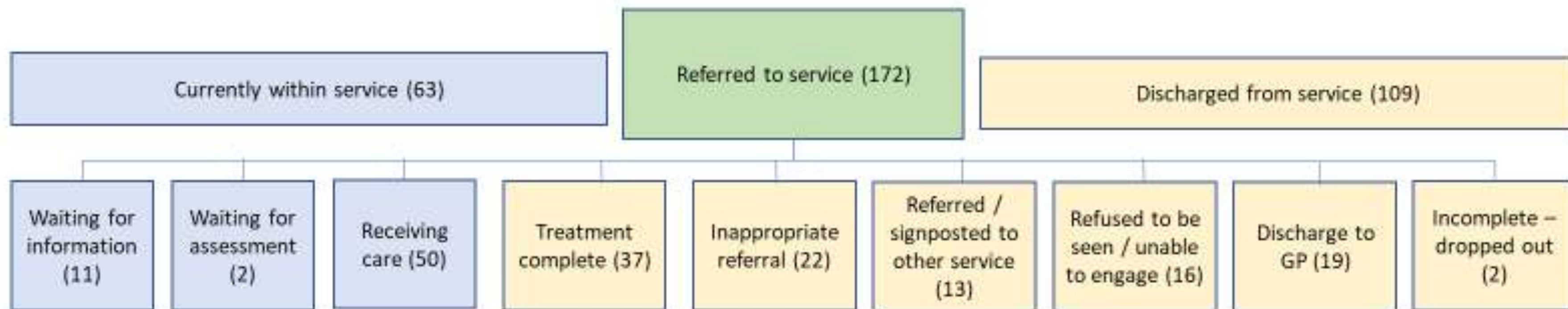

Figure 1. Status of referrals to Together with Baby at 31st October 2020.

Family demographic profiles

Family demographic information indicates that to date, the parents who have been referred to the service were largely female (95%), aged from 16 to over 40 with the largest age group being 30 – 34 years old (29%), of unknown (49%) or single (31%) relationship status, and White (73.9%). For comparison purposes in table 2 we have included census data for Essex indicating the ethnic makeup of the county. This is derived from the 2011 census, as more recent data are not available. Children ranged from 0-3 weeks through to 22 months of age, with the largest group being 3-5 months old (n=36). A substantial number were referred before birth (n = 25).

		Adult n (%)	**Child n (%)**			**2011 census n (%)**
Ethnicity						
	White (any)	127 (73.9)	122 (84.7)			1,313,856 (94.4)
	Mixed	1 (0.6)	9 (6.2)			20,885 (1.5)
	Asian or Asian British	9 (5.2)	6 (4.2)			34,860 (2.5)
	Black or Black British	0	1 (0.7)			18,709 (1.3)
	Any other ethnic group	10 (5.8)	3 (2.1)			5,277 (0.3)
	Not stated	25 (14.5)	3 (2.1)			
	Total	172 (100)	144 (100)			1,393,587 (100)
Relationship status						
	Cohabiting	8 (4.7)				
	Married	25 (14.5)				
	Single	54 (31.4)				
	Unknown	85 (49.4)				
		172 (100)				
Age	16-19	6 (3.5)	Antenatal		25 (15.3)	
	20-24	37 (21.5)	0-3	weeks	16 (9.8)	
	25-29	36 (20.9)	1-2.5	months	24 (14.7)	
	30-34	50 (29.1)	3-5	months	36 (22.1)	
	35-39	32 (18.6)	6-8	months	13 (8.0)	
	40+	11 (6.4)	9-11	months	26 (16.0)	
			12-17	months	12 (7.4)	
			18+	months	11 (6.7)	
	Total	172 (100)			163* (100)	

*The total number of children is larger here than in all other reported data due the child age data report being run at a later date.

Table 2. Demographic characteristics of people referred to Together with Baby 01 May 2019-31 October 2020

Assessment of families

Families referred to the service undergo an assessment based on information collected from a variety of sources. These include information from the referrer and other key agencies involved with the family, information from assessment tools such as the Age and Stages Questionnaire (ASQ) and the risks and stresses checklist (Wave Trust, 2013) made available through Parent-Infant Foundation, as well as information collected through conversation with and observation of the family. Data regarding risk factors and child development indicate that the service is working with relatively high-risk families, as described in more detail below.

Risk factors

Assessment of risk involves consideration of 47 possible risk factors as set out in a checklist developed by the Gloucestershire Infant Mental Health Team (Wave Trust, 2013). Risks are categorised as: potential biological vulnerability in the infant e.g. mother smoked heavily during pregnancy or infant feeding difficulties; parental social and emotional difficulties e.g. a previous child has behaviour problems or own mother was mentally ill; interactional factors e.g. consistent lack of eye-to-eye contact or physical neglect; and socio-demographic factors including chronic unemployment or lack of supportive relationships. Parent-Infant Foundation considers that four to six risk factors are significant, but combinations of a smaller number of risk factors can warrant attention (Bateson, Lang, Hogg, & Clear, 2019).

Risk factor data were available for 56 adults who had between 0 and 45 risk factors each. The mean number of risk factors was 4.9, and the median number of risk factors was 3. Other parent-infant teams typically report families experiencing 4-5 risks/adversities on average, with 29% or more of families reporting 7 or more factors. The Together with Baby data falls within this range, suggesting that the team are working with families similar to other parent-infant teams around the UK, that is to say families experiencing multiple and complex adversities. Data were not available for 116 adults. This level of missing data reflects the team's initial adaptation to the routine practice of recording risk data, as well as the adjustments to the IT system that were required in order to capture the data.

Eleven of the 47 risk factors are high risk factors – each one is a serious condition whose presence alone can indicate that attention is needed. Examples are an absent parent or stepparent in the family, very low birthweight, and substance abuse during pregnancy. Data available for the same 56 adults indicated a mean of 2.2 high risk factors and median 2 high risk factors per adult.

Children's development

The social and emotional development of infants and children is assessed at entry to the service using the Ages and Stages Questionnaire (ASQ:SE-2). The version of the questionnaire used is dependent on the age of the child. Data were available from three versions: 6 months, 12 months and 18 months. In total, ASQ data were available for 32 children at 35 time points (the ASQ was completed for 3 children more than once). Twenty seven of these children had an intervention from the service. Scores indicated that social and emotional development needed monitoring or further intervention from a professional in eight (6 months), six (12 months) and four (18 months) children. In total 51% of children needed monitoring or further intervention for their social and emotional

development. This is much higher than the typical population prevalence of development delay in personal-social skills as assessed by the ASQ-3 at 2-2.5 years which is usually less than 10% (Public Health England, 2020). It is unclear whether this over-representation of self-reported developmental delay in social and emotional skills is (a) a real phenomenon in that parent-infant relationship are more likely in developmental delayed children or that parent-infant relationship problems cause developmental delay, or (b) are a perceived phenomenon because the parents are having trouble reading the child, (c) a combination of any of these factors, or (d) a function of different measurement tools. What it does show is that the Together with Baby service works with some very vulnerable children, and we would need more quantitative data to draw firm conclusions.

Mental health and parent-infant relationship data are also collected for some families at entry to the service and once treatment has been completed. These data are reported in section 3.4.1.

Summary box 1. What is the Together with Baby service and how has it been implemented?

- Together with Baby provides specialist therapy to support the emotional and mental health needs of infants and the relationship between the infant and parent where there are concerns about bonding and attachment.
- The service also supports other professionals through consultations and raise awareness through meetings and online training.
- The service is made up of a multidisciplinary team working across Essex with high-risk families referred from outside agencies such as health visiting and perinatal mental health teams.
- The service fills a gap in provision as no other service focuses on the parent-infant relationship or on very young infants' or children' mental health needs.

3.2 How does Together with Baby produce change?

The service aims to produce change at the individual level through its clinical work with families, and at the system level through its provision of consultations and training for other professionals working with families. Details of how the service produces these types of change are described below.

3.2.1 Working with families (Individual-level change)

Therapeutic interventions

The service offers a range of clinical intervention approaches, enabling the team to provide a tailored package of care to each family. Families are usually seen weekly, and are offered therapeutic sessions either individually and/or within a group. The number of therapeutic sessions provided is tailored to the families' needs. Each of the direct intervention approaches used by the team is based on principles drawn from psychological theory, grounded in research, and is consistent with recommendations in various National Institute for Health and Clinical Excellence (NICE) guidance documents. The team's core toolkit of approaches includes:

- Parent-infant psychotherapy – based in psychoanalytic and attachment theory, it addresses past and/or present influences on the parent's relationship with their child.
- Wait, Watch and Wonder - involving parents following their baby's lead during play, and exploring the feelings and thoughts this evoked for them.
- Video Interaction Guidance (VIG) – involving use of video feedback to support the parent in reflecting on parent-infant interaction and responding sensitively to their child's communication.
- Circle of Security – another video feedback intervention aimed at enhancing parental reflection on their child's needs and their own responsiveness.

The complexities of assessing the outcomes of the team's intervention work with families is discussed in section 3.4.1 Change among families.

Challenges to engaging families in therapeutic interventions

Parental non-engagement with services was identified by interviewees as a primary challenge to working with families. When contacted by the service following a referral, some parents do not respond to calls, or else report that they do not have any problems in their relationship with their child. This difficulty was acknowledged by referrers:

> *It's not that often that we come across ones with the 'lack of attachment' that are definitely willing to work. We get lots that are 'lack of attachment' but there's no way they're going to agree to it (referral) any more than they'll agree to our MECSH's*. (Referrer 9)

To facilitate parental uptake of the service, referrers recognised the need to introduce the idea of referral to Together with Baby in a sensitive way with parents:

> *I think you have to be careful going in, particularly some patients that maybe have had bad experiences with social services in the past. Some of my patients, although they haven't had bad experiences with social services with them and their own child, they have, when they were a child in need, you know. So, you've got to be very aware that when you mention someone's child when you are there for what they perceive to be their (own) mental health needs, alarm bells often ring.* (Referrer 5)

Parental non-engagement also resulted from the team's enforced move to online working since the start of the COVID pandemic. Some parents refused the service because their preference was for face-to-face meetings, while others did not have sufficiently powerful enough Wi-Fi to manage online sessions.

3.2.2 Working with professionals (System-level change)

The service works with other professionals involved in family services to raise awareness of and facilitate understanding of parent-infant attachment issues. It does this through provision of consultations with practitioners and through provision of training, described below.

Consultations

The team provides advice and consultation services for practitioners working with babies and their carers where concerns have been identified. The specific aims of offering such consultation services

are multiple: to increase awareness of the Together with Baby service; to enhance the number of referrals, and enhance the quality of information provided by referrers; to forge professional relationships in order to build a system of professionals working around the family; and to develop the practice of other professionals working with families in relation to parent-infant bonding and infant mental health. Team members framed this work as:

> *…empowering professionals to sort of think about the parent -infant relationship, in quite sort of radical ways compared to the way that is has been thought about over some years. So really about, it is about transforming the way we think about, and deliver the infant parent services across the region.* (Team member 4)

Such consultations can take the form of one-to-one conversations with another professional, or reflexive practice meetings and casework discussions with other teams about the families they work with. The Together with Baby team member can help other professionals to hold the needs of the baby in mind as part of the overall picture of family needs, and inform care planning. This can happen without the need for a formal referral to the service.

Awareness raising and training

The team also raises awareness of the importance of the parent-infant relationship, infant mental health and their service to the wider early years, maternity, mental health and social care workforce. The aim of this awareness raising is to increase knowledge of parent-infant relationship, but also to advertise the service and clarify the referral criteria. It was seen as a key part of the service by service commissioners:

> *So, I know that they're developing a training package aligned with competency levels and things and I think that's great. I think that kind of approach is what, yeah, I really like to see. /…/ we will be able to quantify it in terms of numbers eventually because we'll be having the numbers of people and professionals going through the training, getting feedback from them, how that's impacted on their service delivery and then, you start seeing the benefit of the service at scale once it happens.* (Commissioner 1)

Online training with the aim of increasing awareness of the service and infant mental health was delivered twice; a single webinar in June to coincide with Infant Mental Health Awareness week and in September-November 2020. In June, a one-hour webinar was delivered collaboratively by a service commissioner, Together with Baby service clinical lead, and Parent-Infant Foundation.

The autumn training was made up of 6 sessions, each 90 minutes long. These webinars were developed for early years practitioners to understand what infant mental health is and the importance of it. The content was developed to meet the Association for Infant Mental Health (AIMH) Level 1 Competencies Framework and delivered by the Together with Baby service team (with support from Parent-Infant Foundation in session 1). Each session had a lecture-style presentation, interspersed with videos and opportunity for questions and clarifications. Additional sign-up was needed for two 90-minute case discussions where smaller groups met with one member of the Together with Baby service team to discuss cases and reflect on their learning.

Summary box 2. How has the Together with Baby service produced change?

- The team employs a range of clinical interventions tailored to the individual family and consistent with theory, research evidence and clinical guidelines.
- Selection and use of appropriate outcome measures to measure change is challenging and is an ongoing task.
- The team produces system-level change through consultations with practitioners working with families.
- One webinar and one online multi-session training course to increase awareness and knowledge of infant mental health and of the service were delivered to professionals working or supporting families.

3.3 How has the local and national context affected service implementation and its outcomes?

A number of local issues were identified that influenced the implementation of the Together with Baby service. These included variation in service referrals, geographical spread of the service and partnership working. A national factor that influenced all health and social care services in 2020 was the COVID-19 pandemic. All of this is discussed below.

3.3.1 Referrals to the service

The most common reason for referral was parents experiencing bonding difficulties with their children (74% of referrals, 128 parents). Twenty-two parents (12.8%) were referred for assessment by a parent-infant relationship specialist to understand what difficulties may be occurring, and 11 parents (6.4%) were referred because of perceived attachment difficulties from the infant to the parent.

Referral rates by source and region

There were variations in the source of the 172 referrals, by referral source and across localities, and potential reasons for this were explored with interviewees. Turning first to the source of referrals, it can be seen from figure 2 that most referrals to the service came from the perinatal mental health service (n = 64) and health visiting (n = 61). Smaller numbers of referrals came from other mental health services (n = 18) and social services (n = 10). Five referrals or fewer came from maternity and children's services, other voluntary agencies, Mother and Baby Units and Child and Adolescent Mental Health Services (CAMHS). Five parents self-referred to the service.

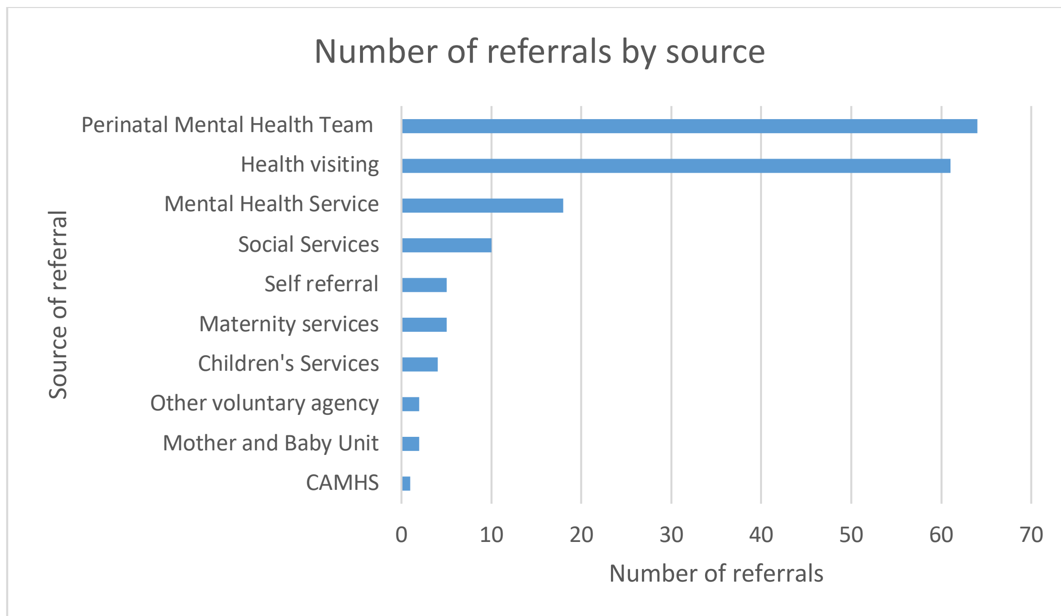

Figure 2. Source of referrals

Referrals also varied in terms of region. Service data indicate that the combination of CCGs in the South region received the largest number of referrals (n = 54). The second largest number of referrals came from Mid Essex CCG (n = 52), followed by West Essex CCG (n = 39). A smaller number came from North East Essex CCG (n =21), and five were from CCGs outside Essex. One CCG was unknown.

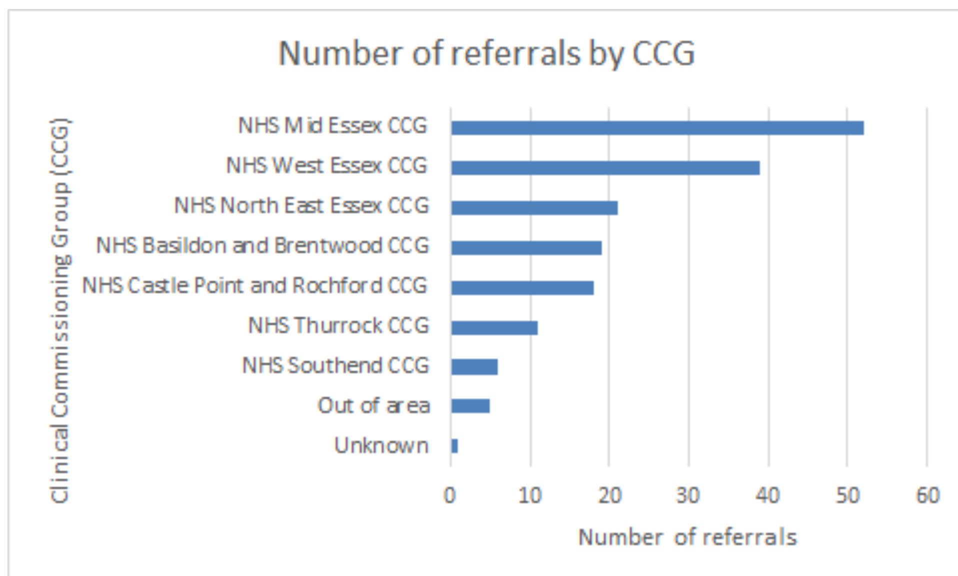

Figure 3. Number of referrals by CCG

Reasons for referral variation

A combination of factors was thought to be contributing to these variations in referral rates by source and region. For example, the high number of referrals from the perinatal mental health service were attributed to their training on parent-infant relationships and outcome measures used. Health visiting services was the second largest referrer. Within this service, variation was due to

already strong links with health visiting in some areas, however in other areas changes to the management of health visiting services, accompanied by restructuring of health visiting roles, loss of experienced health visiting staff, and staff shortage influenced referrals:

> *A lot of experienced health visitors left, and there has been a shortage of health visitors in some of those areas. […] So they really go out to do a new birth visit and that is it. A lot of the other contacts are done by phone or by non-health visiting colleagues. […] and I am not quite sure whether there is a lack of understanding or because there aren't heath visitors going out to identify the problems, or a lack of awareness of what infant mental health is and where that fits in. […] I think because mums don't have regular contact with one health visitor, they are very unlikely to disclose to a person that they don't know very well that they are having difficulties with their baby.* (Team member 3)

Other factors contributing to variations in referral rates related to there being different providers within each locality of Essex. This meant that '*If you speak to somebody in the South of Essex, the word isn't going to spread through to the Northeast'* (Parent-Infant Foundation 3), and work had to be done locally in each area. The team's greater familiarity with some localities facilitated this, however the sheer size of some regions and number of networks to connect with relative to the size of the team made this a slow process in some areas:

> *Whereas in the mid and northeast, they are lesser-known areas, both for the colleagues and for the services. It is hard to get meetings off the ground. It is just taking more time to build that, particularly the northeast. […] It is a massive area. So that is taking longer to kind of network and build those relationships up. And then I think the other thing at the end of the day is that we are still a very small team, and one person can only do so much.* (Team member 2)

Data from the training evaluation surveys suggested that some practitioners lacked knowledge of the range of work the team carries out, or the multidisciplinary make-up of the team, which prevented referrals. This was confirmed by some interviewees:

> *I don't know what else they offer […] I've only really had contact from the psychology side of things. My guess is that there are consultants and nurses and hopefully occupational therapists as well.* (Referrer 5)

The number of inappropriate referrals received by the service peaked in April 2020, one month into the first lockdown and two months before the first awareness raising training event in June. Although inappropriate referrals are still received, the trend has been for a decline in the percentage of inappropriate referrals in the last six months from April 2020 – October 2020, as shown in figure 4.

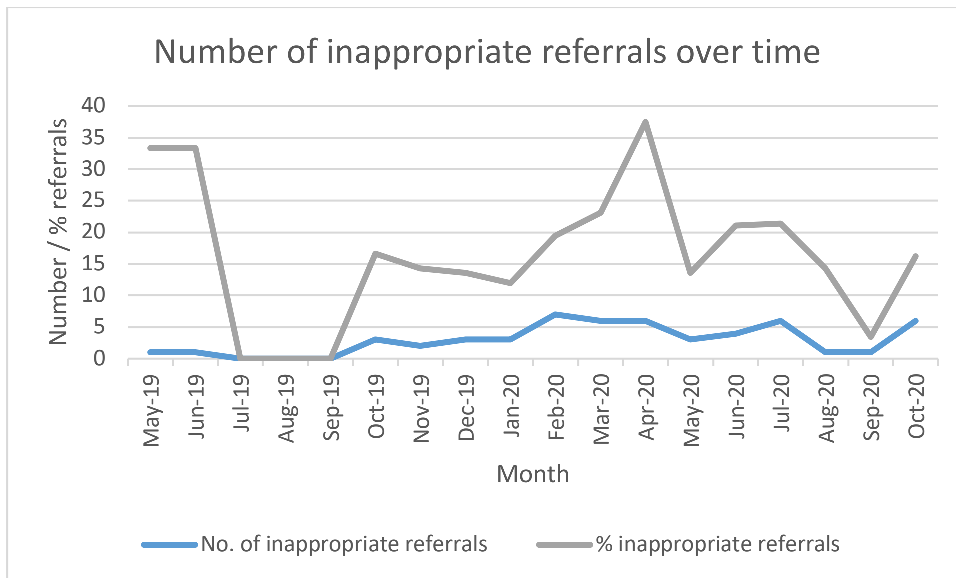

Figure 4. Number and percentage of inappropriate referrals over time (awareness raising training was provided in June and September-November 2020)

Factors facilitating referrals

Although challenged by the size of the region that the service covered, the team facilitated the build-up of referrals through attendance at meetings such as the perinatal parent-infant pathway meeting, which brought several healthcare professionals together. Referrals were also facilitated by attending other healthcare professionals' service team meetings, and by offering consultations and awareness training:

> *Initially we planned to just come along and hear from them what they think might be helpful but our offer really was a kind of consultation space to think about those families that they might be struggling with and offer support to kind of think about those infants within those families.* (Team member 1)
>
> *I think the training has really […] stimulated people's interest in this area and you know people are very excited about the training, we're getting in really good feedback from that […] It appears that this training is targeting people who've not used our service before.* (Team member 2)

Comments from referrers also highlight the factors that influenced their willingness to refer in, including the ease of the referral process, and the team's responsiveness and timeliness of response:

> *It couldn't have been easier […] I filled the form in and sent it off. I wouldn't say it was anywhere difficult at all compared to some of the referrals we do.* (Referrer 9)
>
> *I've always found them to be quite receptive. They're very quick to return calls.* (Referrer 5)

3.3.2 Geographical spread of the service

A considerable challenge that most participants reported in the implementation of the Together with Baby service related to the comparatively small size of the team given the wide geographic area that the service provided for:

> *I know they cover such a wide area and that, what worries me is I'm not sure there's enough of them. But I do look at it and I think, wow it's fabulous, but the capacity, I do wonder.* (Referrer 6)

> *I think the main weakness is probably having to be spread so thinly across Essex because that must make it much harder for them to build that local contact and build that relationship with different professionals because, you know, where do you start? The whole of Essex! So, to me, that's a weakness, I think that perhaps when it was first introduced, often, you know, commissioners or whatever, they don't understand the practicalities and importance of networking with other professionals and building relationships, you know, people understanding your role, that kind of thing. But, you know, they're doing the best they can within the situation that they're faced with.* (Referrer 9)

Due to the sheer number of partners to connect with and their differing geographic boundaries, it took the team time to map service provision and networks across the whole county. The team's connectivity and support was also affected by the service footprint, involving them having to give '*a lot of thought as to how you stay connected as a team, particularly if you are dispersed around such a large area and you are not seeing each other on a daily basis'* (Team member 3). There were also potential implications of this scale of network and geographic spread to deliver interventions and system-wide family support:

> *I think the challenges for the service is that, you know, to kind of align their interventions with the scale of the service, to make sure that they can offer and respond and deliver the outcomes we need when it's at such scale across geographical landscape and across partners and they're a relatively small team.* (Commissioner 1)

> *There is a geographical challenge due to the sort of fragmentation of all of the kind of services that are within the NHS and social care, and education, and all the different CCGs, and it is really difficult to create a coherent sense of team around children and families.* (Team member 4)

To enable coverage of area, the service adopted the strategy of allocating responsibility for developing partner relationships in specific regions to individual team members with local knowledge and prior professional networks within that locality. This was more efficient since less of the team's time was spent travelling across the county, and it also facilitated more rapid network building. Use of remote technology such as video calling, developed in response to COVID, also reduced travel times, and enabled contact with professional networks across the regions, as well as with families living more remotely or in areas with poor transport links.

3.3.3 Partnership working

Partnerships with services and practitioners

Establishing relationships with partner organisations in statutory and voluntary sectors is critical for development of an effective system of support for families. It involves building knowledge of the local landscape of service providers, from universal to acute tiers of provision, and informs inter-professional referral processes, information sharing and care package planning. It was acknowledged by numerous interviewees that '…*with any new service, it takes a while to embed and get people familiar to the offer, really*.' (Commissioner 2) and focus within the first year of the service was on '*learning and evolving that as we go, and that's part of this project.*' (Parent-Infant Foundation 1).

Partnership working was complex for the Together with Baby service due to the large number of providers involved. The team managed this by developing a gradual build-up of relationships with providers, although this inevitably meant some partner relationships were developed more slowly than others:

> *I think I had initial concerns about the fact they were up and running and we didn't know about them […] but that's been allayed now because I do think they have, you know, their presence is a bit more known*. (Referrer 6)

Having strong partner relationships was particularly important for management of the more complex client cases. This involved careful joint care planning to ensure that families were receiving effective support from the most appropriate service in a timely manner to avoid parents becoming overwhelmed by visits from multiple professionals:

> *I went in to do the assessment. We had the perinatal team, the social worker, the social worker's support person, there was the health visitor in doing the MECSH programme, and we had Parent's First, which is the voluntary organisation […] how do we do that in collaboration with everyone else so that this poor mum wasn't overwhelmed with having people knocking on her door, turning up like buses all together?* (Team member 3)

Managing this process required good understand of each other's professional roles and responsibilities, and clear referral criteria and protocols for information sharing. Sharing case notes was made difficult by the lack of a common IT system across services:

> *I think that is a weakness because it's obviously so useful if they can click and see our notes and we can see theirs.* (Referrer 5)

In spite of the difficulties involved in case note sharing, the team were praised by referrers for their '*really good communication'* and for the way that they '*keep keeping in touch'* (Referrer 2).

Partnerships with commissioners

The strong partnership with service commissioners was discussed by several participants. This partnership was characterised by everyone's acknowledgement of the developmental trajectory of the service which allowed for it to '*take it slow, be deliberate, be planned and that's fine'* (Commissioner 1). This approach allowed time for the team to soft launch the service, build up referrals and to identify appropriate measures for assessing outcomes with families when the original ones were found to be inappropriate. The importance of having commissioners who understood the service, its value and who was happy to take part in activities such as webinar and podcast to discuss and share learning was emphasised and seen as reassuring for other commissioners as well as the service.

> *So, when you have a commissioner - albeit the commissioners' lives are really hard, and the CCGs themselves are evolving, if you've got somebody who sees the value of what these teams are delivering, you are already in a much less vulnerable place for funding.* (Parent-Infant Foundation 2)

This good collaborative relationship was found to be invaluable when the impact of COVID-19 meant that timelines, budgets and contracts had to be renegotiated between the commissioners, the service and Parent-Infant Foundation.

> *I feel like there's been a really good level of trust, there's a real sense of shared ownership,* ***[yeah]*** *a shared vision about the kind of partnership we want and the kind of goals we want to achieve together. So that's been really, really great. I mean, I have to say, it's been one of the best examples of partnership working I've experienced, because people are just so mutually concerned about each other's wellbeing and tasks and goals and outcomes. So that's been great.* (Parent-Infant Foundation 4)

Partnership with the Parent-Infant Foundation

The Together with Baby service team regarded the support and guidance provided by the Parent-Infant Foundation team as extremely valuable, particularly the Parent-Infant Foundation's Implementation Support Manager who worked closely with the service. Several interviewees discussed the importance of '*mutual learning'* (Team member 2) and the service also benefited from the Parent-Infant Foundation Toolkit, and from connections facilitated with other parent-infant teams:

> *Having the Parent-Infant Foundation there has really made a difference. It's given us a framework, a framework of development, a framework of training, supportive partners, other people who've been through this development. You know, really it's immeasurable, I think, the value that that's brought.* (Team member 4)

From the Parent-Infant Foundation's perspective regular contact with the clinical team and its lead meant opportunity for '*peer support and a thinking space, you know, where peers come together and just really think collectively*' (Parent-Infant Foundation 4) about implementation and service delivery. After being implemented for over a year, there was also a hope that the Together with Baby service team '…*will actually be able to support other services who are going through similar setup.*' (Parent-Infant Foundation 3). This has already happened thanks to contact being brokered through PIF between the Together with Baby team and other teams around the UK, particularly to discuss assessment tools, Circle of Security and VIG practice.

3.3.4 COVID-19

The impact of COVID-19 on the service

The arrival of the pandemic and the subsequent lockdown placed a hold on the development of the team's work. Inter-professional activities due to take place in person were initially postponed, such as face-to-face awareness training, consultations, and pathways meetings, as were visits to families. Referrals saw a downturn as many referrers also reduced family visits and consequently had less opportunity for observing parent-infant bonding:

> *More people are going undetected because, I mean, we're still, we've been doing visits throughout COVID but they've been whittled down.[…] So, that's been that challenge because then you can't identify people that would benefit from Together with Baby.* (Referrer 8)

Challenges and adaptations

The team adapted their working methods by using telephone contact and video calls instead of face-to-face meetings with families and professionals. This initial adaptation phase was extremely challenging:

> *How do I continue to do this role? How do I do it when everything I have ever known has been based on face-to-face working?* (Team member 2)

> *How do you do parent intervention work with a suicidal mother over a phone?* (Team member 4)

Gathering assessment information was particularly difficult without the benefit of observations of the family in person rather than via a screen. Completion of questionnaire measures with families was also a difficulty, and the team considered use of online methods for solving this. Some families preferred face-to-face visits, which initially could not take place, and consequently work with them had to be put on hold. Other families lacked sufficient Wi-Fi connectivity for video calls, which meant reliance on telephone calls that potentially compromised the team's work. All of this was recognised by service commissioners who also acknowledged how this must be hard for families receiving the service:

> *Yes, I mean, I think [Together with Baby service team] struggled with that initial assessment, getting people to communicate with them for their initial assessment that wasn't face to face, I think that has really affected things because obviously, you know, if you're going through such a difficult time yourself and it's the first time you've been referred to a service to support you, doing that over the phone or in a way that isn't personal could be quite intimidating or quite anxiety inducing, I think.* (Commissioner 2)

Home visiting was only deemed possible by the Trust for the most high-risk families, and RAG-rating of cases for risk was introduced to prioritise family visits. Once introduced, RAG-rating also proved beneficial for enabling a balanced distribution of caseload across practitioners.

The initial introduction of remote working with families and professionals raised technical challenges and information governance issues in establishing a secure and appropriate platform for video calling. The team's intervention approaches involving video feedback also called for specific technical support in their adaptation to remote working, and this took time for the Trust to provide. However, once in place, this technical support enabled the team to offer virtual meetings and consultations to professionals, awareness training through webinars, and intervention with families via video calls including use of VIG.

Benefits of adaptations

Benefits that resulted from this shift to remote working included the development of a set of national guidelines by a member of the team for the use of VIG via online working. Virtual networking opportunities and consultations with other services saved time on travel across regions of the county. Training benefited too since a wider audience could attend webinars compared to attendance in person. There was also the possibility of enhanced reach to families across the broad geographic area that the service served:

> *What this has enabled us to do is to really accelerate the ideas that we had in the beginning, about the geographical reach, and being able to get to families who are not able to get on public transport, and travel two hours on a bus to come and see somebody, which in some parts of the county, that would the case.* (Team member 2)

While offering potential benefits, remote working was not seen as the optimum approach for work with families given the reliance on observation as a core part of parent-infant therapeutic work:

A lot of how you work is by what you see, what you pick up, what you, you know the unspoken in a home. […] *But actually, if you're talking over a phone there's a lot that you're not going to see, you know particularly in the interaction between mum and baby.* (Team member 3)

One of my concerns is that some service providers may see that this (virtual) model is good enough and will curtail face to face visiting. (Team member 2)

Summary box 3. How has the local and national context affected service implementation and its outcomes?

- Establishing relationships with partner organisations is critical for the service to be effective.
- The small size of the team relative to the wide geographic area they serve provides a challenge in the ability to build networks with partner organisations across the county and in staying connected as a team.
- Referral rates varied by region and by source of referral with most referrals coming from the South and Mid-Essex regions and from health visitors and perinatal mental health teams.
- The support, guidance, and implementation framework provided by Parent-Infant Foundation strongly benefitted the implementation of the service.
- The COVID-19 pandemic proved very challenging given the centrality of observation in parent-infant therapy, but the adjustment to online working allowed for training to reach a wider audience.

3.4 What change did the Together with Baby service produce?

This section summarises the change that was produced by the service in relation to work carried out with families and also with professionals. These assessments of change draw on a combination of qualitative and quantitative data.

3.4.1 Change among families

Change among families was assessed using standardised quantitative outcome measures assessing parental mental health and also parental perceptions of their baby's feelings towards them. We additionally collected perceptions of family change as reported by interviewees. Before providing these results, we report on the challenges and facilitating factors affecting the use of quantitative measures with families.

Challenges to using outcome measures

Among several interviewees it was felt that the measures they were initially contracted to use did not reflect the nature of the changes that they saw as a result of their work with families, or they were too lengthy and time-consuming to be clinically practical: '*the outcome measures we'd recommended and put in the contract turned out to be not the best ones for the job*.' (Parent-Infant Foundation 4). The Keys to Interactive Parenting Scale (KIPS) and the DC:0-5 assessment (also called

Levels of Adaptive Functioning; LOAF) were regarded as not fit for purpose due to either the constructs they assessed or their length:

> *I think particularly the KIPS […] we weren't convinced that it was necessarily assessing the parent and infant interaction... the golden ticket almost, is when one can define something that assessed the parent-infant relationship, the interactional element of it, but is not too time-consuming.* (Team member 2)

The Mothers' Object Relations Scale (MORS) was viewed more favourably, though it was acknowledged that it too had some limitations:

> *We're using the MORS and I feel that can be, that's quite, it can be quite an unsettling questionnaire. I think it's invaluable but I think that you know it can ask some questions that can leave parents feeling maybe really bad about something, guilty about something.* (Team member 3)

The use of the Hospital Anxiety and Depression Scales (HADS) for capturing change in parental mental health was also seen as less favourable to the use of the Clinical Outcomes in Routine Evaluation (CORE) measurement tool, since the latter was already being used within the Trust, and therefore better aligned the team's outcomes with the Trust's outcomes.

Another way in which some parental self-report measures were seen as problematic was their subjective nature. Relying solely on a parent's own perceptions of the parent-infant relationship was not always a reliable indicator of objective change:

> *We have had to think quite carefully about a lot of the outcomes because they can be really helpful to show the change, but it can also be quite subjective, you know, rather than an observation of an interaction.* (Team member 1)

> *I was just looking at some of the measures that I did with them on assessments. And I was looking at some of the answers that people gave and thinking how they didn't really reflect you know, what I encountered with that person and their baby.* (Team member 4)

Completion of measures with parents had become even more time consuming in the aftermath of the COVID-19 pandemic, which involved the team having to remotely work with parents on measures through screen sharing of documents to be completed together online.

Factors facilitating use of outcome measures

To facilitate the use of outcome measures with families, the team stressed the importance of using measures sensitively, attending to the timing of their introduction, and using them as part of a therapeutic conversation. The ASQ was seen as particularly helpful for therapeutic discussions with parents about their child's development, though it functions more as an assessment tool rather than a measure for assessing outcomes:

> *I tend not to do them all in one go because I think that would be overwhelming. Sometimes I might leave them with the ASQ for a little while to look at themselves because it is one that they mark themselves and then you go through it with them afterwards. Some of them are quite useful because they are good discussion points. So, you can use them within the initial assessment, and it might open up a conversation about something.* (Team member 3)

The flexibility around having time to identify the correct measures to evidence impact by commissioners was appreciated by the clinical team and acknowledged that it is a learning process.

Family outcomes: Parental perceptions of their baby's feelings towards them

Together with Baby collect information on how the parent perceives their baby's relations towards them – how warm they feel the baby is toward them, and how intrusive or controlling they feel the baby is. Data is collected using the Mothers Object Relations Scale (MORS). A higher score on the warmth scale indicates that the parent perceives their baby shows them more warmth. An average score for warmth is 29, and scores lower than 20 should indicate concern (Oates & Gervai, 2019). A higher score on the intrusion scale indicates that the parent feels their baby shows more unwelcome invasion towards them. An average score for invasion is 10 and a score higher than 12 may indicate concern.

Data were available for 54 parents on entry to the service (52 mothers and 2 fathers). The average score for warmth on entry to the service was 22.43 (SD 6.96) and the average score for invasion was 14.28 (SD 5.82). The average score for warmth on entry to the service for the parents with data available both before and after treatment (n=23) was 21.48 (SD 7.01) and the average score for invasion was 14.87 (SD 6.95) Once parents had completed their treatment, parents perceived their baby as showing more warmth towards them indicated by an average score for warmth of 28.58 (SD 5.63). Invasion scores had decreased (M = 10.13, SD 5.50), indicating that parents saw their baby as less intrusive and controlling than before treatment. Scores on both warmth and invasion were very similar to the population average after treatment (see figure 5).

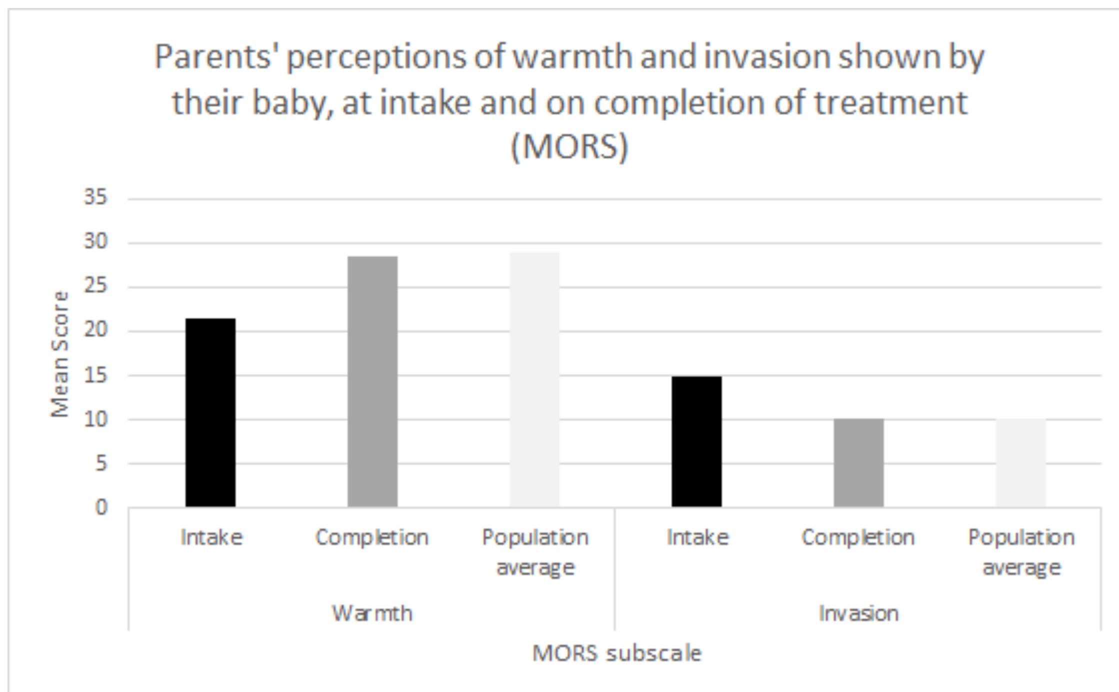

Figure 5. Parental perceptions of warmth and invasion shown by their baby at service intake and after treatment, as measured by the Mothers Object Relations Scale (MORS). Data is from 23 parents who completed MORS at the start and end of service.

Family outcomes: Parental mental health

The Hospital Anxiety and Depression Scale (HADS) is used to collect data on anxiety and depression at entry to the service. Using the original scale scores as a guide, it is suggested that total scores of 0-14 are 'normal'; 15-22 are suggestive of disorder; and 23 or more probable disorder. Total scores were provided for 59 parents at entry to the service and for 17 parents who had completed treatment. At entry to the service scores ranged from 3 to 36; the mean score was 20.57 (SD 7.86), and the median score was 22. Compared with a mean of 9 in the general population (Crawford, Henry, Crombie, & Taylor, 2001) the scores suggest high levels of mental health difficulties among parents. After completing treatment, scores were substantially lower. Scores ranged from 0 to 30; the mean score was 15 (SD 8.93) and the median score was 13. The small amount of data available after treatment mean that this effect should be treated with caution, as there may be a bias toward capturing data from parents who are feeling better after treatment.

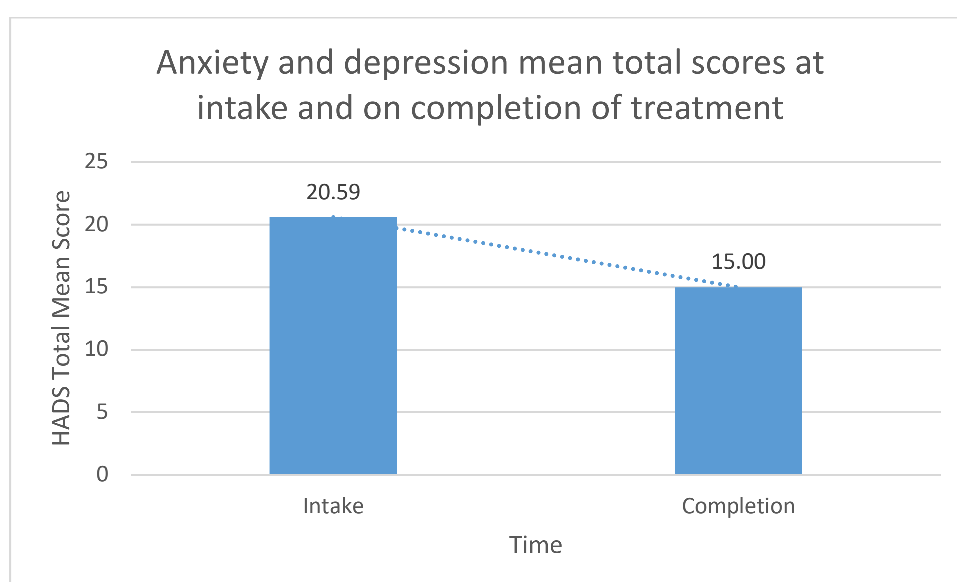

Figure 6. Anxiety and depression mean scores as measured by HADS totals, at intake and on completion of treatment (N = 17 parents with data at the start and end of service).

Family outcomes: Stakeholder perceptions of family change

Referrers reported very positively on changes among families they had referred to the Together with Baby service.

> *I've been referring some of my ladies to her (Together with Baby practitioner) since then and I've heard nothing but good things.[…] From client reports, I think it's going really well* (Referrer 8)

The positive impact of the service was seen to benefit not just the referred parent and child, but stretched beyond to the other children in the family:

> *I think it makes a huge difference in family well-being. I've really seen that knock-on effect to other family members, even if they're not directly receiving treatment. She definitely had a better outcome to her life because of their intervention. And I'm hoping as well, things like that can really make a big impact on this intergenerational pattern that we're seeing and really go some way to helping parenting.* […] *It's been amazing to see.* (Referrer 1)

The use of video feedback in particular was seen as a powerful intervention that parents responded especially well to, enabling more self-aware and confident parenting:

> *The videoing was excellent because she (the mother) said, (name of Together with Baby practitioner) sat and explained to me look, this is actually what you're doing, you have got, you see how the baby's responding back to you. And it's made such a difference between her and the second child and all round. […] She says herself you know it really made such a difference, you know the mum did. I think it meant that the mum just became a bit more confident and believed in herself a bit more.* (Referrer 9)

> *The change was incredible really. And seeing this little one being able to be soothed by mum when he wasn't feeling well […] Yes, it was really quite something, in terms of just seeing the change in that relationship.* (Team member 1)

3.4.2 Change among professionals

The impact of the Together with Baby service on professionals was assessed through feedback concerning consultations, changes in the rate of referral to the service, and evaluation of the awareness training sessions. Each is described below.

Feedback about consultations

Referrers regarded the consultations offered by the team as making a significant difference to the way they carried out their work:

> *They are very thoughtful and it seems as though their responses are very well planned and thought out […] I think in nursing you want to go and you want to help and you want quick results, if you know what I mean. You just want it sorted and I think because of the psychological approach for their team, they really helped me slow down and they really helped me widen that perspective a bit and think about the whole family I think and the impact on each other and those kind of relational things that are happening.* (Referrer 1)

> *To have someone that I was able to go to and get a second set of eyes on the opinion, a second set of assessments on what was going on, for me that was very reassuring that there wasn't an omission that was occurring because of my lack of training in a particular area.* (Referrer 5)

These referrers' comments indicate that the team's consultative work is especially valued by other professionals, particularly in cases where parent-infant bonding forms part of the overall picture of family need, but may lie outside of the practitioners' own area of expertise. Such consultations appear to strengthen confidence among professionals about their own practice, while also deepening their practice by promoting a relational, psychological approach to working with families.

Changes in referral rates

The strategy developed for generating referrals was aimed at building referral rates gradually rather than rapidly. This was regarded as necessary given the size of the area that the team was expected to cover and number of services to connect with, but they also recognised its drawbacks:

> *It was a phased launch so that it became manageable. […] The drawback to that though has been referrals are probably not coming in at the rate that we want them to. So it is a 'for and against', you either get swamped, or it comes in in a bit more of a trickle. So it is trying to find that balance.* (Team member 2)

This meant that there were some instances of referral services that were slow in finding out about the Together with Baby service:

> *They're maybe not so widely known as they should be.* (Referrer 5)

The decision to develop a gradual build-up of referrals is evident in the quantitative reports for referrals numbers, as is the impact of COVID-19. Figure 7 shows a gradual increase in referrals until March 2020 when the first national lockdown was announced. The rise in referrals seen in October followed the provision of awareness training that started in September.

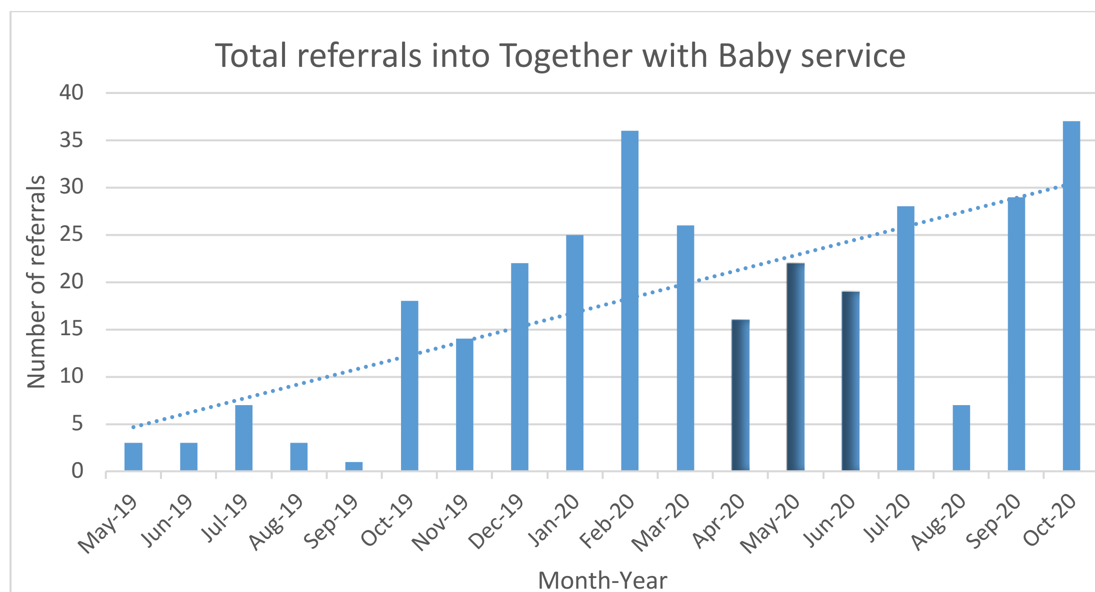

Figure 7. Number of referrals to Together with Baby service by month. Shaded columns (April – June 2020) indicate full months in lockdown due to COVID-19.

Webinar outcomes

The June webinar was attended by 183 individuals. Pre and post webinar evaluation showed that after the webinar participants reported increased knowledge of infant mental health (pre average = 4.33 (n=183), post average 6.77 (n=91)) and the Together with Baby service (pre average = 2.66 (n=183), post average 6.5 (n=91)) as compared to before the webinar. More than 80% of participants reported that they knew how to refer to the service after the webinar.

Awareness training outcomes

Overall, the training was well-attended and reached its target audience. Although data are limited, the training appeared successful in raising awareness and understanding of infant mental health and of the Together with Baby service. Attendees also valued its potential contribution to their work with families. These outcomes are described in detail below.

There were 78 to 120 attendees present at each session (see table 3). The reflective sessions were attended by fewer attendees in line with its aim to facilitate small group discussion and reflection. Findings from the baseline survey (n=66) clearly showed that the training reached the local key audience who perceived it to be important to understand infant mental health in their current role.

Attendees included those working within maternity and early years workforce including family support workers, specialist midwife, health visitors and mental health practitioners. Most participants had contact with pregnant women or families on a daily (44%) or weekly (36%) basis, with remaining participants in contact with families monthly (6%) or every couple of months (14%). Half of participants worked in Mid and South Essex (50%), other participants worked in West Essex (18%) or North East Essex (6%). Other participants did not tell us where they worked (27%) suggesting they may work outside of Essex.

Session	Training topic	Attendees
1	What is Infant Mental Health and its importance in building positive wellbeing.	107
2	What are attachment relationships?	120
3	The developing brain - understanding the importance of early experiences.	120
	Reflective session: Case discussion	26
4	Baby Communication	94
5	Risks and Resilience	77
6	Supporting families who are struggling	78
	Reflection session: Case discussion	17

Table 3. Awareness training schedule and number of attendees

Findings from the baseline survey (n=66) show that attendees deemed it important to understand infant mental health in their current role (on a scale of 1 – not at all important to 10 very important, mean 9.09, SD 1.62). Their understanding of infant mental health (on a scale of 1-poor, 10-excellent, mean 5.53, SD 1.82,) and Together with Baby service (5.62, SD 2.26) was lower. Six participants had already referred to the service.

Twenty six participants completed the mid-point survey. They reported high understanding of infant mental health (mean 7.32, SD 1.51) and Together with Baby service (mean 7.92 , SD 1.32). Two participants had referred a total of three families to the service. 98% of participants said they could apply the information from the session to their own work setting and all respondents agreed that the modules met their professional educational needs. 96% would recommend the training to their colleagues.

From the first four sessions, participants reported learning more about the infant's perspective, the importance of parents bonding with their baby and previous trauma, the need to observe behaviour and infant attachment.

> *I am more aware of the signs of an anxious/insecure attachment so will recognise it easier.*
>
> *I feel that I now have a greater understanding of the impact of trauma on babies and will encourage parents to be more patient and sensitive when they are struggling with their babies behaviour.*

For the 13 participants who completed both the baseline and mid-point survey, their reported understanding of infant mental health (from mean 4.92, SD 1.89 to mean 7.54, SD 1.33) and Together with Baby (from mean 5.85, SD 1.6 to mean 8, SD 1.35) increased. Whilst very encouraging, these findings need to be carefully considered due to the low number of participants we were able to match.

In the post-training survey respondents (N=14) were again positive about the training. Several respondents said that they would share learning with their team. They reported high understanding of infant mental health (mean 8.5, SD 0.73) and the service (mean 8.57, SD 1.8). No respondent had yet referred to the service. 92% of participants said they could apply the information from the session to their own work setting and 78% thought the modules met their professional education needs. 78% would recommend the training to their colleagues.

Only 4 participants completed the mid-point and final survey, making any comparison between their scores inappropriate. In both surveys the delivery of the webinars were scored highly and comments were very positive about the structure and content. It was suggested that future training should also signpost to other resources where participants can learn more if interested.

Summary box 4. What change did the Together with Baby service produce?

- The service understands the need to capture the changes they are facilitating and the search for appropriate measures to capture the parent-infant relationship is ongoing.
- Reports from referrers and quantitative outcome data indicate improvements in parents' mental health and in parents' perceptions of their relationship with their baby after treatment. However quantitative data is limited in number.
- Referrers have a better understanding of infant mental health and of the service following training provided by Together with Baby.

3.5 Sustainability of the service

Funding, service capacity and maintaining awareness of the service were identified during our interviews with all stakeholder groups as factors important for the sustainability of Together with Baby.

Funding and service capacity were seen as closely related. Many interviewees discussed how the Together with Baby service was a small service supporting a large geographical area. The service was seen as likely to reach capacity soon and there was concern it would not be able to meet the need of

the local population. It was also acknowledged that to get further funding to maintain the current service, but ideally grow the clinical team, information was needed regarding the impact and importance of the service.

> *if the service doesn't give me the information that I need to be able to articulate the impact, the value for money, the importance, et cetera, et cetera, then, we're gonna struggle because whether we've got the money or not, it's public money and we've got to be seen to be spending it in the right way and meeting a need of the population. So, I think that's the important thing for me, that's going to be key, that's going to be absolutely key.* (Commissioner 1)

The uncertainty of finances after COVID-19 was also acknowledged.

> *But I think it could affect what purse we end up having because we've had to, kind of, nationally funnel money towards dealing with this unexpected pandemic. So, I think that is a potential threat.* (Commissioner 3)

Ways of managing the mounting demand for the service were being considered by the team, including running more group intervention sessions, offering time-limited interventions, and having a waiting list, though the latter was not seen as preferable given the rapidity of development for babies and very young children. '*Babies can't wait*', as one team member put it. The possibility of developing specialist team roles was also raised as a means of managing the competing tasks:

> *Maybe certain people [could] lead on certain areas like, you know like training, like development, you know, I don't know. I feel like we're doing lots and lots of different things which is really good but it also feels like a huge amount of work.* (Team member 1)

Expansion of the team through recruitment of further trainee psychologists was a possibility, though this had drawbacks as their placements were time-limited and their departure from the service required planning to ensure that remaining staff were not over-stretched as a result.

Finally, the importance of cementing the service into the routine service offer and making sure the early years services remembered the service was mentioned. This included making sure people with influence and commissioners are aware of and reminded of the service and that it is part of the offer in the area:

> *But making sure it's kind of recognised and up there as an integral part of the response, just like the broader perinatal commissioned offer.* (Commissioner 3)

The continuation of the service clearly mattered, as this referrer describes:

> *It's been really useful and I'd be devastated if it ended, to be honest. […] I'd be really sad if it was taken away, if only there were more services that were as useful and as easy to access.* (Referrer 8)

Summary box 5. Sustainability of the service.

- To secure further funding it is vital that the service provides commissioners with evidence of the impact it is making.
- Demand for the service is likely to soon outstrip capacity and whilst planning is underway to mitigate this situation, further discussion is likely to be needed over the medium term.

4. Discussion

The overall finding of this process evaluation is that the Together with Baby service has been implemented very successfully alongside already existing perinatal mental health and maternity and early years services. There is much learning that can be taken from this evaluation, and recommendations are summarised in section 5. That said, it needs to be noted that some of the context may be difficult to replicate such as the highly specialist team with their expertise and strong leadership and the effective partnership working between commissioners, service lead and Parent-Infant Foundation. We have discussed the two main issues coming out of this evaluation below which focuses on the sustainability of the service and evidencing its impact.

4.1 Service sustainability

The commissioning of this service was ambitious considering the small team and large geographic coverage expected of the service. Early signs indicate that it is succeeding in raising awareness of infant mental health among service providers and commissioners across the county, as shown by the training evaluation and the feedback on the impact of the team's consultations with practitioners. Commissioning on this geographic scale places many demands on a team, and its success is in no small part due to the enormous effort, commitment and skills of the team members. The service is highly valued among referrers, but is in danger of becoming overstretched as its reputation continues to grow and referrals continue to build. Increasing the size of the team needs to be considered to sustain the service. This may include a different team structure and specialist roles so that staff can lead on different components of the work. Focus for 2021 also needs to be agreed between the service and its commissioners, as more training of the local workforce will take away capacity to support families. The aftermath of COVID-19 must also be considered when more families than ever may need face-to-face support after months of isolation and reduced routine services (Best Beginnings, Home-Start UK, & Parent-Infant Foundation, 2020).

The COVID-19 pandemic was an enormous challenge that the clinical team managed well. Whilst it is hard to support families remotely, when this can be done the workload for the team can be shared, which is important when some areas provide more referrals than others. Looking to the future, online awareness raising and consultations with other services can save time on travel and can help with the team's capacity issue.

4.2 Evidencing impact

The quantitative data suggest that the service is having a positive impact on families in need: parents' mental health improved, parent-infant relationship perceptions improved, and only two families dropped out of the service once they had been engaged. However, the evaluation found that there were challenges in capturing the quantitative impact of the service and the evaluation is based on incomplete data. Evidencing impact relies on appropriate selection and use of measures that can capture outcomes the service is aiming to change.

As well as evidencing impact, routine outcome measures can be used to beneficially track parent symptoms, facilitate communication between the parent and team, identify parents in need of more treatment, and reduce the number of sessions for those who have improved (Wray, Ritchie, Oslin, & Beehler, 2018). The difficulty experienced by the team in choosing an observational measure to assess the parent-infant relationship is not unusual, with surveys indicating that up to 60% of clinicians do not collect or find it hard to collect outcome data (Boswell, Kraus, Miller, & Lambert, 2015). In parent-infant work there is not a gold-standard outcome measure in use, which was echoed in the findings of the meta-review of measures conducted for the Parent-Infant Foundation (Coates, Olander, Moran, & Ayers, 2020). The review found a potentially overwhelming 57 measures of parent-infant interaction each with a slightly different profile, that the team could potentially use. The lack of gold-standard is evidenced in other parent-infant relationship service evaluations where diverse measures are used such as Maternal/Paternal Antenatal Attachment Scale (Hunter, Glazebrook, & Ranger, 2020) and Parent-Infant Relationship – Global Assessment Scale (Goldsmith, Goldberger, Taylor, & Melbourne, 2018; Lee & Mee, 2015) or Postpartum Bonding Questionnaire (Goldsmith et al., 2018). Once a measure has been chosen, a clear implementation plan detailing how the team will use the measure and supporting them to do so would be beneficial (Wray et al., 2018).

As well as evidencing impact on families through assessment and satisfaction surveys at the end of the service, evidence of the impact of the service's consultation work with outside agencies is recommended. Collecting data about the nature of consultations, who the query came from, the time spent on the consultation and the outcome, would provide evidence for the substantial amount of time the team spend on this area of work and would allow comparison with other services (for example Hunter et al., 2020). It is also important to continue to evaluate the awareness training for attendance and its effect on referrals.

4.3 Evaluation strengths and limitations

There are several strengths to this evaluation. A good working relationship was quickly set up between the evaluation team, Parent-Infant Foundation and the clinical team, which facilitated effective and timely communication throughout the project and helped contextualise the findings. This evaluation is based on both qualitative and quantitative data which is good practice and adds to previous service evaluations who have only used quantitative data to explain service provision (Hunter et al., 2020; Lee & Mee, 2015). Interviewing the clinical team and the Parent-Infant Foundation twice provided information on the service's implementation journey and is something we recommend future similar evaluations to do.

Some limitations also need to be noted. We made attempts to interview potential referrers who had not had contact with the service in order to gather their views, however they did not respond. Our understanding of the perceptions of the service may be limited by the lack of this voice. We also attempted to interview four commissioners, but despite contacting several commissioners, only three gave their time to be interviewed.

Finally, there was a shortfall in the availability of quantitative data, which also limits what we can conclude about certain aspects of the service. Difficulties in the service's collection of quantitative data were in part due to challenges in selecting appropriate outcome measures for capturing parental

mental health and parent-infant relationship factors, as well as challenges in aligning NHS IT systems with data requirements that adequately reflect the service.

5. Recommendations

Interviewees were asked to provide recommendations to others who were going to implement a similar service to Together with Baby. Responses included using the Parent-Infant Foundation toolkit and network of other services, build partnerships in the local area with services and commissioning, consider the aim of meetings to avoid overcomplicating governance issues and have an implementation manager who can work across the charity sector and NHS utilising the strengths of both sectors. Several interviewees also mentioned the service user voice, and the importance of involving parents in the future development of the service.

Regarding funding for the service it was acknowledged that whilst joint funding is good, there must be a 'home' for this funding to make it less vulnerable to cuts. Finally, it was recognised that a service with a smaller geographical area may be able to show impact quicker, and thus focusing on a smaller area first and then expanding its remit could be considered by future services.

In addition to the above recommendations, some further recommendations are below based on the findings of this evaluation.

5.1 Factors facilitating the implementation of a parent-infant relationship team

Team

- High calibre, experienced staff team with a diversity of professional skills and expertise supported by strong leadership.
- Investment in team training and supervision. This builds up team skills and flexibility, alongside enabling a common therapeutic approach to the service offer.
- As the team expands, consider developing team roles and responsibilities to capitalise on individual staff members' skills and strengths.

Service

- RAG-rating cases enable prioritisation of clients that informed the timing and intensity of input to better meet families' needs, as well as enabling the management of cases within the team in order to avoid individual team members being overloaded with very complex cases.
- Team size which matches the geographical spread of the service. With a large geographical spread, there is risk of the service being inequitable due to the team not being able to reach certain geographic pockets.
- Identifying appropriate measures for capturing parent-infant work outcomes, as well as the other work the service does to evidence the impact of the service. Collaborate with Trust IT management department to ensure databases can accurately collect data in a time efficient manner.

Collaboration

- Networking with other Parent-Infant teams who have already developed their services and were in a position to offer guidance was supportive for the team.
- Strong collaboration and support between all key stakeholders including commissioning, clinical team and the Parent-Infant Foundation.
- Adopting a relational stance to all levels of working, whether with families or professionals, creating a system of support for families.

Referrals

- Generating referrals through allocation of regional sectors of the county to each team member to utilise existing their network and develop local knowledge of services.
- Building referrals incrementally helped to avoid overstretching the service in its initial implementation phase.
- Introducing parents sensitively to the service and referral to enable parental engagement.
- Keep raising awareness in local population through online events and visiting teams.
- Maintaining existing awareness by regular contact with referrers, through newsletters or other information sharing and utilising national events such as infant mental health week.

Resources

- Provide appropriate IT systems to allow for remote working following the pandemic outbreak. This can enable easier access to families located more remotely using video calling, and to wide-spread professional networks, and the ability to offer online training to professionals, thereby reaching a larger audience.
- Provide appropriate clinical base for team to meet at and work from.

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