NHS
Birmingham Women's and Children's
NHS Foundation Trust

Nurturing our future: holding young minds in mind

A needs assessment of parent-infant relationship help and support in Birmingham - extended summary

May 2022

By your side

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- Birmingham City Council
- Birmingham Children's Trust
- Birmingham Forward Steps strategic partners
- Birmingham and Solihull Clinical Commissioning Group
- Birmingham and Solihull Mental Health NHS Foundation Trust
- Birmingham Women's and Children's NHS Foundation Trust
- Local Maternity and Neonatal System (Birmingham Women's and Children's NHS Foundation Trust/University Hospitals Birmingham)
- Solihull Metropolitan Borough Council
- South Warwickshire NHS Foundation Trust

Healthy parent-infant relationships enable babies and toddlers to feel safe and secure

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.

Additional acknowledgments go to:

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Paul Joyce, Senior Intelligence Officer, Birmingham Children's Trust

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Parent-Infant Foundation

Throughout planning, implementation, analysis and reporting of the work, the project team received guidance, support, and access to replicable materials from the Parent-Infant Foundation.

The Parent-Infant Foundation is a national charity that supports the development, growth and quality of specialised parent-infant relationship teams, and campaigns for policy change. The organisation provides secretariat to the First 1001 Days Movement, a campaigning alliance of over 200 charities and professional bodies campaigning to improve babies' emotional wellbeing and development. It also provides the secretariat to the Conception to Age Two All-Party Parliamentary Group (APPG), which brings together parliamentarians from across the political spectrum with a shared passion for improving babies' early relationships, experiences, and outcomes.

This knowledge transfer from national body level to local system level was invaluable in enabling the work to be achieved in the timescale and resource available.

We are very grateful to Wook Hamilton, Parent-Infant Foundation National Development Manager, for the support, guidance, and access to replicable materials she offered. This input is reflected at all levels of the work, including content of this report.

Contents:

This report is about babies and their parents, and the critical importance of early intervention to support the parent-infant relationship during the first 1001 days of life

Language and terminology

Parents	We use the term parents to refer to any adult in a parenting role, including foster, adoptive, kinship and step-parents.
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 is dominated by the quality of the parent-infant relationship.
Attachment	Attachment is a term used to describe the relationship that exists between a baby and its parent(s). 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.
Perinatal mental health	Refers to the mental health of parents during pregnancy and up their child's second birthday.
'Specialist' work	'Specialist' refers to a level of intervention, sometimes referred to in mental health services as Tier 3, at which services and staff are highly skilled.
'Specialised' work	'Specialised' or focused relates to the specific intervention focus. When we describe specialised or focused parent-infant work, we mean those activities which directly address the quality of the parent-infant relationship by focusing on containment, reciprocity, parental sensitivity, mentalisation, attunement, responsivity, or internal representations of the relationship.
Statutory	Refers to families who are actively involved 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.
First 1001 days	Refers to the period from conception to a child's second birthday.

Abbreviations

ACE	Adverse Childhood Experiences
BCC	Birmingham City Council
BCT	Birmingham Children's Trust
BFS	Birmingham Forward Steps
BSOL	Birmingham and Solihull
BWC	Birmingham Women's and Children's NHS Foundation Trust
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
FGM	Female Genital Mutilation
FTB	Forward Thinking Birmingham, Birmingham's mental health service for children and young people aged 0 to 25
ICB	Integrated Care Board
ICS	Integrated Care System
ICYP	Infants, Children and Young People
IMHCF	Infant Mental Health Competencies Framework
IMHSG	Infant Mental Health Steering Group
LMNS	Local Maternity and Neonatal System
PIE	Psychologically Informed Environments
PNMH	Perinatal Mental Health
SEND	Special Educational Needs and Disabilities
VCS	Voluntary and Community Sector

Executive summary

This report is about babies and their parents, and the critical importance of early intervention to support the parent-infant relationship during the first 1001 days of life. It describes how we are supporting early parent-infant relationships in Birmingham and why this is so important, and suggests how we can strengthen this support in the future.

Whilst a person's life outcomes are not determined by the age of two, the first 1001 days of life, from conception to age two when the architecture of the brain is being laid down, are a time of unique vulnerability and opportunity. This period offers a crucial window of opportunity for early intervention and prevention that can help address need, which, if it remains unresolved, can drive demand in late intervention services such as children's social care and CAMHS. Supporting the parent-infant relationship and building healthy brain architecture is an investment in inter-generational physical, mental and economic wellbeing at both a personal and population level.

The work that informs this report comprises four connected pieces of work, undertaken in Birmingham between December 2021 and March 2022 in agreement with Birmingham and Solihull Clinical Commissioning Group (BSOL CCG), under the guidance of the Parent-Infant Foundation, in partnership with Solihull, and on behalf of wider services across the city. The Birmingham and Solihull Infant Mental Health Steering Group (BSOL IMHSG) is an official subgroup of the BSOL Local Maternity and Neonatal System (LMNS) Perinatal Mental Health Board. Under the governance of the IMHSG, this work has been undertaken in partnership with Solihull, but has concerned the Birmingham population, and its services, workforce, and parents. The BSOL Integrated Care Board (ICB) will become the statutory body with responsibility for leading the Integrated Care System (ICS) in July 2022. CCG functions will merge into the ICB, with the ICB having a broader remit and a greater system role. The recommendations shared here concern Birmingham, but with a strong commitment to working within the context of the ICS transition, and working closely with infant mental health partners across the ICS footprint. The work was intended to inform the operationalisation of Forward Thinking Birmingham's commitment to parent-infant relationship support, as well as to support the wider network. This summary report describes a selection of our findings and our recommendations. A full report, including appendices and data tables, is available by request from bwc.ftbinfantmentalhealth@nhs.net

Birmingham has the largest proportion of children aged 0-5 years of any local authority in England and the ethnic diversity of this population increases with every cohort of children born. Families in Birmingham can face a range of challenges: in comparison with the rest of England the city has poorer outcomes for several measures of maternal health and infant health, and has higher indications of deprivation on relevant measures of child poverty, children in care, and teenage pregnancy.

A child's experience of being parented influences how they go on to parent their own children

Around one in five babies born in Birmingham are likely to experience parent-infant relationship difficulties so significant that they will place long-term wellbeing in terms of mental and physical health, social relationships, and progress at school and in work, at risk. 86% of parents surveyed stated that they agreed that their relationship with their baby had an impact on their development. Our work identified pockets of good practice across the city that either reduce general risk factors or strengthen protective factors relevant to the parent-infant relationship, and a strong workforce commitment to undertaking and developing this work. Whilst we identified some specialist provision directly concerned with addressing parent-infant relationship difficulties, we found a significant gap in provision for families with children under two experiencing the most significant parent-infant relationship difficulties, who are not eligible for a service from the Perinatal Mental Health (PNMH) Service.

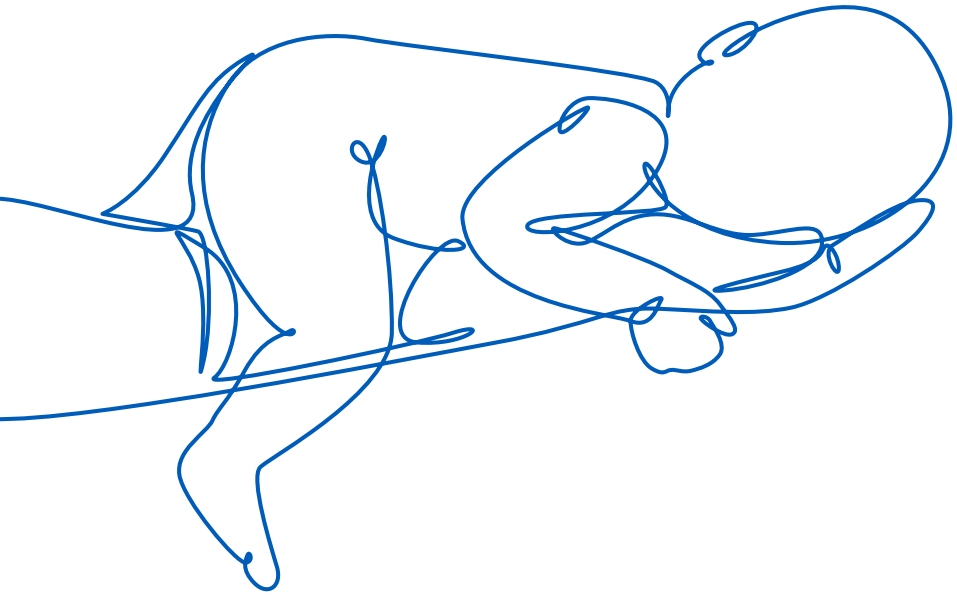
Integrating the information gathered from parents, workers, managers and population data, we provide 38 recommendations for the IMHSG, local services, and commissioners, that together suggest how we can strengthen parent-infant relationship support in Birmingham, and keep young minds in mind to nurture all of our futures.

Introduction

This report is about babies and their parents, and the critical importance of early intervention to support the parent-infant relationship during the first 1001 days of life.

It describes how we are supporting parent-infant relationships from conception to age two in Birmingham, and suggests how we can strengthen this support in the future.

The work that informs this report comprises four connected workstreams.



What we did: four connected pieces of work

Understanding local population need

We gathered a wide range of local, national, and international data to understand the need for parent-infant relationship support from conception to age two in Birmingham.

Service mapping

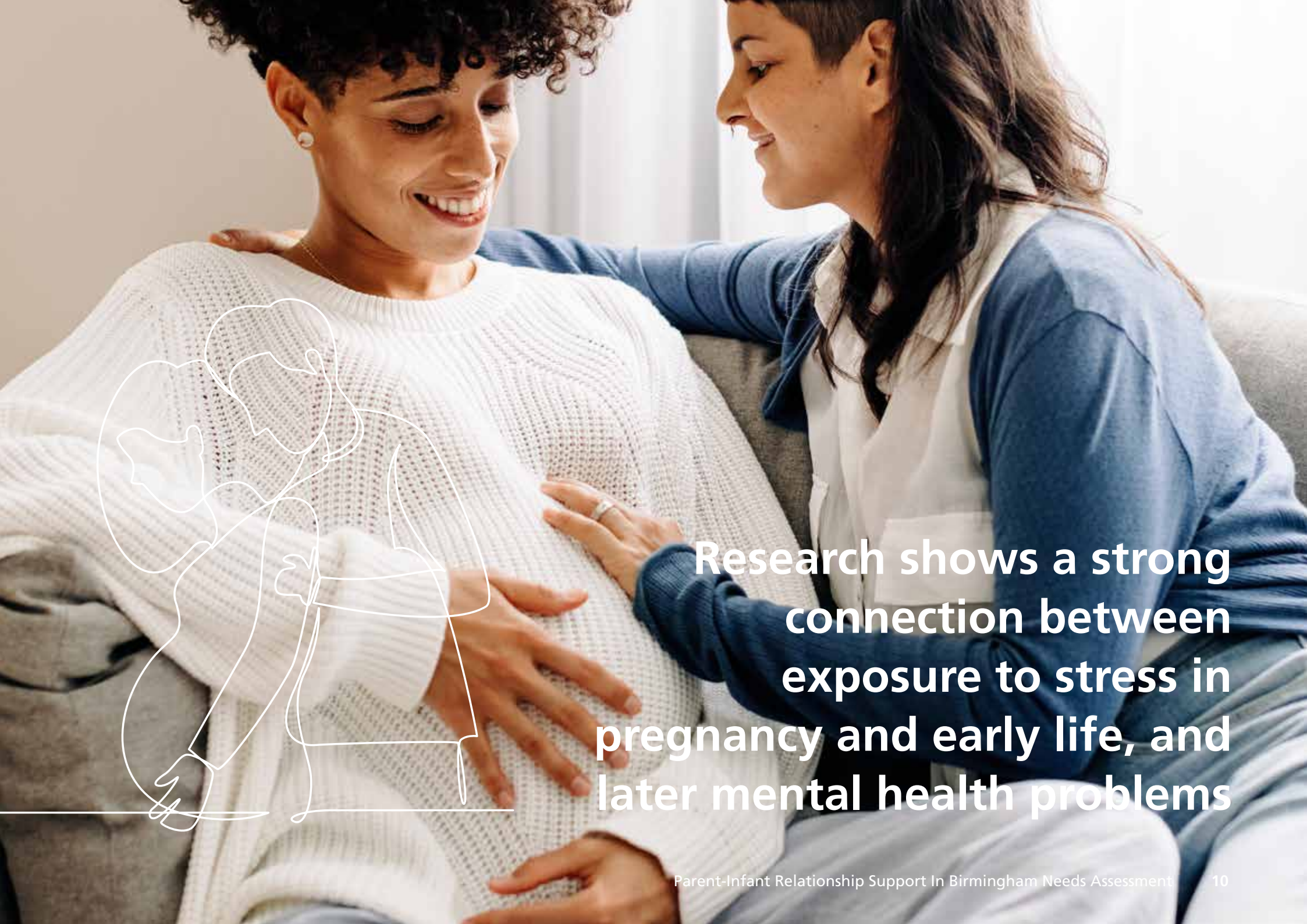
We interviewed 23 practitioners and service managers, gathered service data, and consulted with senior leaders, to map current parent-infant relationship support from conception to age two across Birmingham.

Workforce analysis

We asked 89 local practitioners and managers about current strengths and future training needs, and we researched the likely workforce requirements for improving parent-infant relationships.

Parents' views

We gathered the views of 45 local parents on a range of questions connected to parent-infant relationships and support for these.



Research shows a strong connection between exposure to stress in pregnancy and early life, and later mental health problems

Why this work is needed: the importance of parent-infant relationships

The first 1001 days of life, from conception to age two, are a crucial window of opportunity for early intervention and prevention. Supporting the parent-infant relationship and building healthy brain architecture is an investment in inter-generational physical, mental and economic wellbeing at both a personal and population level.

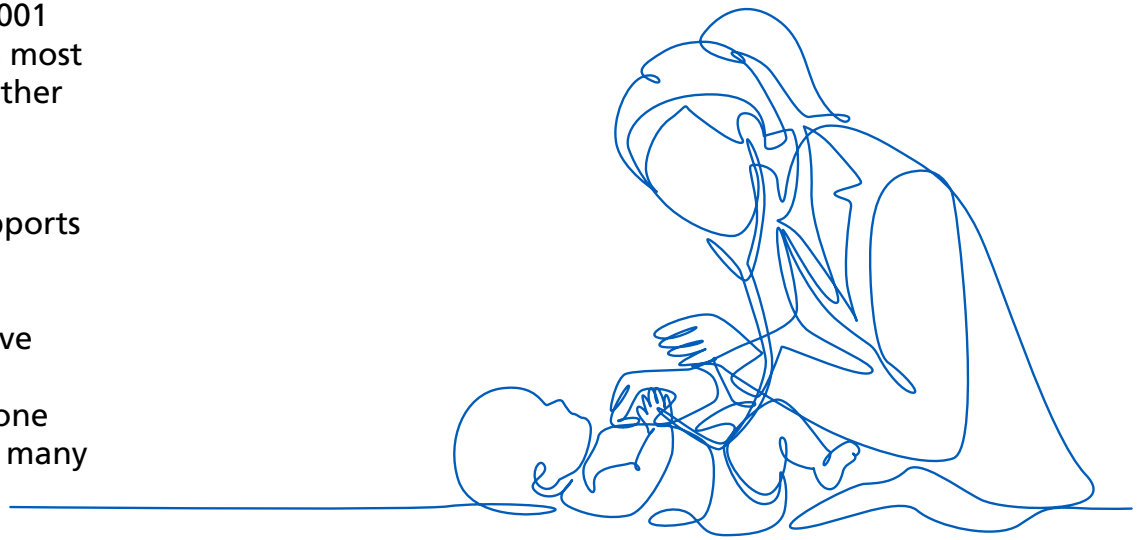
The architecture of the brain, which provides the foundation for other forms of development, is laid down during the first 1001 days of a baby's life. During this time a baby's brain is at its most 'plastic' or adaptable and is developing faster than at any other point in life.

Early brain development involves many millions of neural connections being made and then pruned in a way that supports survival in the environment in which a baby is living. Early exposure to toxic stress can disrupt the building of healthy brain architecture, and early exposure to healthy and positive environments and experiences can support the building of healthy brain architecture. Parent-infant relationships are one of the critical elements of early development and influence many different skills, behaviours, and capacities [1].

In the general population, it is estimated that around 15% of babies experience disorganised attachment with their main caregivers [2], the pattern of parent-child relationship most strongly associated with the poorest lifetime outcomes across a range of domains[3-5]. In children experiencing abuse and/or neglect, up to 80% of children can experience disorganised attachments [6].

By contrast, a secure attachment buffers a person's health against later adversity [7].

A growing body of research has demonstrated how early relationships, and emotional wellbeing and development, can predict later wellbeing in multiple domains such as mental and physical health, emotional and social skills, trusting relationships, learning, positive behaviour, earning and parenting ability.



Mental and physical health

Infant mental health affects a child's developing brain and autonomic nervous system [8]. Research shows a strong connection between exposure to stress in pregnancy and early life, and later mental health problems [9-10]. It also shows a strong connection between insecurity in the parent-infant relationship and intergenerational mental ill-health, behavioural problems, and increased risk of child abuse [11].

Supporting infant mental health can help children to develop behavioural and physiological regulation which are linked to lifelong health and wellbeing. It can prevent emotional disturbances from taking root and escalating into mental health difficulties and patterns of unhealthy intergenerational behaviour.

Emotional and social skills

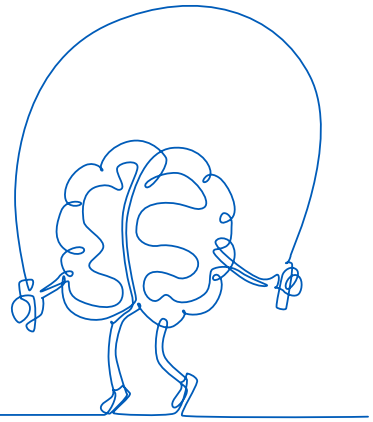
It can be more difficult for babies who have not had responsive care to learn to regulate their own emotions, which in turn can affect their physiological responses, with long-term impacts on both their mental and physical health [12]. A secure parent-infant relationship is a core component of resilience and a child's ability to weather the storm of life's ups and downs [13].

Supporting parent-infant relationships can positively influence a child's self-perception, and their ability to regulate their emotions and control their impulses. This is the foundation for emotional wellbeing, and developing the key competencies of resilience, and adaptability.

Trusting relationships

A secure attachment is associated with a range of positive outcomes such as resilience, positive social skills, an understanding of emotions, and other aspects of human connection [14].

Parent-infant relationships influence how a baby learns about themself and other people, and they set a template for later relationships. Supporting early relationships and secure attachment facilitates babies developing the skills to form trusting relationships with others.



Learning

Children who have had good early relationships start early education and school best equipped to be able to make friends and learn[15-17]. Supporting healthy parent-infant relationships helps babies and toddlers to feel safe and secure and be ready to play and explore and learn.

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 [19].

Positive behaviour

Because good infant mental health enables children to form positive trusting relationships by understanding and managing emotions and behaviours, it can reduce the risk of later risky and antisocial behaviours and the costs they bring [18].

Parenting ability

A child's experience of being parented influences how they go on to parent their own children, so supporting parent-infant relationships can pay dividends for generations to come [20].

Without taking early action to protect and promote secure early relationships, babies can be exposed to toxic levels of stress which damage physical and mental health, potentially for many decades to come [11] and for future generations [21].

Parental sensitivity and the ability to 'mentalise' about a child's behaviour are strong predictors of attachment security, and interventions that enhance these capabilities and strengthen the parent-infant relationship therefore offer the potential to improve lifelong mental health and to make significant economic savings within a generation.

A secure parent-infant attachment relationship is important for good physical and mental health

Implications for service planning and delivery

The understanding that a secure parent-infant attachment relationship is important for good physical and mental health and social wellbeing across the lifespan gives rise to five key implications for service planning and delivery [24].

1. The first 1001 days of life offer the best opportunity to improve health and social wellbeing

The brain can adapt and change throughout life [25], but its capacity to do so decreases with age.

This means that (a) it is much easier to influence a child's development and wellbeing if we intervene earlier in life, and (b) later interventions are more likely to have an impact if a child has had a good start early on.

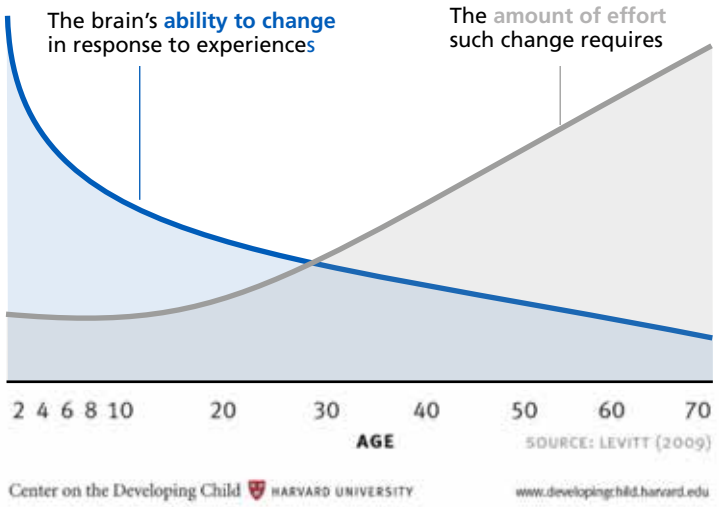


Figure 1: The brain's sensitivity to change through experience vs the effort required for change (Source: Center on the Developing Child at Harvard University)

2. Parent-infant relationships reflect and affect safeguarding risks.

Infants under one account for 36% of serious incident notifications [27] and in England and Wales, babies are eight times more likely to be killed than older children [28]. Babies are highly dependent on parent-infant interactions to shape their rapidly developing nervous system, emotional and behavioural self-regulation[29], and sense of danger [30]. Consequently, child abuse and neglect during babyhood has a disproportionately large and negative effect on a child's development. Up to 80% of children experiencing child abuse and neglect can be categorised as having a "disorganised" attachment [6] the pattern of parent-child relationship most strongly associated with the poorest lifetime outcomes. Research strongly points to the need for prevention of child maltreatment to include assessment of the parent-infant relationship, and the delivery of relevant interventions that begin in pregnancy and continue throughout the first postnatal year[29].

3. There is an economic case for early investment.

A comprehensive review of the economic evidence, found 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."*** [31].

This is because early years interventions can (a) prevent difficulties arising and therefore reduce the need for remedial spending on complex interventions and multiple layers of support later in life [33], and (b) ensure that where children do develop difficulties these are likely to be less serious and more responsive to less intensive interventions.

The most economically efficient time to invest in developing children's skills and social abilities is in the very early years [33].

4. Late intervention can be too little, too late

Whilst there will always be the need for some risk support [3] and later intervention, and we shouldn't over-estimate the strength of parent-infant relationship interventions, it is important to note that late intervention can be too little, too late. Half of all mental health problems are established by age 14[34]. Sadly 75% of people with mental health problems in England "receive no treatment at all" [35] and for those that do, not all treatment is effective. Further information about this can be found in our full report.

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

World Health Organization, United Nations Children's Fund, World Bank Group [22]

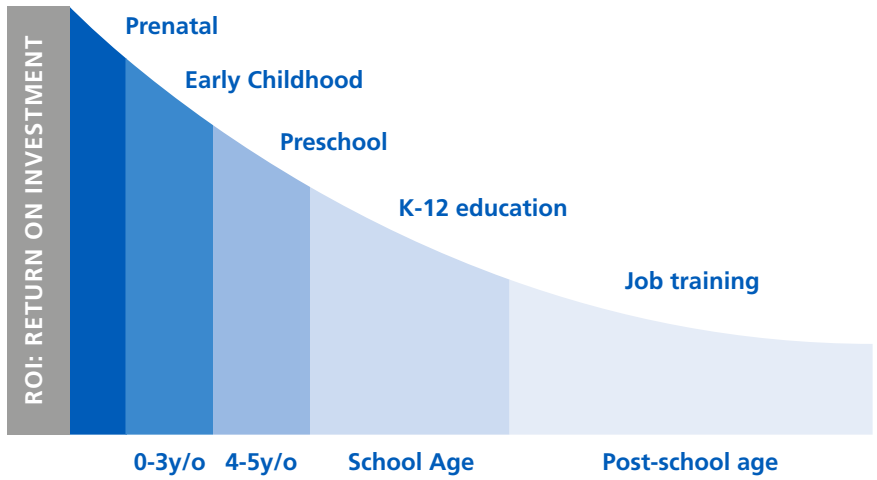


Figure 2: The Heckman curve of return on investment (ROI) over the lifespan [33]

Early intervention, and especially parenting interventions that focus on responsive caregiving rather than reducing challenging behaviour [36], will reduce demand on late intervention services via an effective prevention approach that employs a menu of interventions at all levels of the system tailored to different families.

5. Effective support for the parent-infant relationships offers three key areas of benefit [24]. It can:

- Strengthen a child's resilience to everyday pressures throughout life and promote good mental health and wellbeing (primary prevention)
- Prevent mental health distress during infancy from taking root as disturbance and escalating into mental health disorders (secondary prevention)
- Intervene to reduce and mitigate significant difficulties that may escalate into child protection concerns (tertiary prevention)

Effective parent-infant relationships

Child outcomes

- Reduced risk of later mental health difficulties, emotional behavioural and social problems
- Strengthened resilience
- Improved speech and language

Parent outcomes

- Improved parental and family mental health
- Reduced parenting stress
- Improved parenting

Relationship outcomes

- Reduced potentional for child abuse
- Reduced risk of intergenerational transmisson of difficulties

Figure 3: The impacts of an effective parent-infant relationship intervention [24]

In April 2022 the Government announced Birmingham as one of the local authorities pre-selected for Start for Life Funding

Specialised parent-infant relationship support

Figure 4: The 39 specialised parent-infant relationship teams across the UK. The nearest team to Birmingham is located 42 miles away in Cheltenham, followed by Oxford, Stockport and Runcorn. Map produced for report.

The compelling case for early investment in the parent-infant relationship from both a personal and economic perspective is reflected in international, national and local policy, strategy and reports [37-48] summarised in our full report.

The need for this investment has led to specialised parent-infant relationship support growing across the UK; there are currently 39 specialised parent-infant relationship teams across the UK [49], up from 29 in 2019. However, at present there are no specialist teams in the Midlands. The nearest team to Birmingham is located 42 miles away in Cheltenham, followed by Oxford, Stockport and Runcorn.

The NHS Long Term Plan for England states that ***"Over the coming decade the goal is to ensure that 100% of children and young people who need specialist care can access it"*** [50]. This includes children under two who need specialist care, requiring specialised parent-infant support.

In March 2021 the Early Years Healthy Development Review published the Policy Paper The Best Start for Life A Vision for the 1,001 Critical Days [51] which describes the importance and opportunity of intervening in the first 1001 days and outlines six areas for action to improve the health outcomes of all babies in England:

- Seamless support for families
- A welcoming hub for families
- The information families need when they need it
- An empowered Start for Life workforce
- Continually improving the Start for Life offer
- Leadership for change

In October 2021, as part of the Autumn budget, the Government announced £301.75m to transform Start for Life and Family Hub services in 75 upper-tier local authorities across England by funding ***"a network of Family Hubs, Start for Life and family help services, including breastfeeding services, parenting programmes and parent-infant mental health support."*** [52] On 2 April 2022 Birmingham was pre-selected as one of the 75 local authorities eligible for funding.

Birmingham's response to the 'The Best Start for Life A Vision for the 1,001 Critical Days' report will align with other key local priority areas, working partnerships, and models of delivery outlined in our full report. Strengthening our support for parent-infant relationships has the long-term potential to deliver tangible outcomes across multiple service areas and strategic priorities across the lifespan in Birmingham.

Workstream 1: Understanding local population need

Four key steps can inform commissioning decisions about service transformation for parent-infant relationship support[24]:

1. Current and future population size, workforce and workload trends
2. Research about population prevalence of parent-infant relationship problems
3. Applying research findings to local populations
4. Using local population statistics to calculate actual numbers of children needing a service

We gathered a wide range of local, national, and international data and used these four steps to estimate need for parent-infant relationship support from conception to age two in Birmingham. Here we summarise the findings of this work which is detailed in our full report.

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

Birmingham has a younger population than the national average, with the largest proportion of children aged 0-5 years of any local authority in England [53].

The population of children and young people in Birmingham is more ethnically diverse than the older population of the city and this diversity increases with every cohort of children born.

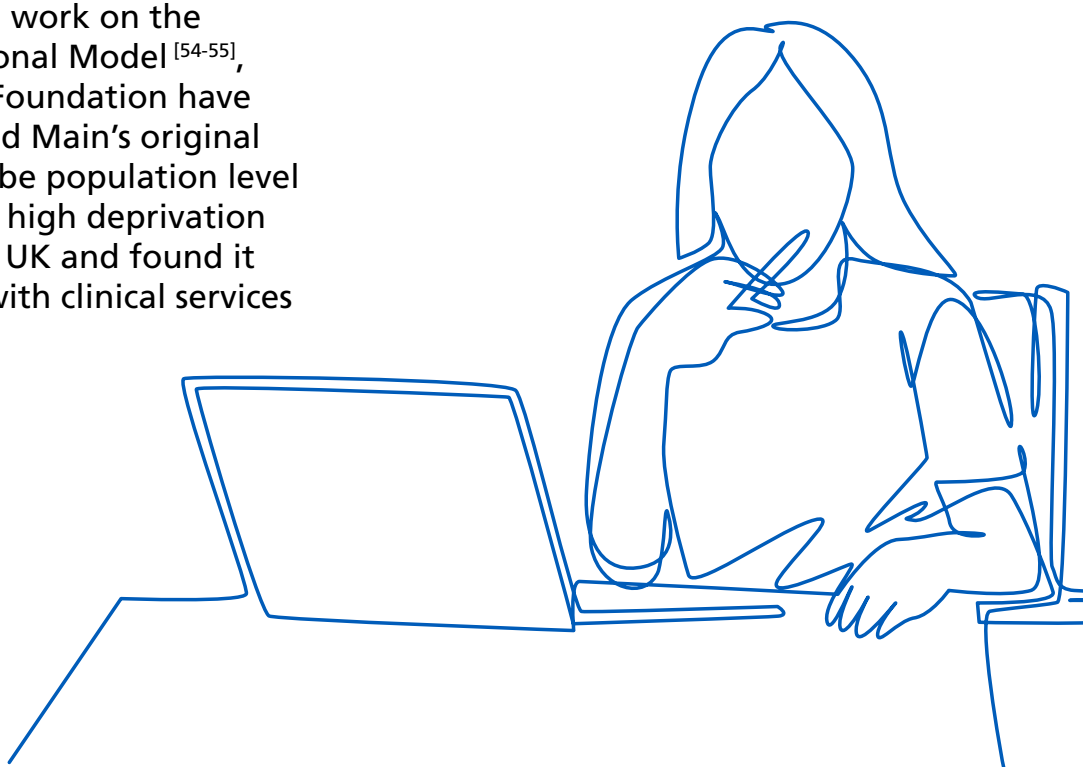
Service demand in the next five years will be affected by community and family impacts of COVID, continued downward pressure on health visitor numbers, and improved identification of parent-infant relationship difficulties earlier.

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

The most researched concept in the literature regarding parent-infant relationships and associated disorders is 'attachment' and there is a body of longitudinal evidence for associated outcomes across the life-course. The attachment concept can provide a useful and reliable, although still imperfect, measure of the parent-infant relationship for commissioning and service-planning purposes.

Our work uses the Ainsworth and Main attachment classifications of 'secure', 'insecure' (combining avoidant and ambivalent) and 'disorganised' attachment originating from the 1970s. Although the concept of attachment has been developed since this time to bring a richer understanding of clinical presentations and potential treatments, for example Patricia Crittenden work on the Dynamic Maturational Model [54-55], the Parent-Infant Foundation have used Ainsworth and Main's original approach to describe population level need in urban and high deprivation populations in the UK and found it triangulates well with clinical services [24].

Higher levels of adversity & trauma are indicative of higher levels of disorganised and insecure attachment and lower levels of secure attachment: according to NICE, around 80% of children who suffer maltreatment are classified as having disorganised attachment [6].



There are currently 39 specialised parent-infant relationship teams across the UK, but none in the Midlands

In the international literature, the distribution of attachment patterns for a reference white, socioeconomic 'middle class' population 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% of babies)

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% of babies)

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.

Footnote: 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 Ijzendoorn M & Kroonenberg P (1988) Cross-cultural patterns of attachment: A meta-analysis of the strange situation. Child Development, 59, 147-156.

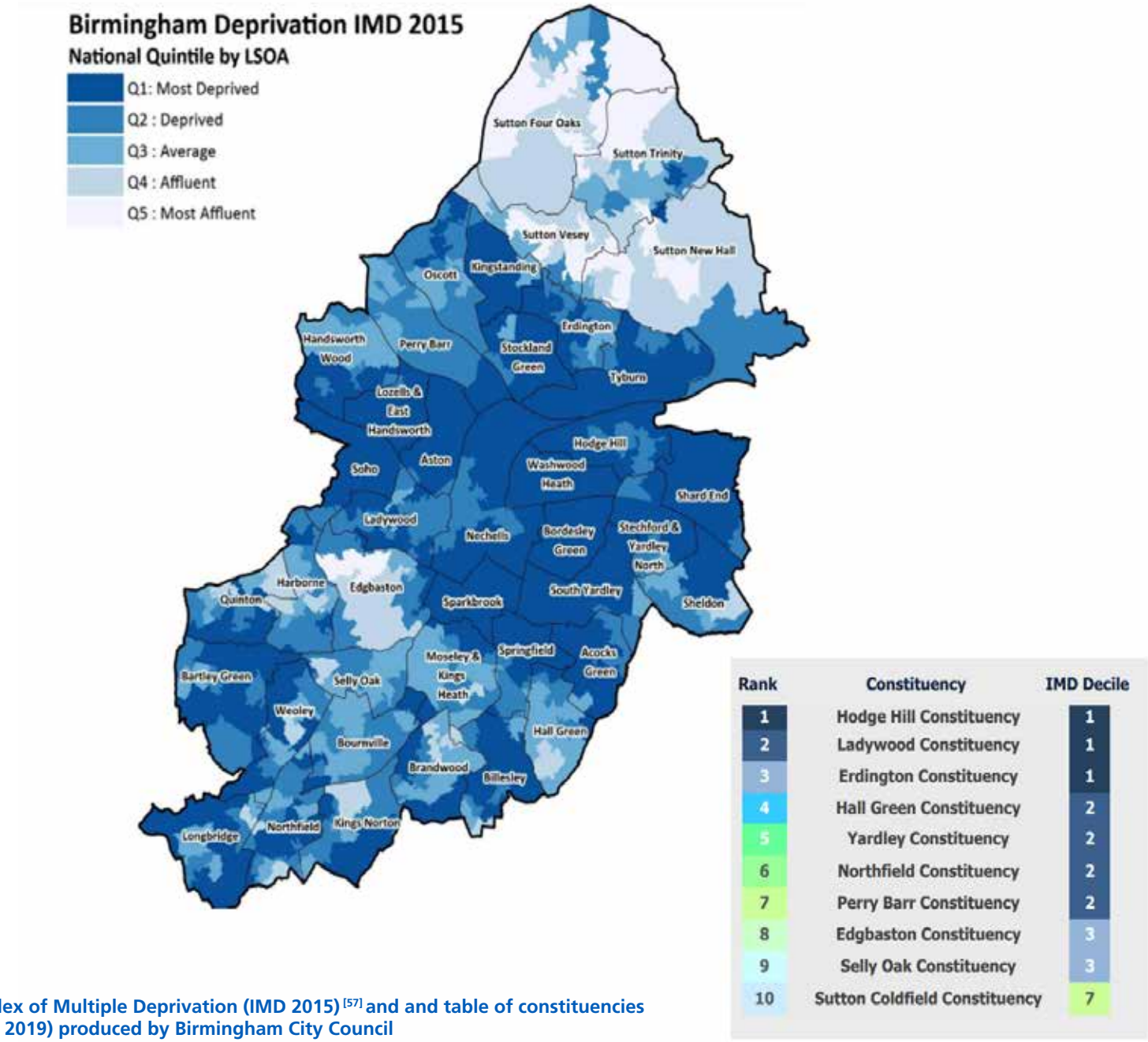
3. Applying research findings to the population of Birmingham

In 2020, it was estimated that 49.6% of children in Birmingham aged 2 and under lived in the most deprived 10% of neighbourhoods in England [57]. Hodge Hill is the most deprived constituency in Birmingham followed by Ladywood and Erdington.

In comparison with the rest of England, Birmingham has poorer outcomes for several measures of maternal health and infant health such as maternal mortality, stillbirth, low birth weight, very low birth weight, and infant mortality [53].

Birmingham has higher indications of deprivation than other parts of England on relevant measures such as poverty including child poverty, children in care, teenage pregnancy, and unemployment [53].

Data from the Childhood Local Data on Risks and Needs dataset [56] shows that Birmingham is in the worst 5% of England local authorities for modelled prevalence of children aged 0-2 in households with all three of the so called 'toxic trio' (domestic abuse, severe mental health problem and substance misuse).



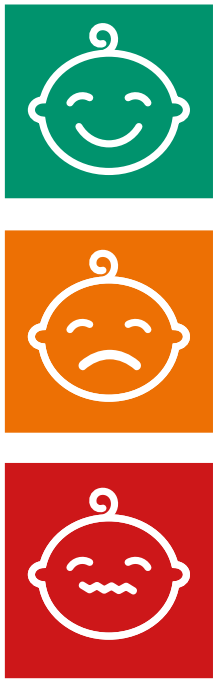
Rank	Constituency	IMD Decile
1	Hodge Hill Constituency	1
2	Ladywood Constituency	1
3	Erdington Constituency	1
4	Hall Green Constituency	2
5	Yardley Constituency	2
6	Northfield Constituency	2
7	Perry Barr Constituency	2
8	Edgbaston Constituency	3
9	Selly Oak Constituency	3
10	Sutton Coldfield Constituency	7

Figure 5: Map of English Index of Multiple Deprivation (IMD 2015) [57] and and table of constituencies ranked by deprivation (IMD 2019) produced by Birmingham City Council

Following guidance from the Parent-Infant Foundation, estimated attachment styles in the local population have been modelled and used as predictors of need for parent-infant relationship support. In our full report we describe in more detail assumptions for our model and for estimates, and how they affect the likely demand on parent-infant support services.

Our conclusion is that communities in Birmingham have experienced more adversity and trauma than other local authorities in England and we suggest that the predicted distribution of attachment is as follows:

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

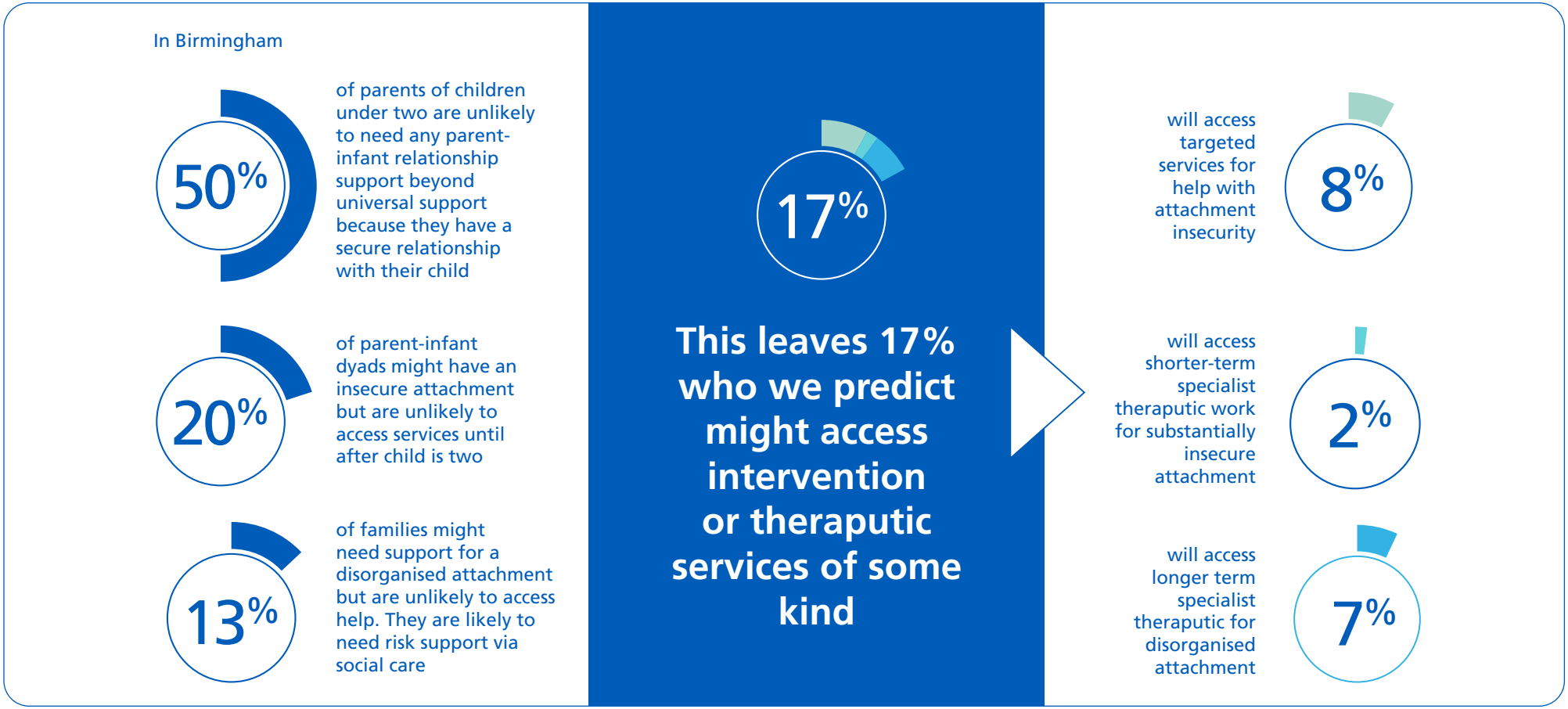


	Reference, non-clinical low-average adversity population	Birmingham region: Mixed socio-economic status population facing moderate to high levels of adversity
Secure attachments	55-60%	Reduced to 50%
Insecure attachments	25-30%	Increased to 30%
Disorganised attachments	15%	Increased to 20%

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

We know from experience that 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 full report, we describe these reasons and how they can affect demand on parent-infant support services.

Figure 6: Percentages of children in Birmingham needing parent-infant relationship support



Our conclusions are that in Birmingham, an area with high family and community adversity and trauma:

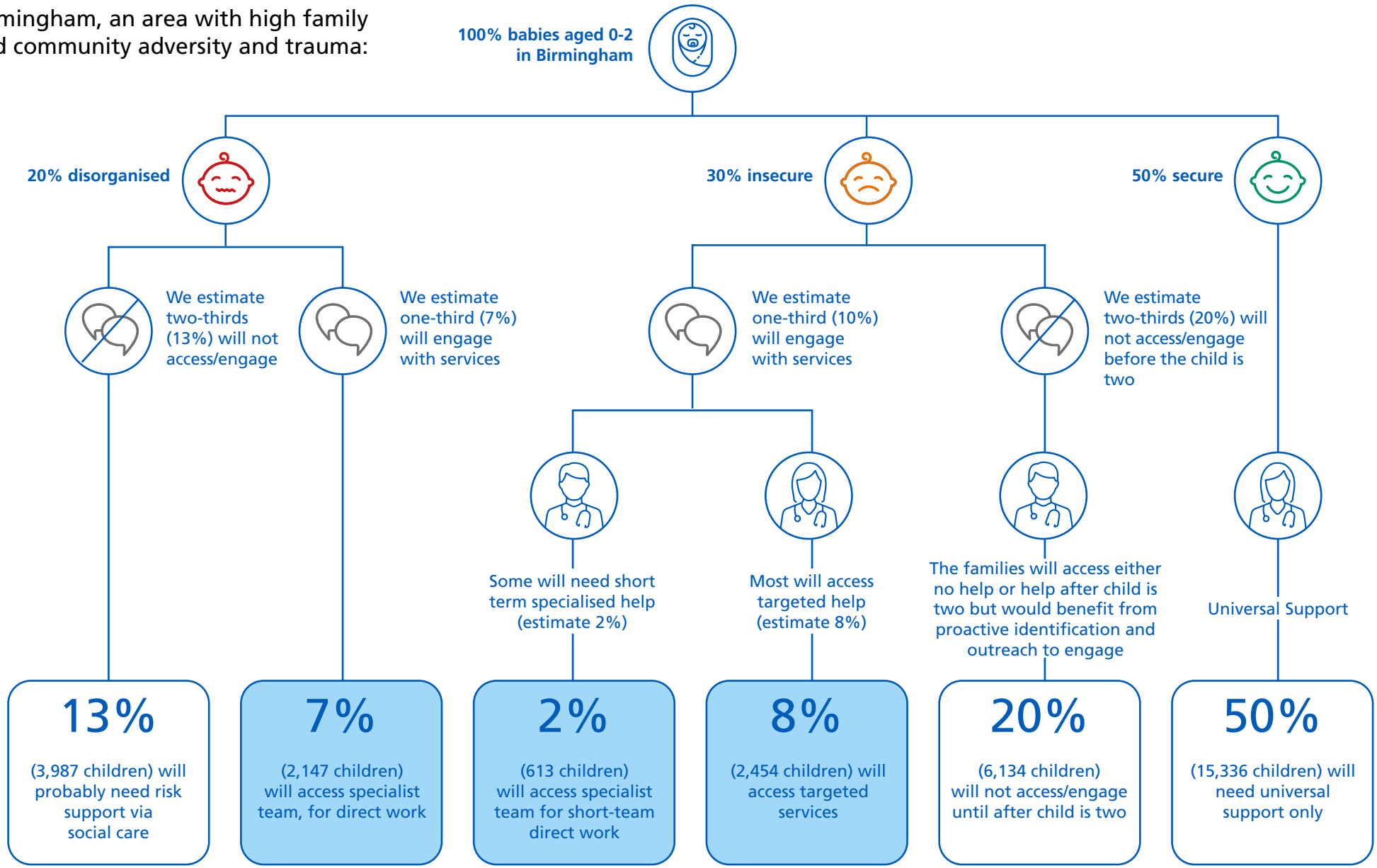


Figure 7: Estimating actual service demand using 2020 total population of 0-2s in Birmingham (30,671)

Specialised parent-infant relationship service provision

These modelled estimates show a significant level of need and demand for specialised parent-infant relationship support in Birmingham with an estimated 2760 families requiring specialist support.

We have recognised that specialist support for the parent-infant relationship is currently being provided by the Community Perinatal Mental Health Service delivered by BSMHFT to mothers with moderate and severe mental health needs. Using the CHLDRN 2020 dataset [56], the prevalence rate for Birmingham of children aged 0-1 with household parental severe mental health illness of approx. 123 per 1000 0-1 yr olds, we estimate that around 340 of the 2760 families requiring specialist parent-infant relationship support will be seen by the BSMHFT PNMH Service. **Given this existing specialised support we have adjusted our calculations to estimate that 2420 families per year in Birmingham require specialist parent-infant relationship support in addition to the families supported by the PNMH Service.**

The Parent-Infant Foundation define specialised parent-infant relationship teams as multi-disciplinary teams with expertise in supporting and strengthening the important relationships between babies and their parents or carers. They note that whilst anyone who works with families during the first 1001 days can help to protect and promote babies' emotional wellbeing, and to support early relationships, specialised teams go further by working at two levels: (i) helping the local early years workforce, and offering advice to system leaders and commissioners; and (ii) offering direct targeted work, and specialist therapeutic support to families where babies are particularly at risk [58].

There should be continued development of universal and targeted services to support the parent-infant relationship.

In this way, teams can help promote healthy relationships for all babies in a locality through working with other services and offering early and effective intervention to those most at risk.

Whilst there is local variation in how specialised parent-infant relationship teams are constituted and commissioned, what they offer, and who they work with, the Parent-Infant Foundation have identified several characteristics common to all teams [58].

- They are ideally multidisciplinary and have at least one and often several highly-experienced psychologists or psychotherapists with specific expertise in parent-infant relationships.
- They use their expertise to help the local workforce through offering training, consultation and/or supervision to other professionals, and advice to system leaders and commissioners.
- They offer direct support for families who need specialised help. This includes targeted work with families experiencing early difficulties whose needs cannot be met by universal services alone, and specialist therapeutic work with families experiencing severe, complex and/or enduring difficulties in their early relationships, where babies' emotional wellbeing and development is particularly at risk.
- They assess families and offer individualised programmes of support to meet their needs drawing on a toolkit of both professional practice and evidence-based programmes.
- Their focus is on the parent-infant relationship. They do not work only with an individual child or parent(s) but with the dyad or triad (although there may be sessions in which parents see a therapist on their own).
- There is a clear referral pathway to enable families who need support to access the service. Families are referred because of concerns about difficulties in their early relationships, which are putting or could put babies' emotional wellbeing and development at risk. Unlike other mental health services there does not need to be a clinical diagnosis in the adult or child for families to be eligible for the service.
- They accept referrals for children aged two and under and their parent(s); some work from conception, others from birth.

It should be clear from the above description that workers in a specialised parent-infant relationship team should be competent at Level 3 of The Infant Mental Health Competencies Framework (IMHCF) - for more information on the IMHCF see page 46, and also our full report.

"During this period, babies are unable to talk about their feelings and needs but communicate these in different ways. They are completely dependent on adults to survive. Therefore, work with babies in the 1001 days is different from work with older children and requires a specific set of competencies: practitioners must have a deep understanding of child development and have the ability to read babies' pre-verbal cues. They need the ability to work with parents, babies and their relationships. This is skilled work that requires specialist expertise".

Parent-Infant Foundation

As previously referenced, there is currently no specialised parent-infant relationship team in the Midlands. Using Parent-Infant Foundation guidance based on each practitioner seeing 52 families per year, it is estimated that the equivalent of 47 full-time practitioners are needed to meet the needs of the 2420 Birmingham families who are estimated to need and be likely to access specialised parent-infant relationship support.

This estimation of 47 full-time practitioners can be broken down by district, with these calculations based solely on the proportion of total 0-2 year olds by district (using 2020 figures); and not taking into account additional factors such as levels of adversity.

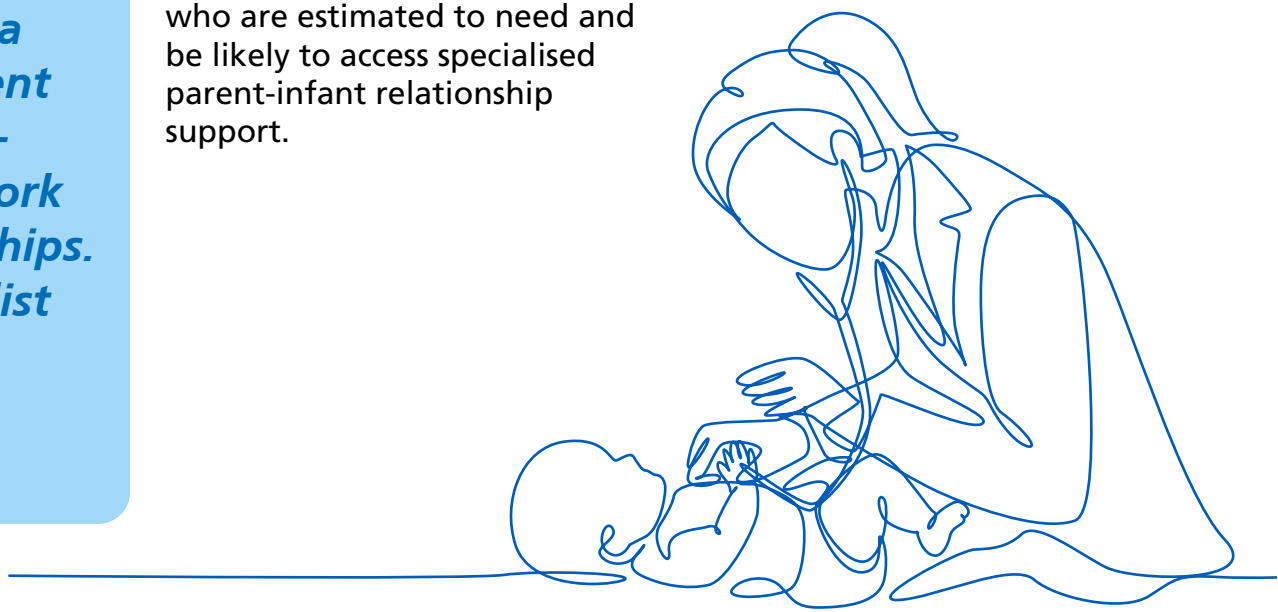


Table 2: Specialist practitioners required for specialised parent-infant support across Birmingham by district

District	Population aged under 2	Proportion of 0-2 year olds by district	Practitioners for specialised support
Edgbaston	2419	8%	3.7
Erdington	2936	10%	4.5
Hall Green	3324	11%	5.1
Hodge Hill	4208	14%	6.4
Ladywood	4058	13%	6.2
Northfield	2740	9%	4.2
Perry Barr	3056	10%	4.7
Selly Oak	2560	8%	3.9
Yardley	3435	11%	5.3
Sutton Coldfield	1935	6%	3.0
Total	**30671**		**47**

Using Parent-Infant Foundation guidance, we recommend that specialised parent-infant relationship practitioners divide their clinical capacity as follows: 50% direct work with families (individual and group interventions) at a general tariff of 4 contacts per day to account for the high level of liaison with the team around the family, and 50% of indirect activities supporting the wider system (consultation, supervision, training delivery and embedding reflective practice groups). This indirect work supports the families that don't access direct specialised interventions but are seen in all other parts of the system.

Forward Thinking Birmingham has a small, dedicated resource (current 0.8 WTE Clinical Psychologist and a temporary 1.0 WTE Assistant Psychologist) to develop work around the first 1001 days, and families can also access the wider CAMHS team, e.g., the city-wide child psychotherapy team, and the core CAMHS hub teams, but this provision does not yet meet the full Parent-Infant Foundation brief of a specialised parent-infant relationship team.

Workstream 2: Service mapping

We researched existing Birmingham public and voluntary sector services which help and support the parent-infant relationship from conception to age two. To do this we interviewed 23 local practitioners and service managers about how local services work as a system, conducted desktop research collecting service data, and attended service team meetings. We identified which level of need each service covered:

- Universal level: services who work with all families irrespective of level of need
- 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

We then looked to draw a distinction at each level between those 'focused/ specialised' services which work specifically on the parent-infant relationship versus 'non-specialised' services which reduce risk factors for parent-infant relationship difficulties and/or strengthen protective factors as part of a wider focus of work. We suggest that these exist on a spectrum.

This is an important distinction: some services which work at a specialist level, may not 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.

Figure 8: Focus and level of support for the parent-infant relationship

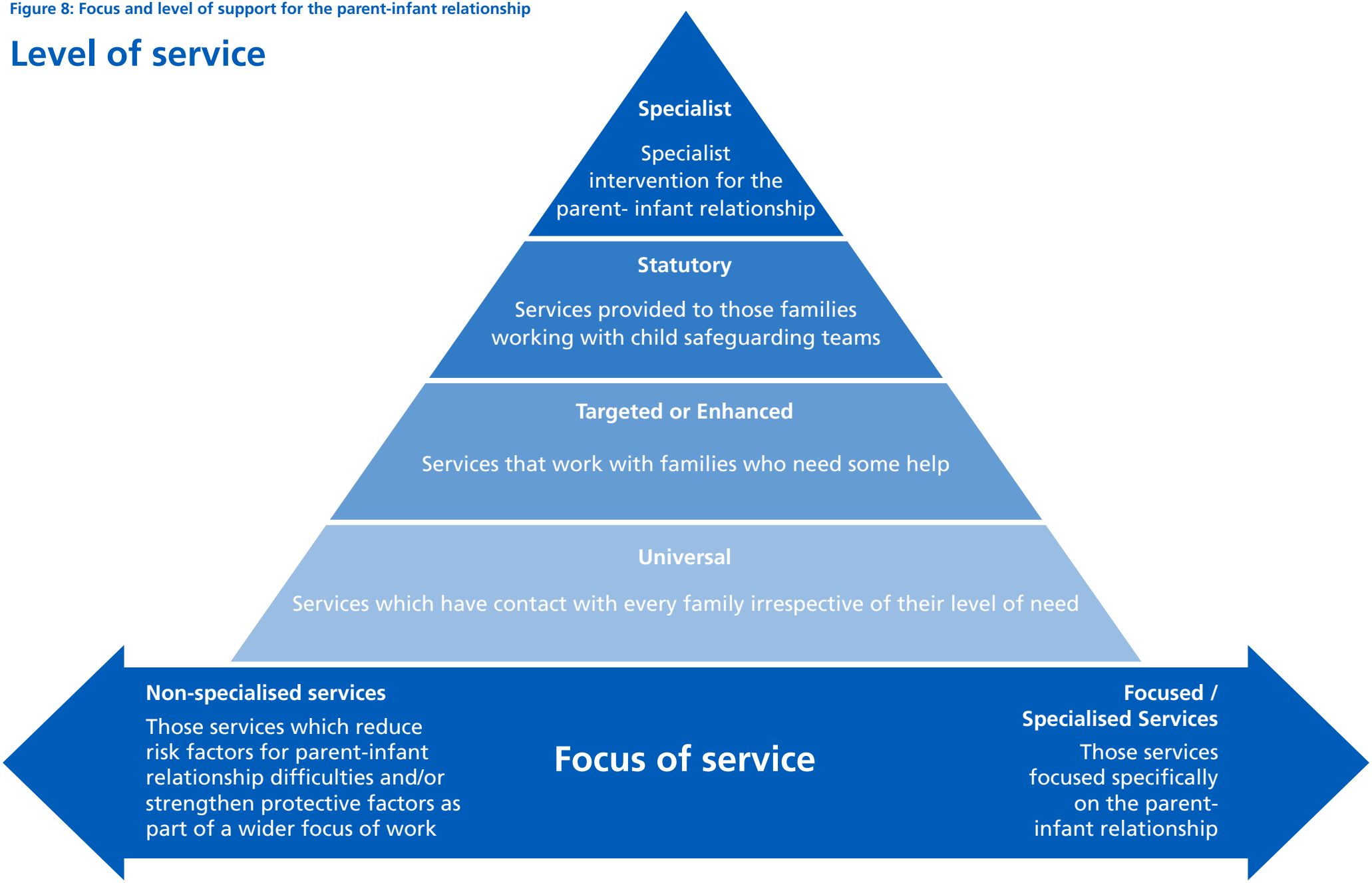
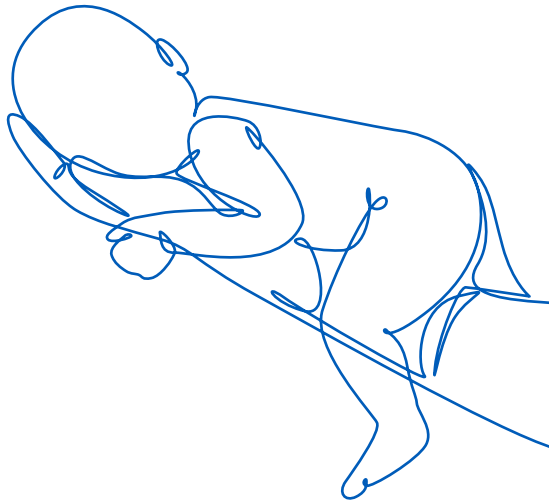


Table 3: Mapping services by level of parent-infant relationship support across Birmingham

Universal parent-infant support	Targeted or enhanced pre-statutory services	Specialist/statutory services (in addition to children's social care)	Specialised support focused on the parent-infant relationship
Birmingham Forward Steps: Early Years and Family Support services (0-5 years) Partner organisations oversee Children's Centres in the 10 districts to provide Early Years and Family Support services		**Community Perinatal Mental Health Team (antenatal to age 12 months, rising to baby's second birthday in development in line with LTP ambitions)** BSMHFT city-wide perinatal mental health support and specialist parent-infant relationship intervention for mothers with moderate to severe PNMH difficulties	
Birmingham Forward Steps: Health Visitors (0-5 years) deliver Healthy Child Programme at district level. There are 5 mandated contacts (1 antenatal and 4 postnatal); low level post-natal depression support, attachment support and listening visits, form part of core offer of targeted family support; specialist health visiting support for vulnerable groups			**Forward Thinking Birmingham (0-25 years)** Small, dedicated resource for under 2s, and input from the child psychotherapy team and the core hub teams to provide specialist support for pre-school aged children, including during the first 1001 days
Community and Specialist Midwives (pregnancy-28 days postnatal) Community midwives across LMNS provide universal support to women antenatally and postnatally. Specialist midwives cover areas of vulnerability: domestic abuse, FGM, PNMH, teenage pregnancy, substance misuse, safeguarding and homelessness			
Early Years Alliance and Thrive Together (BFS VCS partners) Contracted for city-wide support of 211 community-led stay and play groups	**Early Years Inclusion Support (EYIS) (0-5 years)** Specialist early years SEND support services	**St Basils (16-25 years) Birmingham Youth Homelessness Service,** including young parents utilising Psychologically Informed Environments (PIE)	
(VCS) New Baby Network (women, all ages) Promotes secure attachment through face to face/ online peer led support groups	**Early Help Community Connectors (0-25 years)** Birmingham Children's Partnership 'Early Help' model city-wide initiative connects ICYP and their families with local community services	**Forward Thinking Birmingham Children in Care Pathway (0-25 years)** Offering trauma informed psychotherapeutic consultation and care	
(VCS) Anawim Birmingham Centre for Women (women, all ages) Offers support in pregnancy and in developing confidence around parenting	**(VCS) Acacia (0-2 years)** Mild to moderate PNMH support (CCG commissioned), peer based one to one support and groups for one or both parents during pregnancy or with children under 2 years	**BCT Therapeutic Emotional Support Service (TESS) (0-25 years),** non statutory therapy including Dyadic Developmental Psychotherapy	
	(VCS) Approachable Parenting (0-3 years) Parenting programmes and therapeutic support	**BCT Breaking the Cycle Service** Non-statutory, therapeutically informed programme supporting birth parents who have lost child(ren) to adoption	
	(VCS) Birmingham & Solihull Women's Aid Provide frontline specialist support to women and children experiencing domestic abuse	**Birmingham Children's Hospital Children With Medical Complexities Discharge Team (0-18 years)** Family support for complex discharges	
	(VCS) All Saints Youth Project Targeted stay and play for teenage parents in Kings Heath, enhanced support for transgender and adoptive parents	**Birmingham Children's Hospital Health in Mind (0-18 years)** Paediatric psychological support and Solihull Approach informed family groups	
		BCT Birmingham Social and Emotional Mental Health Pathfinder (all ages) Newly emerging 'Roots' project offering PIE care to under 5s in Northfield	
		Birmingham Children's Hospital Neonatal Unit Neonatal psychological support via Health in Mind and family group support. Also small amount of clinical psychology neonatal resource provided by Health in Mind to Heartlands Hospital, and to Good Hope Hospital (consultation to staff only)	
		BCT Northwest Central pre-birth pilot Trauma informed relational approach for mothers at high risk of having babies removed post birth	



Footnote: We cannot guarantee this table to be fully comprehensive of all services. Although we invited all services to participate, our findings and mapping are limited to the information gathered from those services that did take part.

Summary of level and focus of services for parents and babies aged 0-2:

Birmingham currently has a small, dedicated provision of highly specialised parent-infant support, offered by the BSMHFT PNMH service and Forward Thinking Birmingham.

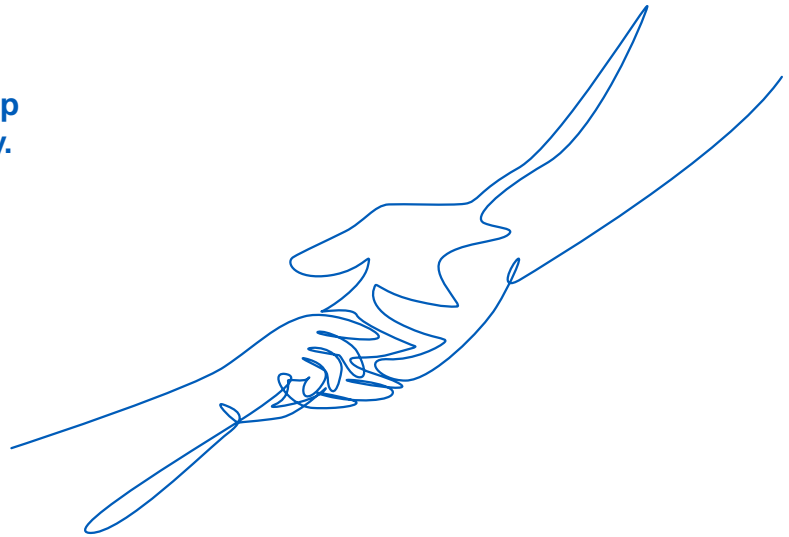
Although not providing highly-specialised parent-infant support, approximately a third of identified services across all levels of need are working with an additional focus on the parent-infant relationship.

Approximately two thirds of services across all levels of need are non-specialised, with most of their work concerned with reducing the risk factors for difficulties in the parent-infant relationship or strengthening protective factors as part of wider service aims.

We found pockets of good practice across all levels of need including health visiting teams, specialist midwifery, children's centre services, paediatric psychology, BCT Breaking the Cycle Service, St Basils Youth Homelessness Service, and BCT Birmingham Social and Emotional Mental Health Pathfinder. Voluntary sector organisations Approachable Parenting and Acacia offer important parenting and perinatal mental health services across the city. We identified a gap within the specialist psychotherapeutic consultation and care provided for 0-25 year olds by Forward Thinking Birmingham Children in Care pathway and Birmingham Children's Trust Therapeutic Emotional Support Service (TESS), where there are currently no 0-2 year olds on the caseload although this age group is eligible for a service.

This gives a good basis to build on current support offered by targeted and specialist services to expand capacity to offer specialised parent-infant relationship support, both antenatally and postnatally. There should be a priority to focus on children under two experiencing maltreatment or who are known to children's social services.

Forward Thinking Birmingham has a small resource specifically dedicated to supporting the first 1001 days, and specialist input from the child psychotherapy team and core CAMHS clinicians. As infant mental health provision develops within Forward Thinking Birmingham, the focus should be on expanding capacity for specialised parent-infant support, continuing to build on internal and external links with staff to offer consultation and training, and increasing service capacity to manage a larger caseload of 0-2s who would benefit from specialised support.



What we learned from services

Health visitors and children centre services are seen as central to provision of universal and targeted parent-infant relationship support

We heard from most services that children's centres or health visitors are the preferred referral route to access parent-infant relationship support for families. These services do not solely focus on the parent-infant relationship; however, the baby is consistently held in mind.

Often, they will address the risk factors or consequences of parent-infant relationship difficulties. We also heard from staff that they wanted future infant mental health service provision to be localised, district based and needs based, using a stepped care approach for families from universal provision upwards.

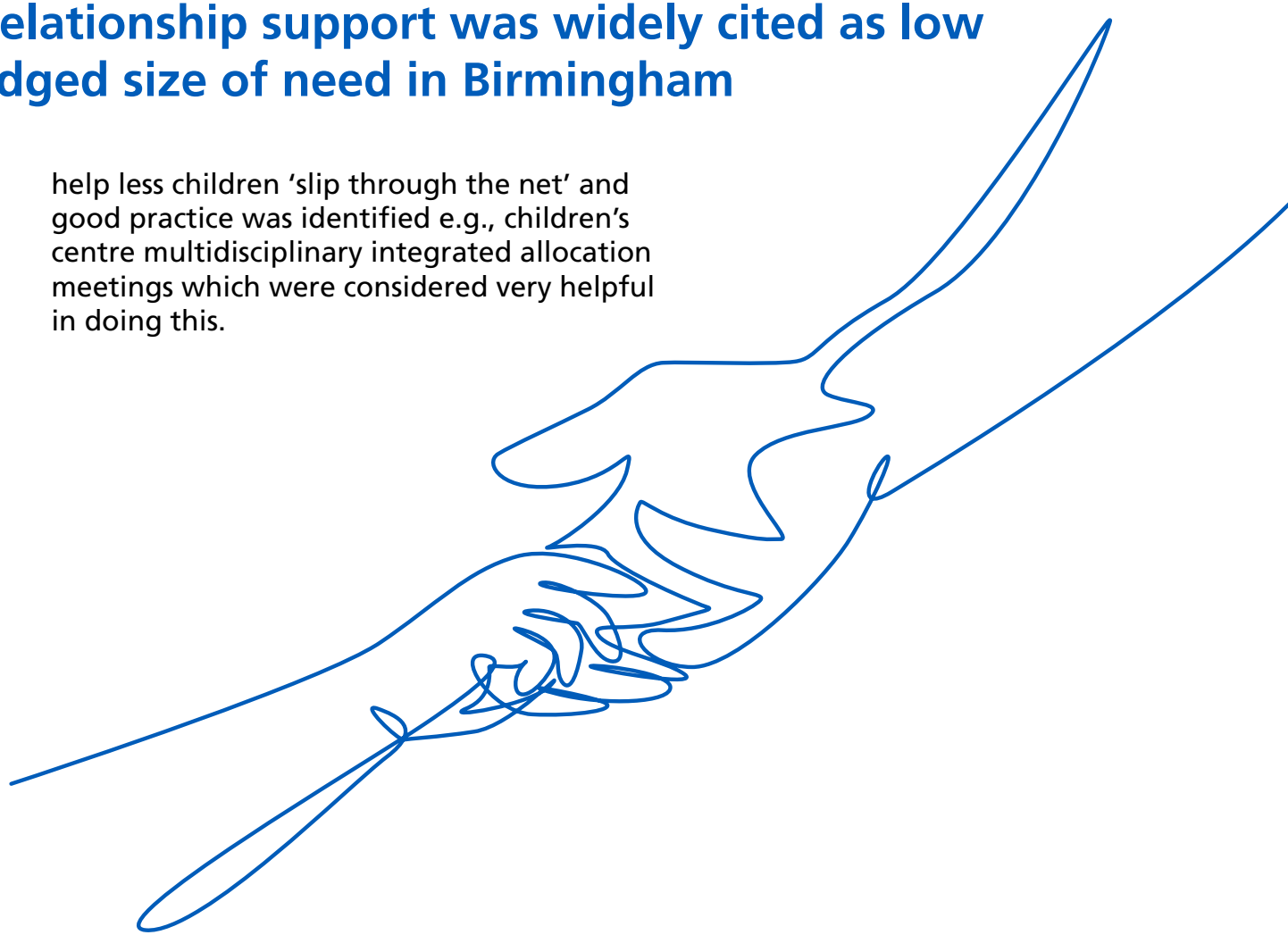
Local assessment processes vary, and there is an opportunity to formalise and standardise the way in which all services ask about or assess the parent-infant relationship

Our review found that services utilised a range of informal and formal methods of assessment of the parent-infant relationship. Services use a range of free-text recording, service-specific proformas, and assessment methods which cover factors relevant to the parent-infant relationship such as parental wellbeing and perinatal mental health. These may not be sensitive enough to identify parent-infant relationships under strain and may underestimate the need for parent-infant relationship support at a preventative stage. We heard that the complexity of needs many families can present with, often results in the child's voice being lost as much of the focus is on other factors.

Specialised services use formal assessments of the parent-infant relationship such as the Parent Infant Interaction Observation Scale (PIIOS) and the Parental Embodied Mentalising Assessment (PEMA).

Provision of parent-infant relationship support was widely cited as low in relation to the acknowledged size of need in Birmingham

We heard that at all levels, insufficient workforce capacity and available staff time to spend with families limits connections with families and the ability of staff to focus on the parent-infant relationship and identify concerns. Long waiting times for families for specialised services was consistently highlighted as an issue. Although in contrast, specialised services noted the low caseloads and limited referrals received for under 2s for parent-infant relationship support. Our review found that services are driven to help less children 'slip through the net' and good practice was identified e.g., children's centre multidisciplinary integrated allocation meetings which were considered very helpful in doing this.



Families benefit the most when the services they access can work effectively in partnership with the wider system

We found that while services understood the scope, remit and boundaries of their own service provision, there were gaps in awareness of external services and some challenges when trying to access support outside their service. This can prove problematic when families are required to transition across services and there is a gap or disruption to their support. Additionally, changes and fragmentation to commissioning and organisational structures can cause confusion for both services and families about where to access support. However, we heard that when services are aware of other services, perhaps through experience, research, or training, then they are better placed to have conversations, promote partnership working and empower staff and parents to have more knowledge.

There was strong motivation and support within services to support the parent-infant relationship; this enthusiasm is what drives services to do what they do.

We heard that the importance of the parent-infant relationship was acknowledged across all services and there was a strong motivation to want to do better in this area of work. Our review prompted thinking and questioning around supporting the under 2s from referrals through to assessment and intervention. Staff showed a willingness to take on training and a desire to strengthen connections across services with an aim to build skills and confidence across the workforce in recognising and supporting parent-infant relationships. Additionally, we found that services endeavour to keep the whole family in mind in their work and remain curious about using wider family networks to improve the quality of support offered.

Building trusted relationships with service users and communities through parent-led approaches and co-production facilitates long term engagement and positive outcomes

Services appear to thrive when they have taken the time to understand and build trusted relationships with the communities they serve. Community outreach helps improve awareness and make services more accessible. Equally, involving parents in service developments and adapting services accordingly to suit the needs of the group was highly respected by families. We found examples of this in the voluntary sector, in Approachable Parenting, and in Birmingham Social and Emotional Mental Health 'Pathfinder' service.

Our review found that professionals thought that future infant mental health service provision should facilitate parents' and families' ownership and design of any intervention. This is to embed interventions into communities and to avoid the potentially negative impact of framing specialist support as 'professional', and to avoid pathologizing the parent-infant relationship.

Changes in working styles and models of service provision during the COVID-19 pandemic have resulted in positive and negative experiences for families. We saw examples of how services expanded and diversified their reach due to the shift in virtual service delivery (e.g., Approachable Parenting, antenatal and infant feeding teams and children's centre family support services). We also heard that physical separation, loss of 'drop-in' facilities, lack of face-to-face meetings, and disrupted group interventions during the period of lockdowns and covid-secure measures had impacted on the quality of parent-infant relationship support on offer. There were also concerns that increased reliance on virtual service delivery worsened outcomes for those experiencing digital exclusion.

The most vulnerable families have been hidden during the period of lockdowns with issues potentially slipping through the net with less face-to-face contact.

For parent-infant relationship support to be meaningful and impactful, families need to receive the right service at the right time

We heard that there was a 'gradient of vulnerability', where those families who are in greatest need of parent-infant relationship support, may also often have multiple wider socioeconomic risk factors for parent-infant relationship difficulties. Professionals wanted any future infant mental health service provision to avoid being tokenistic and a 'tick box' exercise; they wanted it to aim to add value to existing family support. Services also received referrals where there was no explicit mention of a need for parent-infant relationship support, however when there were wider concurrent complex socioeconomic factors, it was likely that parent-infant relationship support was also needed.

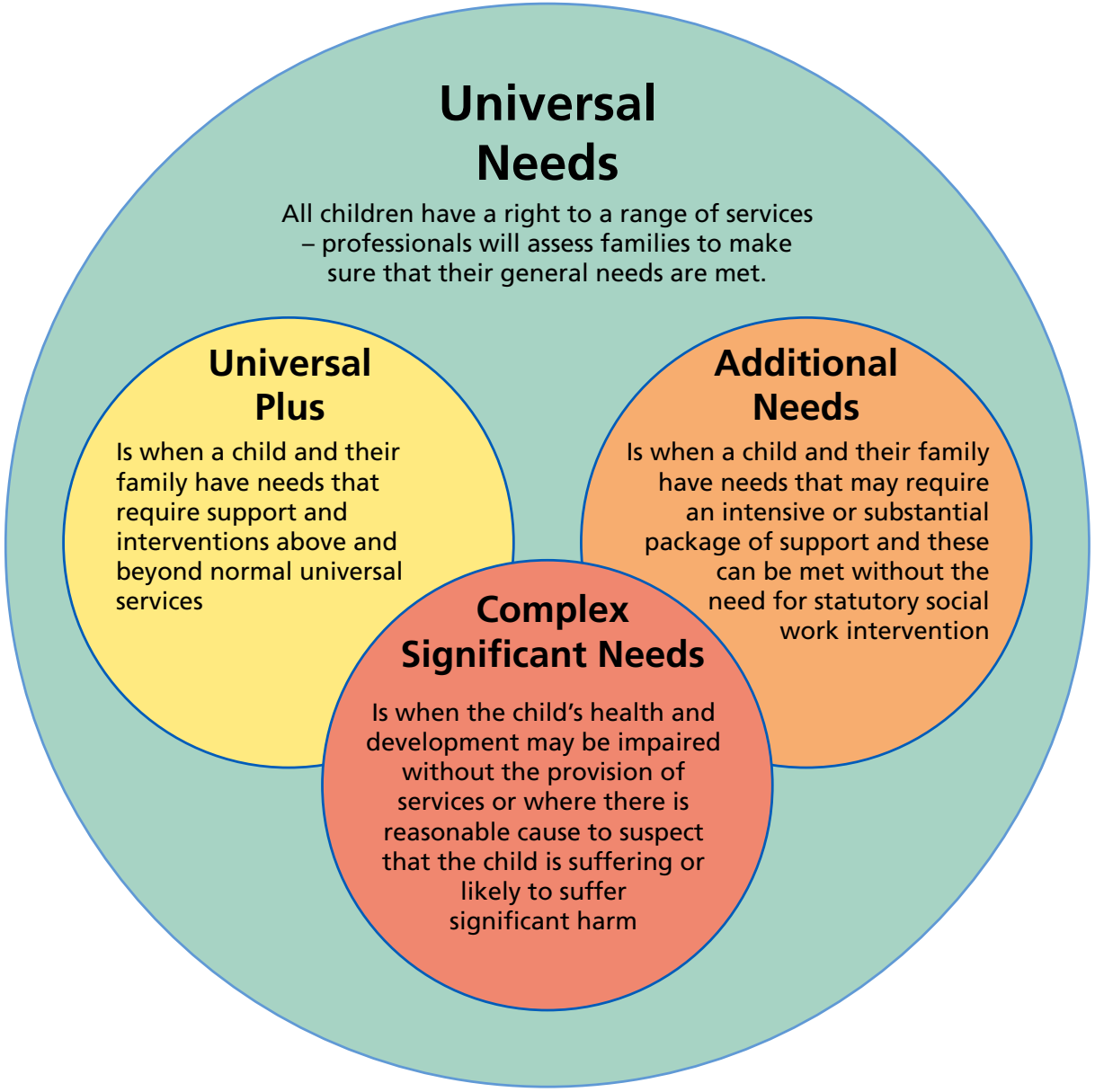


Figure 9: Birmingham Early Help Strategy- Right Help, Right Time

Workstream 3: Analysing workforce strengths and needs

The aim of the workforce analysis was to gain an understanding of the current and future training needs of the workforce, to support efforts to coordinate support across the wider network and achieve best impact from the workforce and resources currently available.

Thinking about competency around parent-infant relationship work is supported by the ***Infant Mental Health Competencies Framework (Pregnancy to 2 years),*** which is designed to support the learning and knowledge of all staff working with infants and their parent(s)/ caregivers during the first 1001 days [59]. The IMHCF is organised around an ability to hold an 'infant mental health frame of mind', and lists several competencies over three levels:

1. General knowledge and skills
2. Advanced knowledge and skills
3. The knowledge and skills required to supervise and manage

The ability to hold an 'infant mental health frame of mind', ***"refers to the capacity of staff working with parents and babies to be able to maintain the perspective not only of the parent but also that of the baby, to be able to use observations in order to imagine. Practitioners need a capacity to maintain a focus on the parent-infant relationship as a dynamic system, and to be able to apply interventions flexibly in-line with the strengths, vulnerabilities and wider social context of each infant, parent and family".***

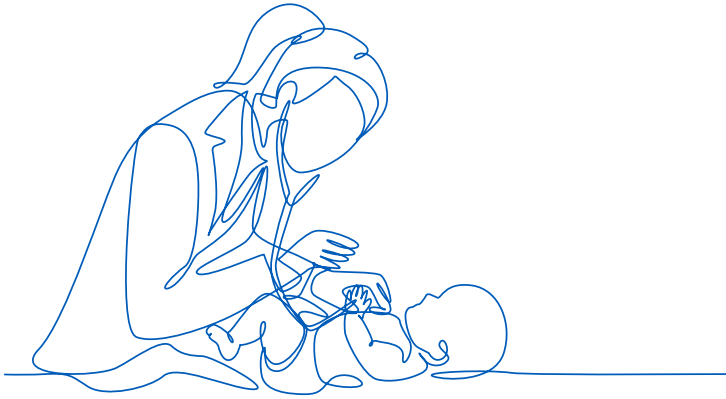
AiMH UK Infant Mental Health Competencies Framework [59]

The Parent-Infant Foundation Development and Implementation Toolkit [63] recommends the use of the IMHCF to think about the competencies, skills and qualities needed to work at different intensities in parent-infant relationship work and identifies various interventions, programmes, and approaches as relevant to developing a 'toolbox' approach that can be flexible in response to a family's situation. More information about both the IMHCF and the interventions, programmes and approaches that can make up a 'toolbox' approach to meeting need can be found in our full report.

The workforce questions asked in our work were consulted on and agreed with the IMHSG. A survey containing these questions was then advertised to, and widely distributed by, health and social care, education, and voluntary and community sector partners to reach as varied a workforce as possible. The survey stayed open for seven weeks from January to March 2022. We received 90 completed responses with geographical representation across all districts and settings. Over 60% of participants worked in the community or a community venue, which included working directly in family homes. We also received responses from a wide range of professional groups, details of which are in our full report. Notably missing from the workforce survey responses was medical doctors (GPs and paediatricians).

Results

The professions most likely to offer direct work to the family antenatally were health visitors, and those working in children's social care, perinatal mental health services, and the voluntary and community sector. There was evidence of all professions reporting that they would refer to another service demonstrating the inter-agency working that takes place during this period. Postnatally, there was evidence of all professions offering additional help or a direct intervention. The professions most likely to offer a direct intervention in this period were Health Visitors, and those working in children's social care, perinatal mental health services and CAMHS.There was also evidence of all professions seeking advice from a colleague postnatally. In terms of understanding how infants communicate through verbal and non-verbal behaviour, 26% found it neither easy or difficult and 3% were not sure. This may demonstrate that there are a cohort of professionals who perhaps don't think about this in their line of work or are not clear on what to look out for.



All professionals found it increasingly more difficult to think about the parent-infant relationship when there were other conflicting demands on time and capacity due to wider socioeconomic determinants of ill-health and inequalities

Table 4: Workforce survey participants answers to 'how easy or difficult it is to keep in mind the parent-infant relationship?'

How easy or difficult is it to think about the parent-infant relationship?					
Very difficult	Difficult	Neither Difficult or Easy	Easy	Very Easy	Not Sure
0%	4%	32%	34%	27%	2%

How easy or difficult is it to think about the parent-infant relationship if...					
There are older children (with or without additional needs) in a family?					
Very difficult	Difficult	Neither Difficult or Easy	Easy	Very Easy	Not Sure
1%	15%	25%	31%	24%	4%
There are challenging/adverse circumstances in the family (e.g poverty, domestic violence, housing issues)					
Very difficult	Difficult	Neither Difficult or Easy	Easy	Very Easy	Not Sure
8%	21%	21%	26%	21%	2%

Staff reported that identifying parent-infant relationship concerns is one thing but taking next steps may be hard if:

- Depending on the setting there are other competing clinical or health needs (child's acute medical condition, SEND, or mother's mental health presentation)
- Insufficient service capacity to meet all need
- Staff are in a managerial or supervisory role and are offering guidance only to practitioners
- Practitioners' own capacity is limited in terms of time pressure
- Expertise is held by a small number of people

Staff perception is that the greatest gap in provision exists at the preventative stage and at the highest level of need

Staff perception is that the greatest gap in provision exists at the preventative stage and at the highest level of need. Family support/ parenting staff were most likely to think that there was enough support at all levels.

"The most difficult part of the work was often in the thinking about how to begin supporting a parent to think about their child's emotional states, when they had most often experienced trauma throughout their own life and not experienced good enough parenting themselves."

Staff response to finding it difficult to think about the parent-infant relationship

Staff perception of available local support for the parent-infant relationship by level of intervention

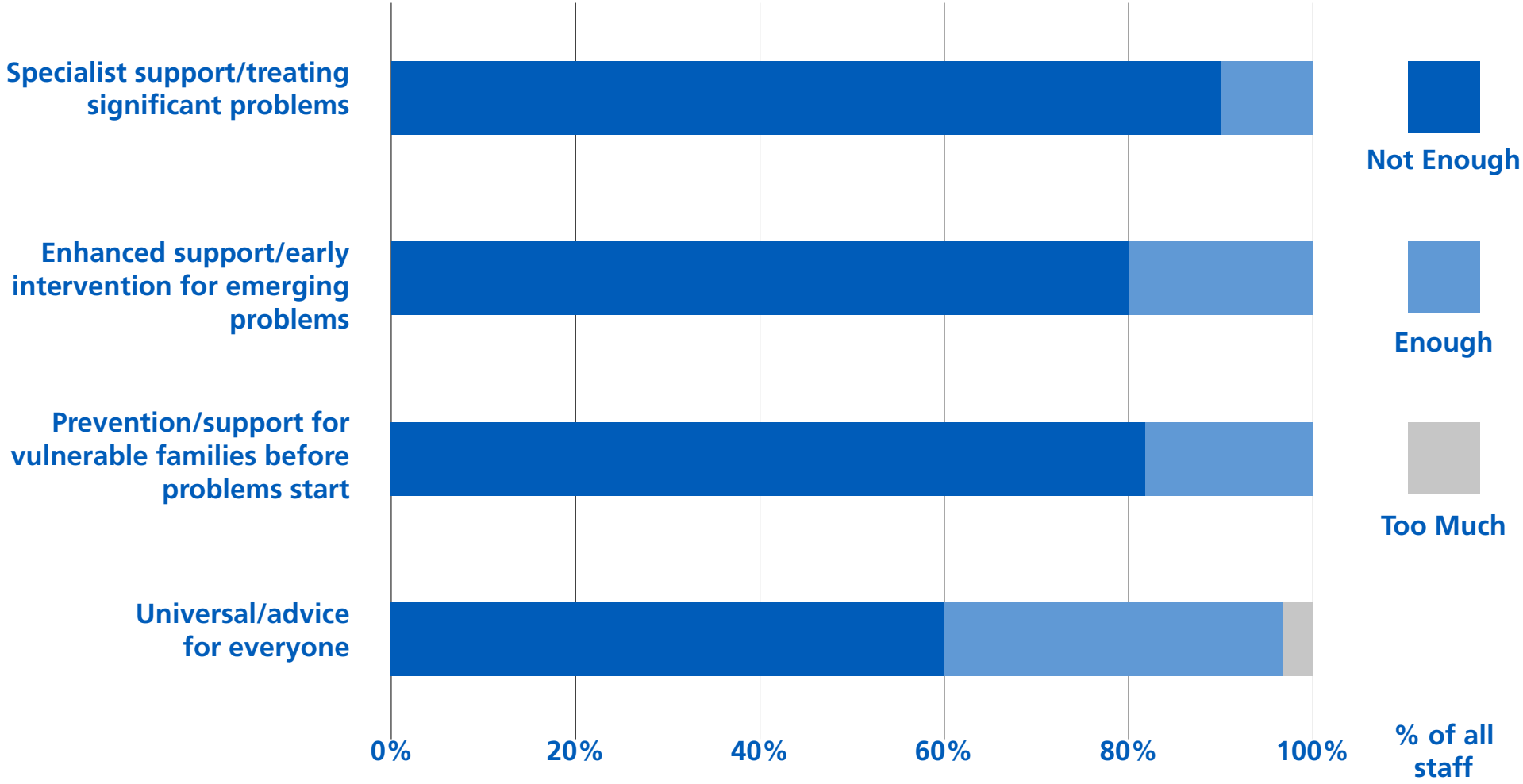


Figure 10: Workforce participants perception of available local support by level of intervention

Formal parent-infant relationship interventions offered by participants (number of responses):

Dyadic Developmental Psychotherapy (DDP), Theraplay, or similar

Video Interaction Guidance (VIG) or similar

Supporting skin-to-skin contact

Listening or Listening visits

Circle of Security Parenting

Psychoanalytic Psychotherapy

Intensive Interaction play approach

Promoting Happier Parenting

5 Pillars of Parenting 'Pregnancy and Beyond' and 5 Pillars of Parenting 'Pregnancy to 3 years' parenting programmes

Journey to Parenthood

Parental Embodied Mentalising Assessment (PEMA) Intervention

Watch, Wait and Wonder

Solihull Approach (pre- and post-natal)

Five to Thrive

Baby Massage

Watch me Play!

Positive parenting programme (PPP)

Targeted 1:1 Stay and Play sessions

Incredible Years

Health visitors and children's centres services are the main workforces seen to be responding to parent-infant relationship concerns

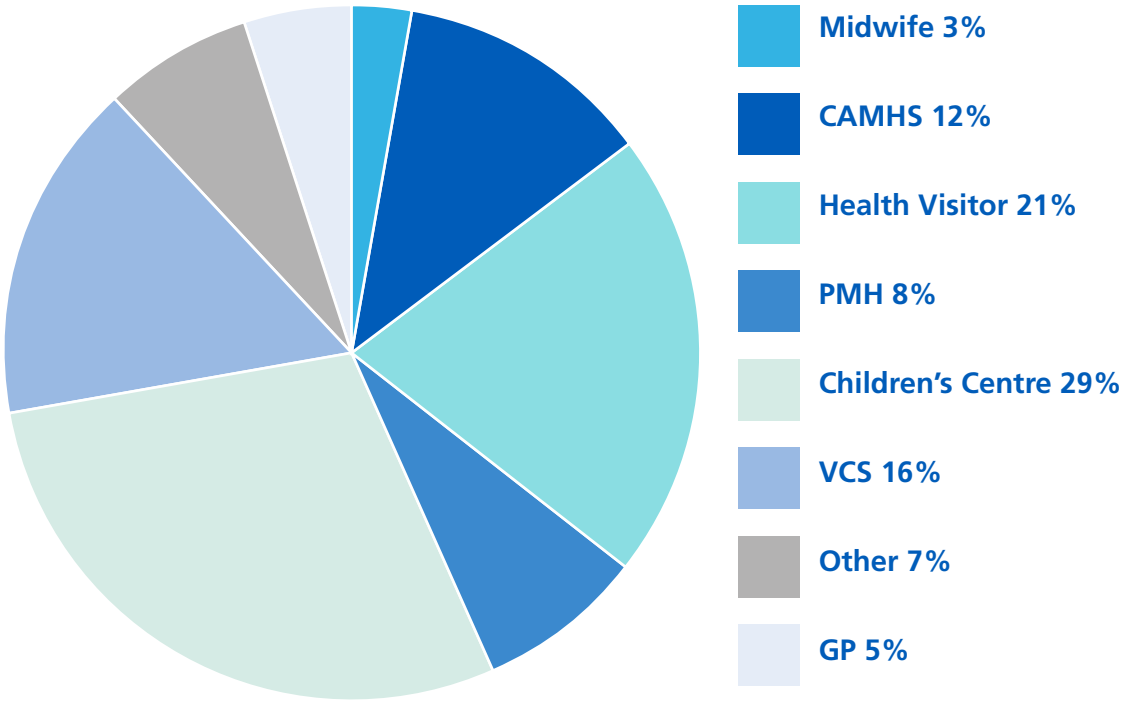


Figure 11: Referral destinations (% of staff) when parent-infant relationship concerns are referred on

There is a need for practitioners and managers across all services and all levels of need to access more specific parent-infant relationship training and to attend refresher training

Just under a third of respondents stated they had received "no specific parent-infant relationship training", above and beyond any vocational training. On average, perinatal mental health professionals had the highest training per person (2.6 courses per person).

Half of those who stated no training in the last five years reported training in the last 10 years. Of those who completed training in the last 10 years 74% stated it was Solihull Approach or Baby Massage training, illustrating the long-standing nature of some trainings over others. Staff also reported unspecified trauma/ ACE informed training and therapeutic life story work training, and reported attending webinars, conferences, online training, out of work training, events, and lectures to boost their knowledge.

Table 5: Workforce participants reporting 'no specific parent-infant relationship training in the last five years' and average number of trainings per person by professional group

	Children's social care	Family support/ parenting	PNMH	VCS	Health visitors	Early Years and/ or childcare/ education	CAMHS
Total number of respondents	7	19	7	10	18	17	10
Total reported training places	8	17	18	10	18	24	9
Total number of respondents reporting "no" to training	1 (14.3%)	8 (42.1%)	1 (14.3%)	4 (40%)	1 (5.6%)	4 (23.5%)	4 (40%)
Of those who have attended some training, what is the average number of training places attended per person	1.3	1.3	2.6	1.1	1.1	1.5	1

Workstream 4: Hearing from local parents and caregivers

The aims of this part of the work were to find out the views of local parents and caregivers across Birmingham with children under two, to inform any future service provision model.

We used a mixed method approach to gathering the parent/caregiver voice. The survey was advertised to, and widely distributed by, health and social care, education, and voluntary and community sector partners to reach as varied a parent and caregiver population as possible. We utilised links with Approachable Parenting, Baby Network, Early Help Community Connectors, children's centres, Think4Brum, health visitors and schools to advertise the survey, and created a poster with a QR code which was distributed. The survey stayed open for five weeks from January to March 2022.

- Online survey (49 parents)
- One-to-one telephone interviews (6 parents)

The survey contained quantitative data and qualitative free text data which was formally thematically analysed along with supplementary telephone interviews.

Limitations to methods and sampling bias are described in the full report.

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

How strongly do you agree with the following statement "My relationship with my baby has an impact on their development"

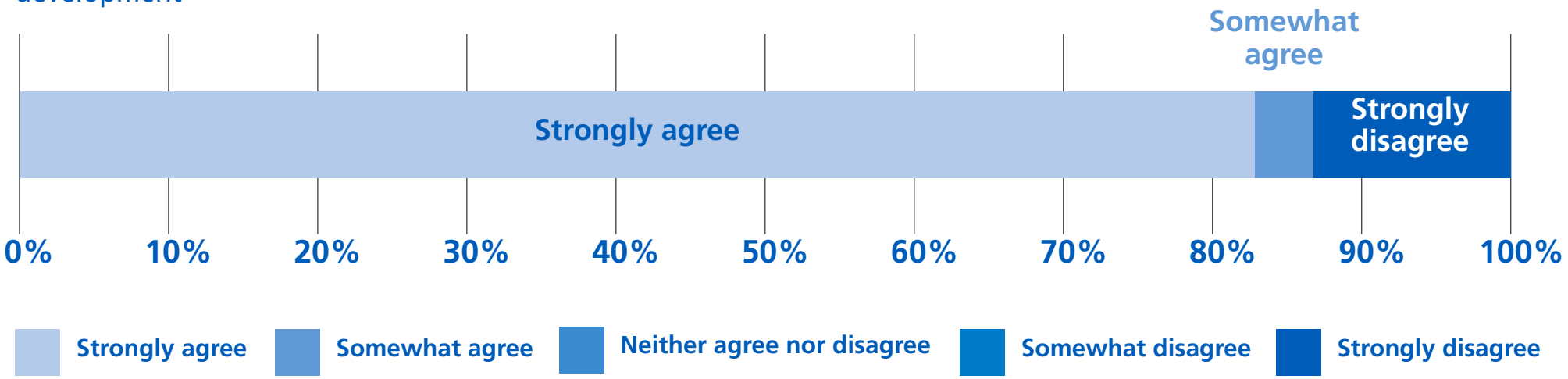
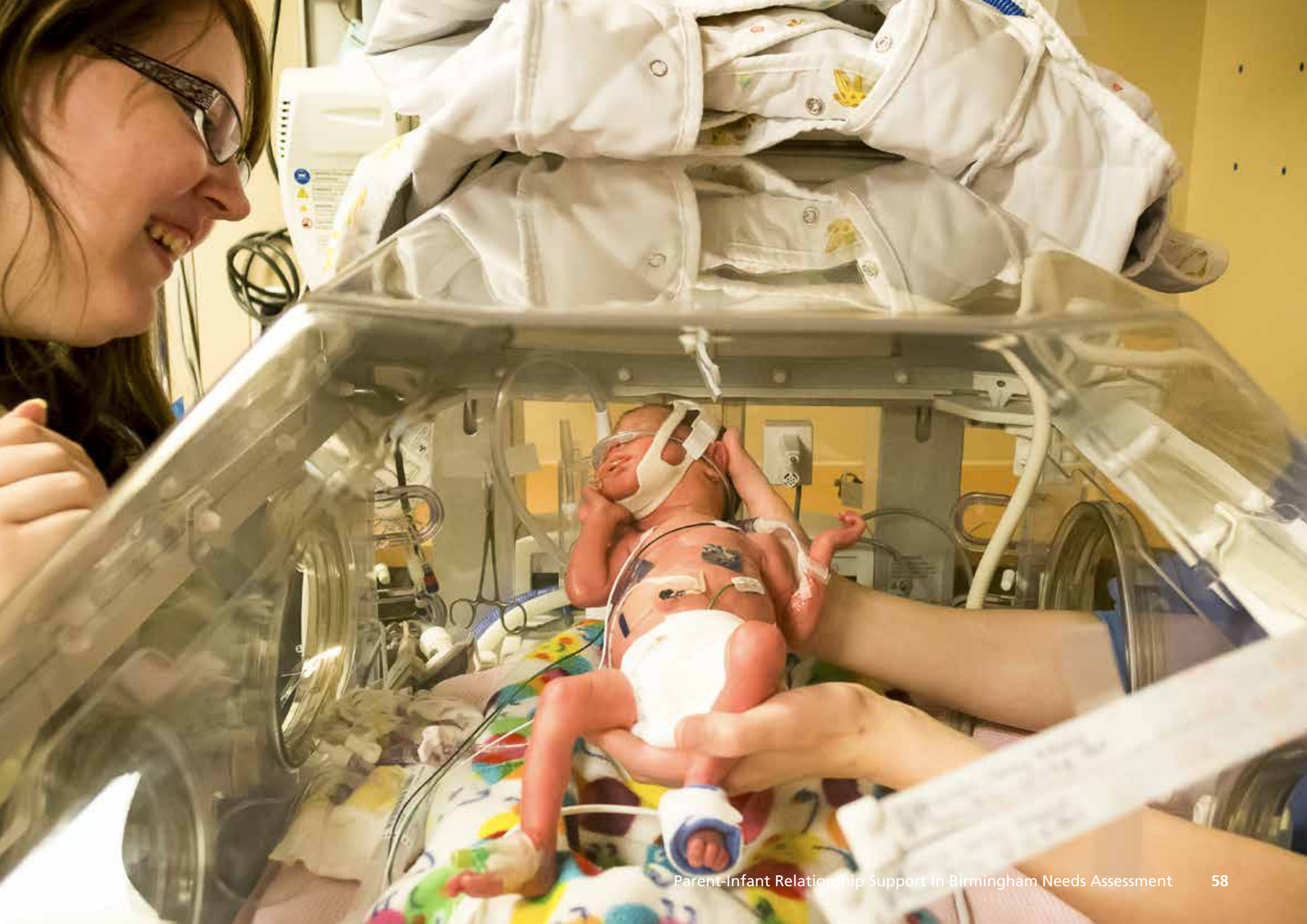


Figure 12: Parent/ carer survey answers agreeing to 'my relationship with my baby has an impact on their development'

- 86% of respondents stated that they strongly agreed or somewhat agreed that their relationship with their baby had an impact on their development.
- 13% stated they strongly disagreed with this statement. Those that strongly disagreed were more likely to have a higher number of children at home who they have regular responsibility for than the main sample, and 100% of them reported never being asked about how they feel about their relationship with their baby.

"Their social emotional development: confidence, self-esteem, feeling safe, secure, loved… impacts on speech and language development… everything really."

Parent speaking about the impact of their relationship on their baby's development



Parents identified a range of factors which they thought impacted on their baby's development

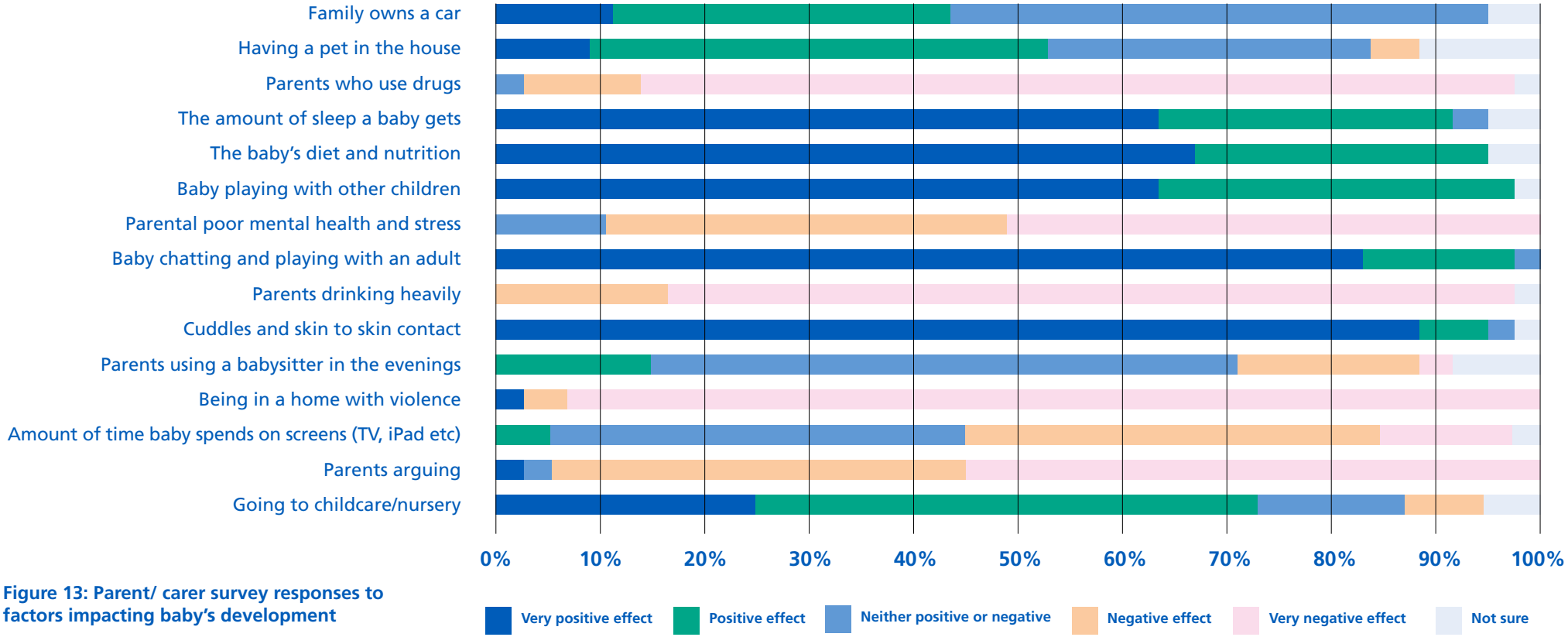


Figure 13: Parent/ carer survey responses to factors impacting baby's development

The top three factors which parents thought had a very positive impact on baby's development were cuddles and skin to skin contact, baby chatting and playing with an adult, and baby's diet and nutrition. The top three factors which parents thought had a very negative impact on baby's development were being in a home with violence, parents drinking heavily and parents who use drugs.

Just over two thirds of parents spoken to said they had never been asked by a professional about how they feel about their relationship with their baby.

Of those that stated they had been asked once or more than once by a professional about their relationship with their baby, the most common professional to have asked was the health visitor, followed by a midwife and mental health professional.

Just over 40% of parents spoken to had been given information (written or verbal) about attachment and bonding with their baby or young child. However, an almost equal number stated they had not received any information.

Of those respondents who had received information, the most mentioned professional sources of this were health visitors and midwives (including NCT and antenatal classes).

Over three quarters of respondents felt that receiving written information about bonding with their baby was either very helpful or helpful.

The most common experiences which could have an impact on bonding were mental health issues, external stressors, and feeling isolated.

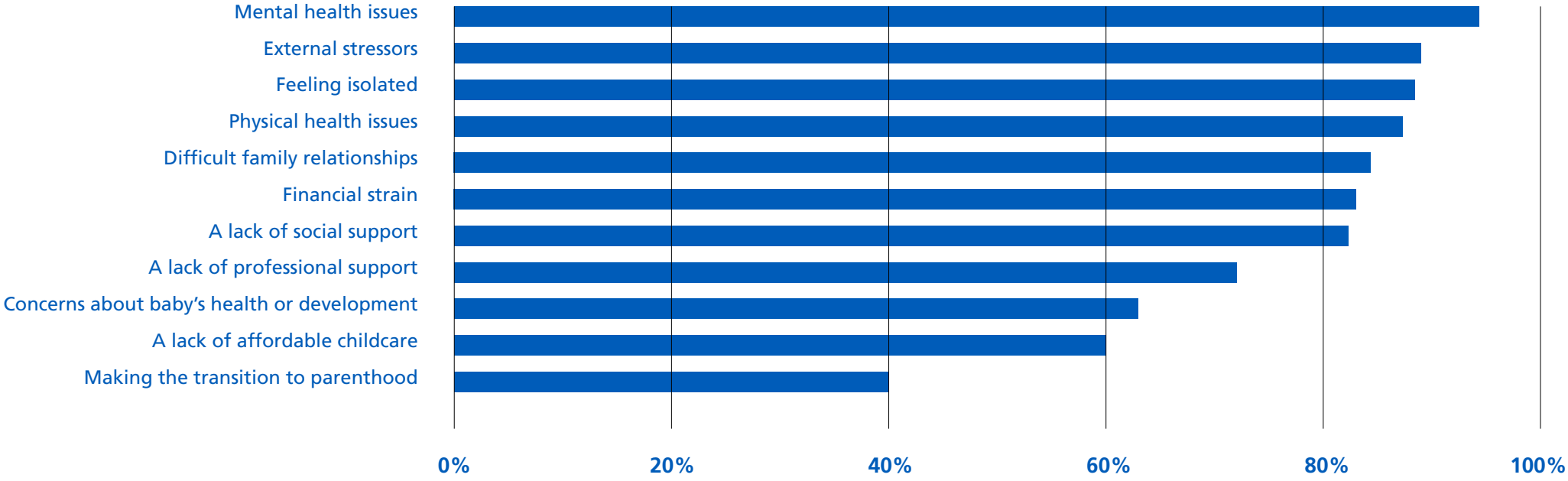


Figure 14: Parent/carer responses to negative experiences on bonding

Parents expressed that it was hard to keep in mind their relationship with their baby when there were other issues going on with themselves or in the family.

Some of the points raised related to their experience of post-natal depression, guilt over not bonding with their baby, and issues arising from baby's physical health conditions. Covid had compounded these feelings, with the experience of childbirth and raising their baby during lockdown taking a toll on emotional and mental health, as well as suffering the impact of direct bereavement and social isolation. The change in professional support during this time to mostly over the telephone was raised; parents preferred face-to-face consultations that didn't feel rushed.

Over half of respondents stated that fear of judgement by others, being unsure of where to seek help, and feeling like a failure would make it difficult to reach out for support.

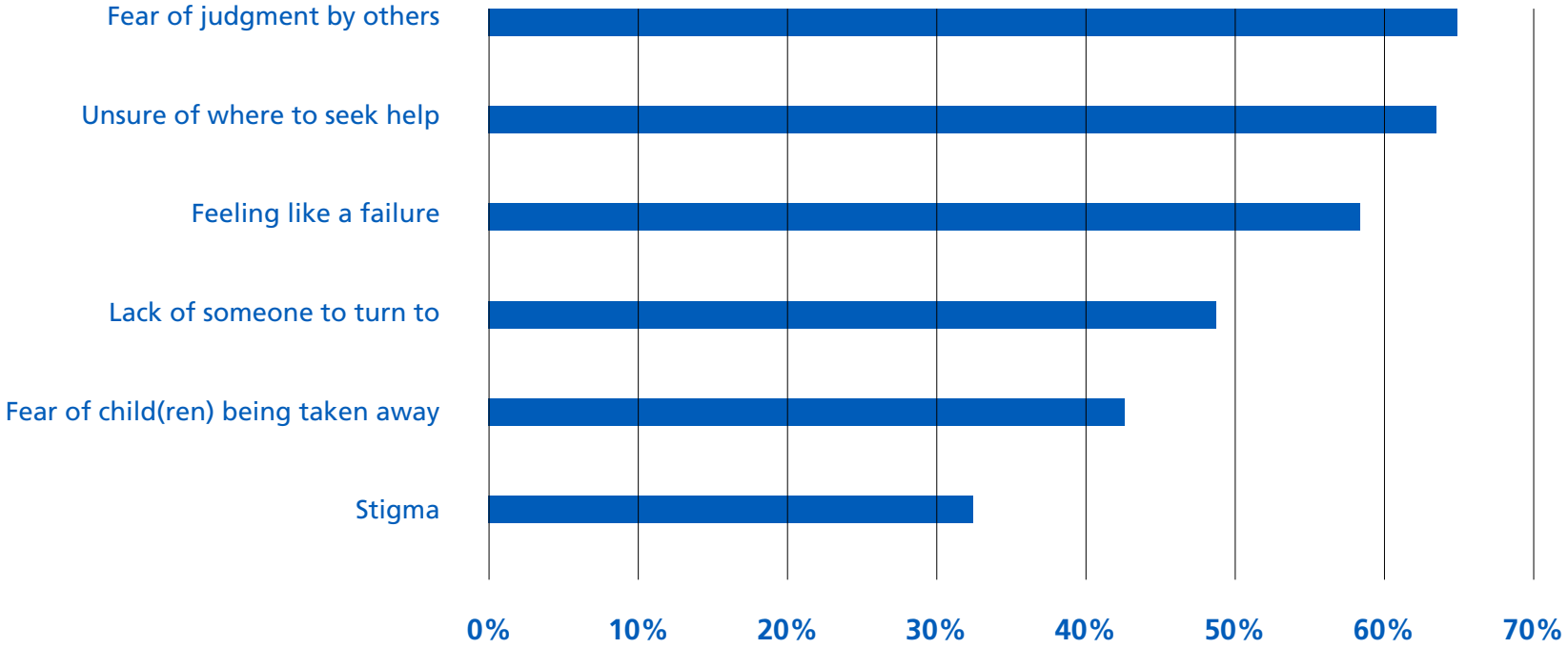


Figure 15: Parent/ carer responses to factors impacting asking for support

What sort of professional support do parents want to help them build their relationship with their baby?

- Parents wanted support which is non-judgemental and reassuring.
- Parents wanted more groups (stay and play, baby clubs).
- Parents wanted these groups to be free or low cost, easily accessible, and widely available in different community venues.
- Parents wanted culturally appropriate support, which met language needs.
- Parents valued professional support offered face to face, over the phone/on an app, and by WhatsApp.
- Parents wanted increased home visits by professionals such as health visitors and consistency of professional where possible, including proactive contact with mums before concerns start.
- Parents wanted more postnatal support.
- Parents wanted support which didn't feel like a 'tick box' activity.
- Parents valued the support of informal peer supporters and befriending.
- Parents wanted support to have a parent-led approach, avoiding a 'one size fits all' model.
- Parents wanted more information and practical advice on (in no prioritised order):
    - how to play with baby
    - how to communicate with baby
    - feeding and nutrition
    - parenting support
    - antenatally for difficulties you may face once baby arrives
    - emotional and mental health support

"I don't know of any groups that just validate that you're enough, you're doing your best, loving your baby is enough."

Parent speaking about what sort of professional support they would like

Recommendations

The information gathered across the four workstreams has informed 38 recommendations across nine areas. Whilst these recommendations concern provision in Birmingham, under the governance of the IMHSG which reports to the LMNS PNMH Programme Board, our work has been undertaken in partnership with Solihull and we retain a strong commitment to working with partners across the ICS footprint footprint. The recommendations refer to both local operational provision and higher level strategic planning and commissioning; the higher level recommendations are likely to be relevant across the ICS footprint.

To support governance and delivery of the recommendations below we suggest the creation of two subgroups within BSOL IMHSG to lead on two distinct but related workstreams:

- **IMHSG service development subgroup leading on the IMHSG service liaison and development workstream**
- **IMHSG workforce development subgroup leading on the IMHSG workforce learning and development workstream**

We refer to these subgroups in the recommendations below whilst acknowledging they are a proposal to strengthen the role of the steering group.

Recommendations 1a-c: Improving the connectedness and inter-agency knowledge of current services supporting the parent-infant relationship across Birmingham

Recommendation	Who is the recommendation for	How can the recommendation be achieved	Next steps
a. Share summary report with all stakeholders and create opportunity for shared discussion around parent-infant relationship inter-agency collaboration.	Forward Thinking Birmingham, IMHSG	Dissemination via a virtual stakeholder events(s) and electronic report distribution by email. IMHSG to support promotion of findings and ongoing collaboration.	Forward Thinking Birmingham to agree and share date for initial stakeholder dissemination event and coordinate email distribution.
b. Create a digital directory/ interactive map of services that support the parent-infant relationship across Birmingham for professionals. This to include information about referral pathways and acceptance criteria. To explore creating a parallel resource for parents.	IMHSG with BWC technical support	IMHSG to hold ownership of content and ensure this remains comprehensive and contemporary. BWC to provide technical support around creation of digital resource.	IMHSG service development subgroup to oversee use of current information to create initial digital resource for professionals and agree a plan and timescale for review.
c. Create opportunities to share service knowledge and good practice through regular inter-agency collaborations. To consider a digital offer to support information sharing.	IMHSG	IMHSG to create a timetable of virtual events that offer maximum accessibility for all potential attendees, e.g. 'coffee mornings' and 'lunch bites' where services offer a brief presentation on their offer and highlight areas of good practice. Areas of good practice to include reaching marginalised or typically excluded groups including children with SEND (see 2b). The possibility of a digital offer to support information sharing to be explored.	IMHSG workforce development subgroup to develop an initial programme of virtual events to gauge interest and begin process of co-production.

Recommendations 2a-e: Improving access to current services (supporting Right Help Right Time)

Recommendation	Who is the recommendation for	How can the recommendation be achieved	Next steps
a. Invite relevant services to complete a self-audit to ensure that referral criteria and processes don't inadvertently exclude Under 2s, and that all opportunity to reach Under 2s is being taken.	IMHSG, local services	IMHSG to support relevant services to complete a self-audit regarding referral criteria and processes and possible barriers to Under 2s achieving access. Offer advice/consultation where needed if/where barriers are identified.	IMHSG service development subgroup to create a simple self-audit tool to be used by local services.
b. Develop and promote more culturally sensitive services, and services that meet the specific needs of marginalised or typically excluded groups.	Commissioners and local services	Commissioners to support strengthened provision across Birmingham through commissioning decisions. Local services to learn from and model existing good practice (see 1c) and pilot new initiatives, to meet the specific needs of marginalised or typically excluded groups including fathers and co-parents, parents with a learning disability, and children with SEND.	Develop initial opportunities to learn about good practice (see 1c) and ensure this recommendation is kept in mind during Start for Life planning.
c. Consider opportunities to offer parenting groups for parents with similar parenting experiences together, to facilitate engagement and a more positive collective learning experience from being with 'people like me'.	Local services and collaborations	Local services to look for, and pilot, opportunities to support marginalised groups, by developing shared learning experiences, e.g. care experienced parents, parents whose babies have required neonatal care, parents who have lost a child to adoption, parents of children with SEND etc. To share learning and good practice from this work as part of wider inter-agency communication and learning (see 1c).	Forward Thinking Birmingham and Breaking the Cycle to share experience of running parenting group for Breaking the Cycle parents (see 1c).

Recommendation	Who is the recommendation for	How can the recommendation be achieved	Next steps
d. Identify community-based services and referral routes as an integral part of the care pathway for families to support engagement and reduce stigma.	Commissioners and local services	Local services to look for opportunities to use community and family support workers with existing relationships with families to support access to statutory/mental health professionals/services. Commissioners and services to consider models of care that support engagement by explicitly addressing the stigma of accessing specialist parent-infant relationship support.	IMHSG workforce development subgroup to create a simple self-audit tool to be used by local services to explore referral routes into services. IMHSG service development subgroup to talk with Solihull about their experience of delivering the Empowering Parents Empowering Communities (EPEC) model and share feedback.
e. Increase free of charge offers at local community venues that families can access more easily.	Commissioners and local services	Local services to identify easily accessible community venues suitable for using with parents and babies. Commissioners and services to explore prioritising free of charge services.	IMHSG service development subgroup to create a simple self-audit tool to be used by local services re. current community venue options. This recommendation to be kept in mind during Start for Life planning.

Recommendations 3a-c: Co-ordinating first 1001 days provision to create a parent-infant relationships system

Recommendation	Who is the recommendation for	How can the recommendation be achieved	Next steps
a. Ensure that a focus on the importance of the parent-infant relationship is embedded in transformation planning and efforts to achieve current strategic aims and priorities across areas and agencies.	Commissioners and local services	Use current report to support discussion around service planning and delivery to support the long-term wellbeing of individuals and families across the city. Ensure that senior service managers and commissioners are aware of the work, and the potential for parent-infant relationship work to support objectives across the lifespan.	IMHSG members to promote current report via existing touchpoints to ensure key leads are aware of this across agencies and organisations.
b. Create a parent-infant relationships system, with a shared statement of purpose and shared models and key resources, which can support integrated working and delivery of a coherent, accessible offer to parents and families.	IMHSG and local services	IMHSG to co-ordinate an infrastructure to support joined up working and communication across all local services working during the first 1001 days. This infrastructure to support the co-production of a statement of purpose and agreement around shared models and key resources, and a process for review to ensure these remain relevant and reflect the latest evidence on infant mental health and the parent-infant relationship.	IMHSG service development subgroup to identify process for co-production of a statement of purpose and shared models and key resources.
c. Pursue opportunities to align record keeping systems and processes across services to support joined up working to strengthen safeguarding and care for families.	Commissioners and local services	Understand, support and develop existing plans to align record keeping systems and ensure these are fit for purpose for work with families during the first 1001 days.	IMHSG to seek understanding about existing plans to align record keeping systems and understand implications and opportunities for first 1001 days' services.

Recommendations 4a-c: Training the workforce

Recommendation	Who is the recommendation for	How can the recommendation be achieved	Next steps
a. Create a multi-agency workforce training and development plan for those working to support the parent-infant relationship across the city.	IMHSG and local services	Under the guidance and co-ordination of the IMHSG and through a process of service co-production, individual services to map workforce competencies against the IMHCF and use this information to create personalised CPD plans. Services to identify workforce needs for supervision, consultation, and reflective practice to support good practice and ensure that training undertaken is consolidated and embedded in practice.	IMHSG workforce development subgroup to identify a plan for co-producing a multi-agency workforce training and development plan.
b. Ensure that the multi-agency workforce training and development plan supports work with marginalised groups, and encourages staff across services to maintain high levels of relevant training and CPD.	IMHSG and local services	Ensure that the multi-agency workforce training and development plan includes thinking about the skills and knowledge needed to support work with black, Asian and minority ethnic communities, fathers and co-partners, and LGBTQI+ parents. The plan to also highlight opportunities for practitioners, managers, commissioners, and system leaders to access free and low-cost online training opportunities; a directory of these is available on the Parent-Infant Foundation website.	IMHSG workforce development subgroup to gather information about current skills and knowledge regarding supporting marginalised groups, and to disseminate information about free and low-cost online training opportunities currently available.
c. Insights from the parents' consultation to inform future service provision.	Forward Thinking Birmingham, Commissioners and local services	Insights from the parents' consultation to be cascaded to all practitioners and included in workforce training.	Forward Thinking Birmingham to share summary report with all stakeholders (see 1a). Insights from the parents' consultation to be kept in mind by both IMHSG subgroups and in planning regarding Birmingham's Start for Life offer.

Recommendations 5a-f: Strengthening identification and assessment of parent-infant relationship difficulties

Recommendation	Who is the recommendation for	How can the recommendation be achieved	Next steps
a. Ensure families feel listened to regarding parent-infant relationship difficulties.	IMHSG and local services	Via the IMHSG and co-production of a parent-infant relationships system (see 3b) identify, agree, promote and support model(s) of parent-infant relationship help and support that prioritise listening to families.	IMHSG service development subgroup to ensure that the plan for co-production with providers includes identifying overarching models for the parent-infant relationships system that prioritise listening to families.
b. Strengthen workforce knowledge and skills around identifying parent-infant relationships under strain, and how to respond.	IMHSG and local services	Ensure that wherever pregnant women and babies enter any part of the help and support system in Birmingham, all staff, supervisors, and managers have a basic awareness of the importance of the parent-infant relationship and are trained to identify which parent-infant relationships might be under strain, and how to access advice or specialised consultation about what to do next.	IMHSG workforce development subgroup to ensure these training needs are integrated in the workforce plan (see 4a).
c. Strengthen cross-agency assessment and support of, and communication about, parent-infant relationships through use of shared assessment/ identification tool(s).	IMHSG and local services	Identify and support the use of shared assessment/ identification tool(s) to support the early identification of parent-infant relationship difficulties across agencies.	IMHSG service development subgroup to ensure that the plan for co-production with providers includes identifying shared assessment/ identification tools.

Recommendation	Who is the recommendation for	How can the recommendation be achieved	Next steps
d. Ensure that babies and relationships with the most significant difficulties can be appropriately assessed and supported by identifying and agreeing a shared menu of additional assessment tools.	IMHSG and local services	Identify and support the use of a shared menu of additional assessment tools that support identification of parent-infant relationship difficulties across agencies.	IMHSG service development subgroup to ensure that the plan for co-production with providers includes identifying a shared menu of additional assessment tools.
e. Ensure anyone who assesses families has training in how to identify and assess risk in parent-infant relationships and has access to specialist advice on assessment techniques and care planning.	IMHSG and local services	Ensure the workforce training and development plan includes opportunity for training and support around risk, assessment techniques and care planning for anyone who assesses families as part of their job.	IMHSG workforce development subgroup to ensure these training needs are integrated in the workforce plan (see 4a). To identify all Birmingham staff who assess families as part of their job.
f. Agree a sensitive and appropriate method of directly asking all parents/caregivers about their relationship with their baby at all universal contacts, and a model for recording and process for responding to answers given.	IMHSG and local services	Identify suitable questions to ask about the parent-infant relationship at universal contacts. Ensure these are acceptable to all service providers and complement existing enquiries. Ensure staff know how to record and respond to potential range of answers given.	Establish this on the agenda for the IMHSG service development workstream. Initially identify existing questions that will sit alongside and best approach to developing new questions. Review existing recording and response process for aligned questions.

Recommendations 6a-e: Developing universal services

Recommendation	Who is the recommendation for	How can the recommendation be achieved	Next steps
a. Ensure every effort is made to deliver routine health visiting provision across Birmingham.	Commissioners and Birmingham Forward Steps (Health Visitors)	The health visiting service to continue with efforts to increase workforce and offer mandatory visits so that routine health visiting provision is available to all.	Ensure that insights from the parents' consultation regarding the health visiting service are shared with Birmingham Forward Steps leads for health visiting.
b. Ensure at least one specialist health visitor per district with enhanced parent-infant relationship training and skills, so that they can offer consultation and support to colleagues.	Birmingham Forward Steps health visitors and IMHSG	Review current parent-infant relationship specialist health visitor provision and explore opportunity to fill any gaps.	Ensure that parent-infant relationship specialist health visitor provision is explored as part of planning for the IMHCF informed service self-audit led by the IMHSG workforce development workstream (see 3a).
c. Ensure that the parent-facing materials of all universal, targeted, and statutory/specialist services are consistent and reflect the latest evidence on the importance of infant mental health and the parent-infant relationship.	IMHSG and local services	Review current parent-facing materials of all universal, targeted, and statutory/specialist services to identify any inconsistencies/older material and improve as needed.	Ensure that this work is part of the IMHSG service development workstream. Collate all current parent-facing materials of all universal, targeted, and statutory/specialist services.

Recommendation	Who is the recommendation for	How can the recommendation be achieved	Next steps
d. Invite all families to access psycho-educational support that enhances their understanding of the importance of the parent-infant relationship.	IMHSG and local services	Ensure that all services and practitioners are aware of, and familiar with, the psycho-educational support on offer in Birmingham (e.g the range of Solihull Approach courses including Understanding pregnancy, labour, birth, and your baby (available in a range of languages) and Understanding your Baby that can be accessed via the Birmingham multi-use licence). Identify all opportunities for services and practitioners to meaningfully promote this support.	IMHSG service development workstream to initially identify current psycho-educational support on offer in Birmingham, service/staff familiarity with these, and existing communication/ promotion.
e. Explore ways of developing peer support opportunities that support the parent-infant relationship and are easily accessible to pregnant/new parents.	IMHSG and local services	Identify existing peer support for the parent-infant relationship and areas of good practice. Identify gaps and opportunities for developing new support and develop these opportunities.	IMHSG service development subgroup to identify current peer support for the parent-infant relationship and areas of good practice.

Recommendations 7a-f: Specific to Forward Thinking Birmingham (current provision)

Recommendation	Who is the recommendation for	How can the recommendation be achieved	Next steps
a. Improve FTB's Under 2s referral pathway as part of wider 0-25 system transformation.	Forward Thinking Birmingham	Pilot a strengthened triage process for Under 2s referrals and address any issues that arise. Explore opportunities for improving communication about the pathway as part of wider service communication (see 1b).	Share this report across Forward Thinking Birmingham. Reach agreement with the FTB Referral Management Centre regarding the pilot process for strengthening triaging of Under 2s referrals.
b. Work with key specialist teams/ pathways in FTB to develop an internal training programme to increase specialist knowledge around supporting the parent-infant relationship across the core teams, and within wider specialist pathways.	Forward Thinking Birmingham and IMHSG	Use the IMHCF to describe level of current infant mental health knowledge and skills across wider FTB service and identify gaps and workforce development needs. Work with FTB managers to agree workforce development plan to address these gaps and needs; this to be aligned with wider service plans around strengthening support for parents.	Linking in with the IMHSG workforce development subgroup, FTB to coordinate workforce self-audit based on the IMHCF.
c. Align and integrate Under 2s provision with (a) wider FTB provision, to avoid a 'cliff edge' at age two, and (b) planning to strengthen FTB support for parents of children across the age range.	Forward Thinking Birmingham	Work across wider FTB collaborations to develop FTB parent-infant/child relationship support and ensure that Under 2s support integrates with the wider service offer.	Continue liaison within FTB around service planning and integration, and establish regular collaboration with the local authority's parenting lead to ensure joined up planning.

Recommendation	Who is the recommendation for	How can the recommendation be achieved	Next steps
d. Whilst dedicated resource remains small, focus on service development, consultation, training, and support, alongside clinical work that offers specialised support to the most vulnerable parent-infant relationships.	Forward Thinking Birmingham and individual services	Work with partners across the city to identify the most vulnerable parent-infant relationships, and identify opportunities to pilot proof-of-concept work to support these relationships, and the staff currently working with these families. Build business case for resource to meet unmet need, and offer consultation, training and support where needed (see 4a).	Work with wider specialist services to build on existing proof-of-concept opportunities with the Children in Care Perinatal Pathway and Breaking the Cycle to develop/extend support to most in need families.
e. Explore how specialised parent-infant work in FTB in the Under 2s pathways can be supported by dedicated parental trauma therapy capacity, to allow parent-infant work to proceed with minimum waiting time for parents who need their own trauma treatment.	Forward Thinking Birmingham	Identify any current parental trauma therapy support offered in FTB and areas of good practice within and outside FTB. Work with colleagues and managers to explore opportunity to develop provision as part of Under 2s pathway.	Identify current parental trauma therapy support offered in FTB and areas of good practice within and outside FTB.
f. Explore the relevance of EPEC (Empowering Parents Empowering Communities) to address need in Birmingham and implications for FTB Under 2s support.	Forward Thinking Birmingham, BSMHFT PNMH Service, Birmingham City Council, IMHSG	BSMHFT Perinatal Mental Health Service and the IMHSG to explore the relevance of the EPEC model for future parent-infant mental health support in Birmingham (see 2d).	Mental health services to meet with Solihull parenting staff to discuss their experience of delivering EPEC in the borough.

Recommendations 8a-e: Forward Thinking Birmingham and wider services/ commissioners: creating specialised parent-infant relationship support

Forward Thinking Birmingham are commissioned to provide secondary mental health care for all infants, children and young people aged 0-25 in Birmingham. Working in partnership with the BSMHFT PNMH Service, this makes Forward Thinking Birmingham best placed to offer specialised parent-infant relationship support that can reach all children 0-2, irrespective of parental mental health needs. For ease, this specialised work to support the Parent And Infant Relationship to be known herein as PAIR support/work.

Forward Thinking Birmingham is currently registered as an emerging team with the Parent-Infant Foundation and is benefitting from 1:1 mentoring support and links with the national network of specialised parent-infant relationship teams. The Parent-Infant Foundation are keen to continue supporting Birmingham to develop specialised PAIR provision to address the unmet need highlighted in the current work. It is worth noting that this lack of specialised parent-infant provision is not unique to Birmingham and exists in many areas of the UK. It is responded to in the vision of the Government 2021 Start for Life offer and the commitment of the 2021 Budget and Spending Review.

Birmingham local authority has recently been pre-selected as eligible for Start for Life funding.

Recommendation	Who is the recommendation for	How can the recommendation be achieved	Next steps
a. Ensure that local development plans for PAIR support are informed by good practice, embedded in wider provision, and co-produced with parents.	Forward Thinking Birmingham, Commissioners and IMHSG	Ensure that any local developments in PAIR support are: • Embedded within a whole system, trauma-informed approach. • Closely integrated with local plans and national guidance, including for perinatal mental health teams to support the parent-infant relationship. • Designed to reduce as far as possible parents' fears about reaching out for support about the parent-infant relationship. • Co-created with parents and the VCS.	Forward Thinking Birmingham, BCT and BCC to continue inter-agency conversations regarding Birmingham's Start for Life offer and opportunity to strengthen and develop specialised PAIR (infant mental health) provision in Birmingham.
b. Identify future funding to develop specialised PAIR provision to address unmet need in Birmingham. This funding to include a budget for specialist therapeutic skills training.	Forward Thinking Birmingham, IMHSG and Commissioners	Business case and service planning to build on the current work, and to be informed by the Parent-Infant Foundation Development and Implementation Toolkit and 1:1 Parent-Infant Foundation mentoring support. Potential sources of funding to be explored include Birmingham Start for Life funding and the ICP Fairer Futures Fund. Planning to include a unified training programme for all parent-infant specialist therapists which will fast-track development of good-quality practice under a clinical lead.	Forward Thinking Birmingham, BCT and BCC to continue initial inter-agency conversations regarding Birmingham's Start for Life offer and opportunity to extend specialised PAIR provision in Birmingham to meet unmet need.
c. Articulate the case for long-term stable increases in baseline funding for future PAIR provision to provide stability to local services.	IMHSG and Commissioners	Address the challenges involved in short-term project based funding and the reported instability in Birmingham family support services over recent years, by articulating the need for PAIR provision to be resourced by long-term stable increases in baseline funding.	Forward Thinking Birmingham, BCT and BCC to continue inter-agency discussions regarding Birmingham's Start for Life offer and opportunity to develop specialised PAIR provision in Birmingham.

Recommendation	Who is the recommendation for	How can the recommendation be achieved	Next steps
d. Planning for PAIR provision to be informed by good practice and learning from the Parent-Infant Foundation Development and Implementation Toolkit and embedded in the wider ecosystem of family support in Birmingham.	Forward Thinking Birmingham, IMHSG and Commissioners	PAIR provision to: • Be needs led and trauma-informed. • Be culturally sensitive and to work with fathers, co-parents, LGBTQI+ and other marginalised parents' relationships with their babies as part of service design and delivery. • Be accessible and inclusive, offering support in the context of established community links and trusted relationships to support family engagement and reduce stigma. • Support partnership working and close links with wider services supporting complex social and emotional need focus on building capacity and connection across the system. • Align referral and recording processes with partner services as far as possible. • Offer multi-disciplinary, evidence-based care that reflects and supports identified local and national good practice. • Support Right Help Right Time by offering general advice, training, practice embedding, joint-working and consultation across lower levels of need as well as specialist assessment and intervention to meet complex/significant needs for more vulnerable families with higher levels of risk. • Be locality based and ensure that services can be tailored to the needs of the local population.	IMHSG service development subgroup to become familiar with the Parent-Infant Foundation Development and Implementation Toolkit and begin process of applying learning in the Birmingham context.

Recommendation	Who is the recommendation for	How can the recommendation be achieved	Next steps
e. Due to scale of developing PAIR specialist provision across Birmingham, identify initial areas for pilot projects/proof-of-concept work based on geography and 'most in need'.	Forward Thinking Birmingham, IMHSG and Commissioners	Consider levels of need, and opportunity to build on existing partnership working to identify suitable areas for pilot projects/proof-of-concept work, e.g. Pathfinder Roots Project in Northfield District; Children in Care Perinatal Pathway support via CCG; Breaking the Cycle pre-birth pilot project.	IMHSG service development subgroup to build on early planning, pilot, and proof-of-concept work being undertaken within the Under 2s pathway in Forward Thinking Birmingham to identify areas for future development.

Recommendations 9a-b: Raising public awareness of the importance of the parent-infant relationship

Recommendation	Who is the recommendation for	How can the recommendation be achieved	Next steps
a. Once service capacity has been strengthened at all levels of the care response, work with parents to co-produce a city-wide public awareness campaign to normalise attention and focus on the parent-infant relationship. This to complement UK government Start for Life public awareness raising.	IMHSG, VCS, local services	The campaign should communicate key messages about what help parents can access to support their parent-infant relationship. Messages should be reassuring, non-judgemental and culturally appropriate and should be shared in all antenatal and postnatal settings.	IMHSG to identify key routes for parent participation including VCS organisations to ensure representation from all parent voices in Birmingham. To keep in mind the risk of consultation fatigue.
b. All communications, internal and external, about the parent-infant relationship should seek to destigmatise difficulties and celebrate the strength in reaching out for support.	IMHSG, VCS, local services	Local services to be encouraged to audit and reassess all communications to parents, including digital and social media messaging.	IMHSG service development subgroup to lead on supporting services on current communication strategies, including providing guidance on use of language and terminology for the parent-infant relationship

Final thoughts

Supporting the parent-infant relationship is not just about supporting babies and their families. It is about nurturing all our futures by investing in the long-term physical, mental and economic well-being of the babies who will become the children, the young adults, and the parents, of the next generation.

Early exposure to healthy and positive environments and experiences can support the building of healthy brain architecture. Parent-infant relationships are one of the critical elements of early development and influence many different skills, behaviours, and capacities. Supporting parent-infant relationships and building healthy brain architecture is an investment in inter-generational physical, mental and economic wellbeing at both a personal and population level.

The current Government is committed to transforming Start for Life and Family Hub services in 75 upper-tier local authorities across England by funding a network of services including parenting programmes and parent infant mental health support. With Birmingham pre-selected as eligible for Start for Life funding there has arguably never been a better time to be considering the opportunities to strengthen parent-infant relationship support for families across the city. Doing so has the long-term potential to deliver tangible outcomes across multiple service areas and strategic priorities across agencies and partnerships and across the lifespan in Birmingham.

By keeping young minds in mind we are nurturing all our futures.

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