Parent-Infant
FOUNDATION

Sicrhau bywydau iach
Securing Healthy Lives

An extended summary of research about parent-infant relationship help and support across Cwm Taf Morgannwg

Dr Karen Bateson, Martha Sercombe and Wook Hamilton

1 December 2021

Acknowledgements

We would like to sincerely thank everyone who helped us to conduct this work, including:

- Every parent and member of staff who contributed to the qualitative and quantitative surveys and interviews.
- Martha Sercombe, specialist health visitor seconded into the project team and co-author of this report, for her hard work over an intense three months of interviewing and researching.
- The project steering group members for their help and advice: Sarah Ostler, Debbie Lewis, Rachael Ceshion, Tina Haddon and with additional thanks to Helen Joseph for her support with questionnaire development and translation services.
- The expert advisory panel, for scrutiny, help and advice regarding process, content and ethical practice: Paddy Martin, Sharon Fernandez, Sarah Witcombe-Hayes, Nicola Canale and Amanda Holland.
- Kath Edwards and colleagues at Valleys Kids.
- Liz Gregory and Benita Nagpal for advice and guidance or direct work. Carmen Power for her thematic analysis of the parents' consultation.
- The Parent-Infant Teams Network of 39 parent-infant relationship teams across the UK who continue to share their learning, expertise and case studies for the benefit of others.

The content of this report was written by, and is the sole responsibility of, the Parent-Infant Foundation and may not be reproduced in any part or for any purpose without written permission from the Foundation.

Wherever possible we have confirmed our reporting and analyses with relevant local people. However, if you spot any inaccuracies, please accept our sincere apologies and let us know at **admin@parentinfantfoundation.org.uk**. We will be happy to correct any mistakes.

Contents

Executive summary 4

A note about language and terminology 6

Why are parent-infant relationships so important? 7

Service mapping 13

Estimating current and future need for parent-infant relationship support 19

Hearing from local parents 25

Analysing workforce strengths and needs 30

Summary of recommendations 34

Moving to action 40

How this work connects to local and national strategy 46

References and footnotes 49

Executive summary

This report is about the importance of the parent-infant relationship and what can be done to strengthen, help and support it in three adjacent local authority areas in South Wales.

Every baby needs a 'good enough' relationship with carers because this builds the foundation for lifelong health and development. Around one in five babies born in the Cwm Taf Morgannwg (CTM) region are likely to experience a parent-infant relationship difficulty so significant that it risks their later mental and physical health, social relationships, progress at school and in work. The scale of need is high due to local communities experiencing high levels of trauma and adversity which contribute to increased pressure on the parent-infant relationship.

Unresolved parent-infant relationship difficulties drive demand in late intervention services, such as children's social care and CAMHS. Whilst there are no silver bullets, early childhood intervention represents a sound economic investment, generating significant cost savings and supporting resilience, health and wellbeing across the life course.

The Parent-Infant Foundation found examples of good practice across all three local authority areas, where services either reduce general risk factors or strengthen protective factors relevant to the parent-infant relationship. We also found some specialist teams and practitioners whose work directly addresses parent-infant relationship difficulties. Alongside joined-up strategic leadership, recent workforce training and a commitment to innovation, these are excellent foundations to build on.

We found a clear gap in provision for families with children under two experiencing the most significant parent-infant relationship difficulties. Identification, help and support for families at all levels of need could be strengthened through strategic workforce development and the creation of a new specialised parent-infant relationship team. Effective parent-infant relationship and parental trauma interventions should be embedded in a trauma-informed approach across the system.

Despite current challenges, practitioners and service managers want to know more and do more to support children during the first 1000 days. Increased pressures due to COVID are being exacerbated by ongoing short-term funding cycles which increase workforce turnover and disrupt family support. A national shortage of appropriately trained parent-infant practitioners will be one of the biggest challenges to scaling parent-infant relationship support locally, across Wales and across the UK.

We heard from 487 parents. Parents understand that the quality of the parent-infant relationship is an important aspect of their child's life, in all domains of child development. They rate the importance of the parent-infant relationship as the third most important factor affecting child development after parental violence and drug use. Parents want to be asked directly and receive support specifically about their parent-infant relationship. Parents want more opportunities for peer contact and for parent-infant relationship support to actively engage fathers and partners.

This report is not just about babies, it is about securing healthy lives throughout the life course. We provide recommendations for local commissioners, practitioners, service managers and national government, which together provide a blueprint for parent-infant help and support across Wales.

Introduction

This report is about the importance of the parent-infant relationship and what can be done to strengthen support for it in three adjacent local authority areas in south Wales. The work was commissioned by the Cwm Taf Morgannwg Early Years Transformation Board (EYTB) with funding from the Welsh Government Early Years Transformation Programme. This Board operates across the boundaries of the Merthyr Tydfil, Bridgend and Rhondda Cynon Taf (RCT) local authorities and the Cwm Taf Morgannwg University Health Board (CTM UHB).

This summary report describes a selection of findings and recommendations. These take into account existing local strengths and service models, likely future population and workforce trends, and opportunities for regional collaboration. The full report, appendices and data tables are available by request from **admin@parentinfantfoundation.org.uk**.

Further resources are available in our comprehensive **Development and Implementation Toolkit**.

We conducted four connected pieces of work:

1. Service mapping

We interviewed practitioners and service managers, gathered service data and consulted with senior leaders to map current parent-infant relationship support from conception up to two years of age across the Cwm Taf Morgannwg (CTM) region.

2. Understanding the local population's needs

We gathered a wide range of local, national and international data to understand the local population's need for parent-infant relationship support.

3. Parents' consultation

We heard from 487 local parents on a range of questions connected to parent-infant relationships and support for it.

4. Workforce analysis

We spoke to local practitioners and service managers about current strengths and future training needs and we researched the likely workforce requirements for improving parent-infant relationships.

The work was conducted by the Parent-Infant Foundation from May to October 2021. We seconded a local specialist health visitor to the project team for three months, and we worked closely with Valleys Kids, a local voluntary sector family-support organisation. Progress was overseen by a Project Steering Group comprised of representatives from the three local authorities, health board and transformation board.

A note about language and terminology

The relationship that exists between a baby and parent(s) is sometimes referred to as the attachment relationship. Professor David Shemmings, Child Protection Research, University of Kent, discourages use of the term attachment[1] except in certain circumstances. This is in part because the term 'attachment' has related but different lay and clinical technical meanings which risk misunderstanding between people from different professional backgrounds and levels of clinical training.

Additionally, in its technical sense, attachment refers to a part but not the whole of the parent-infant relationship, so misses other important parts of the relationship such as reflective functioning and mentalisation. Therefore, in this report we will use the term parent-infant relationship unless we are referring to the specific clinical definition of attachment.

The term 'infant mental health' refers to babies' emotional wellbeing and development. Infant mental health is dependent upon the baby's environment and experiences, which for young children are dependent on their relationships with carers.

The term 'perinatal mental health' refers to the mental health of parents during pregnancy and the postnatal period. The term 'parent and infant mental health' references both the baby's and the parent(s)' mental health and the relationship between them.

There is a difference between 'specialist' and 'specialised' work. 'Specialist' refers to a level of intervention, sometimes referred to as Tier 3, at which services and staff are highly skilled, and see families with the most persistent, significant and/or complex needs. 'Specialised' or focused relates to the specific intervention focus. A health visitor may offer targeted interventions specialised to the parent-infant relationship but not be working at a tier 3 specialist level. When we describe specialised or focused parent-infant work, we mean those activities which directly address the quality of the relationship by focusing on containment, reciprocity, parental sensitivity, attunement, responsivity or internal representations of the relationship.

Throughout this report we use the term 'parents' to refer to any adult in a parenting role, including foster, adoptive, kinship and step-parents.

The local authority areas are referred to as Bridgend, Merthyr Tydfil and RCT (Rhondda Cynon Taf) areas, and collectively the whole region is referred to as the CTM (Cwm Taf Morgannwg) region.

In Wales, the term 'statutory' refers to families who are in the child protection system. The terms 'pre-statutory', 'early help', 'early intervention' and 'preventative' are used interchangeably to refer to families whose needs do not meet the threshold for child protection involvement.

The term 'first 1000 days' refers to the period from conception to a child's second birthday.

Why are parent-infant relationships so important?

Secure parent-infant relationships underpin good physical and mental health and wellbeing across the lifespan

Multiple aspects of our mental and physical development are shaped by environments and experiences during the early years of life[2]. Parent-infant relationships are one of the critical elements of early development and influence many different skills, behaviours and capacities[3].

"Healthy development depends on the quality and reliability of a young child's relationships with the important people in his or her life, both within and outside the family.

Even the development of a child's brain architecture depends on the establishment of these relationships."

Center for the Developing Child, Harvard University (2004)[4]

The accumulated body of knowledge shows that relationships, emotional wellbeing and development in the earliest years of life predict later wellbeing in multiple domains:

Learning

Children who have had good early relationships start early education and school best equipped to be able to make friends and learn.[5-7]

Earning

Good infant mental health increases the chances of babies going on to achieve their potential in later life and contributing to society and the economy.[8,9]

Emotional and social skills

A child's early relationships shape their perceptions of themselves and others and teach them how to regulate their emotions and control their impulses. This lays the groundwork for children's developing emotional wellbeing, resilience and adaptability: key competencies that will help them to thrive.

Mental and physical health

Research shows a strong association between exposure to stress in pregnancy/early life, and later mental health problems.[10,11] Supporting infant mental health can prevent emotional disturbances escalating into mental health problems.

Trusting relationships

Early relationships set templates and expectations for future relationships. Secure nurturing relationships give babies the skills to form trusting relationships with others.

Positive behaviour

Because good infant mental health enables children to understand and manage emotions and behaviours and to form positive trusting relationships it can reduce later risky and antisocial behaviours and the costs they bring.[12]

Parenting ability

A child's experience of being parented also influences how they go on to parent their own children. Supporting parent-infant relationships can pay dividends for generations to come.[13]

A person's life outcomes are **not *determined*** by the age of two, but wellbeing during our earliest years is strongly linked to later outcomes across health, social and educational domains[14,15].

A secure parent-infant relationship is a **core component of resilience** and a child's ability to weather life's ups and downs[16]. A secure attachment buffers a person's mental and physical health against later adversity.[17]

Research shows a strong connection between disorganisation or insecurity in the parent-infant relationship and intergenerational **mental ill-health, behavioural problems and increased risk of child abuse**[18].

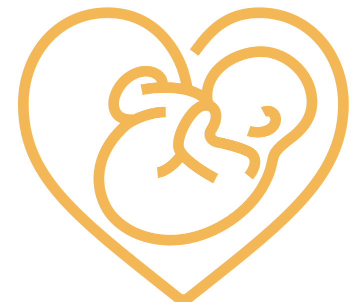
"Young children experience their world as an environment of relationships, and these relationships affect virtually all aspects of their development – intellectual, social, emotional, physical, behavioural, and moral. The quality and stability of a child's human relationships in the early years lay the foundation for a wide range of later developmental outcomes that really matter…"

Harvard Centre for the Developing Child[19]

In the general population, it is estimated that around 15% of babies experience "disorganised attachment" with their main caregivers[20]: the pattern of parent-infant relationship which puts children at greatest risk of poor social, emotional and educational outcomes.

Recent research[21] shows that parenting interventions that include content on responsive caregiving have four times greater effects on child cognitive development, parenting knowledge, parenting practices, and parent-child interactions than interventions that do not include content on responsive caregiving.

"…the pathway followed by each developing individual and the extent to which he or she becomes resilient to stressful life events is determined to a very significant degree by the pattern of attachment developed during the early years." John Bowlby[22]



The first 1000 days of life offer the best opportunity to improve health and social wellbeing

Whilst the brain retains plasticity throughout life[23] it is most sensitive to environmental circumstances and learning during the first years of life.

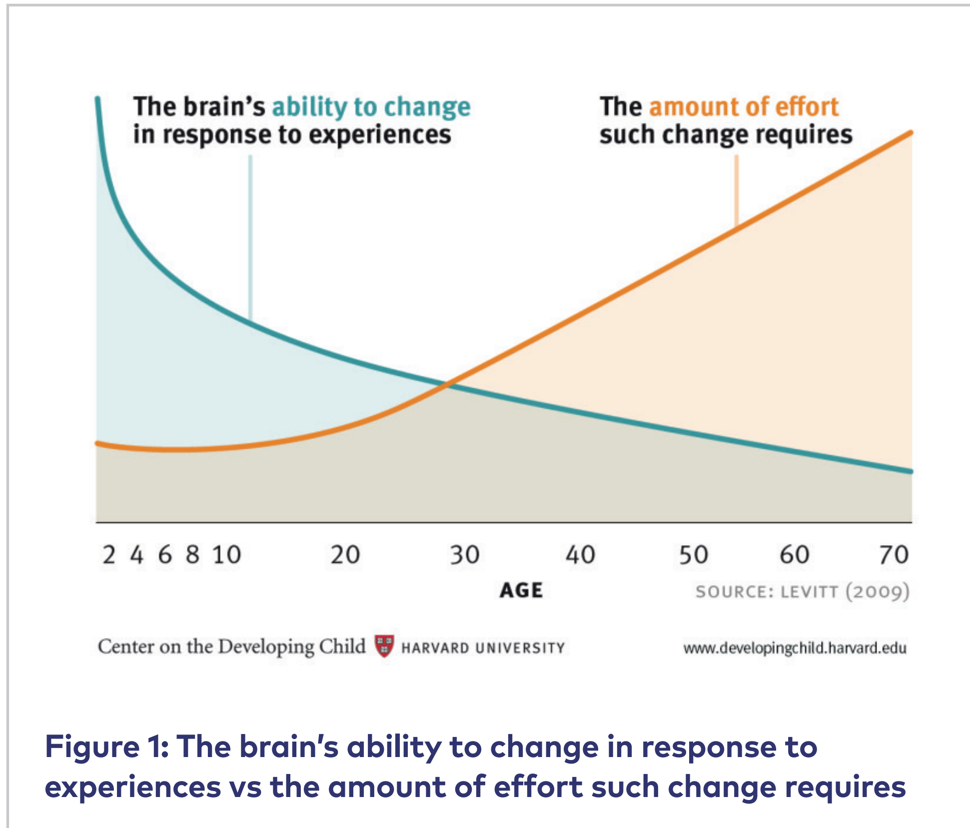


Figure 1: The brain's ability to change in response to experiences vs the amount of effort such change requires

Center on the Developing Child at Harvard University," with URL included: developingchild.harvard.edu. Brandi Thomas Communications Manager. CECD." Center on the Developing Child at Harvard University. https://developingchild.harvard.edu/science/key-concepts/brain-architecture/ (accessed 1 October 2021).

"The early moments of life offer an unparalleled opportunity to build the brains of the children who will build the future."

UNICEF[24]

Parent-infant relationships reflect and affect safeguarding risks

Infants under one account for 36% of serious incident notifications[25] and up to 10% of child protection registrations[26]. Babies are highly dependent on parent-infant interactions to shape their rapidly developing nervous system, emotional and behavioural self-regulation[27] and sense of danger[28]. Consequently, child abuse and neglect during babyhood has a disproportionately large and negative effect on the child's development.

Up to 80% of children experiencing child abuse and neglect can be categorised as having a "disorganised" attachment[29] – the pattern of parent-child relationship most strongly associated with the poorest lifetime outcomes across a range of domains, including personality disorder[30], substance misuse during adolescence[31] and violent offending[32].

In a review of atypical parent-infant relationships connected to child maltreatment, Professor Jane Barlow concluded that effective prevention of child maltreatment includes assessment of the parent-infant relationship and the delivery of relevant interventions that begin in pregnancy and continue throughout the first postnatal year.[33]

The economic case for early investment

A comprehensive review of the economic evidence, written for the Mayor of London's office in 2011[34], reported that:

> **"The evidence clearly shows that well designed and implemented early years programmes can have significant benefits in terms of life-long health, educational attainment, social, emotional and economic wellbeing and reduced involvement in crime that far outweigh their costs.**
>
> **Programmes that improve learning abilities, behaviour and parental relationships early in childhood can help to break the cycle of poverty and inequality and therefore reduce health inequalities. Similarly, ensuring families benefit from timely and effective health care in pregnancy and infancy will have a positive impact on the child's future attainment and wellbeing."**

The economic case for investment for early years interventions is that they:

- Can be extremely cost-effective and generate long-lasting, cumulative benefits. By preventing difficulties arising, they reduce the need for remedial spending on complex interventions and multiple layers of support later in life[35]
- Ensure that where children do develop difficulties, these are likely to be less serious and more responsive to less intensive interventions.

A 2021 research paper shows that in the UK children who are being parented sensitively by the time they are four to six years old cost 13 times less by the age of twelve years than those who are not[36]. Costs were spread across personal family expenditure and education, health, social and justice services. Adolescents whose parents responded less sensitively by the time they were four to six years old cost on average £21,763 compared to only £1,619 incurred by those who were more sensitively parented.

The Nobel economist James Heckman has shown that the most economically efficient time to invest in developing children's skills and social abilities is in the very early years.[37]

For more details on the economic case for investing in early years, see **Investing in Babies, the Economic Case for Investment** (Evidence Brief 6, First 1001 Days, 2021)

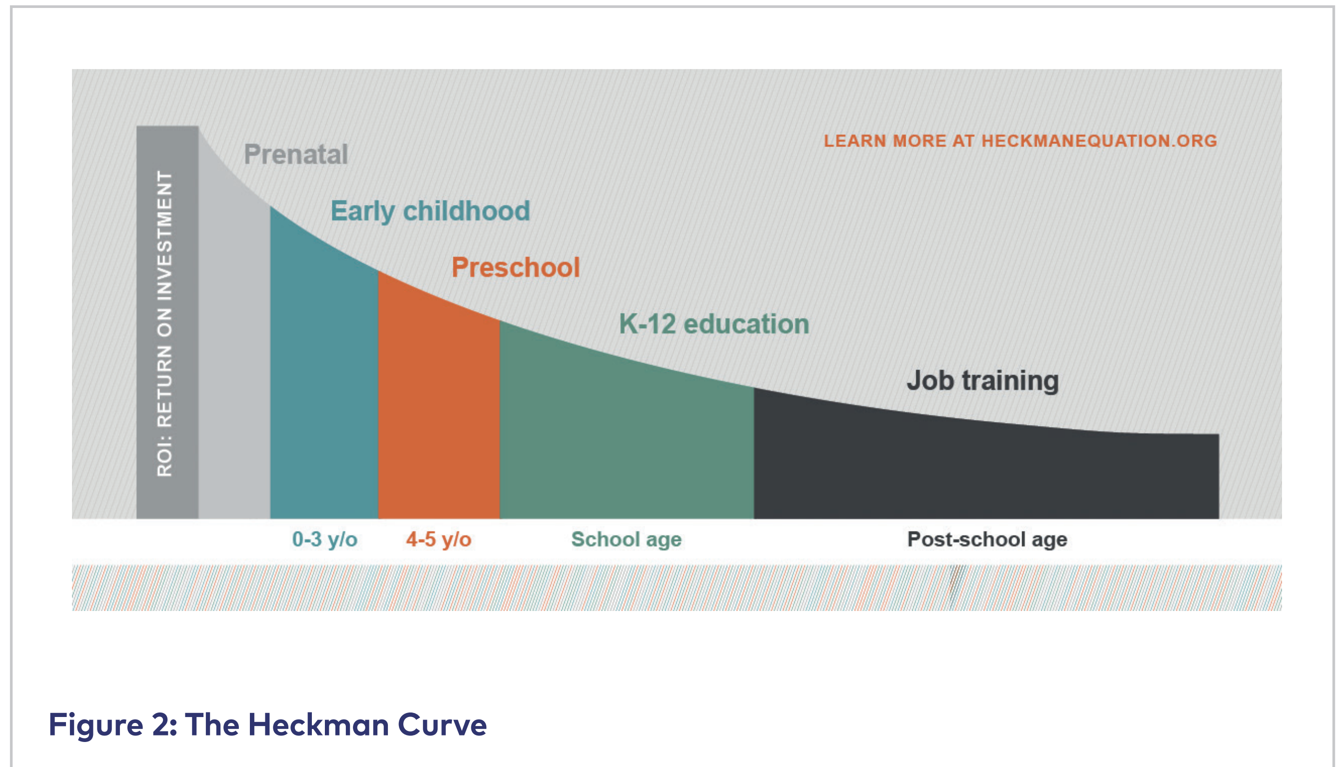


Figure 2: The Heckman Curve

"Investing in the early years is one of the smartest things a country can do. Early childhood experiences have a profound impact on brain development – affecting learning, health, behaviour and ultimately, lifetime opportunities."

World Bank[38]

"Investing in early childhood development is good for everyone – governments, businesses, communities, parents and caregivers, and most of all, babies and young children... And investing in early childhood development is cost-effective: For every $1 spent on early childhood development interventions, the return on investment can be as high as $13."

World Health Organisation, World Bank and UNICEF[39]

Late intervention can be too little, too late

Half of all mental health problems are established by age fourteen[40]. According to the Chief Medical Officer (2013) 75% of people with mental health problems in England "receive no treatment at all"[41]. Additionally, of those that do, not all treatment is effective. The safety net of late intervention is not guaranteed.

However, neither should we overestimate the potency of parent-infant relationship interventions. It is very unlikely that there are any fully effective early interventions that will improve outcomes across the lifespan for all families with particularly complex needs, especially if we are using relatively low-level interventions. **An effective prevention approach employs a menu of interventions at all levels of the system which can be tailored to different families; one intervention does not work for all.**

Based on this compelling case, specialised parent-infant relationship provision is growing across the UK. There are currently 39 specialised parent-infant relationship teams across the UK[42], up from 29 in 2019. There are two in Wales (Cardiff and Gwent).

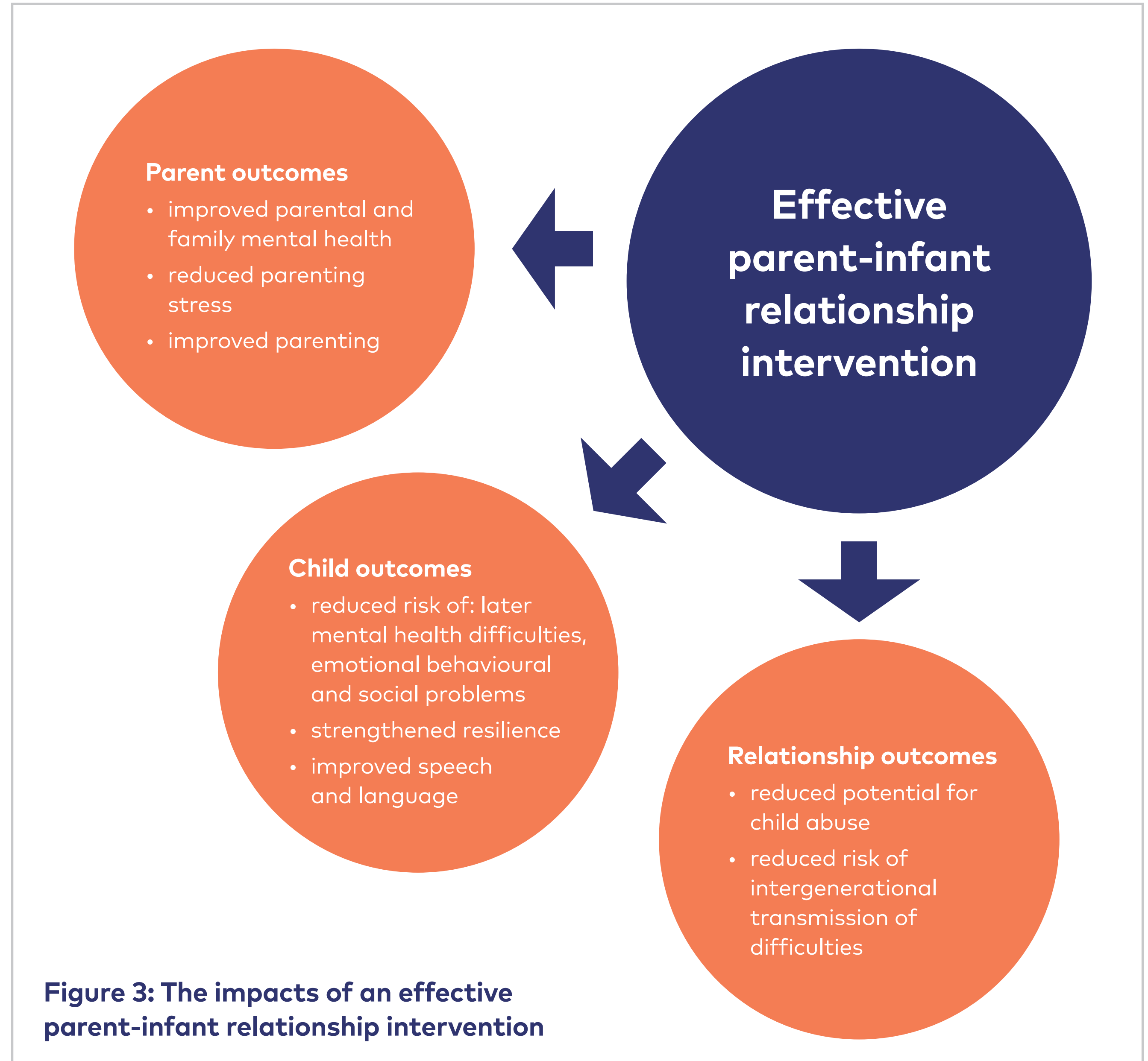


Figure 3: The impacts of an effective parent-infant relationship intervention

Service mapping

In our first workstream, service mapping, we researched local public and voluntary sector services which help and support the parent-infant relationship from conception to second birthday. To do this we interviewed local practitioners and service managers, collected service data and consulted with senior leaders at two online workshops.

We gathered information on inclusion thresholds, referral criteria, geographical boundaries and other forms of service boundary and how these might create interfaces and gaps.

We also identified which level of need each service covered:

- **Universal level:** services who work with the highest level of need and whose work requires, such as GPs, midwives and health visitors
- **Targeted level:** services that work with families who need some help, such as parenting support
- **Statutory level:** services provided to those families working with children's safeguarding teams
- **Specialist level:** services whose work requires a specialist intervention or skill set, such as CAMHS.

Within each of these levels, we drew a distinction between those services which focus specifically on the parent-infant relationship (focused/specialised) versus those services which reduce risk factors for parent-infant relationship difficulties and/or strengthen protective factors as part of a wider focus of work (non-specialised).

This is an important distinction: some services which provide specialist levels of support may not necessarily be "specialised" in, or focused specifically on, the parent-infant relationship. Parent-infant work is highly-specialised at all levels of need, including in specialist services such as CAMHS, and requires post-qualification training for all professions[43]. Three levels of parent-infant competencies are helpfully laid out in the AiMH UK Infant Mental Health Competencies Framework[44].

There are good foundations to build on but very limited capacity for specialised help and support

In all three areas, **excellent health, social care and family support services are delivering helpful and effective work on issues related to the parent-infant relationship**. Much of their work will be reducing general risk factors in the family and strengthening protective factors in ways which support the parent-infant relationship. Some teams have specialist midwives and health visitors with some additional parent-infant training.

We found pockets of good practice across all levels of need including Baby in Mind (Bridgend), Resilient Families Service (RCT), Supporting Change (Merthyr Tydfil), Intensive Family Support teams, educational psychology, health psychology and health visiting. Valleys Kids, a voluntary sector in RCT, and Home-Start across the region offer a range of important, community-based services.

However, we did not discover any targeted therapeutic postnatal work specifically focused on the parent-infant relationship. Across the region, the local CAMHS and perinatal mental health teams do not currently provide any therapeutic parent-infant relationship support and there is no voluntary sector therapeutic service.

So, whilst there are clearly some great foundations to build on, if commissioners are intent on meeting the local need greater investment is needed across the system, increasing the capacity for direct work focused specifically on the parent-infant relationship at specialist and targeted levels.

Children under two experiencing child maltreatment are a priority group to receive specialised therapies focused on the parent-infant relationship.

Local assessment processes do not yet directly ask about or assess the parent-infant relationship

Our review found that whilst various service-specific assessment pro formas cover factors relevant to the parent-infant relationship, none address it directly. This underestimates the need for parent-infant relationship support and leads to missed opportunities to intervene when help is likely to be at its easiest and most effective.

There are opportunities to increase earlier identification of parent-infant relationship difficulties through all frontline health and social care services, including GPs, paediatrics, early language practitioners, and services that see older children and parents, such as child and adult mental health.

We therefore recommend that anyone who assesses families should receive **additional training in how to identify and assess risk in parent-infant relationships** and have **access to consultation** on assessment techniques and care planning from specialist staff.

Additionally, that all statutory and preventative services **review their assessment framework/model** to ensure it is sensitive enough to identify parent-infant relationships under strain.

There is a small group of staff with specialist parent-infant competencies

Parent-infant relationship work is skilled and often complex. **We estimate that there are seven or eight practitioners across the CTM region with training and skills at levels two and three of the AiMH UK Infant Mental Health Competency Framework.** This includes staff in RCT's Therapeutic Families and Intensive Family Support Teams, educational psychology, health psychology and specialist health visiting. However, **if commissioners are intent on meeting the local need, more staff with specialist skills will be required**.

We are therefore recommending both local and national strategic workforce training and development plans to address current and future challenges.

There are an insufficient number of parent-infant practitioners across the UK and we predict this will be one of the biggest challenges to scaling parent-infant relationship interventions across Wales.

Midwives and health visitors are central to parent-infant relationship support

We heard that midwifery and other services meeting families antenatally would particularly welcome more training and access to support and consultation.

We found that there is a commonly held perception that the parent-infant relationship is the responsibility of health visiting, and we believe this needs to be challenged because families enter services at multiple points and a wide range of professions can and do offer helpful and effective support.

Equally, health visiting is a highly skilled, well-placed and universal profession which offers good opportunities to better support parent-infant relationships. We are therefore recommending that, alongside a strategic workforce development plan for the entire children and families' workforce, **at least one specialist HV per local authority area** has enhanced parent-infant relationship training and skills, such that they can offer consultation and support to colleagues.

This is consistent with Recommendation 22 in the *Perinatal Mental Health in Wales* report[45] which encouraged specialist perinatal and infant health visitors to work in "a multidisciplinary way with CAMHS and infant mental health services, provide specialist support to mothers, fathers and their children, and provide specialist training and consultation to the wider health visiting and early years' workforce, particularly with regard to issues relating to attachment and bonding".

Some services address the consequences of parent-infant relationship difficulties rather than the relationship itself

In each of the three areas, there are public and voluntary sector services offering effective parenting, family support and wellbeing services. Families with young children often access these kinds of services for help to reduce symptoms of distress, such as child behaviour problems, family conflict, sleeping, feeding, toileting, and development. CTM has many skilled practitioners who can effectively help families with these issues at a universal and targeted level and this is highly valued by families.

However, **effective prevention requires staff to understand and identify when relational disturbances are leading to behavioural presentations and so provide relationship-based interventions where appropriate.**

Significant parent-infant relationship difficulties almost always require specialised therapies. We heard that in the CTM UHB region, as is commonly the case across the UK, many families that need more specialised interventions are not being matched to the right level of intervention quickly enough.

We are therefore recommending that **all staff in the children's workforce should be trained to**:

a. Understand the central importance of the parent-infant relationship for lifelong outcomes

b. Identify which parent-infant relationships are under strain and be able to access specialised consultation about what to do next. This does not mean equipping everyone with the ability to assess relationships, but it does mean an awareness of indicators of distress in babies and in parent-infant relationships

We are also recommending that **the THRIVE Framework for Systems Change** offers advantages over the traditional 'escalator' model of tiered care and should form the basis of parent-infant relationship systems transformation.

Plans need to include peer support and support for dads and parenting partners

Peer support can be a highly (cost-)effective mechanism to support the parent-infant relationship. It reduces family stress through the creation of social networks and provision of emotional support.[46] Families can find some normalisation and strategies for their concerns. Vulnerable families have the chance to build trust before accessing formal services.

We heard that the continuing pockets of peer support are highly valued by families and staff but have been reduced since the pandemic. Interviewees also told us there is not enough support for dads and partners across the region, sometimes none at all, but that pockets of support that do exist are highly valued by families and staff. We are therefore recommending that **parent-infant relationship support should include peer support and support for dads and parenting partners**.

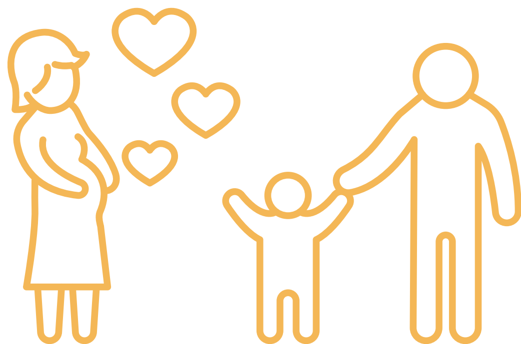
We are also recommending that **the needs of all parents, including dads, LGBTQ+ parents, kinship and foster carers are included in plans to strengthen support for the parent-infant relationship**.

Families need additional support to transition across service boundaries

Interview respondents told us that when transient factors change, a family might drift between statutory and pre-statutory levels of need. However, core difficulties, including the parent-infant relationship, need consistent support irrespective of which part of the system the family find themselves in at any given point.

There needs to be access to specialised parent-infant help and support at both statutory and pre-statutory levels to ensure the focus remains on the parent-infant relationship, and interventions don't stop and start.

We also heard how staff turnover and transitions between services create higher risks of families dropping out of services, suggesting that **transitions need to be managed especially well for families where relationship issues are at the fore**. This might include more joint working across services to ensure more successful transitions.



Signposting, self-management and one off contact

Goals focused, evidence informed and outcomes focused intervention

GETTING ADVICE

GETTING HELP

THRIVING

Prevention and promotion

GETTING RISK SUPPORT

GETTING MORE HELP

Risk management and crisis response

Extensive treatment

Figure 4: The THRIVE framework

Staff want to know more, do more, and see more focus on the first 1000 days

Encouragingly, staff from all parts of the system want to know more and do more to help and support the parent-infant relationship. Practitioners and service managers are highly supportive of a greater focus on services for babies and value highly any teams or interventions perceived to offer help and support. Interviewees often recounted their experiences of working with children for whom early intervention could have avoided later adversity, distress and poorer outcomes.

Strategic workforce development issues are current and future challenges

A strategic workforce development plan would have multiple benefits in developing capacity at all levels of intervention, growing a parent-infant workforce for the future and encouraging a shared understanding and language across the system.

Workforce development should include a broad range of staff including childminders and voluntary sector workers.

Tracking a child's journey from first contact to outcome at age two would highlight successes and missed opportunities of early intervention

It takes a lot of time and effort to track children's journeys through a system but the data is invaluable in understanding the successes, and missed opportunities, of early intervention. We would encourage commissioners to consider a future project to track vulnerable children from first contact to outcome at two years and potentially beyond.

We are also recommending that the health visitor paper records system be replaced with electronic records to support safeguarding practice and easier access to data.

Estimating current and future need for parent-infant relationship support

Using a range of local, national and international data, we estimated the current and future needs for parent-infant relationship help and support across the CTM region. These four steps provide a blueprint for commissioners about how to use data to inform service transformation in parent-infant relationship support.

1. Current and future population size, workforce and workload trends

Our cautious interpretation is that whilst the under two's population in CTM may well decrease slightly over the next four years[47], service demand will, at the very least, be offset by the community and family impacts of COVID and continued downward pressure on health visitor numbers.

All things remaining equal, we predict that improving the early identification of parent-infant relationship difficulties will change service demand:

a. In the short term (6–12 months) we predict that demand for parent-infant support will increase due to improving workforce capability to identify problems earlier.

b. In the medium term (1–2 years) we predict that the average age of referrals to late interventions services such as Looked After services, children's social care and CAMHS will decrease as problems are identified sooner.

c. In the long term (2 years plus) we predict that demand on late intervention services will reduce, leading to longer-term cost savings as parent-infant relationship difficulties are effectively addressed earlier in the life course.

2. Research about population prevalence of parent-infant relationship problems

We consulted the international and national research regarding prevalence of parent-infant relationship disorders. This field is replete with competing constructs (parental sensitivity, attachment, attunement, reciprocity etc.) which frustrates examination of the literature. However, 'attachment' has been the most thoroughly researched construct with the largest and most longitudinal body of evidence to demonstrate lifelong outcomes. Therefore, we have chosen attachment as the most reliable, but still imperfect, measure of the parent-infant relationship for commissioning and service planning purposes.

We have used the Ainsworth and Main attachment classifications of 'secure', 'insecure' (combining avoidant and ambivalent) and 'disorganised'[48]. Clearly, in real life, children cannot be categorised into three discrete boxes. However, the long-term outcomes research is broadly predicated on this understanding of attachment categorisation from the 1970s so we can be more confident about which types of difficulty underpin which types of later life outcome. When we have used this approach to describe need at a population level, we find it triangulates well with clinical services, including the Greater Manchester model of parent-infant mental health services.

In a typical research population of white, middle class families, the distribution of attachment patterns are:

- **Secure (around 55–60% of babies)**

  These are babies who can reliably seek and receive comfort from their caregivers when under stress. These are typically children at lowest risk of later social, emotional and behavioural difficulties.

- **Insecure (around 25–30%)**

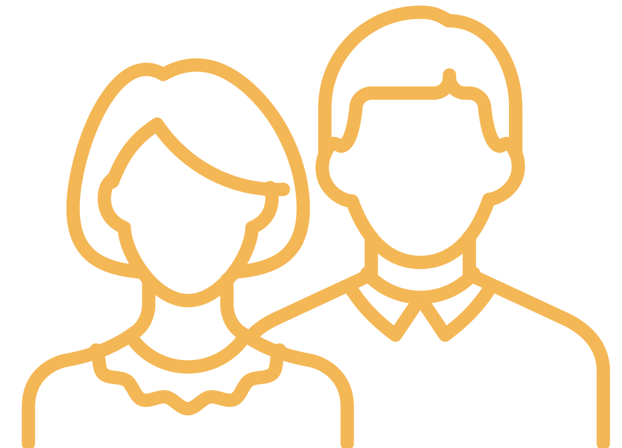
  These are babies who appear to either manage their own distress by not strongly signalling their needs or seem unable to manage their distress and are not soothed when comfort is offered. They often express anger, resistance or avoid contact with a caregiver after separation. These are children at higher risk of later mental health problems.

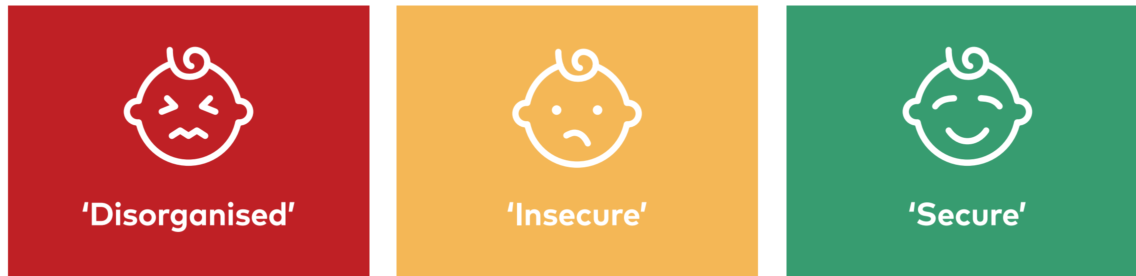
- **Disorganised (around 15%)**

  This type of attachment pattern refers to children who, due to unpredictable or hostile care, have been unable to develop a predominant way of relating to their carer. They may exhibit unpredictable responses to relationships and care. This can include being overly familiar, aggressive, expressing limited emotion or persistent emotional dysregulation. These children are at the highest risk of later emotional, social and behavioural difficulties.

See NICE Guideline No. 26 for a guide[49].

Attachment insecurity or disorganisation is likely to increase in the face of family and community risk and stress factors. Among babies of adolescent mothers, disorganised attachment increases to a population prevalence of around 30%, 34% in low-income samples[50], 43–80% in children of mothers misusing substances/alcohol, and 21% in children of depressed parents[51]. According to NICE, around 80% of children who suffer maltreatment are classified as having disorganised attachment[52].





White, middle-class babies

Babies experiencing abuse and/or neglect

Figure 5: Attachment pattern distribution in typical research population and children experiencing abuse and/or neglect

The foundational research on attachment categories identifies their research participants as mainly white and middle class. For an exploration of cross-cultural patterns of attachment, we recommend Van Izjendoorn M & Kroonenberg P (1988) Cross-cultural patterns of attachment: A meta-analysi of the strange situation. Child Development, 59, 147-156.

3. Applying research findings to local populations

The prevalence of attachment insecurity/disorganisation will be higher in communities affected by trauma, including asylum-seeking, racism, poverty or mass unemployment. The National Household Survey of ACES in England[53] and the Welsh ACEs study show that a greater proportion of adults in Wales have experienced the highest levels of trauma and adversity compared to England.

Data from Stats Wales shows that Bridgend, Merthyr Tydfil and RCT have been in the top five areas for numbers of children in Looked After Care per 10,000 population under 18, in 2019 and 2020. Also, that the CTM region has higher indications of deprivation than other parts of Wales on relevant measures such as poverty including child poverty, children in care, teenage pregnancy, low birth weight and unemployment.

Our conclusion is that as a region, the communities of CTM have experienced more trauma and adversity than England and other health board areas in Wales. These factors, at a population level, are likely to increase the risks and stress factors for less-than-optimal parent-infant relationships.

We therefore suggest that the predicted distribution of attachment patterns be adjusted for the local population as follows:

	International average: White, middle-class population with low-average adversity	**CTM region:** Mixed SES population facing moderate to high levels of adversity
Secure attachments	55–60% of babies	Reduced to 50%
Insecure attachments	25–30%	Increased to 30%
Disorganised attachments	15%	Increased to 20%

Table 1: Attachment pattern distribution adjusted for high adversity/trauma rates in CTM population

4. Using local population statistics to calculate actual numbers of children needing a service

Actual demand for support is lower than the predicted need for various reasons, including the barriers which make it difficult for families with complex needs to access help and support.

In our main report, we describe these reasons and our estimates of how they affect the likely demand on parent-infant support services. The figures (right) derive from our experience of working closely with other services across the UK.

For this summary report, we present our conclusions which are that in an area of high family and community adversity and trauma:

50%

of parents of children under two are unlikely to need any parent-infant relationship support beyond universal support because they have a secure relationship with their child.

20%

parent-infant dyads might have an insecure attachment but are unlikely to access services until after child is two.

13%

of families might need support for a disorganised attachment but are unlikely to access help. They are likely to need risk support via social care.

This leaves 17% who we predict might access intervention or therapeutic services of some kind:

8%

will access targeted services for help with attachment insecurity.

2%

will access shorter-term specialist therapeutic work for substantially insecure attachment.

7%

will access longer-term specialist therapeutic for disorganised attachment.

Using data provided by CTM UHB's child health department, we know what the population of children under two is, from which we can calculate the number of children likely to access services at these different levels.

100% babies

20% disorganised

We estimate two-thirds (13%) will not access/engage

13% (1,641 children) will probably need risk support via social care

We estimate one-third (7%) will engage with services

7% (884 children) will access specialist team for direct work

30% insecure

We estimate one-third (10%) will engage with services

Some will need short-term specialised help (estimate 2%)

2% (253 children) will access specialist team for short-term direct work

Most will access targeted help (estimate 8%)

8% (1,010 children) will access targeted services

We estimate two-thirds (20%) will not access/ engage before the child is two

The families will access either no help or help after child is two but would benefit from proactive identification and outreach to engage

20% (2,525 children) will not access/ engage until after child is two

50% secure

Universal support

50% (6,313 children) will need universal support only

Figure 6: Estimating actual service demand using population figures from CTM region

Hearing from local parents

We used a variety of methods to consult with local parents of children five years or younger. In total, we heard from 487 parents:

Qualitative (n=41):

1. One-to-one semi-structured interviews (9 parents)
2. Focus groups (3 groups: 1 per area, 14 parents in total)
3. An online in-depth qualitative survey (18 parents)

Quantitative (n=446)

4. An online quantitative survey (446 parents)

A local, highly-regarded voluntary sector organisation, Valleys Kids, helped us write and pilot the surveys and recruit parents. The qualitative results were formally thematically analysed. The full method and results are presented in our full report.

The sample included a small number of fathers, a representative number of parents under 25 years, some parents whose children have or had an allocated social worker, some black and brown parents, some same sex couples, some parents of twins but no pregnant parents. The online surveys are likely to have excluded those without access to the internet or social media.

Parents reported they have a high level of awareness about the impact that the parent-infant relationship can have on a child's development.

The parent-infant relationship was ranked as the third most important influence on child development, just below the impact of violence in the home and parental drug use (see Figure 7). Across the survey, young parents appeared to be the group that attributed the most value to the importance of the parent-infant relationship.

"I just think that developmentally you get better progress if you've had that bonding and support because you feel loved, and you feel safe; and I think to provide that environment encourages emotional, mental, physical development ..."
Mother of baby aged six months, Merthyr

Parents identified a range of factors they felt might put pressure on a parent-infant relationship.

This included feeling alone in their parenting role, difficulties in breastfeeding, lack of social and professional support, judgement by others, unmet and unrealistic expectations such as 'love at first sight', parental mental health including birth trauma, past and current stressors and feeling like their baby doesn't like them or favours the other parent.

"I guess just those kinds where perhaps the father doesn't have the same connection and perhaps feeling jealous or left out."
Father of two children, youngest eighteen months, Merthyr

Being in a home where there is violence
Parents who use drugs
The relationship between a parent and their baby
Parents drinking heavily
Cuddles and skin-to-skin contact
Baby chatting and playing with an adult
Parental mental health and stress
Parents arguing
Baby playing with other children
The baby's diet and nutrition
The amount of sleep a baby gets
Singing and musical toys
Amount of time baby spends on screens (TV, iPad etc.)
Going to childcare/nursery
Parents using babysitter in the evenings
Having a pet in the house
Family owns a car or not

0 50 100 150 200 250 300 350 400 450

Number of people

A very big effect | A big effect | Medium effect | A little effect | No effect

Figure 7: Parents' ratings of factors affecting their baby's development

As expected, we heard positive and negative views about support received previously; **half thought there wasn't enough support for the parent-infant relationship**.

> **"There is some information in the book that was given during pregnancy and the health visitor briefly discussed bonding during one visit. I feel this is an area that is lacking."**
> Mother of infant aged fifteen months, RCT

> **"The only physical thing that I was told about bonding specifically, or attachment, was just kangaroo care, and plenty of skin-to-skin, and that can create quite a big bond as well."**
> Focus group parent, RCT

Parents are asking for more open conversations with professionals about their parent-infant relationship and value being asked directly. They seem ready to engage further with this topic and eager to know more about how to translate knowledge into real life parenting.

A third of parents had been asked directly about their relationship with their baby and this was mainly by health visitors and mainly postnatally. Notably, no young parents, fathers, or parents who had had social work input, had been asked about the parent-infant relationship. These groups of parents may be at greater risk of being excluded from parent-infant relationship support and need proactive engagement.

- There was too little relationship support available
- There was about the right amount of relationship support available to me
- There was too much focus on my relationship with my baby
- I don't know

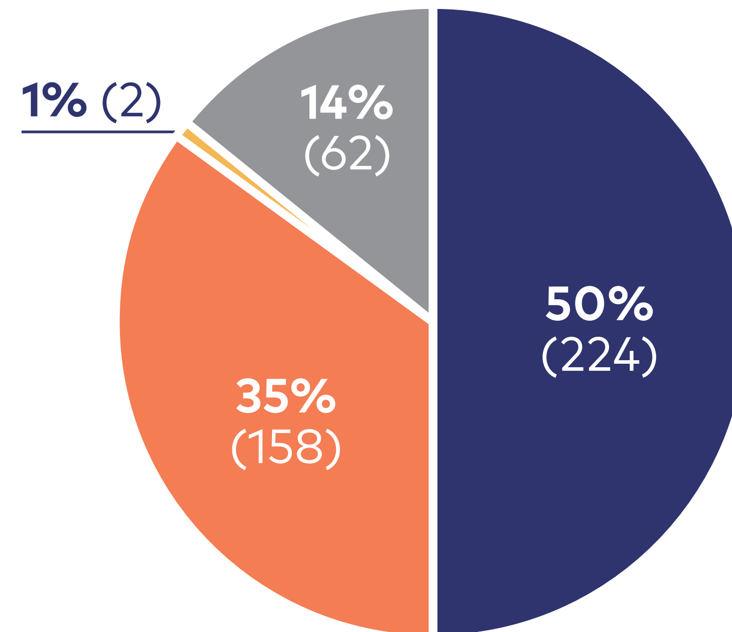


Figure 8: Parents' views about the amount of support available to help them form a good relationship with your new baby

Receiving direct help with the developing parent-infant relationship is rare. When asked if they had ever been given any direct help from a professional specifically to help them bond with their baby, 97% of parents said they hadn't. However, of those 3% of parents who had, 93% said they found it helpful.

Parents commented on the loss of support during lockdown and the reduction in support over the years. Staff in our service mapping workstream also talked about these two issues.

Informal routes to support are important to families. Most parents said they would first turn to friends or family for support with issues in their relationship with their baby, although many also said their first port of call would be their health visitor.

The fear of judgement was marked, and stigma and fear of consequences are barriers to parents coming forward; this is despite parents saying they would want to use a service for parent-infant relationship support. This again triangulates with findings from the service mapping.

	Number of people
I would be worried about being judged	93
I'd be worried about people thinking I was a failure	86
I wouldn't know who could help me	52
I'd be worried about having my children taken off me	44
My family and friends would help me	36
I'd be worried about my partner of family disapproving	24
I'd be worried about what they might want to talk about	19
I wouldn't like people knowing my business	14
Other	10
I'm too busy	4
I wouldn't think it was important	1

Figure 9: Parents' ratings of what prevents them asking for help about the relationship with their baby

> **"I think there is a fear now, you know, like I had a massive irrational fear that if I went to the GP and said I was struggling, that they may take my baby off me …"**
> Mother of two children, Merthyr

Written information about the parent-infant relationship was useful for most parents, but for around 15% of mothers it exacerbated feelings of guilt. Information about what parents and parenting 'should' be like can exacerbate latent feelings of guilt, anxiety and failure and in these cases, can be counterproductive. This is important: worry and fear of judgement are barriers to parents asking for help so we cannot afford to amplify these feelings.

> **"There's lots of information on what you can do to benefit your baby, which is brilliant, but it can also put pressure on new mothers who want the best for the baby as I know it made me feel guilty for not being able to do it all."**
> Mother of twins aged nine weeks, RCT

This alerts us to the fact that 'one size does not fit all' in interventions, as well as to the need to address the context of how information is given to parents by early years professionals and whether it is followed up in future visits.

Therefore, how parent-infant relationship support and services are developed, framed and publicised is of key importance. Messaging needs to emphasise that reaching out for support is a strength in parenting not a weakness. We are recommending an evidence-based public awareness campaign which would also potentially reach friends and family, allowing key messages to soak into the social networks of parents.

Parents had a lot of ideas about what any future support should look like. **Parents wanted a parent-infant relationship service to be easily available, locally accessible, friendly, welcoming and non-judgemental, to actively include fathers and to provide parent-infant groups where they could access peer support.**

A key message from this consultation is that parents want support specifically about their developing relationship with their baby; they value being asked about it, and value any support that they are offered.

> **"Easy to access. Free to attend. Not associated with negativity and shame … greater support. Creating positive peer groups and friendships with others to decrease isolation and loneliness."**
> Mother of infant aged two, RCT

> **"Knowing where to turn to, knowing there was no judgement."**
> Father of two children, youngest eighteen months, RCT

Analysing workforce strengths and needs

The aim of this workstream was to understand the current and future training needs and workforce requirements to ensure partners are able to respond to a future delivery model of strengthened parent-infant relationship help and support.

We developed a workforce online survey with the project steering group and piloted it with a small number of local staff. The survey was available in both Welsh and English and was approved by the Quality Assurance panel at CTM UHB. The survey link was distributed to staff and volunteers who might work with children under two in the health, social care, childcare, education and voluntary sectors. The survey was live for nine weeks from July to September 2021. We received 177 completed responses and these staff were geographically representative of the three local authority areas.

Results

Staff awareness of the importance of the parent-infant relationship is very high which reflects the good investment in training across the region. Recent workforce training in the GroBrain Foundation Course, EarlyYES Babies in Our Minds, and Kate Cairns's Attachment and Brain Development were the first training relevant to the parent-infant relationship for 70% of the attendees. In our workforce survey, this recent training was highly valued and useful.

At least 45% of the population of babies are likely to have some degree of attachment insecurity or disorganisation, and around one in five has significant difficulties. Frontline staff not having seen any concerns could be due to lack of contact with families antenatally/postnatally or of not knowing what to look for. A quarter of health visitors, GPs and more than 40% of children's social care, family support and parenting staff have not had any concerns about a parent-infant relationship antenatally. A third of midwives, a fifth of social care, family support and parenting staff and two individual health visitors had not had any concerns about a parent-infant relationship postnatally.

The professions most likely to offer direct help or support are health visitors/nursery nurses, statutory children's services, midwives, and family support/parenting workers. Health visitors/nursery nurses, midwives and family/support parenting workers have attended more training courses per head, but children's social care staff report less training and should be prioritised for future training.

In terms of formal interventions, the most frequently mentioned were:

- **GroBrain** (43 respondents)
- **Baby massage** (38 respondents)
- **Listening or listening visits** (15 respondents)
- **Supporting skin-to-skin contact** (12 respondents)
- **Solihull Approach** (10 respondents)
- **Video Interaction Guidance (VIG) or similar** (5 respondents)
- **Incredible Years Baby and Toddler Programme** (4 respondents)
- **Five to Thrive** (3 respondents)
- **Watch, Wait and Wonder** (2 respondents)
- **Parenting Puzzle** (2 respondents)

Health Visitors were the most common referral destination when another practitioner was looking to either refer a family on or seek support or advice. This supports findings from the parents' consultation and service mapping that health visitors are seen as the predominant workforce for parent-infant relationship concerns. Health visitors are the professional group with the highest training rate per practitioner (4.7 courses per person) and the lowest proportion of respondents who have had no training at all (0%).

A third of staff would refer to the perinatal mental health team and 3% would refer to CAMHS for support with the parent-infant relationship, yet this help and support is not offered by those teams.

GPs and midwives report a lack of training opportunities, clinical support and supervision regarding the parent-infant relationship. This is important because these are two of the three professional groups most likely to serve as universal entry points into the system for families seeking help.

Over the years, training has mainly been accessed according to practitioners' interests and pots of money available, so some staff have attended quite a few courses and some have attended none. There are opportunities to develop a strategic workforce development approach either within each area or regionally. This would ensure that all staff currently in key roles, particularly those in which families are assessed, have an adequate level of knowledge and skills. The Association of Infant Mental Health UK's Infant Mental Health Competencies Framework is a useful tool to develop individual development plans for practitioners who assess and support families.

Some audit, refresher and/or embedding work for key courses, such as the Solihull Approach, Video Interaction Guidance (VIG) and Neonatal Brazelton Observation (NBO), would help ensure training is translated into practice.

Respondents' perceptions are that the biggest gap in provision is at the highest level of intervention, which triangulates with the service mapping work.

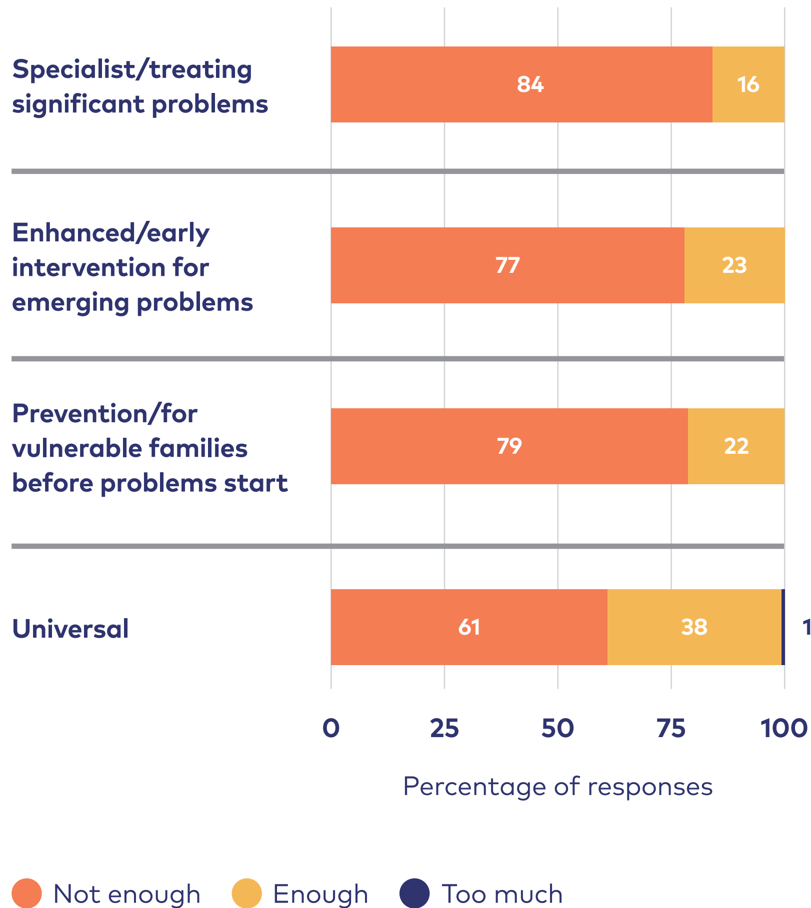


Figure 10: Professionals' ratings of parent-infant relationship support

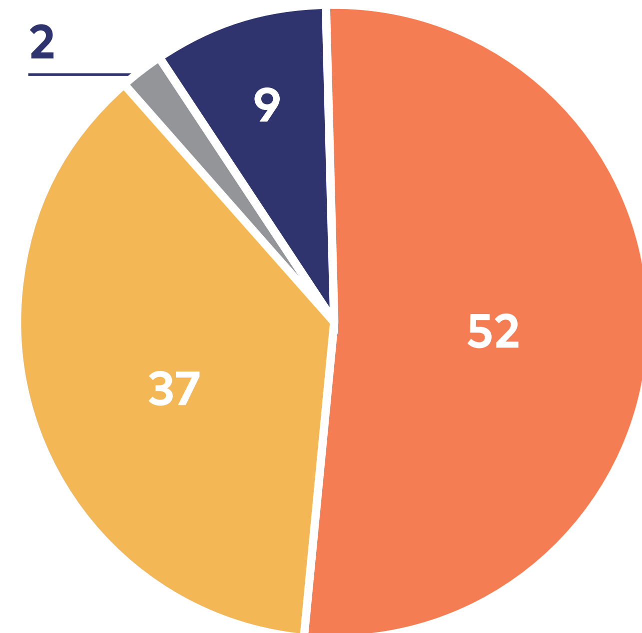


Figure 11: Professionals' self-ratings of parent-infant relationship skills level

About half of the respondents rate themselves as aware of the importance of infant mental health and about a third rate themselves as having some direct skills to support the parent-infant relationship. Two per cent rate themselves as having specialist skills which seems to refer to level of experience with babies generally rather than to specialised therapeutic parent-infant training.

The majority of past workforce training has focused on general awareness raising and interventions at a universal and targeted level. There is a gap in identification and assessment training, particularly during the antenatal period. This is often true in many places, partly because there is a dearth of training courses offering assessment skills for staff at a universal and targeted level. Assessing parent-infant relationships does require additional post-qualification training to decode baby communication, patterns of interactions and indicators of relationship distress. Looking at this workforce survey, it seems unlikely that many practitioners across CTM have had much training in identification/assessment. This is important because families could be being missed and also, intervention is only effective if it is matched to the families' individual needs through a good assessment. Strengthening identification and assessment is, therefore, one of our main recommendations.

Line managers/supervisors and the CAMHS helpline are notable sources of support and supervision and should, therefore, be included in workforce training plans to strengthen parent-infant relationship help and support.

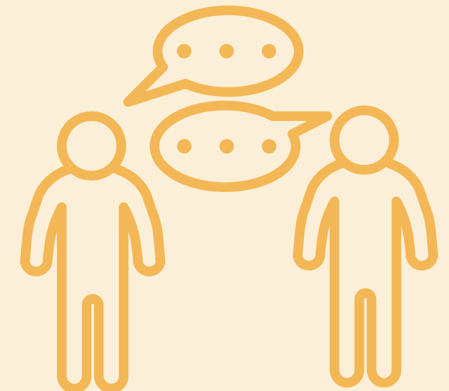
As a group, staff find it slightly harder to raise their concerns about the parent-infant relationship with a parent than regarding other aspects of development.

Summary of recommendations

In the full report there is advice about the sequencing of recommendations and information to support implementation.

Develop a specialised regional parent-infant relationship team

1. The three local authorities, health, voluntary sector and parents work collectively to develop a regional specialised parent-infant relationship team in line with the proposed development options.
2. The specialised parent-infant relationship team to offer a range of consultation, supervision, practice embedding, joint working and workforce training to build capacity and connection across the system.
3. The Head of Service role for the regional specialised team should be recruited early to include responsibility as Strategic Infant Mental Health Lead to:
    a. Oversee a transformation programme that embeds a new focus on the importance of the parent-infant relationship
    b. Oversee the inclusion of the specific needs of babies in all relevant local strategies and a greater focus on babies in service design and delivery
    c. Ensures fathers, LGBTQ+ and other marginalised parents' relationships with their baby are not lost from service design and delivery
4. Any specialised parent-infant team either to include or to integrate very closely with dedicated parental trauma therapy capacity to allow the parent-infant work to proceed without having to wait for parents to have their own trauma treatment elsewhere.
5. Budget to be included for specialist therapeutic skills training within the specialised parent-infant relationships team. A unified training for all parent-infant specialist therapists will fast-track development of good-quality clinical practice and is best designed once a clinical lead is in post.



Strengthen identification and assessment of parent-infant relationship difficulties

6. Wherever babies enter any part of the help and support system, all staff, managers and supervisors to have a basic awareness of the importance of the parent-infant relationship, be trained to identify which parent-infant relationships might be under strain and be able to access specialised consultation about what to do next.

7. Anyone who assesses families to receive additional training in how to identify and assess risk in parent-infant relationships and have access to specialised advice on assessment techniques and care planning.

8. All parents, specifically including partners and dads, younger parents and those with an allocated social worker, to be asked directly about their relationship with their infant at universal contacts. The parent-infant relationship is an explicit topic of conversation at multiple points in the perinatal journey with midwives, health visitors, GPs and nursery nurses.

9. All services to review their assessment framework/model to ensure it is sensitive enough to identify parent-infant relationships under strain.

Train the workforce

10. A multi-agency workforce training and development plan to be developed and delivered. This to include practice with fathers and partners, LGBTQ+ parents and diverse ethnicities.

11. Practitioners to be encouraged to map their parent-infant training and skills on the Association of Infant Mental Health UK competencies framework and use this to create personalised CPD plans.

12. Midwives, GPs, children's social workers, voluntary sector workers and the Early Language Service staff to have priority for workforce training about how to identify and signpost parent-infant relationship difficulties.

13. Insights from the parents' consultation to be cascaded to all practitioners and included in workforce training, including the significant effect of fear of judgement and stigma, and about parents' desire to talk openly about their parent-infant relationship.

14. All staff to feel confident to use printed materials or signposting to information in a sensitive way which acknowledges the risk of parents being made to feel more guilty and anxious and less likely to seek help.

15. In addition to workforce training provided at a regional and local level, practitioners, managers, commissioners and system leaders to be encouraged to access free and low-cost online training opportunities. We provide a directory of these on our **website**.

Create a parent-infant relationships system

16. A new parent-infant relationship care pathway to be developed across the region to ensure timely and appropriate responses to babies' needs, to include the antenatal period.
17. There is additional outreach to marginalised or excluded groups so that staff can understand how best to promote parent-infant relationship help and support to them and to ensure any support meets their specific needs: BAME parents, fathers, young parents, LGBTQ+ parents. An example might be through consultation with existing community groups.
18. Local developments in parent-infant relationship support to be:
    a. Embedded within a whole system, trauma-informed approach
    b. Closely integrated with local plans and national guidance for perinatal mental health teams to support the parent-infant relationship
    c. Designed to reduce, as far as possible, parents' fears about reaching out for support about the parent-infant relationship
    d. Co-created with parents and the voluntary sector.

Develop universal services

19. A co-ordinated plan of specific parent-infant relationships group sessions to be offered to all families, delivered across voluntary, universal and open-access targeted services.
20. Post-COVID recovery to include a comprehensive offer of informal entry points and peer support opportunities which are very easily accessible to pregnant/new parents. This includes activities such as baby massage, play groups and informal peer support groups. Parent peer support, both formal and informal, is championed within a graduated response model. The voluntary sector's role in engaging and supporting parents through a range of activities is supported as an essential part of the parent-infant relationship support system.
21. All families to be offered a strengths-based education package, such as GroBrain or similar, to enhance their understanding of the importance of parent-infant relationships with their current and future children.
22. The distribution of health visitors who have Neonatal Behavioural Observation (NBO), Solihull Approach and Video Interaction Guidance (VIG) training to be audited to ensure all three local authority areas can benefit from these interventions.
23. At least one specialist health visitor per local authority area has enhanced parent-infant relationship training and skills, such that they can offer consultation and support to colleagues.
24. All universal, targeted and statutory/specialist services to ensure their parent-facing material reflects new evidence on the importance of infant mental health and the parent-infant relationship.

Review current processes

25. All services and teams, including CAMHS and perinatal mental health, to complete a self-audit to ensure that they are not inadvertently discriminating against children under two, for example, where referral criteria have not kept pace with research about early childhood mental health.
26. Statutory services to review their spot-purchasing needs for parent-infant work as these might be able to be built into the service specification of specialist therapeutic provision across the region.
27. Consideration to be given to replacing the escalator model of stepped care with the THRIVE framework, with high-quality parent-infant relationship assessment available at all entry points to services so that the babies with the most significant difficulties are referred directly to a specialised or specialist service.
28. All statutory written information given to parents to be reviewed by a specialist health visitor or staff from the regional parent-infant team, to ensure material is consistent with latest research on supporting parent-infant relationships.
29. All evaluation approaches of informal routes of entry into help and support to recognise their important role in building trust, reducing anxiety and facilitating parents accessing help.
30. Future scoping work to consider the role of CAMHS with children aged two to eleven years, for whom there is currently no specialised parent-child relationship support beyond those services previously mentioned.
31. There is new consideration given to the benefits of electronic note keeping systems in key services including health visiting, particularly where speed is of the essence, as it is with babies.

Raise public awareness of the importance of the parent-infant relationship

32. Develop a regional public awareness campaign in co-construction with parents to normalise attention and focus on the parent-infant relationship. The campaign should communicate key messages about what help parents can access to support their parent-infant relationship.

33. All communications, internal and external, about parent-infant relationship should seek to destigmatise difficulties and celebrate the strength in reaching out for support.

34. Content about how to protect and promote your parent-infant relationship should be explicitly included in all antenatal and postnatal groups.

We additionally note some recommendations for wider systems and national policy makers

35. The lack of specialised parent-infant provision is not unique to CTM and exists in many areas of the UK. We recommend that the Welsh Government develops and resources a plan to roll-out parent-infant teams across the country. This should be supported by a funded workforce development plan to address the national shortage of parent-infant practitioners, which should look at pathways, pre-qualification training and continuing professional development.
36. Given the challenges involved in short-term project based funding, wherever possible, services should be resourced by long-term stable increases in baseline funding to provide stability to local services.
37. The Wales Maternity Strategy 2019-2024 be reviewed in light of NICE NG201 Antenatal Care (2021) to include attention to the importance of the parent-infant relationship from conception.
38. This project identified the importance of Health Visitors having the skills, capacity and tools to assess parent infant relationships. The 'Health Visitor Observation and Assessment of the Infant' documentation and other tools like this should be reviewed to ensure they support health visitors in such assessments.

Moving to action

In our full report we provide comprehensive information about the size, constituents and costings of a new specialised parent-infant relationship service in the CTM region. We describe a minimum recommended offer, strengthened offer and full sufficiency options and the types of interventions and outcome measures which will support evidence-based parent-infant relationship work at all levels.

Some of the key points are:

1. Working with families experiencing significant parent-infant relationship difficulties is **highly skilled and often complex work which can only be done by appropriately qualified staff**. We therefore recommend a service which has a least one consultant psychologist and/or psychotherapist, ideally one of each, along with other multi-disciplinary staff all of whom are at level two or three of the AiMH UK Infant Mental Health Competency Framework.
2. A new specialised parent-infant relationship service will help drive transformation and build capacity at all levels of need and intervention by delivering **workforce training, consultation, supervision, embedding good practice, joint working across the system and acting as a resource to policy and strategy makers**. We recommend 50% of their capacity is dedicated to this wider systems transformation and capacity building role.
3. **The lack of an appropriately trained parent-infant workforce is going to be one of the biggest challenges to scaling parent-infant relationship support across Wales.** Therefore, we are recommending one regional service, rather than three separate localised services, to make the service more resilient, sustainable and attractive to applicants.
4. Parent-infant relationship difficulties begin in the emotional worlds of parents, sometimes as a manifestation of unresolved past trauma and adversity. **Any parent-infant relationship work needs to be embedded within a whole system approach to trauma (figure 13), and consequently we are recommending capacity for trauma therapy for parents to be embedded in any new parent-infant relationship service.** This increases the efficiency and effectiveness of parent-infant work because it avoids the parent-infant work having to wait until parents can address their trauma through the adult mental health waiting list.
5. The proposed structure is to have one regional Head of Service (psychologist/ psychotherapist, 8C, 1.0 FTE) with three locality team leads. On the assumption that the team leaders line manage the team members, these would be 8B psychology/ psychotherapy posts. Parent-infant therapist is a generic job title which allows maximum flexibility to recruit multi-disciplinary staff to tailor the service to local needs. This could be health visitors, nursery nurses, midwives, social workers, family support or parenting workers, psychologists and others. We recommend the consideration of joint posts with existing specialist teams to maximise integration and transitions across services.

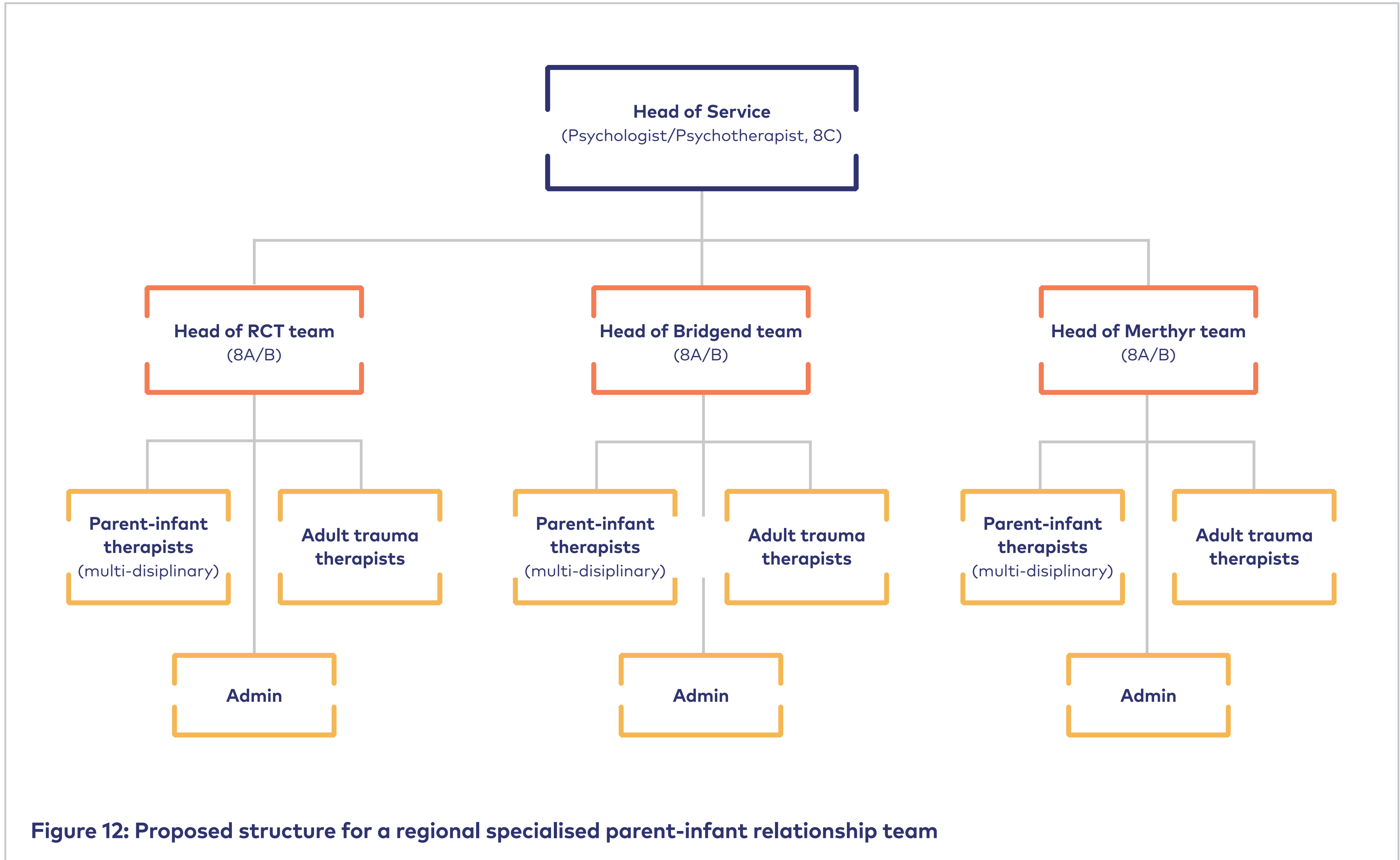


Figure 12: Proposed structure for a regional specialised parent-infant relationship team

Total staffing for regional service	Maximum number of families that could be seen directly	Salary costs	Training costs
All options require a Head of Service role (1.0 8C psychologist/ psychotherapist)		c £75k + on-costs	Given the workforce challenges already described, some new clinical staff would need some post-qualification training once in role. Estimate £1000 per head to cover assessment and intervention training in first post-recruitment year.
Option 1: Minimum recommended 2.5 FTE team lead (psychologist/psychotherapist 8A/B) 4.9 FTE parent-infant therapists 1.0 FTE admin No adult mental health practitioner	382	Team Lead c £137.5k P-I Therapists c £171.5k Admin c £20.5k **Total = £329.5k plus on-costs** (This equates to £ 862 + overheads per family)	
Option 2: Strengthened offer 3.0 FTE team leads (psychologist/psychotherapist 8A/B) 11.6 FTE parent-infant therapists 1.8 FTE admin 2.0 FTE adult mental health practitioner to enhance speed and effectiveness of p-i interventions	759	Team Lead c £165k P-I Therapists c £406k Admin c £37.5k AMH c £94k **Total = £702.5k plus on-costs** (This equates to £926 + on-costs per family)	
Option 3: Full sufficiency 3.0 FTE psychologist/psychotherapist 8A/B 1.0 FTE psychologist/psychotherapist 8A 17.9 FTE parent-infant therapists 2.7 admin 3.0 FTE adult mental health practitioner to enhance speed and effectiveness of p-i interventions.	1,139	Team Lead c £165k 8A psych c £47k P-I Therapists c £626.5k Admin c £54k AMH c £141k **Total = £1,033,500 plus on-costs** (This equates to £907 + on-costs per family)	

Table 2: Options for resourcing a specialised parent-infant relationship team across the CTM region

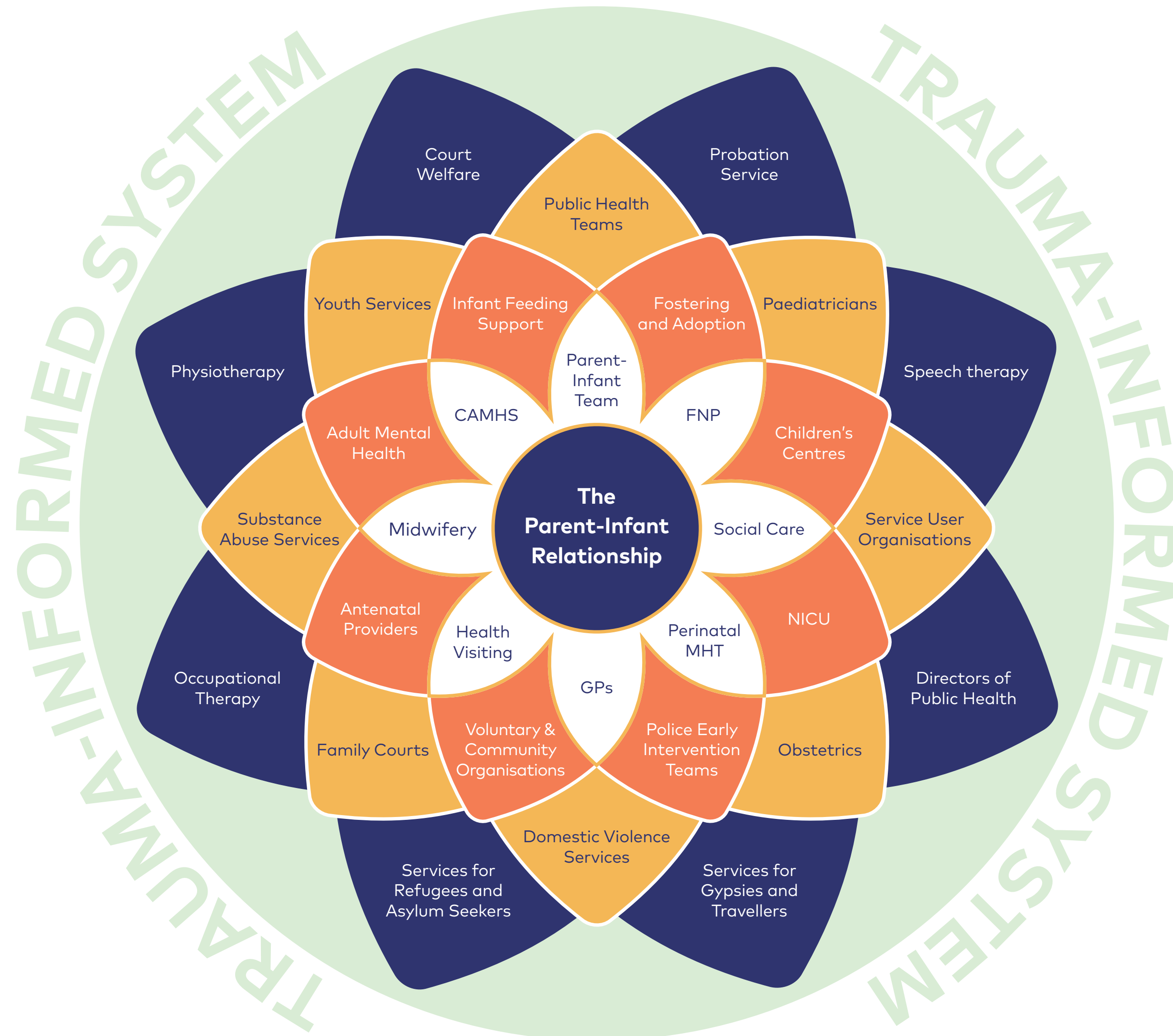


Figure 13: The parent-infant relationship sits at the heart of a multi-disciplinary trauma-informed system

Families build trust and access help through formal and informal entry points ('right first time' principle)

All staff have access to advice about parent-infant relationships.

All assessors know what to look for, how to get advice and which level of help matches families' needs.

All parts of the system have access to joint working, consultation, supervision, reflective practice support, training, and practice embedding from specialised parent-infant team.

SPECIALISED PARENT-INFANT TEAM

TARGETED SERVICES

STATUTORY SERVICES

THRIVING AND GETTING ADVICE (UNIVERSAL)

Universal services retain a role with all families

STRATEGIC WORKFORCE DEVELOPMENT PLAN

Figure 14: A systems model for parent-infant relationship help and support

A whole systems approach to parent-infant relationship help and support in CTM

- A regional service is likely to be best hosted by a regional organisation; in the CTM region this probably means the new service would be hosted by CTM UHB. However, **teams across the UK vary in size, focus, level of intervention and place in the system, and many are successfully funded, staffed and governed through multi-agency partnerships**, so this should be discussed widely with stakeholders locally.
- **The THRIVE framework of systems change offers a useful model.** It retains the understanding that families have different needs at different times, but promotes quicker, more detailed assessment when families enter services to ensure their needs are appropriately matched to the interventions they are offered. It also promotes a 'right first time' approach and reduces families becoming frustrated and dropping out of support if the intervention is too low-level.
- Parents struggling with parent-infant relationship difficulties are often also struggling with trust, so informal points of entry, where trust can be built over time, and carefully managed transitions between services are essential.
- Strengths-based **public campaigning** would encourage help-seeking and disseminate positive messages about the help available. This component of the system is developed last to manage demand capacity.
- As part of this model, **strategic workforce development** would see all staff across public and voluntary sectors aware of the importance of the parent-infant relationship and able to identify risk indicators. All parts of the system would be able to seek advice on how to best guide families to the help they need. Staff at each level of intervention have the skills they need to help families effectively.
- **Everyone who assesses families** has additional training in how to assess protective and risk factors regarding the parent-infant relationship. Families can opt to attend assessment appointments with the member of staff they first talked to about their parent-infant relationship to build trust and support the transition between services.
- **Universal staff retain a role with all families** but may offer additional parent-infant relationship support depending on the outcome of assessment.
- **Families that need help beyond universal services** are matched to targeted services. Those that need more help are matched to the specialised parent-infant relationship team. Statutory services provide risk support in all cases and often in conjunction with the specialised parent-infant relationship team.

Further details about systems transformation to strengthen the parent-infant relationship, including interventions and assessment tools, can be found in our comprehensive **Development and Implementation Toolkit**.

How this work connects to local and national strategy

This project and its recommendations align with:

Cwm Taf Morgannwg University Health Board (CTM UHB) Organisational Strategy

Although supporting the parent-infant relationship concerns babies, it should not be mistaken for work which only has impact in the first 1000 days. Parent-infant relationship work contributes to strategic goals across the lifespan including in education, employment, social relationships, public health, safeguarding, speech and language, mental health and physical health. This work therefore contributes towards the Born Well, Growing Well, Living Well and ultimately Ageing Well strategies within CTM UHB's organisation strategy.

A Healthier Wales: our plan for Health and Social Care (2019)

A Healthier Wales sets out a long-term future vision of a 'whole system approach to health and social care', which is focused on health and wellbeing, and on preventing illness. It includes a specific action plan to transform children and young people's services into "a system of seamless health and care provision".

Work which supports the parent-infant relationship is inter-disciplinary, concerning both the health and social care of families. Our report urges connections to be forged across the system to provide the safety net for our most vulnerable babies. Our recommendations include multiple ways in which health and social care colleagues can collaborate on "new ways of joined-up working" and facilitate transfers between services so that families do not fall between the gaps.

Wellbeing of Future Generations Act (2015)

Two central tenets of the Wellbeing of Future Generations Act (2015) are a healthier Wales and a more equal Wales. This report explains how improvements to parent-infant support can improve lifelong health and reduce health inequalities. For example, about two-thirds of the social inequality in adolescent mental health is explained by early life risk factors measurable by the age of three years[54]. Timely support for the parent-infant relationship can mitigate against these later mental health outcomes by helping to provide a secure base for children's emotional and cognitive development.

Healthy Child Wales Programme (2016)

The Healthy Child Wales Programme (HCWP) focuses on how families with young children are supported. One of the HCWP aims is "to promote bonding and attachment to support positive parent-child relationships resulting in secure emotional attachment for children" which this work will contribute directly towards in CTM.

Prosperity for All – the National Strategy (2017)

Prosperity for All – The National Strategy recognises the role that good health and wellbeing can play in creating a prosperous nation and points out that "the early years are the most crucial time in shaping life chances ... getting this right for every child means they stand the best chance of benefitting from the move into formal education".

Parent-infant interventions play an important part in this strategic objective by supporting cognitive and psychological development in the early years and supporting better educational and employment outcomes[55].

Talk with me: Speech, Language and Communication (SLC) Delivery Plan (2020)

Interventions which improve parent-infant relationships also support speech, language and communication development in very young babies due to their mutual focus on the quality of sensitive interaction[56]. Our recommendations show how the children's workforce can better identify and respond to babies experiencing difficulties in their interactions with caregivers.

Together for Mental Health (2012)

Together for Mental Health is the Welsh Government's 10-year cross-governmental strategy to improve mental health and wellbeing across all ages. It lays out high-level outcomes aimed at achieving a significant improvement to both the quality and accessibility of mental health services for all ages.

Work to improve parent-infant relationships contributes to two of the priority areas:

- Improving access to support for the emotional and mental health wellbeing of children and young people
- Preventing poor mental health and maintaining mental wellbeing

In written evidence to the Perinatal Mental Health enquiry for the Welsh Senedd in 2017[57], Public Health Wales noted: "It is not clear currently whether the full range of interventions to address poor attachment are in place in each local area". This report contributes substantial insights into how supporting attachment can be delivered in real terms.

National Child and Adolescent Mental Health (CAMHS) Strategy

In addition to the aspirations of Together for Mental Health, NEST/NYTH[58] has been proposed as the future vision for CAMHS across Wales. NEST/NYTH is a service planning tool which aims to ensure that every child, from birth, has everyday relationships which are Nurturing, Empowering, Safe and Trusted. The NEST framework is predicated on the importance of attachment theory[59] and calls for parent-infant mental health services to be available in all regions of Wales for those babies who need them.

The recommendations in this report are very closely aligned to the NEST/NYTH proposal, including work to establish the 'no wrong door principle' for babies, improved access to expert consultation and advice, early assessment of families' needs, matching to the right level of intervention from first contact, and close collaboration between agencies to provide a seamless safety net of care.

Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) include all forms of child maltreatment. Research suggests that ACEs during the first months of life may have the biggest impact[60]. The National Institute for Health and Care Excellence (NICE) estimate that 80% of maltreated children have a significantly disordered early relationship with their parent(s)[61].

By contrast, having a trusted relationship with at least one adult during childhood is a source of resilience, associated with a lower risk of mental illness[62]. Work to secure healthy parent-infant relationships therefore contributes to the prevention of ACEs throughout childhood referred to in multiple national and local strategies including Together for Mental Health.

References and footnotes

1. Shemmings D (2018) *Why social workers shouldn't use 'attachment' in their records and reports* (communitycare.co.uk).
2. Center on the Developing Child. *What is Early Childhood Development? A Guide to Brain Development* (harvard.edu) (accessed 1 October 2021).
3. Center on the Developing Child National Scientific Council (2004) *What is Early Childhood Development? A Guide to Brain Development* (harvard.edu).
4. National Scientific Council on the Developing Child (2004). *Young Children Develop in an Environment of Relationships: Working Paper No. 1. Young Children Develop in an Environment of Relationships* (harvard.edu).
5. Geddes, H. (2006) *Attachment in the Classroom: the links between children's early experience, emotional wellbeing and performance in school*. London: Worth Publishing.
6. Bergin, C. and Bergin, D. (2009) Attachment in the Classroom. *Educational Psychology Review*, 21, 141–170.
7. Siegel, D. (2012) *The Developing Mind: How relationships and the brain interact to shape who we are*. New York: Guildford Press.
8. Feinstein, L. (2003). Inequality in the early cognitive development of British children in the 1970 cohort. *Economica*, 70(277), 73–97.
9. Feinstein, L (2015) *Social and Emotional learning: skills for life and work*. Early Intervention Foundation.
10. O'Donnell, K., Glover, V., Barker, E. D. & O'Connor, T. G. (2013). The persisting effect of maternal mood in pregnancy on childhood psychopathology. *Development and Psychopathology*.
11. Straatmann, V. S., Lai, E., Lange, T., Campbell, M. C., Wickham, S., Andersen, A. M. N., & Taylor-Robinson, D. (2019). How do early- life factors explain social inequalities in adolescent mental health? Findings from the UK Millennium Cohort Study. *J Epidemiol Community Health*, 73(11), 1049–1060.
12. Sitnick, SL., Galán, CA., & Shaw, DS (2018). Early childhood predictors of boys' antisocial and violent behavior in early adulthood. *Infant Mental Health Journal*, 40(1): 67–83. https://onlinelibrary.wiley.com/doi/full/10.1002/imhj.21754.
13. Fraiberg, S., Adelson, E., & Shapiro, V. (2003). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. *Parent-infant psychodynamics: Wild things, mirrors and ghosts*, 87, 117.
14. Feinstein, L. (2003). Inequality in the early cognitive development of British children in the 1970 cohort. *Economica*, 70(277), 73-97.
15. Center on the Developing Child Brain Architecture (harvard.edu) (accessed 1 October 2021).
16. Darling RP, Storebø OJ, Løkkeholt T, et al. Attachment as a Core Feature of Resilience: A Systematic Review and Meta-Analysis. *Psychological Reports*. 2019;122(4):1259-1296. doi:10.1177/0033294118785577.
17. Corcoran M, McNulty M. *Examining the role of attachment in the relationship between childhood adversity, psychological distress and subjective well-being*. Child Abuse Negl. 2018 Feb;76:297-309. doi: 10.1016/j.chiabu.2017.11.012. Epub 2017 Nov 23. PMID: 29175733.
18. Rodriguez & Tucker (2011) Behind the Cycle of Violence, Beyond Abuse History: A Brief Report on the Association of Parental Attachment to Physical Child Abuse Potential. *Violence and Victims*, Vol 26, Issue 2, DOI: 10.1891/0886-6708.26.2.246 https://connect.springerpub.com/content/sgrvv/26/2/246.abstract (accessed 1 Oct 2021)
19. National Scientific Council on the Developing Child. (2004). *Young children develop in an environment of relationships*. Working Paper No. 1.
20. Van Ijzendoorn, M. H., Schuengel, C., & Bakermans-Kranenburg, M. J. (1999). Disorganized attachment in early childhood: Meta-analysis of precursors, concomitants, and sequelae. *Development and psychopathology*, 11(2), 225–250.
21. Jeong J et al.(2021) Parenting interventions to promote early child development in the first three years of life: A global systematic review and meta-analysis. *PLoS Med* 18(5): e1003602. https://doi.org/10.1371/journal.pmed.1003602.
22 Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. Basic Books.
23. Nelson CA. Neural Plasticity and Human Development. *Current Directions in Psychological Science*. 1999;8(2):42-45. doi:10.1111/1467-8721.00010.
24. UNICEF (2017) *For every child, early moments matter.* https://www.unicef.org.uk/babyfriendly/early-moments-matter/.
25. UK Government Serious Incident Notifications (2021–22) https://explore-education-statistics.service.gov.uk/find-statistics/serious-incident-notifications/2020-21.
26. Stats Wales https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Social-Services/Childrens-Services/Service-Provision/childrenonchildprotectionregister-by-localauthority-categoryofabuse-agegroup.
27. Barlow J (2012) *Child maltreatment during infancy: atypical parent–infant relationships, Paediatrics and Child Health*, 22 (11), 465–469, https://doi. org/10.1016/j.paed.2012.06.006 (accessed 1 Oct 2021).
28. Eltringham S, Aldridge J. Parenting on Shifting Sands: The Transfer of Responsibility for Safely Managing Danger. *Clinical Child Psychology and Psychiatry*. 2002;7(2):137–145. doi: 10.1177/1359104502007002003.
29. National Institute for Health and Care Excellence. *Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care.* https://www.nice.org.uk/guidance/ng26/documents/childrens-attachment-final-scope2.

30. Steele H, Siever L. An attachment perspective on borderline personality disorder: advances in gene-environment considerations. *Curr Psychiatry Rep*. 2010 Feb;12(1):61–7. doi: 10.1007/s11920-009-0091-0. PMID: 20425312.
31. Andreas Schindler & Sonja Bröning (2015) *A Review on Attachment and Adolescent Substance Abuse: Empirical Evidence and Implications for Prevention and Treatment, Substance Abuse*, 36:3, 304–313, DOI: 10.1080/08897077.2014.983586.
32. Ogilvie et al. (2014) Attachment & violent offending: A meta-analysis. *Aggression and Violent Behavior*, 19(4): 322–339, https://doi.org/10.1016/j.avb.2014.04.007.
33. Barlow J (2012) *Child maltreatment during infancy: atypical parent–infant relationships, Paediatrics and Child Health*, 22 (11), 465–469, https://doi. org/10.1016/j.paed.2012.06.006 (accessed 1 Oct 2021).
34. Mayor of London's Office (2011) Early Years Interventions to address Health Inequalities in London. *Early Years Interventions to address Health Inequalities in London. London City Hall.*
35. First 1001 days (2021), *Evidence Brief 6, Investing in Babies; The Economic Case for Action* https://parentinfantfoundation.org.uk/1001-days/resources/evidence-briefs/.
36. Bachmann, C.J., Beecham, J., O'Connor, T.G., Briskman, J. and Scott, S. (2021), A good investment: longer-term cost savings of sensitive parenting in childhood. *J Child Psychol Psychiatr*. https://doi.org/10.1111/jcpp.13461.
37. https://heckmanequation.org/resource/the-heckman-curve/
38. World Bank (2021) Early Childhood Development. *Early Childhood Development Overview* (worldbank.org).
39. World Health Organization, United Nations Children's Fund, World Bank Group. (2018). Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential.
40. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62 (6) pp. 593–602. doi:10.1001/archpsyc.62.6.593.
41. Department of Health. (2014). *Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/413196/CMO_web_doc.pdf (accessed 23.9.21).
42. https://parentinfantfoundation.org.uk/teams/locations/.
43. The only exception being parent-infant psychotherapy.
44. AiMHUK (2020) UK IMH Competency Framework *UK IMH Competency Framework • AiMH UK Association for Infant Mental Health.*
45. National Assembly for Wales (2017) *Perinatal mental health in Wales* cr-ld11234-e.pdf (senedd.wales).
46. Shalaby RA, Agyapong VI. Peer Support in Mental Health: Literature Review. JMIR Ment Health 2020;7(6):e15572. DOI: 10.2196/15572.
47. Stats Wales https://statswales.gov.wales/Catalogue/Population-and-Migration/ Population/ Projections/Local-Authority/2018-based/populationprojections-by-localauthority-variantyear (Accessed 1 October 2021).
48. Patricia Crittenden and others have developed the concept of attachment into the more nuanced Dynamic Maturational Model which brings a rich understanding of clinical presentations and potential treatments.
49. National Institute for Health and Care Excellence. Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care. https://www.nice.org.uk/guidance/ng26/documents/childrens-attachment-final-scope2.
50. van IJzendoorn, M. H., & Kroonenberg, P. M. (1988). Cross-Cultural Patterns of Attachment: A Meta-Analysis of the Strange Situation. *Child Development*, 59(1), 147–156. https://doi.org/10.2307/1130396.
51. Cyr, C., Euser, E. M., Bakermans-Kranenburg, M. & Van IJzendoorn, M. (2010) Attachment security and disorganization in maltreating and high-risk families: A series of meta-analyses. Development and Psychopathology. 22 (1), 87–108.
52. National Institute for Health and Care Excellence. Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care. https://www.nice.org.uk/guidance/ng26/documents/childrens-attachment-final-scope2.
53. Bellis et al (2014) National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviours in England. BMC Med 12, 72. https://doi.org/10.1186/1741-7015-12-72.
54. Straatmann VS, Lai E, Lange T, et al. [1]How do early-life factors explain social inequalities in adolescent mental health? Findings from the UK Millennium Cohort Study, *J Epidemiol Community Health* 2019;73:1049–1060. https://jech.bmj.com/content/73/11/1049.
55. Feinstein, L (2015) *Social and Emotional learning: skills for life and work*. Early Intervention Foundation.
56. Crystal Day (2007) *Attachment and Early Language Development: Implications for Early Intervention*, NHSA Dialog, 10:3–4, 143–150, DOI: 10.1080/15240750701741637 https://www.tandfonline.com/doi/abs/10.1080/15240750701741637?journalCode=hnhd20.
57. National Assembly for Wales (2017), Perinatal Mental Health in Wales. https://senedd.wales/laid%20documents/cr-ld11234/cr-ld11234-e.pdf.
58. NHS Wales Collaborative (2021) *The NEST Framework – NHS Wales Health Collaborative.*
59. Ibid, pp26–28.
60. Hambrick EP, Brawner TW, Perry BD, Brandt K, Hofmeister C, Collins JO. Beyond the ACE score: Examining relationships between timing of developmental adversity, relational health and developmental outcomes in children. Arch Psychiatr Nurs. 2019 Jun;33(3):238-247. doi: 10.1016/j.apnu.2018.11.001. Epub 2018 Nov 9. PMID: 31227076.
61. NICE: Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care. https://www.nice.org.uk/guidance/ng26/documents/childrens-attachment-final-scope2.
62. Hughes et al (2018) *ACE & Resilience Report* (Eng_final2).pdf (wales.nhs.uk).

www.parentinfantfoundation.org.uk

Registered Charity 1152082, Company Limited by Guarantee registered in England and Wales No. 08191666.